SUMMARY PLAN DESCRIPTION

ASBESTOS WORKERS LOCAL No. 42 WELFARE FUND

Revised Effective January 1, 2016

Grandfathered Plan

The Asbestos Workers Local No. 42 Welfare Fund believes this plan is a ñgrandfathered health planò under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Asbestos Workers Local No. 42 Welfare Fund may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at 1-888-490-8800. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

ASBESTOS WORKERS UNION LOCAL No. 42 WELFARE FUND

7130 Columbia Gateway Drive, Suite A
Columbia, MD21046
Telephone: (888) 490-8800

To All Participants:

We are pleased to present you with this new booklet which incorporates all changes and improvements to the Plan as of January 1, 2016.

The Fund provides four plans of benefits: Healthcare, Life Insurance and Accidental Death and Dismemberment, Scholarship, and Vacation benefits. Each plan of benefits has its own rules pertaining to eligibility, the scope of benefits provided and other terms and contributions governing such benefits. Most of the benefits provided by the Fund are paid out of Plan assets which have been allocated for those benefits. The exceptions are life insurance and accidental death and dismemberment benefits which are insured benefits for which the Fund pays a premium.

The Board of Trustees consists of Trustees designated by the Employers and Trustees designated by the Local Union who have equal voting authority and who jointly administer the Fund. We in turn employ the services of a Contract Administrator to carry out the day to day functions pursuant to our instructions. The Contract Administrator is Carday Associates, Inc. located at the above address. Trustees meetings are held whenever the Trustees deem it necessary but at least once each quarter.

The Trustees have the full and exclusive authority and discretion to determine pursuant to the rules of the Plan all questions of coverage, eligibility, and the entitlement to benefits, the methods of providing or arranging for benefits, and other related matters.

Each Employer who contributes to the Fund makes a monthly report on forms provided by the Fund. Each Trustee is provided monthly with a report of the activities of the Fund.

This booklet has been organized into four sections: General Provisions and Information, Healthcare, Life Insurance and Related Benefits, Scholarship Benefits and Vacation Benefits. Please read this booklet carefully and keep it in a safe place for future reference. If you have any questions or desire assistance at any time, please feel free to contact the Fund Administrator.

Very truly yours,

THE BOARD OF TRUSTEES

☙…DIRECTORY…❧

ADMINISTRATOR

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

(410) 872-9500 ï Membership Services
(410) 872-1275 ï Fax
(888) 490-8800 ï Toll Free Membership Services

www.cardayassociates.com

PRESCRIPTION DRUG PROVIDER

EnvisionRx
Address for Mail Order Pharmacy
Orchard
PO Box 3094
Canton, OH 44799-2043
www.orchardrx.com

Address to Submit Paper Claims:
EnvisionRx DMR Department
2181 E Aurora Rd, Ste 201
Twinsburg, OH 44087
(800) 361-4542 Help Desk
www.envisionrx.com

PREFERRED PROVIDER ORGANIZATION

CIGNA Healthcare Network
P.O. Box 188004
Chattanooga, TN 37422
(800) 768-4695 ï Member Services

www.cignasharedadministration.com

LIFE BENEFITS and ACCIDENTAL DEATH AND DISMEMBERMENT

The Hartford
31 St. James Avenue, 5th Floor
Boston, MA 02116
Policy No: 872400
Please contact the Administrator

PHYSICAL EXAMS AND RESPIRATOR QUALIFICATION SCREENINGS

Omega Medical Center
15 Omega Drive, Building K
Newark, DE 19713
(302) 368-5100

www.omegamedicalcenter.com

☙…TABLE OF CONTENTS…❧

I. GENERAL PROVISIONS AND INFORMATION

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

Summary Plan Description

A. Asbestos Workers Union Local No. 42 Welfare Fund

B. This Plan is maintained by the:

Joint Board of Trustees
Asbestos Workers Union Local No. 42 Welfare Fund
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
Telephone: (888) 490-8800

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 52-6079218.

D. This Welfare Plan is a group health and disability plan which provides coverage for hospitalization, physician's care, disability income, life benefits, dental care, vision care and prescription benefits. It also provides scholarship and vacation benefits.

E. The day to day administration of the Plan is carried out by a contract Administrator, Carday Associates, Inc.

F. The Plan Administrator is:

Board of Trustees
Asbestos Workers Union Local No. 42 Welfare Fund
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046

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

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

H. The name, title and address of the principal place of business of each Trustee of the Plan follows:

UNION TRUSTEES	**EMPLOYER TRUSTEES**
Preston ñJeffò Smith, III Asbestos Workers Local 42 1188 River Road New Castle, DE 19720	Eric Dudzinski Advanced Specialty Contractors Route I 95 Industrial Park 30 MacDonald Blvd. Aston, PA 19014
Kevin F. Galbraith Asbestos Workers Local 42 1188 River Road New Castle, DE 19720	John Dillon Patriot Insulation Contractors 316 Wooddale Avenue New Castle, DE 19720
Philip S. Mitchener Asbestos Workers Local 42 1188 River Road New Castle, DE 19720	John Kline Delaware Insulation & Firestopping, Inc. 427 Lovers Lane Bear, DE 19701
Nick Smith Asbestos Workers Local 42 1188 River Road New Castle, DE 19720	Robert Zimny Advanced Specialty Contractors Route I 95 Industrial Park 30 MacDonald Blvd. Aston, PA 19014
	Gary Fedor (Alternate Trustee) Brand Energy & Infrastructure Svcs. 740 Veterans Drive Swedesboro, NJ 08085

I. The Plan is maintained pursuant to one or more collective bargaining agreements and a copy of any such agreement may be obtained by participants and beneficiaries upon written request to the Plan Administrator.

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

The above described materials are available for examination by participants and beneficiaries at all times at the principal office of the Plan Administrator, and within 10 calendar days after written request to the Plan Administrator at the principal office of the employee organization, International Association of Heat and Frost Insulators and Allied

Workers Local No. 42, 1188 River Road, New Castle, Delaware 19720 and at each employer establishment at which at least 50 participants covered under the Plan are customarily working.

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

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

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

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

M. The Plan is financed by contributions to the Trust and any income earned from investment of contributions. All monies are used exclusively for providing benefits to eligible employees or their Dependents, and the paying of all expenses incurred with respect to the operation of the Plan. Plan assets are held by TD Bank, 7330 Lancaster Pike, Hockessin, DE 19707.

Life Benefits not paid directly from the Plan are provided by an insurance company contracted by the Fund. Such benefits are currently provided by The Hartford.

The Fund has entered into contracts with EnvisionRx for prescription benefits and with CIGNA Healthcare Network for Preferred Provider Organization (PPO) services.

N. The Plan's annual year end date is: June 30.

EXPLANATION OF ELIGIBILITY

All active employees within the jurisdiction of Local 42 employed by participating employers who are subject to the Agreement and Declaration of Trust, or collective bargaining agreement of Local Union No. 42 will be eligible for benefits based on the following rules.

The calendar year is divided into four (4) periods of Qualifying, or employment quarters and four (4) periods of eligibility, or insured, quarters as follows:

Qualifying Period	Eligibility Period
Monday before last Wednesday of December through Sunday before last Wednesday of March	June-July-August
Monday before last Wednesday of March through Sunday before last Wednesday of June	September-October-November
Monday before last Wednesday of June through Sunday before last Wednesday of September	December-January-February
Monday before last Wednesday of September through Sunday before last Wednesday of December	March-April-May

Initial Eligibility

An employee shall be required to be employed for one Qualifying Period and have at least 300 hours of employment during this period before becoming eligible for benefits in the Eligibility Period following the Qualifying Period set forth above.

Continuation of Eligibility

An employee shall be covered each "Eligibility Period" provided that he is employed for at least 300 hours or more in the applicable "Qualifying Period".

In the event an employee is employed less than 300 hours in a "Qualifying Period", if he has enough hours in his Hour Bank to transfer to his "employment account" and bring his "employment account" to 300 hours he shall continue to be eligible during the applicable "Eligibility Period".

Hour Bank

There will be established for each employee an Hour Bank. Each employee who has worked in excess of 300 hours for a participating employer and or employers during a qualifying period will have 50% of those hours in excess of 300 hours credited to his Hour Bank. The maximum that can be credited to any employee's Hour Bank is 600 hours.

When an employee is employed less than 300 hours during a ñQualifying Periodò, up to 300 hours will be transferred from the employee's Hour Bank to continue his eligibility, provided there is a sufficient balance in the Hour Bank.

If at any time the balance in the ñHour Bankò is called upon and there are insufficient hours available in the ñHour Bankò to continue eligibility, the Hour Bank will be continued for one year following the end of the eligibility period during which time there is no work activity. Notwithstanding anything herein to the contrary, an employee may not draw upon banked hours to maintain eligibility if the employee has been employed by an employer in the asbestos or insulation industry who is not a Participating Employer under a collective bargaining agreement which requires contributions to this Fund either during the ñqualifying periodò or during any ñeligibility periodò. The use of the Hour Bank shall be suspended under such circumstances for the entire quarter without regard to the length of time that the employee was employed by a non-participating employer during the quarter. Retirees cannot maintain active coverage through the Hour Bank.

Use of the Hour Bank shall also be terminated and Banked Hours reduced to zero for any employee who withdraws from employment in the asbestos or insulation industry under a collective bargaining agreement requiring contributions to this Fund and who is unavailable or ineligible for referral to work under the terms of a collective bargaining agreement with a Participating Employer. The use of the Hour Bank shall be terminated under such circumstances commencing with the qualifying or eligibility period in which the employee withdraws from employment and is unavailable or ineligible for referral to work.

Rescissions

Coverage cannot be retroactively cancelled unless you failed to make required payments towards the cost of coverage or you committed fraud or intentionally misrepresented material facts to the Plan.

Termination of Eligibility

Any employee who fails to work at least 300 hours in a "Qualifying Period", and does not have sufficient hours in his Hour Bank to transfer to his "employment account" to equal 300 hours, shall cease to be eligible for the applicable "Eligibility Period".

Once an employee ceases to be eligible, he will remain ineligible until he has once again satisfied the requirements as defined in "Initial Eligibility".

The following may result in disqualification for, ineligibility or denial of, loss of, or forfeiture or suspension of benefits under the Plan because of:

A. Failure to satisfy eligibility requirements because of:

    1. insufficient employment under jurisdiction of the Plan
    2. being disabled for periods of time prior to or following periods during which credit is available

B. Non-covered employment.

C. Failure to file required forms in support of a claim.

D. Failure to file claims within the time limit specified in the Plan.

E. Loss of eligibility as a result of employment with a non-participating employer - a participantôs eligibility for benefits shall be suspended if the participant is employed by an employer in the asbestos and insulation industry who is not a participating employer under a collective bargaining agreement which requires the payment of contributions to the Fund. In such event, the suspension of the participantôs eligibility shall be effective upon the first day of employment with such a non-participating employer. Such suspension shall continue until the termination of the disqualified employment and the re-establishment of eligibility utilizing either the Hour Bank or by working the required hours under the rules pertaining to initial eligibility.

F. An employee who withdraws from employment in the asbestos or insulation industry under a collective bargaining agreement requiring contributions to this Fund and who is unavailable or ineligible for referral to work under the terms of a collective bargaining agreement with a Participating Employer shall have his eligibility for benefits terminated as of the first date on which the employee has withdrawn from employment and is no longer available or eligible for referral to work with a Participating Employer. Such employees will be required to meet the initial eligibility requirements upon return to covered employment.

Termination of Eligibility Upon Change in Home Local

When a participant in the Fund decides to permanently transfer from Local 42 to another Local Union of the International Association of Heat and Frost Insulators and Allied Workers and therefore becomes an employee within the jurisdiction of the other Local Unionôs Health & Welfare Fund, the participant will continue to be eligible in the Fund until the earlier of the following occurrences:

1. The participant becomes eligible for benefits under the terms of the Health and Welfare Fund of the other Local Union or

2. The later of either the exhaustion of the participantôs Hour Bank in this fund or the end of the current eligibility period for which the participant had previously qualified.

When Your Eligibility Commences

You will be covered on the date you become eligible according to the eligibility rules previously stated.

Each of your eligible Dependents will be covered on the date you become eligible or the date he becomes a Dependent, whichever is later. For more information, please contact the Fundôs Administrative Agent.

SPECIAL RULES FOR ELIGIBILITY FOR MEDICAL BENEFITS FOR EMPLOYEES IN NEWLY ORGANIZED GROUPS

Employees Who Qualify For These Special Rules

There are special eligibility rules for ñEmployees in Newly Organized Groupsò (ñNewly Organized Groupsò). Persons who may qualify for these benefits are individuals who are current employees of a newly organized company which signs a Collective Bargaining Agreement with Asbestos Workers Union Local No. 42 (ñLocal Unionò) or newly organized employees represented by the Local Union who are then employed by a contributing Employer to 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 to be used by current members of, or employees represented by, the Local Union, newly indentured apprentices of the Local Union or regular applicants for representation by the Local Union.

Before becoming a participant in the Fund, a person eligible for coverage under these Special Rules must elect, in writing, to either choose coverage under the Special Rules or under the regular Initial Eligibility Rules of the Plan. This decision, once made, cannot be changed for any reason during the period of Special Eligibility.

Period These Special Rules Apply

These Special Rules apply to persons in Newly Organized Groups for the limited period of time before a person establishes eligibility under the regular Initial Eligibility Rules of the Plan. During this limited time period, the Sections below set out the eligibility requirements for persons in Newly Organized Groups. All other provisions of this Summary Plan Description shall apply to persons in Newly Organized Groups during this limited period, except the Schedule of Benefits, which are replaced by the Schedule of Benefits set out in this Section.

After a person in a Newly Organized Group meets the regular Initial Eligibility Rules of the Plan as described in the Eligibility section of this SPD, all rules and benefits of the Plan as described in the SPD shall apply to such person(s) and these Special Rules shall no longer apply. Also, if an Employee in a Newly Organized Group loses eligibility under the special Continuing Eligibility Rules described herein, these special rules shall no longer apply.[1] Such a person can then become eligible for benefits only by meeting the regular Initial Eligibility Rules of the Plan as described in the Eligibility section of this SPD.

[1]An exception to this rule is that if a person eligible under these Special Rules is laid off because of a lack of work being available with a collective bargaining employer. In such event, the person will continue his or her eligibility uninterrupted by such period of ñlay off.ò

Initial Eligibility Under These Special Rules

If you are a person employed in a Newly Organized Group, you will become eligible for benefits[2] on the first day of the second month following the completion of at least 100 Hours worked in the required reporting month for which the Fund is due contributions. The names of the new Employees eligible under this provision must be received in the Fund Office prior to the first day of the first month of coverage.

An employee is required to have 100 Hours Worked in each Qualifying Reporting Month to be eligible for benefits in the corresponding Eligibility Calendar Month as set out below.

Qualifying Reporting Month	Eligibility Calendar Month
Monday before last Wednesday of December through Sunday before last Wednesday of January	March
Monday before last Wednesday of January through Sunday before last Wednesday of February	April
Monday before last Wednesday of February through Sunday before last Wednesday of March	May
Monday before last Wednesday of March through Sunday before last Wednesday of April	June
Monday before last Wednesday of April through Sunday before last Wednesday of May	July
Monday before last Wednesday of May through Sunday before last Wednesday of June	August
Monday before last Wednesday of June through Sunday before last Wednesday of July	September
Monday before last Wednesday of July through Sunday before last Wednesday of August	October
Monday before last Wednesday of August through Sunday before last Wednesday of September	November
Monday before last Wednesday of September through Sunday before last Wednesday of October	December
Monday before last Wednesday of October through Sunday before last Wednesday of November	January
Monday before last Wednesday of November through Sunday before last Wednesday of December	February

Reverse Hour Bank for Employees Covered by These Special Rules

Once a newly organized person attains Initial Eligibility, as described in this Special Rules section, the person will be credited with 300 Hours in an individual Reverse Hour Bank. These hours are considered a loan from the Fund for the purposes of attaining coverage under the Plan and are reflected as a negative amount in the employeeôs Hour Bank. Before the person can establish regular eligibility under the Plan, these hours must be paid back to the Fund. This is done by applying hours worked in excess of 100 per month to the amount owed in the Hour Bank. Once the 300 hours has been repaid to the Fund via the Reverse Hour Bank, AND the person has established regular eligibility under the Plan, a normal Hour Bank will be maintained for the person as described in the Hour Bank section of this SPD.

[2] Eligibility for benefits and benefits are paid based on the calendar month.

Continuing Eligibility Under These Special Rules

Once a person has earned initial eligibility, that person will remain eligible under the terms of these Special Rules as long as he/she works at least 100 hours per month. After a person has repaid the 300 hours of ñloaned hoursò and met the regular Initial Eligibility Rules of the Plan as described in this SPD, all of the rules and benefits of the Plan apply as described in the SPD and the terms of these Special Rules no longer apply.

How A Person Can Lose Eligibility Under These Special Rules

A Participant who is covered by these Special Rules, and his/her Dependents, will lose eligibility if:

- Fewer than 100 hours of Employer contributions are earned in a month.
- A person works for a non-participating employer in the insulation industry within the geographic jurisdiction of Asbestos Workers Local No. 42.
- A person who is not available for work in Covered Employment in the jurisdiction of Local 42 will terminate immediately and irrespective of whether you have any entitlement to any extended coverage under the fund because of your Hour Bank.
- A person is inducted into the Armed Forces (see below).
- There is a future Plan amendment that affects eligibility.

