

RESTATED SUMMARY
PLAN
DESCRIPTION
FOR THE

***ASBESTOS WORKERS
SYRACUSE
WELFARE FUND***

Effective Date: January 1, 2013



ASBESTOS WORKERS SYRACUSE WELFARE FUND
150 Midler Park Drive
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TO: PARTICIPANTS IN THE ASBESTOS WORKERS SYRACUSE WELFARE FUND

FROM: TRUSTEES OF THE ASBESTOS WORKERS SYRACUSE WELFARE FUND

DATE: January 1, 2013

This booklet is a description of the Welfare Plan as it is in effect on January 1, 2013. You will find that the benefits are described, as well as the eligibility requirements that you must satisfy. These and other matters are discussed in the six major parts of the booklet as follows:

- General Information (Part A.)
- Description of Benefits (Part B.)
- Self-Pay Coverage (Part C.)
- Claim and Appeal Procedure (Part D.)
- Miscellaneous Plan Provisions (Part E.)
- Technical Details (Part F.)

This section of the booklet is required to be given you under the terms of the Employee Retirement Income Security Act of 1974 and contains many technical details of the plan intended to ensure you that you will be able to enjoy all the rights to which you are entitled under the provisions of the plan.

It is in your interest and that of your family to familiarize yourself completely with this booklet. If, after having gone through the booklet thoroughly, you have any questions regarding the plan or its operation, please do not hesitate to contact the plan office. You may also direct questions to the Trustees, in writing.

Sincerely,

Board of Trustees

ASBESTOS WORKERS SYRACUSE WELFARE FUND

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IMPORTANT ASPECTS OF YOUR WELFARE PLAN

- FAMILIARIZE YOURSELF WITH THE **WHOLE** BOOKLET.
- **ALL** BENEFITS MUST BE **APPLIED FOR**.
- MAKE SURE THAT THE PLAN OFFICE IS AWARE OF ALL YOUR **DEPENDENTS** AND YOUR **CURRENT** ADDRESS.
- YOU **MUST** NOTIFY THE FUND OFFICE IF YOU AND YOUR SPOUSE **DIVORCE** OR IF YOUR DEPENDENT CHILD **CEASES TO QUALIFY AS A DEPENDENT** UNDER THE TERMS OF THE PLAN.
- ALL CLAIM FORMS MUST BE **COMPLETELY** FILLED IN; INCOMPLETE ONES WILL BE **RETURNED**.

PLAN CHANGE OR TERMINATION

The Trustees reserve the right to change or discontinue (1) the Plan, (2) the types and amounts of benefits under the plan, and (3) the eligibility rules.

Benefits provided by the plan:

- are not guaranteed;
- are not intended or considered to be deferred income;
- are subject to the rules and regulations adopted by the Trustees; and
- may be modified or discontinued at any time and such modification or termination is not contingent on financial necessity.

The nature and amount of plan benefits are always subject to the actual terms of the plan as it exists at the time the claim occurs.

MODIFICATION OF BENEFITS AND ELIGIBILITY RULES FOR ALL PARTICIPANTS, INCLUDING EMPLOYEES AND DEPENDENTS

This Summary Plan Description includes information concerning the benefits provided by the Trustees to participants and their eligible dependents, and the circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture, or suspension of benefits that an employee or dependent might otherwise reasonably expect the plan to provide.

The benefits and eligibility rules applicable to employees and dependents have been established by the Trustees as part of an overall benefit plan for participants. The right to amend or modify the eligibility rules and plan of benefits for employees and dependents is reserved by the Trustees in accordance with the Agreement and Declaration of Trust. The continuance of benefits for employees and dependents and the eligibility rules relating to qualification therefore are subject to modification and revision by the Trustees in accordance with their responsibility and authority contained in the Agreement and Declaration of Trust.

In accordance with the rules and regulations of the plan and the Trust Agreement, no participant or dependent has a vested right or contractual interest in any of the benefits provided. In addition to the right to terminate benefits of employees and/or dependents at any time, the Trustees also reserve the right to terminate the plan of benefits for employees and/or dependents and there shall not be any vested right by any employee or dependent or beneficiary nor contractual rights after the disposition of all plan assets and the termination of the plan. Employees and dependents shall have no priority with respect to the disposition of plan assets in connection with the termination of this plan. The provision for employees' and dependents' coverage shall be reviewed periodically by the Trustees.

IMPORTANT NOTICE

Nothing in this booklet is meant to interpret or extend or change in any way the provisions expressed in the insurance policies that may be purchased by the Trustees. The Trustees reserve the right to amend, modify, or discontinue all or part of this plan whenever, in their judgment, conditions so warrant. This booklet describes the plan as it exists on January 1, 2013.

CAUTION

This booklet and the personnel at the plan office are authorized sources of plan information for you. The Trustees of the plan **have not empowered any one else** to speak for them with regard to the plan. No employer, union representative, supervisor or steward is in a position to discuss your rights under this plan with authority.

COMMUNICATIONS

If you have a question about any aspect of your participation in the plan, you should, for your own permanent record, write to the Administrative Manager or Trustees. You will then receive a written reply, which will provide you with a permanent reference.

NO GUARANTEE OF INCOME TAX CONSEQUENCES

Neither the Board of Trustees nor the Fund Office makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for Federal or State income tax purposes, or that any other Federal or State tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for Federal and State income tax purposes, and to notify the Fund Office if the Participant has reason to believe that any such payment is not so excludable.

CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION

A federal law, the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan’s privacy notice, which will be distributed to you in accordance with HIPAA and which is available from the Plan’s Privacy Official, the Administrative Manager.

This Plan, and the Plan Sponsor (the Plan Sponsor for HIPAA purposes is Asbestos Workers Syracuse Welfare Fund), will not use or further disclose information that is protected by HIPAA (“protected health information” or “PHI”) except as necessary for treatment, payment, health care operations and plan administration, or as permitted or required by law.

“Payment” includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and the provision of plan benefits that relate to an individual to whom health care is provided. The activities include, but are not limited to, the following:

- (a) determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and co-payments as determined for an individual’s claim);
- (b) coordination of benefits;
- (c) adjudication of health benefit claims (including appeals and other payment disputes);
- (d) subrogation of health benefit claims;
- (e) establishing employee contributions;
- (f) risk adjusting amounts due based on enrollee health status and demographic characteristics;
- (g) billing, collection activities and related health care data processing;
- (h) claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
- (i) obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- (j) medical necessity reviews or reviews of appropriateness of care or justification of charges;
- (k) utilization review, including pre-certification, preauthorization, concurrent review and retrospective review;
- (l) disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and
- (m) reimbursement to the plan.

“Health Care Operations” include, but are not limited to, the following activities:

- (a) quality assessment;
- (b) population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- (c) rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;
- (d) underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
- (e) conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- (f) business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
- (g) business management and general administrative activities of the Plan, including, but not limited to:
 - (1) management activities relating to the implementation of and compliance with HIPAA’s administrative simplification requirements, or
 - (2) customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;
- (h) resolution of internal grievances; and
- (i) due diligence regarding a merger with a potential successor in interest, if the potential successor in interest is a “covered entity” under HIPAA or, following completion of the merger, will become a covered entity.

Only the employees of the Asbestos Workers Syracuse Welfare Fund who assist in the Plan’s administration will have access to your protected health information. These individuals may only have access to use and disclose your protected health information for plan administration functions that the Plan Sponsor performs for the Plan. This Plan provides a complaint mechanism for resolving noncompliance matters. If these individuals do not comply with the above rules, they will be subject to disciplinary sanctions.

By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose your protected health information for employment related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

HIPAA provides that this Plan may disclose your protected health information to the Plan Sponsor only upon receipt of a Certification by the Plan Sponsor that it agrees to the following: (a) not use or further disclose the information other than as permitted or required by the plan documents or as required by law; (b) ensure that any agents, including a subcontractor, to whom it provides protected health information received from this Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information; (c) not use or disclose the information for employment related actions in connection with any other benefit or employee benefit plan of the Plan Sponsor; (d) report to this Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware; (e) make available protected health information; (f) make available protected health information for amendment and incorporate any amendments to protected health information; (g) make available the information required to provide an accounting of disclosures; (h) make its internal practices, books, and records relating to the use and disclosure of protected health information received from this Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by this Plan; (i) if feasible, return or destroy all protected health information received from this 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 the 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; and (j) maintain adequate separation between the Plan and the Plan Sponsor. The Plan Sponsor has made such Certification to the Administrative Manager and the participating insurance carriers.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with this Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan's privacy notice provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, please contact the Administrative Manager. If you have questions about the privacy of your health information or if you wish to file a complaint under HIPAA, please contact the Administrative Manager.

The Plan Sponsor will:

- (a) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains or transmits on behalf of the Plan;
- (b) ensure that the adequate separation between the Plan and the Plan Sponsor, as required by HIPAA, with respect to electronic protected health information, is supported by reasonable and appropriate security measures;
- (c) ensure that any agent, including a subcontractor, to whom it provides electronic protected health information agrees to implement reasonable and appropriate security measures to protect the information;
- (d) report to Plan any security incident of which it becomes aware concerning electronic protected health information; and
- (e) appoint the Administrative Manager as the HIPAA Security Official.

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PART A.
GENERAL INFORMATION

SECTION 1. HOW THE FUND WORKS

1. WHAT BENEFITS ARE PROVIDED BY THE FUND?

Protecting yourself and your family against unexpected and burdensome health care expenses is undoubtedly one of your top priorities. As a person whose employment is governed by a collective bargaining agreement to which the Local No. 30, International Association of Heat & Frost Insulators & Asbestos Workers of the United States and Canada [the “Union” or “Asbestos Workers Local 30”] is a party or who is otherwise eligible to participate, you can have this important protection through the Fund.

The Fund helps you pay for medical care through its contract with Excellus BlueCross. The Schedule of Benefits and list of network providers is available to any participant and beneficiary who requests them, at no charge.

Part B of this Summary Plan Description describes the benefits provided by the Fund.

2. WHO PAYS THE COST OF PROVIDING THE FUND’S BENEFITS?

The cost of these benefits is paid through contributions made by your employer pursuant to a collective bargaining agreement or other written document. You do not contribute. However, you will be allowed to make personal contributions in certain situations to continue this valuable coverage if employer contributions for you end.

This booklet explains how the Fund works, who is eligible, what is covered, and how to file a claim when you have covered expenses. If you have any questions after you read this material, please feel free to contact the Fund Office for additional information.

3. HOW DOES THE FUND COLLECT MONIES AND PAY FOR THE BENEFITS?

The Fund provides important health care benefits for you and eligible members of your family. Here is generally how the Fund works:

- The Fund is established under the terms of collective bargaining agreements between various contractors and Asbestos Workers Local 30. A “contributing employer” is an employer who has a collective bargaining agreement with the Union and who is required to make contributions to the Fund on behalf of its employees. The Fund also

receives contributions from other employers pursuant to written agreements between them and the Fund.

