

# **INSULATORS LOCAL 84 HEALTH CARE PLAN**

**33 Fitch Boulevard  
Austintown, Ohio 44515  
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August 3, 2011

To All Health Plan Participants:

The Trustees of the Insulators Local 84 Health Plan (hereinafter "Health Plan" or "Plan") are pleased to present you with the enclosed updated Plan Document/Summary Plan Description ("SPD") governing the terms of your benefit plan. The SPD describes the Health Plan's provisions and includes advisory information required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

We urge you to read this booklet carefully in order to become familiar with the Health Plan. The Health Plan described in this booklet is for employees who are eligible to be covered under the Health Plan on or after July 1, 2011. If you have questions pertaining to your coverage under the Health Plan, your rights are determined in accordance with the terms of the plan document then in effect.

This Plan booklet reflects the changes to your Plan since you last received a Plan Document/Summary Plan Description. You have been advised of some changes to the previous Plan by receipt of various Summary Descriptions of Material Modification. This restated Plan includes some recent changes made to the Plan. For example, the Plan was amended to set a maximum on the active participant self-pay rate so that such rate will not exceed the current total self-pay contribution rate for Retired Employees. In addition, the Plan was amended to provide coverage for the prescription drug Tarceva under the Basic Comprehensive Major Medical Benefit of the Plan instead of the Prescription Benefit of the Plan. Lastly, the Plan was amended to provide Vision Benefits as set forth in Article VII of the SPD. Moreover, effective June 1, 2011, the individual deductible was raised from \$250.00 to \$275.00, and the family deductible was raised from \$500.00 to \$550.00.

In addition, the SPD sets forth various changes that were made to the Plan in order to comply with the Patient Protection and Affordable Care Act (or more commonly known as Health Care Reform). Most of the changes made with regard to Health Care Reform are effective June 1, 2011. These changes included (1) extension of dependent child coverage to age 26 (unless the child has other available coverage through the child's employer); (2) removal of lifetime limits on essential benefits and replacement with an annual maximum (\$750,000 from June 1, 2011 through May 31, 2012); limitation of rescissions of coverage to instances of fraud or misrepresentation; and removal of preexisting condition limitations for children under age 19.

Only the full Board of Trustees is authorized to interpret the Health Plan. No other individual or organization, such as your union or employer, nor any employee or representative of any individual or organization, is authorized to interpret the Health Plan or to act as an agent of the Board of Trustees. Should you have any questions regarding the Health Plan, please direct them to the Plan's Third Party Administrator.

We suggest that you share this booklet with the members of your family since they may have an interest in the Health Plan. You should keep this booklet with your other important papers and let your family members know where it is being kept.

Sincerely,

**THE BOARD OF TRUSTEES**

### **DISCLOSURE OF GRANDFATHERED STATUS**

This group health plan 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 your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventative 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's Third Party Administrator at 33 Fitch Boulevard, Austintown, Ohio 44515, or toll free at (800) 435-2388. 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](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.

SUMMARY PLAN DESCRIPTION/  
PLAN DOCUMENT

INSULATORS LOCAL 84 HEALTH CARE PLAN



Revised June 2011

**SUMMARY PLAN DESCRIPTION/  
PLAN DOCUMENT**

**INSULATORS LOCAL 84 HEALTH CARE PLAN**

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## INSULATORS LOCAL 84 HEALTH CARE PLAN

June 2011

To All Health Plan Participants:

The Trustees of the Insulators Local 84 Health Plan (hereinafter "Health Plan" or "Plan") are pleased to present you with this booklet. This booklet describes the Health Plan's provisions and includes advisory information required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

We urge you to read this booklet carefully in order to become familiar with the Health Plan, which was established effective June 1, 2005. The Health Plan described in this booklet is for employees who are eligible to be covered under the Health Plan on or after June 1, 2011. If you have questions pertaining to your coverage under the Health Plan, your rights are determined in accordance with the terms of the plan document then in effect.

This Plan booklet reflects the changes to your Plan since you last received a Plan Document/Summary Plan Description. You have been advised of some changes to the previous Plan by receipt of various Summary Descriptions of Material Modification. This restated Plan includes some recent changes made to the Plan. For example, the Plan was amended to set a maximum on the active participant self-pay rate so that such rate will not exceed the current total self-pay contribution rate for Retired Employees. In addition, the Plan was amended to provide coverage for the prescription drug Tarceva under the Basic Comprehensive Major Medical Benefit of the Plan instead of the Prescription Benefit of the Plan. Lastly, the Plan was amended to provide Vision Benefits as set forth in Article VII herein.

Only the full Board of Trustees is authorized to interpret the Health Plan. No other individual or organization, such as your union or employer, nor any employee or representative of any individual or organization, is authorized to interpret the Health Plan or to act as an agent of the Board of Trustees. Should you have any questions regarding the Health Plan, please direct them to the Plan's Third Party Administrator.

We suggest that you share this booklet with the members of your family since they may have an interest in the Health Plan. You should keep this booklet with your other important papers and let your family members know where it is being kept.

Sincerely,

**THE BOARD OF TRUSTEES**

## TABLE OF CONTENTS

INTRODUCTION.....	1
<b>I. PLAN IDENTIFICATION AND GENERAL INFORMATION .....</b>	<b>3</b>
A. Name of the Fund.....	3
B. Names and Addresses of the Employers .....	3
C. Name and Address of the Plan Sponsor .....	3
D. Name and Address of the Third Party Administrator.....	3
E. Plan Numbers Assigned to the Plan .....	4
F. Type of Plan.....	4
G. The Plan Year .....	4
H. Type of Administration Used for the Plan Assets .....	4
I. Attorneys for the Fund and Agent for Service of Process .....	4
J. Funding Medium for the Accumulation of Plan Assets .....	5
K. Effective Date When Health Plan Began.....	5
L. Sources of Contributions to the Health Plan .....	5
M. Plan Amendment and Termination.....	5
N. Plan is Not a Contract.....	5
<b>II. ELIGIBILITY .....</b>	<b>5</b>
A. Initial Eligibility.....	5
B. Continuation of Eligibility .....	6
C. Reinstatement of Eligibility.....	9
D. Reserve Hours.....	9
E. Termination of Eligibility .....	10
F. Special Enrollment Rights .....	11
G. Employment Outside of Jurisdiction .....	11
H. Maintenance of Eligibility.....	11
I. Military Service.....	11
J. Termination of Coverage and Loss of Reserve Hours for Employment with Non-Contributory Employer.....	12
K. Eligibility through Reciprocity.....	13
L. Change in Classification or the Amount of Coverage.....	14
M. When Coverage Ends .....	14
N. Disability Coverage.....	14
O. Summary of Rights and Obligations Regarding Continuation of Group Health Insurance Coverage under Plan through Self-Contribution.....	15
<b>III. DEPENDENTS' ELIGIBILITY .....</b>	<b>20</b>
A. Eligible Dependents.....	20
B. Dependents Not Eligible.....	21
C. Mentally or Physically Disabled Child .....	22
D. When Dependent's Coverage Begins .....	23
E. When Dependent's Coverage Ends .....	23
F. Surviving Spouse's Continuation Coverage.....	23
G. Eligible Dependent's Temporary Extension of Coverage For Medically Necessary Leave of Absence from School .....	24
<b>IV. RETIREE PROGRAM ELIGIBILITY FOR RETIRED EMPLOYEES .....</b>	<b>25</b>
A. Eligibility Requirements for Retired Employees.....	25
B. Limits on Retiree Actively Working at the Trade .....	26
C. Change of Eligibility Rules and Schedule of Benefits .....	26
D. Medicare Supplemental Benefits for Medicare-Eligible Retirees.....	26
E. Incorporation of Other Plan Documents.....	27

F.	Termination of Benefits.....	27
G.	Retired Employee's Surviving Spouse's Continuation.....	27
H.	Prescription Drug Coverage for Retired Employees under Medicare Part D .....	28
I.	Prescription Drug Coverage for Active Employees under Medicare Part D.....	28
V.	<b>SCHEDULE OF BENEFITS.....</b>	<b>29</b>
A.	Eligible Active Employees, Dependents, and Retirees.....	29
B.	Use of Preferred Provider Organization .....	33
C.	Weekly Accident and Sickness Benefits.....	33
D.	Death Benefits.....	36
E.	Prescription Benefits.....	37
F.	Exclusions from Coverage.....	37
VI.	<b>HEALTH REIMBURSEMENT ARRANGEMENT.....</b>	<b>40</b>
A.	Purpose of HRA.....	40
B.	Plan Year.....	40
C.	Funding Medium for the Accumulation of Plan Assets .....	40
D.	HRA's Effective Date.....	40
E.	Sources of Contributions to the HRA .....	41
F.	Incorporation of Other Plan Documents.....	41
G.	Initial Eligibility for HRA Benefits.....	41
H.	Continuation of Eligibility .....	41
I.	Termination of Eligibility .....	41
J.	Reinstatement of Eligibility after Termination .....	42
K.	Change of Eligibility Rules.....	42
L.	HRA Benefits .....	42
M.	Limit on Benefits .....	42
N.	Eligibility for Reimbursement or Payment from Other Source .....	42
O.	Procedure for Filing An HRA Claim .....	43
P.	Claimant Payment.....	44
Q.	Change in Terms .....	44
R.	Administrative Charges and Earnings.....	44
VII.	<b>VISION CARE BENEFITS .....</b>	<b>404</b>
VIII.	<b>DEFINITIONS.....</b>	<b>47</b>
A.	Accident.....	47
B.	Agreement and Declaration of Trust or Trust Agreement.....	47
C.	Association.....	47
D.	Benefit Period.....	47
E.	Benefit Verification .....	48
F.	Billed Charges .....	48
G.	Brand Name Prescription Drug .....	48
H.	Child or Children .....	48
I.	Claimant.....	48
J.	Clinically Necessary .....	48
K.	Coinsurance .....	48
L.	Coinsurance Limit.....	48
M.	Collective Bargaining Agreement .....	49
N.	Contracting .....	49
O.	Contracting Mail Order Pharmacy.....	49
P.	Cosmetic or Reconstructive Surgery.....	49
Q.	Course of Treatment.....	50
R.	Coverage/Covered Services .....	50
S.	Covered Charges .....	50
T.	Copayment.....	50
U.	Credit Account .....	50

V.	Custodial Care.....	50
W.	Deductible.....	51
X.	Doctor, Physician or Surgeon .....	51
Y.	Eligible Dependent.....	51
Z.	Eligible Employee, Covered Member or Covered Person.....	55
AA.	Eligibility Rules .....	55
AB.	Employee .....	55
AC.	Employer.....	56
AD.	Employer Contributions .....	57
AE.	Excess Charges .....	57
AF.	Expense Incurred or Charges.....	57
AG.	Experimental, Investigational or Medically Unproven .....	57
AH.	Family or Family Member.....	58
AI.	Formulary Brand Name Prescription Drug.....	58
AJ.	Generic Prescription Drug .....	58
AK.	Health and Welfare Plan or Health Care Plan.....	58
AL.	Hospital Confinement.....	59
AM.	HRA .....	59
AN.	Illegal and Willful Misconduct.....	59
AO.	Illness .....	59
AP.	Injury .....	60
AQ.	Inpatient .....	60
AR.	Intensive Care Unit.....	60
AS.	Lesser Amount.....	60
AT.	Mail Order Prescription Drug.....	61
AU.	Medical Emergency .....	61
AV.	Medically Necessary or Reasonably Necessary.....	61
AW.	Negotiated Amount.....	61
AX.	Newborn Care.....	62
AY.	Non-Contracting.....	62
AZ.	Non-Covered Charges .....	62
BA.	Non-Formulary Brand Name Prescription Drug .....	62
BB.	Non-Occupational .....	62
BC.	Non-Participating .....	62
BD.	Non-PPO Network Coinsurance .....	62
BE.	Non-PPO Network Coinsurance Limit.....	63
BF.	Non-PPO Network Provider .....	63
BG.	Other Facility Provider .....	63
BH.	Other Professional Provider .....	63
BI.	Outpatient .....	63
BJ.	Out-of-Pocket Limit.....	64
BK.	Participant.....	64
BL.	Participating .....	64
BM.	Plan.....	64
BN.	PPO Network Provider.....	64
BO.	Pre-Existing Condition .....	64
BP.	Prescription Drug Copayment.....	65
BQ.	Prescription Drug Covered Charges.....	65
BR.	Prescription Order .....	65
BS.	Provider.....	66
BT.	Reasonable and Customary Charge or Amount.....	66
BU.	Rider .....	66
BV.	Sickness.....	66
BW.	Spouse .....	66
BX.	Surgery.....	66

BY.	Total Disability or Totally Disabled .....	66
BZ.	Trust Fund, Trust or Fund .....	67
CA.	Trustee .....	67
CB.	Union .....	67
<b>IX.</b>	<b>PROCEDURE FOR FILING A CLAIM .....</b>	<b>67</b>
A.	Types of Claims .....	67
B.	Who Must File .....	68
C.	When to File a Claim .....	68
D.	Where to File a Claim .....	68
E.	What to File .....	68
F.	Method of Claims Delivery .....	69
G.	Timing of Claims Determinations .....	69
H.	Notice of Claims Denial (Adverse Benefit Determination) .....	70
<b>X.</b>	<b>PROCEDURE FOR APPEALING A CLAIM .....</b>	<b>70</b>
A.	First Level Review .....	70
B.	Timetable for Deciding First Level Review .....	71
C.	Notice of Decision on First Level Review .....	72
D.	Second Level Review .....	72
E.	Timetable for Deciding Second Level Review .....	74
F.	Notice of Decision on Second Level Review .....	74
G.	Official Plan Records .....	75
H.	Voluntary Appeal to Full Board of Trustees .....	75
I.	Commencement of Legal Action .....	75
<b>XI.</b>	<b>ASSIGNMENT OF BENEFITS .....</b>	<b>75</b>
<b>XII.</b>	<b>COORDINATION OF BENEFITS .....</b>	<b>76</b>
A.	Coordination .....	76
B.	Order of Benefit Determination .....	77
C.	Plan Benefit Limits .....	78
D.	Plan Rights .....	78
<b>XIII.</b>	<b>SUBROGATION, RESTITUTION AND REIMBURSEMENT .....</b>	<b>78</b>
A.	Definition .....	78
B.	Subrogation, Restitution and Reimbursement Rights .....	79
<b>XIV.</b>	<b>QUALIFIED MEDICAL CHILD SUPPORT ORDERS .....</b>	<b>82</b>
<b>XV.</b>	<b>FAMILY AND MEDICAL LEAVE .....</b>	<b>82</b>
<b>XVI.</b>	<b>PRIVACY POLICY UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT .....</b>	<b>83</b>
A.	Your Rights under HIPAA .....	83
B.	Disclosure Without Your Written Authorization .....	85
C.	Privacy Officer .....	88
<b>XVII.</b>	<b>MISCELLANEOUS PROVISIONS .....</b>	<b>82</b>
A.	Change of Plan Provisions .....	88
B.	Change in Terms .....	88
C.	Amendment and Termination .....	88
D.	Authority to Interpret Plan .....	89
E.	Legal Actions .....	89
F.	Right to Receive and Release Necessary Information .....	89
G.	Right of Recovery .....	90
H.	Nondiscrimination Rights .....	90
I.	Prohibited Discrimination .....	90
J.	Guaranteed Renewability .....	91

K.	Employment Rights .....	92
L.	Medical Examination.....	92
M.	Trustee Rights .....	92
N.	Payment of Benefits .....	92
O.	Delinquent Contributions.....	92
P.	Post-Mortem Benefits.....	93
Q.	Right of Recovery .....	93
R.	Compliance with Claim Rules.....	93
S.	Governing Laws .....	93
<b>XVIII. SPECIAL NOTICE REGARDING MASTECTOMY COVERAGE.....</b>		<b>93</b>
<b>XIX. REQUIREMENTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 .....</b>		<b>94</b>
<b>XX. THE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 (CHIPRA) .....</b>		<b>94</b>
<b>XXI. STATEMENT OF ERISA RIGHTS.....</b>		<b>95</b>
A.	Receive Information about Your Plan and Benefits .....	95
B.	Continue Group Health Coverage .....	95
C.	Prudent Actions by Plan Fiduciaries .....	96
D.	Enforce Your Rights .....	96
E.	Assistance with Your Questions .....	96

## INTRODUCTION

This booklet, distributed in June 2011, is designed to describe the benefits available to you under the Insulators Local 84 Health Care Plan. It is intended that this information will satisfy the requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), for a Summary Plan Description (hereinafter "Summary"). This booklet also constitutes the Plan Document ("Plan"), setting forth the terms and conditions of the Plan.

This Plan is maintained pursuant to the Collective Bargaining Agreement between the International Association of Heat and Frost Insulators and Asbestos Workers, Local Union No. 84 (hereinafter "Union" or "Local 84") and the Master Insulators Association of Akron, Ohio and the Builders Association of Eastern Ohio and Western Pennsylvania (hereinafter collectively referred to as the "Association,") and other Employers who, by virtue of collective bargaining agreements with the Union, have agreed to participate in the Health Plan and contribute to the Health Plan's trust fund and who became parties thereto. A copy of the Collective Bargaining Agreement is available for your examination at the Union Hall, and Participants and their Beneficiaries may also obtain a copy of the Collective Bargaining Agreement for a reasonable charge by writing to the International Association of Heat and Frost Insulators and Asbestos Workers Local No. 84, 1000 Mogadore Road, Unit B, Kent, OH 44240.

## SPECIAL NOTICE!

It is extremely important you keep the Fund Office informed of any changes in address or marital status. This is your obligation, and failure to fulfill this obligation could jeopardize your eligibility for benefits.

The importance of maintaining a current, correct address on file in the Fund Office cannot be overstated! It is the **ONLY** way the Trustees can keep in touch with you regarding changes to the Plan and other developments affecting your interests under the Plan.

## **DISCLOSURE OF GRANDFATHERED STATUS**

This group health plan 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 your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventative 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’s Third Party Administrator at 33 Fitch Boulevard, Austintown, Ohio 44515, or toll free at (800) 435-2388. 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](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.

**I.**  
**PLAN IDENTIFICATION AND GENERAL INFORMATION**

**A. Name of the Fund**

The formal name of the Health Plan is the “Insulators Local 84 Health Care Plan.”

**B. Names and Addresses of the Employers**

The Health Plan is a multiemployer plan as that term is defined under ERISA, and numerous Employers contribute to it. It would not be practical to list them all here; however, upon written request to the Health Plan’s Third Party Administrator, you will receive information as to whether a particular Employer or Union is contributing to the Health Plan, and if so, its address.

**C. Name and Address of the Plan Sponsor**

The Plan Sponsor of the Health Plan is the Board of Trustees of the Insulators Local 84 Health Care Plan. The name and address of the Plan Sponsor is as follows:

Board of Trustees  
Insulators Local 84 Health Care Plan  
33 Fitch Boulevard  
Austintown, OH 44515  
Toll Free Phone: (800) 435-2388  
Fax: (330) 270-0912

**D. Name and Address of the Third Party Administrator**

The Health Plan shall be administered and maintained by the Board of Trustees; however, the Trustees have the authority to select and retain a professional Administrator, if and when the need arises. The Board of Trustees, exercising its authority to select and retain a professional Administrator, has presently engaged Compensation Programs of Ohio to administer and process the claims of the Health Plan. The name and address of the Third Party Administrator is as follows:

Compensation Programs of Ohio  
33 Fitch Boulevard  
Austintown, OH 44515  
Toll Free Phone: (800) 435-2388  
Fax: (330) 270-0912

Questions pertaining to your eligibility or your Dependent’s eligibility under the Health Plan and claims processing should be directed to the Third Party Administrator.

**E. Plan Numbers Assigned to the Plan**

The Employer Identification Number (EIN) assigned by the Internal Revenue Service to the Board of Trustees is 30-0224279, and the Plan number for purposes of identification is 501.

**F. Type of Plan**

The Health Plan is maintained for the purpose of providing benefits to Participants and their Eligible Dependents as provided herein only where accident, injury, illness or related illnesses are incurred when the Participant is otherwise eligible, as described in this Summary, for coverage under the Health Plan. In addition, the Health Plan provides reimbursement to Participants for medical expenses not covered under other health insurance programs and other benefits, including the opportunity for Participants to purchase group-term life insurance and to make self-payments from their Credit Accounts.

**G. The Plan Year**

The Plan Year is a twelve (12) month period beginning June 1 and ending May 31. Annual limits on deductibles, co-pay maximums, out-of-pocket expenses, and related limits are based on the Plan Year.

**H. Type of Administration Used for the Plan Assets**

The Trust Fund shall be administered by a Board of Trustees consisting of six (6) voting Trustees, three (3) of whom shall be designated by the Employers (Employer Trustees), and three (3) of whom shall be designated by the Union (Union Trustees). At the present time, they are:

**UNION TRUSTEES**  
Richard Quintrell  
William Max Marcavish  
Jason Penix

**EMPLOYER TRUSTEES**  
Carl E. Hughes II  
Charles R. White  
Larry Knittle

Correspondence can be sent to the Board of Trustees at: Trustees of the Insulators Local 84 Health Plan, 33 Fitch Boulevard, Austintown, Ohio 44515

**I. Attorneys for the Fund and Agent for Service of Process**

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2222 Centennial Road  
Toledo, Ohio 43617  
Phone: (419) 535-0075  
Fax: (419) 535-1935  
Website: [www.afwlaw.com](http://www.afwlaw.com)

**J. Funding Medium for the Accumulation of Plan Assets**

Assets are accumulated and benefits are provided directly by the Trust Fund. The principal and income of this Health Plan are to be used for the exclusive benefit of Participants and their Eligible Dependents, and for defraying proper expenses of administering the Health Plan.

**K. Effective Date When Health Plan Began**

June 1, 2005.

**L. Sources of Contributions to the Health Plan**

Contributions to the Health Plan are made by Employers together with self-contributions by Participants in accordance with the terms and conditions of the Health Plan and such other requirements as the Board of Trustees may determine. Contributions to the Health Plan made by Employers shall be made to the Trust Fund only under the obligations of a collective bargaining agreement and/or other written agreement between the contributing Employer and the Union. The Union shall be the authority for the specific provisions of the collective bargaining agreement establishing the obligation of the Employer to make contributions.

**M. Plan Amendment and Termination**

The Trustees reserve the right to amend or terminate the Health Plan at any time and for any reason. If the Health Plan is amended or terminated, you and other active and retired employees may not receive benefits as described in other sections of this Summary. You may be entitled to receive different benefits under different conditions. However, it is possible that you will lose all benefit coverage. This may happen at any time, even after you retire, if the Trustees decide to terminate the Health Plan or your coverage under the Health Plan. In no event will you become entitled to any vested rights under this Health Plan. Further, the provisions of this paragraph cannot be modified in any manner except by resolution of the Board of Trustees.

**N. Plan is Not a Contract**

The Health Plan shall not be deemed to be a contract between the Plan Sponsor and any Participant and/or Beneficiary, or to be an inducement to or condition of employment. Nothing in the Health Plan shall be deemed to give an Employee the right to be retained in the service of any Employer, or to interfere with the right of any Employer to discharge any Employee at any time.