How to Get Your Eligibility Back Once It is Lost

If for any reason, except for being laid off, you lose your eligibility for benefits during the limited period covered by the Special Rules, you become eligible for benefits only by meeting the regular Initial Eligibility Rules of the Plan as described in the Eligibility section of this SPD.

The only exceptions are if you lose eligibility because of induction into the Armed Forces or are laid off. In the case of induction into the Armed Forces, you must 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 will regain your status in the Fund.

Continuing Eligibility if You Don't Have Enough Hours, Become Totally Disabled or For Your Dependents After Your Death

If you lose your eligibility for benefits during the limited period covered by these Special Rules for one of the reasons mentioned above, the Self-Payment Rules (COBRA) described in this SPD, under Health Plan Continuation Coverage, apply to you or your eligible dependents.

Benefits Available under These Rules

The following contains a Schedule of Benefits for which the employee and applicable dependents would be eligible for under these Special Rules. Once the employee meets the regular Initial Eligibility rules under the Plan as described in the SPD, the employee will be entitled the benefits as outlined in this SPD under ñActive Eligible Employeesò.

SCHEDULE OF BENEFITS - SPECIAL RULES FOR EMPLOYEES IN NEWLY ORGANIZED GROUPS

EMPLOYEES AND DEPENDENTS

Annual Deductible
- Per Individual ..... $ 200.00
- Per Family (3 members) ..... $ 600.00

Basic Hospital Expense Benefit - Per Confinement
Covered Expenses in Full[3] ..... $ 3,000.00

Basic Surgical Benefit (Per Surgery) ..... $ 1,500.00

Basic Medical Expense Benefit
- Maximum any one Illness or Injury ..... $ 500.00
- Percentage Paid by Fund..... 80% of the R&C[4] charge

Major Medical Benefits
- Maximum Per Individual Per Year..... Unlimited
- Percentage Paid by Fund..... 80% of the R&C charge

[3] Charge for Private Room covered only to the extent of the prevailing Semi-Private Room rate, except when confined in an Intensive Care Unit the full daily rate will be covered.

[4] R&C means Reasonable and Customary. Reasonable and Customary charges by a service provider which are reasonable and not higher than the usual or Reasonable and Customary charges rendered by similar service providers in your geographic area.

Military Service

An active employee who is eligible for benefits and who leaves covered employment for service in the Uniformed Services may elect to continue his coverage (and coverage for his eligible dependents, if any) by giving notice to the Fundôs Administrative Agent 30 days in advance of commencing the Uniformed Service. The time period for the notice will be waived where such notice is impossible, unreasonable or precluded by military necessity. The failure to give notice of Uniformed Service and to elect continuation of benefits will result in the termination of benefits as otherwise provided under the terms of the Plan. An employee who gives timely notice of Uniformed Service but does not initially elect to continue benefits shall have up to 90 days from the commencement of Uniformed Service to elect to continue benefits.

An employee who elects to continue benefits (and his eligible dependents, where applicable) has the right to extend his benefits for the shorter of 24 months from the commencement of Uniformed Service or the period from the commencement of Uniformed Service until the date the employee fails to return from the service or to apply for reemployment (usually within 90 days after the end of such Uniformed Service or as otherwise permitted under the Act). For the first 30 days of Uniformed Service, the Welfare Fund will pay the cost of continuation coverage for the employee and, where applicable, the employeeôs eligible dependents. Commencing with the 31st day of Unformed Service, the employee must pay the cost of continuation coverage in such amounts as determined by the Trustees which shall not exceed 102% of the actual premiums. The failure of the employee to pay required costs, including the cost of retroactive coverage, within 90 days after the commencement of Uniformed Service will result in the termination of eligibility as otherwise provided under the Plan. Notwithstanding anything in this paragraph to the contrary, however, in the event of a declaration of war or the existence of an armed conflict involving the United States, as determined by Congress or by the President of the United States as permitted under law, the Fund will pay the cost of continuation coverage for an employee who commences Uniformed Service, and for the employeeôs eligible dependents where applicable, where the employee has been an active eligible participant in the Welfare Plan (including the use of the hour bank) for a period of 2 two years prior to entering Uniformed Services. Such continuation coverage at the expense of the Fund shall commence upon entry of the employee into Uniformed Services and shall continue for the shorter of a period of two (2) years or until the employee returns from Uniformed Services as set forth below.

Upon conclusion of the Uniformed Service, an employee who returns to active employment within 90 days of the termination of the Uniformed Service, or within such additional time as permitted under the regulations, will again be eligible for benefits upon meeting the continuing eligibility requirements of the Plan. An employee who fails to return to active employment within the time permitted shall be required to meet the initial eligibility requirements of the Plan.

An employee who has hours in his hour bank can elect to use these hours to offset the cost of continuation coverage and/or to meet the continuing eligibility requirements upon return to employment. Any banked hours not so utilized will remain in the employeeôs hour bank consistent with the terms of the Plan.

Family and Medical Leave

If you have to take a leave of absence from your job because of the birth of a child and in order to care for such child; because of the placement of a child with you for adoption or foster care; or because you must care for your spouse, child or parent because your spouse, child or parent has a serious health condition, you may be entitled to Family and Medical Leave under the provisions of the Family and Medical Leave Act, 29 U.S.C. §§ 2601 et seq.

If you are entitled to such leave, your employer is required to continue making contributions to the Fund on your behalf for up to twelve (12) weeks. The Fund will continue to provide benefits during any period for which your employer makes contributions under the Act. Please note that you may be required to repay your employer for such contributions if you fail to return to work following the conclusion of your leave period, unless such failure is caused by the continuation, recurrence or onset of a serious health condition that would have entitled you to take leave, or by other circumstances beyond your control.

Health Plan Continuation Coverage – Consolidated Omnibus Budget Reconciliation Act ("COBRA")

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (commonly known as COBRA). COBRA continuation coverage, which is a temporary extension of coverage under the Plan, can become available to you and other members of your family when group health coverage would otherwise end. This is intended to explain COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.

You may have other options available to you when you lose group health coverage. 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 spouseôs plan), even if that plan generally doesnôt accept late enrollees.

1. What is COBRA continuation coverage? COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a ñqualifying event.ò Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a ñqualified beneficiary.ò You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

   If youôre an employee, youôll become a qualified beneficiary if you lose your coverage under the Plan because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you're the spouse of an employee covered by this Plan, you'll become a qualified beneficiary if you lose your coverage under this Plan for any of the following reasons:

a. The death of your spouse;
b. Termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
c. Divorce or legal separation from your spouse; or
d. Your spouse becoming entitled to Medicare.

Your dependent children will become qualified beneficiaries if they lose coverage under this Plan for any of the following reasons:

a. The death of a parent;
b. The termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with a participating employer;
c. Parents' divorce or legal separation;
d. A parent becoming entitled to Medicare; or
e. The dependent ceasing to be a "dependent child" under this Plan.

A child born to, or placed for adoption with, the covered employee during a period of continuation coverage also is a Qualified Beneficiary.

2. When is COBRA continuation coverage available? The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. Participating employers have the responsibility to notify the Plan Administrator of the employee's death, termination of employment or reduction in hours, or Medicare eligibility.

   For all other qualifying events (divorce or legal separation or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

3. How is COBRA continuation provided? Once the Plan Administrator is notified that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. Under the law, you have at least 60 days from the date you would lose coverage because of one of the events described above to inform the Plan Administrator that you want continuation coverage.

   COBRA continuation coverage is a temporary continuation of coverage that allows you to maintain continuation coverage for 36 months, unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

a. *Disability extension of 18-month period of COBRA continuation coverage* - If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator within 60 days of the date of disability determination and before the end of the original 18 month continuation coverage period, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18 month period of COBRA continuation coverage. If, during continued coverage, the Social Security Administration determines that the employee or family member is no longer disabled, the individual must inform the Plan Administrator of this redetermination within 30 days of the date it is made. If an employee or family member is disabled and another qualifying event (other than bankruptcy of your employer) occurs within the 29 month continuation period, then the continuation coverage period is 36 months after the termination of employment or reduction in hours.

b. *Second qualifying event extension of 18-month period of continuation coverage* ï If your family experiences another qualifying event during the 18 month of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA properly coverage if the employee or former employee dies; becomes entitled to Medicare benefits; gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a depending child. This extension is only available if the second qualifying event would have cause the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

4. Choosing Continuation Coverage. If you do not choose continuation coverage within the time period described above, your group health insurance coverage will end.

If you choose continuation coverage, the Plan is required to give you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members. This means that if the coverage for similarly situated employees or family members is modified, your coverage will be modified. (ñSimilarly situatedò refers to current employees or their dependents who have not had a qualifying event.)

Continuation coverage may be cut short. The law provides that your continuation coverage may be cut short prior to the expiration of the 18, 29, or 36 month period for any of the following five reasons:

a. Your employer no longer provides group health coverage to any of its employees through this Plan;

b. The premium for continuation coverage is not paid in a timely manner (within the applicable grace period);
c. The individual becomes covered under another group health Plan (whether or not as an employee);
d. The individual becomes entitled to Medicare;
e. Coverage has been extended for up to 29 months due to disability (see ñSpecial rules for disabilityò) and there has been a final determination that the individual is no longer disabled.

Once your continuation coverage terminates for any reason, it cannot be reinstated.

5. Payment of Premiums. An employee, spouse, or dependent child who has elected COBRA continuation coverage must pay a premium of 102% of the applicable premium for the period of coverage. The premium may be paid in monthly installments. The Fund Administrator will calculate the required premium and provide notice of it to you.

   Premiums for continuation coverage become payable 45 days after the day on which the employee, spouse, or dependent elects to obtain COBRA continuation coverage.

6. Are there other coverage options besides COBRA Continuation Coverage? Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouseôs plan) through what is called a ñspecial enrollment period.ò Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

   Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Laborôs Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSAôs website. For more information about the Marketplace, visit www.HealthCare.gov.

   In addition, information about the Plan and COBRA Continuation Coverage can be obtained upon request from the Planôs Administrative Manager, Carday Associates, Inc. 7130 Columbia Gateway Drive, Suite A, Columbia, MD 21046; Telephone: (410) 872-9500; Toll Free: (888) 490-8800. In order to protect your familyôs rights, you should keep the Administrative Manager informed of any changes in the addresses of family members. You should also keep a copy, for your records of any notices you send to the Plan Administrative Manager.

Qualified Medical Child Support Orders

A Qualified Medical Child Support Order (QMCSO) is either an order entered by the Court or a Notice issued by a state agency pursuant to the Child Support Performance and Incentives Act of 1998. The Order or Notice creates or recognizes the right of an alternate recipient ï or assigns to

the alternate recipient the right ï to receive benefits to which a participant or other beneficiary is entitled under a group health Plan. The alternate recipient is the child of the Participant for whom the Participant has support obligations under state domestic relations law. The Order or Notice cannot require the Plan to provide any type or form of benefit, or any option, not otherwise provided to Participants and eligible beneficiaries.

Upon receipt of a Medical Child Support Order, the Fund Administrator will review the Order or Notice as soon as administratively possible to determine whether it is in fact a Qualified Medical Child Support Order (QMCSO). Notice will be sent to the Participant and each alternate recipient, in writing, advising that the Order or Notice has been received. If the Order or Notice is determined to be a QMCSO, the Notice to the Participant and alternate recipients will advise that the alternate recipients have been enrolled as dependents under the Plan and will further set forth the benefits which will be provided. If it is determined that the Order or Notice does not meet the standards of a QMCSO, the Notice to the Participant and alternate recipients will set forth in detail the reasons for this determination. The determination of whether the Order or Notice is a QMCSO will be made within 30 days of receipt of the Order or Notice by the Fundôs Administrator.

It should be noted that benefits under a QMCSO will be provided only so long as the QMCSO is in effect and the Participant maintains eligibility for benefits. Benefits for the alternate recipient will terminate upon either the termination of the QMCSO or the termination of the Participantôs eligibility. In either event, a notice of COBRA continuation rights will be sent to the alternate recipient.

PENSIONER ELIGIBILITY

Retiree medical and death benefit coverage is available to retired participants and beneficiaries receiving a pension under the Asbestos Workers Union Local No. 42 Pension Fund. The terms and conditions of eligibility for retiree medical and death benefits are set forth below.

In order for the retiree medical and death benefit coverage to become effective, the retired participants and beneficiaries must elect the coverage. In order to pay for the coverage, the retired participant and beneficiary (where applicable) must assign to the Welfare Fund the full supplemental pension benefit to which the retiree or beneficiary is entitled under Asbestos Union Local 42 Pension Fund. In addition, the retired participants and beneficiaries must pay an additional premium as set forth below. The additional premium is a per covered person premium and must be paid by an automatic deduction from your monthly pension benefit pursuant to an authorization form signed by you. The execution of the deduction authorization form is a condition of receiving benefits. The required payments must commence with the month in which you desire to commence receiving medical and death benefit coverage.

In order to be eligible to receive retiree medical and death benefit coverage, retired participants and beneficiaries must fall within one of the following categories:

1. Retired participants who have 25 or more years of credited service (or less than 25 years if retirement occurred prior to July 1, 1982) and are receiving the basic benefit (180 month guaranteed) or the 50% Joint & Survivor benefit.

2. Retired participants receiving a disability pension.

3. Surviving spouses of eligible retired participants *based on spouse's age* at the time of participantôs death.

4. Surviving children of eligible retired participants up to age 26. Until July 1, 2014, however, where a child is eligible for employer-sponsored health care through his or her own employer or a spouseôs employer, the child shall not be eligible for benefits under the Plan.

5. Surviving spouses and children of non-retired participants with 25 or more years of credited service and receiving a pension from the Local 42 Pension Plan.

6. Retired participants currently participating in Medicare.

As noted on the previous page, an additional premium must be paid to obtain the coverage. This premium is based on whether the retiree or spouse is covered by Medicare and whether the retiree or spouse desires the dependent children also be covered. These current premiums are as follows and are a per person monthly premium. These premiums may be changed by the Trustees at any time.

	Premium per person covered
Adult on Medicare	$60
Adult No Medicare	$225
Each Dependent Child	$100

EXAMPLES

One Adult on Medicare	$60
Two Adults on Medicare	$120
One Adult, non-Medicare	$225
Two Adults, non-Medicare	$450
Two Adults, one Medicare, one non-Medicare	$285
Two Adults, one Medicare, one non-Medicare, Plus one Dependent Child	$385

A retiree who upon retirement elects (or who has elected) to decline retiree health coverage for the retiree or the retireeôs spouse (and eligible dependents) may subsequently elect, on a one-time basis, to ñopt inò for retiree health coverage for the retiree and, if desired, also for the retireeôs spouse and other dependents. A retiree who upon retirement elects (or who has elected) to receive retiree benefits for just the retiree and who later desires to obtain benefits for a spouse and other eligible dependents may also elect to do so on a one-time basis. Finally, a retiree who upon retirement elects (or who has elected) to obtain retiree health coverage (including spousal and dependent coverage) but who after retirement determines to drop such coverage and who

then later desires to again obtain such coverage for the retiree (including the retireeôs spouse and eligible dependents) may also elect to do so on a one-time basis.

These ñopt out/opt inò opportunities can only be exercised provided the following conditions are met:

a. The opportunity for a spouse and eligible dependents to obtain coverage is available only where the retired participant has also elected to obtain coverage. Spouses and eligible dependents cannot elect to have coverage independent of the retired participant. If the retired participant has not elected to obtain coverage, the spouse and eligible dependents may not do so independently.

b. Once having elected not to obtain health coverage under the Plan, an election can be made to obtain coverage under the Plan only if the retiree (including spouse and eligible dependents if coverage is sought for them) has been covered by other health insurance comparable to the benefits offered under the Plan for the entire period of time from the date that the retiree elected to discontinue benefits under the Plan to the effective date of the retireeôs election to obtain Plan coverage.

c. The opportunity to obtain coverage under the Plan can be exercised only where there has been a documented qualifying event that causes the participant or spouse to lose their existing coverage.

d. A retiree who elects not to obtain benefits under the Plan and who later elects to obtain Plan benefits must, as a condition to obtaining such benefits, assign his supplemental pension benefit to the Welfare Fund in partial payment of the cost of retiree coverage. The retiree must in addition pay such other premium costs to the Fund as the Trustees determine from time to time for retiree coverage.

e. The opportunity to elect coverage after having discontinued coverage (either upon retirement or thereafter) can be exercised on a one-time basis only.

The retiree medical and death benefit coverage stops on the earliest of the following to occur:

a. The date of death of the retiree or surviving beneficiary.

b. The date the retiree or surviving beneficiary elects not to have the coverage.

c. The end of the month to which the last monthly charge for the coverage applies.

d. The date the surviving spouse stops receiving a pension from the Local 42 Pension Plan because the form of benefit pays a pension for 180 months only or because monthly benefits stop upon remarriage under that form of benefit.

e. The date the surviving child stops receiving a pension from the Local 42 Pension Plan because he or she reaches age 26.