- Contributing employers pay the cost of coverage. The amount they contribute is determined by your specific bargaining agreement or other written agreement. The Fund has been set up to receive these contributions.
- When you become a participant, an individual account with the Fund will be established for you. Contributions made by your employer to your individual account will be used to purchase health insurance for you and to pay for miscellaneous health care benefits.
- You remain eligible for coverage for health insurance premiums and for miscellaneous health care benefits as long as there is a sufficient amount in your account to pay the premiums for your coverage. Coverage terminates at the end of a month when there are not sufficient contributions in your account to pay the premiums for the coverage you have selected, unless you self-pay as described in Part C.
 - For life insurance, accidental death & dismemberment, and short-term disability you remain eligible for three-month periods or six-month periods, based on hours worked as described in Question 5 below.

4. WHAT IS THE PLAN YEAR?

For purposes of governmental reporting and maintaining the Fund's fiscal records, the fiscal year ends December 31 and the Plan Year is January 1 – December 31.

SECTION 2. GENERAL ELIGIBILITY REQUIREMENTS

5. HOW DO I INITIALLY BECOME ELIGIBLE TO PARTICIPATE IN ALL OF THE FUND BENEFITS?

You will become eligible for participation in all of the Fund benefits as follows: on

January 1 st	for 350 hours worked during September, October & November, or 700 hours worked June through November.
April 1 st	for 350 hours worked during December, January & February, or 700 hours worked September through February.

- July 1st for 350 hours worked during March, April & May, or 700 hours worked December through May.
- October 1st for 350 hours worked June, July & August, or 700 hours worked March through August.

6. WHEN DOES MY COVERAGE BEGIN?

Coverage begins on January 1st, April 1st, July 1st, and October 1st, as described in Question 5 of this section.

7. HOW DO I REMAIN ELIGIBLE TO PARTICIPATE IN THE FUND?

FOR HEALTH INSURANCE, AND MISCELLANEOUS HEALTH EXPENSE PERSONAL ACCOUNT PLAN BENEFITS: Once initial eligibility is obtained, health insurance coverage will continue as long as the required balance is maintained in your individual account, or you self-pay. The miscellaneous health expense coverage will continue only as long as the required balance is maintained in your individual account.

FOR LIFE INSURANCE, ACCIDENTAL DEATH & DISMEMBERMENT, AND SHORT-TERM DISABILITY INSURANCE: Once initial eligibility is obtained, coverage will continue for three-month periods or six-month period, based on hours worked as outlined in Question 5 above. Coverage will terminate if you fail to work the above-referenced 350 or 700 hours.

8. WHAT HAPPENS IF I NO LONGER WORK IN COVERED EMPLOYMENT?

FOR HEALTH INSURANCE, AND MISCELLANEOUS HEALTH EXPENSE PERSONAL ACCOUNT PLAN BENEFITS: If you terminate your employment under the bargaining agreement, your coverage under the Fund will continue for the remainder of the period during which there is money left in the account to pay the premium. You will then be allowed to make personal contributions in some cases to continue your coverage (See Part C.).

FOR LIFE INSURANCE, ACCIDENTAL DEATH & DISMEMBERMENT, AND SHORT-TERM DISABILITY INSURANCE: If you terminate your employment under the bargaining agreement, you may self-pay in order to keep the life insurance and accidental death and dismemberment insurance. You may not self-pay for the short term disability insurance. The cost of continuing life and accidental death and dismemberment insurance cannot be deducted from your individual account.

9. ARE OTHER MEMBERS OF MY FAMILY ELIGIBLE FOR BENEFITS?

Your Eligible Dependents for health insurance and other health related benefits include your legal spouse and your children to age 26 under your family coverage. Children include your natural children, your step-children, adopted children, or foster children. The Fund will also provide benefits pursuant to the terms of any Qualified Medical Child Support Order, as defined in Section 609 of ERISA. Your step-child, adopted child or foster child will become eligible for benefits on the earliest of the following: when the child starts living with you in a regular parent-child relationship; when a court of law accepts a consent to adopt and you enter into an agreement to support the child; or, when a court of law makes you legally responsible for the child's support and maintenance.

Under New York State law, health insurance coverage is expanded to include unmarried children through the age of 29 years if they are living or working in New York and not otherwise insured or eligible for health insurance through their own employers or Medicare. A separate premium will be charged for this coverage. Coverage ends when you (the parent) are no longer enrolled in this Plan, your adult child no longer meets the eligibility requirements or the premium for coverage is not paid in full within the required time period.



Mentally handicapped, developmentally disabled, or physically handicapped children over age 26 incapable of self-support may be covered under family coverage indefinitely at no additional cost. This condition must have happened before the dependent's coverage would have normally ended under the contract. A special application should be obtained from the Fund Office to cover such dependents. Once you complete this form, you must submit it to the Fund Office.

10. CAN I GET COVERAGE IF I LEAVE COVERED EMPLOYMENT TO SERVE IN THE MILITARY?

When a participant leaves employment for full-time Qualified Military Service, as defined by Federal law, the participant and his eligible dependents are permitted to elect to continue health care coverage under the Plan, subject to certain limitations under Federal law. This coverage, subject to the rules of the Plan, must last for up to twenty-four (24) months beginning on the date of your absence from employment. However, the coverage will terminate before the end of the twenty-four (24) month period if you enter Qualified Military Service and are discharged earlier and fail to make a timely application for reemployment upon discharge.

If you elect such continuation coverage, you will not be required to pay any premium for the first thirty (30) days of such coverage. However, thereafter, and until the cessation of such coverage, you will be required to make a monthly premium payment to the Plan, which will be based on the average cost that the Plan incurs annually per participant plus a two (2%) percent administrative charge.

11. COULD MY INDIVIDUAL ACCOUNT BE ELIMINATED DUE TO INACTIVITY?

An individual participant's account may be closed and the monies deposited in the general account of the Fund under the following circumstances:

- (a) No contributions have been made to the participant's individual account within the preceding twenty-four (24) months; and
- (b) No activity, whatsoever, has occurred in said account for the preceding twenty-four (24) months; and
- (c) No response to the Fund's inquiry has been received from a mailing to the participant's last known address.

A participant's account may be reestablished and the amount in the account at the prior closing re-deposited, if:

- (a) The participant makes application to the Trustees within three (3) years of the closing of the account; and
- (b) The Trustees determine, in their sole discretion, to re-establish the account upon being convinced that there existed good cause for the lack of activity in the account and for the lack of response to the Trustees' inquiry.

In the event a participant's account is closed pursuant to this provision, the participant shall not be entitled to any benefits from the Fund unless and until the participant's account has been re-established as described above.

SECTION 3. RETIREE BENEFITS

12. WHAT BENEFITS ARE AVAILABLE TO RETIREES?

Health benefits provided by Excellus BlueCross BlueShield are available to retirees on a self-pay basis once the balance in the participant's individual account has been used up. These benefits are described in detail in the contract provided to you by Excellus BlueCross BlueShield.

13. WHAT IS THE MEDICARE SUPPLEMENT PROGRAM?

A Medicare Supplement Program is available through the UnitedHealthcare Plan. In order to be eligible for this program the following conditions must be met:

- (1) You must be a retired participant of the Asbestos Workers Syracuse Welfare Fund or the legal spouse of the retired participant; and
- (2) You or your legal spouse must have enrolled in Part A and Part B Medicare coverage and pay the monthly Part B premium.

You must enroll in the program as soon as eligible. The eligibility period for those reaching age 65 is the first of the month in which your 65th birthday takes place.

SECTION 4. ENROLLMENT AND CHANGES IN COVERAGE

14. WHAT MUST I DO TO ENROLL IN THE FUND?

Participation in the Fund is not automatic. You need to enroll. It is your responsibility to:

- Obtain, complete, and return to the Fund Office enrollment documents, which include an enrollment form and application form for Excellus BlueCross BlueShield.

UNTIL THOSE FORMS, FULLY COMPLETED AND PROPERLY EXECUTED, ARE RETURNED TO THE FUND OFFICE, NEITHER YOU NOR YOUR BENEFICIARIES WILL BE ENTITLED TO ANY BENEFITS UNDER THE TERMS OF THE PLAN.

- Elect Single, Two Person (if available in your area), or Family Coverage.

Coverage cannot begin until your application has been completed.

15. WHAT IF MY FAMILY STATUS OR ADDRESS CHANGES?

It is important to notify the Fund Office of any change in your family status due to marriage, birth or adoption of a child, death, divorce or legal separation, or any change of address.

SPECIAL ENROLLMENTS: If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you will in the future be able to enroll yourself or your dependents in this plan,

provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you will be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

You and your dependents may also enroll in this plan if you (or your dependents) have coverage through Medicaid or a State Children’s Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends.

You and your dependents may also enroll in this plan if you (or your dependents) become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after you (or your dependents) are determined to be eligible for such assistance.

16. DOES THIS PLAN RECOGNIZE QUALIFIED MEDICAL CHILD SUPPORT ORDERS?

Yes. The Omnibus Budget Reconciliation Act of 1993 requires health plan administrators to recognize qualified medical child support orders (“QMCSOs”). A QMCSO is a court decree under which a court order mandates health coverage for a child. Under a QMCSO, children who might otherwise lose rights to benefits under a group health plan will be entitled to enrollment in a parent’s group health plan as “alternate recipients.” Both you and your beneficiaries can obtain, without charge, a copy of the Plan’s QMCSO procedures from the Fund Administrator.

Upon receipt of a medical child support order, the administrative manager will promptly notify the participant and each child of receipt of the order. The participant and each child will be notified within a reasonable period of time whether the order is qualified. A child may designate a representative to receive copies of any notices that are sent to the child. If it has been determined that the order is a Qualified Medical Child Support Order, the child will then be considered a participant under the Health Fund and will receive copies of summary plan descriptions, summary annual reports, and summaries of any amendments made to the plan according to current ERISA requirements.

SECTION 5. ALLOCATIONS TO INDIVIDUAL ACCOUNTS

17. WHAT HAPPENS TO THE MONEY RECEIVED FROM MY EMPLOYER?

Income received by the Fund from contributing employers is held in a Trust Fund for the purpose of providing benefits to covered employees and their

dependents, and defraying reasonable administrative expenses. The funds, assets, and reserves are held in custody and are invested by the Board of Trustees.

18. HOW WILL THE MONIES CONTRIBUTED ON MY BEHALF BE ALLOCATED?

Your Individual Account will have credited to it a portion of the contributions made to the Fund with respect to your hours of work. The remainder of the contributions is used to pay for administrative expenses and to provide benefits on a pooled, rather than individual account, basis. For example, effective May 1, 2009, hourly contributions made to the Fund on your behalf will have \$0.50 deducted for purposes of paying administrative costs. Prior to May 1, 2009, the Fund had deducted \$0.75 from each hourly contribution to pay for administrative expenses. Please note the any monies that have accumulated in accounts for individuals who have not met the eligibility requirements set forth in Section 2 will be forfeited to the administrative account at the end of the Plan Year.

