SUMMARY PLAN DESCRIPTION/
PLAN DOCUMENT

INSULATORS LOCAL 84 HEALTH CARE PLAN

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INSULATORS LOCAL 84 HEALTH CARE PLAN

June 2005

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, 2005. Prior to June 1, 2005, employees who are eligible to be covered under the Health Plan were covered by the National Asbestos Workers Medical Fund. 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.

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

I. PLAN IDENTIFICATION AND GENERAL INFORMATION 2
- A. Name of the Fund 2
- B. Names and Addresses of the Employers 2
- C. Name and Address of the Plan Sponsor 2
- D. Name and Address of the Third Party Administrator 2
- E. Plan Numbers Assigned to the Plan 3
- F. Type of Plan 3
- G. The Plan Year 3
- H. Type of Administration Used for the Plan Assets 3
- I. Attorneys for the Fund and Agent for Service of Process 3
- J. Funding Medium for the Accumulation of Plan Assets 4
- K. Effective Date When Health Plan Began 4
- L. Sources of Contributions to the Health Plan 4
- M. Plan Amendment and Termination 4
- N. Plan is Not a Contract 4

II. ELIGIBILITY 4
- A. Initial Eligibility 4
- B. Continuation of Eligibility 5
- C. Reinstatement of Eligibility 6
- D. Reserve Hours 6
- E. Termination of Eligibility 7
- F. Employment Outside of Jurisdiction 8
- G. Maintenance of Eligibility 8
- H. Military Service 8
- I. Termination of Coverage and Loss of Reserve Hours for Employment with Non-Contributory Employer 9
- J. Eligibility through Reciprocity 10
- K. Change in Classification or the Amount of Coverage 10
- L. When Coverage Ends 10
- M. Disability Coverage 11
- N. Summary of Rights and Obligations Regarding Continuation of Group Health Insurance Coverage under Plan through Self-Contribution 12
  - COBRA Continuation Coverage for Employees Who Have Elected Eligible Dependent Coverage 12
  - Qualifying Event 13
  - Disability Extension of 18-Month Period of Continuation Coverage 14
  - Second Qualifying Event Extension of 18-Month Period of Continuation Coverage 14
  - If You Have Questions 15
  - Duty to Keep Plan Administrator Informed of Address Changes 15
  - Payment for COBRA Coverage 15
  - Cancellation of COBRA Coverage 16

III. DEPENDENTS' ELIGIBILITY 17
- A. Eligible Dependents 17
- B. Dependents Not Eligible 18
- C. Mentally or Physically Disabled Child 18
- D. When Dependent's Coverage Begins 19
- E. When Dependent's Coverage Ends 19
- F. Surviving Spouse's Continuing Coverage 20

IV. RETIREE PROGRAM ELIGIBILITY FOR RETIRED EMPLOYEES 20
- A. Eligibility Requirements for Retired Employees 20

B. Retiree Must Not Be Actively Working at the Trade 21
C. Change of Eligibility Rules and Schedule of Benefits 21
D. Medicare Supplemental Benefits for Medicare-Eligible Retirees 22
E. Incorporation of Other Plan Documents 22
F. Termination of Benefits 22
G. Retired Employee's Surviving Spouse's Continuation 23

V. SCHEDULE OF BENEFITS 23
A. Eligible Active Employees, Dependents, and Retirees 23
B. Use of Preferred Provider Organization 25
C. Weekly Accident and Sickness Benefits 25
1. Benefits Available 26
2. Limitations 26
3. Submission of Claims 27
4. Appeals 28
5. When Benefits End 28
D. Death Benefits 28
E. Prescription Benefits 29
F. Exclusions from Coverage 29

