ASBESTOS WORKERS LOCAL 6

HEALTH AND WELFARE FUND

SUMMARY PLAN DESCRIPTION

2013 EDITION

ASBESTOS WORKERS LOCAL 6
HEALTH AND WELFARE FUND
P.O. Box 9631
Boston, MA 02114-9631

Telephone (617) 666-3100

BOARD OF TRUSTEES

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LEGAL COUNSEL

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CONSULTANTS AND ACTUARIES

The Segal Company

AUDITOR

Buckley, Frame, Boudreau & Co., P.C.

INSURED BENEFITS UNDERWRITTEN BY

Tufts Health Plan
Amalgamated Life

Weekly Accident and Sickness Benefits, Dental Benefits, Vision Benefits, Hearing Benefits, Retiree Life Insurance and Health Allowance, Asbestos Screening, and Employee Assistance Program Provided Directly By The Fund

If you do not understand English and have questions about the benefits or rules of the Plan, contact the Fund Office to find out how to obtain such help.

THE TRUSTEES RESERVE THE RIGHT TO AMEND, MODIFY OR DISCONTINUE ALL OR PART OF THE PLAN, THE POLICIES OR THIS SUMMARY WHENEVER, IN THEIR JUDGMENT, CONDITIONS SO WARRANT. No benefits or rules described in this Summary Plan Description (SPD) are guaranteed (vested) for any participant, retiree, spouse or dependent. All benefits and rules may be changed, reduced or eliminated prospectively at any time by the Board of Trustees, at its discretion. This SPD is a summary of the provisions of the Plan and the insurance policies in effect on the date this SPD was issued. The insurance policies take precedence over the SPD; to the extent, if any, that the terms of the policies differ from the terms of the SPD, the terms of the policies prevail. This SPD is not meant to interpret, extend or change any of the provisions of the policies.

Only the Trustees have the authority to make decisions for the Fund. No Local Union Officer, Business Agent, Local Union Employee, Employer or Employer Representative, Fund Office personnel, consultant, attorney or any other person is authorized to speak for, or on behalf of, or to commit the Trustees of this Fund on any matter relating to that Fund without the express authority of the Trustees.

Only the Trustees of the Fund have the authority to determine, among other things, eligibility for benefits and the right to participate in the Fund, including the manner in which hours are credited, eligibility for any benefit, discontinuance of benefits, status as a covered or non-covered employee, the level of benefits, and the interpretation and application of Rules and Regulations to a particular claim or application.

The Trustees have selected Tufts Health Plan to provide an exclusive contracted panel of hospitals and physicians throughout your area, ready to offer a complete continuum of care. Tufts represents that it selected these health care providers based on their demonstrated commitment to providing and maintaining the highest quality of care. Tufts Health Plan and the physicians and providers in its network are independent and separate entities, not affiliated with or under the control of the Board of Trustees of the Fund. The Trustees cannot take responsibility for the quality of care or treatment decisions received through Tufts Health Plan, its CareLink plan option, or its providers nor will the Trustees interfere in the professional relationship between a member and his or her physician.

NOTE: The contents of this SPD contain only a brief summary of the benefits available to you under the group policies. For full and complete provisions and conditions of your insurance, other than weekly accident and sickness, dental, vision and hearing benefits, retiree life insurance and health coverage allowance, asbestos screening, and employee assistance program, refer to the insurance certificates.

IMPORTANT TELEPHONE NUMBERS

FUND OFFICE	(617) 666-3100
MEDICAL	
Tufts Health Plan (CareLink) Member Services	1-866-352-9114
DENTAL	
BLUE CROSS BLUE SHIELD OF MASSACHUSETTS	
Dental Blue Freedom (with Orthodontics) Member Services	1-800-241-0803
PRESCRIPTION DRUGS	
Teamsters Rx	1-866-888-0103
VISION	
Davis Vision	1-800-999-5431
EMPLOYEE ASSISTANCE PROGRAM	
Modern Assistance Programs, Inc.	(617) 774-0331 or 1-800-878-2004

OTHER BENEFITS

For any questions regarding Hearing, Weekly Accident and Sickness, or other benefits, please call the Fund Office.

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September 2013

To All Participants:

The Board of Trustees of the Asbestos Workers Local 6 Health and Welfare Fund is pleased to issue this updated Summary Plan Description (SPD), which describes the Plan's benefits for eligible members and their dependents in effect on September 1, 2013. You and your family should read this SPD together so that you understand the Plan. The health and well-being of all of our members are important to us.

