FOURTH SUMMARY DESCRIPTION OF MATERIAL MODIFICATION OF THE INSULATORS LOCAL 84 HEALTH CARE PLAN SUMMARY PLAN DESCRIPTION/PLAN DOCUMENT

March 28, 2014

I. INTRODUCTION

This document is designed to describe modifications to the Insulators Local 84 Health Care Plan (hereinafter "the Plan"). This document should be read in conjunction with the Summary Plan Description/Plan Document (hereinafter "SPD"), which was provided to you previously. Information contained in this Summary Description of Material Modification (hereinafter "Summary Description") supersedes what is contained in the SPD. However, this Summary Description materially modifies only those provisions of the SPD to which it refers. The remaining provisions of the SPD remain unaltered. The changes set forth in this Summary Description are all effective June 1, 2014.

II. HRA ACCOUNT CHANGES

The Affordable Care Act ("ACA") prohibits a Plan from imposing annual dollar limitations on coverage. Health reimbursement accounts like your HRA Account contain dollar limitations in that the coverage you receive under the HRA Account is limited to your account balance. The ACA permits such HRA Accounts to continue beyond January 1, 2014 as long as they are fully integrated with coverage under a group health plan that does comply with the ACA's prohibition on annual dollar limits on coverage because the combined benefit satisfies the ACA requirements.

In order to be fully integrated, the HRA Account provisions of your Plan need to be amended effective January 1, 2014 to provide that coverage under the HRA Account provisions is contingent on first meeting the hours requirement and becoming eligible for and covered for benefits under the comprehensive medical benefits portion of the Plan. Moreover, the ACA rules also require that Participants in the HRA Account be allowed to permanently waive coverage under the HRA Account if they wish to do so in order to qualify for a tax subsidy if they decide to purchase individual coverage on the ACA market exchange.

Accordingly, effective January 1, 2014, Section G of Article VI is amended to read as follows:

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; and

(3) become eligible for comprehensive medical benefits coverage under Article V, Section A, above as of the time of the HRA contribution or thereafter. (For any contributions received to your HRA Account prior to you becoming eligible for comprehensive medical benefits

coverage under Article V, Section A, above, you will not be able to use such HRA Account contributions until you do become eligible for comprehensive medical benefits coverage).

Your Credit Account is funded exclusively through Employer Contributions.

Moreover, a new Section S is added to Article VI to read as follows:

S. Right to Opt Out of HRA Account

After termination of your medical coverage, you may not be entitled to a premium tax credit from the government for the purchase of health insurance from a health insurance exchange unless you permanently opt out of and waive further reimbursements from your HRA Account. Accordingly, upon termination of your coverage under the major medical Plan sponsored by the Insulators Local 84 Health Care Plan, you are permitted to permanently opt out of and waive future reimbursement from your HRA Account. Please contact the Fund Administrator to obtain the necessary waiver form.

III. DEFINITION OF SPOUSE

This change to your Plan expands the definition of "Spouse" to include any person recognized by the laws of any domestic or foreign jurisdiction to be lawfully married. Prior to this change, Spouse was defined in terms of law of the state in which the participant resided. However, after the Supreme Court of the United States determined that the Defense of Marriage Act was unconstitutional, the Internal Revenue Service issued guidance determining that Plans such as your Pension Plan are now required to follow a "place of celebration" rule and recognize an individual as a Participant's Spouse as long as the law of the state in which the marriage took place recognized the marriage as legally valid.

Effective January 1, 2014, Section "BW" of Article VIII of the SPD is deleted and amended to read as follows:

BW. Spouse

"Spouse" or "spouse" means that person, if any, who:

a. is recognized as legally married to the Participant by a domestic or foreign jurisdiction whose laws authorized the marriage at the time the Participant and such person entered into the marital relationship; and

b. has not been declared legally separated from the Participant by any judicial order.

IV. LOSS OF GRANDFATHERED STATUS

Effective June 1, 2014, this group health plan will no longer be considered a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act" or "ACA"). 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. Now that this Plan is no longer grandfathered, it must include certain protections for Participants offered by the Affordable Care Act; for example, the requirement for the provision of preventative health services without any cost sharing, coverage of emergency room services without prior authorization, coverage of out-of-network emergency room services at in-network copay and coinsurance levels, limited out-of-pocket

maximums for in-network care, the removal of an annual maximum benefit, and the addition of an external review process for denied claims. The requirements for non-grandfathered plans under the Affordable Care Act have been incorporated herein, and it is the intent of the Plan to comply with all requirements for non-grandfathered plans under the Affordable Care Act beginning June 1, 2014. Accordingly, the provision entitled "Disclosure of Grandfathered Status" on page two of the SPD is deleted in its entirety.