PART B.
DESCRIPTION OF BENEFITS

INDIVIDUAL ACCOUNT BENEFITS

SECTION 6. HEALTH INSURANCE BENEFIT

19. WHAT IS COVERED BY THE FUND'S HEALTH INSURANCE BENEFIT?

As a participant in the Fund, you and your eligible dependents are covered by excellent health benefits. The health insurance benefit includes Hospitalization, Medical, Surgical and Prescription Drug coverage provided by insurance policies purchased from Excellus BlueCross BlueShield. Detailed descriptions of these benefits are provided in certificates issued by the insurance carrier.

20. HOW ARE THE COSTS FOR THIS BENEFIT PAID?

Each month the charges for this coverage will be subtracted from your account so long as your account balance is sufficient to cover the total monthly charges. If your account runs out, you will be permitted to self-pay for your medical premiums under certain conditions. The self-pay provisions are described in Part C.

The health insurance benefit is available to you, as an eligible participant, your lawful spouse, and your eligible dependent children. If your spouse and/or dependent children are already covered under your spouse's employer's health care plan, you may elect "single" or "parent and child" insurance protection only. If you, yourself, are also covered under your spouse's health care plan or some other employer health care plan, you may elect NOT to be covered under the Fund's health insurance benefit. However, in order to forego coverage for your dependents or yourself, you must show the Trustees that the coverage of your dependents (and/or, you) under your spouse's employer's (or other employer's) health care plan meets certain standards set down by the Trustees. The Administrative Manager will let you know what these standards are if you contact the Fund Office. Further, if through no fault of your own such other health coverage stops (except for COBRA), your coverage under the health insurance benefit will start again immediately provided your account is large enough to cover the total charges for the entire month or you make the appropriate self-payment.

21. ARE THERE ANY RESTRICTIONS TO THE LENGTH OF STAY FOR A MOTHER OR NEWBORN IN CONNECTION WITH CHILDBIRTH?

In accordance with Federal Law, the Plan 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 normal vaginal delivery, or less than

ninety-six (96) hours following a cesarean section, or require that a provider obtain authorization from the insurance issuer for prescribing a length of stay not in excess of the above periods. However, Federal Law does not prohibit the mothers' or newborns' attending provider, after consulting with the mother, from discharging the mother or her newborn at an earlier time.

SECTION 7. MISCELLANEOUS HEALTH-RELATED BENEFITS

22. WHAT OTHER HEALTH-RELATED BENEFITS AM I ENTITLED TO?

Aside from the Excellus BlueCross BlueShield benefits provided to you, you are entitled to miscellaneous health-related benefits from your individual account plan. In the event you or your dependents incur any health related expense including, but not limited to, charges by any doctor, dentist, optometrist, ophthalmologist, hospital, or other health facility, pharmacy, optical dispensing service, or hearing aid provider which is not covered by the Excellus BlueCross BlueShield or other health insurance plan available to you, and which expenses are for medical care as defined in Section 213(d) of the Internal Revenue Code, you are entitled to reimbursement of such expenses out of your individual account, as long as your account remains large enough to cover three (3) months of health insurance premiums and you submit proper documentation of such expenses. The Welfare Fund will not reimburse expenses submitted more than one (1) year after they were incurred. Notwithstanding any provision of this Summary Plan Description to the contrary, expenses for a medicine or a drug shall only be treated as Qualified Medical Expenses eligible for reimbursement if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.

23. WHAT HAPPENS TO MY INDIVIDUAL ACCOUNT IF I DIE?

If you should die while there is still a balance in your account, your surviving spouse and/or dependent children may use it for their health care expenses, including health insurance. If you have no spouse or dependent children when you pass away your account will be forfeited.

INSURED BENEFITS

SECTION 8. LIFE INSURANCE BENEFIT

24. WHAT IS THE AMOUNT OF LIFE INSURANCE COVERAGE?

You, the Participant, are covered in the amount of \$30,000. Your spouse is covered in the amount of \$5,000. Children between the age of 14 days and 6 months are covered for \$1,000. Federal tax dependent children six months to age 19 (or age 24 for unmarried, federal tax dependent children who are full-time students at qualified educational institutions (or who are on a medically necessary leave of absence from such institutions)) are covered for \$4,000. No other children are considered "Dependents" for purposes of the Plan's Life Insurance benefit. No life insurance coverage is provided for retirees or their spouses or dependents.

25. WHEN AND TO WHOM ARE BENEFITS PAYABLE?

The person you name as your beneficiary will receive these benefits in the event of your death from any cause. You may direct at any time that your beneficiary be changed by submitting a written request to the Fund Office.

26. HOW ARE BENEFITS PAYABLE?

This insurance will be paid in a single lump sum from the life insurance carrier.

27. HOW SHOULD BENEFICIARIES BE NAMED?

You should designate a beneficiary under your Group Life and Accidental Death and Dismemberment Insurance. Always show the full name of the beneficiary, that is, Mary Doe not Mrs. John Doe.

The following are examples of the standard wording for the beneficiary designations most commonly used where the proceeds are to be payable in a single sum:

1. One Beneficiary – MARY T. DOE, wife
2. Two Beneficiaries – in equal shares to the insured's children, JOHN DOE and JANE DOE if living at the death of the insured or the survivor of them if then living.
3. Three Beneficiaries – in equal shares to the insured's mother, RUTH DOE and the insured's aunts, EDNA JONES and ANN BROWN if living at the death of the insured or to such of them as shall then be living.

4. Unnamed Children – in equal shares to the insured’s children if living at the death of the insured or to such of them as shall then be living.
5. Successive Beneficiaries – The insured’s wife, MARY T. DOE if living at the death of the insured, if not then living, in equal shares to insured’s children if then living or to such of them as shall then be living.
6. Estate – The insured’s executors or administrators.
7. Specific Amounts – For example, if an employee is insured for \$30,000, and he wants the proceeds to be paid \$24,000 to his wife, MARY T. DOE, and \$6,000 to the insured’s son, JOE DOE, the request should be worded: 80% to the insured’s wife, MARY T. DOE if living at the death of the insured, if not then living to the insured’s son, JOE DOE and the remaining 20% to said son if living at the death of the insured, if not then living to said wife.

IMPORTANT POINTS TO REMEMBER

1. An organization or endowment should not be designated as beneficiary unless such organization or endowment has a recognized legal existence such as a corporation, trust, partnership, etc.
2. The relationship of the beneficiary should not be designated as “FRIEND”, “GUARDIAN” or “HOUSEKEEPER” as there is no kinship either by descent or marriage. If you make such a beneficiary designation, the relationship portion of the Request for Change of Beneficiary and/or Change of Name should be left blank.
3. You should give careful consideration before designating your estate as beneficiary since it requires the application to the Court for certification of the executor or appointment of an administrator. This may result in a delay and additional expense which could be avoided by naming an individual as beneficiary.
4. Foreign Beneficiary: Whenever possible the designation of a beneficiary located in a foreign country should be avoided. It is more difficult to locate such beneficiaries and to obtain proof of their identity, and there may also be foreign rules and regulations hampering prompt settlement of death claims. Existing political conditions in certain situations may even necessitate deferment of claim payments.

5. If you have applied to have your Group Life Insurance converted to Individual Life Insurance and the beneficiary named under the individual policy is different from the beneficiary named under the group policy, any amount payable under the group policy will be payable to the beneficiary named under the individual policy.

Note: If you wish to change your beneficiary, contact the Fund Office for the necessary forms.

28. WHAT HAPPENS IF NO SPECIFIC BENEFICIARY DESIGNATION IS IN EFFECT?

If at the time of your death, no specific beneficiary designation is in effect, the proceeds shall be payable to the first surviving classes of successive preference beneficiaries:

Your (a) widow or widower; (b) surviving children including those legally adopted; (c) surviving parents; (d) surviving brothers and sisters including those of whole or half blood; (e) executors or administrators.

In the absence of the appointment of a legal guardian, any minor's share may be paid at a rate not exceeding \$50 a month to such adult or adults as have in the insurance carrier's opinion assumed the custody and principal support of such minor.

29. WHAT HAPPENS TO MY LIFE INSURANCE WHEN I LEAVE MY EMPLOYMENT?

For 31 days after your insurance terminates due to your leaving your employment your group life protection continues in force. During this 31-day period you can obtain, in replacement, individual life insurance as explained in your certificate. You can do this without having to pass a medical examination, by applying to the insurance carrier and paying the premium for the individual insurance during this 31-day period.

The rate for individual insurance will be determined by your age at the time you apply for such individual insurance. The group rate is not applicable.

Note: If a benefit becomes payable under the group policy after you have converted your group Life Insurance to individual Life Insurance, any amount paid as a death benefit under the individual policy will be considered as a payment toward the amount of the benefit payable under the group policy. Any premiums paid under the individual policy will be paid to the beneficiary hereunder upon surrender of the policy.

30. WHAT ARE MY BENEFITS IF I AM TOTALLY DISABLED?

If you become Totally Disabled, as defined below, while you are insured by this policy, and if (1) you are less than 60 years old; and (2) due proof of your disability is furnished to the insurance carrier within one year from the date you cease to be available for work because of your disability; then the insurance carrier will: (a) continue your insurance; and (b) waive premiums for your insurance.

However, your continued insurance shall be subject to any reductions provided by any part of the policy.

31. HOW IS TOTAL DISABILITY DEFINED?

Total Disability means: (1) a disability caused by accidental bodily injury or sickness (2) has existed continuously for at least nine months; and (3) which prevents you from doing any work for which you are or could become qualified by: (a) education; or (b) training; or (c) experience.

The insurance carrier will have the right: (1) to require satisfactory proof of continuance of Total Disability; and (2) to examine you at reasonable intervals during the first two years after receiving proof of total disability; and not more than once a year after that. If you fail to submit any proof of Total Disability required by the insurance carrier, or refuse to be examined as required by the insurance carrier, then premiums will no longer be waived.

The waiver of premiums will cease on the date you attain age 65. You will be entitled to the Conversion Privilege as of that date. You may convert no more than the amount of life insurance that was in force for you on the date you attained age 65.

32. WHAT IS THE EXTENDED INSURANCE BENEFIT?

If you become Totally Disabled, as defined, while insured by this policy, and if: (1) you die while you are Totally Disabled; and (2) your death occurs within one year from the date you cease to be available for work because of your disability; and (3) you were continuously disabled from the date you cease to be available for work because of your disability until the time you died; and (4) you were qualified for the waiver of premium or would have become qualified; and (5) proof of items (1) through (4) above is furnished to the insurance carrier within one year of your death; then the insurance carrier will pay to the beneficiary the amount of Life Insurance which would have been in force for you if your insurance has not terminated. Any such payment will fully discharge the insurance carrier's liability for your insurance.

33. HOW IS DEPENDENT LIFE INSURANCE PAID?

When the insurance carrier receives due proof of a Dependent’s death, the Amount of Life Insurance on his or her life will be paid, as shown in the Plan of Insurance. Payment will be based on the Dependent’s classification at the time of death. Payment will be made in a lump sum to you, if you are living at the time of payment; if not, payment will be made to the executors or administrators of your estate.