**II.  
ELIGIBILITY**

**A. Initial Eligibility**

You will become initially eligible for coverage under the Health Plan on the first day of the coverage month following the date on which contributions for at least three hundred (300) hours, at the rate established by the current collective bargaining agreement, were required to be made on your behalf

during two (2) consecutive calendar months by one or more participating Employers. For example, if a contributing Employer is required to pay total contributions on your behalf for three hundred (300) hours in January and February, you would begin your coverage under the Health Plan on May 1.

In no event may any person become initially eligible for coverage under the Health Plan if he or she is receiving a pension benefit from either the National Asbestos Workers Pension Fund or the Local #84 Asbestos Workers Pension Fund. Any hours accumulated in excess of one hundred forty (140) in any calendar month will be credited to your Reserve Hours.

**B. Continuation of Eligibility**

**(1) General Rule of Continuation of Eligibility**

After satisfying the initial eligibility requirements, you will continue to remain eligible for participation in the Plan so long as contributions are made on your behalf by an Employer and/or Reserve Hours are applied for one hundred twelve (112) hours per month at the hourly rate established in the current collective bargaining agreement. For example, once you become eligible, you will remain eligible if you meet the minimum working requirements set forth in the following schedule:

<u>Work Month</u>	<u>Minimum Number of Hours Required in the Following Months</u>	<u>Month Participant is Eligible for Benefits</u>
APRIL	112 HOURS	JULY
MAY	112 HOURS	AUGUST
JUNE	112 HOURS	SEPTEMBER
JULY	112 HOURS	OCTOBER
AUGUST	112 HOURS	NOVEMBER
SEPTEMBER	112 HOURS	DECEMBER
OCTOBER	112 HOURS	JANUARY
NOVEMBER	112 HOURS	FEBRUARY
DECEMBER	112 HOURS	MARCH
JANUARY	112 HOURS	APRIL
FEBRUARY	112 HOURS	MAY
MARCH	112 HOURS	JUNE

If, after expending all unused Reserve Hours, you have fewer than one hundred twelve (112) hours in any calendar month, you may make a self-contribution at the hourly rate established in the current collective bargaining agreement to remain eligible for participation in the Plan in an amount not to exceed the current self-pay contribution rate for Retired Employees under Article IV. The amount due is the number of hours by which you are short of one hundred twelve (112) hours multiplied by the current hourly rate not to exceed the current total self-pay contribution rate for Retired Employees under Article IV. The maximum number of self-contributions that an active Employee may make is eighteen (18) consecutive self-contributions in the full amount required under the Collective Bargaining Agreement.

Self-contributions must be received by the Fund Office not later than the 10<sup>th</sup> day of each month. Failure to make a timely self-contribution payment or making payment in less than the invoiced amount shall result in a loss of eligibility. However, if you lose your Union membership pursuant to the Union Constitution and/or Collective Bargaining Agreement or Bylaws, then immediately as of the date of the loss of Union membership and upon notification to the Fund Office you will not be eligible to make self-contributions pursuant to this Section, and you shall forfeit all unused Reserve Hours. Thereafter, you may elect to continue your health coverage under the Plan as provided for under Article II, Sections N and O below.

**(2) Continuation of Eligibility While Working for Delinquent Employer**

A Participant who is employed by a contributing Employer may be granted up to three (3) work months of credit toward remaining eligible as a Participant in the Fund to receive benefits if the contributing employer has not paid its required contributions to the Fund and filed the appropriate Employer reports.

If an Employer is delinquent for three (3) work months, consecutive or nonconsecutive, of contributions to the Fund, whether the delinquency is for a full or partial work month, an employee of that Employer will no longer receive credit allowing the employee to maintain his/her eligibility.

Prior to the employee no longer receiving credit, the Trustees or their designee shall notify the employee at least fifteen (15) days prior to the fifteenth day of the month in which the employee will no longer receive credit.

Once the employee is no longer granted credit, the employee may continue to maintain his/her eligibility in the Fund by using his/her reserve dollar bank or making self-payments for a period of time not to exceed twelve (12) months from the date the first self-payment is made.

An employee will lose eligibility and receive the option to elect to continue his/her health coverage under the Plan as provided under Article II, Sections N and O below, upon the earliest of (a) making twelve (12) consecutive months of self-payments, (b) failing to make the full amount of the self-payment on or before the required due date or (c) no longer being an Employee as defined herein.

Upon payment by the Employer for delinquent contributions for work months in which the employee previously made self-payments or reduced its dollar bank, the employee shall receive credit to his/her dollar bank in the amount the Employer paid the Fund.

Examples of how this procedure is applied are as follows:

- (i) Employer A fails to make contributions on behalf of its employees for the work months of April and May. On June 15, Employer A fails to make the full amount of the three (3) months contributions. On June 25, the employees of Employer A are sent notification that their Employer will be three (3) months delinquent on July 15. On July 16 the employees are sent notification that their Employer did not make its required Fund contributions and the employees will no longer be receiving credit to maintain eligibility. The employees have until August 10 to either self-pay or use the

amounts accumulated in their respective dollar bank. On September 1, Employer A makes full payment to the Fund for the contributions for the work months of April, May, June and July. The employees of Employer A are given credit for the self-payment made on or before August 10 into their dollar banks or if no self-payment was made but their dollar banks were reduced, their dollar banks are reimbursed by the amount contributed to the Fund on each employee's behalf.

- (ii) Employer B fails to make contributions on behalf of its employees for the work months of April and May. On June 15, Employer B fails to make the full amount of the three (3) months contributions. On June 25, the employees of Employer B are sent notification that their Employer will be three (3) months delinquent on July 15. On July 16 the employees are sent notification that their Employer did not make its required contributions and the employees will no longer be receiving credit to maintain eligibility. The employees have until August 10 to either self-pay or use the amounts accumulated in their respective dollar banks. On September 1, Employer B makes a payment to the Fund for the work month of April. Since Employer B did not make full payment for all months delinquent, the employees of Employer B must continue to either make self-payments or deplete their dollar banks or lose eligibility.
- (iii) Employer C fails to make contributions on behalf of its employees for the work months of April and May. On June 15, Employer C fails to make the full amount of the three (3) months contributions. On June 25, the employees of Employer C are sent notification that the Employer will be three (3) months delinquent on July 15. On July 16 the employees are sent notification their Employer did not make its required contributions to the Fund and they will no longer receive credit to maintain eligibility. The employees have until August 10 to either self-pay or use the amounts accumulated in their respective dollar banks. On September 1, Employer C continues to remain delinquent although Employer C is paying one (1) month of full contributions at a time but fails to make full payment to the Fund for all delinquent months. Several employees of Employer C deplete their banked hours and/or fail to make timely self-payments. Those employees lose eligibility and receive COBRA notices in order to maintain health insurance.
- (iv) Employer D fails to make contributions on behalf of its employees for the work months of April and May. On June 15, Employer D fails to make the full amount of the three (3) months contributions. On June 25, the employees of Employer D receive notification that their Employer will be three (3) months delinquent on July 15. Employer D pays the Fund its full contributions for the work month of April prior to July 15. Since the employer is not three (3) months delinquent by July 15, the employees of Employer D do not have to make self-payments or use their respective dollar bank.
- (v) Employer E fails to make contributions on behalf of its employees for the work months of April and May. On June 15, Employer E fails to make the full amount of the three (3) months contributions. On June 25, the employees of Employer E are sent notification their Employer will be three (3) months delinquent on July 15.

Employer E pays the Fund its contribution for the work month of May (not April) prior to July 15. On July 15, Employer E is delinquent for April and June but not May. Employees of Employer E do not have to self-pay or use their dollar bank. Since Employer E failed to make the payment for the work month of June making Employer E two (2) months delinquent (April and June), the employees of Employer E are sent notification of the delinquency on July 25. The employer pays the Fund full contributions for the work month of July. The employees do not have to use their dollar bank or self-payments (Employer E is only two months delinquent). Employer E fails to pay the Fund contributions for August work month, the employees are sent notification of self-payment by August 25. Employer E fails to make the August work month by September 15. The Employer E employees must self-pay or use their dollar bank by October 10 or Employer E must make full payment for the work months of April, June and August in order for coverage to continue (full payment of one or two months will not be sufficient to prevent Employer E employees from having to use their dollar banks or make self-payments).

### **C. Reinstatement of Eligibility**

If you fail to remain eligible to participate in the Plan pursuant to Article II, Section B, "Continuation of Eligibility," above, and such failure to remain eligible lasts less than twelve consecutive months, you will again become eligible to participate in the Plan and benefits will be reinstated on the first day of the coverage month following the date on which contributions for:

- (1) one hundred forty (140) or more hours during a calendar month; or
- (2) two hundred twenty-four (224) or more hours during two (2) *consecutive* calendar months were required to be made, at the rate established by the current collective bargaining agreement, on your behalf by one or more participating Employers. For example, if a contributing Employer is required to pay contributions on your behalf for two hundred twenty-four (224) hours during January and February, you would begin your coverage under the Plan on May 1.

If you fail to remain eligible to participate in the Plan pursuant to Article II, Section B, "Continuation of Eligibility," above, and such failure to remain eligible lasts more than twelve consecutive months, you will again become eligible to participate in the Plan upon the completion of the initial eligibility requirements set forth in Article II, Section A, "Initial Eligibility," above.

In no event may any person become reinstated for eligibility for coverage under the Health Plan if he or she is receiving a pension from either the National Asbestos Workers Pension Fund or the Local #84 Asbestos Workers Pension Fund.

### **D. Reserve Hours**

For each calendar month in which you are credited with fewer than the required number of hours, you will lose one (1) month of eligibility for benefits unless you have sufficient credited hours in

reserve (Reserve Hours) to satisfy the monthly requirement of one hundred twelve (112) hours. You may accumulate Reserve Hours as follows:

- (1) all hours in excess of one hundred forty (140) credited during the initial eligibility period; and
- (2) all hours in excess of one hundred forty (140) credited during any one (1) calendar month after the initial eligibility period.

The maximum amount of Reserve Hours that you may accumulate is the Reserve Hours equivalent of \$7,000 in contributions, calculated at the hourly rate established in the current collective bargaining agreement.

Reserve Hours will be used to provide continuous eligibility only, and will not be used to establish or reestablish initial eligibility. The Board of Trustees may, in its discretion, adjust the number of Reserve Hours, and its decision will be final and binding. Reserve Hours are not a vested or an accrued benefit and may be lost under certain conditions determined by the Board of Trustees.

**NOTE:** There is no carryover of any Reserve Hours you may have previously accrued under the National Asbestos Workers Medical Fund.

If you retire under the National Asbestos Workers Pension Plan or the Insulators Local 84 Pension Plan, you may use your Reserve Hours to maintain your eligibility under this Plan. Further, if you have insufficient Reserve Hours to satisfy the monthly requirement of one hundred twelve (112) hours and fail to maintain your eligibility through timely self-contributions in the invoiced amount, your Reserve Hours balance will be forfeited.

#### **E. Termination of Eligibility**

Your eligibility will terminate on the first day of the calendar month following a calendar month in which you have:

- (1) after expending all unused Reserve Hours, fewer than one hundred twelve (112) hours, and you fail to make a timely self-contribution payment or make a timely self-contribution payment in less than the invoiced amount; or
- (2) lost Union membership pursuant to the Union Constitution and/or Collective Bargaining Agreement or Bylaws. As of the date of the loss of union membership and upon notification to the Fund Office, you will not be eligible to make self-contributions and you shall forfeit all unused Reserve Hours.

If you have your eligibility terminated, you may elect to continue your health coverage under the Plan as provided for under Article II, Sections N and O below. In the event an Employer is delinquent in the payment of its Employer Contributions on your behalf, the Trustees will credit you as though the Employer Contributions were paid by the Employer.

## **F. Special Enrollment Rights**

If you are declining or declined enrollment for yourself or your Dependents (including your Spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this plan if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards you or your Dependents' other coverage). However, you must request enrollment within 30 days after you or your Dependents' other coverage ends (or after the employer stops contributing toward the 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. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Third Party Administrator at the address listed above.

## **G. Employment Outside of Jurisdiction**

A participating Employer may continue to contribute on your behalf for work performed outside the territorial jurisdiction of the Fund only if approved by the Board of Trustees.

## **H. Maintenance of Eligibility**

If you are eligible to participate and are receiving accident and sickness benefits or are receiving benefits under any workers' compensation or occupational disease law, you shall, beginning with:

- (1) the first day of a disability caused by accident; or
- (2) the eighth day of a disability caused by sickness,

receive thirty-five (35) hours of contribution credit for each week you are entitled to or drawing such benefits, up to a maximum total credit of nine hundred ten (910) hours.

## **I. Military Service**

If you are called to military service with the United States Armed Forces other than for temporary service, you may elect to continue coverage under the Plan for yourself, without any reduction in benefits, for a period not exceeding eighteen (18) months. In the case of temporary service, you will receive thirty-five (35) hours of contribution credit for each week of such service, up to a maximum of one hundred and forty (140) hours.

If you are called to non-temporary military service, you will be provided with the following three (3) options:

- (1) First Option. You may elect not to continue the medical coverage under the Plan for yourself, in which case your eligibility, including your continuation of eligibility [the look-back period], would freeze, and you would resume your eligibility and

continuation of eligibility under the Plan when you return from military service. Any accumulated eligibility to your credit on the Plan's records will be maintained and will be made available to you when you return from military service. Upon discharge from military service, and upon written notice given within thirty-one (31) days of the discharge, your "frozen" eligibility will be reinstated effective on the first day of the then current benefit period. To qualify for the resumption of your eligibility under the Plan, you must satisfy the eligibility requirements set forth in the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") when you return from military service.

- (2) Second Option. You may elect to continue medical coverage under the Plan for yourself by submitting to the Fund Office monthly premiums for a period not exceeding eighteen (18) months. The monthly premium paid by you will be at the COBRA premium rate. Your continuation of eligibility [the look-back period] would freeze, and you would resume your continuation of eligibility under the Plan when you return from military service. To qualify for the resumption of your eligibility under the Plan, you must satisfy the eligibility requirements set forth in USERRA when you return from military service.
- (3) Third Option. You may elect to continue medical coverage under the Plan for yourself for a period not exceeding eighteen (18) months. However, if you have a preexisting medical condition and/or are receiving medical treatment from a medical provider or physician which is not covered under the medical insurance provided by the military armed services, then you may continue your eligibility and continuation of eligibility [the look-back period] until exhausted. After you exhaust your eligibility and continuation of eligibility, then you would submit monthly payments at the COBRA premium rate to the Fund Office for the balance of the eighteen (18) month period. When you return from military service, you would have to satisfy the Plan's initial eligibility provisions to resume coverage under the Plan.

In order for the Plan to properly handle your medical coverage during your period of military service, you must affirmatively elect, in writing, one of these three options. Likewise, when your military service ends, you are required to timely notify the Fund Office of the date you were discharged from military service.

To qualify for the protection given to those in military service under USERRA, your period of military service may not exceed five (5) continuous years, you must not have been discharged from military service under dishonorable or other punitive conditions, and you must report back to work for your Employer in a timely manner and/or contact the Union office to sign up for employment.

#### **J. Termination of Coverage and Loss of Reserve Hours for Employment with Non-Contributory Employer**

You shall cease to be eligible to be a Participant in this Plan if you are employed by an employer that is not obligated to make contributions to this Plan unless the purpose of such employment is to encourage the employer to become signatory and begin making contributions to this Plan and you

enter into a written salting agreement with the Union. Your coverage under this Plan shall terminate on the last day of the calendar month during which such employment occurs. In addition, you shall also lose any accumulated Reserve Hours.

If you are eligible for retiree benefits as described in Article IV below, you shall be exempt from this Section, provided that you are:

- (1) employed by an Employer performing work within the trade jurisdiction as defined in the current Constitution of the International Association of Heat and Frost Insulators and Asbestos Workers; and
- (2) the Employer is required to make contributions to this Plan on behalf of its bargaining unit employees but not for you.

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you will be provided with Certificate of Creditable Coverage forms if you lose Coverage under the Plan. You may contact the Third Party Administrator to obtain a Certificate of Creditable Coverage before you lose Coverage under the Plan or to obtain an additional Certificate of Creditable Coverage.

#### **K. Eligibility through Reciprocity**

You are eligible to be a Participant in this Plan if you are employed by an Employer who is obligated to make contributions pursuant to a reciprocal agreement with the Insulators Local 84 Health Care Plan. If you have signed an authorization letter with the Insulators Local 84 Health Care Plan, the monies will be transferred as follows:

- (1) The administrator of the non-home fund shall transfer the amount of monies received based on the hours worked times the contribution rate of the non-home fund's area wide collective bargaining agreement(s).
- (2) If the home fund contribution rate is equal to or greater than the non-home fund contribution rate, all monies will be transferred, and you will be credited with contribution hours equal to the amount of money received divided by the contribution rate in the home fund.

Therefore, if the home fund contribution rate is higher than the non-home fund contribution rate, you may be credited with fewer contribution hours than the hours you actually worked.

In certain cases, the reciprocal agreement with the Health Care Plan may require a transfer of monies based on the *lesser* of the home fund contribution rate or the non-home fund contribution rate. In such cases, the monies will be transferred as follows:

- (1) If the home fund contribution rate is lower than the non-home fund contribution rate, the administrator of the non-home fund shall transfer an amount equal to the hours worked times the home fund contribution rate.

- (2) If the home fund contribution rate is higher than the non-home fund contribution rate, the administrator of the non-home fund shall transfer an amount equal to the hours worked times the non-home fund contribution rate.

Transferred monies will first be allocated to the Health Care Plan in an amount equal to the amount required under the current contribution rate to maintain your Health Care Plan coverage. Any monies in excess of the amount required to maintain your Health Care Plan coverage will be allocated to your Credit Account under the HRA as described below.

**L. Change in Classification or the Amount of Coverage**

The amount of coverage based on your classification is shown in the schedule of benefits. The change will take effect on the day of the change.

**M. When Coverage Ends**

Your coverage will end at midnight on the earliest of:

- (1) the day the Plan ends; or
- (2) the day any self-contribution is due and unpaid; or
- (3) the day before entering military service on active duty (except for temporary active duty of four (4) weeks or less); or
- (4) the day in which you lose your eligibility; or
- (5) the day which you become employed by an Employer that is not obligated to make contributions to this Fund, as described in Article II, Section J above.

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you will be provided with Certificate of Creditable Coverage forms if you lose Coverage under the Plan. You may contact the Third Party Administrator to obtain a Certificate of Creditable Coverage before you lose Coverage under the Plan or to obtain an additional Certificate of Creditable Coverage.

**N. Disability Coverage**

If you are found to be totally disabled by the Trustees, then you shall be allowed to make Self-Contributions for the full amount and continue participation in the Plan (the coverage shall remain either single or family, depending on what coverage you have at the time of the disability).

If, in the opinion of the Trustees, you become able to work in the trade as defined by the Constitution of the International Association of Heat and Frost Insulators and Asbestos Workers, then your disability coverage will terminate at the end of the calendar month in which you are no longer disabled. You would then be eligible to continue as a Participant without requalifying.

Upon the request of the Trustees, you or your Dependent may be required, as a condition to continuing your eligibility under this Plan, to apply for Social Security Benefits, Medicare and Medicaid, or the program then in effect. You or your Dependent may also be required, as a condition to continuing eligibility under this Plan, to sign any authorizations or releases provided by the Trustees, as the Trustees deem necessary, enabling the Trustees to obtain information from you or your Dependent and appropriate government agencies pertaining to your or your Dependent's claim for Social Security Benefits, Medicare and Medicaid benefits.

Employers are required to contribute on behalf of all nonseasonal, full-time nonbargaining unit employees, defined as officers, owners, partners, shareholders, managers, clerical workers, estimators, supervisors and any other full-time employees (hereinafter collectively referred to as "Nonbargaining Unit Employees"), if they elect such participation in the Plan and enter into a participation agreement with the Trust Fund (subject to the review and approval of, and any other conditions regarding contributions and participation imposed by the Trustees), at the contribution rate determined by the Board of Trustees. Employers that elect to have Nonbargaining Unit Employees participate in the Plan shall be required to contribute at the contribution rate determined by the Board of Trustees to become eligible initially and to remain eligible thereafter. The number of Nonbargaining Unit Employees who become Participants as a result of a participation agreement shall not exceed ten percent (10%) of the total number of Participants.

**O. Summary of Rights and Obligations Regarding Continuation of Group Health Insurance Coverage under Plan through Self-Contribution**

**1. COBRA Continuation Coverage for Single Employees**

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 and related regulations and amendments ("COBRA"), any member who loses coverage under the Plan by reason of a life event known as a "qualifying event" may elect to continue health coverage under the Plan on a temporary basis from the day the member's eligibility ends. Specific qualifying events are listed below. COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary." A Qualified Beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent Children of employees may be Qualified Beneficiaries. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

- (i) Your hours of employment are reduced, or
- (ii) Your employment ends for any reason other than your gross misconduct.

**2. COBRA Continuation Coverage for Employees Who Have Elected Eligible Dependent Coverage**

A special rule applies if you are an Eligible Dependent of an Employee and you are covered as an Eligible Dependent under the Plan. In such cases, you will become a Qualified Beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

- (1) Your Spouse dies;
- (2) Your Spouse's hours of employment are reduced;
- (3) Your Spouse's employment ends for any reason other than his or her gross misconduct;
- (4) Your Spouse becomes enrolled in Medicare (Part A, Part B, or both); or
- (5) You become divorced or legally separated from your Spouse.

Your dependent Children will become Qualified Beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- (1) The parent-Employee dies;
- (2) The parent-Employee's hours of employment are reduced;
- (3) The parent-Employee's employment ends for any reason other than his or her gross misconduct;
- (4) The parent-Employee becomes enrolled in Medicare (Part A, Part B, or both);
- (5) The parents become divorced or legally separated; or
- (6) The Child stops being eligible for coverage under the Plan as a "Dependent Child."

### **3. Qualifying Event**

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, or the Employee's becoming entitled to Medicare benefits (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 30 days following the date coverage ends.

For other qualifying events (divorce or legal separation of the Employee and the Spouse, or a dependent Child's losing eligibility for coverage as a dependent Child), you must notify the Plan Administrator. **The Plan requires you to notify the Plan Administrator within 60 days after the date you lose coverage.** You must send this notice to:

Compensation Programs of Ohio  
33 Fitch Boulevard  
Austintown, OH 44515  
Toll Free Phone: (800) 435-2388  
Fax: (330) 270-0912

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each Qualified Beneficiary. Each Qualified Beneficiary has an independent right to elect COBRA continuation coverage. Covered employees can elect COBRA continuation coverage on behalf of their Spouses, and parents can elect COBRA continuation coverage on behalf of their Children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, enrollment of the Employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent Child's losing eligibility as a dependent Child, COBRA continuation coverage lasts for up to thirty-six (36) months.

When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for Qualified Beneficiaries other than the Employee lasts until thirty-six (36) months after the date of Medicare entitlement. For example, if a covered Employee became entitled to Medicare eight (8) months before the date on which employment terminated, COBRA continuation coverage for his or her Spouse and Children can last up to thirty-six (36) months after the date of Medicare entitlement, which is equal to twenty-eight (28) months (36 minus 8 months) after the date of the qualifying event.