V. CHANGES TO COMPREHENSIVE MEDICAL BENEFITS, PLAN DEDUCTIBLES, MAXIMUM BENEFITS AND PRESCRIPTION BENEFITS

Effective June 1, 2014, in compliance with the Affordable Care Act, as a non-grandfathered plan, this plan must provide certain preventative services without any cost sharing as well as other consumer protections such as elimination of an out-of-pocket maximum for in-network services and the elimination of an annual or lifetime maximum amount of benefits paid by the Plan. In order to accommodate these changes required by the Affordable Care Act and to protect the financial integrity of the plan to ensure that participants and their beneficiaries continue to receive health care benefits under the Plan, changes in the prescription co-pays as well as out-of-pocket maximums and annual maximums for in-network medical care were necessary. Specifically, the co-pays for retail prescription drugs have increased to $15.00 for generic, $40.00 for formulary brand name, and $65.00 for non-formulary brand name drugs. Moreover, the co-pays for 90-day mail order prescriptions have increased to $35.00 for generic, $60.00 for formulary brand name, and $85.00 for non-formulary brand name drugs. In addition, for both retail and mail-order specialty drugs (high-cost injectable, infused, oral, or inhaled drugs that generally require special storage or handling and close monitoring of a patient's drug therapy) participants are now responsible to pay twenty-five percent (25%) of the cost. Prior to these changes, the prescription drug copays for retail prescriptions were $10.00 for generic, $20.00 for formulary brand name, and $35.00 for non-formulary brand name drugs, and the copays for mail-order prescriptions were $20.00 for generic, $40.00 for formulary brand name, and $70.00 for non-formulary brand name drugs.

The Plan has also been amended to increase the out-of-pocket maximum for in-network health care from $1,400.00 to $2,000.00. Therefore, for in-network care, the plan will pay 80% of the preferred provider organization's allowance on the first $10,000 of medical care costs, and will pay 100% of the allowance for costs exceeding $10,000.

Accordingly, Article V, Section A is amended to read as follows:

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
Annual Physical*	One visit maximum per eligible person, per plan year	No specific dollar maximum	No specific dollar maximum
Annual Mammogram	One Mammogram per eligible person, per plan year**	Covered	Not Covered
Colonoscopy	Once every five years per eligible person over age 50**	Covered	Not Covered
Individual Deductible	Maximum per eligible person per year	$350.00	$350.00
Family Deductible	Maximum per family per Plan Year	$700.00	$700.00
Basic Benefit	After deductible	First $10,000 of Covered Services paid at 80% of PPO allowance	60% of reasonable and customary fee
Maximum Benefit* **	After deductible and after first $10,000 beyond deductible	Balance of Covered Services paid at 100% of PPO allowance	Covered Services paid at 60% of Reasonable and Customary Charge or Amount
Maximum Annual Benefit	Per eligible person, per plan year	No Limit	No Limit

*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.

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

Benefits with Specific Maximums	
Annual Physical	Maximums no longer apply.
Inpatient Mental and Nervous	No limitation applies.
Inpatient Substance Abuse	No lifetime limit on number of treatments.
Out-Patient Substance Abuse	Limitations no longer apply.
Well-Baby Care Checkups or Routine Exams	Limited to 2 visits per Plan Year per Dependent Child up to age 5.
Immunizations	Covered for each Dependent Child through age 13
Sleep Apnea	Limited to 1 test per Plan Year
Chiropractic Treatments	Limited to 20 visits per Plan Year for all combined Physical Therapy, Chiropractic Treatments, Occupational Therapy, or Rehabilitation unless treatment is necessary for Illness, Injury or rehabilitation following Surgery. Coverage for Physical Therapy, Chiropractic Treatments, 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%. If an out-of-network provider is used, Coverage for Physical Therapy, Chiropractic Treatments, Occupational Therapy, and Rehabilitation is limited to 60% of the reasonable and customary fee allowance for such treatment. The Participant is responsible for the remaining 40%.

Emergency room services are covered without prior authorization at either in-network or out-of-network facilities. Additionally, treatment at out-of-network emergency rooms are covered at in-network coverage levels.

Dental Benefits
Eligible Active Employees, Dependents and Retirees

The Plan will pay 100% of the Reasonable and Customary Charge for dental examinations and cleanings (once every 6 months per person). All other dental services, including but not limited to teeth whitening and orthodontia as well as any procedures necessary to address tooth injury, cavities and tooth decay associated with dental examinations are subject to a $400.00 per person annual limit and are covered at 80% of covered services.