34. HOW DOES THE DEPENDENT CONVERSION PRIVILEGE WORK?

If your dependent’s insurance terminates because: (1) he or she ceases to be a Dependent for purposes of the Plan’s Life Insurance benefit, as defined in Questions 24, above; or (2) your employment ceases; or (3) your membership in a class eligible for Dependents Life Insurance ceases; then such Dependent may convert the Amount of Insurance on his life to a personal life insurance policy.

To obtain such a personal life insurance policy, he must, within 31 days of the date he ceases to be a Dependent; (1) make written application to the carrier; and (2) pay the premium required for personal life insurance for his age and class of risk. If he does so, the carrier will issue him a personal insurance policy.

Such policy will: (1) be issued without evidence of insurability; and (2) be on one of the life insurance policy forms, except term insurance, then customarily issued by the carrier; and (3) be for no more than the amount for which he was last insured under this Benefit; and (4) contain no disability or supplementary benefits; and (5) be effective on the 32nd day after the group life insurance on his life terminates.

Any Dependent who is eligible for Insured Persons Coverage or who is in the full-time military, naval, or air force service will not be deemed to be a Dependent.

SECTION 9. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

35. WHEN AND TO WHOM ARE BENEFITS PAYABLE?

These benefits are payable in the event you suffer a loss as a result of accidental injury caused directly and exclusively by purely accidental means and independently of all other causes, within 365 days following an accidental injury which occurs either on or off the job and while you are insured.

If you die as a result of such accidental injury, the benefits will be paid to your beneficiary. If you become blind or lose your hands or feet because of such accidental injury, benefits will be paid to you.

Loss of Life.....	100%
Loss of Both Hands or Both Feet	100%

Loss of Entire Sight of Both Eyes.....	100%
Loss of One Hand and One Foot.....	100%
Loss of One Hand and the Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of Hearing in Both Ears and Loss of Speech	100%
Loss of One Hand and One Foot.....	50%
Loss of Entire Sight of One Eye	50%
Loss of Speech.....	50%
Loss of Hearing in Both Ears	50%
Loss of Thumb and Index Finger of Same Hand.....	25%

“Loss” as above used with reference to hand or foot means the actual, complete, and permanent severance through or above the wrist or ankle joint; as used with reference to eye means irrecoverable loss of entire sight thereof; as used with reference to speech means complete and irrecoverable loss of speech; as used with respect to hearing means complete and irrecoverable loss of hearing in both ears; and as used with respect to thumb and index finger means the actual, complete, and permanent severance through or above the metacarpophalangeal joints. Indemnity provided under this provision will not be paid, under any circumstances, for more than one of the above losses, the greatest, sustained by any one Insured Person as the result of any one accident.

These Benefits are payable in addition to any other Group Insurance Benefits.

Common Carrier Provisions: Loss sustained while riding as a fare-paying passenger in, or boarding or leaving any public conveyance will be two times the benefit otherwise payable. This provision shall not apply to aircraft owned, operated, chartered or leased by the policyholder.

36. WHAT LOSSES ARE NOT COVERED?

Losses resulting from, or caused directly or indirectly, wholly or partly by, (a) bodily or mental infirmity, bacterial infections (except infections caused by pyogenic organisms which shall occur with and through an accidental cut or wound) or disease or illness of any kind, (b) self-destruction or self-inflicted injury, if intentional or while insane, except as result of a physical or mental condition, (c) war or an act of war, service in any military, naval or air force of any country while such country is engaged in war or performing police duty as a member of any military or naval organization, or (d) participation in or in consequence of having participated in the committing of a felony.

QUESTION AND ANSWER

Will my beneficiary receive these death benefits if I die as a result of a work-related accident?

Answer: Yes.

SECTION 10. SHORT-TERM DISABILITY INSURANCE BENEFIT

37. IS SHORT-TERM DISABILITY INSURANCE AVAILABLE?

The Fund has acquired Short-Term Disability insurance from The Guardian Insurance Company. This insurance provides a \$200.00 weekly benefit during disability for active participants. Benefits are payable for 26 weeks. Benefits begin on the first day for an accident and on the eighth day for sickness. This Plan covers disabilities caused by either job-related or non-job-related sickness or injury.

PART C.
SELF-PAY COVERAGES

SECTION 11. REGULAR SELF-PAY COVERAGE

38. WHAT HAPPENS IF THE BALANCE IN MY ACCOUNT IS NOT ENOUGH TO PAY THE MONTHLY PREMIUM?

The Fund provides two different types of self-pay coverage. The first type is Regular Self-Pay Coverage and is described in Questions 38 through 46 below. The other type is COBRA Continuation Coverage and is described at Questions 47 through 58 below.

39. WHAT IS REGULAR SELF-PAY COVERAGE?

If there is not enough in your account to pay the monthly premium, you may continue coverage for yourself and for your dependents by making self-payments equal to the current monthly premium rate established by the Fund.

40. WHAT MUST I DO TO BE ELIGIBLE FOR REGULAR SELF-PAY COVERAGE?

To qualify to self-pay, the contributions in your individual account must be exhausted and you must be:

- (a) Unemployed and working reduced hours but seeking employment covered by a Union collective bargaining agreement; or
- (b) Working for an employer delinquent in making contributions to the Fund; or
- (c) Working for an employer signatory to a collective bargaining agreement with the Union not obligated to make contributions to the Fund; or
- (d) A retiree (i.e., a former participant who is now retired); or
- (e) Disabled and as a result of said disability unable to maintain or continue employment as an Asbestos Worker (The Trustees may require medical proof of your disability); or
- (f) On leave under the Family and Medical Leave Act and your contributing Employer has failed to make contributions on your behalf.

41. WHICH BENEFITS ARE INCLUDED IN REGULAR SELF-PAY COVERAGE?

Active and retired participants may self-pay to receive the health insurance benefit provided by Excellus BlueCross BlueShield.

42. CAN I SELF-PAY IF I AM UNEMPLOYED?

If you are unemployed, you must actively be seeking employment covered by a bargaining agreement of the Union in order to self pay. You must submit proof to the Trustees at least semi-annually to demonstrate that you are actively seeking employment.

43. ARE THERE SPECIAL SELF-PAYMENT PROVISIONS FOR THOSE WHO ARE DISABLED OR ON WORKERS' COMPENSATION?

If you are receiving the New York State Disability benefit or Workers' Compensation benefit, you can receive benefits by self-paying a monthly dollar amount into the Welfare Fund. Individual coverage will be provided at no cost to the participant for a period of disability not exceeding six months. Family coverage will be provided during this six-month period of disability by self-paying the difference between the individual and family coverage. After the six-month period, you will be entitled to continue to self-pay for the remaining 23 months of COBRA Continuation Coverage. Coverage to be afforded will be on the same basis as the benefits available for active participants.

44. WHEN DOES REGULAR SELF-PAY COVERAGE END?

Regular Self-Pay Coverage will terminate if:

- (a) You fail to make timely payments of the premiums;
- (b) You fail to meet the eligibility requirements described in Question 5; or
- (c) You ask to have your self-pay coverage terminated.

45. UNDER WHAT CIRCUMSTANCES CAN REGULAR SELF-PAY COVERAGE BE REINSTATED?

Your Regular Self-Pay Coverage may be reinstated if:

- (a) You again meet the eligibility requirements described in Question 5 and you make the required premium payments.
- (b) If your Regular Self-Pay Coverage is terminated for more than one month, you will not be allowed to receive Regular Self-Pay Coverage until you have again worked under a collective bargaining agreement requiring contributions to the Fund.

46. CAN MY SURVIVING SPOUSE BE COVERED IF I DIE?

If you die while a participant, unemployed bargaining unit member, or retiree, your surviving spouse (until such time as he or she remarries) may purchase Regular Self-Pay Coverage for himself or herself by making self payments equal to the current monthly premium rate established by the insurance carrier plus any service charge made by the Fund. For anyone other than a retiree or a surviving spouse, you must remain an active member of the Union.

SECTION 12. COBRA CONTINUATION COVERAGE

47. WHAT IS COBRA CONTINUATION COVERAGE?

The Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”) provides that you, your spouse, and your other dependents are entitled to elect to continue coverage on a self-pay basis under the Plan, under certain circumstances, if coverage would otherwise stop.

There are two parts to your coverage under the Plan: (1) your insured health benefits; and (2) your health reimbursement account benefits. You, your spouse, and your dependents may elect COBRA continuation coverage for the health insurance benefits only or for both the health insurance benefits and the health reimbursement benefits.

48. WHEN AM I ELIGIBLE TO ELECT COBRA CONTINUATION COVERAGE?

For individuals covered by the Plan as employees, COBRA continuation coverage may be elected upon loss of coverage under the Plan due to voluntary or involuntary termination of employment (except for gross misconduct) or because the employee no longer meets the eligibility requirements of the Plan due to a reduction in hours worked, including a strike, walkout or layoff, or a loss of eligibility due to reduction of personal account. ***You are NOT required to elect COBRA continuation coverage or pay COBRA premiums to continue to receive reimbursements from your Individual Account. You will continue to have access to your Individual Account and to receive reimbursements from your Individual Account so long as the account balance is sufficient to cover your claims and exceeds the minimum required account balance. In fact your Individual Account can be used to pay the required COBRA premiums for health insurance benefits.***

49. WHEN IS MY SPOUSE ELIGIBLE TO ELECT COBRA CONTINUATION COVERAGE?

Your spouse may elect COBRA continuation coverage upon the occurrence of any of the following events:

1. Your death.
2. Your spouse's loss of coverage under the Plan due to voluntary or involuntary termination of your employment (except for gross misconduct) or because you no longer meet the eligibility requirements of the Plan due to a reduction in hours worked including a strike, walkout or layoff, or a loss of eligibility due to reduction of personal account.
3. Divorce or judicial order of legal separation.
4. Your enrollment in Part A or Part B of Medicare.

If your spouse has a COBRA Qualifying Event as a result of your death, because you have terminated covered employment, because of your enrollment in Part A or Part B of Medicare, or because of a reduction of your hours of Covered Employment, your spouse is NOT required to elect COBRA continuation coverage or pay COBRA premiums to continue to receive reimbursements from your Individual Account. Your spouse will continue to have access to your Individual Account and to receive reimbursements from your Individual Account so long as the account balance is sufficient to cover the claims and exceeds the minimum account balance.

In the event your spouse has a COBRA Qualifying Event as a result of divorce or judicial order of legal separation, to continue to have access to your Individual Account and to receive reimbursements from your Individual Account, your spouse MUST elect COBRA continuation coverage and pay COBRA premiums.

50. WHEN ARE MY DEPENDENT CHILDREN ELIGIBLE TO ELECT COBRA CONTINUATION COVERAGE?

Your dependent children can elect COBRA continuation coverage upon the occurrence of any of the following events:

1. Your death.
2. Your dependent child's loss of coverage under the Plan due to termination of your employment (for reasons other than gross misconduct) or because you no longer meet the eligibility requirements of the Plan due to a reduction in hours worked including a strike, walkout or layoff, or loss of eligibility due to reduction of personal account.