Note: The pensioner "Life Insurance" Benefit is not provided to spouse or children.

DEFINITIONS

There are certain terms are used in your Plan which have a special meaning. Some of these terms define or limit benefits or rights under the Plan so it is important that you be familiar with them:

Children

The term "children" shall mean your own natural children, step-children, your legally adopted children or children placed in the eligible participantôs home in anticipation of adoption, and any children for whom you have been legally appointed as guardian of the person regardless of the childôs marital status, financial dependency on the participant, residency with the participant, student status, or any other dependency-test.

Dependent

1. As used in the Plan, "Dependent" means your spouse and children to their 26th birth date.
2. The term "Dependent" shall not include a spouse from whom you are divorced or from whom you are legally separated. It also shall not include, in the absence of a domestic relations court order to the contrary, a spouse with whom you do not cohabitate and who has for a period of 12 months or more maintained his or her separate legal or permanent residence.

Hospital

Hospital shall mean an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an in-patient basis at the patient's expense and which fully meets all of the tests set forth in (1) or (2) or (3) below:

1. It is a Hospital accredited by the Joint Commission on Accreditation of Hospitals.
2. It is a hospital, a psychiatric hospital, or a tuberculosis hospital, as those terms are defined in Medicare, which is qualified to participate and eligible to receive payments under and in accordance with the provisions of Medicare.
3. It is an institution which fully meets all of the following tests:

    (a) It maintains on the premises diagnosis and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified physicians; and
    (b) It continuously provides on the premises 24 hour a day nursing service by or under the supervision of a staff of duly qualified physicians; and
    (c) It is operated continuously with organized facilities for operative surgery on its premises.

Medically Necessary/Medical Necessity

Medically Necessary and/or Medical Necessity shall mean care and treatment for those services, supplies and places where treatment is rendered which are: (1) appropriate for the Injury or Illness being treated and consistent with the medical conditionôs recorded diagnosis; (2) broadly accepted, at the time furnished by the organized medical community in the United States as being required in accordance with good medical practice and generally recognized professional standard; (3) approved for reimbursement by the Health Care Financing Administration; (4) Not primarily for the convenience of the patient or any provider of services; and (5) Not generally regarded as experimental, investigational or unproven.

Physician or Surgeon

ñPhysicianò or ñSurgeonò shall mean a legally qualified Physician and Surgeon (M.D. or D.O.) licensed to practice medicine in the state in which he practices. To the extent that benefits are provided and while practicing within the scope of his license, the term ñPhysicianò includes a dentist, podiatrist, chiropractor, psychiatrist or psychologist.

Reasonable & Customary Charges

Reasonable & Customary Charges shall mean charges by a service provider which are reasonable and not higher than the usual or Reasonable and Customary charges rendered by similar service providers in your geographic area.

Skilled Nursing Facility

Skilled Nursing Facility shall mean a facility that provides additional short-term care necessary due to Hospital confinement as follows:

1. It is a facility approved by Medicare;
2. confinement must be directly from a Hospital confinement or within a reasonable time thereafter;
3. charges will be payable at semi-private room rate;
4. maximum care is 30 days;
5. expenses will be covered only for those which are proven to be medically necessary;
6. treatment for drug and alcohol related conditions are not covered.
7. Excluded from payment are charges in a Skilled Nursing Facility, unless such confinement:
   (a) starts within 14 days after the insured individual has been confined for at least three days in a Hospital for which room and board charges were paid;
   (b) is for treatment of the illness causing the Hospital confinement;
   (c) is one during which a doctor visits the insured individual at least once every 30 days;
   (d) is not routine custodial-type care.

SCHEDULE OF BENEFITS
ACTIVE ELIGIBLE EMPLOYEES

Employee Coverage Only

Life Insurance	
(Not applicable to spouse or dependent)	$ 30,000.00
Accidental Death and Dismemberment	$ 30,000.00
Weekly Accident and Sickness	$ 300.00
Maximum	26 weeks

Employee and Dependent Coverage

Annual Deductible[5]	
Per Individual	$ 200.00
Per Family (3 members)	$ 600.00
Basic Hospital Expense Benefit - Per Confinement[6]	
Covered Expenses in Full. . . . . First	$ 6,000.00
Basic Surgical Benefit	$ 3,000.00
Basic Medical Expense Benefit	
Maximum any one Illness or Injury	$ 500.00
Percentage Paid by Fund	90%
Major Medical Benefits	
Maximum Per Individual Per Year	Unlimited
Percentage Paid by Fund	90%
Prescription Drug Co-Pays	
Retail per 30-day Supply	$10.00 Generic/15% Brand (with $15.00 minimum)
Mail Order per 90-day Supply	$20.00 Generic/15% Brand (with $30.00 minimum)

Dental Care Benefits for Participants and Children Age 19 and Over

Basic Dental Benefits	
Maximum Per Individual Per Calendar Year	$500.00
Percentage Paid by Fund	100%
Major Dental Benefits	
Maximum Per Individual Per Calendar Year	$ 2,000.00
Percentage Paid by Fund	50%
Example: 50% of $4,000 in charges equals maximum of $2,000	

*5*The deductible is waived for a dependent child from birth to 14 days

*6*Charge for Private Room covered only to the extent of the prevailing Semi-Private Room rate, except when confined in an Intensive Care Unit the full daily rate will be covered

Pediatric Dental Care (Benefits for Children Age 18 and Under)

Basic Dental Benefits*
- Annual Cap $500
- Percentage Paid by Fund 100%

Major Dental Benefits*
- Annual Cap $2,000
- Percentage Paid by Fund 50%

*After the annual cap has been met, pediatric dental will fall under the Planôs major medical coinsurance. All required co-pays, medical protocols and Usual and Customary Rate limits will apply.

Vision Care Benefits for Participants and Children Age 19 and Over

Maximum for all Covered Services (Per Person Every Two Calendar Years) ..... $ 500.00

Pediatric Vision Care Benefits for Children Age 18 and Under

Annual Cap* (Per Person Every Two Calendar Years) ..... $ 500.00

*After the annual cap has been met, pediatric vision will fall under the Planôs major medical coinsurance. All required co-pays, medical protocols and Usual and Customary Rate limits will apply.

Hearing Aid Benefits

Maximum for all Covered Services (Per Person Every Two Calendar Years) $2,000.00

SCHEDULE OF BENEFITS
RETIRED ELIGIBLE EMPLOYEES

Retired Employee Only

Life Insurance
(Not applicable to spouse or dependent) $12,500.00

Retirees and Dependents[7]

Annual Deductible[8]
Per Individual ..... $ 200.00
Per Family (3 members) ..... $ 600.00
Basic Hospital Expense Benefit - Per Confinement
Covered Expenses in Full[9] . . . . . First ..... $ 4,000.00
Basic Surgical Benefit ..... $ 3,000.00
Basic Medical Expense Benefit
Maximum any one Illness or Injury ..... $ 300.00
Percentage Paid by Fund 90%
Major Medical Benefits
Maximum Per Individual Per Year ..... Unlimited
Percentage Paid by Fund 90%
Prescription Drug Co-Pays .....
Retail per 30-day Supply .....$10.00 Generic/15% Brand (with $15.00 minimum)
Mail Order per 90-day Supply ..... $20.00 Generic/15% Brand (with $30.00 minimum)

Note: 1) No maternity coverage is provided under this schedule for Retirees and their spouse. 2) A retired employee and spouse shall not be entitled to any benefits from this schedule for which payment is available from the Medicare program regardless of whether or not the retired employee or spouse elected to participate in the Medicare program. 3) A Retiree or dependent who elects Medicare Part D prescription coverage will not be eligible for prescription drug coverage under this Plan's Retiree coverage.

7 Dependents are the spouse and children (defined elsewhere) of the employee pensioner only. New Dependents of spouse pensioners are not covered.

8 Deductible is waived for a dependent child from birth to 14 days.

9 Charge for Private Room covered only to the extent of the prevailing Semi-Private Room rate, except when confined in an Intensive Care Unit the full daily rate will be covered.

Dental Care Benefits for Participants and Children Age 19 and Over

Basic Dental Benefits
- Maximum Per Individual Per Calendar Year $500.00
- Percentage Paid by Fund 100%

Major Dental Benefits
- Maximum Per Individual Per Calendar Year ..... $ 2,000.00
- Percentage Paid by Fund 50%
- Example: 50% of $4,000in charges equals maximum of $2,000

Pediatric Dental Care (Benefits for Children Age 18 and Under)

Basic Dental Benefits*
- Annual Cap $500
- Percentage Paid by Fund 100%

Major Dental Benefits*
- Annual Cap $2,000
- Percentage Paid by Fund 50%

*After the annual cap has been met, pediatric dental will fall under the Planôs major medical coinsurance. All required co-pays, medical protocols and Usual and Customary Rate limits will apply.

Vision Care Benefits for Participants and Children Age 19 and Over

Maximum for all Covered Services (Per Person Every Two Calendar Years) ..... $ 500.00

Pediatric Vision Care Benefits for Children Age 18 and Under

Annual Cap* (Per Person Every Two Calendar Years) ..... $ 500.00

*After the annual cap has been met, pediatric vision will fall under the Planôs major medical coinsurance. All required co-pays, medical protocols and Usual and Customary Rate limits will apply.

Hearing Aid Benefits

Maximum for all Covered Services (Per Person Every Two Calendar Years) ..... $ 2,000.00

II. DESCRIPTION OF BENEFITS

LIFE INSURANCE BENEFITS
(Eligible Active and Retired Employees Only)

General Information About this Benefit

In the event of your death from any cause whatsoever while insured under this plan, the death benefit as shown in the Schedule of Benefits will be payable, either in a lump sum or installments, to the beneficiary named by you.

Proof of Disability

If you become totally and permanently disabled while insured and before age 60, your Life Insurance will remain in force as long as you remain so disabled, provided proofs of disability are furnished as requested. The Fund Office should be advised immediately of such disability. Submission of proof should be filed with the Plan Administrator within three months after total disability has lasted nine months. Subsequent proofs of disability must be furnished each year thereafter.

Conversion Privilege

Should your employment terminate while the Master Policy is in force you may convert your group life insurance, without medical examination, to get a regular policy on any of the plans customarily issued by the insurance company within 31 days after termination of employment. Applications for the conversion of your group insurance may be made at the Fund Office.

The insurance under the converted policy will take effect at the end of the 31-day period within which you are entitled to make application and during this period your group life insurance is regarded as remaining in force.

Changes in Policy

Suitable forms are available in the Fund Office to effect any changes in your insurance, such as Change of Beneficiary, Change of Address, etc.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT
(Applicable to Eligible Actives Only)

General Information About This Benefit

If death, dismemberment or loss of sight should occur solely through external violent or accidental means and within 90 days after such accident, you will receive a cash payment as follows:

For loss of:	
Life (Paid to your beneficiary)	Principal Sum
Both hands or both feet	Principal Sum
Sight of both eyes	Principal Sum
One hand and one foot	Principal Sum
One hand and sight of one eye	Principal Sum
One foot and sight of one eye	Principal Sum
One hand or one foot	One Half Principal Sum
Sight of one eye	One Half Principal Sum

The Principal Sum is shown in the Schedule of Benefits.

Not more than the Principal Sum is payable for all injuries resulting from any one accident. Any payment of this benefit is in addition to the life insurance benefit, if any.

No indemnity shall be payable if the death or injury of the employee results from or was in any manner or degree associated with or occasioned by:

1. Suicide while sane or insane;
2. Intentionally self-inflicted injury while sane;
3. Ptomaine or bacterial infections (except phylogenic infections which occur with and through an accidental cut or wound);
4. War or any act incident thereto;
5. Any form of disease or illness or physical or mental infirmity or medical or surgical treatment thereof.

Additional information is available in the benefit booklet provided by Standard Life Insurance Company. Please contact the Planôs Administrative Agent for further details.

WEEKLY INDEMNITY
(Eligible Active Employees Only)

General Information About This Benefit

You will receive a Weekly Indemnity for each week that you are totally disabled because of a covered sickness or injury as a result of a non-occupational accident or a disease for which benefits are not payable under a Worker's Compensation Law. To receive this benefit you need not be confined at home or in a Hospital but the disability must be sufficiently severe to prevent you from performing your regular work and you must be continuously under treatment by a Physician or surgeon.

Period of Coverage

Benefits, as set forth in the Schedule of Benefits, begin with the first day of disability due to injury or the fourth day of disability due to sickness provided you have been treated by a doctor by that date. If disability due to injury starts more than 30 days after the accident, the waiting period for sickness will apply.

A maximum of 26 weeks of benefits is payable for each period of disability.

If you are totally disabled on the date your insurance terminates, your Weekly Indemnity benefits will continue for that disability as if your insurance was still in force.

Successive Absences

Successive absences from work are considered to be in the same period of disability unless separated by (1) two weeks of active full-time work, or (2) one full day of work and due to wholly different causes.

DENTAL CARE BENEFITS

General Information About This Benefit

This benefit is provided to help defray the cost of dental care for all eligible participants and eligible Dependents.

The annual deductible is not applied to this benefit.

You may attend the dentist of your choice, but a claim form must be completed in all instances in order to receive benefits. Forms are available from the Fund Office and Local Union Office. Benefits will be paid directly from the assets of the Fund.

The dentist must complete the form in detail and sign. A separate claim form must be completed for each member of the family receiving benefits.

Dental Benefits for Participants and Children Age 19 and Over

Basic Dental Benefits

The Fund will provide for the payment of 100% of the dentist's charge, limited to the maximums in the Schedule of Benefits.

Major Dental Benefits

The Fund will provide for the payment of 50% of the dentist's charges in excess of the Basic Dental Benefits, limited to the maximums in the Schedule of Benefits.

Charges for denture repair and realignment are payable once every five (5) calendar years limited to the maximums in the Schedule of Benefits.

Orthodontics for a Participant and eligible dependents are included under the Major Dental Benefits.

The maximum that will be paid for all Major Dental Benefits in a calendar year is currently $2,000 per eligible person.

Pediatric Dental Benefits for Children Age 18 and Under

Basic Dental Benefits

The Fund will provide for the payment of 100% of the dentist's charge, limited to the annual cap in the Schedule of Benefits.

Major Dental Benefits

The Fund will provide for the payment of 50% of the dentist's charges in excess of the Basic Dental Benefits, limited to the annual cap in the Schedule of Benefits.

Charges for denture repair and realignment are payable once every five (5) calendar years limited to the maximums in the Schedule of Benefits.

Orthodontics for a Participant and eligible dependents are included under the Major Dental Benefits.

After the annual caps have been met, pediatric dental will fall under the Plan's major medical coinsurance. All required co-pays, medical protocols and Usual and Customary Rate limits will continue to apply.

Exclusions

The Fund will not provide for the payment of the following:

1. Charge for services and materials for cosmetic purposes (except charges of cosmetic dental procedures as a result of and within twelve (12) months after an accident suffered while eligible for benefits).

2. Replacement of a bridge or denture within five (5) years following the date of original installation.

VISION CARE BENEFITS

General Information About This Benefit

This benefit is provided to help defray the cost of routine vision care for all eligible participants and eligible Dependents. If the vision care you are receiving is for other than a routine exam, frames or lenses, it will be covered under the major medical portion of the plan if the service is medically necessary.

The annual deductible is not applied to this benefit.

Claim forms must be completed in all instances in order to receive benefits. Forms are available from the Fund Office and the Local Union Office. Benefits are paid directly from the assets of the Fund. You may attend the Physician of your choice as often as necessary but the Physician (Optician, Optometrist, and Ophthalmologist) must complete the form in detail and sign. A separate claim must be completed for each member of the family obtaining benefits.

Benefits

The Fund will pay charges made by the Physician for any claims, and charges for prescription lenses and frames, limited to the maximum or annual caps amount listed in the Schedule of Benefits.

Pediatric Vision Benefits

Vision Benefits provided to children age 18 and under will no longer be subject to an annual cap. Instead, the Fund will pay the cost of one routine exam each year and will also pay for one pair of frames every two years and one set of lenses per year. In substitution for the frame and lens benefit, a 12 month supply of contact lenses will be fully covered each year.

HEARING AID BENEFITS

General Information About This Benefit

This benefit is provided to help defray the cost of hearing aids for all eligible participants and eligible Dependents. The annual deductible is not applied to this benefit.

Benefits

The Fund will pay charges made by the Provider for any claims, and charges for hearing aids, limited to the maximum amount listed in the Schedule of Benefits. If you have not used up the maximum amount listed in the Schedule of Benefits, the balance may be used for repairs and batteries.

PRESCRIPTION DRUG BENEFITS

General Information About This Benefit

You and your eligible Dependents are covered by the Fundôs prescription drug program. The program is administered by EnvisionRx. For information, call 1-800-361-4542.

You may obtain prescription drugs and medicines either through retail pharmacies that are in the EnvisionRx network or by mail order through EnvisionRxôs Mail Order pharmacy, Orchard Pharmaceutical Services. A list of the retail pharmacies in the network can be obtained from the Fund Office or from EnvisionRx. In order to purchase prescription drugs and medicines by mail order, each time that you fill a prescription, you will be required to pay a co-pay based upon whether the prescription is for a generic or brand drug and based on whether you fill the prescription through a retail pharmacy or by mail order. The required co-pays are contained in the Schedule of Benefits. If you purchase a prescription without your EnvisionRx card, you will only be reimbursed up to the amount that would have been paid to the pharmacist.