V. DEFINITIONS 32
A. Accident 32
B. Agreement and Declaration of Trust or Trust Agreement 32
C. Association 32
D. Benefit Period 32
E. Benefit Verification 32
F. Billed Charges 32
G. Brand Name Prescription Drug 32
H. Claimant 32
I. Clinically Necessary 32
J. Coinsurance 33
K. Coinsurance Limit 33
L. Collective Bargaining Agreement 33
M. Contracting 33
N. Contracting Mail Order Pharmacy 33
O. Cosmetic or Reconstructive Surgery 33
P. Course of Treatment 34
Q. Coverage/Covered Services 34
R. Covered Charges 34
S. Copayment 34
T. Deductible 34
U. Doctor, Physician or Surgeon 35
V. Eligible Dependent 35
W. Eligible Employee, Covered Member or Covered Person 36
X. Eligibility Rules 37
Y. Employee 37
Z. Employer 37
AA. Employer Contributions 38
AB. Excess Charges 39
AC. Expense Incurred or Charges 39
AD. Experimental, Investigational or Medically Unproven 39
AE. Family or Family Member 40
AF. Formulary Brand Name Prescription Drug 40
AG. Generic Prescription Drug 40
AH. Health and Welfare Plan 40
AI. Hospital Confinement 40
AJ. Illegal and Willful Misconduct 40
AK. Illness 41

AL. Injury 41
AM. Inpatient 41
AN. Intensive Care Unit 41
AO. Lesser Amount 42
AP. Mail Order Prescription Drug 42
AQ. Medical Emergency 42
AR. Medically Necessary or Reasonably Necessary 42
AS. Negotiated Amount 42
AT. Newborn Care 43
AU. Non-Contracting 43
AV. Non-Covered Charges 43
AW. Non-Formulary Brand Name Prescription Drug 43
AX. Non-Occupational 43
AY. Non-Participating 44
AZ. Non-PPO Network Coinsurance 44
BA. Non-PPO Network Coinsurance Limit 44
BB. Non-PPO Network Provider 44
BC. Other Facility Provider 44
BD. Other Professional Provider 44
BE. Outpatient 45
BF. Out-of-Pocket Limit 45
BG. Participant 45
BH. Participating 45
BI. Plan 45
BJ. PPO Network Provider 45
BK. Pre-Existing Condition 45
BL. Prescription Drug Copayment 46
BM. Prescription Drug Covered Charges 46
BN. Prescription Order 46
BO. Provider 46
BP. Reasonable and Customary Charge or Amount 46
BQ. Rider 47
BR. Sickness 47
BS. Spouse 47
BT. Surgery 47
BU. Total Disability or Totally Disabled 47
BV. Trust Fund, Trust or Fund 48
BW. Trustee 48
BX. Union 48

VII. PROCEDURE FOR FILING A CLAIM 48
A. Types of Claims 48
B. Who Must File 49
C. When to File a Claim 49
D. Where to File a Claim 49
E. What to File 49
F. Method of Claims Delivery 49
G. Timing of Claims Determinations 49
H. Notice of Claims Denial (Adverse Benefit Determination) 50

VIII. PROCEDURE FOR APPEALING A CLAIM 51
A. First Level Review 51
B. Timetable for Deciding First Level Review 52
C. Notice of Decision on First Level Review 53
D. Second Level Review 53
E. Timetable for Deciding Second Level Review 54
F. Notice of Decision on Second Level Review 55
G. Voluntary Appeal to Full Board of Trustees 55