3. Divorce or judicial order of legal separation of the child's parents.
4. Your enrollment in Part A or Part B of Medicare.
5. The child ceases to qualify as an "eligible dependent" as described in Question 9.

If your dependent child has a COBRA Qualifying Event as a result of your death, because you have terminated covered employment, because of your enrollment in Part A or Part B of Medicare, or because of a reduction of your hours of Covered Employment, your dependent child is NOT required to elect COBRA continuation coverage or pay COBRA premiums to continue to receive reimbursements from your Individual Account. Your dependent child will continue to have access to your Individual Account and to receive reimbursements from your Individual Account so long as the account balance is sufficient to cover the claims and exceeds the minimum account balance.

In the event your dependent child has a COBRA Qualifying Event as a result of your divorce or judicial order of legal separation or because your child ceases to qualify as an "eligible" dependent, to continue to have access to your Individual Account and to receive reimbursements from your Individual Account, your dependent child MUST elect COBRA continuation coverage and pay COBRA premiums.

51. HOW IS A PERSON ELIGIBLE FOR COBRA CONTINUATION COVERAGE NOTIFIED OF HIS OR HER ELIGIBILITY?

Your employer has the obligation to notify the Fund Office of your death or your enrollment in Part A or Part B of Medicare. The Trustees have determined that because employees frequently work for more than one employer making contributions to the Plan and because of the difficulty which this causes employers in providing this notice, employment will be deemed to have terminated and/or the number of hours worked will be deemed to have been reduced when your regular group health care coverage terminates.

You have the responsibility to inform the Fund Office of a divorce, judicial order of legal separation, a child's loss of status as an eligible dependent or the birth or adoption of a dependent. This notice must be given within 60 days after the occurrence of the qualifying event or the date coverage would be lost because of the event, whichever is later. Failure to give notice to the Fund Office within the time limits may result in your ineligibility for COBRA continuation coverage.

After the Fund Office receives notice of the occurrence of one of the above qualifying events, it will notify each eligible individual whether he or she has the right to elect COBRA continuation coverage and will send the materials necessary to make the proper election. In general, the Fund Office will notify

eligible individuals of their COBRA rights within 14 days after receiving notice of the occurrence of one of the qualifying events described above or after it has determined that your regular group health care coverages has terminated.

52. WHEN MUST THE ELECTION BE MADE?

The employee, spouse and dependent children each have independent election rights. Covered employees may elect COBRA continuation coverage on behalf of their spouses and parents may elect COBRA continuation coverage on behalf of their children. Each individual will have 60 days from the date he or she would lose coverage because of one of the qualifying events described above or the date on which he or she is advised of the right to elect continuation coverage, whichever date is later, to inform the Fund Office that he or she wants COBRA continuation coverage. If no election of COBRA continuation coverage is made, the individual's group health coverage will terminate. You will not have another opportunity to elect continuation coverage. However, you may change your election within the 60 day period described above as long as the completed COBRA Election Form, if mailed, is post-marked no later than the due date. If the election is hand-delivered, the date of delivery must be on or before the due date. If you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date the completed Election Form, if mailed, is post-marked. If the election is hand-delivered, your COBRA continuation coverage will begin on the date of delivery.

You are NOT required to elect COBRA continuation coverage or pay COBRA premiums to continue to receive reimbursements from your Individual Account. You will continue to have access to your Individual Account and to receive reimbursements from your Individual Account so long as the account balance is sufficient to cover your claims and exceeds the minimum required account balance. In fact your Individual Account can be used to pay the required COBRA premiums for health insurance benefits.

53. WHAT TYPE OF BENEFITS ARE AVAILABLE IN COBRA CONTINUATION COVERAGE?

The benefits an eligible individual is allowed to elect to receive will include all benefits the individual was entitled to before the occurrence of the event making the individual eligible for COBRA continuation coverage. However, no life insurance, disability benefits, accidental death and dismemberment benefits, or other non-health benefits will be included.

54. WHAT ARE THE CONSEQUENCES OF FAILING TO ELECT OR WAIVING COBRA CONTINUATION COVERAGE?

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your

future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

55. HOW LONG DOES COBRA CONTINUATION COVERAGE LAST?

If the election is due to termination of your employment or a reduction in hours worked, under New York State law, COBRA coverage is available for up to 36 months following the loss of employer-sponsored coverage due to job loss. If federal COBRA coverage has been exhausted under an insured group health plan, qualified beneficiaries will have the opportunity to extend coverage under New York law for an additional 18-month period for up to a total of 36 months following the date federal COBRA continuation coverage began. However, if you or your spouse or one of your dependent children is determined by the Social Security Administration to be disabled on the day regular coverage terminates or within 60 days thereafter, the disabled person can receive a total of 29 months of COBRA continuation coverage. If you are the disabled person, your spouse and your dependent children also qualify for 29 months of this coverage. For all other situations, such coverage is available for 36 months. COBRA continuation coverage will end at an earlier time for any of the following reasons:

1. The employer no longer provides group health coverage.
2. Failure to pay the monthly premium on time.
3. The individual becomes covered under another group health plan (other than one sponsored by the employer) except for any period the other group health plan limits coverage of your pre-existing conditions.
4. The individual enrolls in Part A or Part B of Medicare.
5. Circumstances are such that the individual's participation could be canceled if the individual were an active employee.

If any of these events occur, the Fund Office will send you a Notice of Termination of Coverage, explaining the reason the COBRA coverage terminated early, the date coverage terminated, and any rights the employee, spouse or dependent child may have under the Plan to elect alternate coverage.

56. HOW IS COBRA CONTINUATION COVERAGE COORDINATED WITH OTHER SELF-PAY COVERAGE?

If you are entitled to both COBRA continuation coverage and the self-pay coverage described elsewhere in this booklet, you will receive the information necessary to permit you to make a choice between the two. Regular Self-Pay Coverage may provide coverage for you after COBRA continuation coverage stops.

57. WHAT IS THE COST OF COBRA CONTINUATION COVERAGE AND HOW IS THE COST COMPUTED?

Each month, any individual electing COBRA continuation coverage will be required to make a payment to the Fund Office to continue COBRA continuation coverage. The monthly premium will be based on the average cost which the Plan incurs annually per participant plus a two percent administrative charge. The extra 11 months of COBRA continuation coverage available to disabled participants are at a monthly charge based on one and one-half times the average annual per participant cost incurred by the Plan.

58. IS THERE ANYTHING ELSE I SHOULD KNOW ABOUT COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is described in the Summary Plan Description distributed by the Fund Office to each participant when the participant becomes eligible to participate in the Fund or when COBRA first became applicable to the Fund, if later. If you have any questions concerning COBRA continuation coverage, you should contact the Fund Manager.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website @ www.dol.gov/ebsa. (Addresses and telephone number of Regional and District EBSA Offices are available through EBSA's website).

PART D.
CLAIM & APPEAL PROCEDURE

SECTION 13. SUBMITTING CLAIMS

59. WHAT ARE THE PROCEDURES FOR SUBMITTING CLAIMS FOR BENEFITS?

Claims for insured health benefits will be submitted directly by the Provider to the Insurance Company or otherwise handled directly by the Provider. Claims for insured benefits submitted must be accompanied by any information or proof requested as reasonably required to process such claims for benefits.

Claims for individual account benefits can be submitted to the Fund Office quarterly, on January 1, April 1, July 1, and October 1, for the preceding three-month period. The Trustees have the right to determine these benefits.

SECTION 14. PLAN INTERPRETATION AND DETERMINATIONS

60. WHO HAS AUTHORITY TO INTERPRET THE PLAN AND MAKE DETERMINATIONS ABOUT THE PAYMENTS OF BENEFITS?

In order to carry out their responsibility for interpreting the plan and making determinations under it, the Trustees have exclusive authority and discretion:

- (a) To determine whether an individual is eligible for any benefits under the Plan;
- (b) To determine the amount of benefits, if any, an individual is entitled to from the Plan;
- (c) To determine or find facts that are relevant to any claim for benefits from the Plan;
- (d) To interpret all of the Plan's provisions;
- (e) To interpret all of the provisions of the Summary Plan Description;
- (f) To interpret the provisions of any Collective Bargaining Agreement or written Participation Agreement involving or impacting the Plan;
- (g) To interpret the provisions of the Trust Agreement governing the operation of the Plan;
- (h) To interpret all of the provisions of any other document or instrument involving or impacting the Plan; and

- (i) To interpret all of the terms used in the Summary Plan Description, and all of the other previously mentioned Agreements, documents, and instruments.

All such determinations and interpretations made by the Trustees or their designee:

- (a) Shall be final and binding upon any individual claiming benefits under the Plan and upon all the employees, all employers, the Union, and any party who has executed any agreement with the Trustees or the Union;
- (b) Shall be given deference in all courts of law to the greatest extent allowed by applicable law; and
- (c) Shall not be overturned or set aside by any court of law unless the court finds that the Trustees, or their designee, abused their discretion in making such determination or rendering such interpretation.

SECTION 15. CLAIM DENIALS AND APPEALS

61. WHAT HAPPENS IF MY CLAIM IS DENIED?

Initial Decisions

Time Frames

Health Insurance

For these medical claims, the rules that apply depend on the type of claim. There are four types of claims: Pre-Service, Urgent, Concurrent, and Post-Service. A Pre-Service Claim is any claim with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. An Urgent Care Claim is a Pre-Service Claim for medical care or treatment in which application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or the treatment that is the subject of the claim. A Concurrent Care Claim is a claim involving a pre-approved ongoing course of treatment, including a request for extension of a course of treatment. A Post-Service Claim means any claim that is not a Pre-Service claim, i.e., prior Plan approval is not a prerequisite to obtaining medical care and payment is being requested for medical care already rendered to the claimant.

Post-Service Claims

For Post-Service Claims, you will be notified of any adverse benefit determination (by the insurance company, for insured benefits; otherwise, by the Plan) within a reasonable period, but not later than 30 days after receipt of the claim. The 30-day period may be extended up to 15 days for matters beyond the Plan's control (or the insurance company's, if applicable) if, before the end of the initial 30-day period, the Plan (or the insurance company, if applicable), notifies you of the reasons for the extension and of the date by which it expects to render a decision. If the extension is needed because you did not submit the information necessary to decide the claim, the notice of extension will describe the required information and give you at least 45 days from receipt of the notice to provide it. A determination will then be made within 15 days after the earlier of the date by which you must provide the additional information.

Pre-Service Claims

For Pre-Service Claims, you will be notified of the insurance company's determination (whether adverse or not), within a reasonable period, but not later than 15 days after receipt of the claim. The 15-day period may be extended for up to 15 days for matters beyond the insurance company's control if, before the end of the initial 15-day period, you are notified of the reasons for the extension and of the date by which the insurance company expects to render a decision. If the extension is needed because you did not submit the information necessary to decide the claim, the notice of extension will describe the required information and the claimant will have 45 days from receipt of the notice to provide the specified information. A decision will then be made within 15 days after the earlier of the date by which you must provide the additional information. In addition, if the claim is improperly filed, the insurance company will provide notice of the failure within 5 days.