Otherwise, when the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA continuation coverage generally lasts for up to a total of eighteen (18) months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

#### **4. Disability Extension of 18-Month Period of Continuation Coverage**

If you (or anyone in your family covered under the Plan if he or she is covered as an Eligible Dependent under the Plan) are determined by the Social Security Administration to be disabled at any time during the first sixty (60) days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you (and your entire family, if applicable) can receive up to an additional eleven (11) months of COBRA continuation coverage, for a total maximum of twenty-nine (29) months. **You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within sixty (60) days after the date of the determination and before the end of the 18-month period of COBRA continuation coverage.** This notice should be sent to:

Compensation Programs of Ohio  
33 Fitch Boulevard  
Austintown, OH 44515  
Toll Free Phone: (800) 435-2388  
Fax: (330) 270-0912

The extended coverage terminates:

- (1) upon your receiving Medicare; or
- (2) thirty (30) days after the month in which the Social Security Administration determines you are no longer disabled.

**5. Second Qualifying Event Extension of 18-Month Period of Continuation Coverage**

If you (or anyone in your family covered under the Plan if he or she is covered as an Eligible Dependent under the Plan) experience another qualifying event while receiving COBRA continuation coverage, you (or your Spouse and dependent Children in your family, if applicable) can get additional months of COBRA continuation coverage, up to a maximum of thirty-six (36) months.

This extension is also available to a Spouse and/or dependent Children of a former Employee who were covered as Eligible Dependents under the Plan if the former Employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. Similarly, the extension is available to a dependent Child when that Child stops being eligible under the Plan as an Eligible Dependent.

**In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within sixty (60) days after the second qualifying event occurs. This notice must be sent to:**

Compensation Programs of Ohio  
33 Fitch Boulevard  
Austintown, OH 44515  
Toll Free Phone: (800) 435-2388  
Fax: (330) 270-0912

**6. If You Have Questions**

If you have questions about your COBRA continuation coverage, you should contact Compensation Programs of Ohio, 33 Fitch Boulevard, Niles, OH 44515, Toll Free Phone (800) 435-2388, Fax (330) 270-0912, or you may contact the nearest Regional or District Office of the United States Department of Labor's Employee Benefits Security Administration ("EBSA"). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's web site at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

**7. Duty to Keep Plan Administrator Informed of Address Changes**

In order to protect your rights (and your family's rights, if applicable), you should keep the Plan Administrator informed of any changes in your address (and the addresses of family members, if applicable). You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

## **8. Payment for COBRA Coverage**

Any member (or other individual) who has the right to COBRA coverage ("Qualified Beneficiary") must complete the application and make the first payment within the time limits as set forth herein. The Plan is not required to segregate any dental, vision and other miscellaneous benefits provided by the Plan from the COBRA benefit package. The Plan will offer the same COBRA benefit package to a Qualified Beneficiary as the COBRA benefit package to which the Qualified Beneficiary was entitled on the day before the qualifying event, including dental, vision care, or any other health care benefits that were part of the Qualified Beneficiary's benefit package on the day before the qualifying event. In addition, if the Plan permits members to elect among different benefit packages, then after the qualifying event the Plan does not have to provide the Qualified Beneficiary with an election among the different benefit packages and will offer only the same benefit package to which the Qualified Beneficiary was entitled on the day before the qualifying event.

The Qualified Beneficiary has sixty (60) days from the date he or she loses regular coverage to elect COBRA continuation coverage. COBRA continuation coverage will be made available for the entire sixty (60) day election period if the Qualified Beneficiary elects COBRA continuation coverage prior to the end of the election period. A Qualified Beneficiary may reject or waive COBRA continuation coverage but then revoke the waiver at any point during the sixty (60) day period and elect COBRA continuation coverage; however, if this occurs, the COBRA continuation coverage will not apply retroactively to the beginning of the sixty (60) day election period but applies only back to the date on which the rejection or waiver was revoked and COBRA continuation coverage was elected. The Qualified Beneficiary is not covered during the election period prior to his or her election, but will have retroactive coverage if COBRA continuation coverage is timely elected and timely paid.

The Fund Office will inform the Qualified Beneficiary of the monthly premium to be paid. The Qualified Beneficiary has forty-five (45) days from the date he or she elects COBRA continuation coverage to make the first payment. After the first payment, the Qualified Beneficiary is allowed thirty (30) days to make each payment after the date it is due. For subsequent months, the Fund Office will bill the Qualified Beneficiary on the fifteenth (15<sup>th</sup>) day of the month preceding the month in which the Qualified Beneficiary receives coverage. The Qualified Beneficiary is not covered during the forty-five (45) day grace period permitted for payment of the first COBRA premium or during the thirty (30) day grace period permitted for payment of the monthly COBRA premium prior to his or her timely payment of the COBRA premium, but will have retroactive coverage if the COBRA premium is timely paid.

The cost of COBRA continuation coverage will not exceed 102% of the premium applicable to active employees. However, a Qualified Beneficiary who has been determined disabled as defined by the Social Security Administration and requests coverage for an additional eleven (11) months for a total of twenty-nine (29) months of continuation coverage may be required to pay a premium which is one hundred fifty percent (150%) of the amount of the regular COBRA premium for all months of coverage after the first eighteen (18) months. In addition, the cost of COBRA continuation coverage may be increased at any time when the Plan is charging less than the allowable COBRA premium (i.e., less than the 102% or the 150%) or in a situation where a

Qualified Beneficiary is permitted by the Plan's rules and procedures to change to a more expensive form of coverage under the Plan.

### **9. Cancellation of COBRA Coverage**

Coverage ends immediately for any member who:

- (1) Fails to make a premium payment on time. After the first payment, the person is allowed thirty (30) days to make each payment after the date it is due. If it is not post-marked on or before the end of the 30-day period, COBRA coverage will be canceled as of the due date; or
- (2) First becomes enrolled in either Part A or Part B of Medicare after the date of the qualifying event; or
- (3) First becomes covered under another group health care plan after the date of the qualifying event, except that if the Member has a pre-existing condition that is not covered under the new employer's plan, then the Member may continue COBRA coverage under this Plan for the remainder of the continuation coverage period; or
- (4) COBRA coverage will also be canceled as of the date the Plan terminates and no longer provides group health coverage; or
- (5) COBRA coverage will also be canceled on the date on which the COBRA continuation coverage period applicable to the Qualified Beneficiary expires.

## **III.**

### **DEPENDENTS' ELIGIBILITY**

#### **A. Eligible Dependents**

The Plan provides coverage for Eligible Dependents. An Eligible Dependent shall be considered eligible for coverage on the date the Employee becomes eligible for benefits, subject to all limitations and requirements of the Health Plan, and according to the following:

- (1) Newborn Children of an Eligible Employee will be covered from the moment of birth, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or prematurity, provided the Child is properly enrolled as an Eligible Dependent of the Eligible Employee within thirty (30) days of the Child's date of birth. If not, the Eligible Dependent will be covered from the date of enrollment.
- (2) A Spouse will be considered an Eligible Dependent from the date of marriage, provided the Spouse is properly enrolled as an Eligible Dependent of the Eligible

Employee within thirty (30) days of marriage. If not, the Eligible Dependent will be covered from the date of enrollment.

- (3) If an Eligible Dependent is acquired, other than at the time of birth, due to a court order, decree or marriage, that Eligible Dependent will be considered an Eligible Dependent from the date of such court order, decree or marriage, if this new Eligible Dependent is properly enrolled as an Eligible Dependent of the Eligible Employee within thirty (30) days of the court order, decree or marriage. If not, the Eligible Dependent will be covered from the date of enrollment.
- (4) Adopted Children of an Eligible Employee will be eligible for coverage as of the date of legal custody, or as of the date of actual adoption, whichever occurs first. Coverage under the Health Plan for the Child shall be the same coverage which is available to all other Eligible Dependent Children under the Plan except that all pre-existing condition exclusions or waiting periods are hereby waived for such adopted Children.

An adopted Child of an Eligible Employee who is otherwise eligible for coverage under this Health Plan shall remain eligible even though such individual is eligible for coverage under a state plan for medical assistance approved under Title XIX of the Social Security Act ("Medicaid"). The Health Plan will make payment of all benefits under the Health Plan for an adopted Child covered by Medicaid coverage in accordance with the assignment of rights requirements of that adopted Child's Medicaid coverage. Coverage provided by the Health Plan shall be considered primary coverage and shall pay services before Medicaid.

If the Participant's coverage is canceled, Dependent coverage is also canceled, except as provided by COBRA. In addition, an Eligible Dependent loses regular coverage as of the date:

- (1) family coverage is canceled for the class of Employees to which the Participant belongs; or
- (2) the individual ceases to meet the Health Plan's requirements to qualify as an Eligible Dependent.

The Trustees have the sole discretion to determine:

- (1) if your Spouse or your Child qualifies as an Eligible Dependent, and
- (2) the definition of an "Eligible Dependent," where there is a possible ambiguity.

The determination of the Trustees shall be final, binding and conclusive.

#### **B. Dependents Not Eligible**

Prior to June 1, 2011, the following are not Eligible Dependents:

- (1) your spouse from whom you are divorced or legally separated, effective on the date of the decree of legal separation, divorce or dissolution; or
- (2) any married Child of yours; or
- (3) an individual eligible for coverage under the Plan as an Employee or member; or
- (4) a Child who has obtained the limiting age. The limiting age is:
  - (i) the Child's 19<sup>th</sup> birthday
  - (ii) the Child's 24<sup>th</sup> birthday if the Child is a full-time student or if the Child is on a medically necessary leave of absence pursuant to Section G. of this Article.

Beginning June 1, 2011, the following are not Eligible Dependents:

- (1) your spouse from whom you are divorced or legally separated, effective on the date of the decree of legal separation, divorce or dissolution; or
- (2) an individual eligible for coverage under the Plan as an Employee or member; or
- (3) a Child who has obtained the Limiting Age. The Limiting Age is the Child's 26<sup>th</sup> birthday.
- (4) a Child who is over age 19 and who is eligible under any other employer-sponsored group health plan; provided, however that this exclusion (4) shall not apply beginning June 1, 2014.

### **C. Mentally or Physically Disabled Child**

The coverage for a mentally or physically disabled Child of yours who attains the Limiting Age while insured under the Plan may be continued if the Child:

- (1) is chiefly dependent on you for support; and
- (2) is not capable of self-sustaining employment.

The coverage will continue only if the Board of Trustees receives proof of the Child's disability and determines that the Child is mentally and physically disabled:

- (1) no later than thirty-one (31) days after the Child attains the Limiting Age; and
- (2) thereafter the Board of Trustees may require additional proof, but not more often than once every two years.

Determination of whether such unmarried Child over the Limiting Age qualifies as an Eligible Dependent pursuant to this Section will be made by the Trustees in their sole discretion and the Trustees determination shall be final, binding and conclusive.

**D. When Dependent's Coverage Begins**

- (1) A Dependent's coverage will begin the later of:
  - (i) the day you are insured; or
  - (ii) the day you first acquire an Eligible Dependent.
- (2) Once you have an Eligible Dependent insured, any newly acquired Eligible Dependent will be insured upon your notification to the Third Party Administrator.

**E. When Dependent's Coverage Ends**

A Dependent's coverage will end at midnight on the *earliest* of:

- (1) the last day of the month in which your Dependent is no longer eligible under the Plan, if loss of eligibility is due to reasons other than divorce or marriage; or
- (2) the day your Dependent is no longer eligible under the Plan, if loss of eligibility is due to divorce or marriage; or
- (3) the day any self-pay premium/contribution is due and unpaid; or
- (4) the day the Plan terminates; or
- (5) the day before a Dependent enters military service on active duty (except for temporary active duty of four weeks or less); or
- (6) the day your eligibility terminates.

**F. Surviving Spouse's Continuing Coverage**

If you die, then coverage for your surviving Spouse who qualifies as an Eligible Dependent will continue until your eligibility is exhausted. Coverage of your surviving Spouse will terminate if your surviving Spouse remarries or fails to make the required payment to continue coverage. The premium for surviving spouse coverage is subject to change by the Board of Trustees and may be obtained by contacting the Third Party Administrator.

Your surviving spouse may also elect to continue coverage for your dependent Children who qualify as Eligible Dependents.

An insured Spouse and/or insured dependent Child may also elect to continue health insurance when eligibility ends in accordance with the provisions of COBRA, as described above. In the event that more than one continuation provisions applies, the periods of continued coverage will run concurrently.

**G. Eligible Dependent's Temporary Extension of Coverage For Medically Necessary Leave of Absence from School**

Any Eligible Dependent who was covered under the Plan as a full-time student as defined in Article VI, Section V(3) is granted continuing coverage during a Medically Necessary Leave of Absence. A Medically Necessary Leave of Absence is a leave of absence from a postsecondary educational institution or any other change in enrollment at such an institution that:

- (1) Commences while the Child is suffering from a serious illness or injury;
- (2) Is medically necessary; and
- (3) Causes such Child to lose student status for purposes of coverage under the terms of the plan or coverage.

To be eligible for continuing coverage under this section, the Eligible Dependent must have been covered under the plan immediately before the first day the medically necessary leave of absence involved. The Plan must also receive written notification from the Eligible Dependent's treating physician which states that the Child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

The Plan shall not terminate coverage of such Eligible Dependent due to a Medically Necessary Leave of Absence before the date that is the earlier of:

- (1) The date that is one (1) year after the first day of the Medically Necessary Leave of Absence; or
- (2) The date on which such coverage would otherwise terminate under the terms of the Plan or by termination of the Plan as a whole.

An Eligible Dependent who receives benefits under this section shall be entitled to the same benefits (during the medically necessary leave of absence) as if the Child continued to be a covered student at the institution of higher education and was not on a medically necessary leave of absence. Any future change in coverage terms or conditions that would apply to any Eligible Dependent shall apply with equal force to an Eligible Dependent covered under this section.

(Effective June 1, 2011, this Section G shall no longer apply and is unnecessary in light of the extension of coverage to a Child's 26<sup>th</sup> birthday regardless of whether the Child is enrolled in school.)

**IV.**  
**RETIREE PROGRAM ELIGIBILITY FOR RETIRED EMPLOYEES**

The Trustees reserve the right to change or eliminate the Retiree Programs, including, but not limited to, the benefits available, at their sole discretion, at any time and for any reason. Participants and retired Employees do not have any vested rights in the Retiree Programs.

**A. Eligibility Requirements for Retired Employees**

A retired Employee who was a Participant in the Plan may become eligible for retiree benefits only if he/she meets all of the following requirements:

- (1) On the date you retire you are a member in good standing of Local 84.
- (2) You are retired from active employment as evidenced by the receipt of benefits under the National Asbestos Workers Pension Plan or the Insulators Local 84 Pension Plan.
- (3) You were eligible for active Employee coverage under the Plan on the date you retired.

If you qualify under the above rules, you may elect to continue coverage under this Plan as a retired member by using your Reserve Hours to satisfy the monthly requirement of one hundred twelve (112) hours. Thereafter, you may continue coverage by paying the current self-pay rate established by the Board of Trustees. Your Reserve Hours will be exhausted prior to any self-payment. You must make self-payments in accordance with the requirements of the Fund Office as determined by the Board of Trustees. Your self-payments must be received by the Fund Office no later than the 10<sup>th</sup> day of each month.

The amount of the required monthly self-payment for participation in the Retiree Program shall be determined by the Board of Trustees and is subject to change. You may obtain the current monthly self-payment amount from the Third Party Administrator.

Both the extent of coverage and the amounts of self-payment are subject to revision by the Trustees in accordance with any applicable results.

If you qualify under these rules of eligibility to participate in the Retiree Program, then you must elect coverage within the first sixty (60) days after the last month in which you were covered for benefits under the Plan and make the required self-payments in accordance with the requirements of the Fund Office as set by the Board of Trustees. If you do not elect coverage within the sixty (60) day period or make the required self-payments timely to the Fund Office, you will not be eligible for coverage at any time in the future, and you will be notified that you may continue coverage at your own expense as provided for under COBRA, as described above.

## **B. Limits on Retiree Actively Working at the Trade**

It is a condition to coverage under this Plan that the Eligible Retiree shall not engage in or perform employment in the trade jurisdiction, as defined in the current Constitution of the International Association of Heat and Frost Insulators and Asbestos Workers, for remuneration or profit, except that an Eligible Retiree may work:

- (1) as an instructor in a recognized apprenticeship program of the Asbestos Workers; or
- (2) as an Employee for an Employer contributing to the Plan if such employment does not exceed a total of eight hundred (800) hours worked in a calendar year.

Your coverage will terminate on the first day of the month following the month in which you either:

- (1) obtain employment, without following all of Local 84's procedures, in which you use the knowledge, skill, or experience gained as an Insulator/Asbestos Worker; or
- (2) obtain employment with an Employer contributing to the Plan and work in excess of eight hundred (800) hours in a calendar year. The Board of Trustees shall determine if an Eligible Retiree is engaging in or performing disqualifying employment.

## **C. Change of Eligibility Rules and Schedule of Benefits**

The Trustees have granted retiree benefits as a privilege, not a right. No person has any vested right in any retiree benefits. The Trustees, in their sole discretion, are empowered to change or amend the foregoing rules of eligibility or the Schedule of Benefits at any time. Further, the Trustees may expand, reduce, or cancel the Retiree Program, change the cost of contributions, and otherwise exercise their prudent discretion at any time without legal right or recourse by a retiree or any other person.

## **D. Medicare Supplemental Benefits for Medicare-Eligible Retirees**

If you are eligible for coverage under Parts A and B of Medicare, the Plan will pay benefits supplemental to Medicare reimbursement. The supplemental benefits, when combined with what would be available from Medicare, will equal what would have been payable under the Plan. (Benefits will be processed as if you have Medicare coverage on the first day you are eligible for Medicare, whether or not you actually become covered under Parts A and B of Medicare.)

Therefore, if you are eligible for Medicare coverage for either hospital or doctor services and you **DO NOT** take advantage of this privilege by making the necessary payment to have Medicare coverage, your claims under the Plan will be calculated just as if you had signed up for both Parts A and B of Medicare. Benefit limits will be restricted by the Plan's regular rules, and will be reduced by any payments that would have been made by Medicare if you had been enrolled in the Medicare program.

Since payment is coordinated with Medicare, the Explanation of Medicare Benefits (“EOMB”) must be sent to the Third Party Administrator along with the expenses before any payment can be made by the Plan.

**E. Incorporation of Other Plan Documents**

All basic plan documents and all definitions, terms, conditions and provisions therein are adopted and made a part of this Plan. Any questions, interpretations and disputes concerning eligibility for and amount of benefits shall be resolved by the Trustees in their sole discretion and shall be final, binding and conclusive.

**F. Termination of Benefits**

Benefits under the Retiree Program shall terminate for you when you indicate an intention to no longer participate in the Plan or you fail to make the required payments as provided in Section C above.

If you return to employment covered by this Plan and work for more than eight hundred (800) hours in a calendar year, your coverage as a Retiree will terminate at the earlier of either (1) the first of the month following the date on which your total hours worked in a calendar year for an Employer contributing to the Plan exceeds eight hundred (800) hours; or (2) immediately once you become employed in the insulation industry within the geographical jurisdiction of the International Association of Heat and Frost Insulators and Asbestos Workers by a non-participating employer, unless such work is pursuant to a written agreement between Local 84 and yourself. If you gain eligibility as an active eligible Employee, you will receive benefits as an active eligible Employee and no longer be required to make payments for Retiree benefits.

When you stop working in employment covered by this Plan, you will continue your eligibility as an active eligible Employee until your eligibility terminates, at which time no self-payments may be made to continue active eligibility. At that time you may reinstate your coverage as a Retiree if you meet the requirements of Article IV, Section A. (Please note: the five year requirement includes time before and after your initial retirement.) You may become eligible for Retiree coverage only twice. If your coverage is terminated a second time, you are not eligible for any successive coverage.

**G. Retired Employee’s Surviving Spouse’s Continuation**

If you die while receiving benefits under the Retiree Program, then coverage for your surviving Spouse who qualifies as an Eligible Dependent will continue until your eligibility is exhausted. Afterwards, your surviving spouse may elect to continue coverage, provided (1) he or she has been married to you for at least one (1) year immediately prior to your death, (2) there is no other group health benefits coverage on the surviving Spouse [exclusive of Medicare], and (3) the surviving Spouse makes the required payment to continue coverage as determined by the Trustees. Coverage of your surviving Spouse will terminate if the surviving Spouse remarries or fails to make the required payment to continue coverage.

Your surviving Spouse may also elect to continue coverage for your dependent Children who qualify as Dependents. If your Dependents are not your natural born Children, but became your Dependents as a result of marriage less than one (1) year prior to your death, their benefits will terminate upon your death. Continuing coverage for your Dependents is available only if your surviving Spouse elects continuing coverage for himself or herself. If your surviving spouse does not elect continuing coverage for himself or herself, your Dependents may not independently elect continuing coverage for themselves. If your surviving Spouse elects continuing coverage for himself or herself and also for your Dependents, their continuing coverage will end upon your surviving Spouse's death.

An insured Spouse and/or insured dependent Child may also elect to continue health insurance when eligibility ends in accordance with the provisions of COBRA, as described above. In the event that more than one continuation provisions applies, the periods of continued coverage will run concurrently.

#### **H. Prescription Drug Coverage for Retired Employees under Medicare Part D**

If you:

- (1) meet the qualifications for participation in the Retiree Program;
- (2) have health care coverage under this Plan;
- (3) are eligible for prescription drug coverage under Medicare Part D; and
- (4) enroll in a Medicare prescription drug plan under Medicare Part D,

you will permanently forfeit prescription drug coverage under this Plan for yourself and your Eligible Dependents as of the date of enrollment in the Medicare Part D prescription drug plan, but you will be entitled to maintain medical coverage under this Plan for yourself and your Eligible Dependents until medical coverage under this Plan is otherwise terminated. Upon termination of medical coverage under this Plan, you will permanently forfeit prescription drug coverage and medical coverage under this Plan for yourself and your Eligible Dependents. If you completely terminate health care coverage under this Plan upon enrollment in the Medicare Part D prescription drug plan, you will permanently forfeit health care coverage, including prescription drug coverage, for yourself and your Eligible Dependents under this Plan.

#### **I. Prescription Drug Coverage for Active Employees under Medicare Part D**

If you:

- (1) have health care coverage under this Plan as an Employee;
- (2) are eligible for prescription drug coverage under Medicare Part D; and
- (3) enroll in a Medicare prescription drug plan under Medicare Part D,

you will be entitled to continuing medical and prescription drug coverage under this Plan for yourself and your Eligible Dependents until health care coverage under this Plan is otherwise terminated. During any period in which you have continuing prescription drug coverage under this Plan and prescription drug coverage under the Medicare Part D prescription drug plan, prescription drug coverage under this Plan will be primary to prescription drug coverage under the Medicare Part D prescription drug plan.