Thanks to the members' use of the Plan's managed care features, the Trustees have been able to keep the cost of the Plan (including out-of-pocket expenses) down. At the same time, the Plan has become more generous as a result of amendments made to comply with the Patient Protection and Affordable Care Act (PPACA). For example, we have expanded the definition of eligible dependent to include married or unmarried children up to age 26. In addition, the prior $2,000,000 overall limit on out-of-network medical benefits no longer applies: the Plan now features unlimited lifetime benefits for all covered services. We believe these changes will enhance the value of the Plan to both you and your family. Additional details about the Plan's eligibility rules, benefits, and other features are explained in detail in this SPD.

For information concerning a particular plan of benefits, and how to use them, you should refer to the pertinent section of this SPD, which discusses each specific benefit. Also, you may refer to the Tufts Health Plan Certificate of Insurance.

This SPD also sets out the information that must be given to Plan participants to comply with the Employee Retirement Income Security Act of 1974 (ERISA), including a statement of your rights and protections under that law. This information is located at the back of this descriptive SPD. This SPD supersedes and replaces all prior SPDs issued for the Asbestos Workers Local 6 Health and Welfare Fund.

We urge you to study this Summary Plan Description carefully and make full use of the coverage to which you are entitled.

If you have any questions concerning the benefits or your eligibility, please feel free to contact the Fund Office at (617) 666-3100.

Sincerely yours,

BOARD OF TRUSTEES

TABLE OF CONTENTS

1. ELIGIBILITY RULES

Who Is Eligible?

Each Employee of an Employer who participates in the Health and Welfare Fund is eligible, provided:

- the Employer is making contributions to the Fund on the Employee's behalf in accordance with the terms of the Collective Bargaining Agreement between the Local Union and the Employer; and
- the Employee satisfies the eligibility rules.

When Does A New Member Become Eligible?

You and your eligible dependents will become eligible on the first day of either June, September, December, or March if you have contributions made on your behalf for a minimum of 350 hours during the six-month period specified below.

350 Hours of Contributions During *Six Months* Ending	**Coverage Begins**	**Insured Period**
March 31	June 1	June, July, August
June 30	September 1	September, October, November
September 30	December 1	December, January, February
December 31	March 1	March, April, May

How Does A Current Member Continue Eligibility?

Eligibility for continued coverage is determined quarterly in accordance with the following schedule:

350 Hours of Contributions During *Quarter* Ending	**Coverage Begins**	**Insured Period**
March 31	June 1	June, July, August
June 30	September 1	September, October, November
September 30	December 1	December, January, February
December 30	March 1	March, April, May

You must have contributions made on your behalf for a minimum of 350 hours during a calendar quarter (known as the Qualifying Period), in order to remain eligible for the next Insured Period. For example,

- If you have 350 hours of contributions in the **Qualifying Period** ending June 30, you will be covered beginning September 1 for the months of September, October and November.
- If you have only 300 hours of contributions in the **Qualifying Period** ending September 30, you will lose eligibility, and will not be covered for the months of December, January and February.

Banking of Hours

If you have not worked the required 350 hours at the end of a **Qualifying Period,** you may use your Banked Hours to maintain eligibility for Plan benefits. Banked Hours are surplus hours (hours in excess of 350) credited to a member during a Qualifying Period. The total number of banked hours may be built up to a maximum of 700 hours.

With Banked Hours, you may be eligible for up to two (2) three-month periods of future benefit coverage.

One-Time Special Eligibility Rule

Every member may use the following special rule once per lifetime.

Available upon request, you and your eligible dependents will be eligible for Fund benefits for an Insured Period beginning on the first day of either June, September, December, or March, provided that you have a minimum 200 hours worked during the immediately preceding three-month period (e.g., March, April, and May for June 1st eligibility). The Fund Administrator may rely on pay stubs or other proof if employer remittance reports have not yet been filed.

If you are a new or reinstating member and elect this one-time rule, your coverage will continue during the next Insured Period (the one after the period triggered by this 200-hour special eligibility rule), provided that you earned a minimum of 350 hours of contributions during the appropriate six-month Qualifying Period.

If you are a current member (*i.e.*, earned eligibility for the previous Insured Period under the regular eligibility rules) and elect this one-time rule, your coverage will continue during the next Insured Period (the one after the period triggered by this 200-hour special eligibility rule), provided that you earned a minimum of 350 hours of contributions during the appropriate three-month Qualifying Period.