H. Commencement of Legal Action 56
IX. ASSIGNMENT OF BENEFITS 56
X. COORDINATION OF BENEFITS 56
A. Order of Benefit Determination 57
B. Plan Benefit Limits 58
C. Plan Rights 58
XI. PLAN'S RIGHT TO SUBROGATION, REIMBURSEMENT AND RESTITUTION 59
A. Definitions 59
B. Subrogation and Reimbursement Rights 59
XII. QUALIFIED MEDICAL CHILD SUPPORT ORDERS 61
XIII. FAMILY AND MEDICAL LEAVE 62
XIV. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT 62
A. Definition of Protected Health Information 63
B. Permitted Disclosure of Enrollment/Disenrollment Information 63
C. Permitted Uses and Disclosure of Summary Health Information 63
D. Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administrative Purposes 64
E. Conditions of Disclosure for Plan Administration Purposes 64
F. Adequate Separation between Plan and Plan Sponsor 65
G. Certification of Plan Sponsor 65
XV. MISCELLANEOUS PROVISIONS 66
A. Change of Plan Provisions 66
B. Change in Terms 66
C. Amendment and Termination 66
D. Authority to Interpret Plan 66
E. Legal Actions 67
F. Right to Receive and Release Necessary Information 67
G. Right of Recovery 67
H. Nondiscrimination Rights 67
I. Prohibited Discrimination 68
(1) Eligibility to Enroll 68
(2) Premium Contributions 69
J. Guaranteed Renewability 69
K. Employment Rights 69
L. Medical Examination 70
M. Trustee Rights 70
N. Payment of Benefits 70
O. Delinquent Contributions 70
P. Post-Mortem Benefits 71
Q. Right of Recovery 71
R. Compliance with Claim Rules 71
S. Governing Laws 71
XVI. SPECIAL NOTICE REGARDING MASTECTOMY COVERAGE 71
XVII. REQUIREMENTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 72
XVIII. STATEMENT OF ERISA RIGHTS 72
A. Receive Information about Your Plan and Benefits 72
B. Continue Group Health Coverage 73
C. Prudent Actions by Plan Fiduciaries 73
D. Enforce Your Rights 73
E. Assistance with Your Questions 74

INTRODUCTION

This booklet, distributed in June 2005, 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 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, 2199 Fifth Street, SW, Akron, Ohio 44314.

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.

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 their authority to select and retain a professional Administrator, have 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
Michael Dorsey,First Alternate
Michael Cotyk, Second Alternate
Rollin Reth, Third Alternate

EMPLOYER TRUSTEES
Carl E. Hughes II
Charles R. White

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

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

Allotta, Farley & Widman Co., L.P.A.
2222 Centennial Road
Toledo, Ohio 43617
Phone: (419) 535-0075
Fax: (419) 535-1935
Email: labor@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

Prior to June 1, 2005, eligible Local 84 members participated in the National Asbestos Workers Medical Fund. If you were a Local 84 member on May 31, 2005 and participated in the National

Asbestos Workers Medical Fund on that date, you will automatically be covered by the Health Plan on June 1, 2005 and receive coverage for June, July, and August 2005. Likewise, if you are a Local 84 member in good standing on May 31, 2005 and contributions for at least one thousand (1,000) hours were required to be made on your behalf during the period beginning January 1, 2004 and ending April 30, 2005, you will automatically be covered by the Health Plan on June 1, 2005 and receive coverage for June, July, and August 2005. If you did not satisfy the one thousand (1,000) hours requirement at that time, you may satisfy the requirement by making a self-contribution equal to $.91 multiplied by the number of hours by which you have fewer than one thousand (1,000) hours.

Otherwise, you will become initially eligible for coverage under the Health Plan on the first day of the calendar month following the date on which contributions for at least one hundred forty (140) hours, at the rate established by the current collective bargaining agreement, were required to be made on your behalf during a calendar month by one or more participating Employers. In the alternative, you can satisfy the Health Plan's eligibility requirements on the first day of the calendar month following the date on which contributions for at least two hundred twenty-four (224) 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 contributions on your behalf for one hundred forty (140) hours in January, you would begin your coverage under the Health Plan on April 1.

Any hours accumulated in excess of one hundred forty (140) in any calendar month will be credited to your Reserve Hours. Once you become eligible, you will remain eligible if you meet the minimum working requirements set forth in the following schedule:

Work Month	Minimum Number of Hours Required in the Following Months	Month Participant is Eligible for Benefits
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

B. 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 required to be 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. 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. The amount due is the number of hours by which you are short of one hundred twelve (112) hours multiplied times the current hourly rate. The maximum number of self-contributions that an active Eligible Employee may make is twelve (12) 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 10th 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 M and N below.