Urgent Care Claims

The rules are slightly different for Pre-Service Claims that involve urgent care, i.e., Urgent Care Claims. For Urgent Care Claims, you will be notified by the insurance company regarding the benefit determination (whether adverse or not) as soon as possible, and not later than 72 hours after receipt, unless you fail to provide sufficient information to decide the claim. In the case of a failure to provide sufficient information or to follow filing procedures, you will be notified of the failure as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information needed to complete the claim. Notification of the decision on that claim will then be provided within 48 hours after the insurance company's receipt of the specified information or the end of the additional period afforded you to provide such information. Notification can be made orally, provided a written or electronic communication is provided within 3 days of the oral notification.

Concurrent Care Claims

If the insurance company has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the insurance company of such course of treatment is an adverse benefit determination. You will receive notice of such an adverse determination sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review before the reduction or termination occurs. Also, for any request to extend an urgent care ongoing course of treatment beyond the initially-prescribed period of time, you will be notified of the determination (whether adverse or not) within 24 hours after receipt of the claim, if the claim is made at least 24 hours before the end of the initially-prescribed period of time or number of treatments.

Disability Benefit

If your claim for Disability Benefit is denied in whole or in part for any reason, then within 45 days after the insurance company receives your claim, the insurance company will send you written notice of its decision. This period may be extended for up to two 30-day periods due to matters beyond the control of the insurance company. For any extensions, the insurance company will provide advance written notice indicating the circumstances requiring the extension and the date by which the insurance company expects to render a decision. Any notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues (if any), and you shall be afforded at least 45 days within which to provide specified information (if applicable). A decision will then be made within 30 days after the earlier of the date you supply the requested information or the date by which you must provide the additional information.

Life Insurance and Accidental Death and Dismemberment Benefits

If your claim for Life Insurance and Accidental Death and Dismemberment Benefits is denied in whole or in part for any reason, then within 90 days after the insurance company receives your claim, the insurance company will send you written notice of its decision, unless special circumstances require an extension, in which case the insurance company will send you written notice of the decision no later than 180 days after the insurance company receives your claim. If an extension is necessary, you will be given written notice of the extension before the expiration of the initial 90-day period, which shall indicate the special circumstances requiring the extension of time and the date by which the insurance company expects to render the benefit determination. However, any decision regarding life insurance coverage that is based on a finding of total and permanent disability is subject to the same rules that apply to Disability Benefit claims.

Content of Notification of Initial Adverse Benefit Determination

In an initial notification of adverse benefit determination, the notification shall set forth:

1. The specific reasons for the adverse determination;
2. Reference to the specific Plan provisions (including any internal rules, guidelines, protocols, etc.) on which the determination is based;
3. A description of any additional material or information necessary for you to complete the claim and an explanation of why such material or information is necessary;
4. A description of the Plan's applicable internal and external review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under § 502(a) of ERISA following an adverse benefit determination on review;
5. In a case of an adverse determination involving a claim for urgent care, a description of the expedited review process applicable to such claims;
6. If an internal rule, guideline, or protocol was relied upon in making the adverse determination, the rule, etc., or a statement that the rule was relied upon and that a copy of it will be provided free of charge upon request; and
7. If the adverse benefit determination is based on medical necessity or experimental treatment, either an explanation of the scientific judgment for the determination, applying the Plan's terms to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request.

Notice of an adverse benefit determination will also include the following:

1. Information sufficient to identify the claim, including, the date of service, the health care provider, the claim amount, any applicable denial code and its corresponding meaning (if applicable), including a description of the Plan standards used in denying the claim, and a description of your right to request diagnosis and treatment codes and their corresponding meanings (if applicable);
2. A description of the Plan's standard that was used in denying the claim;
3. A detailed description of the available internal appeals and external review processes, including information regarding how to start an appeal; and

4. The availability of, and contact information for the New York State Insurance Department for additional information or assistance with your claim.

The Plan (or the insurer, if applicable) will also disclose, free of charge, any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim, and any new or additional rationale on which a final adverse benefit determination will be based. This information will be made available sufficiently in advance of an appeal decision deadline so that the claimant has adequate time to respond.

Appeals of Adverse Benefit Determinations

An adverse benefit determination is defined as: (1) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, or failure to provide or make payment that is based on a determination of a participant's eligibility to participate in this Plan; (2) a denial, reduction, or termination of, or a failure to make payment (in whole or in part) for a benefit resulting from the application of any utilization review or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; and (3) a rescission of coverage, which is defined as any cancellation or discontinuance of coverage that has a retroactive effect, except to the extent that it results from a failure to pay a required premium or contribution toward the cost of coverage.

62. DO I HAVE THE RIGHT TO APPEAL A CLAIM WHICH HAS BEEN DENIED?

If you are not satisfied with the reason or reasons why your claim was denied, then you may appeal the adverse benefit determination. To appeal an insured medical benefit, you must follow the procedures set forth in the underlying insurance policy. You must be given at least 180 days to file such appeal. To appeal an adverse determination of a miscellaneous health-related benefit, you must write to the Trustees within 180 days after you receive this Plan's initial adverse benefit determination. To appeal an adverse benefit determination of a Life Insurance or Accidental Death and Dismemberment benefit, you must follow the procedures set forth in that underlying insurance policy and must be given at least 60 days to file an appeal. To appeal an adverse benefit determination of a Disability Benefit, you must follow the procedures set forth in that underlying insurance policy and must be given at least 180 days to file an appeal. Notwithstanding anything in this paragraph to the contrary, for Concurrent Claims involving a reduction or termination of a pre-approved, ongoing course of treatment, you will be afforded a reasonable period of time to appeal.

For appeals to the Board of Trustees, your correspondence (or your representative's correspondence) must include the following statement: "I AM WRITING IN ORDER TO APPEAL YOUR DECISION TO DENY ME BENEFITS. YOUR ADVERSE BENEFIT DETERMINATION WAS DATED _____, 20____." If this statement is not included, then the Trustees may not understand that you are making an appeal, as opposed to a general inquiry. If you have chosen someone to represent you in making your appeal, then your letter (or your representative's letter) must state that you have authorized him or her to represent you with respect to your appeal, and you must sign such statement. Otherwise, the Trustees may not be sure that you have actually authorized someone to represent you, and the Trustees do not want to communicate about your situation to someone unless they are sure he or she is your chosen representative.

You shall have the opportunity to submit written comments, documents, records, and other information related to the claim for benefits. You shall also be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In addition, all appeals other than those involving the Life Insurance and Accidental Death and Dismemberment Benefits must adhere to the following criteria: (1) the review will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination nor the subordinate of such individual; (2) insofar as the adverse benefit determination is based on medical judgment, the Board will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment; (3) such health care professional shall not be the individual, if any, who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; and (4) medical or vocational experts whose advice was obtained on behalf of the Plan, without regard to whether the advice was relied upon in making the adverse benefit determination, will be identified.

Special Rule Regarding Urgent Care Claims: If Urgent Care Claims are involved, you may request an expedited appeal, either orally or in writing, and all necessary information, including the Plan's benefit determination on review, shall be transmitted between you and the Plan (or the insurance company, as applicable) by telephone, facsimile, or other similarly expeditious method. Further, if the appeal involves an Urgent Care Claim, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative. In certain circumstances, you may also have the right to request an expedited independent external review as described under the Section titled "External Review," below.

Determinations on Appeal

Time Frames

Pre-Service Claims: You will be notified of the decision within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the request for review. The insurance company will decide appeals of insured claims in accordance with the ERISA regulations within the same time frame (except that if the insurer provides two (2) levels of appeal, the decision has to be made within 15 days at each level).

Urgent Care Claims: Appeals of adverse determinations must be decided and communicated to you as soon as possible, taking into account medical exigencies, but not later than 72 hours after receipt of the request for review. The insurance company will decide appeals of insured claims within the same time frame in accordance with ERISA regulations.

Insured Post-Service Claims: The insurance company will notify you of its decision on appeal within a reasonable period of time appropriate to the medical circumstances, but not later than 60 days after receipt of the request for review (except that if the insurance company provides two (2) levels of appeal, the decision has to be made within 30 days at each level).

All Other Claims: The Trustees at their next regularly scheduled meeting will make a determination of appeal. However, if the appeal is received less than 30 days before the meeting, the decision may be made at the second meeting following receipt of the request. If special circumstances require an extension of time for processing, then a decision may be made at the third meeting following the date the appeal is made. Before an extension of time commences, you will receive written notice of the extension, describing the special circumstances requiring the extension and the date by which the determination will be made. The Plan will notify you of the benefit determination not later than 5 days after the determination.

Content of Adverse Benefit Determination on Review

The notification of adverse benefit determination on review shall set forth the following:

1. The specific reasons for the adverse benefit determination;
2. Reference to specific Plan provisions (including any internal rules, guidelines, protocols, etc.) on which the determination is based;

3. 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 your claim for benefits;
4. A statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act;
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, the notice will provide either the specific rule, guideline, protocol, or other similar criterion, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and
6. If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, the written notice shall contain an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided upon request.

The notification of adverse benefit determination on review shall also set forth the following:

1. Information sufficient to identify the claim, including the date of service, the health care provider, any applicable denial code and its corresponding meaning (if applicable), including a description of the Plan standards used in denying the claim, the claim amount, and a description of your right to request diagnosis and treatment codes and their corresponding meanings (if applicable));
2. A statement of your right to request an external independent review of the adverse benefit determination (if applicable);
3. A description of the Plan's standard that was used in denying the claim as well as a discussion of the decision;
4. A detailed description of the available internal appeals and external review processes, including information regarding how to start an appeal; and
5. The availability of, and contact information for the New York State Insurance Department for additional information or assistance with your claim.

The Plan (or the insurer, if applicable) will also disclose, free of charge, any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim, and any new or additional rationale on which a final adverse benefit determination will be based. This information will be made available sufficiently in advance of an appeal decision deadline so that the claimant has adequate time to respond.

The Trustees' (or their designee's) final decision with respect to their review of your appeal will be final and binding upon you because the Trustees have exclusive authority and discretion to determine all questions of eligibility and entitlement under the Plan. Any legal action against this Plan must be started within 90 days from the date the adverse benefit determination denying your appeal is deposited in the mail to your last known address. You also have the right to request an independent external review of your appeal within 4 months of receipt of the adverse benefit determination as described in the section titled, "External Review," below. More detailed information regarding your right to request an external review will also be provided by the insurance company.

External Review

You have the right to request an independent external review of an adverse benefit determination within four (4) months after receipt of the notice of an adverse benefit determination. This right only extends to adverse benefit determinations by the health insurance carrier or its designee utilization review organization that involve medical judgment or a rescission in coverage.

The external review will be made by an independent review organization with health care professionals who have no conflict of interest with respect to the benefit determination. Except for approved expedited external reviews, this external review is only available once you have exhausted the internal grievance process. You may request an external review by completing the request for external review with the insurance company. A copy of the full external review procedure will be provided upon request. You may also contact the New York State Insurance Department with any questions.