For purposes of earning the 350 hours of contributions needed to become eligible, reinstate, or continue eligibility in the next Insured Period, the Fund will double-count hours used under the 200-hour rule if necessary. This means that the Fund will use the same hours used to determine your eligibility for the 200-hour special rule to determine if you have the 350 hours needed for

continued eligibility. Only hours in excess of the 200 hours required under this rule PLUS the 350 hours required under the regular eligibility rules combined (i.e., hours over and above 550 hours) can be credited to your bank.

Again, each member may use this special eligibility rule only once per lifetime. Bank hours may not be used for this one-time special eligibility rule.

Applying "Unused" Contribution Hours to Reduce the COBRA Cost

If you are currently eligible for Fund benefits and lose eligibility for the next Insured Period due to reduction in hours or retirement, the following rule is available to you:

Your "unused" contribution hours will be applied to your COBRA Continuation Coverage premium due. The hours will be credited at the employer contribution rate currently in effect. This will reduce the actual cost of coverage until your "unused" contribution hours have been depleted.

Eligibility of Dependents

Eligible spouses and dependent children become eligible for benefits on the same date that you become eligible; or on the date that they first become eligible dependents, if that is later.

Definition of Eligible Dependents

Eligible dependents are defined as a member's: (a) lawful spouse (or, as described below, member's former spouse), (b) each dependent Child (as defined below) until age 26, (c) each Child who is physically or mentally handicapped age 26 or older, provided proof of incapacity is received by the Fund Office within 30 days of the child's 26th birthday, and (d) the offspring of a dependent identified in (b) or, if unmarried, (c), provided that the Fund Office receives written notice no more than 30 days after the offspring's birth.

"Child," as defined in this section, means the member's child or the member's spouse's child by birth or adoption (including a child placed for adoption), and any child under the member's or spouse's legal guardianship.

Termination of Eligibility

Your insurance will terminate on the last day of an Insured Period following any Qualifying Period during which you fail to have contributions for at least 350 hours of work in covered employment, and when you do not have enough hours in your hour bank to maintain eligibility.

Dependents' insurance terminates on the date they cease to be an Eligible Dependent, or on the date an employee's insurance terminates, except that upon the death of an eligible employee, eligible dependents remain insured until the employee would have lost eligibility based on actual credited hours (which include hours in your hour bank).

When insurance for you and/or your dependents terminates, you may be eligible for continuation of benefits on a self-pay basis. See Part 2 of this SPD for more information.

If you are divorced or legally separated, your ex-spouse remains insured under the Plan unless the court decree provides otherwise. However, your ex-spouse's coverage will terminate when the first of the following occurs:

(a) on the date your coverage under this Plan terminates;

(b) on either your or your ex-spouse's remarriage; or

(c) at such time as provided by the court decree.

In addition, the surviving spouse of a retiree will lose eligibility for the retiree health insurance allowance upon remarriage.

Other circumstances which will result in termination of eligibility are:

- misrepresentation or fraud by a member or covered dependent;
- a Medicare-eligible member reaches age 65 and retires;
- a covered individual becomes eligible for Medicare due to disability; or
- termination of the Plan.

However, in accordance with the requirements of the Affordable Care Act, the Plan will not retroactively cancel coverage except when contributions are not timely paid, or in cases of fraud or intentional misrepresentation of a material fact.

Reinstatement of Eligibility

If your eligibility terminates and you return to work, coverage will begin on the first day of June, September, December or March if you have contributions received on your behalf for a minimum of 350 hours in the six-month period specified in the following table:

350 Hours of Contributions During *Six Months* Ending	**Coverage Begins**	**Insured Period**
March 31	June 1	June, July, August
June 30	September 1	September, October, November
September 30	December 1	December, January, February
December 31	March 1	March, April, May

Any hours used to achieve eligibility for a prior Insured Period may not be used to qualify for reinstatement.

Qualified Medical Child Support Orders (QMCSOs) (Special Rule for Enrollment)

According to federal law, a Qualified Medical Child Support Order, or QMCSO, is a child support order of a court or state administrative agency that has been received by the Fund Office, and that:

- Designates one parent to pay for a child's health plan coverage;
- Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by QMCSO;
- Contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which such type of coverage is to be determined; and
- States the period for which the QMCSO applies.

An order is not a QMCSO if it requires the Fund to provide any type or form of benefit or any option that the Fund does not otherwise provide. For a state administrative agency order to be a QMCSO, state law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.