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, you will again become eligible to participate in the Plan upon the completion of the initial eligibility requirements set forth in Article I, Section A, "Initial Eligibility," above. Your eligibility 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.

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 accrued under the National Asbestos Workers Medical Fund. Any Reserve Hours you accumulate between June 1, 2005 and December 31, 2005 may not be used to provide continuous eligibility under this Plan until January 1, 2006.

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 M and N 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. 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.

G. 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.

H. 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.

I. 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. 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.

J. 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.

(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.

Accordingly, 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.

K. Change in Classification or the Amount of Coverage

The amount of coverage based on your classification is shown in the schedule of benefits.

(1) if the change involves an increase in coverage, the change will take effect on the day of the change; and

(2) if the change involves a decrease in coverage, the change will take effect on the day of the change.

L. When Coverage Ends

Your coverage will end at midnight on the earliest of:

(1) the day the policy ends; or

(2) the day any premium 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 describe in Article II, Section I 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.

M. 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.

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

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:

(1) Your hours of employment are reduced, or

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

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."

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.

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.

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

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**.

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.

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^{th}) 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.

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

The following are not Eligible Dependents:

(1) The divorced spouse or any married child of yours; or

(2) An individual eligible for coverage under the Plan as an Employee or member; or

(3) A child who has attained the limiting age. The limiting age is:

(i) the child's 19th birthday; or

(ii) the child's 24th birthday if the child is a full-time student.

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:

(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 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

(2) the day any premium is due and unpaid; or

(3) the day the Plan terminates; or

(4) the day before a Dependent enters military service on active duty; or

(5) 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. 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 in Article II, Sections N and O above. In the event that more than one continuation provisions applies, the periods of continued coverage will run concurrently.

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 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 10th 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. Effective June 1, 2005, the monthly self-payments for participation by retired members are as follows:

Medicare Eligible	$200 - single $250 - married $50 for each additional Dependent
Non-Medicare Eligible	$450 - single $550 - married $50 for each additional Dependent
One Medicare Eligible/One Non-Medicare Eligible	$550 - married $50 for each additional Dependent

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 in Article II, Sections N and O above.

B. Retiree Must Not Be 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 as an instructor in a recognized apprenticeship program of the Asbestos Workers. Your coverage will terminate on the first day of the month following the month in which you 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. 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, your coverage as a Retiree will terminate once you become eligible as an active eligible Employee or when you are 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

requirements include 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 in Article II, Sections N and O above. In the event that more than one continuation provisions applies, the periods of continued coverage will run concurrently.

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
Annual Physical	Maximum per eligible person, per Plan Year	$200	$200
Individual Deductible	Maximum per eligible person, per Plan Year	$250	$250
Family Deductible	Maximum per family, per Plan Year	$500	$500

Basic Benefit	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 allowance
	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
Maximum Benefit	Per eligible person, per lifetime	$500,000	$500,000

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 E. below.**

Benefits with Specific Maximums	
Annual Physical	$200 per person; no co-pay or out-of-network penalty applied. Includes routine office visits and immunizations.
In Patient Mental and Nervous	Paid the same as all other in-patient confinements.
Out Patient Mental and Nervous	Limited to 25 visits per Plan Year.
In Patient Substance Abuse	$5,000 maximum per treatment; lifetime limit of two treatments (two treatments must be separated by three years).
Out Patient Substance Abuse	Limited to 25 visits per Plan Year; $2,500 annual maximum; $5,000 lifetime maximum.
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.

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 Caremark, Inc. ("Caremark"). Your prescription drug benefits are more fully described in the prescription drug benefit booklet prepared by Caremark. 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 Caremark.