Note - If either you or your physician insists on a brand name drug when there is a generic equivalent, you must pay the difference between the cost of the generic drug and the brand name. If your physician determines a generic drug will not have the same effect as the brand name drug, your physician must present written relevant medical evidence to the Trustees as to the basis for this conclusion, and a written request that full coverage be provided to you for the brand name drug.

Note ï There is a considerable savings to both you and the Fund if you use generic drugs and mail order service. If purchasing drugs at a retail pharmacy, there is a $10.00 co-payment for generic drugs and a 15% co-payment of the full price of medication with a $15.00 minimum co-payment for brand name drugs. You are also limited to a 30-day supply of any prescription drug each time you fill a prescription at retail. If you use mail order, there is a $20.00 co-payment for generic drugs and a 15% co-payment based on the full price of the medication, with a $30.00 minimum, for brand drugs. When you obtain your drugs and medication through mail order, you may obtain a 90-day supply each time you fill the prescription.

Covered Charges

(a) Charges for prescription drugs which are necessary to the care and treatment of non-occupational accident, bodily injury, or sickness and which are prescribed by a legally qualified physician.

(b) Charges for drug and medicines which can be obtained only by prescription and bear the legend "Caution, Federal Law Prohibits Dispensing Without a Prescription".

(c) Insulin syringes, glucose test strips, lancets, lancet devices and glucose test machines.

Note ï Glucose test strips and glucose test machines are no longer covered under your major medical benefits.

Limitations on Quantity

The maximum amount of prescription drugs in accordance with the direction of the prescriber, that will be considered as eligible charges cannot exceed:

(a) A 30-day supply obtained through a retail pharmacy.

(b) A 90-day supply of maintenance drugs obtained through a retail pharmacy.

(c) A 90-day supply obtained through mail order.

(d) Viagra - The Fund provides benefits for no more than eight (8) Viagra tablets per month at a maximum dosage of 100 mg. per tablet.

(e) Zyban (Bupropion) prescribed for cessation of smoking shall be limited to one course of treatment per lifetime for participants, spouses and eligible dependents.

(f) Tamiflu and Relenza are limited to one course of treatment every 180 days, if needed. You must take the prescription for either of these drugs to your pharmacy to be filled.

Generic Drugs

In accordance with the terms of this program, the pharmacy will, whenever possible, dispense generic prescription drugs. The plan pays the cost of a brand name only when a generic drug equivalent is not available. If either you or your Physician insists on a brand name drug when there is a generic equivalent, you must pay the difference between the cost of the generic drug and the brand name. If your Physician determines a generic drug will not have the same effect as the brand name drug, your doctor must present relevant medical evidence to the Trustees as to the basis for this conclusion, and request that full coverage be provided to you for the brand name drug.

Charges Which Are Not Covered

Charges not listed as covered drug charges:

(a) non-legend, patent or proprietary medicine or medication not requiring a prescription;

(b) canes, crutches, wheelchairs or any other similar medical aid;

(c) braces, splints, dressings, bandages, sick room equipment or supplies, heat lamps or similar items;

(d) abdominal supports, trusses, hypodermic syringes and/or needles, oxygen;

(e) immunizing agents, biological sera, blood or blood plasma, injectables or any prescription directing parental administration or use, except insulin;

(f) vitamins, vitamin prescriptions, cosmetics, dietary supplements, health or beauty aids;

(g) medication which is to be taken or administered, in whole or part, to the individual while a patient in a Hospital, rest home, sanitarium, extended care facility, convalescent Hospital, nursing home or similar institution;

(h) any delivery charges for any drugs or medicines or any charges for administering any drugs or medicines to the eligible individual by the prescriber;

(i) any drug labeled, "Caution-Limited by Federal Law to Investigational Use," or experimental drugs, even though a charge is made to the individual;

(j) contraceptive materials, contraceptive devices or infertility medications; except for birth control pills or injectable contraceptive drugs prescribed by a Physician (for member and spouse and eligible dependent only), provided that injectable contraceptives will be covered only if they are purchased through the Fundôs prescription benefit manager and administered by your physician;

(k) any charges payable under any of the other benefits of the Plan to the extent of the portion of such charges so paid. Please note the items listed under the Major Medical portion of the Plan; and

(l) Compound drugs over $200, unless Letter of Medical Necessity and Prior Authorization is received.

PREFERRED PROVIDER ORGANIZATION (PPO)

The Trustees have retained the services of CIGNA HealthCare Network preferred provider network. Using a CIGNA HealthCare Network doctor or Hospital is optional, however; if you choose to go to a CIGNA HealthCare Network doctor or hospital, there is a considerable savings to both you, the Participant, and the Fund. For information, call 1-800-768-4695.

CIGNA Healthcare Network has special arrangements with certain health care providers, such as doctors and hospitals, providing for substantial discounts in their normal fees. Because you usually pay a percentage of the billed charges for your medical treatment, if you use the CIGNA HealthCare Network, you will pay a percentage of a smaller amount. Therefore, the benefit in using a CIGNA HealthCare Network Physician or Hospital for medical or mental health benefits is a direct out-of-pocket cost savings to you.

When you go to a participating Physician or Hospital, show your identification card which will identify you as a member of Asbestos Workers Union Local 42 Welfare Fund which participates in the CIGNA HealthCare Network. Your medical and prescription drug card has the CIGNA HealthCare Network group number on the front. The Physician or Hospital will submit your claim directly to CIGNA HealthCare Network, who will discount the bill and forward it to the Fund Office for payment.

No matter how long you have been going to your current physician, inform him or her that the Asbestos Workers Union Local No. 42 Welfare Fund participates in the CIGNA HealthCare Network.

Optional Medical Care Management Enhancements through the CIGNA Program

The following additional member enhancements are available through the CIGNA program, via a CIGNA subsidiary called CareAllies. These programs are intended to improve your health, make the benefits program more convenient and easier to use, help you access the right level of care, and help the Fund control future claims expenses.

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

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

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

Through this program, care coordination will be provided into transplant Centers of Excellence across the country and case management will be provided to the participant and their family. Should you wish to access this program, please contact the Fund Office at 410-872-9500 or 888-490-8800.

asbestos42.myCareAllies.com: There are several other unique services available to Fund participants through asbestos42.myCareAllies.com, a component of our care management program, which we strongly encourage you to utilize. These services will enable you to:

- Visit an electronic Health Library and learn about a disease states, your current medical condition(s), how to treat your condition(s), questions to ask your doctor(s) about your condition(s), etc.
- Take a Health Risk Assessment to help you determine what medical conditions you have a risk of getting over time due to your personal habits and family history, and what to do to reduce the chances of getting these conditions
- Access to CIGNA's Healthy Rewards Program. The program will provide participants of the Asbestos Workers Union Local 42 Welfare Fund with access to discounts on treatments and items that are not covered under your benefit program.
- Review medications and their potential interactions and alternatives
- Review preventative care tips
- Gain access to tools to quit smoking, lose weight and live a healthier life.

You may visit the asbestos42.myCareAllies.com website. Our Fund specific password is asbestos42 (password is not case sensitive).

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

LIFE LINE SCREENING BENEFIT

Life Line Screening is the nationôs leading provider of mobile health risk screenings. The Plan provides coverage to participants and their dependents who are age 35 and over for the following screenings performed by Life Line Screenings:

- Carotid artery/stroke screening
- Abdominal aortic aneurysm screening
- Peripheral arterial disease (PAD) screening
- Osteoporosis screening

You must pay for the screenings (currently $129 for the four screenings above) and then submit a receipt for reimbursement.

These screenings will take place at various locations in the community. To determine where the next screening is taking place, contact Life Line Screening at 1-800-324-1851. You must make an appointment.

HOSPITAL BENEFITS

Hospital Expenses

For each day you or your Dependents are confined in the Hospital as a result of a non-occupational accident or sickness for which benefits are not payable under the Worker's Compensation Law, the Plan will pay the following expenses in full, up to the amount shown in the Schedule of Benefits.

1. Room and Board - Charges for room and board. For private accommodations, room and board charges in excess of the hospital's standard semi-private room rate will not be eligible for payment, except when confined in an intensive care unit the full daily room rate will be covered.

2. Other Services - Expenses for such necessary services as operating room, drugs, x-rays, and laboratory tests.

3. Newbornsô and Mothersô Health Protection Act - The Fund is required by law to permit newborns and their mother to remain in the hospital for at least 48 hours. If there has been a cesarean delivery, the hospitalization period is extended to 96 hours. Discharge earlier than these times can occur only if the attending care provider and the mother determine in

consultation that this is appropriate. The law does not require mothers either to give birth in a hospital or to stay in that hospital for a fixed period of time, as long as the attending physician and mother agree to an earlier discharge.

Confinement

In order to collect these benefits, you or your Dependents must be confined in a legally constituted hospital and must be under the care of a legally qualified physician. Benefits are payable only if the Hospital makes a charge for room and board except that when surgery is performed or emergency treatment is given for an accident, a charge for room and board is not required. Emergency treatment, to be covered, must be given within 72 hours after a non-occupational accident.

Successive Periods of Hospital Confinement

Successive periods of Hospital confinement are considered as having occurred during one continuous period of disability unless separated by complete recovery, or, in the case of an employee, by return to active work for at least two weeks of active and full time employment, or an unrelated illness, or in the case of a dependent, or retired employee, unless the later confinement is due to causes entirely unrelated to the cause of the previous confinement or the periods of Hospital confinement are separated by at least ninety days.

Extension of Benefits

If you or your Dependent have incurred covered expense for a disabling sickness or injury before your eligibility terminated, benefits will continue to be paid for that individual for that sickness or injury only until the earliest of the following dates:

1. The end of the calendar year following the calendar year in which eligibility terminated.
2. The date the total disability ceases.
3. The last day of a period equal to the length of time you or your Dependents were eligible under the Plan.
4. The date maximum benefits have been paid.

HOME HEALTH CARE

General Information About This Benefit

A participant recovering at home is entitled to coverage for home care services for up to 90 consecutive visits from your home health care team and one Physician visit per week. Any single visit up to four hours by a member(s) of a home health care team will equal one home health care visit. Home care benefits are renewable (1) after 60 days without such service, or (2) if you are admitted to a Hospital for one or more days and then return to home care.

Covered Benefits

1. Registered nurse service and licensed practical nurse service;
2. Physical, respiratory and occupational therapist services;
3. Rental of durable medical equipment; and
4. Medical/surgical supplies.

Services Not Included

1. Professional ambulance service to or from a hospital;
2. Diversional or recreational therapy;
3. Purchase or rental of handrails, ramps, telephone, air conditioners, humidifiers and similar convenience items;
4. Services provided by volunteer organizations for which you are not obligated to pay;
5. Services by a member of your family or household, or by a person related to you by blood or marriage;
6. Private duty nursing;
7. Home Health Care primarily for rest or custodial care;
8. Charges for which you are entitled to payment from other sources;
9. Prosthetic devices;
10. Food or housing;
11. Hearing aids, eyeglasses or contact lenses;
12. Services provided to a participant whose place of residence is an institution which provides treatment to injured or disabled persons;
13. Services or supplies not listed as a covered service.

Benefits will be paid under the Major Medical portion of the Plan and included under the annual maximum.

SURGICAL BENEFITS

You and your Dependents are reimbursed by the Plan for expenses that you/they incur for a primary surgeon in connection with a Surgical Procedure that is performed in a Hospital or in a Physicianôs office or some other outpatient facility. Benefits are also payable for outpatient surgeries. The Surgical Benefit will include coverage of the facility fees up to the Reasonable and Customary fee subject to the maximum payable. Surgical services consist of surgeonôs fees for all surgeries performed in or out of a Hospital as well as endoscopic procedures (inserting a tube to examine internal organs) including cystoscopy, proctoscopy and sigmoidoscopy.

The maximum amount payable, including benefits for assistant surgeons is 100% of the Reasonable and Customary fee up to the maximum amount shown in the Schedule of Benefits. Surgical claims will be paid up to the Reasonable and Customary fee for the given procedure up to the maximum amount shown in the Schedule of Benefits. Amounts in excess of the maximum will be payable under the Major Medical portion of the Plan and subject to all Plan coinsurances and deductibles.

Limitation

Benefits are not payable for surgical services that are a result of Workers Compensation or occupational injury.

SPECIAL PROVISIONS PERTAINING TO THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Pursuant to the Womenôs 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 stages of mastectomy, including lymphedemas.

DIAGNOSTIC X-RAY AND LABORATORY BENEFITS

The Plan pays expenses incurred by you or your Dependents for laboratory tests or x-rays for diagnosis of a disease for which benefits are not payable under any Worker's Compensation Law or an accidental bodily injury which does not arise out of or in the course of employment.

If you use a facility through the CIGNA PPO Network, the Fund Office will pay 90% of the reduced amount and you will be responsible for paying 10% of the reduced amount along with applicable Plan deductibles or coinsurances. If you fail to use a provider through the CIGNA Network, the Plan will only pay up to the maximum amount that would have been paid through the CIGNA Network.

ASBESTOSIS PROGRAM

This benefit is provided to help defray the out-of-pocket costs to eligible participants who incur charges for claims incurred as a result of asbestosis or possible asbestosis. The appropriate assignment forms must be completed in all instances to receive benefits. This form states that you will actively seek compensation from Worker's Compensation or any other third party, and upon receipt of settlement from Worker's Compensation or any other third party the Fund will be reimbursed any money paid on behalf of the asbestos claim. Assignment forms are available in the Fund Office.

BASIC MEDICAL BENEFITS

General Information About This Benefit

Once your deductible has been satisfied, the Plan pays the amount charged by the doctor, or doctors, for medical treatments received by you or your Dependents during a period of Hospital confinement and for visits to the doctor's office or the doctor's visits to your home up to the amount shown in the Schedule of Benefits.

Method of Payment

The maximum amount payable for all treatments with respect to any one period of disability is the amount shown in the Schedule of Benefits. Payment will be made for as many separate and distinct periods of disability as may occur.

Successive Periods of Disability

Successive periods of disability are considered as having occurred during one continuous period of disability unless separated by complete recovery, or, in the case of an employee, by return to active work for at least two weeks of active and full time employment, or an unrelated illness, or in the case of a Dependent or retired employee, unless the later disability is due to causes entirely unrelated to the cause of the previous disability or the periods of disability are separated by at least ninety days.

Benefits Not Covered

Since the Surgical Benefits cover surgical operations, no payments are payable for treatments received in connection with pregnancy or resulting childbirth or miscarriage, or for any dental work or treatment, or for eye examination or the fitting of glasses, or for drugs, dressings, and medicines, except as provided elsewhere in this booklet.

MAJOR MEDICAL BENEFITS

Once your deductible has been satisfied, the Major Medical Expense Benefit, an extension of Basic Medical Expense Benefits, will provide substantial benefits for serious injuries or diseases which may involve hospital, surgical and medical expense of many hundreds or thousands of dollars. The deductible is waived for your dependent child from birth to age 14 days.

This coverage is designed to reimburse you to a large extent for major expenses incurred as a result of non-occupational accidental bodily injury or disease which are in excess of the benefits you receive under the Basic Expense Benefits, regardless of the number of injuries or diseases suffered. Whether or not Hospital confinement is involved, benefits are also payable under the Basic plan.

How the Major Medical Coverage Works

To determine the amount payable under the Major Medical coverage for you and each of your Dependents in any calendar year, first add up all covered expenses incurred by each person in that year. Then deduct the amount payable for those expenses under all other group health plans, including the basic benefits provided by this Plan.

The Major Medical coverage pays 90% of the balance up to the scheduled maximum for each covered person per year. All claims should be filed promptly.

Major Medical Expense Benefits for each of your eligible Dependents will be on the same basis as your own.

Extension of Benefits

If you or your Dependent have incurred covered expense for a disabling sickness or injury before your eligibility terminated, benefits will continue to be paid for that individual for that sickness or injury only until the earliest of the following dates:

1. The end of the calendar year following the calendar year in which eligibility terminated.
2. The date the total disability ceases.
3. The last day of a period equal to the length of time you or your Dependents were eligible under the Plan.
4. The date maximum benefits have been paid.

Covered Expenses

The following services or supplies which are performed or prescribed by a Physician or Surgeon are eligible expenses subject to any limitations or exclusions described elsewhere in this booklet.

A. Reasonable and Customary charges by a Hospital necessarily incurred for:
    1. Room and board for each day of confinement, limited to usual charge for semi-private care, except when confined in an intensive care unit, the full daily room rate will be covered.
    2. Other necessary Hospital services and supplies furnished to the individual and required for treatment, other than Room and Board, professional services of any Physician and any private duty, or special nursing services (including intensive nursing care by whatever name called), regardless of whether such services are rendered under the direction of the Hospital or otherwise.