If a court or state administrative agency has issued an order with respect to health care coverage for any of your dependent Children, the Fund Administrator will determine if that order is a QMCSO as defined by federal law, and that determination will be binding on you, the other parent, the child and any other party acting on behalf of the child. If an order is determined to be a QMCSO, the Fund Administrator will notify the parents and each child, and advise them of the Fund's procedures that must be followed to provide coverage to the dependent Child(ren).

Coverage of the dependent Child(ren) will be subject to all terms and provisions of the Fund, including any limits on the selection of providers, and requirements for authorization of services, insofar as is permitted by applicable law.

No coverage will be provided for any dependent Child under a QMCSO unless all of the Fund's requirements for coverage of that dependent Child have been satisfied. Coverage of a dependent Child under a QMCSO will terminate when your coverage terminates for any reason, subject to the dependent Child's right to elect COBRA Continuation Coverage (if that right applies).

Special Enrollment Events

1. Newly Acquired Spouse and/or Dependent Child(ren)

If you **are enrolled for individual coverage** and if you acquire a Spouse by marriage, or if you acquire any dependent Children by birth, adoption or placement for adoption, you may enroll your newly acquired Spouse and/or any Dependent Child(ren) no later than 31 days after the date of marriage, birth, adoption or placement for adoption. Contact the Fund Office for information on how to enroll a new Spouse or Child.

- If you **are <u>not</u> enrolled for individual coverage** and if you acquire a Spouse by marriage, or if you acquire any dependent Children by birth, adoption or placement for adoption, you may enroll yourself and your newly acquired Spouse and/or any dependent Child(ren) no later than 31 days after the date of marriage, birth, adoption or placement for adoption.
- If you **did not enroll your Spouse for coverage within 31 days of the date on which he or she became eligible for coverage**, and if you subsequently acquire a dependent Child by birth, adoption or placement for adoption, you may enroll your Spouse together with your newly acquired dependent Child no later than 31 days after the date of your newly acquired dependent Child's birth, or placement for adoption.

2. Loss of Other Coverage

If:

- You did not enroll yourself, your Spouse and/or any dependent Child(ren) for coverage within 31 days after the date on which you or they first became eligible for coverage because you or they had health care coverage under any other health insurance policy or program or employer plan, including COBRA Continuation Coverage, individual insurance, Medicare, Medicaid, or other public program; **and**
- You, your Spouse and/or any dependent Child(ren) cease to be covered by that other health insurance policy or plan;

Then:

You may enroll yourself and/or that Spouse and/or Dependent Child(ren) within 31 days after the termination of their coverage under that other health insurance policy or plan if that other coverage terminated because:

- Of the loss of eligibility for that other coverage as a result of termination of employment or reduction in the number of hours of employment, or death, divorce or legal separation; or
- Of the termination of employer contributions toward that other coverage; or
- A covered individual reaches the lifetime limit for all benefits under the other health plan; or
- If that other coverage was COBRA Continuation Coverage, the coverage was "Exhausted." COBRA Continuation Coverage is Exhausted" if it ceases for any reason other than either the failure of the individual to pay the applicable COBRA premium on a timely basis, or for cause (such as making a fraudulent claim). For example, COBRA coverage is considered "exhausted" when the 18- or 36-month maximum coverage period expires; or
- When the individual no longer resides, lives, or works in a service area of an HMO or similar program (whether or not by the choice of the individual) and there is no other COBRA Continuation Coverage available to the individual.

  Also, an individual may be eligible for Special Enrollment even if they did not have other health coverage when they initially refused to enroll in the Fund. This may occur if, after subsequently obtaining other health coverage, they later lose that other health coverage.

- Finally, if you or your dependent lose eligibility for Medicaid or the Children's Health Insurance Program (CHIP), or become eligible to participate in a premium assistance program under Medicaid or CHIP, you may enroll yourself or your eligible dependent in the Fund's health coverage if you request enrollment within 60 days of the loss of Medicaid or CHIP coverage, or the date you or your dependent are determined to be eligible for a Medicaid or CHIP premium assistance program.

If you have any questions about Special Enrollment Events, contact the Fund Office.

Family and Medical Leave Act (FMLA)

Under this federal law, you may have the right to take up to 12 weeks of unpaid leave for your serious illness, after the birth or adoption of a child, or to care for your seriously ill spouse, parent, or child. FMLA leave requires certain Employers to maintain health coverage during the leave period.

In addition, under the FMLA, you may be able to take up to 26 weeks of unpaid leave during any 12-month period to care for a military service member. The military service member must:

- Be your spouse, son, daughter, parent or next of kin;
- Be undergoing medical treatment, recuperation, or therapy, for a serious illness or injury incurred in the line of duty while in military service; and
- Be an outpatient, or on the temporary disability retired list of the armed services.