Maximum Prescription Benefit per Plan Year		$12,000 individual $25,000 family
Retail Prescription, up to 30-day supply	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 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 les $70 co-pay

When you take a medication on a routine basis to treat a medical condition, it is considered a maintenance medication. **Your plan now requires use of a Caremark Mail Service Pharmacy after 3 fills of a maintenance medication at a retail pharmacy.**

Exclusions include vitamins, Rogaine, Viagra, fertility drugs, erectile dysfunction drugs, smoking cessation drugs, and biotech and specialty injectible drugs. 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"), Medical Mutual of Ohio (hereinafter "MMO"), to provide a network of physicians, hospitals, and other medical service providers. MMO 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 on pages 23-25 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 through the twenty-sixth (26^{th}) 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 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 (2) 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 (84) days of the receipt of your approved claim form. 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 option, 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 in a lump sum in the amount set forth in the Schedule of Benefits on pages 23-24. The death benefit for active Employees is different from the death benefit for Retirees. If the Participant's designated beneficiary is no longer living upon the Participant's death, the death benefit will be paid in a lump sum to 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 on pages 23-24 and the prescription drug benefit booklet prepared by Caremark, the Plan's prescription drug benefit administrator.

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 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-fractions, and the fitting of eyeglasses and hearing aids.

(3) Injuries caused by declared or undeclared war.

(4) Plastic 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 provided in the Schedule of Comprehensive Medical Benefits in A. 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 an individual who ordinarily resides in the patient's home or is related to the patient by blood or marriage.

(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 for the treatment of the patient's Illness or Injury.

(12) Services, treatment, drugs and supplies which are experimental or investigational in nature, 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 Usual, Customary and Reasonable 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.

(23) Occupational therapy or rehabilitation, except following Illness or Injury.

(24) Physical therapy, unless required for rehabilitation following Surgery.

(25) Services provided or paid for by any other group health plan sponsored by an employer.

(26) Charges for treatment of intentionally self-inflicted Injury, or Injury sustained in the act of committing a crime.

(27) Charges for dietary control.

(28) Services or supplies not specifically listed as a covered service.

(29) Non-legend drugs.

(30) Vitamins (except prescription prenatal vitamins), minerals, dietary supplements, dietary drugs, etc.

(31) Medications which can be legally purchased over the counter without a prescription, even if prescribed by a doctor.

(32) Therapeutic devises or appliances.

(33) Hypodermic needles or syringes (except those associates with insulin injection).

(34) Genetically engineered drugs.

(35) Anabolic steroids.

(36) Diet Aids.

(37) Fluoride.

(38) Treatments for Temporo-Mandibular Joint dysfunction.

(39) Infertility treatments.

(40) Charges for treatment of obesity.

(41) Charges in excess of the limits provided by the Plan.

V. 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 MMO 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. Claimant

"Claimant" means the person making the claim.

I. Clinically Necessary

"Clinically Necessary" means a service or supply that is required to diagnose or treat a Condition and which MMO 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.

J. 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.

K. Coinsurance Limit

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

L. 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.

M. Contracting

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

N. 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 Caremark to provide the services.

O. 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) medical and surgical benefits with respect to a masectomy will be covered for Eligible Participants and Dependents of the Plan who elect breast reconstruction in connection with such masectomy 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.

P. Course of Treatment

"Course of Treatment" means a planned series of procedures or treatments performed by a Dentist.

Q. 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.

R. Covered Charges

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

S. 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.

T. 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.

U. 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.

V. Eligible Dependent

"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:

(1) An Eligible Employee's legal Spouse, while not divorced or legally separated from the Eligible Employee.

(2) 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 3 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 3 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 2. Determination of whether such unmarried child qualifies as an Eligible Dependent pursuant to this paragraph 2 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 2 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 2, if subsequent to such a determination the conditions in this paragraph 2 to qualify as an Eligible Dependent are not met. Determination will be made by the Trustees in their sole discretion and will be conclusive.

(3) 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 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 shall be required by the Fund Office annually.

(4) 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 reach age nineteen (19), or twenty-four (24) if covered under Paragraph 3 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. The limiting age is the unmarried child's 19th birthday or the child's 24th 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.

(5) 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.

W. 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.

X. Eligibility Rules

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

Y. 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, and (iv) 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.

(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.