B. Customary charges necessarily incurred for:
    1. Services of physicians and surgeons, psychiatrists, psychologists and other licensed mental health professionals in excess of basic benefits, plastic surgery except when the operation is performed to correct deformities resulting from illness or such congenital defects as interfere with function.
    2. Anesthetics and their administration.
    3. Treatment by x-ray, radium, and radioactive isotopes.
    4. (a) Charges for sigmoidoscopic examination subject to the annual deductible with no

annual maximum on the allowed amount. There is a limitation of one examination per eligible participant and one per each Dependent of an eligible participant per calendar year except in those instances whereby more than one examination per year is deemed medically necessary by a physician.

(b) Charges for routine colonoscopy exams. In order to be eligible to receive coverage, you must be age 50 or older. Participants and eligible Dependents who are age 50 or older will receive coverage for a routine colonoscopy exam once every ten (10) years. If based on the results of an earlier colonoscopy exam or other medical test or criteria, you are considered to be at higher risk, then a routine colonoscopy exam required by your doctor will be covered once every five (5) years consistent with the criteria of the American Cancer Society. Whether you meet the standards to receive coverage for a colonoscopy exam more frequently than once every ten (10) years must be determined by your doctor based on established medical criteria. The Trustees may rely upon the guidelines issued by the American Cancer Society in making a determination of whether your exam will be covered.

5. Oxygen and its administration.
6. Blood and blood transfusions.
7. Diagnostic X-ray and diagnostic laboratory procedures (including pap test) and dental x-rays as described in (10) below.
8. Services of registered graduate nurses other than members of your family.
9. Services of duly Qualified Physiotherapists other than members of your family, Qualified Occupational Therapists, and Qualified Speech Therapists.
10. Dental services for the treatment of a fractured jaw or of accidental injuries to natural teeth within 6 months of accident.
11. Professional ambulance service.
12. Rental of wheelchair, Hospital bed or iron lung.
13. Splints, trusses, braces, crutches, casts, artificial limbs and eyes.
14. Emergency Room or other emergency medical services ï all emergency treatment that is rendered as the result of an accident (such as broken bone or an injury requiring stitches) or other emergency medical reasons is paid at 100%. If treatment is rendered for a routine illness, the Plan will pay 90% once your annual deductible is satisfied. Wherever possible, a medical facility which meets the definition of a Hospital, under the Plan, should be utilized in lieu of a Hospital emergency room in order to reduce costs. Contact the Fund Office to verify whether an emergency medical facility which you desire to utilize is qualified under the Plan.
15. Birth Control Implants including office visits, surgical procedures, and other related costs. Limitation of once every 3 years for implants.
16. Breast reconstructive surgery as follows: (a) following a mastectomy (b) surgery and reconstruction to the other breast to produce a symmetrical appearance; and (c) prosthesis and physical complications for all stages of mastectomy including lymphedemas; in a manner determined in consultation with the attending Physician and the patient.
17. Breast Prosthesis and a special bra.
18. Mammography Screening for individuals 40 and over (or under age 40 when deemed medically necessary by physician) with a limitation of one per year except in those instances whereby more than one exam a year is deemed medically necessary by a physician.
19. Hearing Aid Instrument up to a maximum of $2,000 once every two calendar years. If the $2,000 maximum is not exhausted, the balance may be used for repairs and batteries. The

annual deductible is not applied to this benefit.

20. Charges incurred for organ transplants as follows:
    (a) If only the donor is an eligible participant, no benefits are provided;
    (b) If only the recipient is an eligible participant, benefits are provided for both donor and recipient under the recipient record;
    (c) If both donor and recipient are eligible participants, benefits are provided for each under respective record.
21. Services provided for treatment of Temporomandibular Joint Syndrome (TMJ) regardless of whether the treatment is by a medical doctor or a dentist.
22. Flu injections, Hepatitis B vaccine, Shingles and Pneumonia vaccine for member, spouse, and Dependents.
23. Durable medical equipment not specified must be submitted to the Fund Office with a letter of medical necessity.
24. Uterine monitoring device which is used in cases of high risk pregnancy for eligible member or eligible spouse only, provided a letter of medical necessity from your physician is submitted to the Fund Office with your claim form.
25. Charges for maternity coverage and newborn care for member/spouse only (excluding retirees and their spouses).
26. Orthotics and orthopedic appliances up to 50% of Reasonable and Customary charges under Major Medical Benefit only, provided a letter of medical necessity from your Physician is submitted to the Fund Office with your claim form.
27. Charges for pediatric care (well visits) includes services and injections administered in office for eligible children from birth to their seventh (7^{th}) birthday. This benefit is not subject to the annual deductible.
28. Charges related to a school physical, including booster shots for Dependent students. This benefit is not subject to the annual deductible.
    A "Dependent student" will include pre-school children who are attending nursery, day care, and early kindergarten. Any claims submitted for these services must be designated by the Physician as a "school physical" and are not subject to the annual deductible.
29. HPV Vaccine (human papillomavirus) for female participants, spouses and eligible Dependent children between the ages of 9 to 26 where recommended by the treating physician in accordance with the recommendations of the American Cancer Society.
30. Diabetic Nutritional Counseling up to a maximum of six (6) visits per calendar year for participants, spouses and eligible Dependents.

Exclusions

The Fund will not provide for the payment of the following:

1. Charges in connection with injuries sustained in the course of any employment for remuneration or profit for which benefits are payable in accordance with the provisions of any Workers' Compensation or similar law, except as provided under the Planôs Subrogation Policy.
2. Charges in connection with illness for which the employee or Dependent is entitled to indemnity in accordance with the provisions of any Worker's Compensation or similar law, except as provided under the Planôs Subrogation Policy.
3. Eyeglasses, eye refractions and the fitting of eye glasses.

4. Illness or injuries resulting from insurrection, commission of a felony or war, declared or undeclared.
5. Plastic surgery except when the operation is performed to correct deformities resulting from injury or sickness or such congenital defects as interfere with function.
6. Certification or routine examinations other than those previously defined as covered medical expenses.
7. Treatment in a government hospital, and expenses which would not be incurred except for the existence of insurance.
8. Services rendered without charge.
9. Services provided or paid for by any group insurance plan having premiums paid by an employer.
10. Charges incurred while you or your dependent are confined in a hospital operated by the United States of America or an agency thereof, or charges which you would not be required to pay if there were no insurance.
11. Charges on account of a Dependent for any medical expense for which he is entitled to benefits as an employee or former employee under the Fund.
12. Charges on account of a Dependent for any medical expenses incurred during or in connection with a Hospital confinement which commenced prior to the date the Dependent became covered under this plan.
13. Services or supplies not Medically Necessary for the treatment of illness or injury, other than those previously defined as covered medical expenses.
14. Charges for education, training and bed and board while you or your Dependent is confined in an institution which is primarily a school or other institution for training, a place of rest, a place for the aged or a nursing home.
15. Charges for custodial care.
16. Charges for which payment is provided under a Governmental Program regardless of whether or not you elect to participate in the Governmental Program.
17. Charges for Private Room covered only to the extent of the prevailing Semi-Private Room rate, except when confined in an Intensive Care Unit the full daily rate will be covered.
18. Charges for maternity coverage, surgeries relating to pregnancy and tubal ligations provided to Dependent children.
19. Items not included or approved for payment within this Plan document.
20. Charges for treatment relating to drug abuse and/or alcohol abuse.
21. Charges for co-pay required by a Prescription Drug Program.
22. Services or care of any kind that are experimental in nature or not generally accepted medical practice.

HAZWOP and Asbestos Certification

The Plan provides coverage for medical examinations and related tests required under Government Regulations to obtain certification to handle hazardous materials (i.e. HAZWOP Certification). Such coverage is subject to the following conditions:

1. The Plan shall provide payment of 100% of the cost of the initial medical exam and related tests necessary to obtain such certification as is required under Government Regulations to handle hazardous materials.
2. In order to be eligible for such coverage, a participant must be employed on a job which requires such certification. The scope of medical exams and test covered will be limited

to those which are required in order to meet the terms of applicable Government Regulations.

3. These benefits will be provided to all apprentices and journeymen who are actively employed under a Collective Bargaining Agreement requiring contributions to be paid on their behalf to Asbestos Workers Local 42 Welfare Fund. Actively employed apprentices and journeymen will be eligible for these benefits without regard to whether they meet the other initial and continuing eligibility requirements of the Plan. This exception is limited exclusively to the asbestos physicals and HAZWOP Certification physicals. This exception and the benefits hereunder also shall not apply to any employee working within the jurisdiction of Insulators and Allied Workers Local 42 who is a traveler from another Local Unionôs jurisdiction and who falls within the jurisdiction of another Health and Welfare Fund. **To be eligible under this provision, the Local Union must provide prior approval.**

OMEGA MEDICAL CENTER

The Plan has engaged the services of Omega Medical Center to provide annual physical exams and respirator qualification screenings to eligible members of the Fund. This benefit is not available to Dependent spouses or children. The Fund will pay 100% of the charges for these services provided by Omega. The services include a consulting board certified radiologist to provide the necessary ñB Readingò for chest x-rays.

Annual physical examinations through Omega Medical Center may be done at any time during the year. This will allow you to combine your annual physical exam and respirator qualification screening to one appointment. All related services (lab work, chest x-rays, et.) will be performed at Omega and you must see the doctor on the same day as you have your lab work performed. Omega will issue a report detailing their findings.

To schedule an appointment with Omega:

- ✓ Call Omega at 302-328-5100.
- ✓ Advise that you are a member of Asbestos Workers Local 42.
- ✓ Make sure that you sign a Release of Records to permit Omega to forward your test results to your physician. If you do not fill out the Release, the results will be sent to your home address.
- ✓ Schedule your physician visit to go over the results of your exam no sooner than 30 days following your Omega Medical Center visit. This will allow Omega sufficient time to obtain your lab/test results, transcribe the results and forward on to your physician.
- ✓ Three to four days prior to your physician office visit, call your physicianôs office to confirm receipt of your test results. If they do not have your results, you should contact Omega to ask them to fax your results to the physicianôs office.

Omega is open from 7:30 am to 6:00 pm Monday through Friday. The latest scheduled appointment will be at 5:00 pm.

Note ï In order to obtain 100% coverage for annual physicals and respirator qualification screenings, you must utilize Omega. If you utilize any other physician or medical facility, any

charges for your physical and respirator screening will be paid under the Major Medical portion of your benefits at 90% of the reasonable and customary fee and will be subject to the Major Medical deductible.

DOUBLE COVERAGE

This provision is intended to prevent payment of benefits which exceed the charge for a service. It applies when a member (or dependent) of this plan also has, or is entitled to benefits as a result of, any other kind of health coverage, Medicare, or automobile insurance. Information about the other health coverage must be disclosed to this plan.

When double coverage exists, one plan pays its benefit in full and the other plan pays a reduced benefit. This plan always pays either (1) its benefits in full or (2) a reduced amount which, when added to the benefits payable by the other plan, does not exceed the total charge for a service.

This plan is entitled to reimbursement when payments are received from another source.

This provision applies whether or not a claim is filed under Medicare or the other plan. If needed, authorization must be given to this Plan to obtain information as to benefits or services available from Medicare or the other plan, or to recover overpayments from other plans.

III. HEALTHCARE, LIFE INSURANCE AND RELATED BENEFITS

NOTICE OF HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA") PRIVACY POLICY

Use or Disclosure of Protected Health Information

(a) How We Protect Your Privacy ï The Fund is required by law to protect the privacy of your protected health information (PHI) and to provide you with notice of its privacy practices. We will not disclose confidential information without your authorization unless it is necessary to provide your health benefits and administer the Plan, or as otherwise required or permitted by law. When the Fund needs to disclose individually identifiable information, we will follow the policies described in this Notice to protect your confidentiality.

The Fund maintains confidential information and has procedures for accessing and storing confidential records. The Fund restricts internal access to your confidential information to employees who need that information to provide your benefits. The Fund trains those individuals on policies and procedures designed to protect your privacy. The Fundôs Privacy Officer monitors how the Fund follows those policies and procedures and educates our organization on this important topic.

(b) The Fund will not use your confidential information or disclose it to others without your written authorization, except for the following purposes. When required by law, the Fund will restrict disclosures to the Limited Data Set, or otherwise as necessary, to the minimum necessary information to accomplish the intended purpose.

1. Treatment. We may disclose your protected health information to your health care provider for its provision, coordination or management of your health care and related services. For example, we may disclose your protected health information to a health care provider when the provider needs that information to provide treatment to you. We may also disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities or accreditation, certification, licensing or credentialing.

2. Payment. We may use or disclose your protected health information to provide payment for the treatment you receive under the Plan. For example, we may use and disclose your protected health information to pay and manage your claims, coordinate your benefits and review health care services provided to you. We may use and disclose your protected health information to determine your eligibility or coverage for health benefits and evaluate medical necessity or appropriateness of care or charges. In addition, we may use and disclose your protected health information as necessary to preauthorize services to you and review the services provided to you. We may also use and disclose your protected health information to obtain payment under a contract for reinsurance, including stop-loss insurance. We may use and disclose your protected health information to adjudicate your claims. Also, we may

disclose your protected health information to other health care providers or entities who need your protected health information to obtain or provide payment for your treatment.

3. Health Care Operations. We may use or disclose your protected health information for our health care operations. We may use or disclose your protected health information to conduct audits, for purposes of underwriting and rate-making, as well as for purposes of risk management. We may use or disclose your protected health information to provide you with customer service activities or develop programs. We may also provide your protected health information to our attorneys, accountants and other consultants who assist us in performing our functions. We may disclose your protected health information to other health care providers or entities for certain health care operations activities, such as quality assessment and improvement activities, case management and care coordination, or as needed to obtain or maintain accreditation or licenses to provide services. We will only disclose your protected health information to these entities if they have or have had a relationship with you and your protected health information pertains to that relationship, such as with other health plans or insurance carriers in order to coordinate benefits, if you or your family members have coverage through another health plan.

4. Disclosures to the Plan Sponsor. The Board of Trustees of the Asbestos Workers Local 42 Welfare Fund is the Plan sponsor. We may disclose your protected health information to the Plan sponsor. The Plan sponsor is not permitted to use protected health information for any purpose other than the administration of the Plan. The Plan sponsor must certify, among other things, that it will only use and disclose your protected health information as permitted by the Plan, it will restrict access to your protected health information to those individuals whose job it is to administer the Plan and it will not use protected health information for any employment-related actions or decisions. The Plan may also disclose enrollment information to the Plan sponsor. The Plan may also disclose summary health information to the Plan sponsor for purposes of obtaining bids for health insurance or lending or modifying the Plan.

5. Disclosures to Business Associates. We contract with individuals and entities (business associates) to perform various functions on our behalf or provide certain types of services. To perform these functions or provide these services, our business associates will receive, create, maintain, use or disclose protected health information. We require the business associates to agree in writing to contract terms to safeguard your information, consistent with federal law. For example, we may disclose your protected health information to a business associate to administer claims or provide service support, utilization management, subrogation or pharmacy benefit management.

6. Disclosures to Family Members or Others. Unless you object, we may provide relevant portions of your protected health information to a family member, friend or other person you indicate is involved in your health care or in helping you receive payment for your health care. If you are not capable of agreeing or objecting to these disclosures because of, for instance, an emergency situation, we will disclose protected health information (as we determine) in your best interest. After the

emergency, we will give you the opportunity to object to future disclosures to family and friends.

7. Other Uses and Disclosures. The law allows us to disclose protected health information without your prior authorization in the following circumstances

   a). Required by law. We may use and disclose your protected health information to comply with the law.

   b). Public health activities. We will disclose protected health information when we report to a public health authority for purposes such as public health surveillance, public health investigations or suspected child abuse.

   c). Reports about victims of abuse, neglect or domestic violence. We will disclose your protected health information in these reports only if we are required or authorized by law to do so, or if you otherwise agree.

   d). To health oversight agencies**.** We will provide protected health information as requested to government agencies that have the authority to audit or investigate our operations.

   e). Lawsuits and disputes. If you are involved in a lawsuit or dispute, we may disclose your protected health information in response to a subpoena or other lawful request, but only if efforts have been made to tell you about the request or obtain a court order that protects the protected health information requested.

   f). Law enforcement. We may release protected health information if asked to do so by a law enforcement official in the following circumstances: (a) to respond to a court order, subpoena, warrant, summons or similar process; (b) to identify or locate a suspect, fugitive, material witness or missing person; (c) to assist the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; (d) to investigate a death we believe may be due to criminal conduct; (e) to investigate criminal conduct; and (f) to report a crime, its location or victims or the identity, description or location of the person who committed the crime (in emergency circumstances)

   g). Coroners, medical examiners and funeral directors. We may disclose protected health information to facilitate the duties of these individuals

   h). Organ procurement. We may disclose protected health information to facilitate organ donation and transplantation

   i). Medical research. We may disclose protected health information for medical research projects, subject to strict legal restrictions.

   j). Serious threat to health or safety. We may disclose your protected health information to someone who can help prevent a serious threat to your health and safety or the health and safety of another person or the general public.

k). Special government functions. We may disclose protected health information to various departments of the government such as the U.S. military or U.S. Department of State.

l). Workers' compensation or similar programs. We may disclose your protected health information when necessary to comply with worker's compensation laws.