V.  
**SCHEDULE OF BENEFITS**

**A. Eligible Active Employees, Dependents, and Retirees**

The following chart summarizes medical and other benefits that are available to active Employees, their Eligible Dependents, if any, and Retirees:

**COMPREHENSIVE MEDICAL BENEFITS**  
**ELIGIBLE ACTIVE EMPLOYEES, DEPENDENTS, AND RETIREES**

		In Network	Out of Network
<b>Annual Physical*</b>	One visit maximum per eligible person, per plan year	\$200 maximum until May 31, 2011  No specific dollar maximum beginning June 1, 2011	\$200 maximum until May 31, 2011  No specific dollar maximum beginning June 1, 2011
<b>Annual Mammogram</b>	One Mammogram per eligible person, per plan year**	Covered	Not Covered
<b>Colonoscopy</b>	Once every five years per eligible person over age 50**	Covered	Not Covered
<b>Individual Deductible</b>	Maximum per eligible person per year	\$250.00 (through 5/31/11) \$275.00 (beginning 6/1/11)	\$250.00 (through 5/31/11) \$275.00 (beginning 6/1/11)
<b>Family Deductible</b>	Maximum per family per Plan Year	\$500.00 (through 5/31/11) \$550.00 (beginning 6/1/11)	\$500.00 (through 5/31/11) \$550.00 (beginning 6/1/11)
<b>Basic Benefit***</b>	After deductible	First \$5,000 of Covered Services paid at 80% of PPO allowance	First \$5,000 of Covered Services paid at 60% of reasonable and customary fee

		In Network	Out of Network
<b>Maximum Benefit***</b>	After deductible and after first \$5,000 beyond deductible	Balance of Covered Services paid at 100% of PPO allowance	Covered Services paid at 60% of reasonable and customary fee allowance
<b>Maximum Lifetime Benefit prior to 6/1/2011</b>	Per person, per lifetime	\$500,000	\$500,000
<b>Maximum Annual Benefit from 6/1/2011 through 5/31/2012</b>	Per eligible person, per plan year	\$750,000	\$750,000
<b>Maximum Annual Benefit from 6/1/2012 through 5/31/2013</b>	Per eligible person, per plan year	\$1,250,000	\$1,250,000
<b>Maximum Annual Benefit from 6/1/2013 through 5/31/2014</b>	Per eligible person, per plan year	\$2,000,000	\$2,000,000

\*Annual Physical includes a routine medical examination. In addition, for Participants only, an Annual Physical includes a chest x-ray and a Pulmonary Function Test.

\*\*Additional and more frequent Mammograms and/or Colonoscopies may be covered as determined to be Medically Necessary or Reasonably Necessary by a Physician.

\*\*\* Coverage for the prescription drug Tarceva shall be covered under the Basic Comprehensive Major Medical Benefit of the Plan and not the Prescription Benefits of the Plan. Coverage for Tarceva shall be subject to the provisions related to the Comprehensive Major Medical Benefit instead of the provisions related to the Prescription Benefits set forth below.

The Benefit Schedule shall be applied to Covered Services as described in this booklet. Please note the requirements regarding use of the Preferred Provider Organization (In-Network) in B. below.

<b>Benefits with Specific Maximums</b>	
<b>Annual Physical</b>	Prior to June 1, 2011, \$200 per person; no co-pay or out-of-network penalty applied. Includes routine office visits and immunizations. Effective June 1, 2011, these maximums no longer apply.
<b>Inpatient Mental and Nervous</b>	Prior to June 1, 2012, limited to 25 visits per Plan Year. Effective June 1, 2012, this limitation no longer applies.
<b>Inpatient Substance Abuse</b>	Prior to June 1, 2012, \$5,000 maximum per treatment; lifetime limit of two treatments (two treatments must be separated by three years). Effective June 1, 2012, \$5,000 maximum per treatment with no lifetime limit on number of treatments.
<b>Out-Patient Substance Abuse</b>	Prior to June 1, 2012, limited to 25 visits per Plan Year; \$2,500 annual maximum; \$5,000 lifetime maximum Effective June 1, 2012, these limitations no longer apply.
<b>Well-Baby Care Checkups or Routine Exams</b>	Limited to 2 visits per Plan Year per Dependent Child up to age 5.
<b>Immunizations</b>	Covered for each Dependent Child through age 13
<b>Sleep Apnea</b>	Limited to 1 test per Plan Year
<b>Chiropractic Treatments</b>	Limited to 20 visits per Plan Year for all combined Physical Therapy, Occupational Therapy, or Rehabilitation unless treatment is necessary for illness, injury or rehabilitation following Surgery. Coverage for Physical Therapy, Occupational Therapy, and Rehabilitation is limited to 80% of the reasonable and customary fee allowance for such treatment. The Participant is responsible for the remaining 20%.

**Dental Benefits**  
**Eligible Active Employees, Dependents, and Retirees**

Dental benefits are limited to 80% of Covered Services, with a maximum benefit of \$400 per person, per Plan Year.

**Prescription Benefits**  
**Eligible Active Employees, Dependents, and Retirees**

Prescription drug benefits under the Plan are administered by a Third Party Pharmacy Benefit Manager. Your prescription drug benefits are more fully described in the prescription drug benefit booklet prepared by the Pharmacy Benefit Manager. The following is a summary of the major limitations on your prescription drug benefits. For complete information, you should refer to the booklet prepared by the Pharmacy Benefit Manager.

<b>Prescription Benefits</b>		
<b>Maximum Prescription Benefit per Plan Year through June 1, 2011 (Effective June 1, 2011, subject to Plan's overall annual maximums)</b>	\$15,000 Individual	\$25,000 Family
<b>Retail Prescription, up to 30-day supply; limited to 3 fills</b>	Generic Prescription Drug	Approved cost of prescription less \$10 co-pay
	Formulary Brand Name Prescription Drug	Approved Cost of prescription less \$20 co-pay
	Non-Formulary Brand Name Prescription Drug	Approved Cost of prescription less \$35 co-pay
<b>Mail Order Prescription; up to 90-day supply; limited to 3 refills; required for maintenance medication</b>	Generic Prescription Drug	Approved cost of prescription less \$20 co-pay
	Formulary Brand Name Prescription Drug	Approved cost of prescription less \$40 co-pay
	Non-Formulary Brand Name Prescription Drug	Approved cost of prescription less \$70 co-pay

Exclusions include vitamins, Rogaine, Viagra, fertility drugs, erectile dysfunction drugs, smoking cessation drugs, and specialty injectable drugs. For biotech drugs, the co-pay in all cases is 25% of the approved cost of the prescription. Generic Prescription Drugs must be used when available unless Physician specifies "dispense as written" on script.

**Death Benefits**

Death Benefit – Active Employees	\$10,000
Death Benefit – Retirees	\$2,000

## **B. Use of Preferred Provider Organization**

The Plan has contracted with a Preferred Provider Organization (hereinafter "PPO"), to provide a network of physicians, hospitals, and other medical service providers. The PPO will provide services to eligible Participants at a reduced fee structure. Participation in the PPO helps to reduce the Plan's costs and permits you to maximize your benefits.

When you receive health care services from a provider that is not a PPO network provider, your benefits will be reduced. Please see the Schedule of Benefits above for an itemization of benefits for in-network and out-of-network providers.

Use of an in-network provider is necessary for active Eligible Employees, retired Employees who are not on Medicare, Surviving Spouses not on Medicare, and Eligible Dependents.

**NOTE:** The PPO requirement is not enforced if you require treatment for an Illness or an Injury that qualifies as a Medical Emergency. However, once you receive treatment and are medically stable, you will be subject to non-PPO charges.

To obtain a directory of in-network providers, contact the Fund Office.

## **C. Weekly Accident and Sickness Benefits**

### **1. Benefits Available**

The Weekly Sickness and Accident Benefit is available to you if you have met the Plan's eligibility requirements, are an active Participant, and have become Totally Disabled due to a non-occupational injury or illness that prevents you from working at your occupation. Weekly Sickness and Accident Benefits are not available to Retirees or your Dependents.

The Weekly Sickness and Accident Benefit is \$300 per week through the twenty-sixth (26<sup>th</sup>) week of disability. Weekly benefits begin on the *earliest* of:

- (i) the first day of a disability caused by accident;
- (ii) the first day of hospitalization;
- (iii) the first day of a surgical procedure performed in an outpatient facility; or
- (iv) the eighth day of a disability caused by other sickness.

For purposes of maintaining your coverage under the Plan during your period of disability, you will be credited with thirty-five (35) hours for each week that the Trustees determine you are Totally Disabled. Your coverage will continue for a maximum of twenty-six (26) weeks during any twelve (12) consecutive month period or for any single disability. This maximum coverage period of twenty-six (26) weeks during a twelve (12) consecutive month period applies even if you have more than one period of disability during a consecutive twelve (12) month period.

**EXAMPLE:** In February you are involved in an accident which results in a continuous period of disability for twenty-four (24) weeks. You receive twenty-four (24) weeks of Weekly Sickness and Accident Benefits. In September you are afflicted with pneumonia, which results in a continuous period of disability for six (6) weeks. You will be eligible for Weekly Sickness and Accident Benefits for only two (2) out of the six (6) weeks because the maximum amount of Weekly Sickness and Accident Benefits payable during any twelve (12) consecutive month period is twenty-six (26) weeks.

Successive periods of disability separated by less than two (2) weeks of continuous employment will be considered one (1) period unless the two disabilities arise from different causes. If the disabilities arise from different causes, you will be eligible for a new period of disability benefits if you have worked at least one full working day before the second period of disability begins.

**NOTE:** The maximum benefit available for any one disability is twenty-six (26) weeks.

## **2. Limitations**

Determination of whether Sicknesses or Accidents are included or excluded under this Plan will be made by the Trustees in their sole discretion and will be conclusive.

No Weekly Sickness and Accident Benefits will be paid for, or on account of, any period of disability:

- (i) for which you are not under the regular care of a doctor; or
- (ii) for which you have or had a right to payment under any workers' compensation law, occupational disease law or similar law; or
- (iii) which is due to work related Sickness or Accident; or
- (iv) for which you have or had a right to payment under the temporary disability benefit laws of any state or unemployment.

**NOTE:** Weekly Sickness and Accident Benefits are available for a non-occupational disability only.

## **3. Submission of Claims**

To obtain Weekly Sickness and Accident Benefits, you must provide written notice to the Third Party Administrator within twenty (20) days after the Accident or Sickness causing your Total Disability occurs. If written notice cannot be given within that time, it must be given as soon as reasonably possible. The written notice must contain enough information to identify who is making the claim.

When the Third Party Administrator receives written notice of a claim, the Third Party Administrator will send you an approved claim form. You must complete and submit the approved claim form, completed and signed by your Physician stating the nature of the disability, length of disability and date you can return to work. It must also be signed by your Physician.

The Third Party Administrator may, in its sole discretion, require you to be examined or have your claim reviewed by a physician or clinic of its choice on behalf of the Trustees or require you to submit additional evidence to support your claim for Weekly Sickness and Accident Benefits.

If your claim for Weekly Sickness and Accident Benefits is denied, you will be notified in writing by the Third Party Administrator the reasons why your claim was denied. Notification of an adverse decision shall occur within forty-five (45) days of the receipt of your approved claim form. In the event of denial, your notice will state specifically the reasons for rejecting your application and will reference those specific portions of the Plan and/or rules and regulations upon which the decision is based. Any non-approval shall also be accompanied by a description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary. Further, any denial or restricted acceptance will be accompanied by an explanation of your rights to and procedure for appealing the decision to the Board of Trustees. Any non-approval will also include a statement regarding your right to bring a civil action under ERISA §502(a) following an adverse benefit determination on appeal. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, the adverse determination will also advise that such rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge upon request.

If the Third Party Administrator determines more time is needed to process the claim due to matters beyond his/her control, the Third Party Administrator will notify you of a thirty (30) day extension. If a second extension is necessary due to matters beyond his/her control, the Third Party Administrator will notify you of a final thirty (30) day extension. No further extensions shall occur. Any notice of an extension shall include the standards on which an entitlement to Weekly Sickness and Accident Benefits is based, the unresolved issues preventing a decision and any additional information that is needed to resolve the claim.

#### **4. Appeals**

If your claim for Weekly Sickness and Accident Benefits is denied, you may, by written notice received by the Third Party Administrator within one hundred and eighty (180) days of your receipt of the notice denying your claim for Weekly Sickness and Accident Benefits, appeal the decision. The written notice should state your name, address and the reasons why you are appealing the decision of the Third Party Administrator, and should give the date of the decision from which you are appealing.

The Trustees shall consider the appeal of the Claimant no later than its next regularly scheduled meeting, which immediately follows the receipt of the notice of appeal unless such notice was filed within thirty (30) days prior to the next regularly scheduled meeting, then the Board of Trustees may consider the appeal at the second meeting following the receipt of the notice of appeal. If special

circumstances require an extension of time for processing, then the Board of Trustees may consider the appeal no later than the third meeting following the receipt of the notice of appeal.

After consideration of the appeal as above, the Board of Trustees shall advise the Claimant of its decision in writing within five (5) days following the meeting at which the appeal was considered. The decision of the Board of Trustees shall state the specific reason or reasons for the determination and refer to the specific plan provisions on which the benefit determination is based. Any non-approval shall be accompanied by: (i) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; (ii) a statement apprising claimants that "You or your plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."; and (iii) a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA. The Trustees shall have full authority to interpret the provisions of this Plan and it is within the sole and absolute discretion of the Trustees to determine if a Claimant is entitled to receive a benefit and the amount of the benefit. The decision shall be final and binding upon the Claimant.

#### **5. When Benefits End**

Weekly Sickness and Accident Benefits will cease on the earliest of:

- (i) the date you are no longer Totally Disabled; or
- (ii) the end of the maximum benefit period (26 weeks during any 12 month period); or
- (iii) your date of death.

#### **D. Death Benefits**

When a Participant dies, the Plan will pay a death benefit to the Participant's designated beneficiary listed on the appropriate form that is on file at the time of death in a lump sum in the amount set forth in the Schedule of Benefits. If the beneficiary is a minor at the time benefits become payable, the benefits may be paid to the Child's parent or legal guardian as custodian of the minor pursuant to the Ohio Transfers to Minors Act (R.C. 5814). The death benefit for active Employees is different from the death benefit for Retirees. If the Participant fails to designate a beneficiary on an appropriate form that is on file at the time of the Participant's death or if his or her designated beneficiary is no longer living upon the Participant's death, the death benefit will be paid to the person (or in equal shares to the persons) in the first of the following classes of successive preference beneficiaries then surviving: the Participant's (1) spouse, (2) lineal descendants, (3) parents, (4) siblings, and (5) executor or administrator of the Participant's estate. A Participant may designate a new beneficiary at any time by filing a written beneficiary change form with the Fund Office. Any change of beneficiary form will *not* be effective until the form is received by the Plan. To be effective, the form must be received prior to the Participant's death.

#### **E. Prescription Benefits**

The Plan provides prescription benefits to Participants and their Eligible Dependents, if any, in accordance with the Schedule of Benefits above and the prescription drug benefit booklet prepared by the Pharmacy Benefit Manager.

#### **F. Exclusions from Coverage**

The Plan provides coverage for most health care expenses you can expect to incur. You should be aware, however, that the Plan does not cover any of the expenses, disabilities, or types of care listed below:

- (1) Injury, Illness or disease for which benefits are payable in accordance with the provisions of any worker's compensation or similar law.
- (2) Eye glasses, hearing aids, eye re-refractions, and the fitting of eyeglasses and hearing aids, except if covered under the Vision Care Benefits set forth below after an election for such coverage by the Participant.
- (3) Injuries caused by declared or undeclared war.
- (4) Treatment or Charges for Cosmetic or Reconstructive Surgery except when the operation is performed to correct deformities resulting from Injury or Illness or such congenital defects which interfere with function; however expenses for treatment of medical complications arising from cosmetic treatment will be covered.
- (5) Check-ups, certifications, well-baby care, or routine examinations not incident to or necessary in the diagnosis of sickness, or an accidental bodily injury, except as specifically provided in the Schedule Benefits above.
- (6) Charges for medical services or supplies furnished in a government Hospital or institution or by federal, state or local government agency or program unless required by law.
- (7) An expense which would not be incurred except for the existence of insurance.
- (8) Services rendered without charge.
- (9) Charges for medical services or supplies furnished by Family, a Family Member, or an individual who ordinarily resides in the patient's home.
- (10) Dental services, including dental x-rays, except for accidental injuries, osseous surgery and TMJ treatment subject to the limits of the Plan.
- (11) Charges for any service or supply that is not Medically Necessary or Clinically Necessary for the treatment of the patient's Illness or Injury.

- (12) Services, treatment, drugs and supplies which are Experimental, Investigational or Medically Unproven, including any services, treatment drugs or supplies which are not recognized as acceptable medical practice or any items requiring Governmental approval for which approval was not granted or in existence at the time the services were rendered.
- (13) Charges in excess of the Reasonable and Customary Charge as defined in this Plan.
- (14) Charges for a Dependent for any medical expense for which the Dependent is entitled to benefits as an Employee or former Employee under this Plan.
- (15) Charges for education, training, and bed and board while you or your Dependent are confined in an institution which is primarily a school, or other institution for training, a place of rest, a convalescent home, a place for the aged or a nursing home.
- (16) Charges for Custodial Care.
- (17) Charges in excess of the most prevalent semi-private Hospital rate except as specifically provided by this Plan.
- (18) Charges for reversals of tubal ligations and vasectomies.
- (19) Transsexual surgery.
- (20) Radial keratotomy, lasix or other laser eye surgery.
- (21) Acupuncture, unless performed by a Physician.
- (22) Chiropractic treatments, except as specifically provided in the Schedule of Benefits above.
- (23) Occupational therapy or rehabilitation, except following Illness or Injury and except as specifically provided in the Schedule of Benefits above.
- (24) Physical therapy, unless required for rehabilitation following Surgery and except as specifically provided in the Schedule Benefits above.
- (25) Charges for treatment of intentionally self-inflicted Injury, or Injury sustained in the act of committing Illegal and Willful Misconduct.
- (26) Charges for dietary control.
- (27) Services or supplies not specifically listed as a covered service.
- (28) Non-legend drugs.

- (29) Vitamins (except prescription prenatal vitamins), minerals, dietary supplements, dietary drugs, etc.
- (30) Medications which can be legally purchased over the counter without a prescription, even if prescribed by a doctor.
- (31) Therapeutic devices or appliances.
- (32) Hypodermic needles or syringes (except those associated with insulin injection).
- (33) Genetically engineered drugs.
- (34) Anabolic steroids.
- (35) Diet Aids.
- (36) Fluoride.
- (37) Treatments for Temporomandibular Joint dysfunction.
- (38) Infertility treatments.
- (39) Charges for treatment of obesity.
- (40) Charges in excess of the limits provided by the Plan.
- (41) Treatment or charges not prescribed by or performed by or under the direction of a Doctor, Physician, Surgeon or Other Professional Provider or not performed within the scope of the Provider's license.
- (42) Treatment or charges for which payment was made or would have been made under Medicare Parts A or B if benefits were claimed. This applies when you are eligible for Medicare even if you did not apply for or claim Medicare benefits. This does not apply, however, if in accordance with federal law, this coverage is primary and Medicare is the secondary payer of your health care expenses.
- (43) Treatment or charges received in a military facility for a military service related Condition.
- (44) Treatment or charges for the removal of tattoos.
- (45) Charges for arch supports and other foot care or foot support devices only to improve comfort or appearance.
- (46) Charges for weight loss drugs.

- (47) Charges for massotherapy or massage therapy.
- (48) Charges for hypnosis or acupuncture.
- (49) Physician charges for completion of claim forms or missed appointments.
- (50) Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a physician.
- (51) Charges for exercise equipment and health club memberships.

**VI.**  
**HEALTH REIMBURSEMENT ARRANGEMENT**

The Trustees have established a health reimbursement arrangement (“HRA”) under the Insulators Local 84 Health Care Plan (“Health Care Plan”), with the following terms and conditions:

**A. Purpose of HRA**

The purpose of the HRA is to provide medical care reimbursements for each Participant and his or her Eligible Dependents. It is the intention of the Board of Trustees that—

- (1) this HRA qualify as a health reimbursement arrangement within the meaning of Internal Revenue Service Notice 2002-45, 2002-28 I.R.B. 93, and an accident and health plan within the meaning of Code Section 105; and
- (2) the benefits payable under the HRA be eligible for exclusion from gross income under Code Section 105.

**B. Plan Year**

The Plan Year for the HRA shall be the same as the Plan Year for the Health Care Plan.

**C. Funding Medium for the Accumulation of Plan Assets**

Assets are accumulated and benefits are provided directly by the Trust Fund of the Health Care Plan. The principal and income of the HRA are to be used for the exclusive benefit of Participants and their Eligible Dependents, and for defraying proper expenses of administering the HRA.

**D. HRA’s Effective Date**

The HRA’s effective date is July 1, 2006.

**E. Sources of Contributions to the HRA**

Contributions to the HRA are made solely by Employers in accordance with the terms and conditions of the HRA and such other requirements as the Board of Trustees may determine. Employer Contributions to the HRA shall be made to the Trust Fund only under the obligations of a Collective Bargaining Agreement and/or other written agreement between a contributing Employer and the Union. The Union shall be the authority for the specific provisions of the collective bargaining agreement establishing the obligation of an Employer to make contributions.

**F. Incorporation of Other Plan Documents**

All definitions, terms, conditions and provisions of the Health Care Plan are adopted and made a part of this HRA unless the context otherwise indicates. Any questions, interpretations and disputes concerning eligibility for and amount of benefits shall be resolved by the Trustees in their sole discretion, and their decision shall be final, binding and conclusive.

**G. Initial Eligibility for HRA Benefits**

You are eligible to participate in and receive benefits from the HRA if you:

- (1) are an Employee; and
- (2) have a Credit Account with a positive balance.

Your Credit Account is funded exclusively through Employer Contributions.

**H. Continuation of Eligibility**

You will continue to remain eligible for participation in the HRA as long as you have a positive balance in your Credit Account and are an Employee. Once the money in your Credit Account is exhausted, you are ineligible for benefits until your coverage is reinstated when you again satisfy the requirements for initial eligibility in the same manner as a new Employee.

**I. Termination of Eligibility**

Your coverage under the HRA will end on the earlier of the following:

- (1) the first day of the month following the twelve (12) consecutive month period during which your Credit Account begins at \$0 and remains at \$0 for the duration of such period; or
- (2) the day the HRA is terminated.

**J. Reinstatement of Eligibility after Termination**

If you terminate your coverage pursuant to I. above, your coverage will be reinstated when you again satisfy the requirements for initial eligibility in the same manner as a new Employee.

**K. Change of Eligibility Rules**

The Trustees, in their sole discretion, may change or amend the foregoing rules of eligibility or the benefits provided by this HRA at any time and for any reason.

**L. HRA Benefits**

Eligible Participants are entitled to reimbursement from their Credit Account for any itemized medical bills submitted for payment that:

- (1) are not covered by any other health insurance plan under which the Participant is covered;
- (2) relate to expenses for medical care incurred by the Participant or an Eligible Dependent after his or her commencement of participation in the HRA; and
- (3) satisfy the requirements for amounts paid to an individual as reimbursement for medical care expenses under Code Section 213(d).

Examples of eligible medical care expenses are medical bills, pharmaceutical bills, vision and/or dental co-pays, premiums and deductibles. Certain over-the-counter medications that are purchased for the diagnosis, cure, mitigation, treatment, or prevention of disease are also eligible for reimbursement. Expenses for items that are merely beneficial to your general health are not eligible for reimbursement. Examples of ineligible expenses are vitamins, dietary supplements, herbal remedies, toiletries, cosmetics, and sundry items.

A Participant may also use his or her Credit Account balance to maintain eligibility under the Health Care Plan.

**M. Limit on Benefits**

No Participant shall be entitled to receive reimbursements under this HRA in excess of the amount in his or her Credit Account.