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.

Prescription Benefits		
Maximum Prescription Benefit per Plan Year	Subject to overall annual plan maximums	
Retail Prescription, up to 30-day supply; limited to 3 fills (Aspirin and other over the counter drugs are covered without copays only when prescribed by a Provider as preventative care.)	Generic Prescription Drug	Approved cost of prescription less $15 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 $65 co-pay
Mail Order Prescription; up to 90-day supply; limited to 3 refills; required for maintenance medication	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 non-specialty injectable drugs. **For "Specialty Drugs," the co-pay in all cases is 25% of the approved cost of the prescription. Specialty Drugs** are high-cost injectable, infused, oral, or inhaled drugs that generally require special storage or handling and close monitoring of a patient's drug therapy. For Specialty Drugs, Participants must first try the formulary drugs on the preferred product list prior to trying a non-preferred brand unless overridden by the treating physician by a separate letter establishing that the non-preferred brand is medically necessary

Death Benefits

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

VI. PREVENTATIVE CARE SERVICES

The Affordable Care Act requires that non-grandfathered plans provide certain preventative care services and immunizations at no cost to participants. Because this Plan is non-grandfathered as of June 1, 2014, participants will no longer pay copayments, deductibles or coinsurance on certain in-network preventative care services and immunizations. The list of preventative services may be changed regularly by the Department of Labor and the Plan will update the list at the start of each new Plan Year.

Accordingly, Article V of the SPD is amended to add the following Section G to read as follows:

G. Preventive Care – Preventive Care means care that includes:

i. Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventative Services Task Force.

ii. Immunizations that have in effect a recommendation from the Advisory Committee on Immunizations Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

iii. With respect to infants, children, and adolescents, evidence-informed preventative care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

iv. With respect to women, such additional preventative care and screenings not described in paragraph (i) above as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

v. Tobacco cessation programs

Lists of all of the current items and services provided for in the guidelines discussed in subsections i. through iv. can be found at the following website: http://www.healthcare.gov/center/regulations/prevention.html.

Moreover, the exclusions set forth in Article V, Section F, subsections (2), (5), and (10) are deleted and amended to read as follows:

(2) Eye glasses, hearing aids, eye re-fractions, 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 and except if required to be covered in Article V, Section G.

* * *

(5) Check-ups, certifications, well-baby care, or routine examinations not incident to or necessary in the diagnosis of sickness, or of an accidental bodily injury, except as specifically provided in the Schedule of Benefits above and except if required to be covered in Article V, Section G.

* * *

(10) Dental services, including dental x-rays, except for accidental injuries, osseous surgery and TMJ treatment subject to the limits of the Plan and except if required to be covered in Article V, Section G.

VII. ESSENTIAL HEALTH BENEFITS

Beginning in 2014, the Affordable Care Act requires non-grandfathered health plans to cover benefits considered as "Essential Health Benefits" by the Department of Labor. These benefits encompass services and items in ten (10) specific categories.

Therefore, effective June 1, 2014, the following definition of "Essential Health Benefits" will be inserted into the provisions of Article VIII, as Section AE and all other sections in Article VIII will be relettered accordingly:

AE. Essential Health Benefits

"Essential Health Benefits" means benefits defined under federal law (The Affordable Care Act or "ACA") and accompanying regulations as including benefits in at least the following categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

VIII. EXTERNAL REVIEW PROCESS

The Affordable Care Act now requires that non-grandfathered plans, in addition to updated internal claims procedures, must maintain a formal external appeals procedure. This means that after the Plan's current appeals are exhausted through the Plan, a Participant may ask for a further review by an in independent external review organization. An external review decisions will be binding on the Plan. Therefore, effective June 1, 2014, Article X of the Plan is amended to insert the following Section I and change the current Section I to Section J:

I. External Review Procedure

After exhausting the internal review process described above, you may appeal an adverse benefit determination through an external review process. For more information regarding this process, contact the Plan Administrator

IX. CONCLUSION

As stated in the Introduction, this Summary Description should be read in conjunction with the SPD and SBC. Information contained in this Summary Description supersedes what is contained in the SPD and SBC. However, this Summary Description changes only the provisions to which it specifically refers and any other provisions in the SPD and SBC have not been materially modified.

THE BOARD OF TRUSTEES OF
THE INSULATORS LOCAL 84 HEALTH CARE PLAN