Z. 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.

(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.

(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.

(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.

(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.

(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.

(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.

AA. Employer Contributions

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

AB. Excess Charges

"Excess Charges" means the amount of Billed Charges less Non-Covered Charges, in excess of the Covered Charges determined by MMO 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.

AC. 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.

AD. 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.

AE. 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.

AF. 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.

AG. 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.

AH. Health and Welfare Plan

"Health and Welfare Plan" means the plan, program, methods and procedures for the payment of benefits from the Trust Fund (directly or indirectly) 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.

AI. 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.

AJ. 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.

AK. 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.

AL. 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.

AM. Inpatient

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

AN. 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.

AO. 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).

AP. Mail Order Prescription Drug

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

AQ. 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.

AR. 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.

AS. Negotiated Amount

"Negotiated Amount" means the amount the Provider has agreed with Medical Mutual of Ohio ("MMO") 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, MMO may have an agreement or arrangement with a vendor which purchases the services, supplies or products from the Provider instead of MMO contracting directly with the Provider itself. In these circumstances, the Negotiated Amount will be based upon the agreement or arrangement MMO 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.

AT. 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.

AU. 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.

AV. Non-Covered Charges

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

AW. 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.

AX. 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.

AY. Non-Participating

"Non-Participating" means the status of a Physician or Other Professional Provider that does not have an agreement with MMO about payment for Covered Services.

AZ. 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.

BA. 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.

BB. 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 MMO as a PPO Network Provider.

BC. 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. MMO 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 MMO 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.

BD. Other Professional Provider

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

X dentist;
X doctor of chiropractic medicine;
X durable medical equipment or prosthetic appliance vendor;
X laboratory (must be Medicare Approved);
X licensed practical nurse (L.P.N.);
X licensed vocational nurse (L.V.N.);
X mechanotherapist (licensed or certified prior to November 3, 1975);
X nurse-midwife;
X occupational therapist;
X Pharmacy;
X physical therapist;
X podiatrist;

X Psychologist;
X registered nurse (R.N.); and
X Urgent Care Provider.

BE. Outpatient

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

BF. Out-of-Pocket Limit

"Out-of-Pocket Limit" means the Coinsurance which are 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 are 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 lifetime, annual or other Plan maximums; or

4. Any expenses for Covered Services which require a Copayment.

BG. 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.

BH. Participating

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

BI. Plan

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

BJ. 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 MMO and for which the greatest benefit will be payable when one of these Providers is used.

BK. 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.

Effective January 1, 1998, 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.

BL. Prescription Drug Copayment

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

BM. Prescription Drug Covered Charges

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

BN. 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.

BO. Provider

"Provider" means a Hospital, Other Facility Provider, Physician or Other Professional Provider.

BP. 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.

BQ. Rider

"Rider" means a provision added to the insurance policy to expand or limit benefits or coverage.

BR. 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.

BS. 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.

BT. 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.

BU. 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 , in the opinion of the Board of Trustees, 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.

BV. 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.

BW. 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 in the Act.

BX. Union

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

VII. 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. There are two special kinds of pre-service claims:

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 (84) 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 (84), 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) 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.

VIII. 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 your 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 your 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 you 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 United States Department of Labor office and/or your state insurance regulatory agency"; and

(7) 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 Benefits Committee for the Board of Trustees is final and binding.

G. 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.

H. 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 hundred eighty (180) days of receiving the final review notice under these procedures.

IX. 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.

X. COORDINATION OF BENEFITS

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:

(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:

A. 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.

XI. PLAN'S RIGHT TO SUBROGATION, REIMBURSEMENT AND RESTITUTION

A. Definitions

(1) "Subrogation" shall mean the Plan's right to recover any benefit payment:

(i) because of injury or illness to You or Your dependent caused by either You or a third party's conduct; and

(ii) You or Your dependent later recover from a third party's insurer or Your own insurer.

(2) "Third party" shall mean another person or organization.