**N. Eligibility for Reimbursement or Payment from Other Source**

Reimbursement under this HRA shall be made only in the event, and to the extent, that reimbursement for amounts expended, or payment, for medical care is not provided through any insurance policy or under any other plan in which the Employee is a Participant or under any federal or state law. If there is such a policy, plan or law in effect providing for such reimbursement or payment, in whole or in part, then, to the extent of the coverage under such policy, plan or law, the

Trustees shall be relieved of any and all liability hereunder for reimbursement of the amounts expended or paid for medical care.

**O. Procedure For Filing An HRA Claim**

Except as otherwise provided in this Appendix A, claims procedures under the HRA shall be governed by Article VII of the Health Care Plan.

To file an HRA claim, you must first obtain claim forms from the Union Office at: International Association of Heat and Frost Insulators and Asbestos Workers Local No. 84, 1000 Mogadore Road, Unit B, Kent Ohio 44240. You may also obtain claim forms from the Third Party Administrator at: Compensation Programs of Ohio, 33 Fitch Boulevard, Austintown, OH 44515 (Toll Free Phone: (800) 435-2388; Fax: (330) 270-0912)

All sections of the claim form must be completed carefully and accurately, signed, dated and filed with the Third Party Administrator within one (1) year after the charge is incurred, along with an itemized bill for all expenses incurred.

Claims filed after the filing deadline will be considered only if there was reasonable cause for failure to timely file the claim, as determined by the Trustees in their sole discretion. If proof of a claim cannot be furnished to the Third Party Administrator by the filing deadline, the claim will not be denied or reduced if proof is furnished as soon as reasonably possible. Unless you are legally incapacitated, failure to file the claim within two (2) years after the charge is incurred will invalidate the claim or reduce benefits, as determined by the Trustees, in their sole discretion.

A decision as to the validity of the claim will be made as promptly as possible after the claim is received, with necessary documentation. If a delay occurs, you will be notified of the reasons for the delay, as well as the anticipated length of the delay, in writing. If further information or other material is required, you will also be informed.

All reimbursements payable under the HRA shall be paid as soon as practicable after the end of the calendar quarter in which the necessary claim form is received by the Third Party Administrator. However, if your claim totals \$200 or more, the Third Party Administrator may pay your reimbursement sooner, upon request. If the amount of your claim exceeds your Credit Account balance when you file the claim, you will be reimbursed in an amount not exceeding your Credit Account balance. If you wish to be reimbursed for the remaining portion of your claim, you may file an additional claim when your Credit Account again has a positive balance, as long as your additional claim is filed by the filing deadline applicable to the original claim.

In order for the HRA to pay a claim, you must provide proof that you have actually incurred an expense for medical care which meets the requirements of this Article and proof of the exact amount of the medical care expense. You must honor any reasonable request for further information or for a repayment agreement. Otherwise, the HRA will not be able to pay your claim.

If the Third Party Administrator questions whether a claim should be paid or whether the services provided to you were unreasonably priced, the Third Party Administrator has the right to rely on the Health Care Plan's advisors for the decision.

**P. Claimant Payment**

All claim payments will be made to you and/or your Eligible Dependent. However, if you and/or your Eligible Dependent are: (1) deceased; or (2) a minor (under 18 years of age); or (3) in the Board of Trustees' opinion, not legally competent, then the Board of Trustees may make payment to you or another Eligible Dependent, as applicable, or to a service provider on behalf of you and an Eligible Dependent.

**Q. Change in Terms**

The terms of this HRA may be changed at any time without advance notice to you, except as prohibited by law. All changes in benefits will be made on a uniform basis, affecting similarly situated Participants and Employees equally, and will not apply to claims incurred before the amendment is effective.

**R. Administrative Charges and Earnings**

Individual Credit Accounts of Participants may be assessed a quarterly service charge to cover the costs of account administration. The amount charged to each Credit Account shall be determined from time to time by a majority vote of the Trustees. The amount charged shall reasonably reflect the pro-rata cost of administering accounts. Individual Credit Accounts of Participants shall be credited with earnings. Any such earnings shall be credited semiannually.

**VII.  
VISION CARE BENEFITS**

Eligible Participants in the Plan will be offered the opportunity to elect Vision Care Benefits under the Plan on June 1<sup>st</sup> of each year. The coverage period for those Participants that choose to enroll in the Plan will be the 12 month period beginning June 1<sup>st</sup> and ending May 31<sup>st</sup>. In order to be eligible for coverage, a Participant must submit an enrollment form no later than May 14<sup>th</sup> preceding the effective date of coverage.

Annual premiums will be set annually by the Board of Trustees and shall be deducted from Participants' Health Reimbursement Arrangement ("HRA") Account. If there is insufficient money in a Participant's HRA Account, the Participant will be billed the difference.

Vision Care Benefits covered under the Plan are set forth in the following Schedule:

<u>Vision Care Services</u>	<u>In Network Cost</u>	<u>Out of Network Reimbursement</u>
Exam with Dilation as Necessary	\$0 Copay	Up to \$30.00
Contact Lens Fit and Follow Up: (Contact lens fit and follow-up visits are available once a comprehensive eye exam has been completed.)		
Standard	Up to \$40.00	N/A
Premium	10% off Retail	N/A
Frames	\$0 Copay \$130.00 allowance 20% off balance over \$130	Up to \$65.00
Standard Plastic Lenses:		
Single Vision	\$10 Copay	Up to \$25.00
Bifocal	\$10 Copay	Up to \$40.00
Trifocal	\$10 Copay	Up to \$55.00
Standard Progressive	\$75.00	Up to \$40.00
Premium Progressive	\$75, 80% of charge less than \$120 allowance	Up to \$40.00
Lens Options (paid by the Participant and added to the base price of the lens):		
Tint (Solid and Gradient)	\$0.00	Up to \$5.00
UV Treatment	\$0.00	Up to \$5.00
Standard Plastic Scratch Coating	\$0.00	Up to \$5.00
Standard Polycarbonate	\$0.00	Up to \$5.00
Standard Anti-Reflective Coating	\$45.00	N/A
Other Add-ons and Services	20% off retail price	N/A
Contact Lenses (allowance covers materials only):		
Conventional	\$0 Copay, \$130 allowance, 15% of balance over \$130	Up to \$104
Disposables	\$0 Copay, \$130 allowance, balance over \$130	Up to \$104
Medically Necessary	\$0 Copay, paid in full	Up to \$200
LASIK and PRK Vision Correction Procedures	15% off retail price OR 5% off promotional pricing	N/A

<b>Additional Pairs Benefit:</b> Participant also receive a 40% discount off complete pair eyeglass purchase and 15% off conventional contact lenses once the funded benefit has been used. <b>Frequency:</b> Exam Frames Standard Plastic Lenses or Contact Lenses	   Once every 12 months Once every 12 months Once every 12 months	   N/A N/A N/A
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**Additional Purchases and Out-of-Pocket Discount:**

Participant will receive a 20% discount on remaining balance at Participating Providers beyond plan coverage. This discount does not apply to In-Network Providers' professional services or disposable contact lenses.

Participants receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.

Participants receive an Eye Care Supplies benefit of 20% off the retail price for eye care supplies like cleaning cloths and solutions purchased at In-Network providers (not valid on doctor's services or contact lenses).

The following benefits are excluded from coverage under the Vision Benefits Plan:

1. Orthoptic or vision training, subnormal vision aids and any associated supplemental testing;
2. Aniseikonic lenses;
3. Medical and/or surgical treatment of the eye, eyes or supporting structures;
4. Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a conditions of employment;
5. Safety eyewear;
6. Services provided as a result of any Workers' Compensation law or similar legislation or required by any governmental agency or program whether federal, state or subdivisions thereof;
7. Plano (non-prescription) lenses and/or contact lenses;
8. Non-prescription sunglasses;

9. Two pair of glasses in lieu of bifocals;
10. Services or materials provided by any other group benefit plan providing vision care;
11. Certain brand name Vision Materials in which the manufacturer imposes a no-discount policy;
12. Services rendered after the date a Participant ceases to be covered under the Plan, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Participant are within 31 days from the date of such order;
13. Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next Benefit frequency when Vision Materials would next become available

## **VIII.** **DEFINITIONS**

### **A. Accident**

“Accident” shall mean any accidental bodily injury which requires treatment by a physician and is recognized by the terms of the Plan and the Trustees.

### **B. Agreement and Declaration of Trust or Trust Agreement**

“Agreement and Declaration of Trust” or “Trust Agreement” means the Agreement and Declaration of Trust which has been entered into by and between the Union and the Association and those Employers who, by virtue of Collective Bargaining Agreements with the Union, have agreed to participate in and contribute to this Trust Fund and who became parties thereto and that document, as may from time to time be amended.

### **C. Association**

“Association” means the Employers who negotiate with the Union to participate in the Trust Fund on behalf of themselves, other individual Employers on whose behalf they negotiate and/or Employers who make contributions into the Trust Fund pursuant to a collective bargaining agreement or written participation agreement with the Board of Trustees and any successors thereof.

### **D. Benefit Period**

“Benefit Period” means the period of time specified in the Schedule of Benefits during which Covered Services are rendered and benefit maximums are accumulated. The first and/or last Benefit Periods may be less than twelve (12) months, depending on the Effective Date and the date your coverage terminates.

**E. Benefit Verification**

“Benefit Verification” means the method by which the PPO determines Covered Services and benefits that will be provided for a proposed service or Course of Treatment. For further information see the How Claims are Paid section.

**F. Billed Charges**

“Billed Charges” means charges for all services and supplies that the Covered Person has received from the Provider, whether they are a Covered Service or not.

**G. Brand Name Prescription Drug**

“Brand Name Prescription Drug” means a Prescription Drug that has been patented with a brand name and is produced by the original manufacturer under that brand name.

**H. Child or Children**

“Child” or “Children” include a Participant’s natural sons and daughters, stepchildren, adopted children (including children placed for adoption), and foster children.

**I. Claimant**

“Claimant” means the person making the claim.

**J. Clinically Necessary**

“Clinically Necessary” means a service or supply that is required to diagnose or treat a Condition and which the PPO determines is:

- (1) appropriate with regard to the standards of good dental practice;
- (2) not primarily for your convenience or the convenience of a Dentist; and
- (3) the most appropriate supply or level of service which can be safely provided to you.

**K. Coinsurance**

“Coinsurance” means the percentage of covered charges for which a Participant, dependent or family is responsible to pay after the Deductible or Copayment has been met. Coinsurance does not apply to expenses applied toward the individual or family deductible.

**L. Coinsurance Limit**

“Coinsurance Limit” means a specified dollar amount of Coinsurance expense incurred in a Benefit Period by a Covered Person for Covered Services.

**M. Collective Bargaining Agreement**

“Collective Bargaining Agreement” means any Collective Bargaining Agreement existing between an Employer and the Union which provides for contributions into the Trust Fund as well as any extension or extensions, renewal or renewals of any such Collective Bargaining Agreement or any Collective Bargaining Agreement which provides for contributions into this Trust Fund.

**N. Contracting**

“Contracting” means the status of a Hospital or Other Facility Provider which has an agreement with the PPO Provider about payment for Covered Services; or which is designated by the PPO Provider as Contracting.

**O. Contracting Mail Order Pharmacy**

“Contracting Mail Order Pharmacy” means a Pharmacy which dispenses Prescription Drugs through the mail and which has a contractual obligation with the Pharmacy Benefit Manager to provide the services.

**P. Cosmetic or Reconstructive Surgery**

“Cosmetic or Reconstructive Surgery” means any surgical procedure performed primarily: to improve the physical appearance or to change or restore bodily form without materially correcting a bodily malfunction; or to prevent or treat a mental or nervous disorder through a change in bodily form. Determination will be made by the Trustees in their sole discretion and will be conclusive. In no event shall this Plan provide payment for any loss, expense or charge which results from Cosmetic or Reconstructive Surgery, except:

- (1) for injuries received in an accident; or
- (2) for repair of congenital defects of new-born Dependent Children; or
- (3) for repair of the effects of a previous surgical procedure performed and for which benefits were paid while the individual was eligible under the Plan; or
- (4) for medical and surgical benefits with respect to a mastectomy, which will be covered for Eligible Participants and Dependents of the Plan who elect breast reconstruction in connection with such mastectomy as listed below:
  - (i) reconstruction of the breast on which the mastectomy has been performed; or
  - (ii) surgery and reconstruction of the other breast to produce symmetrical appearance; or

- (iii) coverage for prostheses and physical complications of all stages of mastectomy including lymphedemas.

Any such mastectomy will be covered in a manner determined in consultation with the attending physician and the patient. Such coverage will be subject to the deductibles and coinsurance provisions that are consistent with those established for other benefits under the Plan.

**Q. Course of Treatment**

“Course of Treatment” means a planned series of procedures or treatments performed by a Dentist or Physician.

**R. Coverage/Covered Services**

“Coverage” or “Covered Services” means the benefits payable under this Plan as a consequence of Injury or Illness which are allowed under this Plan.

**S. Covered Charges**

“Covered Charges” means the charges eligible for reimbursement under this Plan.

**T. Copayment**

“Copayment” means a dollar amount, as specified in the Schedule of Benefits that you are required to pay at the time Covered Services are rendered.

**U. Credit Account**

“Credit Account” means the method of crediting Employer Contributions received on behalf of each Employee to the Employee’s individual Credit Account under the Health Care Plan. The cost of benefits plus the HRA’s administrative expenses shall be deducted from the Participant’s individual Credit Account.

**V. Custodial Care**

“Custodial Care” means care that does not require the constant supervision of skilled medical personnel to assist the patient in meeting their activities of daily living. Custodial Care is care which can be taught to and administered by a lay person and includes but is not limited to:

- (1) administration of medication which can be self-administered or administered by a lay person; or
- (2) help in walking, bathing, dressing, feeding or the preparation of special diets.

Custodial Care does not include care provided for its therapeutic value in the treatment of a Condition.

## **W. Deductible**

“Deductible” means the specified dollar amount of Covered Charges which a Participant or family must incur during the Plan Year before a Covered Charge will be partially or fully paid. Separate individual and family deductibles are set forth on the Schedule of Benefits.

If both husband and wife are Eligible Participants under the Plan, their dependent Children shall be considered Eligible Dependents of either parent, but not both. A dependent legal Spouse who is an eligible Participant shall only receive benefits as an Eligible Participant and benefits will be coordinated so that 100% of the eligible Expense shall be compensated.

## **X. Doctor, Physician or Surgeon**

“Doctor,” “Physician” or “Surgeon” means a doctor of medicine (M.D.), doctor of osteopathy (D.O.), chiropractor (D.C.), ophthalmologist, optometrist, podiatrist, dentist, psychiatrist or psychologist practicing within the scope of his or her license. Doctor does not include the Participant nor the spouse, parent, Child, brother or sister or any other family member of the Participant.

## **Y. Eligible Dependent**

### **1. Prior to June 1, 2011:**

“Eligible Dependent” includes only the following, provided they are not eligible to be covered under the Plan as Employees and, if previously covered as Employees, are not eligible to receive any benefits under the Plan as a result of a disability existing when coverage as an Employee was discontinued:

- (a) An Eligible Employee’s legal Spouse, while not divorced or legally separated from the Eligible Employee.
- (b) An unmarried natural Child (hereinafter “unmarried Child”) of the Eligible Employee if the unmarried Child is less than nineteen (19) years of age, except as provided in paragraph (1)(c) below. A stepchild, legally adopted Child or legal ward (hereinafter “unmarried Child”) of the Eligible Employee who has been placed under the legal guardianship of the Eligible Employee if the unmarried Child is less than nineteen (19) years of age, except as provided in paragraph (1)(c) below. To qualify as an Eligible Dependent the unmarried Child must:
  - (i) physically live in the same household as the Eligible Employee on a daily basis at the time the claim was incurred; and
  - (ii) be in the custody of and financially dependent upon the Eligible Employee for maintenance and support; and
  - (iii) be allowed as a federal tax exemption for the Eligible Employee.

The Trustees may request proof, including but not limited to, the extent of maintenance and support, tax returns of the Eligible Employee and the duration of living with the Eligible Employee to verify a claim that an unmarried Child is an Eligible Dependent pursuant to this paragraph (b). Determination of whether such unmarried Child qualifies as an Eligible Dependent pursuant to this paragraph (b) will be made by the Trustees in their sole discretion and will be conclusive.

The Trustees may, in their sole discretion, require subsequent proof, including, but not limited to, the extent of maintenance and support, tax returns of the Eligible Employee and the duration of living with the Eligible Employee, to verify that such unmarried Child previously determined by the Trustees to be an Eligible Dependent pursuant to this paragraph (b) continues to meet the conditions to qualify as an Eligible Dependent. The Trustees may discontinue the health coverage for such unmarried Child who was determined to qualify as an Eligible Dependent pursuant to this paragraph (b), if subsequent to such a determination the conditions in this paragraph (b) to qualify as an Eligible Dependent are not met. Determination will be made by the Trustees in their sole discretion and will be conclusive.

- (c) An unmarried Child of the Eligible Employee between nineteen (19) years of age and twenty-four (24) years of age who is a full-time student enrolled in an accredited educational institution or who is on a Medically Necessary Leave of Absence as set forth in Article III, Section G, and dependent on the Eligible Employee for his/her primary support and maintenance and, provided, further; that the unmarried Child is not eligible for benefits under the Plan as an Eligible Employee. Proof of enrollment in an accredited educational institution and/or proof of a Medically Necessary Leave of Absence shall be required by the Fund Office annually.
  
- (d) An unmarried Child of the Eligible Employee who is dependent upon the Eligible Employee for primary support and maintenance because of a physical handicap or mental retardation as certified by a Physician. The Fund may request a statement indicating the extent of maintenance and support. For benefits to be effective, the physical handicap or mental retardation must have occurred before the unmarried Child reaches age nineteen (19), or twenty-four (24) if covered under Paragraph (c) above. If, however, an unmarried Child, on such unmarried Child's termination date, is incapable of self-sustaining employment by reason of mental retardation or physical handicap and such incapacity commenced prior to the Limiting Age and such unmarried Child is primarily dependent upon the Eligible Employee for support and maintenance, the Plan will, subject to the conditions in the following paragraph, continue the health coverage for such unmarried Child so long as such Employee's coverage remains in force and such incapacity continues, provided proof of such incapacity is submitted to the Board of Trustees within thirty-one (31) days of the date such Eligible Dependent's coverage would otherwise terminate. For purposes of this paragraph (d), the Limiting Age is the unmarried Child's 19<sup>th</sup> birthday or the Child's 24<sup>th</sup> birthday if the Child is a full-time student.

The Board of Trustees may require, at reasonable intervals during the two (2) years following the Child's attainment of the Limiting Age, subsequent proof of the unmarried Child's incapacity and dependency. After such two (2) year period, the Board of Trustees may require subsequent proof of incapacity and dependency of such unmarried Child once each year.

- (e) An unmarried Child above for whom an Eligible Employee is ordered by a United States court or administrative agency of competent jurisdiction to provide medical coverage in accordance with the provision of a Qualified Medical Child Support Order.

**2. On and after June 1, 2011 but Prior to June 1, 2014:**

Beginning on June 1, 2011, through May 31, 2014, "Eligible Dependent" includes only the following:

- (a) An Eligible Employee's legal Spouse, while not divorced or legally separated from the Eligible Employee.
- (b) All Children from birth to age twenty-six (26), regardless of marital status, work status, living status, or financial dependency; provided, however, that Children are not entitled to coverage under the Plan if (1) they are over age 18; and (2) they are eligible for employer-based health care coverage under another health care plan. Grandchildren are not considered eligible dependents. No Child who is under age nineteen (19) shall be denied coverage under the Plan on account of a preexisting condition.
- (c) Regardless of age, an unmarried Child of the Eligible Employee who is dependent upon the Eligible Employee for primary support and maintenance because of a physical handicap or mental retardation as certified by a Physician. The Fund may request a statement indicating the extent of maintenance and support. For benefits to be effective, the physical handicap or mental retardation must have occurred before the unmarried Child reaches age twenty-six (26). If, however, an unmarried Child, on such unmarried Child's termination date, is incapable of self-sustaining employment by reason of mental retardation or physical handicap and such incapacity commenced prior to the Limiting Age and such unmarried Child is primarily dependent upon the Eligible Employee for support and maintenance, the Plan will, subject to the conditions in the following paragraph, continue the health coverage for such unmarried Child so long as such Employee's coverage remains in force and such incapacity continues, provided proof of such incapacity is submitted to the Board of Trustees within thirty-one (31) days of the date such Eligible Dependent's coverage would otherwise terminate. For purposes of this paragraph (c), the Limiting Age is the unmarried Child's 26<sup>th</sup> birthday.

The Board of Trustees may require, at reasonable intervals during the two (2) years following the Child's attainment of the Limiting Age, subsequent proof of the unmarried Child's incapacity and dependency. After such two (2) year period, the

Board of Trustees may require subsequent proof of incapacity and dependency of such unmarried Child once each year.

- (d) A Child above for whom an Eligible Employee is ordered by a United States court or administrative agency of competent jurisdiction to provide medical coverage in accordance with the provision of a Qualified Medical Child Support Order.

**3. On and after June 1, 2014:**

Effective June 1, 2014, "Eligible Dependent" includes only the following:

- (a) An Eligible Employee's legal Spouse, while not divorced or legally separated from the Eligible Employee.
- (b) All Children from birth to age twenty-six (26), regardless of marital status, work status, living status, financial dependency, or whether the Child is eligible for employer-based health care coverage under another health care plan. Grandchildren are not considered eligible dependents. No Child who is under age nineteen (19) shall be denied coverage under the Plan on account of a preexisting condition.
- (c) Regardless of age, an unmarried Child of the Eligible Employee who is dependent upon the Eligible Employee for primary support and maintenance because of a physical handicap or mental retardation as certified by a Physician. The Fund may request a statement indicating the extent of maintenance and support. For benefits to be effective, the physical handicap or mental retardation must have occurred before the unmarried Child reaches age twenty-six (26). If, however, an unmarried Child, on such unmarried Child's termination date, is incapable of self-sustaining employment by reason of mental retardation or physical handicap and such incapacity commenced prior to the Limiting Age and such unmarried Child is primarily dependent upon the Eligible Employee for support and maintenance, the Plan will, subject to the conditions in the following paragraph, continue the health coverage for such unmarried Child so long as such Employee's coverage remains in force and such incapacity continues, provided proof of such incapacity is submitted to the Board of Trustees within thirty-one (31) days of the date such Eligible Dependent's coverage would otherwise terminate. For purposes of this paragraph (3), the Limiting Age is the unmarried Child's 26<sup>th</sup> birthday.

The Board of Trustees may require, at reasonable intervals during the two (2) years following the Child's attainment of the Limiting Age, subsequent proof of the unmarried Child's incapacity and dependency. After such two (2) year period, the Board of Trustees may require subsequent proof of incapacity and dependency of such unmarried Child once each year.

- (d) A Child above for whom an Eligible Employee is ordered by a United States court or administrative agency of competent jurisdiction to provide medical coverage in accordance with the provision of a Qualified Medical Child Support Order.

**Z. Eligible Employee, Covered Member or Covered Person**

“Eligible Employee,” “Covered Member” or “Covered Person” means any person who meets the Eligibility Rules as adopted by the Trustees and as set forth herein.