(c) Uses and Disclosures With Your Written Authorization - We will not use or disclose your confidential information for any purpose other than the purposes described in this Notice, without your written authorization. For example, we will not (1) supply confidential information to another company for its marketing purposes (unless it is for certain limited Health Care Operations), (2) sell your confidential information (unless under strict legal restrictions), or (3) provide your confidential information to a potential employer with whom you are seeking employment without your signed authorization. You may revoke an authorization that you previously have given by sending a written request to our Privacy Officer, but not with respect to any actions we already have taken.

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.

a). Right to inspect and copy your protected health information. Except for limited circumstances, you may review and copy your protected health information. Your request must be addressed to the Privacy Officer. In certain situations we may deny your request, but if we do, we will tell you in writing of the reasons for the denial and explain your rights with regard to having the denial reviewed. If the information you request is in an electronic health record, you may request that these records be transmitted electronically to yourself or a designated individual.

If you request copies of your protected health information, we may charge you a reasonable fee to cover the cost. Alternatively, we may provide you with a summary or explanation of your protected health information, upon your request if you agree to the rules and cost (if any) in advance.

b). Right to correct or update your protected health information. If you believe that the protected health information we have is incomplete or incorrect, you may ask us to amend it. Your request must be made in writing and must be addressed to the Privacy Officer. To process your request, you must use the form we provide and explain why you think the amendment is appropriate. We will inform you in writing as to whether the amendment will be made or denied. If we agree to make the amendment, we will make reasonable efforts to notify other parties of your amendment. If we agree to make the amendment, we will also ask you to identify others you would like us to notify.

We may deny your request if you ask us to amend information that:

1). Was not created by us, unless the person who created the information is no longer available to make the amendment;

2). Is not part of the protected health information we keep about you;

3). Is not part of the protected health information that you would be allowed to see or copy; or

4). Is determined by us to be accurate and complete.

If we deny the requested amendment, we will notify you in writing on how to submit a statement of disagreement or complaint or request inclusion of your original amendment request in your protected health information.

c). Right to obtain a list of the disclosures**.** You have the right to get a list of protected health information disclosures, which is also referred to as an accounting. You must make a written request to the Privacy Officer to obtain this information.

The list will not include disclosures we have made as authorized by law. For example, the accounting will not include disclosures made for treatment, payment and health care operations purposes (except as noted in the following paragraph). Also, no accounting will be made for disclosures made directly to you or under an authorization that you provided or those made to your family or friends. The list will not include other disclosures, including incidental disclosures, disclosures we have made for national security purposes, disclosures to law enforcement personnel or disclosures made before April 14, 2004.The list we provide will include disclosures made within the last six years (subject to the April 14, 2004 beginning date) unless you specify a shorter period.

You may also request and receive an accounting of disclosures of electronic health records made for payment, treatment, or health care operations during the prior three years for disclosures made on or after (1) January 1, 2014 for electronic health records acquired before January 1. 2009, or (2) January 1, 2011 for electronic health records acquired on or after January 1, 2009.

The first list you request within a 12-month period will be free. You may be charged for providing any additional lists within a 12-month period.

d). Right to choose how we communicate with you. You have the right to ask that we send information to you at a specific address (for example, at work rather than at home) or in a specific manner (for example, by e-mail rather than by regular mail). We must agree to your request if you state that disclosure of the information may put you in danger.

e). Right to request additional restrictions on health information**.** You may request restrictions on our use and disclosure of your confidential information for the treatment, payment and health care operations purposes explained in this Notice. While we will consider all requests for restrictions carefully, we are not required to agree to a requested restriction. However, we must comply with your request to restrict a disclosure of your confidential information for payment or health care operations if you paid for these services in full, out of pocket.

Questions and Complaints

If you believe your privacy rights have been violated, you may file a complaint with us at the address listed below or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, put your complaint in writing and address it to the Privacy Officer listed below. The Plan will not retaliate against you for filing a complaint. You may also contact the Privacy Officer if you have questions or comments about our privacy practices.

Future Changes to Our Practices and This Notice

We are required to follow the terms of the privacy notice currently in effect. However, we reserve the right to change our privacy practices and make any such change applicable to the protected health information we obtained about you before the change. If a change in our practices is material, we will revise this Notice to reflect the change. We will send or provide a copy of the revised Notice. You may also obtain a copy of any revised Notice by contacting the Privacy Officer.

Contacts

If you have any questions concerning your privacy rights, the Fundôs policies and procedures regarding privacy, or your protected health information, contact us at:

Privacy Officer
Asbestos Workers Local No. 42 Welfare Fund
c/o Carday Associates, Inc.
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
1-888-490-8800
T: 410-872-9500
F: 410-872-1275

SUBROGATION

Conditional Benefit Payments

When injury or illness for which any benefits would otherwise be payable under this Plan is caused under circumstances which may create a legal liability on the part of some other person or party or for which a third party is or may be held responsible, the Plan may make advance expense reimbursements or otherwise pay claims to or on behalf of the participant or dependent subject to the Plan's subrogation rights. Acceptance by the participant, dependent, or provider shall constitute an agreement to repay such amounts to the Plan in the event a recovery is made from the other person or party. Such acceptance shall also constitute an agreement by the participant or dependent and by any agent acting on his or her behalf that the Plan shall have an equitable lien with respect to the proceeds of any claims asserted by the participant or beneficiary against any third party. Furthermore, the proceeds arising out of such third party claims, whether obtained by settlement or judgment, shall be held in an equitable trust for the benefit of the Plan to the extent of the payments or payment of claims advanced by the Plan on behalf of the participant or dependent. In addition, the Fund shall have a subrogation lien in the amount of such reimbursements and payments and shall be entitled to recover its lien directly from the third party. Such reimbursements or payments shall be conditioned upon the participant or dependent (or the dependent's legal guardian if the dependent is a minor) executing an agreement that acknowledges and affirms (a) the conditional nature of the reimbursements or payments and (b) the Plan's rights of subrogation as provided below. The payment of conditional advances or benefits under this provision shall, however, be limited to a maximum of $5,000.00 in the aggregate for all payments or claims arising out of an injury.

Subrogation

Subrogation means that the Fund is entitled to recover, by legal or equitable action if necessary, benefits paid by it to or on behalf of a participant or a dependent with regard to injuries or illness for which a third party is responsible. The Fund can recover its payments from the participant or dependent or from any other person or entity, including another insurance company or plan of benefits that is responsible for the injuries or for the payment of benefits or claims relating to those injuries. If a participant or eligible dependent receives any benefits arising out of an injury or illness for which the participant or dependent (or the participant or dependent's guardian or estate) has, may have, or asserts any claim or right of recovery against a third party or parties, any payment or payments under this Plan for such benefits shall be made on the condition and with the understanding that this Plan will be reimbursed. Such reimbursement will be made by the participant or dependent (or the participant or dependent's guardian or estate) to the extent of, but not exceeding, the total amount payable to or on behalf of the participant or dependent (or the participant or dependent's guardian or estate) from (a) any policy or contract with any insurance company or carrier (including the participant's or dependent's insurer) and/or (b) any third party, plan or fund, whether as a result of a judgment or settlement. The proceeds of any such payments by any third party shall be held in an equitable trust on behalf of this Plan. This Plan shall also have an equitable lien on all such proceeds to the extent of the payments, payment of claims, or other benefits advanced by this Plan on behalf of the participant or participant's dependent.

Under the Planôs subrogation provisions, a participant has the following obligations in order to be entitled to receive the conditional advances which are provided under this Section:

1. To sign a Subrogation Agreement in a form approved by the Trustees which provides, among other terms, that the participant or dependent on behalf of himself (or his guardian or estate) acknowledges and agrees that this Plan will be reimbursed in full before any amounts (including attorneyôs fees incurred by the participant or dependent or his guardian or estate) are deducted from the policy, proceeds, judgment or settlement, and which also creates on behalf of the Plan an equitable lien on the proceeds of any claims asserted against any third party and which further creates on behalf of the Plan an equitable trust with respect to the proceeds of any such claim whether as a result of settlement or judgment.

2. To take such action and cooperate with Plan representatives as may be necessary or appropriate to recover from any third party, as damages, those payments made by the Plan.

3. To immediately pay to the Plan the benefits or expenses advanced by the Plan from any money recovered from third persons, insurers, or other entities.

4. Not to do anything to impair, prejudice or discharge the Planôs right of subrogation or to assign to the Plan the right to bring an action against any third party responsible for the injuries sustained if the participant fails to bring such action.

5. To execute and deliver any and all documents (in their original form) required by the Trustees and to do whatever else is necessary to fully protect the Planôs subrogation rights.

6. To specifically notify the administrative agent, in writing, of any injury or illness for which the Plan is requested to pay benefits and for which the Plan may have a right or interest in subrogation under this Section. Such notification shall include the name, address, and phone number of any person, insurance company, or other entity who may be legally responsible for such injury or illness or against whom the participant or dependent intends to or has asserted a claim. Such notification shall also provide the name and address of any attorney acting on behalf of the participant or beneficiary as well as the name of any insurance adjuster or claims representative which has been assigned to such third party claims.

   This Plan will be subrogated to all claims, demands, actions and right of recovery against any entity including, but not limited to third parties and insurance companies and carriers (including the participant or dependentôs insurer) to the fullest extent permitted by law. The amount of such subrogation will equal the total amount paid under this Plan arising out of the injury or illness for which the participant or dependent (or the participant or dependentôs guardian or estate) has, may have or asserts a cause of action. In addition, this Plan will be subrogated for attorneyôs fees incurred in enforcing its subrogation rights under this Section.

The Fund has no duty or obligation to pay a fee to your attorney for services in making any recovery on your behalf. Absent written approval of the Fund, you are obligated to inform your attorney of the Fundôs subrogation lien, and to make no distributions from any settlement or judgment that will in any way result in the Fund receiving less than the full amount of its lien.

Failure by the participant or dependent (or his estate or guardian) to comply with the requirements of this Section may, at the Trusteesô sole discretion, result in a forfeiture of benefits, including future benefits under this Plan. In the event, however, that the participant or dependent is unsuccessful in asserting claims against a third party for the injury or illness for which the Plan has advanced payments or benefits and the participant or dependent has exhausted all available appeals and available legal process, the Plan shall not require the participant or dependent to make reimbursement.

If any participant or dependent has any questions or if you are asked to waive any rights covering any conditions for which you have received or expect to receive payment from the Plan, contact the Planôs Administrative Agent as soon as possible.

COORDINATION OF BENEFITS

This provision will coordinate the health benefits payable as described on the preceding pages with similar benefits payable under other plans. The other plans are those which provide benefits or services in connection with medical or dental care or treatment and any government or tax supported program, including but not limited to the Medicare Program.

When this Provision Is Applicable

This provision is applicable when the total benefits that would be payable in the absence of any coordination of benefits provisions under our Plan and under all other plans covering an individual exceed the Allowable Expenses incurred during a Claim Determination Period.

An Allowable Expense is any necessary, Reasonable and Customary item of expense, at least a portion of which is covered under at least one of the plans covering the individual with respect to whom a claim is made. A Claim Determination Period is a calendar year.

What Happens When this Provision Is Applicable

One of the two or more plans involved is the Primary Plan and the other plans are Secondary Plans. The Primary Plan pays benefits first and without consideration of the other plans. The Secondary Plans then makes up the difference up to the total Allowable Expense. No plan will pay more than it would have paid without this special provision. If one plan has no coordination of benefits provision, it automatically is Primary.

Here's how benefits will be coordinated:

- A policy covering a person as an employee will pay benefits as the Primary Plan. A policy covering a person as a Dependent will pay as the Secondary Plan.

Å If a Dependent child is covered by both parents' policies, the benefits of the policy which covers the child of the parent whose date of birth, excluding year of birth, occurs earlier in a calendar year will be determined the Primary Plan. The benefits of the policy which covers the child of the parent whose date of birth, excluding year of birth, occurs later in a calendar year, will be determined the Secondary Plan.

Å If a policy containing the "birth date" rule is coordinating with a policy which contains the gender-based rule and as a result the policies do not agree on the order of benefits, the birth date of the parent will determine the order of benefits.

Å When the parents are divorced or separated the order is:

1. The policy of the parent with custody pays first. The policy of the parent without custody pays second.

2. If the parent with custody has remarried, the order is:

   a. the policy of the parent with custody,
   b. the policy of the step-parent,
   c. the policy of the parent without custody.

▪ If there is a court case decree which states that one of the parents is responsible for the child's health care expenses, the policy of that parent will pay first. That order will supersede any order given in 1 or 2 above.

Å If a person is covered under more than one policy, the policy he or she was covered under longer pays first. The exception to this rule is:

A group policy that covers a person other than as a laid-off or retired employee, or Dependent of such person, will determine the benefits that are paid first. A group policy that covers a person as a laid-off or retired employee, or Dependent of such person, will determine the benefits that are paid second.

MEDICARE PROGRAM

The Medicare Program commenced providing benefits to persons 65 years of age and older, effective July 1, 1966. All persons 65 years of age or over are entitled to Hospital care and they are also entitled to surgical and medical care provided they elected to pay a monthly premium.

The Fund will not provide for payment of any of the benefits that are provided under the Medicare Program regardless of whether or not you elected to participate in the Medicare Program. **Employees and their spouses as they become age 65 are urged to enroll with Medicare as they will only be provided benefits as stated above.**

Note: This Plan provides prescription drug coverage for Retirees and their eligible dependents. A Retiree or eligible dependent who elects to enroll in Medicare Part D prescription drug coverage will not be eligible for prescription drug benefits under this Plan.

Disabled employees who are entitled to participate in the Medicare Program will not receive payment for benefits that are provided under Medicare. Contact your local Social Security Administration Office for enrollment procedures.

Coordination with Medicare

If you or your Dependent becomes eligible for Social Security at age 65 while you are still working, coverage by Medicare is possible even if you don't retire. Medicare includes Hospital insurance benefits (called "Part A") as well as supplementary medical insurance (called "Part B").

If you or your spouse reach age 65 while you are still working, or if you are covered under this Plan as a Disabled Employee not receiving any form of pension benefits, benefits are paid under this Plan before they are paid under Medicare, unless you notify the Fund Office in writing that you want to waive your right to receive those benefits.

If you or your spouse retires while you are covered under this Plan (even if you retire because of Disability), any coverage under this Plan is coordinated with Medicare coverage when you become eligible for Medicare, whether or not you or your spouse are enrolled under Medicare. It is important that you or your spouse enroll for Medicare at the earliest opportunity since your failure to do so results in lower medical protection.

After retirement, you should submit all of your medical claims to Medicare first. This Plan considers a claim for any remaining expenses and pays any balance unpaid by Medicare for covered Plan expenses that are considered Reasonable and Customary.

It is important that you or your Dependents visit an office of the Social Security Administration during the three-month period before your 65th birthday to learn all about Medicare. If you have any questions about the coverage provided by this Plan, or need help in comparing benefits offered by this Plan and Medicare, please contact the Fund Office.

PAYMENT OF CLAIMS

Each employee must complete and submit to the Fund Office an enrollment form and proof for Dependents immediately upon coming under the jurisdiction of this Fund. Enrollment forms may be obtained from the Business Manager or the Fund Office. Claims cannot be processed until the enrollment form and proof for Dependents are filed with the Fund Office.

Types of Claim Forms

There different claim forms which are normally used in connection with your Welfare Trust Fund:

1. The form for Accident and Sickness Benefits, Surgical Benefits, Medical Benefits, or any combination thereof.

2. Vision Claim form.

3. Dental Claim form.

4. Life and Accidental Death form.

File Your Claim at Once!

The Fund Office and the Union have available all claim forms needed in connection with this Fund, including the Life and Accidental Death and Dismemberment claim forms, which are used less frequently. In case of death, it is necessary in filing the claim to furnish the Fund Office with a certified copy of the death certificate from the Bureau of Vital Statistics. If this certificate for some reason is unobtainable, the necessary form to be completed by the attending Physician may be obtained upon request from the Fund Office.

The Accident and Sickness benefits will be paid weekly and will include payments for fractional parts of a week. These benefits will be paid promptly if you furnish proof of your disability. Do not wait until you return to work before filing claim.

Claims must be submitted to the Fund Office within twelve (12) months from the date of service in order to be considered for payment.

Steps to Take

1. Get your claim form from the Fund Office or your local Business Manager;
2. Have the claim form completed by the doctor and/or Hospital;
3. Attach all receipts and bills to the claim form; and
4. Mail the claim form to:

Asbestos Workers Union Local 42 Welfare Fund
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046

If you receive services from a CIGNA PPO provider, you will not be required to complete the claim form approved by the Fund Office. Such claims will be submitted directly to CIGNA for repricing and forwarded to the Fund Office.

NOTIFICATION OF CHANGES

When your initial eligibility becomes effective, it is necessary to submit to the Fund Office proof of each Dependent listed on your Enrollment Form (marriage, birth certificate, or legal court papers).

After your eligibility becomes effective, it is necessary to submit similar proof whenever there is a change in Dependents.