(3) "Reimbursement" shall mean repayment to the Plan for, any benefit, including but not limited to medical, dental or vision that the Plan paid toward care and/or treatment for an injury or illness.

(4) "Constructive Trust" shall mean a trust in which any amount, compensation and/or money You recover shall be deemed to be held for Your exclusive benefit and not commingled with other funds. Any such Constructive Trust shall be subject to an equitable lien by the Plan and any other equitable remedies available to the Plan under ERISA Section 502(a)(3) for the purpose of preserving the Plan's right to restitution for benefits paid by the Plan on Your behalf.

(5) "You" or "Your" shall mean the following: You, Your dependents and/or Your or Your dependent's heirs, estate or assigns. Therefore, all references herein to "You" shall also include Your dependents and/or Your or Your dependents heirs, estate and assigns.

B. Subrogation and Reimbursement Rights

(1) To the extent of any payment made under the Plan, the Plan shall be subrogated to Your rights of recovery, which rights arise from any claim or cause of action which may occur because of Your or a third party's conduct. This right of subrogation and reimbursement extends to any

recovery received by You, 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. The Plan has a first priority on any recovery. You and Your 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 You are made whole or fully compensated. The Plan will not pay future claims to the extent of any recovery You received in the past in connection with an accident, unless the Plan's claim for subrogation or reimbursement has been satisfied.

(2) You and Your representatives are required to provide all assistance and cooperation requested by the Plan so that the Plan can exercise its subrogation and reimbursement rights**.** If You or Your 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 You cooperate to the satisfaction of the Plan. In addition, if You fail to cooperate and/or pay the Plan the full amount owed, the Plan shall have the right to withhold Your payment(s) for future or different claims on behalf of Yourself or Your dependents until the amount owed in the subrogation or reimbursement claim, in the estimation of the Plan, has been obtained through the withholding of the claims.

(3) You and Your attorney are required to sign the Plan's subrogation and reimbursement agreement, which is a contract, prior to the Plan's payment of any benefits on Your behalf for any injury or illness resulting from the actual or alleged negligent conduct of a third party. This Plan's subrogation 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 and reimbursement agreement You sign will obligate You, among other things, to reimbursement the Plan for any benefits paid by the Plan if You recover any moneys 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 You recover under Your own insurance coverage, including uninsured or underinsured coverage. If You are represented by an attorney, Your attorney is also required to sign the subrogation and reimbursement agreement. If You do not have an attorney at the time of signing the subrogation and reimbursement agreement but You subsequently are represented by an attorney, You are required to have Your attorney sign a subrogation and reimbursement agreement at the time Your attorney begins representing You.

(4) If You and Your attorney do not sign a subrogation and reimbursement agreement**,** and the Plan Administrator later learns that benefits were paid to You or on Your behalf because of medical treatment which was rendered due to the negligent (actual or alleged) conduct of a third party or You, the Plan has the right to stop benefit payments and/or deny all future applications for the payment of benefits of whatever kind until You sign a subrogation and reimbursement agreement. In addition, You and Your attorney are obligated to avoid doing anything that would prejudice the Plan's right of subrogation and reimbursement.

(5) If litigation is commenced, the Plan may cause to be recorded a Notice of Payment of Benefits, and such notice will constitute a lien on any judgment recovered less a pro rata of court costs. Further, if litigation is commenced, You and Your 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 and reimbursement rights. The Plan shall have the right to intervene in any litigation involving You to protect its subrogation and reimbursement rights. Any action taken by the Plan to protect its subrogation and reimbursement rights shall be without any charge or cost to You. However, the Plan shall not be liable to pay Your attorney fees or costs or Your attorney or his/her costs.

(6) If You fail to make a claim or file a lawsuit against the responsible party or parties or insurance company or any other entity, the Plan may sue, compromise or settle in Your name all claims and may execute and sign releases and endorse checks or drafts given in settlement of such claims in Your name with the same force and effect as if You had executed and endorsed them. You and Your attorney agree to cooperate fully with the Plan in the prosecution of such claims and to attend court and testify if the Plan, in its sole discretion, deems Your attendance and testimony to be necessary.