**AA. Eligibility Rules**

“Eligibility Rules” means the Eligibility Rules as established by the Trustees pursuant to the provisions of the Plan and the Trust Agreement.

**AB. Employee**

“Employee” means and includes:

- (1) A Member of a Collective Bargaining Unit represented by the Union who is eligible to participate in and receive the benefits of the Health and Welfare Plan and Trust in accordance with the Agreement and Declaration of Trust; and
- (2) A full-time, regular Employee of the Union, the Trustees, the Fund Office and/or the Joint Apprenticeship Training Committee, subject to the review and approval of, and any conditions regarding contributions and participation imposed by the Trustees whose decision shall be final and binding; and
- (3) A full-time, non-seasonal, Employee of an Employer who is not a member of a Union Collective Bargaining Unit represented by the Union including, but not limited to, an officer, owner, partner, shareholder, manager, clerical worker, estimator, supervisor and any other full-time employee (hereinafter collectively referred to as “Nonbargaining Unit Employees”), but only if: (i) equal contributions are made for all Employees, (ii) all Employees receive equal benefits, (iii) all full-time Employees are covered under the Plan established hereunder, (iv) a Participation Agreement is entered into between the Employer and the Plan; and (v) subject to the review and approval of, and any other conditions regarding contributions and participation imposed by the Trustees. The Employer shall contribute to the Fund for all of its full-time, non-seasonal Employees subject to the non-discrimination requirements of applicable provisions of the Internal Revenue Code and the Regulations thereunder; and
- (4) An individual formerly employed by an Employer as a member of the Collective Bargaining Unit represented by the Union for purposes of allowing Self-Contribution direct payments to the Fund in accordance with the Rules and Regulations adopted by the Trustees and as set forth herein.

## **AC. Employer**

“Employer” means:

- (1) Any individual, firm, association, partnership or corporation who is a member of the Association and/or is represented in collective bargaining by the Association and who is bound by the Collective Bargaining Agreement with said Union, and in accordance therewith, agrees to participate in and contribute to the Trust Fund herein created and provided for; and
- (2) Any individual, firm, association, partnership or corporation who is not a member of nor represented in collective bargaining by the Association, but who has duly executed and/or is bound by the Collective Bargaining Agreement with said Union or signs a participation agreement with the Trust Fund and in accordance therewith agrees to participate in and contribute to the Trust Fund herein created and provided for; and
- (3) The Union, to the extent and solely to the extent that it acts in the capacity of an Employer of its Employees on whose behalf it makes contributions to the Trust Fund in accordance with the Collective Bargaining Agreement and/or a participation agreement, the Plan document, the Trust Agreement and the rules and procedures prescribed by the Trustees; and
- (4) The Trustees, to the extent that they act in the capacity of an Employer of their Employees on whose behalf they make contributions to the Trust Fund in accordance with the Collective Bargaining Agreement and/or participation agreement, the Plan document, the Trust Agreement and the rules and procedures prescribed by the Trustees; and
- (5) The Joint Apprenticeship Training Committee to the extent, and solely to the extent, that it acts in the capacity of an Employer of its Employees on whose behalf it makes Contributions to the Trust Fund pursuant to a Collective Bargaining Agreement and/or participation agreement, the Plan document, the Trust Agreement and the rules and procedures prescribed by the Trustees; and
- (6) The Fund Office to the extent, and solely to the extent, that it acts in the capacity of an Employer of its Employees on whose behalf it makes Contributions to the Trust Fund pursuant to a Collective Bargaining Agreement and/or participation agreement, the Plan document, the Trust Agreement and the rules and procedures prescribed by the Trustees; and
- (7) The Employers, as defined herein, shall, by the making of payments to the Trust Fund pursuant to the Collective Bargaining Agreement and/or participation agreement, be conclusively deemed to have accepted and be bound by the Trust Agreement, the Collective Bargaining Agreement, this Plan, the Rules and Regulations and all actions of the Trustees.

**AD. Employer Contributions**

“Employer Contributions” means payments made to the Trust Fund by an Employer.

**AE. Excess Charges**

“Excess Charges” means the amount of Billed Charges less Non-Covered Charges, in excess of the Covered Charges determined by the PPO for a Non-Contracting Institutional Provider. It is also the amount of billed charges less non-covered charges in excess of the Usual, Customary and Reasonable Amount (UCR Amount) for a Non-Participating Physician or other Professional Provider.

**AF. Expense Incurred or Charges**

“Expense Incurred or Charges” includes only those charges made for services and supplies ordered by a Physician which a prudent person would consider to be reasonably priced and reasonably necessary in the light of the injury or sickness being treated. Expense Incurred or Charges are deemed to be incurred on the day the purchase is made or the service is rendered unless specifically stated in this Plan. Expense Incurred or Charges does not include any charge for a service or supply which is not covered by this Plan; or which is in excess of the usual and customary charge for a service or supply; or not approved by the Board of Trustees. Expense Incurred or Charges as a result of an intentionally self-inflicted injury or illness are excluded under this Plan.

**AG. Experimental, Investigational or Medically Unproven**

“Experimental,” “Investigational” or “Medically Unproven” means any treatment, procedure, facility, equipment, device, supply, drug or medicines (hereinafter collectively referred to as “treatment”) or the use thereof which falls within any of the following categories:

- (1) Which is considered by the American Medical Association or any government agency or subdivision, including but not limited to the Food and Drug Administration, the Office of Health Technology Assessment, or the HCFA Medicare Coverage Issues Manual to be:
  - (i) experimental, investigational or medically unproven;
  - (ii) not considered reasonable and necessary; or
  - (iii) any similar finding; or
- (2) Which is not covered under Medicare reimbursement laws, regulations or interpretations as a regular and normal medical procedure; or
- (3) Which is not commonly and customarily recognized by the medical profession in the State of Ohio as appropriate and necessary for the condition being treated.

If a treatment is Experimental, Investigational or Medically Unproven, then any part of such treatment shall be considered Experimental, Investigational or Medically Unproven.

The Trustees have sole, full and exclusive authority to deny or discontinue medical benefits for any treatment, including the covered services related to the treatment. Determination of whether a treatment is Experimental, Investigational or Medically Unproven will be made by the Trustees in their sole discretion and will be conclusive. The Trustees reserve the right in their sole discretion to change, from time to time, the treatments considered to be Experimental, Investigational or Medically Unproven. The burden of proof is upon the Eligible Employee, Participant and/or Eligible Dependent to establish the treatment is not Experimental, Investigational or Medically Unproven.

**AH. Family or Family Member**

“Family” or “Family Member” means the Eligible Employee and all of his or her Eligible Dependents, provided however; that if both the husband and the wife are Eligible Employees under the Plan, their eligible Children shall be considered Eligible Dependents of either parent, but not both. However, benefits shall be coordinated so that 100% of the Expenses Incurred or Charges shall be compensated. A dependent legal spouse who is also an Eligible Employee shall only receive benefits as an Eligible Employee and benefits will be coordinated so that 100% of the Expenses Incurred or Charges shall be compensated.

**AI. Formulary Brand Name Prescription Drug**

“Formulary Brand Name Prescription Drug” means a Brand Name Prescription Drug that the Plan’s prescription drug benefit administrator has listed among preferred brand-name products in each of a number of therapeutic categories.

**AJ. Generic Prescription Drug**

“Generic Prescription Drug” means a Prescription Drug that is produced by more than one manufacturer. It is chemically the same as and usually costs less than the Brand Name Prescription Drug for which it is being substituted.

**AK. Health and Welfare Plan or Health Care Plan**

“Health and Welfare Plan” or “Health Care Plan” means the Insulators Local 84 Health Care Plan, as the Health Care Plan may, from time to time, be amended as well as any plan, program, methods and procedure for the payment of benefits from the Trust Fund (directly or indirectly) adopted by the Trustees in accordance with such eligibility requirements as the Trustees may, from time to time, adopt and promulgate, and as set forth herein.

**AL. Hospital Confinement**

“Hospital Confinement” means a person shall be considered to be hospital confined under the following conditions:

- (1) A room and board charge is made; or
- (2) He/she enters the hospital for a surgical procedure, except as an outpatient.

**AM. HRA**

“HRA” means the health reimbursement arrangement provided to Participants under the Health Care Plan in accordance with this Appendix A.

**AN. Illegal and Willful Misconduct**

“Illegal and Willful Misconduct” means expenses incurred by a Participant or Eligible Dependent resulting from or occurring (1) during the commission of a crime; or (2) during illegal and willful misconduct; or (3) while engaged in an illegal occupation; or (4) while committing or attempting to commit a felonious act or aggravated assault, or (5) while participating in a riot or civil insurrection. No payment shall be made under any health benefit of this Plan for expenses incurred by a Participant or Dependent resulting from Illegal and Willful Misconduct (except Death Benefit). Determination will be made by the Trustees in their sole discretion and such determination will be conclusive.

**AO. Illness**

“Illness” means a sickness or disease (including mental health) which requires treatment by a doctor and is recognized by the terms of this Plan and the Trustees. Unless otherwise excluded under this Plan, “Illness” includes pregnancy, childbirth or miscarriage, and complications associated therewith. Charges as a result of intentionally self-inflicted illness are excluded under this Plan. Illnesses resulting from or contributed to the same or related cause or causes shall be considered one illness. Determination of whether Illnesses are included or excluded under this Plan will be made by the Trustees in their sole discretion and will be conclusive.

An occupational disease which the person is entitled to benefits under Workers’ Compensation law or similar legislation is excluded under this Plan. This Plan excludes any treatment, service, or expense which may be connected with an occupational disease in which the person has received a lump sum settlement for his or her claim for benefits under Workers’ Compensation law or similar legislation. This Plan also does not provide benefits for services, supplies or charges which are received in a military facility for a military service related injury, ailment, condition, disease, disorder or illness.

**AP. Injury**

“Injury” means any accidental bodily injury which requires treatment by a physician and is recognized by the terms of this Plan and the Trustees. It must result in loss independently of illness and other causes. All injuries sustained by a person in connection with one accident will be considered one Injury. Determination of whether Injuries are included or excluded under this Plan will be made by the Trustees in their sole discretion and will be conclusive.

An Injury which the person is entitled to benefits under Workers’ Compensation law or similar legislation is excluded under this Plan. This Plan excludes any treatment, service, or expense which may be connected with an Injury in which the person has received a lump sum settlement for his or her claim for benefits under Workers’ Compensation law or similar legislation. This Plan also does not provide benefits for services, supplies or charges which are received in a military facility for a military service-related injury, ailment, condition, disease, disorder or illness. Charges as a result of a self-inflicted Injury or attempt at self destruction while sane or insane are excluded under this Plan. Determination of whether Injuries are included or excluded under this Plan will be made by the Trustees in their sole discretion and will be conclusive.

**AQ. Inpatient**

“Inpatient” means a person who is a resident patient using and being charged for a room and board facility of the Hospital.

**AR. Intensive Care Unit**

“Intensive Care Unit” means a section, ward or wing within a hospital which is separated from other facilities and:

- (1) Is operated exclusively for the purpose of providing professional medical treatment for critically ill patients; and
- (2) Has special supplies and equipment necessary for such treatment available on a standby basis for immediate use; and
- (3) Provides constant observation and treatment by registered nurses or other highly trained hospital personnel.

**AS. Lesser Amount**

“Lesser Amount” means for Contracting and Participating Providers, the Lesser Amount means the Lesser of the Negotiated Amount or the Covered Charges. For Non-Participating Physicians and Other Professional Providers, the Lesser Amount means the Usual, Customary and Reasonable Amount (UCR Amount).

**AT. Mail Order Prescription Drug**

“Mail Order Prescription Drug” means a Prescription Drug which can be provided through a mail service program.

**AU. Medical Emergency**

“Medical Emergency” means the sudden and unexpected onset of a severe medical ailment, condition, disease, illness or disorder, including severe pain, requiring Emergency Services.

**AV. Medically Necessary or Reasonably Necessary**

“Medically Necessary” or “Reasonably Necessary” means a service or supply which is ordered by a Physician and which is: provided for the diagnosis or direct treatment of an Injury or Illness; appropriate and consistent with the symptoms and findings or diagnosis and treatment of the covered individual’s Injury or Illness; provided in accordance with generally accepted standards of medical practice; and the most appropriate supply or level of service which can be provided on a cost effective basis (including, but not limited to, inpatient versus outpatient care, electric versus manual wheelchair, surgical versus medical or other types of care). No treatment or service, or expense in connection therewith, which is Experimental, Medically Unproven or Investigational in nature, is considered “Medically Necessary” or “Reasonably Necessary.” Determination of whether a course of treatment is Medically Necessary or Reasonably Necessary will be made by the Trustees in their sole discretion and will be conclusive.

**AW. Negotiated Amount**

“Negotiated Amount” means the amount the Provider has agreed with the PPO or the Pharmacy Benefit Manager to accept as payment in full for Covered Services. The Negotiated Amount for Institutional Providers does not include adjustments and/or settlement due to most favored nations rate violations, prompt payment discounts, guaranteed discount corridor provisions, maximum charge increase limitation violations or any settlement, incentive, allowance or adjustment that does not accrue to a specific claim.

The Negotiated Amount for Prescription Drugs does not include any share of formulary reimbursement savings, volume based credits or refunds or discount guarantees. The Negotiated Amount for Contracting Institutional Providers may exceed the Covered Charges. The Negotiated Amount for Participating Physicians and Other Professional Providers does not include any performance withhold adjustments.

In certain circumstances, the PPO may have an agreement or arrangement with a vendor which purchases the services, supplies or products from the Provider instead of the PPO contracting directly with the Provider itself. In these circumstances, the Negotiated Amount will be based upon the agreement or arrangement the PPO has with the vendor and not upon the vendor’s actual negotiated price with the Provider, subject to the further conditions and limitations set forth herein.

**AX. Newborn Care**

“Newborn Care” means routine Expense Incurred or Charges by a well, but Hospital confined, dependent newborn Child but only while the mother is Hospital-confined as the result of giving birth to such Child, including Expense Incurred or Charges for room and board provided by the Hospital for such newborn Child and Expense Incurred or Charges for routine medical examination and “check-up” purposes. “Newborn Care” does not mean Expense Incurred or Charges as a result of premature birth, Injury suffered, Illness contracted, or a congenital birth defect.

**AY. Non-Contracting**

“Non-Contracting” means the status of a Hospital or Other Facility Provider which does not meet the definition of a Contracting Institutional Provider.

**AZ. Non-Covered Charges**

“Non-Covered Charges” means the Billed Charges for services and supplies which are not Covered Services.

**BA. Non-Formulary Brand Name Prescription Drug**

“Non-Formulary Brand Name Prescription Drug” means a Brand Name Prescription Drug that the Plan’s prescription drug benefit administrator has not listed among preferred brand-name products in each of a number of therapeutic categories.

**BB. Non-Occupational**

“Non-Occupational” means, with respect to injury, an injury which does not arise out of and in the course of any employment for wage or profit, and with respect to disease, a disease in connection with which the person is entitled to no benefits under any Workers’ Compensation law, Veterans Department of Affairs or similar legislation.

**BC. Non-Participating**

“Non-Participating” means the status of a Physician or Other Professional Provider that does not have an agreement with the PPO regarding payment for Covered Services.

**BD. Non-PPO Network Coinsurance**

“Non-PPO Network Coinsurance” means a percentage of the Lesser Amount for Non-PPO Network Providers for which you are responsible after you have met your Deductible or paid your Copayment.

**BE. Non-PPO Network Coinsurance Limit**

“Non-PPO Network Coinsurance Limit” means a specified dollar amount of Non-PPO Network Coinsurance expense for which you are responsible in each Benefit Period.

**BF. Non-PPO Network Provider**

“Non-PPO Network Provider” means a Physician or Other Professional Provider, Contracting Hospital or Contracting Other Facility or Home Health Care Agency or Hospice Provider which is not designated by the PPO as a PPO Network Provider.

**BG. Other Facility Provider**

“Other Facility Provider” means the following institutions which are licensed, when required, and where Covered Services are rendered which require compensation from their patients. Other than incidentally, these facilities are not used as offices or clinics for the private practice of a Physician or Other Professional Provider. The PPO will only provide benefits for services or supplies for which a charge is made. Only the following institutions are considered in the sole discretion of the Plan to be Other Facility Providers: Alcoholism Treatment Facility, Ambulatory Surgical Facility, Day/Night Psychiatric Facility, Dialysis Facility; Drug Abuse Treatment Facility, Home Health Care Agency, Hospice Facility, Psychiatric Facility, Psychiatric Hospital, Skilled Nursing Facility.

**BH. Other Professional Provider**

“Other Professional Provider” means only the following persons or entities which are licensed as required:

1. Dentist;
2. Doctor of Chiropractic Medicine;
3. Durable Medical Equipment or Prosthetic Appliance Vendor;
4. Laboratory (must be Medicare Approved);
5. Licensed Practical Nurse (L.P.N.);
6. Licensed Vocational Nurse (L.V.N.);
7. Mechanotherapist (licensed or certified prior to November 3, 1975);
8. Nurse-Midwife;
9. Occupational Therapist;
10. Pharmacy;
11. Physical Therapist;
12. Podiatrist;
13. Psychologist;
14. Registered Nurse (R.N.); and
15. Urgent Care Provider.

**BI. Outpatient**

“Outpatient” means a person who receives Hospital services and treatments but is not an inpatient.

**BJ. Out-of-Pocket Limit**

“Out-of-Pocket Limit” means the Coinsurance which is the responsibility of the Participant or Eligible Dependent which must accrue before Covered Charges will be paid at 100% for the remainder of the calendar year. The Schedule of Benefits outlines which Coinsurance is eligible to be accrued under the Out-of-Pocket Limit.

The following shall NOT be counted towards the Out-of-Pocket Limit:

1. Any expenses not covered by the Plan; or
2. Expenses incurred by an Eligible Employee or Eligible Dependent for Mental or Nervous Disorders treatment; or
3. Any expenses incurred by an Eligible Employee or Eligible Dependent which exceed the annual or other Plan maximums; or
4. Any expenses for Covered Services which require a Copayment.

**BK. Participant**

“Participant” means any Employee or former Employee of an Employer or any member or former member of the Union who is or may become eligible to receive a benefit of any type from the Trust Fund, or whose Beneficiaries may be eligible to receive any such benefit.

**BL. Participating**

“Participating” means the status of a Physician or Other Professional Provider that has an agreement with the PPO about payment for Covered Services.

**BM. Plan**

“Plan” means the Insulators Local 84 Health Care Plan, as the Plan may, from time to time, be amended as hereinafter provided.

**BN. PPO Network Provider**

“PPO Network Provider” means a Physician, Other Professional Provider, Contracting Hospital or Contracting Other Facility Provider which is included in a limited panel of Providers as designated by the PPO and for which the greatest benefit will be payable when one of these Providers is used.

**BO. Pre-Existing Condition**

“Pre-Existing Condition” means an injury, illness or related condition for which medical advice, diagnosis, care or treatment was recommended or received within the ninety (90) day period of time

immediately prior to becoming covered under the Plan. Participants and/or Eligible Dependents who become eligible for benefits shall not be entitled to benefits for major medical expenses incurred as the result of an injury, illness or related condition for which medical advice, diagnosis, care or treatment was recommended or received within the ninety (90) day period of time immediately prior to becoming covered under the Plan until the expiration of a period of twelve (12) consecutive months during which the Participant and/or Eligible Dependent was continuously covered under the Plan. Determination of whether an injury, illness or related condition is a Pre-Existing Condition shall be made by the Trustees in their sole discretion and will be conclusive.

The Health Insurance Portability and Accountability Act of 1996 (hereinafter "HIPAA") provides that the twelve (12) consecutive month pre-existing condition exclusion period shall be reduced by qualifying prior group health plan coverage, provided there has not been an intervening break in group health plan coverage of sixty-three (63) days or more and a certificate statement of group health plan coverage is timely provided to the Plan. The Plan shall also comply with the requirements under HIPAA to provide a certificate statement of group health plan coverage at the time coverage of a Participant and/or Eligible Dependent ceases within the next two years or, upon request of the individual within a reasonable time after receipt of the request.

No pre-existing condition exclusion shall apply to newborns, adoptees, or Children placed for adoption which are enrolled in the Plan within 30 days from the date of the birth, adoption or placement for adoption. No pre-existing condition shall apply to the pregnancy of a Participant or the spouse of a Participant.

Effective June 1, 2011, no Pre-Existing Condition exclusion shall apply to enrollees under age nineteen (19).

Effective June 1, 2014, no Pre-Existing Condition exclusion shall apply to any enrollee regardless of age.

**BP. Prescription Drug Copayment**

"Prescription Drug Copayment" means a percentage of the Prescription Drug Lesser Amount for which you are responsible.

**BQ. Prescription Drug Covered Charges**

"Prescription Drug Covered Charges" means the amount which the Pharmacy Benefit Manager determines to be reasonable for a covered Prescription Drug.

**BR. Prescription Order**

"Prescription Order" means the request for medication by a Physician appropriately licensed to make such a request in the ordinary course of professional practice.

**BS. Provider**

“Provider” means a Hospital, Other Facility Provider, Physician or Other Professional Provider.

**BT. Reasonable and Customary Charge or Amount**

“Reasonable and Customary Charge” or “Amount” means the lesser amount of any amount negotiated between the Plan Administrator and any Provider of Services and the usual charge made by a doctor or other supplier of medical services or supplies, so long as it does not exceed the general level of charges made by others of similar training and experience rendering the same services or supplies in that same Geographical Area to treat a sickness or injury of comparable nature and severity. “Geographical Area” means a county or such area as is necessary to obtain a representative cross-section of charges. Determination of whether a charge or amount is a Reasonable and Customary Charge or Amount will be made by the Trustees in their sole discretion and will be conclusive.

**BU. Rider**

“Rider” means a provision added to the Plan to expand or limit benefits or coverage.

**BV. Sickness**

“Sickness” means an illness or disease (including mental disorders) which requires treatment by a doctor and is recognized by the terms of this Plan and the Trustees. Sickness shall include pregnancy, childbirth or miscarriage.

**BW. Spouse**

“Spouse” means that person, if any, who is recognized under the laws of the State of Ohio, based on a union of two (2) persons, as being the member’s lawful husband or wife and who has not been declared divorced or legally separated from the member by any judicial order.

**BX. Surgery**

“Surgery” means the performance of generally accepted operative and other invasive procedures; or the correction of fractures and dislocations; or usual and related preoperative and postoperative care.

**BY. Total Disability or Totally Disabled**

“Total Disability” or “Totally Disabled,” unless otherwise specifically defined, means as a direct result of an Injury or Illness, the Participant is unable to:

- (1) In the case of an Eligible Employee during the first twelve (12) months of such disability, perform the material and substantial duties of the occupation of the Eligible Employee at the onset of the disability; or

- (2) In the case of an Eligible Employee during the period after the first twelve (12) months of such disability, perform the material and substantial duties of any occupation for which the Eligible Employee is qualified by education, training or experience which provides other health insurance coverage; or
- (3) In the case of an Eligible Dependent, perform the normal substantial activities of a person of like age and sex in good health.

Determination of whether an Eligible Employee or an Eligible Dependent is Totally Disabled or Total Disability will be made by the Trustees in their sole discretion and will be conclusive.