An expedited external review is available in the following two situations:

- (1) After an Adverse Initial Determination: An adverse initial determination involves a medical condition where the timeframe for completing an expedited internal appeal would seriously jeopardize the claimant's life or health or would jeopardize ability to regain maximum function, and the claimant requests an expedited internal appeal.

- (2) After an Adverse Appeal Decision: A final internal appeal decision involves a medical condition where the timeframe for completing a standard external review would seriously jeopardize the claimant's life or health or would jeopardize ability to regain maximum function, or the appeal decisions concerns an admission, availability of care, continued stay, or a health care item or service for which the claimant received emergency services but has not been discharged from a facility.

SECTION 16. GENERAL PROVISIONS

63. WHAT HAPPENS IF I BECOME INCOMPETENT OR UNABLE TO CARE FOR MY AFFAIRS?

In the event it is determined that a claimant is unable to care for his or her affairs because of illness, accident, or incapacity, either mental or physical, payments due may, unless claim has been made therefor by a duly appointed guardian, committee, or other legal representative, be paid to the spouse or such other object of natural bounty of the claimant or such person having care and custody of the claimant, as the Trustees will determine in their sole discretion.

64. WHAT KIND OF INFORMATION MUST I FURNISH TO THE TRUSTEES IF THEY ASK FOR IT?

Every claimant will furnish to the Trustees all such information in writing as may be reasonably requested by them for the purpose of establishing, maintaining and administering the plan. The failure on the part of the claimant to comply with such requests promptly and in good faith will be sufficient grounds for delaying payments of benefits. The Trustees will be sole judges of the standard of proof required in any case, and they may from time to time adopt such formulas, methods, and procedures as they consider advisable.

65. WHAT IF I MOVE?

If a claimant fails to inform the Trustees of a change of address and the Trustees are unable to communicate with the claimant at the address last recorded by the Trustees and a letter sent by first class mail to such claimant is returned, any payments due the claimant will be held without interest until payment is successfully made.

66. WHAT CAN THE FUND DO IF BENEFITS ARE INCORRECTLY PAID?

The Trustees will have the right to recover any benefit payments made in reliance on any false or fraudulent statement, information, or proof submitted, as well as any benefit payments made in error.

SECTION 17. STATEMENT OF ERISA RIGHTS

67. ISN'T THERE A FEDERAL LAW WHICH APPLIES TO ALL EMPLOYEE BENEFIT PLANS?

As a participant in the Asbestos Workers Syracuse Welfare Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Fund Office, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have 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 preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. Pre-existing condition exclusions do not apply to children under the age of 19, and will not apply to anyone effective January 1, 2014.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “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.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of 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.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, JFK Federal Building, 15 New Sudbury Street, Room 575, Boston, Massachusetts 02203, (617) 565-9600. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PART E.
MISCELLANEOUS PLAN PROVISIONS

SECTION 18. COORDINATION OF BENEFITS

68. WHAT RULES APPLY IF A PERSON ELIGIBLE FOR BENEFITS FROM THIS PLAN IS ALSO COVERED UNDER ANOTHER HEALTH CARE PLAN?

You, your spouse and your dependent children are obligated to notify the Fund Office of any other health care coverage for which any of you is eligible. By coordinating benefits with other group health plans the monthly premiums which participants in this Fund must pay can be reduced.

When you and/or your dependents are covered under more than one group health plan, the combined benefits payable by this Plan and all other group health plans will not exceed 100% of the eligible expenses incurred by the individual. The Plan assuming primary payer status will determine benefits first without regard to benefits provided under any other group health plan. When this group health plan is the secondary payer, it will reimburse, subject to all Plan provisions, the balance of remaining eligible expenses, not to exceed normal Plan liability. For purposes of coordination, eligible expense means any usual and customary charge considered in part or in full by at least one of the group health plans. Any individual, non-group insurance plan (the cost of which is entirely paid by the beneficiary) is specifically excluded from this coordination-of-benefits provision. The term group health plan includes the Federal programs Medicare and CHAMPUS. The regulations governing these programs take precedence over the order of determination of this Plan.

Coordination With Other Plans

If a person is eligible for benefits under this Plan and another plan or plans that also have a coordination-of-benefits provision, the following rules establish the order in which the various plans will pay, so that no more than 100% of eligible charges incurred are paid:

- If the person who received care is covered as an active employee under one coverage, and as a dependent under another, the employee's coverage pays first.
- If the person who received care is covered as an active employee under one coverage and as an inactive employee under another, the coverage through active employment pays first.
- If a person is an active employee under one or more coverages, the coverage covering the person for the longer period of time will pay first.

- If a person is covered by a state’s Medicaid program, the coverage under the group health plan will be considered primary.
- For dependent children with parents not separated or divorced, when this Plan and another plan cover the same child as a dependent of the child’s parents:
 - The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
 - If both parents have the same birthday, the benefits of the plan that covered one parent longer are determined before those of the plan that covered the other parent for a shorter period of time;
 - If the other plan does not use the parents’ birthdays for this purpose but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of the benefits.
- When all plans covering a person as a dependent child of divorced or separated parents contain a coordination of benefits provision, the order of payment will be:
 - The plan covering the dependent child of the natural parent designated by court order to be responsible for the child’s health-care expenses will be considered primary; or
 - In the absence of a court order specifying otherwise, the plan covering the dependent child of the natural parent having legal custody of the child will be considered primary; or
 - In the absence of a court order specifying otherwise, the plan covering the dependent child of a stepparent who is the spouse of the natural parent having legal custody of the child will be considered primary.
 - Joint Custody. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health-care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in the steps for a dependent child with parents not separated or divorced.
- When none of the above applies, the coverage the person has had for the longest continuous period of time pays first.

- If a covered person under this Plan is also covered under a health maintenance organization, this Plan will not provide benefits for any non-health maintenance organization treatment that would have been covered by the health maintenance organization if treatment had been obtained from the health maintenance organization.
- Any group health plan that does not contain a coordination of benefits provision will be considered primary.

Coordination With Medicare

In general, if you are covered by this Plan as an active employee and this Plan is receiving employer contributions on your behalf, then this Plan will be primary and Medicare will be secondary to the extent that you are also entitled to coverage under Medicare. However, notwithstanding this general rule, this Plan will not be primary for individuals (including eligible active employees) who:

- Work for an employer that does not have 20 or more employees (including Plan participants and employees who are not eligible for coverage under this Plan) for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year; or
- Are age 65 and over and who have end stage renal disease and are, or would upon application be, entitled to benefits under Section 426-1 of Title 42 of the United States Code.

However, this Plan will be primary and Medicare will be secondary for 30 months for eligible individuals under age 65 who have Medicare solely because of permanent kidney failure. Thereafter, Medicare would be primary.

Coordination With No-Fault Insurance

If a person covered by this Plan has a claim which involves a motor vehicle accident covered by the “no-fault” insurance law of any state, the “no-fault” insurance carrier will be primary. Only when the claimant has exhausted his health care benefits under the “no-fault” coverage will he or she be entitled to excess health care coverage under this Plan. If there are expenses for services which are covered under this Plan and that are not completely reimbursable by the “no-fault” carrier, this Plan will cover claims for the difference up to the various coverage limits described above and subject to all of the provisions of this Summary Plan Description.

Right to Make Payments to Other Organizations

Whenever payments that should have been made by this Plan have been made by any other plan(s), this Plan has the right to pay the other plan(s) any amount necessary to satisfy the terms of this coordination-of-benefits provision. Amounts paid will be considered benefits paid under this Plan and, to the extent of such payment, the Plan will be fully released from any liability regarding the person for whom payment was made.

SECTION 19. CLAIMS WHERE A THIRD PARTY IS LIABLE

Note: This provision applies to all participants, spouses, dependent children, retirees, their spouses and their dependent children and beneficiaries with respect to all of the benefits provided under this Plan. For the purpose of this provision, the terms “you” and “your” refer to all participants, spouses, dependent children, retirees, their spouses and their dependent children and beneficiaries.

69. WHAT HAPPENS IF A THIRD PARTY IS LIABLE FOR MY MEDICAL EXPENSES?

Occasionally, a third party may be liable for your medical expenses. This may occur when a third party is responsible for causing your illness or injury, or otherwise responsible for your medical bills. The Trustees, in their discretion, may determine to not provide benefits under the Plan for you if a third party may be responsible for the payment of benefits, until a determination is made by the proper and final decision-maker regarding the third party’s responsibility to you. The rules in this Section govern how the Plan pays benefits, if at all, in such situations.

These rules have two purposes. First, the rules ensure that your benefits will be paid promptly. Often, where there is a question of third party liability, many months pass before the third party actually pays. These rules permit the Plan to pay your covered expenses until your dispute with a third party is resolved.

Second, the rules protect the Plan from bearing the full expense in situations where a third party is liable. Under these rules, once it is determined that a third party is liable in any way for the injuries giving rise to these expenses, this Plan must be reimbursed for the benefits it has advanced to you. That reimbursement must come out of any recovery whatsoever that you receive that is in any way related to the event which caused you to incur the medical expenses.

70. HOW DOES THIS PROCESS WORK?

If you incur covered expenses for which a third party may be liable, you are required to advise the Welfare Fund Office of that fact. By law, the Plan automatically acquires any and all rights which you may have against the third party.

71. WHAT DOCUMENTS MUST BE SIGNED IN THESE CASES?

The Trustees may, in their sole discretion, require the execution of this Plan's Subrogation Agreement by you (or your authorized representative, if you are a minor or you cannot sign) before this Plan pays you any benefits related to such expenses. If the Trustees have required execution of the Plan's Subrogation Agreement, no benefits will be provided unless you, your spouse (if any) and your attorney (if any) sign the form. You must also notify the Plan before you retain another attorney or an additional attorney, since that attorney must also execute the Subrogation Agreement.

IN NO EVENT SHALL THE FAILURE OF THE TRUSTEES TO REQUIRE EXECUTION OF THE SUBROGATION AGREEMENTS DIMINISH OR BE CONSIDERED A WAIVER OF THE PLAN'S RIGHT OF SUBROGATION AND REIMBURSEMENT.

At the Plan's request, you must complete a form(s) which includes, but is not limited to the following information:

1. The details of your accident or injury;
2. The name and the address of the person you claim caused the accident or injury as well as the name and address of that person's insurance company and attorney; and
3. The name and address of your attorney.

You must also:

1. Sign the Fund's Subrogation Agreement;
2. Have your attorney sign the Subrogation Agreement and return it to the Fund Office before any benefits are paid;
3. Provide the Fund Office with quarterly reports regarding status of your third party claim or action including, but not limited to, motions, depositions, pretrial conferences, trial dates, settlement conferences, etc.; and
4. Promptly respond to any inquiries from the Fund regarding the status of the third party claim or action including, but not limited to, motions, depositions, pretrial conferences, trial dates, settlement conferences, etc.

Your duty to provide this information to the Plan is a continuing one.