The Fund Office must be notified promptly of any changes from one to another of the following classifications:

1. Member without Dependents.
2. Member with Dependents.

The Fund Office should also be notified of the following information so that there may be no delay in the handling of your claims:

1. Any change in marital status;

NOTE – If your marriage is terminated or you are separated from your spouse, you must immediately notify the Fund upon entry of a divorce decree, date of legal separation, or date you no longer cohabitate with your spouse. The Fund does not provide benefits to the divorced or legally separated spouse of a participant, or in the absence of a domestic relations court order to the contrary, a spouse with whom you do not cohabitate and who has for a period of 12 months or more maintained his or her separate legal or permanent residence. If you fail to promptly notify the Fund of your divorce or separation, you will be personally responsible and must reimburse or indemnify the Fund for any claims paid by the Fund on behalf of your former or estranged spouse which were incurred after the date your former or estranged spouse is no longer eligible under the Fund rules.

2. Names and birth dates of newborn or adopted children;

3. Date that any Dependent child reaches his or her 26th birthday.

4. Any changes of address.

A new enrollment form should be completed and filed with the Fund Office when any of the above changes occur.

IV. SCHOLARSHIP BENEFITS

The Welfare Fund provides a scholarship benefit to dependent children of members of Asbestos Workers Union Local 42 for purposes of post-secondary education or its equivalent. The benefit is funded through contributions negotiated under the Collective Bargaining Agreement between Local 42 and participating employers specifically for this purpose. In addition, at the discretion of the Trustees the Fund may also engage in other fund raising activities to raise additional contributions to the scholarship benefit. What follows below is a description of the rules of eligibility and procedures to apply for the scholarship benefit.

Eligibility

In order to be eligible for a scholarship under this Plan, an applicant must be a dependent child (either natural, adopted or a stepchild) of a member of Asbestos Workers Union Local 42 who is a full time continuous employee of any employer who has a Collective Bargaining Agreement with the Union which provides for the payment for employer contributions to the Scholarship Plan. Dependent children of a retired, disabled or deceased member who is or was a full time continuous employee of such an employer are also eligible.

Selection of Qualified Applicants

An independent professional educator selected by the Trustees will determine from the eligible applicants a pool of applicants who are qualified to receive benefits under the Planôs selection criteria.

In order to be a qualified applicant, the applicant must:

1. have graduated from an accredited high school, equivalency program, or trade school with a C average or better;

2. have successfully completed any entrance examination required by a qualified post-secondary educational institution which the candidate has selected;

3. have applied to and been accepted by a qualified post-secondary educational institution on either a part time or full time basis. The term ñqualified educational institution,ò means a post-secondary college, university or trade school of recognized standing offering a course leading to a degree or certification;

4. in order to compete for an additional Supplemental Scholarship Benefit, must submit an essay on a topic pertaining to trade unionism. It is not mandatory that an applicant compete for the Supplemental Scholarship Benefit.

An applicant may also qualify to receive a scholarship if the applicant is currently enrolled in a qualified educational institution and has earned a grade point average of C or better upon completion of the first year. Such applicants must have applied to or otherwise been accepted or continued to be enrolled in a qualified educational institution on either a part time or full time basis.

In addition to the entrance examinations referred to above, the school which the applicant is currently attending must submit a secondary school report form for use in that selection process.

At least once per year a determination will be made of the qualified applicants who will receive a scholarship benefit. Where the number of qualified applicants exceeds the number of available scholarships, the scholarships shall be made from the pool of qualified applicants through the use of a random lottery conducted pursuant to a blind selection procedure established by the Fund.

Obligation of Winners

Within ten days following notification of selection, a winner must notify the Fund, in writing, of his or her acceptance of the scholarship. Within twenty days of notification of selection or sooner, if possible, a winner must submit evidence, in writing, of his or her official acceptance by a qualified educational institution.

In the event a winning candidate does not meet the obligations outlined in these rules or fails to enter a qualified educational Institution at the beginning of the term following the award of a scholarship, the Trustees of the Fund reserve the right to withdraw the candidate's scholarship benefits.

Schools and Courses

Winners of scholarships may choose a qualified educational institution of recognized standing and any program or course leading to a degree or certification which is offered therein. Accelerated courses may be taken, if authorized by the proper school authorities.

Payment of Scholarships

In each year of a scholarship award, the Fund shall pay tuition fees directly to the school or university up to the limit of the annual pro-rated scholarship amount divided equally among the number of semesters attended during the year.

If the total annual tuition payment is less than the pro-rated annual scholarship amount, the difference will be available to the scholar, through the school, for mandatory extras, required text books or other proper charges billed by the school, or certified to by the financial aid officer of the school. If, at the end of any full school year, there remains an unexpended balance from the pro-rated annual scholarship amount, after all charges have been paid, such balance may be applied to proper charges billed by the school for any subsequent year or years of undergraduate or postgraduate study. In case any undergraduate is graduated with a degree without having used his or her entire scholarship benefits, the remaining value of the scholarship may be applied to tuition and other proper charges billed by a recognized school or university or certified to by the financial aid officer of the school for any postgraduate work leading to a degree or advanced certification during a two year period following graduation. Any balance remaining after the application of a scholarship grant as set forth above is to be returned to the Fund.

Academic Standing

The continuing benefits of a scholar shall be dependent upon the student maintaining continuous matriculated academic standing as well as scholastic and behavior standings satisfactory to the school authorities. Any student who is absent from or otherwise does not attend a recognized school for more than two consecutive semesters shall forfeit entitlement to further benefits and the balance of said scholar's scholarship award shall revert to the reserves of the Fund. In case of prolonged illness or hardship which prevents continuous attendance, the student's unused scholarship rights may be reinstated if in the sole judgment of the Fund Trustees the circumstances so warrant. The reinstatement of scholarship benefits shall not be predicated upon continued employment by the member through whom eligibility is provided. In a case where a school suspends a student, the Fund Trustees reserve the right to withdraw all further scholarship benefits.

Changing Schools

There will be no restriction as to a scholar changing schools before graduation provided the transfer is approved by the authorities of both schools.

Military Service

If a scholar enters the Armed Services of the United States, the unused scholarship rights may be resumed after the student returns to school, not later than the opening of the school term next following the date of discharge. To take advantage of this provision, a scholar must inform the Fund, in writing, upon entering any such Service, and again within thirty days of discharge.

Duty to Provide Information

All scholars who are awarded a benefit shall have the obligation to provide to the Trustees any information which the Trustees deem necessary, in their sole discretion, to the proper administration of the Fund and its rules. Any scholar who fails or otherwise refuses to provide such requested information within sixty (60) days of written notice shall forfeit any further entitlement to scholarship benefits.

V. VACATION BENEFITS

Vacation benefits are provided under the terms of the Collective Bargaining Agreements between Local 42 and signatory Employers and are paid through the Welfare Fund. Vacation benefits are funded by each employee through deductions from the employeeôs paycheck. In order to receive a vacation benefit, you must be an employee under a Local 42 Collective Bargaining Agreement that provides for a vacation benefit and must authorize the deduction of the vacation benefit contributions from your weekly pay. The deducted employee contributions are then paid by your employer to the Fund. A list of employers who are party to a Collective Bargaining Agreement with Local 42 that provides for the vacation benefit can be obtained from Carday Associates.

Vacation payouts will automatically be distributed on a semi-annual basis. The first payout of the year will be mailed out by the third week of June and the second payout of the year will be mailed out by the third week of December.

The first semi-annual vacation year commences on the Monday before the last Wednesday in October and ends on the Sunday before the last Wednesday in April. Vacation benefits for all contributions received by May 31 are distributed in the third week of June. In the event that contributions are not received by the cutoff date, the Fund will recheck the receipt of contributions at thirty (30) and sixty (60) day intervals and if received, issue payment of any additional vacation benefits.

The second semi-annual vacation year commences on the Monday before the last Wednesday in April and ends on the Sunday before the last Wednesday in October. Vacation benefits for all contributions received by November 30 are distributed in the third week of December. In the event that contributions are not received by the cutoff date, the Fund will recheck the receipt of contributions at thirty (30) and sixty (60) day intervals and if received, issue payment of any additional vacation benefits.

VI. CLAIMS AND APPEALS FOR BENEFITS

A. Claims and Appeals for Group Health Benefits

To file a claim for major medical, dental, vision or other group health benefits, you must follow all of the procedures set forth on page 57 of the Summary Plan Description. In addition, the following procedures apply:

1. Applicable Definitions

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

a. Urgent Care Claim

This is a claim which (1) involves emergency medical care needed immediately in order to avoid serious jeopardy to your life, health,

or ability to regain maximum function; or (2) in the opinion of a physician with knowledge of your medical condition would subject you to severe pain if your claim were not dealt within the ñurgent careò time frame described below. Whether your claim is one involving urgent care will be determined by the Plan, applying an average laypersonôs knowledge of health and medicine. If a physician with knowledge of your medical condition determines that your claim is one involving urgent care, the Plan will treat your claim as an urgent care claim.

b. Pre-service claim

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

c. Post-service claim

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

d. Concurrent care claim

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

e. Incomplete Claims

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

2. Notification of Initial Benefit Determination

a. Urgent Care Claims

The Fund will notify you whether your claim is approved or denied within 72 hours after it receives your claim, unless your claim is incomplete. The Fund will notify you if your claim is incomplete, within 24 hours after receiving your claim. The Fund will notify you orally, unless you request written notification (written

notification will extend the time constraints). You then have 48 hours to provide the specified information. Upon receiving this additional information, the Fund will notify you of its determination, within 48 hours after receiving the information.

b. Pre-service claim

The Fund will notify you whether your claim is approved or denied as soon as practicable, but not later than 15 days after receipt of your claim. This period may be extended by one 15-day period, if circumstances beyond the control of the Fund require additional time to process your claim. If an extension is needed, the Fund will notify you prior to the expiration of the initial 15-day period of the circumstances requiring an extension and the date by which the Fund expects to reach a decision. If the Fund needs an extension because you have submitted an incomplete claim, the Fund will notify you within 5 days of receipt of your claim. The notice will include the information needed to make a decision. The Fund will notify you orally, unless you request written notification (written notification will extend the time constraints). You will have 45 days after receiving notice to provide the specified information. If you fail to submit information necessary for the Fund to decide a claim, the period for making the benefit determination will 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.

c. Post-service claims

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

d. Concurrent care

If the Fund has approved an ongoing course of treatment to be provided over a period of time, it will notify you in advance of any reduction in or termination of this course of treatment. If you submit a claim to extend a course of treatment, and the claim involves urgent care, the Fund will notify you of its determination

within 24 hours after receiving your claim, but only if the Fund receives your claim at least 24 hours prior to the expiration of the course of treatment. If the claim does not involve urgent care, the request will be decided set out above, depending on whether it is a pre-service or post-service claim.

3. Denial of Claim for benefits

If any claim for benefits described above is denied, in whole or in part, the Fund will provide a written or electronic notice which states the reasons for the denial, refers to any pertinent Plan provisions, rules, guidelines, protocols or other criteria used as a basis for the denial, describes any additional material or information which might aid your claim, explains why the information is necessary, and describes the Planôs review procedures and applicable time limits, including a right to bring a civil action under 502(a) of ERISA. If an internal rule, guideline, protocol or other criterion is relied on in making the adverse determination, you will be provided with the specific rule, guideline, protocol or criterion, or advised that such will be provided to you free of charge upon request. If the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the denial notice will include either an explanation of the scientific or clinical judgment for the determination, or a statement that such explanation will be provided free of charge upon request.

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

4. Appeals

a. General

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

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

Any written appeal should state your name and address, the date of the denial, the fact that you are appealing the denial and the reasons for your appeal. You should also submit any documents that support your claim. The review of your claim will take into account all comments and documents that support your position, even if the Fund did not have this information in making the initial determination. This does not mean that you are required to cite all of the Plan provisions that apply or to make ñlegalò arguments; however, you should state clearly why you believe you are entitled to the benefit or why you disagree with a Fund policy, determination or action. The Board of Trustees can best consider your position if your claims, reasons and/or objections are clearly stated.

The review on appeal shall be made by the Board of Trustees or a designated Committee of the Board of Trustees. The Board of Trustees or the designated Committee of the Board of Trustees deciding the appeal shall give no deference to the initial denial or adverse determination. In case of a claim based in whole or in part on a medical judgment, a health care professional who has appropriate training and expertise in the field of medicine, and who was not consulted in connection with the initial claim, may be consulted. Any medical or vocational expert(s) whose advice was obtained by the Plan in connection with the adverse determination will be identified upon request.

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

b. Notification of Decision on Appeal

i. Timing of Notification

A) <u>Urgent Care Claim</u>

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

B) <u>Pre-Service Claim</u>

The Fund will notify you of its determination of a pre-service later than 30 days after it receives your request for review.

C) Post-Service Claim

In the case of a post-service claim, the Board of Trustees or a designated Committee of the Board of Trustees will review your appeal at the 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 such 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 timely. If circumstances require an extension of time for review by the Board of Trustees, a benefit determination will be rendered not later than the third Board of Trustees meeting following receipt of your appeal. You will be notified in writing prior to the extension of the circumstances requiring the extension and the date by which the Board of Trustees expect to reach a decision. You will receive written or electronic notice of the decision of the Board of Trustees after review by the Board of Trustees within 5 days of a decision.

ii. Content of Notification

The Fund will provide you with written or electronic notice of its determination on review. If there is an adverse determination, the notice will set forth the specific reason(s), the specific plan provisions on which the benefit determination is based, a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, relevant information regarding the determination, and a statement of your right to bring a civil action under 502(a) of ERISA. You will also be notified of the availability of other voluntary alternate dispute resolution options, such as mediation, and that further information on these options can be obtained from the local office of the Department of Labor or the applicable state insurance regulatory agency. In addition, if an internal rule, guideline, protocol or similar criterion was relied on in making the adverse determination, either you will be provided with the specific rule, guideline, protocol or similar criterion, or you will receive a statement that such a rule, guideline, protocol or similar criterion was relied on in making the adverse determination, and a copy of such rule, guideline, protocol or other criterion will be provided to you free of charge upon request. If the adverse determination was based on a medical necessity or experimental treatment or similar exclusion or limit, the

denial notice will include either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request.

5. Board of Trusteesô Decision on Appeal is Conclusive, Final and Binding

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

B. Claims and Appeals for Weekly Accident and Sickness Benefits

1. General

To file a claim for weekly accident and sickness benefits, you must follow all of the procedures set forth in pages 26 and 52 of the Summary Plan Description. In addition, the following procedures apply.

2. Notification of Initial Benefit Determination

The Fund will decide claims for accident and sickness benefits 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. The Fund Office will notify you of the extensions prior to the expirations of the initial 45 day and first 30-day extension period, respectively. Any notice of extension will indicate the circumstances requiring an extension, the date by which a decision is expected to be reached, the standards upon which entitlement to a benefit is based, the unresolved issues that require an extension, and any 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.

3. Denial of Claim for Benefits

If your application for benefits is denied, in whole or in part, the Fund Office will provide you with a written or electronic notice which states the reasons for the denial, refers to any pertinent Plan provisions, rules, guidelines, protocols or other criteria used as a basis for the denial,

describes any additional material or information which may help your claim, explains why that information is necessary, and describes the Planôs review procedures and applicable time limits, including a right to bring a civil action under 502(a) of ERISA. If an internal rule, guideline, protocol or criterion was relied on in making the adverse determination, you will be provided with the specific rule, guideline, protocol or criterion, or advised that such will be provided to you free of charge upon request. If the adverse determination was based on a medical necessity or experimental treatment or similar exclusion or limit, the denial notice will include either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request. Once you receive the decision, you may consider the claim approved or denied. If the claim is denied, you may take steps to appeal the denial.

4. Appeals

a. General

If your claim is denied, you may request the Board of Trustees to review your benefit denial by submitting a written appeal to the Board of Trustees. Your written appeal must be submitted within 180 days of receiving the denial notice. Failure to file a timely appeal will result in a complete waiver of your right to appeal and the decision of the Plan Administrator will be final and binding.

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

Any written appeal should state your name and address, the date of the denial, the fact that you are appealing the denial and the reasons for your appeal. You should include documents that support your claim. The review of your claim will take into account all comments and documents that support your position, even if the Fund did not have this information in making the initial determination. This does not mean that you are required to cite all of the Plan provisions that apply or to make ñlegalò arguments; however, you should state clearly why you believe you are entitled to the benefit or why you disagree with a Fund policy, determination or action. The Board of Trustees can best consider your position if your claims, reasons and/or objections are clearly stated.