#### **BZ. Trust Fund, Trust or Fund**

“Trust Fund,” “Trust” or “Fund” means the Insulators Local 84 Health Care Fund and the entire assets thereof, including all funds received by the Trustees in the form of Employer contributions, together with all contracts (including dividends, interest, refunds and other sums payable to the Trust Fund on account of such contracts), all investments made and held by the Trustees, all income, increments, earnings and profits therefrom, and any and all other property of funds received and held by the Trustees under the Trust Agreement.

#### **CA. Trustee**

“Trustee” means any natural person designated as Trustee under the terms of the original Agreement and Declaration of Trust and his successor or successors in office. The Trustees, collectively, shall be the “Administrator,” as that term is used under ERISA.

#### **CB. Union**

“Union” means International Association of Heat & Frost Insulators & Asbestos Workers, Local 84 and its successors.

### **IX.**

#### **PROCEDURE FOR FILING A CLAIM**

##### **A. Types of Claims**

How you file a claim for benefits depends on the type of claim it is. There are several categories of claims for benefits:

***Pre-Service Care Claim***—A pre-service claim is a claim for a benefit under the Plan which the terms of the Plan require approval of the benefit in advance of obtaining medical care.

***Urgent Care Claim***—An urgent care claim is any pre-service claim for medical care or treatment which, in the opinion of the treating physician, if not immediately processed, could seriously jeopardize the life or health of you or your dependent. This type of claim generally includes those

situations commonly treated as emergencies. Only the treating Physician can classify a pre-service claim as “urgent”.

***Concurrent Care Claim***—A concurrent care claim is a claim for an extension of the duration or number of treatments provided through a previously approved pre-service claim. Where possible, this type of claim should be filed at least twenty-four (24) hours before the expiration of any course of treatment for which an extension is being sought.

***Post-Service Care Claim***—A Post-Service Claim is a claim for payment or reimbursement after services have been rendered.

### **B. Who Must File**

You may initiate pre-service claims yourself if you are able or your treating physician may file the claim for you. You are responsible for filing post-service claims yourself, although the Plan may accept billings directly from providers on your behalf, if they contain all of the information necessary to process the claim.

***Appointing an Authorized Representative.*** If you or your Dependent wishes to have someone act on your behalf for purposes of filing claims, making inquiries and filing appeals, you must furnish the Claims Payor with a written designation of your Authorized Representative. You can appoint any individual as your Authorized Representative *except* a health care provider. Nevertheless, a health care provider with knowledge of your medical condition can act as your Authorized Representative for purposes of an urgent care claim as defined above. Once you appoint an Authorized Representative in writing, all subsequent communications regarding your claim will be provided to your Authorized Representative.

### **C. When to File a Claim**

You must file claims within twelve (12) months of receiving covered services. Your claim must have the data the Plan needs to determine benefits.

### **D. Where to File a Claim**

Claims should be filed with the Claims Office.

### **E. What to File**

The Claims Office and the Claims Payors furnish claim forms. When filing claims, you should attach an itemized bill from the health care provider. The Claims Payor may require you to complete a claim form for a claim. Please make sure that the claim contains the following information:

- (1) Participant's Name and Social Security Number
- (2) Patient's Name
- (3) Name of Employer

#### **F. Method of Claims Delivery**

Pre-service claims may be initiated by telephone. The Plan may require you to provide follow-up paperwork in support of your claim.

Other claims may be submitted by U.S. Mail, by hand delivery, by facsimile (FAX), or as a HIPAA compliant electronically filed claim.

#### **G. Timing of Claims Determinations**

***Urgent Care Claims.*** If your claim involves urgent care, you or your authorized representative will be notified of the initial decision on the claim, whether adverse or not, as soon as is feasible, but in no event not more than seventy-two (72) hours after receiving the claim. If the claim does not include sufficient information to make an intelligent decision, you or your representative will be notified within twenty-four (24) hours after receipt of the claim of the need to provide additional information. You will have at least forty-eight (48) hours to respond to this request; the Plan then must inform you of its decision within forty-eight (48) hours of receiving the additional information.

***Concurrent Care Claims.*** If your claim is one involving concurrent care, the Plan will notify you of its decision, whether adverse or not, within twenty-four (24) hours after receiving the claim, if the claim was for urgent care and was received by the Plan at least twenty-four (24) hours before the expiration of the previously approved time period for treatment or number of treatments. You will be given time to provide any additional information required to reach a decision. If your concurrent care claim does not involve urgent care or is filed less than 24 hours before the expiration of the previously approved time period for treatment or number of treatments, the Plan will respond according to the type of claim involved (i.e., urgent, other pre-service or post-service).

***Other Pre-Service Claims.*** If your claim is for any other pre-service authorization, the Plan will notify you of its initial determination, whether adverse or not, as soon as possible, but not more than fifteen (15) days from the date it receives the claim. This 15-day period may be extended by the Plan for an additional fifteen (15) days if the extension is required due to matters beyond the Plan's control. You will have at least forty-five (45) days to provide any additional information requested of you by the Plan.

***Post-Service Claims.*** If your claim is for a post-service reimbursement or payment of benefits, the Plan will notify you within thirty (30) days of receipt of the claim that the claim has been approved, denied. The thirty (30) days can be extended to forty-five (45), if the Plan notifies you within the initial thirty (30) days of the circumstances beyond the Plan's control that require an extension of the time period, and the date by which the Plan expects to render a decision.

If more information is necessary to decide a post-service claim, the Plan will deny the claim and notify you of the specific information necessary to complete the claim.

#### **H. Notice of Claims Denial (Adverse Benefit Determination)**

If, for any reason, your claim is denied, in whole or in part, you will be provided with a written notice containing the following information:

- (1) The reason(s) why the claim or a portion of it was denied;
- (2) Reference to plan provisions on which the denial was based;
- (3) If the denial was based in whole or in part on any internal rules, guidelines or protocols, a statement that you may request a copy of the rule, guideline or protocol, which will be provided free of charge;
- (4) If the denial was based in whole or in part on Medical Necessity, Experimental/Investigative treatment or a similar limit or exclusion, a statement that you may request the scientific or clinical judgment for the determination which applies the terms of the plan to the patient's medical circumstances, which will be provided free of charge;
- (5) A description of what additional information, if any, is required to perfect the claim and why the information is necessary; and
- (6) A copy of the Plan's review procedures and time periods that the claimant needs to follow in order to appeal the claim, plus a statement that the claimant can bring suit under ERISA following the review.

### **X.**

#### **PROCEDURE FOR APPEALING A CLAIM**

##### **A. First Level Review**

If you dispute a denial of benefits, you may file an appeal to the Administrative Manager for the Board of Trustees within one hundred eighty (180) days of receipt of the denial notice. This appeal must be in writing (unless the claim involves urgent care, in which case the appeal may be made orally). Your request for review must contain the following information:

- (1) Your name and address;
- (2) Your Social Security number;
- (3) Your phone number;

- (4) the fact that you are appealing from an initial claims determination, and the date of the notice;
- (5) Your reasons for making the appeal; and
- (6) The facts supporting your appeal.

The appeal should be addressed to:

Administrative Manager  
Insulators Local 84 Health Care Plan  
33 Fitch Boulevard  
Austintown, OH 44515

In connection with your right to appeal the initial claims determination, you also:

- (1) May review pertinent documents and submit issues and comments in writing;
- (2) Will be given the opportunity to submit written comments, documents, records, or any other matter relevant to your claim;
- (3) Will, at your request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; and
- (4) Be given a review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, regardless of whether such information was submitted or considered in the initial benefit determination.

The claim review will be subject to the following rules:

- (1) The claim will be reviewed by an appropriate party, who is neither the individual who made the initial denial nor a subordinate of that individual.
- (2) The review will be conducted without giving deference to the initial denial.
- (3) If the initial denial was based in whole or in part on a medical judgment (including any determinations of Medical Necessity or Experimental/Investigative treatment), the reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This medical expert shall not be an individual who was consulted on the initial claim denial nor the subordinate of such an individual. Any medical experts consulted in the review process shall be identified by name.

**B. Timetable for Deciding First Level Review**

The Plan must issue a review decision on your first level appeal according to the following timetable:

***Urgent Care Claims***—not later than seventy-two (72) hours after receiving your request for a review.

***Pre-Service Claims***—not later than thirty (30) days after receiving your request for a review.

***Post-Service Claims***—The Board of Trustees shall consider the appeal no later than its next regularly scheduled meeting, which immediately follows the receipt of the notice of appeal, unless such notice was filed within thirty (30) days prior to the next regularly scheduled meeting, then the Board of Trustees may consider the appeal at the second meeting following the receipt of the notice of appeal. If special circumstances require an extension of time for processing, then the Board of Trustees may consider the appeal no later than the third meeting following the receipt of the notice of appeal.

Decisions will be issued on concurrent claim appeals within the time frame appropriate for the type of concurrent care claim (i.e., urgent, other pre-service or post-service).

### **C. Notice of Decision on First Level Review**

If your first level appeal has been either partially or completely denied, you will be provided with a written notice containing the following information:

- (1) The specific reasons for the appeal denial;
- (2) Reference to the specific provisions of the Plan on which the denial is based;
- (3) A statement that you may request reasonable access to and copies of all documents, records and other information relevant to your appealed claim for benefits, which shall be provided to you without charge;
- (4) If the appeal denial was based in whole or in part on any internal guidelines or protocols, a statement that you may request a copy of the guideline or protocol, which will be provided to you without charge;
- (5) If the appeal denial was based in whole or in part on Medical Necessity, Experimental/Investigative treatment or a similar limit or exclusion, a statement that you may request the scientific or clinical judgment for the determination which applies the terms of the plan to the patient's medical circumstances, which will be provided to you without charge;
- (6) A notice of your right to file a second level appeal to the Benefits Committee of the Board of Trustees.

### **D. Second Level Review**

You may file an appeal to the Benefits Committee for the Board of Trustees within sixty (60) days of receipt of the notice of denial of the first level review. This appeal must be in writing (unless the claim involves urgent care, in which case the appeal may be made orally). Your appeal must contain the following information:

- (1) Your name and address;

- (2) Your Social Security number;
- (3) Your phone number;
- (4) the fact that you are appealing from a decision of the Plan's Administrative Manager, and the date of the notice;
- (5) Your reasons for making the appeal; and
- (6) The facts supporting your appeal.

The appeal should be addressed to:

Benefits Committee  
Insulators Local 84 Health Care Plan  
33 Fitch Boulevard  
Austintown, OH 44515

In connection with your right to appeal the decision of the Plan's Administrative Manager, you also:

- (1) May review pertinent documents and submit issues and comments in writing;
- (2) Will be given the opportunity to submit written comments, documents, records, or any other matter relevant to your claim;
- (3) Will, at your request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; and
- (4) Be given a review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, regardless of whether such information was submitted or considered in the initial benefit determination.

The claim review will be subject to the following rules:

- (1) The claim will be reviewed by an appropriate party, who is neither the individual who made the initial denial nor a subordinate of that individual.
- (2) The review will be conducted without giving deference to the initial denial.
- (3) If the initial denial was based in whole or in part on a medical judgment (including any determinations of Medical Necessity or Experimental/Investigative treatment), the reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This medical expert shall not be an individual who was consulted on the initial claim denial nor the subordinate of such an individual. Any medical experts consulted in the review process shall be identified by name.

#### **E. Timetable for Deciding Second Level Review**

The Plan must issue a review decision on your second level appeal according to the following timetable:

***Urgent Care Claims***—not later than seventy-two (72) hours after receiving your request for a review.

***Pre-Service Claims***—not later than thirty (30) days after receiving your request for a review.

***Post-Service Claims***—The Board of Trustees shall consider the appeal no later than its next regularly scheduled meeting, which immediately follows the receipt of the notice of appeal, unless such notice was filed within thirty (30) days prior to the next regularly scheduled meeting, then the Board of Trustees may consider the appeal at the second meeting following the receipt of the notice of appeal. If special circumstances require an extension of time for processing, then the Board of Trustees may consider the appeal no later than the third meeting following the receipt of the notice of appeal.

Decisions will be issued on concurrent claim appeals within the time frame appropriate for the type of concurrent care claim (i.e., urgent, other pre-service or post-service).

#### **F. Notice of Decision on Second Level Review**

If your second level appeal has been either partially or completely denied, you will be provided with a written notice containing the following information:

- (1) The specific reasons for the appeal denial;
- (2) Reference to the specific provisions of the Plan on which the denial is based;
- (3) A statement that you may request reasonable access to and copies of all documents, records and other information relevant to your appealed claim for benefits, which shall be provided to you without charge;
- (4) If the appeal denial was based in whole or in part on any internal guidelines or protocols, a statement that you may request a copy of the guideline or protocol, which will be provided to you without charge;
- (5) If the appeal denial was based in whole or in part on Medical Necessity, Experimental/Investigative treatment or a similar limit or exclusion, a statement that you may request the scientific or clinical judgment for the determination which applies the terms of the plan to the patient's medical circumstances, which will be provided to you without charge;
- (6) A statement apprising the claimant that "You may have the right to bring a civil action under Section 502(a) of ERISA."

The decision of the Board of Trustees is final and binding.

**G. Official Plan Records**

You may submit whatever records and evidence you believe are appropriate in support of your claim for benefits. However, the Trustees shall rely upon the records of the Plan (“Official Plan Records”) in determining your eligibility for benefits and, if you are eligible, the amount of your benefits. In the event of a discrepancy between the Official Plan Records and the records or other evidence supporting the claim asserted by you or your beneficiary, the Trustees shall rely upon the Official Plan Records unless shown to their satisfaction that the additional or other records/evidence you submitted are valid and that the Trustees should rely upon those records/evidence. The burden of proving a claim for benefits which differs from the Official Plan Records shall be upon you or your beneficiary.

**H. Voluntary Appeal to Full Board of Trustees**

You will receive notice of the Plan’s procedure to filing a voluntary appeal to the full Board of Trustees after you exhaust the two-level appeal procedure set forth above.

**I. Commencement of Legal Action**

You may not begin any legal action, including proceedings before administrative agencies, until you have followed these procedures and exhausted the opportunities described in this section. You may, at your own expense, have legal representation at any stage of these review procedures. These review procedures shall be the exclusive mechanism through which determinations of eligibility and benefits may be appealed. If, after following the review process outlined here, you are not satisfied with the result, then you must file any legal action within one year of receiving the final review notice under these procedures.

**XI.**

**ASSIGNMENT OF BENEFITS**

Benefits under this Plan may be assigned by you or your Eligible Dependent(s) to a provider of services only. Assigned benefits shall be paid to the Assignee regardless of your intervening death. No claim payment may be made to your creditors or any other person or entity except as provided specifically in the Plan. No right or interest of you (or your beneficiary) to benefits provided under the Health and Welfare Plan (other than to a provider of services only) shall be assignable, pledged, alienated, transferred or otherwise encumbered.

**XII.**  
**COORDINATION OF BENEFITS**

**A. Coordination**

If the Claimant is covered by another plan or plans, the benefits under the policy and the other plan(s) will be coordinated. This means one plan pays its full benefits first, then the other plan(s) pay(s).

The primary plan (which is the plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of this provision.

The secondary plan (which is the plan that pays benefits after the primary plan) will limit the benefits it pays so that the sum of its benefits and all other benefits paid by the primary plan will not exceed the greater of:

- (1) 100% of total covered expense; or
- (2) The amount of benefits it would have paid had it been the primary plan.

Plans That Coordinate Payments with This Plan include all of the following:

- (1) Individual, Group, blanket or franchise insurance (except student accident insurance); or
- (2) Group Blue Cross and/or Blue Shield and other prepayment coverage on a group basis, including Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs); or
- (3) Coverage under a labor-management trusted plan, a union welfare plan, an employer organization plan, an employee benefit organization plan or any other arrangement of benefits for individuals or a group; or
- (4) Coverage under government programs, other than Medicare or Medicaid, and any other coverage required or provided by law; or
- (5) Coverage under an automobile insurance policy; or
- (6) Other arrangements of insured or self-insured group coverage.

The paragraph below explains the order in which plans must pay for benefits:

## **B. Order of Benefit Determination**

When another Plan does not have a coordination-of-benefits (“COB”) provision, that Plan must pay benefits first. When another Plan does have a COB provision or the terms of a court order determines the order of benefits, the first of the following rules which applies govern:

- (1) **Employee/Dependent**: If a person is covered by two different plans, under one as an employee and the other as a dependent, the plan under which he is an employee must pay its benefits before the plan under which he is a dependent.
- (2) **Active Employee/Inactive Employee**: If an Employee is covered by two different plans, under one as an active employee and the other as an inactive employee (laid-off or retired), the plan which he is an active employee must pay its benefits before the plan under which he is an inactive employee.
- (3) **Dependent Children of Parents Not Divorced or Separated**: If a Child is covered as a dependent under the father’s and mother’s group plan, the plan covering the parent whose birthday falls earlier in the calendar year must pay its benefits before the plan which covers the parent whose birthday falls later in the year. If another Plan does not include this COB rule based on the parents’ birthdays, but instead has a rule based on the gender of the parent, then the birthday rule will determine the order of benefits.
- (4) **Dependent Children of Divorced or Separated Parents**: The plan of the parent with custody pays first. The plan of the spouse of the parent with custody (step-parents) pays next. The plan of the parent without custody pays last. However, if the specific terms of a court order state that one of the parents is responsible for the Child’s health care expenses, the terms of the court order control. If the parent who by court decree must provide health coverage cannot be located or fails to provide health coverage, then the other parent who has custody of the Child pays next.  
  
The Trustees may request proof that attempts were made to collect from the parent which has the responsibility under a court order to pay for health care expenses and the Trustees in their sole discretion may deny payment if they believe insufficient action has been taken to collect from the parent which has the responsibility under a court order to pay for health care expenses.
- (5) **Longer/Shorter Length of Coverage**: If none of the above rules determine the order of benefits, the plan covering the person for the shorter time will pay second.
- (6) **Medicare**: When Medicare is involved, Medicare is considered to be the primary payor when allowed by law.

- (7) **Automobile Insurance**: When automobile insurance is involved, it is the primary payor when allowed by law. If this Plan pays, a Subrogation Agreement must be signed by the Participant prior to the Plan paying any benefits on behalf of the Participant.

**B. Plan Benefit Limits**

If COB reduces the benefits payable under more than one Plan provision, each benefit will be reduced proportionately. Only the reduced amount will be charged against any benefit limit in those Plan provisions.

**C. Plan Rights**

The Plan has the right to:

- (1) Obtain and share information with any other plan which may be subject to this provision without your consent; and
- (2) Require that you provide information about other coverage which may be subject to this provision as a requirement for filing adequate proof of loss; and
- (3) Pay over any amount due under this Plan to any entity entitled to payment under this Plan; and
- (4) Reimburse any other Plan which paid benefits which should have been paid by this Plan. Amounts reimbursed are Plan benefits and are treated like other Plan benefits in satisfying Plan liability.

If this Plan pays more for a Covered Expense than is required by this provision, the excess payment may be recovered from:

- (i) the claimant; or
- (ii) any person to whom the payment was made; or
- (iii) any insurance company, service plan or any other organization which should have made payment.

**XIII.**

**SUBROGATION, RESTITUTION, AND REIMBURSEMENT.**

**A. Definitions**

- (1) "Constructive Trust" shall mean a trust in which any amount, compensation and/or money the Participant and/or Eligible Dependent and/or the Participant's or Eligible Dependent's heirs, estate or assigns (hereinafter collectively referred to as "Participant") recovers shall be deemed to be held for the Participant's exclusive

benefit and not commingled with other funds. Any such Constructive Trust shall be subject to an equitable first lien by the Plan and any other equitable remedies available to the Plan under ERISA §502(a)(3) for the purpose of preserving the Plan's right to restitution for benefits paid by the Plan on the Participant's behalf.

- (2) "Reimbursement" shall mean repayment to the Plan for, any benefit, including but not limited to medical, dental, prescription or vision that the Plan paid toward care and/or treatment for an injury, disease or illness.
- (3) "Restitution" shall mean the return or restoration to the Plan of, any benefit, including but not limited, to medical, dental, prescription or vision, the Plan paid toward care and/or treatment for an injury, disease or illness.
- (4) "Subrogation" shall mean the Plan's right to recover any benefit payment:
  - (i) because of injury, disease or illness to the Participant caused by either the Participant or a third party's conduct; and
  - (ii) the Participant later recovers from a third party's insurer or Participant's own insurer.
- (5) "Third party" shall mean another person, entity or organization.

**B. Subrogation, Restitution and Reimbursement Rights**

- (1) To the extent of any payment made under the Plan, the Plan shall be subrogated to the Participant's rights of recovery, which rights arise from any claim or cause of action which may occur because of the Participant's or a third party's conduct. This right of subrogation, restitution and reimbursement extends to any recovery received by the Participant, regardless of how it is characterized, such as for pain and suffering, regardless of who makes the payment, for any type of third-party injury. This also includes, but is not limited to:
  - (i) Payments made directly by a third party, or any insurance company on behalf of a third party or any other payments on behalf of a third party;
  - (ii) Any payments, settlements, judgments, or arbitration awards paid by any insurance company under an uninsured or underinsured motorist coverage, whether on the Participant's or other person's behalf;
  - (iii) Any other payments from any source designed or intended to compensate the Participant for injuries sustained as the result of negligence or alleged negligence of a third party.
  - (iv) Any worker's compensation award or settlement;
  - (v) Any recovery made pursuant to no-fault insurance;

- (vi) Any medical payments made as a result of such coverage in any automobile or homeowners insurance policy.

The Plan has a first priority lien on any recovery. The Participant and the Participant's attorney are deemed to hold any recovery in Constructive Trust on behalf of the Plan. The Plan is entitled to repayment in full, without reduction for attorney's fees and costs, and regardless of whether the Participant is made whole or fully compensated. The Plan will not pay future claims to the extent of any recovery the Participant received in the past in connection with an accident, unless the Plan's claim for subrogation, restitution or reimbursement has been satisfied.

