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

April 2013

IV. INTRODUCTION

This document is designed to describe modifications to the May 2011 Summary Plan Description/Plan Document (hereinafter "SPD") of the Insulators Local 84 Health Care Plan (hereinafter "the Plan"). This document should be read in conjunction with the 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 specifically refers. The remaining provisions of the SPD remain unaltered.

II. PRESCRIPTION DRUG CHANGES

The Trustees have amended the Plan to change the process regarding prescription drug coverage effective April 1, 2013. The Trustees have instituted a step therapy program, which requires participants to first try a generic drug alternative before approval for coverage of a brand name drug is allowed. Participants must now try a generic drug alternative unless their treating physician submits a separate letter detailing why taking the brand name drug instead of a generic version is medically necessary. In addition, for specialty drugs, Participants are required to first try preferred drugs on the pharmacy benefit manager's formulary prior to receiving authorization for coverage of a non-preferred drug. Lastly, the Trustees have determined to limit the circumstances under which a Participant can avoid the dispense as written penalty (DAW penalty) that requires Participants who choose brand name drugs to pay the cost difference between the brand name and generic alternative. The Plan will no longer accept a physician simply writing dispense as written on a prescription slip in order to avoid the DAW penalty. The only exception to the imposition of the DAW penalty is if a participant obtains a letter of medical necessity from his or her treating physician establishing that there is a medical need to use the brand name drug instead of a generic drug.

Accordingly, effective April 1, 2013, the section of Article V, Section A entitled "Prescription Benefits, Eligible Active Employees, Dependents, and Retirees" is deleted and amended to read as follows (the other provisions of Section A remain the same).

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	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
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 injectible drugs. For specialty drugs, the co-pay in all cases is 25% of the approved cost of the prescription. The Plan has adopted step therapy for utilizers of new drugs on or after April 1, 2013. Under step therapy, in order for a Participant to use a brand name drug, the Participant must first try to use the generic version unless overridden by their Physician via a letter establishing that use of the brand name drug is medically necessary.

A "dispense as written" penalty (DAW penalty) applies to the use of brand name drugs when a generic version is available. Under the DAW penalty, if a Participant chooses a brand name drug when a generic version is available, the Participant is responsible to pay both the applicable co-pay as well as the cost difference between the brand name drug and the generic drug. The only exception to application of a DAW penalty is if the Participant obtains from their physician a letter of medical necessity establishing that there is a medical need to use the brand name drug instead of a generic drug.

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. For a list of preferred drugs, please contact the Third Party Administrator at the address on the front of the SPD.

III. DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM CHANGES

Due to increased medical costs and in order to keep your health plan adequately funded, the Trustees determined to increase the deductible and coinsurance for participants under the plan. These changes will be effective June 1, 2013. Prior to this change, the deductible was $275.00 per person and $550.00 per family. Also, prior to this change, after

the deductible, the first $5,000.00 of Covered Services were only covered at eighty percent (80%) of the allowed amount at in network facilities and sixty percent (60%) at out-of-network facilities, with the remaining services covered at one hundred percent (100%). Accordingly, after the deductible was exhausted, participants were responsible for one thousand dollars ($1,000.00) of the first $5,000.00 of Covered Services if treated in an in-network facility (20% of $5,000.00) and two thousand dollars ($2,000.00) of the first $5,000.00 of Covered Services if treated in an out-of- network facility (40% of $5,000.00). Effective June 1, 2013, the deductible has been increased to $350.00 per person and $700.00 per family. In addition, effective June 1, 2013, the first $7,000.00 of Covered Services will be covered at eighty percent (80%) of the allowed amount if treated in an in-network facility and sixty percent (60%) of the allowed amount if treated in an out-of-network facility. Accordingly, after the deductible is exhausted, participants will be responsible for one thousand four hundred dollars ($1,400.00) of the first $7,000.00 of Covered Services if treated in an in-network facility (20% of $7,000.00) and two thousand eight hundred dollars ($2,800.00) of the first $7,000.00 of Covered Services if treated in an out-of-network facility (40% of $7,000.00).

Therefore, effective June 1, 2013, the table located in Article V, Section A, entitled "Comprehensive Medical Benefits Eligible Active Employees, Dependents, and Retirees" is amended to read as follows (this change does not amend the notations after said table and also does not change the table entitled "Benefits with Specific Maximums" in Article V, Section A):

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 dollar maximum	No 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 $7,000 of Covered Services paid at 80% of PPO allowance	First $7,000 of Covered Services paid at 60% of reasonable and

			customary fee
Maximum Benefit* **	After deductible and after first $7,000 beyond deductible	Balance of Covered Services paid at 100% of PPO allowance	Covered Services paid at 60% of reasonable and customary fee allowance
Maximum Annual Benefit from 6/1/2012 through 5/31/2013	Per eligible person, per plan year	$1,250,000	$1,250,000
Maximum Annual Benefit from 6/1/2013 through 5/31/2014	Per eligible person, per plan year	$2,000,000	$2,000,000

IV. CHANGES TO RESERVE HOUR BANK

Due to increased medical costs and in order to keep your health plan adequately funded, the Trustees have amended the Plan to increase the threshold hours necessary to begin banking of reserve hours. Prior to this change, hours contributed in one month in excess of 140 were transferred to the bank to be used as reserve hours to maintain future eligibility. Effective June 1, 2013, hours contributed in one month in excess of 144 will be transferred to the bank to be used as reserve hours to maintain future eligibility.

Accordingly, effective June 1, 2013, Article II, Section A of the SPD is deleted in its entirety and amended to read as follows:

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 from either the National Asbestos Workers Pension Fund or the Local No. 84 Asbestos Workers Pension Fund. Any hours accumulated in excess of one hundred forty-four (144) in any calendar month will be credited to your Reserve Hours.

Moreover, effective June 1, 2013, Article II, Section D of the SPD is deleted in its entirety and amended to read as follows:

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-four (144) credited during the initial eligibility period; and

(2) all hours in excess of one hundred forty-four (144) credited during any one (1) calendar month after the initial eligibility period.

The maximum amount of Reserve Hours that you may accumulate it the Reserve Hour 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 neither a vested nor an accrued benefit, and Reserve Hours are subject to forfeiture by decision of the Board of Trustees at any time and for any reason.

Note: There is no carryover of any Reserve Hours that 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-contribution in the invoiced amount, your Reserve Hours balance will be forfeited.

V. CONCLUSION

As stated in the Introduction, this Summary Description should be read in conjunction with the SPD. Information contained in this Summary Description supersedes what is contained in the SPD. However, the changes set forth in this Summary Description are limited to the provisions specifically identified herein, and the remainder of the SPD has not been materially modified.

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*. This website has a table summarizing which protections do and do not apply to grandfathered health plans.