The review on appeal shall be made by the Board of Trustees or a designated Committee of the Board of Trustees. The Board of Trustees or the designated Committee of the Board of Trustees deciding the appeal shall give no deference to the initial denial or adverse determination. In case of a claim based in whole or in part on a medical judgment, a health care professional who has

appropriate training and expertise in the field of medicine, and who was not consulted in connection with the initial claim, may be consulted. Any medical or vocational expert(s) whose advice was obtained by the Plan in connection with the adverse determination will be identified upon request.

b. Notification of Decision on Appeal

i. Timing of Decision and Notification

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

ii. Content of Notification

If there is an adverse determination, the notice will set forth the specific reason(s), the specific plan provisions on which the benefit determination is based, a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, relevant information regarding the determination and a statement of your right to bring a civil action under 502(a) of ERISA. You will also be notified of the availability of other voluntary alternate dispute resolution options, such as mediation, and that further information on these options can be obtained from the local office of the Department of Labor or the applicable state insurance regulatory agency. In addition, if an internal rule, guideline, protocol or similar criterion was relied on in making the adverse determination, either you will be provided with the specific rule, guideline, protocol or similar criterion, or you will receive a statement that such a rule, guideline, protocol or similar criterion was relied on in making the adverse determination, and a copy of such rule, guideline, protocol or other criterion will be provided to you free of charge upon request. If the adverse

determination was based on a medical necessity or experimental treatment or similar exclusion or limit, the denial notice will include either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request. The decision of the Board of Trustees on review shall be final and binding upon all parties including any person claiming a benefit on your behalf.

c. Board of Trusteesô Decision on Appeal is Conclusive, Final and Binding

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

C. Claims and Appeals for Death and Accidental Death and Dismemberment Insurance Claims

1. To file a claim for life and accidental death and dismemberment benefits, you must follow all of the procedures set forth in the Plan. CIGNA Insurance Company will handle claims and appeals for these benefits according to the following procedures.

a. If your claim for benefits is denied, in whole or in part, you will receive a written notice *from CIGNA* that states the reasons for the denial, refers to any pertinent Plan provisions, rules, guidelines, protocols or other similar criteria used as a basis for the denial, describes any additional material or information that might help your claim, explains why that information is necessary, and describes the review procedures and applicable time limits, including a right to bring a civil action under 502(a) of ERISA.

b. This notice will be given to you within a reasonable time but not more than 90 days after the date of receipt of your claim. This 90-day period may be extended for up to an additional 90 days if special circumstances require that additional time is needed to process your claim. If an extension is needed, you will be given written notice of the delay prior to the expiration of the 90-day period stating the reason(s) why the extension is necessary and the date by which a decision is expected to be reached. Once you receive the decision, you may consider the claim approved or denied. If the claim is denied, you may take steps to appeal the denial.

c. If your claim is denied, you may request CIGNA to review your benefit denial by submitting a written appeal. Your written appeal must be submitted within 60 days of receiving the denial notice. Failure to file a timely appeal will result in a complete waiver of your right to appeal and the initial benefit decision will be final and binding. Upon receipt of an adverse benefit determination, you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, relevant information regarding a claim determination.

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

e. CIGNA will notify you of its decision on appeal within a reasonable period of time, but not later than 60 days after receipt of your request for review, unless special circumstances require an extension of time to process your claim. If an extension is needed, you will be notified, prior to the expiration of the initial 60-day period, of the circumstances requiring an extension and the date by which a decision is expected to be reached. Such an extension will not exceed 60 days.

f. Notice of an adverse benefit determination on review will set forth the specific reason(s) for the adverse determination, the specific plan provisions on which the benefit determination is based, a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, relevant information regarding a claim determination, and a statement of your right to bring a civil action under 502(a) of ERISA. The decision on review shall be final and binding upon all parties including the claimant and any person claiming a benefit on behalf of the claimant.

g. CIGNA has full discretion or authority to determine all matters relating to the life and accidental death and dismemberment benefits provided under this Plan including, but not limited to, all questions of coverage, eligibility, and methods of providing or arranging for benefits. If CIGNA denies your appeal of a claim, and you decide to seek judicial review, CIGNAôs decision shall be subject to limited judicial review to determine only whether the decision was arbitrary and capricious.

D. Fund Policies, Determinations, or Actions, Claims Concerning Eligibility for Scholarship and Vacation Benefits

1. If you disagree with a policy, determination, or action of the Fund, you may request the Board of Trustees to review the Fund policy, determination or action with which you disagree by submitting a written appeal to the Board of Trustees. Your written appeal must be submitted within 60 days after you learn of a Fund policy, determination or action with which you disagree and which is not a benefit denial.

2. Your written appeal should state the reasons for your appeal. This does not mean that you are *required* to cite all applicable Plan provisions or to make ñlegalò arguments; however, you must state clearly why you believe you are entitled to the benefit which you claim or why you disagree with a Fund policy, determination, or action. The Board of Trustees can best consider your position if your claims, reasons, and/or objections are clearly stated.

3. The Board of Trustees or a designated Committee of the Board of Trustees will review your appeal at the 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 such 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 timely. If special circumstances require an extension of the time for review by the Board of Trustees, you will be notified in writing.

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

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

E. General Information on Claims and Appeals

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

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

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

VII. AMENDMENT AND TERMINATION OF THE PLAN

A. The Trustees have the right to amend, modify, reduce, or increase benefits under the Plan in their sole discretion. The Trustees shall notify all covered participants of any such amendments which modify the substantive terms of the Plan as soon as is administratively feasible but in no event later than 210 days after the close of the Plan year in which the amendment has been adopted. Where the amendment constitutes a material reduction in benefits, however, the Trustees shall notify all covered participants of the change within sixty (60) days from the date on which the amendment has been adopted.

B. Under the Agreement and Declaration of Trust, the Plan can be terminated in the event that either the Union and the Employers signatory to the Agreement and Declaration of Trust, or their designated successors, mutually agree to the termination of the Plan or if the Collective Bargaining Agreement between the Union and Employers expires and there is no reasonable possibility of a successor Collective Bargaining Agreement being negotiated in the foreseeable future under which contributions to the Fund continue. In the event of Plan termination, the assets of the Plan shall not revert to any Employer but shall be used to defray administrative costs of termination and to thereafter provide such termination benefits to participants which are consistent with the purpose, intent, and terms of the Agreement and Declaration of Trust. The Trustees shall notify all participants of the Plan's termination as soon as administratively feasible but no more than sixty (60) days after the date on which the decision to terminate is made.

VIII. INTERPRETATION OF THE PLAN AND TRUSTEE DISCRETION

A. The Trustees have the sole and absolute discretion to determine eligibility for benefits under the Plan and to construe and interpret the provisions of the Plan and Agreement and Declaration of Trust. The decision of the Trustees shall be final and binding unless it is arbitrary and capricious.

B. Notwithstanding any other provision of the Plan, the Trustees shall have the absolute right, in their sole discretion, to amend, modify, suspend or terminate health and welfare benefits for employees, dependents, participants and qualified beneficiaries at any time. Nothing in this Summary Plan Description or elsewhere should be construed to mean the Fund's benefits are guaranteed. The Plan may be terminated, suspended, amended or modified by a majority vote of Trustees.

IX. ERISA

As a participant in the Asbestos Workers Union Local No. 42 Welfare 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:

A. Receive Information About Your Plan and Benefits:

Examine, without charge, at the plan administrator's office and at other specified locations, such as work sites 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 administrator may make a reasonable charge for the copies.

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

B. Continued Group Health Plan Coverage

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.

C. Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may in the future be able to enroll yourself or your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if an employer stops contributing towards your or your dependents' other coverage), provided that you request enrollment within 30 days after your other coverage ends (or the employer stops contributing towards your or your dependents' other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

D. Prudent Actions 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 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.

E. Enforce Your Rights

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

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

F. Assistance with Your Questions

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 Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Asbestos Workers Local No. 42
Welfare Fund

7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
888-490-8800

Important Notice to Local 42 Members
Summary of Material Modification No. 1

June 2016

Dear Participant:

The Board of Trustees continues to strive to provide you and your family with high quality, cost-effective benefit coverage, and at the same time monitor the financial condition of the Fund to assure these benefits will continue for you and your dependents. The Trustees are please to advise of the following increase to the dental benefits provided by the Fund.

The following is a supplement to your Summary Plan Description describing changes adopted by the Board of Trustees:

CHANGE IN DENTAL COVERAGE EFFECTIVE SEPTEMBER 1, 2016

The sections that describe Dental coverage on Pages 21 and 24 of the Summary Plan Description has been amended, effective September 1, 2016 to read:

Dental Care Benefits for Participants and Children Age 19 and Over:

	Percentage Paid Paid By Fund	Maximum paid Per Calendar Year
First $1,000 per calendar year	100%	$ 1,000
Next $5000 per calendar year	75%	$ 3,750
Total Paid by Plan per calendar year		$ 4,750

The sections that Pediatric Dental coverage on pages 22 and 24 of the Summary Plan Description has been amended, effective September 1, 2016 to read:

Pediatric Dental Care (For Children Age 18 and Under):

	Percentage Paid Paid By Fund	Maximum paid Per Calendar Year
First $1,000 per calendar year	100%	$ 1,000
Next $5000 per calendar year *	75%	$ 3,750

*After annual cap has been met, pediatric dental will fall under the Plan's major medical coinsurance. All required co-pays, medical protocols and Usual and Customary Rate limits will apply.

Grandfathered Plan

The Asbestos Workers Local No. 42 Welfare Fund believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Asbestos Workers Local No. 42 Welfare Fund may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at the telephone numbers listed below. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Additional Information

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

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

Sincerely,

THE BOARD OF TRUSTEES

SMM#1/January 2016

Asbestos Workers Local No. 42 Welfare Fund

7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046

888-490-8800

Important Notice to Local 42 Members
Summary of Material Modification No. 2

November 2016

Dear Participant:

This notice contains important information concerning changes that have been made to the terms of your Welfare Plan benefits. These changes modify the existing Summary Plan Description for your Plan. Please read this notice carefully so that you understand the changes which have been made and retain this notice with your Summary Plan Description.

1. Your Summary Plan Description contains definitions of certain important terms starting on page 19. The following are additional definitions which have been added to the terms of your Plan. It is important to understand these because they may define or limit benefits or rights under the Plan.

Experimental or Investigational:

EXPERIMENTAL OR INVESTIGATIONAL means, for purposes of determining Eligible Expenses under the Plan, a treatment, device, supply, service, procedure or drug (other than covered Off-Label Drug Usage), which, in the discretion of the Trustees:

1. Is not yet fully approved or recognized (for other than experimental, investigational, research or clinical trial purposes) by the National Cancer Institute (NCI), Food & Drug Administration (FDA), or other pertinent governmental agency or professional organization, or is approved for a specific medical condition but applied to another condition;

2. Is not proven through controlled clinical trials with results published in peer-reviewed English language medical journals, to be of the greater safety and efficacy than conventional treatment, in both the short and long term;

3. Is not generally accepted medical practice in the state where the claimant resides or as generally accepted throughout the United States as determined in the Trustees' discretion, by referenced to any one or more of the following: peer-reviewed English-language medical literature, consultation with physicians, authoritative medical compendia, the American Medical Association, or other pertinent professional organization or governmental agency; or

4. Is described as investigational, experimental, a study, or for research or the like in any consent, release or authorization which the claimant, or someone acting on his or her behalf, may be required to sign.

Off-Label Drug Use:

OFF-LABEL DRUG USAGE means the use of a drug for a purpose other than for which it is was approved by the Federal Drug Administration (FDA).

Incurred:

INCURRED means, with respect to medical services or supplies, the date on which the services are rendered or supplies are purchased by the Covered Person.

Usual, Customary and Reasonable Charge – The existing language in the Summary Plan Description defining Usual, Customary and Reasonable Charge is deleted and replaced with the following definition:

USUAL, CUSTOMARY, AND REASONABLE CHARGE is defined as the amount determined by the Fund as the amount generally charged by others in the same geographic area who render or furnish the same or similar services, treatments or supplies. If the Plan has a contracted fee arrangement with certain Providers, UCR shall mean the lesser of the applicable fees as defined in that fee arrangement contract or the amount generally charged by others in the same geographic area who render or furnish the same or similar services, treatments or supplies.

2. Information concerning your Prescription Drug Benefits is found at page 31 of your Summary Plan Description which includes a statement of the types of charges for prescription drugs which will be treated as Covered Charges under the Plan. The description of Covered Charges is amended to provide coverage of charges for Off-Label Drug Use pursuant to the following terms and conditions:

(d) Off-Label Drug Use Charges-Charges related to Off-Label Drug Use may be considered covered expenses if all of the following criteria are satisfied:

1. The drug is otherwise covered under the Plan;
2. The drug has been approved by the FDA;
3. Usage of the drug is appropriate and generally accepted standard for the condition being treated; and
4. If used for the treatment of cancer, the American Hospital Formulary Service Drug Information, the Compendia-Based Drug Bulletin, National Comprehensive Cancer Network, Centers for Medicare and Medicaid Services recognize it as an appropriate treatment for that form of cancer.

3. Your Summary Plan Description also provides information at pages 32-33 on charges for prescription drugs which are not covered. This section of your Summary Plan Description is amended by adding the following additional exclusion from covered prescription drug charges:

m) Charges for experimental or investigational drugs (other than covered Off-Label Drug Usage).

4. Your Plan provides Basic Medical Benefits which are described on page 39 of the Summary Plan Description and Major Medical Benefits which are described commencing on page 39 of the Summary Plan Description through page 43. There is also a schedule of benefits contained at pages 21 through 24 of the Summary Plan Description. Your Summary Plan Description also describes certain injuries, illnesses and related charges for services which are excluded from coverage under your Plan. These exclusions can be found on pages 38 (Surgical Benefits), 39 (Basic Medical Benefits) and pages 42 through 43 (Major Medical Benefits). These sections of your Summary Plan Description are amended by the inclusion of the following exclusions and limitations on benefits and covered charges:

Occupational Injuries/Illnesses

Any payment which is Incurred for an Injury or Illness for which the claimant has or had a right to compensation under any Workers' Compensation insurance or similar insurance, or under any Workers' compensation law, occupational disease law, or similar law, whether or not coverage under such law is actually in force.

Experimental or Investigational

Any Expenses Incurred for Experimental or Investigational treatment, services, device, supply or procedure or for any hospital confinement or treatment or medical care and services of any kind that result from treatment, services, device, supply or procedure that is Experimental or Investigational.

Foreign Care

Any payment for expenses Incurred outside the United States except in emergency. Emergencies are defined as instances of a serious injury; the onset of a serious or life-threatening condition which requires immediate medical intervention.

5. Your Summary Plan Description contains information about how to submit claims and your rights to appeal the denial of a claim which you have submitted. This information can be found at pages 62 through 74 of your Summary Plan Description. Under the Affordable Care Act, a special procedure must be established for a claim by a Participant or Beneficiary that they have been subject to discrimination by the Plan on the basis of race, color, national origin, sex, age or disability. Accordingly, your Summary Plan Description is amended by inclusion of the following grievance procedure under the Claims and Appeals procedure of your Plan:

(F) Grievance Procedure for Claims of Unlawful Discrimination under Section 1557 of the Affordable Care Act

Procedure

It is the policy of Asbestos Workers Local 42 Welfare Fund not to discriminate on the basis of race, color, national origin, sex, age or disability. Asbestos Workers Local 42 Welfare Fund has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. § 18116) and its implementing regulations of 45 C.F.R. pt. 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of Amanda Christie, Carday Associates, Inc., 7130 Columbia Gateway Drive, Suite A, Columbia, MD 21046-2966, telephone number: 410-872-9500, fax number: 410-872-1275 and email: achristie@cardayassociates.com, who has been designated to coordinate the efforts of Asbestos Workers Local 42 Welfare Fund to comply with Section 1557.

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for Asbestos Workers Local 42 Welfare Fund to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure

1) Grievances must be submitted to the Section 1557 Coordinator within (60 days) of the date of person filing the grievance becomes aware of the alleged discriminatory action.

2) A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.

3) The Section 1557 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 1557 Coordinator will maintain the files and records of Asbestos Workers Local 42 Welfare Fund relating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.

4) The Section 1557 Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than 30 days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.

5) The person filing the grievance may appeal the decision of the Section 1557 Coordinator by writing to the Board of Trustees Asbestos Workers Local 42 Welfare Fund in care of Carday Associates, Inc., 7130 Columbia Gateway Drive, Suite A,

Columbia, MD 21046-2966 within 15 days of receiving the Section 1557 Coordinator's decision. The Board of Trustees shall issue a written decision in response to the appeal no later than 30 days after its filing.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201. Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html. Such complaints must be filed within 180 days of the date of the alleged discrimination.

Asbestos Workers Local 42 Welfare Fund will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements.

6. Correction to SMM#1

The sections that describe Dental coverage on Pages 21 and 24 of the Summary Plan Description has been amended, effective September 1, 2016 to read:

Dental Care Benefits for Participants and Children Age 19 and Over:

	Percentage Paid Paid By Fund	Maximum paid Per Calendar Year
First **$1,000** per calendar year	100%	$ 1,000
Next $5000 per calendar year	75%	$ 3,750
Total Paid by Plan per calendar year		$ 4,750

The sections that Pediatric Dental coverage on pages 22 and 24 of the Summary Plan Description has been amended, effective September 1, 2016 to read:

Pediatric Dental Care (For Children Age 18 and Under):

	Percentage Paid Paid By Fund	Maximum paid Per Calendar Year
First **$1,000** per calendar year	100%	$ 1,000
Next $5000 per calendar year *	75%	$ 3,750

*After annual cap has been met, pediatric dental will fall under the Plan's major medical coinsurance. All required co-pays, medical protocols and Usual and Customary Rate limits will apply.

Grandfathered Plan

The Asbestos Workers Local No. 42 Welfare Fund believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Asbestos Workers Local No. 42 Welfare Fund may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at 1-888-490-8800. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

If you have any questions concerning the contents of this notice, please contact Carday Associates, Inc. 7130 Columbia Gateway Drive, Suite A, Columbia, MD 21046-2966, telephone number: 410-872-9500.

Very truly yours,

Board of Trustees

SMM#2/January 2016