- (2) The Plan shall automatically have a first lien upon any recovery that the Participant receives, or may be entitled to receive, from a third party. The Lien shall be in the amount of the benefits paid under this Plan for the treatment of any illness, disease, injury or condition for which the Responsible Third Party may be liable to the Participant.
- (3) The Plan shall be entitled to equitable relief, including without limitation the imposition of a constructive trust or an injunction, to the extent necessary to enforce the Plan's lien and to obtain (or to preclude the transfer or dissipation of) any recovery. The Plan shall be entitled to enforce its lien even if the recovery is less than the actual loss suffered by the Participant.
- (4) The Plan shall have a specific and first right of reimbursement, up to the amount of the Plan's lien, out of the proceeds of any recovery that the Participant may receive from a Responsible Third Party.
- (5) The Participant and the Participant's representatives are required to provide all assistance and cooperation requested by the Plan so that the Plan can exercise its subrogation, restitution and reimbursement rights. If the Participant or the Participant's representative fail to cooperate with the Plan, the Plan has the right to stop benefit payments and/or deny all future applications for the payment of benefit of whatever kind including, but not limited to, recovery from any full or partial recovery of revenue/money including, but not limited to, full or partial recovery for pain and suffering, loss of wages and punitive damages until the Participant cooperates to the satisfaction of the Plan. In addition, if the Participant fails to cooperate and/or pay the Plan the full amount owed, the Plan shall have the right to withhold the Participant's payment(s) for future or different claims on behalf of the Participant or Participant's dependents until the amount owed in the subrogation, restitution or reimbursement claim, in the estimation of the Plan, has been obtained through the withholding of the claims.
- (6) The Participant and Participant's attorney are required to sign the Plan's subrogation, restitution and reimbursement agreement prior to the Plan's payment of any benefits on the Participant's behalf for any injury, disease or illness resulting from the actual or alleged negligent conduct of a third party. This Plan's subrogation, restitution and reimbursement agreement may be obtained from the fund office or the administrative

manager and may include terms and conditions beyond the scope of provisions listed in the Summary Plan Description. The Plan's subrogation, restitution and reimbursement agreement the Participant signs will obligate the Participant, among other things, to reimburse the Plan for any benefits paid by the Plan from any monies or other property recovered if the Participant recovers any monies or other property from a third party as the result of a judgment, settlement or other recovery against or with a third party or if the Participant recovers under the Participant's own insurance coverage, including uninsured or underinsured coverage. If the Participant is represented by an attorney, the Participant's attorney is also required to sign the subrogation, restitution and reimbursement agreement. If the Participant does not have an attorney at the time of signing the subrogation, restitution and reimbursement agreement but subsequently becomes represented by an attorney, the Participant is required to have the Participant's attorney sign a subrogation, restitution and reimbursement agreement at the time the Participant's attorney begins representation

- (7) If the Participant and Participant's attorney do not sign a subrogation, restitution and reimbursement agreement, and the Plan Administrator later learns that benefits were paid to the Participant or on the Participant's behalf because of medical treatment which was rendered due to the negligent (actual or alleged) conduct of a third party or the Participant, the Plan has the right to stop benefit payments and/or deny all future applications for the payment of benefits of whatever kind until the Participant signs a subrogation, restitution and reimbursement agreement. In addition, the Participant and Participant's attorney are obligated to avoid doing anything that would prejudice the Plan's right of subrogation, restitution and reimbursement.
- (8) If litigation is commenced, the Plan may cause to be recorded a Notice of Payment of Benefits, and such notice will constitute a first lien on any judgment recovered less a pro rata of court costs. Further, if litigation is commenced, the Participant and the Participant's attorney are required to deliver to the Plan a copy of the complaint filed in court, the name of the insurance company for the defendant(s) and any other instruments, documents or information for which the Plan requests to insure the Plan's subrogation, restitution and reimbursement rights. The Plan shall have the right to intervene in any litigation involving the Participant to protect its subrogation, restitution and reimbursement rights. Any action taken by the Plan to protect its subrogation, restitution and reimbursement rights shall be without any charge or cost to the Participant. However, the Plan shall not be liable to pay the Participant's attorney fees or costs or the Participant's attorney or his/her costs.
- (9) The Participant is required to segregate any recovery received by the Participant (up to the amount of the Plan's first lien) in a separate account, and the Participant must preserve such recovery so that the Plan may enforce its lien and any disputes as to entitlement may be resolved.

- (10) The Participant may not assign any right, claim or cause of action against a Responsible Third Party to recover for any illness, disease, injury or condition on account of which benefits were paid by the Plan.
- (11) The Plan's rights of reimbursement, restitution and subrogation shall not be affected, reduced or eliminated by the make whole doctrine, comparative or contributory fault, or the common fund doctrine, or payment of the Participant's attorney fees or court costs.

#### **XIV.** **QUALIFIED MEDICAL CHILD SUPPORT ORDERS**

This Plan will provide benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order (hereinafter "QMCSO"), as required by ERISA Section 609.

This Plan, in accordance with law, must recognize a Qualified Medical Child Support Order. A "medical child support order" is a judgment, decree, or order (including approval of a settlement agreement) entered by a court or administrative agency of competent jurisdiction that:

- (1) Provides for child support with respect to a Participant's child under a group health plan or provides for health benefit coverage to a Participant's child; and
- (2) Is made pursuant to a state domestic relations law.

A "medical child support order" is a "Qualified Medical Child Support Order" (QMCSO) if it creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a Participant or beneficiary is eligible under a group health plan, specifies required information, and does not alter the amount or form of plan benefits. An "alternate recipient" means any Child of a Participant who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such Participant.

Thus, if a Qualified Medical Child Support Order provides health benefit coverage under the Plan to an alternate recipient, the Trustees are required to comply with the QMCSO. Participants may obtain a copy of the QMCSO procedures from the Plan Administrator without charge.

#### **XV.** **FAMILY AND MEDICAL LEAVE**

This Plan will provide benefits in accordance with the applicable requirements of the Family and Medical Leave Act of 1993 (hereinafter "FMLA"). Pursuant to the FMLA, eligibility for benefits shall be extended to active Participants and their dependents if the Participant has been granted unpaid leave by his/her Employer pursuant to the FMLA and meets all eligibility requirements of FMLA.

In order to prevent a loss of eligibility to the Participant, the Participant and/or the Employer granting the FMLA leave must comply with the following requirements:

- (1) Notify the Fund Office at least fourteen (14) days before the onset of FMLA leave, except in an emergency, and then no later than seven (7) days after FMLA leave begins;
- (2) Obtain and submit to the Fund Office a certificate of the Participant's eligibility for FMLA leave; and
- (3) Notify the Fund Office of the beginning date and ending date of the FMLA leave.

The Employer will be required to continue to submit payment for the cost of the Participant's (and their Eligible Dependent's) coverage during the FMLA leave. In addition, the Employer granting the FMLA leave must notify the Administration Office of the date a Participant advises the Employer that he/she does not intend to return to work. If a Participant on FMLA leave advises the Employer that he/she does not intend to return to work, then the obligation of the Employer to submit payment for the cost of the Participant's coverage will immediately cease.

## **XVI.** **PRIVACY POLICY UNDER THE HEALTH INSURANCE PORTABILITY** **AND ACCOUNTABILITY ACT**

The Plan is required to protect the confidentiality of your private health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules issued by the U.S. Department of Health and Human Services.

### **A. Your Rights under HIPAA**

Your rights under HIPAA include all of the following:

- (1) **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;

- (2) **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:
- a. Was not created by us, unless the person who created the information is no longer available to make the amendment;
  - b. Is not part of the protected health information we keep about you;
  - c. Is not part of the protected health information that you would be allowed to see or copy; or
  - d. 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.

- (3) **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, or disclosures to law enforcement personnel. The list we provide will include disclosures made within the last six years 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.
- (4) **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.

- (5) **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.
- (6) **File a complaint with the Plan or with the Secretary of Health and Human Services.** If you believe your rights under HIPAA have been violated, you may file a complaint with us or 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.

#### **B. Disclosure Without Your Written Authorization**

The Plan may disclose Protected Health Information (PHI) as defined under HIPAA without your written authorization to the Board of Trustees of the Insulators Local 84 Health Care Plan (Sponsor) or to other entities as explained below:

- (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 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:
- (i) **Required by law.** We may use and disclose your protected health information to comply with the law.
  - (ii) **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.
  - (iii) **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.
  - (iv) **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.
  - (v) **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.
  - (vi) **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).
  - (vii) **Coroners, medical examiners and funeral directors.** We may disclose protected health information to facilitate the duties of these individuals.
  - (viii) **Organ procurement.** We may disclose protected health information to facilitate organ donation and transplantation.

- (ix) **Medical research.** We may disclose protected health information for medical research projects, subject to strict legal restrictions.
- (x) **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.
- (xi) **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.
- (xii) **Workers' compensation or similar programs.** We may disclose your protected health information when necessary to comply with worker's compensation laws.
- (xiii) **Reporting of Disclosures of PHI.** The Plan Sponsor will, as soon as possible after becoming aware of an actual or suspected disclosure of PHI in violation of this document by the Plan Sponsor, their officers, employees, contractors, agents and administrators, report any such disclosure to the Plan.

#### **C. Privacy Officer**

The Plan's Privacy Officer is currently Compensation Programs of Ohio, 33 Fitch Boulevard, Austintown, OH 44515, phone number (800) 435-2388.

### **XVII. MISCELLANEOUS PROVISIONS**

#### **A. Change of Plan Provisions**

The Board of Trustees, in its sole discretion, is empowered to change or amend any Plan provision, including, but not limited to, the Eligibility Rules or Schedule of Benefits, at any time by amendment or resolution duly executed.

#### **B. Change in Terms**

The terms of this Plan may be changed at any time except as prohibited by law. All changes in coverage will be made on a uniform basis, affecting similarly situated Participants, Employees and Eligible Dependents equally, and will not apply to claims incurred before the amendment or termination is effective.

#### **C. Amendment and Termination**

The Trustees expect and intend to continue the Plan indefinitely. However, the Trustees reserve the right, within their sole discretion, to amend or terminate this Plan at any time for any reason as they

deem necessary to carry out the purposes and objectives of the Plan and Trust Agreement. If the Plan is amended or terminated, you and other active and retired members may not receive benefits as described in this document. You may be entitled to receive different benefits, or benefits under different conditions. If any modification or change to the Plan is a material reduction in covered services or benefits provided under the Plan, you and other active and retired members will be furnished with a summary of such modification or change no later than sixty (60) days after the adoption of the modification or change.

It is also possible that you will lose all benefit coverage. Loss of coverage may happen at any time, even after you retire, if the Trustees decide to terminate the Plan or your coverage under the Plan. In no event will you become entitled to any vested rights under this Plan.

#### **D. Authority to Interpret Plan**

The Board of Trustees has complete authority and sole discretion to construe and interpret the provisions of the Plan and the Trust Agreement, and any ambiguity regarding whether coverage is permitted shall be construed against coverage. The Board of Trustees has the authority to decide all questions of eligibility and all questions regarding the amount and payment of any benefits provided by the Plan within the Plan's terms, as interpreted by the Trustees, in their sole discretion. No Employer, Union or representative of any Employer or Union is authorized to interpret the provisions of either the Plan or Trust Agreement. Any interpretation of the Plan or Trust Agreement made by the Trustees shall, subject to the claimant's right to legal action, be final and binding on all parties. No provision of this Plan shall be construed to conflict with any Treasury Department, Department of Labor or Internal Revenue Service regulation, ruling, release or proposed regulation or other which affects or could affect the terms of this Plan, and this Plan shall be deemed to be amended to such extent necessary to resolve any such conflict.

#### **E. Legal Actions**

No actions at law or in equity shall be brought to recover any benefits provided under this Plan prior to the expiration of sixty (60) days after written proof of loss has been furnished, nor shall any such action be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

#### **F. Right to Receive and Release Necessary Information**

To determine the applicability of and to implement the terms of this provision or any provision of similar purpose in any other plan, the Plan Administrator may, without the consent of or notice to any person, release to or obtain from any other insurance company or other organization or person any information with respect to any person which the Plan Administrator deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

Upon the request of the Trustees, you or your Dependent may be required, as a condition to continue eligibility under this Plan to apply for Social Security Benefits, Medicare and Medicaid or the program then in effect. You or your dependent may also be required as a condition to continue

eligibility under this Plan to sign any authorizations or releases provided by the Trustees, as the Trustees deem necessary, enabling the Trustees to obtain information from the Participant or Dependent and appropriate government agencies pertaining to their claim for Social Security Benefits, Medicare and Medicaid benefits.

#### **G. Right of Recovery**

Whenever payments have been made by the Trust Fund with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Trust Fund shall have the right to recover such payments to the extent of such excess from among one or more of the following, as the Trust Fund shall determine: Any persons to or for or with respect to whom such payments were made, any insurance companies, or any other organizations. The Trustees reserve the right to reduce or withhold future benefit payments under the Plan in order to correct a prior payment to any Participant, Employee and/or Dependent.

#### **H. Nondiscrimination Rights**

The Plan shall not discriminate against you or your dependents based on health status in eligibility, enrollment or premium contributions in accordance with federal law. However, the Trustees shall have the right to require you or your Dependent to be examined by a Physician selected by them as often as they may reasonably deem necessary in order to process a claim.

#### **I. Prohibited Discrimination**

##### **(1) Eligibility to Enroll**

- (i) **In General.** Subject to (ii) below, the Plan may not establish rules for eligibility (including continued eligibility) of any Participant to enroll under the terms of the Plan based on any of the following factors in relation to the Participant or the Eligible Dependent of the Participant: (a) health status; (b) medical condition (including both physical and mental illnesses); (c) claims experience; (d) receipt of health care; (e) medical history; (f) genetic information; (g) evidence of insurability (including conditions arising out of acts of domestic violence); or (h) disability.
- (ii) **No Application to Benefits or Exclusions.** To the extent consistent with the pre-existing condition exclusion provisions, (i) above shall not be construed:
  - (a) to require the Plan to provide particular benefits (or benefits with respect to a specific procedure, treatment, or service) other than those provided under the terms of such Plan; or
  - (b) to prevent the Plan from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for

similarly situated Participants or Eligible Dependents enrolled in the Plan.

- (iii) **Construction.** For purposes of (i) above, rules for eligibility to enroll under the Plan include rules defining any applicable waiting periods for such enrollment.

(2) **Premium Contributions**

- (i) **In General.** The Plan may not require any Participant or Eligible Dependent (as a condition of enrollment or continued enrollment under the Plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated Participant or Eligible Dependent enrolled in the Plan on the basis of any factor described in Section 1 above.
- (ii) **Construction.** Nothing in Section 1 above shall be construed to restrict the amount that an Employer may be charged for coverage under the Plan; or to prevent the Plan from establishing premium discounts or rebates or modifying otherwise applicable co-payments or deductibles in return for adherence to programs of health promotion and disease prevention.

**J. Guaranteed Renewability**

This Plan may not deny an Employer continued access to the same or different coverage under the Plan, other than:

- (1) for nonpayment of contributions; or
- (2) for fraud or other intentional misrepresentation of material fact by the Employer; or
- (3) for noncompliance with material Plan provisions; or
- (4) because the Plan is ceasing to offer any coverage in a geographic area; or
- (5) in the event the Plan offers benefits through a network plan, because there is no longer any individual enrolled through the Employer who lives, resides, or works in the service area of the network plan and the network plan applies this paragraph uniformly without regard to the claims experience of Employers or a factor described in Section I(1) in relation to such Participants or their Eligible Dependents; or
- (6) for failure to meet the terms of an applicable Collective Bargaining Agreement, to renew a collective bargaining or other agreement requiring or authorizing contributions to the Plan, or to employ Employees covered by such an agreement.

#### **K. Employment Rights**

The establishment of this Plan shall not be construed as conferring any legal rights upon any Employee or any other person for continuation of employment, nor shall it interfere with the rights of any Employer to discharge any Employee and/or treat him or her without regard to the effect which such treatment might have upon him or her as a Participant in this Plan.

#### **L. Medical Examination**

No medical examination shall be required of any person in order to obtain coverage for benefits initially. However, the Trustees shall have the right to require any Eligible Employee or Eligible Dependent whose Accident, Injury or Illness is the basis of a claim to be examined by a Physician selected by them as often as they may reasonably deem necessary in order to process the claims.

#### **M. Trustee Rights**

The Trustees shall have the exclusive right and sole discretion to make any finding of fact necessary or appropriate for any purpose under the Plan including, but not limited to, the determination of eligibility for and the amount of any benefit payable under the Plan. The Trustees shall have the exclusive right and sole discretion to interpret the terms and provisions of the Plan and to determine any and all questions arising under the Plan in connection with administration thereof, including, without limitation, the right to remedy or resolve possible ambiguities, inconsistencies or omissions, by general rule or particular decision. The Trustees shall make or cause to be made by engaging individuals or entities, to make all reports or other filing necessary to meet the reporting and disclosure requirements of the Act. All decisions made by the Trustees, any action taken by them in respect of the Plan or the Trust Agreement, shall be conclusive and binding on all persons, and shall be given the maximum possible deference allowed by law.

#### **N. Payment of Benefits**

All benefits under the Plan shall be payable through Employees or agents of the Trustees acting under their authority. Benefits as authorized under the Plan will be paid as long as the Fund can operate on a sound financial basis. Anything in the Plan to the contrary notwithstanding, no benefits shall be payable except those which can be provided under the Plan, and no person shall have any claim for benefits against the Union, any Employer, or the Trustees. The Trustees, the Employers and Union shall not be held liable for any benefits or contracts, except as provided in the Agreement between the Employers and the Union.

#### **O. Delinquent Contributions**

In order to protect the interests of the Participants and beneficiaries of the Plan, the Trustees reserve the right to promulgate rules and regulations denying further participation in the Plan by Employees where Employer contributions on behalf of one or more Employees have been in arrears for a specified number of hours or weeks of service, as determined by the Trustees in their sole discretion, and/or to delay the payment of claims arising on such individual until contributions are received by the Trust Fund office on behalf of all Employees.

**P. Post-Mortem Benefits**

Any benefit payable under the Plan after the death of a Participant is to be paid to the Beneficiary listed on file at the Third Party Administrator's office, and otherwise to the following classes of successive preference beneficiaries then surviving: the Participant's (1) spouse, (2) lineal descendants, (3) parents, (4) siblings, and (5) executor or administrator of the Participant's estate. If any doubt exists about the right of any beneficiary to receive any amount, the Plan Administrator may retain the disputed amount until the rights to that amount are determined, without any liability for any interest on the amount, or the Plan Administrator may pay the amount to any court of appropriate jurisdiction. In either event, neither the Plan Administrator nor any Employer is under any further liability to any person.

**Q. Right of Recovery**

Whenever payment of benefits has been made by the Trust Fund in excess of the maximum amount of payment necessary at that time to satisfy the claim, the Trust Fund shall have the right to recover such payments to the extent of such excess from among one or more of the following, as the Trust Fund shall determine: any persons to or for or with respect to whom such payments were made, or any other organizations, including but not limited to Participants and their Beneficiaries. The Trustees reserve the right to reduce or withhold future benefit payments under the Plan in order to correct a prior overpayment to you.

**R. Compliance with Claim Rules**

The Trustees reserve the right to deny benefits to any claimant who is, in their opinion, attempting to subvert the Plan's purposes, or who does not present a bona fide claim.

**S. Governing Laws**

This Plan shall be construed, enforced and administered and the validity determined in accordance with ERISA, as amended, the Internal Revenue Code of 1986, as amended, and, to the extent not preempted by federal law, the law of the State of Ohio.

**XVIII.**

**SPECIAL NOTICE REGARDING MASTECTOMY COVERAGE**

Under federal law, group health plans and health insurance issuers offering group health insurance coverage that includes medical and surgical benefits with respect to a mastectomy shall, at a minimum, provide for:

- (1) Reconstruction of the breast on which the mastectomy was performed;
  - (2) Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- and

- (3) Prostheses and physical complications for all stages of mastectomy, including lymphedemas

in a manner determined in consultation with the attending physician and the patient. As part of the Plan's Schedule of Benefits, such benefits are subject to the Plan's appropriate cost control provisions such as deductibles and coinsurance.

If you have any questions regarding these federal requirements, please contact the Plan Administrator.

**XIX.**  
**REQUIREMENTS UNDER THE NEWBORNS' AND MOTHERS'**  
**HEALTH PROTECTION ACT OF 1996**

Maternity and obstetrical benefits are available only to you and your Spouse (while you are eligible). The Plan also covers complications arising during pregnancy that result in Surgery or treatment in a hospital.

Under the Newborns' and Mothers' Health Protection Act, group health plans and health insurance issuers may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn Child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, this law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

If you have any questions regarding these requirements under federal law, please contact the Plan Administrator.

**XX.**  
**THE CHILDREN'S HEALTH INSURANCE PROGRAM**  
**REAUTHORIZATION ACT OF 2009 (CHIPRA)**

Under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), employees and dependents who are eligible for coverage but who are not enrolled for coverage may exercise special enrollment rights and enroll in the plan if the Employee or dependent:

- A. Loses coverage under a Medicaid Plan under Title XIX of the Social Security Act; or
- B. Loses coverage under State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act; or

- C. Becomes eligible for group health plan premium assistance under Medicaid or SCHIP.

If any of these circumstances arises and the Employee or dependent wishes to take advantage of these special enrollment rights, the employee or dependent must request to enroll for coverage within 60 days from the date (1) the coverage terminates under the Medicaid or SCHIP plan, or (2) the Employee or dependent Child is determined eligible for state premium assistance.

If you believe you are eligible for Special Enrollment under this provision, you must contact the Fund Office to request an election form as soon as possible. A request for enrollment must be made in writing on the form provided by the Fund Office. Requests for Special Enrollment right must be made within 60 days of an event described above that occurs.

## **XXI. STATEMENT OF ERISA RIGHTS**

As a Participant in the Insulators Local 84 Health Care Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all plan Participants are entitled to the following:

### **A. Receive Information about Your Plan and Benefits**

You may examine, without charge, at the Plan Sponsor's office and at other locations (certain worksites and the Union Hall), all documents governing the plan, including insurance contracts, 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.

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

You may receive a summary of the Plan's Annual Financial Report. The Plan Sponsor is required by law to furnish each Participant with a copy of this summary annual report.

### **B. Continue Group Health Coverage**

You may 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 and the rules governing your COBRA continuation coverage rights.

You may qualify for reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You

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

### **C. Prudent Actions by Plan Fiduciaries**

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

### **D. Enforce Your Rights**

If your claim for a welfare benefit is denied 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 Plan Administrator's control. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order 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 court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### **E. Assistance with Your Questions**

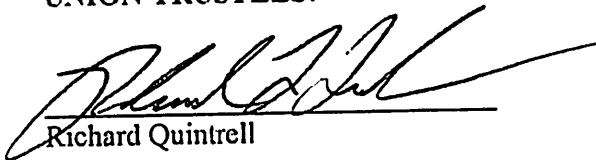
If you have any questions about your Plan, you should contact the Third Party Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee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

20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. The nearest Area Office of the Employee Benefits Security Administration is the Cincinnati Regional Office, 1885 Dixie Highway, Suite 210, Fort Wright, Kentucky 41011 at (606) 578-4680.

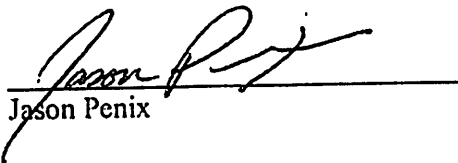
### THE BOARD OF TRUSTEES

IN WITNESS WHEREOF, this instrument has been executed by the Board of Trustees on the Insulators Local 84 Health Care Plan this 1<sup>st</sup> day of June, 2011.

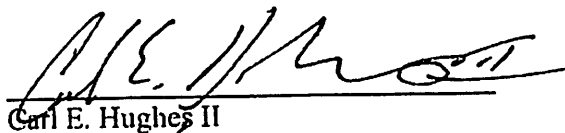
#### UNION TRUSTEES:

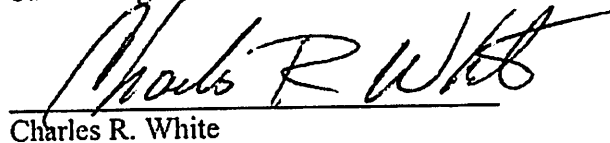
  
Richard Quintrell

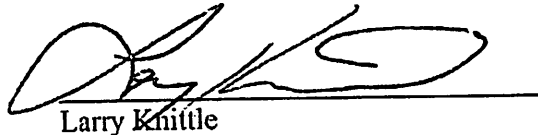
  
William Max Marcavish

  
Jason Penix

#### EMPLOYER TRUSTEES

  
Carl E. Hughes II

  
Charles R. White

  
Larry Knittle