XII. 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.

XIII. 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.

XIV. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

A. Definition of Protected Health Information

The Board of Trustees of the Insulators Local 84 Health Care Plan (the "Plan Sponsor") sponsors the Plan. The Plan's administrative staff may have access to the individually identifiable health information of Plan participants required for administrative functions of the Plan. When this health information is provided from the Plan to the Plan Sponsor, it is Protected Health Information ("PHI").

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations restrict the Plan Sponsor's ability to use and disclose PHI. The following HIPAA definition of PHI applies to this Plan:

> *Protected Health Information.* Protected health information means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present, or future payment for provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased.

The Plan Sponsor will have access to PHI from the Plan only as required or permitted by HIPAA.

B. Permitted Disclosure of Enrollment/Disenrollment Information

The Plan (or a health insurance issuer) may disclose to the Plan Sponsor information on whether an individual is participating in the Plan.

C. Permitted Uses and Disclosure of Summary Health Information

The Plan (or a health insurance issuer) may disclose Summary Health Information to the Plan Sponsor, provided the Plan Sponsor requests the Summary Health Information for the purpose of:

(1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or

(2) modifying, amending, interpreting or terminating the Plan.

"Summary Health Information" means:

(1) information that summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a health plan; and

(2) information from which certain confidential information described in HIPAA has been deleted, except that certain geographic information need only be aggregated to the level of a five-digit zip code.

D. Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administrative Purposes

Unless otherwise permitted by law, and subject to the conditions of disclosure described in E. below and obtaining written certification pursuant to G. below, the Plan (or a health insurance issuer) may disclose PHI to the Plan Sponsor, provided the Plan Sponsor uses or discloses such PHI only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Plan Sponsor on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor, and they do not include any employment related functions.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with HIPAA.

E. Conditions of Disclosure for Plan Administration Purposes

The Plan Sponsor agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Plan (or a health insurance issuer), the Plan Sponsor will:

(1) Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law.

(2) Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI.

(3) Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

(4) Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.

(5) Make available PHI to comply with HIPAA's right to access in accordance with applicable provisions of HIPAA.

(6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with applicable provisions of HIPAA.

(7) Make available the information required to provide an accounting of disclosures in accordance with applicable provisions of HIPAA.

(8) Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements.

(9) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(10) Ensure that the adequate separation between the Plan and the Plan Sponsor (i.e., the "firewall"), required by HIPAA, is satisfied.

The Plan Sponsor further agrees that if it creates, receives, maintains, or transmits any *electronic PHI* (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the covered entity, it shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI, and it shall ensure that any agents (including subcontractors) to whom it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect the information. For these purposes, "electronic PHI" means any PHI that is transmitted by, or maintained in, electronic media. The Plan Sponsor shall report to the Plan any security incident of which it becomes aware.

F. Adequate Separation between Plan and Plan Sponsor

The Plan Sponsor will allow third party service providers access to the PHI, subject to business associate agreement restrictions. No other persons will have access to PHI. These specified individuals or entities will only have access to and use PHI to the extent necessary to perform the plan administration functions that the Plan Sponsor performs for the Plan. In the event that any of these service providers do not comply with the provisions of this Section, that service provider will be subject to termination pursuant to the business associate agreement in place. The Plan Sponsor will ensure that the provisions of this Section are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

G. Certification of Plan Sponsor

The Plan (or a health insurance issuer) will disclose PHI to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Plan has been amended to incorporate

applicable provisions of HIPAA, and that the Plan Sponsor agrees to the conditions of disclosure set forth in E. above.

XV. 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 without advance notice to you or your Dependent, 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 his/her surviving spouse, if any, and otherwise to 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 the law of the State of Ohio.

XVI. 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:

A. Reconstruction of the breast on which the mastectomy was performed;

B. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

C. 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.

XVII. 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.

XVIII. 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.

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