72. WHAT OTHER RIGHTS DOES THE PLAN HAVE?

In addition to its subrogation rights, the Plan has the right to be reimbursed for payment made on your behalf under these circumstances. The Plan must be reimbursed from any settlement, judgment, or other payment that you obtain from the liable third party before any other expenses, including attorneys' fees and costs, are taken out of the payment regardless of how you or the Court characterize the nature of the recovery.

The Plan must be paid in full without regard to whether you have received compensation for all of your damages and without regard to whether you have been "made whole". The Plan has no responsibility to contribute to the payment of your attorneys' fees and costs with respect to any aspect of your representation including the third party action itself, the reimbursement action or any other matter.

73. IS THE PLAN ENTITLED TO FUTURE CREDIT FOR FUTURE RELATED EXPENSES EQUAL TO THE NET PROCEEDS RECEIVED BY YOU?

In addition to satisfaction of the existing lien from any recovery by you, the Plan is also entitled to a future credit for future related expenses equal to the net proceeds received by you.

"Net proceeds" shall be defined as the amount of your total recovery and/or judgment less payment in full of the amount of the Fund's lien, less payment of your attorneys' fees and costs related to the third party action. You must spend the net proceeds on medical or related expenses arising out of or related to the injuries which were the subject of the third party action and which would have otherwise been covered by the Plan until the amount of said proceeds is exhausted.

It is only at that point that your further related Plan benefits will again be the responsibility of the Plan pursuant to the terms of the Plan. The Fund will not resume payment of medical and related benefits until such time as you have provided the Fund with proof that you have utilized the net proceeds of the recovery and/or judgment to pay for medical and related expenses arising out of or related to the injuries which were the subject of the third party settlement or action. The Administrator will determine the net proceeds available for a future credit.

The Trustees, in their sole discretion, may require you to assign your entire claim against the third party to the Plan. If this Plan recovers from the third party any amount in excess of the benefits paid to you, plus the attorneys' fees, costs and expenses incurred in making the recovery, then the excess will be paid to you.

74. WHAT IF I FAIL TO COMPLY WITH THESE RULES?

You will be personally liable to the Plan for reimbursement owed to the Plan and we will discontinue your benefits if any of the following occurs:

1. You fail to tell the Plan that you have a claim against a third party;
2. You fail to assign your claim against the third party to this Plan when required to do so;
3. You fail to cooperate with the Plan's efforts to recover the full amount of benefits paid by the Plan;
4. You fail to require any attorney you subsequently retain to sign the Plan's Subrogation Agreement;
5. You and/or your attorney fail to reimburse the Plan;
6. You fail to provide the Plan with medical or other authorization to obtain the necessary information; or
7. You or your attorneys fail to file written quarterly reports regarding your case with the Fund Office.

This Plan may offset the amount you owe from any future claims submitted by you as well as by your dependents and beneficiaries and/or will discontinue benefits to you, your dependents and beneficiaries, or, if necessary, take legal action against you. The Plan may also recover the amount you owe from your Personal Account Plan. The Board of Trustees has the sole discretion to determine whether you and your attorney have cooperated with the Fund's efforts to recover the entire amount of its lien.

PART F.
TECHNICAL DETAILS

(As required by the Employee Retirement Income Security Act of 1974)

1. PLAN NAME: Asbestos Workers Syracuse Welfare Fund
2. EDITION DATE: This Summary Plan Description is produced as of January 1, 2013.
3. PLAN SPONSOR: Board of Trustees of the Asbestos Workers Syracuse Welfare Fund.
4. PLAN SPONSOR'S EMPLOYER IDENTIFICATION NUMBER: 15-6022551.
5. PLAN NUMBER: 501.
6. TYPE OF PLAN: Welfare Plan
7. PLAN YEAR ENDS: December 31.
8. PLAN ADMINISTRATOR: Board of Trustees of the Asbestos Workers Syracuse Welfare Fund, 150 Midler Park Drive, Syracuse, NY 13206. Phone Number: (315) 424-1809.
9. AGENT FOR SERVICE OF LEGAL PROCESS: Donna Maggiolino, Asbestos Workers Syracuse Welfare Fund, 150 Midler Park Drive, Syracuse, NY 13206. Phone Number: (315) 424-1809.

In addition to the person designated as agent for legal process, service of legal process may also be made upon any plan Trustee, or the Fund Counsel, Blitman & King LLP.
10. TYPE OF FUNDING: Some benefits are insured – some are self-insured.
11. SOURCES OF CONTRIBUTIONS TO PLAN: Employers required to contribute to the Asbestos Workers Syracuse Welfare Fund, certain welfare plans with whom this plan has reciprocal agreements from time to time, and, in certain circumstances, individual participants and other employers who voluntarily elect to participate in the Plan and who do so with the consent of the Board of Trustees.
12. COLLECTIVE BARGAINING AGREEMENTS: This plan is maintained in accordance with collective bargaining agreements. A copy of an agreement may be obtained by you upon written request to the Fund Administrator and is available for examination by you at the plan office.

13. PARTICIPATING EMPLOYERS: You may receive from the Administrative Manager, upon written request, information as to whether a particular employer participates in the sponsorship of the plan. If so, you may also request the employer's address.

14. INSURANCE PLAN BENEFITS PROVIDED BY:

Excellus BlueCross BlueShield, 165 Court Street, Rochester, New York 14647
(800) 499-1275, Guardian Life, Accidental Death and Disability, PO Box 26035, Lehigh Valley, PA 1800, (800) 525-4542.

15. ELIGIBILITY REQUIREMENTS, BENEFITS & TERMINATION PROVISIONS OF THE PLAN: See Parts A., B., and C. of this booklet.

16. HOW TO FILE A CLAIM: See Part D. of this booklet.

17. REVIEW OF CLAIM DENIAL: If you submit a benefit application to the plan office and it is denied, in whole or in part, you will be so notified.

If a denial takes place, you are entitled to appeal the decision. See Part D. of this booklet.

18. NO INSURANCE UNDER THE PBGC: Since this plan is not a defined benefit pension plan, it does not enjoy coverage under the Pension Benefit Guaranty Corporation.

19. TRUSTEES: The Plan Sponsor is the Board of Trustees of the Asbestos Workers Syracuse Welfare Fund.

NOTES

ASBESTOS WORKERS SYRACUSE WELFARE FUND

SUMMARY PLAN DESCRIPTION

AMENDMENT

Pursuant to the provisions of Article V, Section 25 of the Restated Agreement and Declaration of Trust of the Asbestos Workers Welfare Fund, the Summary Plan Description is hereby amended as follows:

I.

Part A, General Information, Section 2, General Eligibility Requirements, Question and Answer 5, "HOW DO I INITIALLY BECOME ELIGIBLE TO PARTICIPATE IN ALL OF THE FUND BENEFITS?" is amended to add the following paragraphs to the end thereof:

"Beginning January 1, 2014, you must actually be enrolled in the Plan's Health Insurance Benefit (or such other employer sponsored health plan that has been certified to the Plan Administrator as providing "minimum value," as such term is defined under the Affordable Care Act) in order to qualify to participate in the Miscellaneous Health Expense Personal Account Plan.

If you leave covered employment or do not enroll in the Plan's Health Insurance Benefit (or another employer sponsored health plan that provides "minimum value" as described above) as of January 1, 2014, you may continue to receive reimbursements from the Miscellaneous Health Expense Personal Account Plan as long as the required balance is maintained in your account. However, utilization of benefits will be applicable to only those contributions made while you were covered under the Plan's Health Insurance Benefit (or such other employer sponsored health plan providing "minimum value" as discussed above)."

II.

Part A, General Information, Section 2, General Eligibility Requirements, Question and Answer 11 "COULD MY INDIVIDUAL ACCOUNT BE ELIMINATED DUE TO INACTIVITY?" is amended to add the following paragraph to the end thereof:

“Notwithstanding the foregoing, a participant who has elected to opt-out of and permanently waive future reimbursements from their personal account will not be eligible to have their account reinstated pursuant to these provisions.”

III.

Part A, General Information, Section 4, Enrollment and Changes in Coverage, Question and Answer 14, “WHAT MUST I DO TO ENROLL IN THE FUND?” is amended to add the following paragraph to the end thereof:

“The government requires that you must also be given the option to permanently opt out of and waive all future reimbursements from your personal account at least annually. If you are continuing to work in covered employment, this means that you will be choosing to forego your benefits despite the fact that contributions will continue to be made to the Fund for your work. Depending on the amount of work you perform in covered employment, choosing to permanently forego this coverage could result in adverse financial and tax consequences for you and your family. Thus, you should carefully consider the consequences of permanently opting to forego all medical and personal account plan benefits, and should discuss any such decision with a qualified tax professional.”

IV.

Part C, Self-Pay Coverage, Section 12, COBRA Continuation Coverage, Question and Answer 47, “WHAT IS COBRA CONTINUATION COVERAGE?” is amended to add the following paragraph to the end thereof:

“As an alternative to purchasing COBRA through this Plan, you may purchase health coverage through the exchange Marketplace. The Marketplace is designed to help people without employer sponsored coverage find health insurance that meets their needs and fits their budget. More information about the Health Insurance Marketplace generally is available at: www.HealthCare.gov. In considering whether coverage through the Marketplace is better for you than COBRA coverage, you could be eligible for a tax credit that lowers your monthly premiums right away. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. If you would like more information regarding the Marketplace, you should contact the Health Benefit Exchange Marketplace in your state of residence. In New York State, the website for the Marketplace is: www.healthbenefitexchange.ny.gov.”

V.

Part C, Self-Pay Coverage, Section 12, COBRA Continuation Coverage, the Answer to Question and Answer 54, "WHAT ARE THE CONSEQUENCES OF FAILING TO ELECT OR WAIVING COBRA CONTINUATION COVERAGE?" is hereby replaced with the following:

"In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you."

VI.

Part C, Self-Pay Coverage, Section 12, COBRA Continuation Coverage, the Answer to Question and Answer 55, "HOW LONG DOES COBRA CONTINUATION COVERAGE LAST?" is hereby amended in Number three as indicated in bold italics below:

"3. The individual becomes covered under another group health plan (other than one sponsored by the employer) except for any period the other group health plan limits coverage of your pre-existing conditions (*note: there are limitations on plans imposing a preexisting condition exclusion and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act*)."

VII.

Part E, Miscellaneous Plan Provisions, Section 18, Coordination of Benefits, the Answer to Question and Answer 68, "WHAT RULES APPLY IF A PERSON ELIGIBLE FOR BENEFITS FROM THIS PLAN IS ALSO COVERED UNDER ANOTHER HEALTH CARE PLAN?" is amended to add the following new paragraphs to the end of the subsection entitled "Coordination With Other Plans" to read as follows:

- For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the plan that covered the person for the longer period of

time is the primary plan, and the plan that covered the person for the shorter period of time is the secondary plan.

- In the event that a dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule described above."

This is to certify that the above amendment was duly adopted by the Board of Trustees on the 19th day of December, 2013, effective January 1, 2014.

Dated: 12/19/13



UNION TRUSTEE

Dated: 12.21.13



EMPLOYER TRUSTEE

smk\Asbestos Workers\amd\2014 Health Reform Amendment