If you qualify, during your FMLA leave your medical coverage will be maintained under the Fund. You may be eligible for FMLA leave if you:

- Have worked for a covered Employer for at least 12 months;
- Have worked at least 1, 250 hours during the previous 12 months; and
- Work at a location where at least 50 employees are employed by the Employer within 75 miles.

If you think that this law may apply to you, please contact your Employer or the Fund Administrator.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

The Fund complies with the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). This legislation guarantees certain rights to individuals called to active duty in the Armed Forces of the United States.

If you are on active duty for 31 days or less, you will continue to receive health care coverage (medical, dental, prescription drug and vision benefits) provided under the Fund for up to 31 days.

If you are on active duty for more than 31 days, you can continue coverage for you and your dependents at your own expense for up to 24 months. In addition, your dependent(s) may be eligible for health care coverage under a government health coverage program known as TRICARE. The Fund will coordinate coverage with TRICARE. The Fund will not cover any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. The uniformed services and the Department of Veterans Affairs will provide care for service-connected disabilities.

You must report your military leave to the Fund Office in order to maintain eligibility for benefits. Under USERRA, an active employee is also required to notify his or her Employer that he or she is leaving for military service unless circumstances or military necessity make notification impossible or unreasonable. Your Employer is required to notify the Fund within 30 days after you are reemployed following military service.

Returning to work following discharge.

After receiving an honorable discharge, your full eligibility in the Fund will be reinstated on the day you return to work if you return to employment within one of the following time frames:

- 90 days of the date of discharge if the period of military service is more than 180 days;
- 14 days from the date of discharge if the period of military service was 31 days or more but less than 180 days; or
- At the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of service was less than 31 days.

These time limits may be extended for up to two (2) years if you are hospitalized or convalescing from an injury resulting from active duty.

Questions regarding your entitlement to leave under USERRA should be directed to your Employer. Questions regarding the continuation of health coverage while on USERRA leave should be directed to the Fund Office.

2. CONTINUATION OF BENEFITS

In 1986, Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA), which requires that most employers with group health plans offer employees and their covered dependents the opportunity to temporarily continue their health care coverage at group rates when coverage under the plan would be lost.

What is COBRA Continuation Coverage?

COBRA coverage is a temporary continuation of Plan health and life insurance coverage when those coverages would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost due to a qualifying event. Under the Plan, qualified beneficiaries are required to pay for COBRA continuation coverage.

Qualifying Events

When Plan coverage is lost due to any of these events, the employee and each Eligible Dependent may self-purchase group health benefits:

QUALIFYING EVENT	WHO MAY PURCHASE
Employee loses eligibility due to a termination of employment or a reduction in hours of employment (including retirement)	Employee and each Eligible Dependent
Employee becomes entitled to Medicare	Each Eligible Dependent
Employee dies	Each Eligible Dependent
Employee is divorced or legally separated from spouse *	Spouse
Child ceases to be a dependent child as defined under the Plan	Dependent child

* If the employee is divorced or legally separated, his ex-spouse remains insured under certain circumstances. Please see Page 4 for details.

How Long Does Continuation Coverage Last?

QUALIFYING EVENT	MAXIMUM LENGTH OF CONTINUATION
Employee loses eligibility due to a termination of employment or a reduction in hours of employment (including	18 Months
Employee becomes entitled to Medicare	36 Months
Employee dies	36 Months
Employee is divorced or legally separated from spouse	36 Months
Child ceases to be a dependent child as defined under the Plan	36 Months

If you become covered by Medicare (Part A, Part B, or both) before a qualifying event that is a termination of employment or reduction in hours, your entitlement to Medicare will not cause a loss Plan coverage. In that situation, the maximum COBRA coverage period for your spouse and dependent children who are qualified beneficiaries will last until the later of 18 months (or 29 months if there is coverage extension due to disability) from your date of termination of employment or reduction in hours or 36 months after the date you became covered by Medicare.

When Continuation Coverage May Be Cut Short

The law also provides that COBRA Continuation Coverage may be cut short for any of the following reasons:

1. The Employer no longer provides group health coverage to any of its similarly situated employees;
2. You do not pay the applicable premium for your COBRA Continuation Coverage on time;
3. The covered person is or becomes entitled to Medicare;
4. The covered person is or becomes covered under another group health plan that does not contain an exclusion or limitation that applies to any pre-existing condition of that covered person, or by law, may no longer apply its pre-existing condition limitation or exclusion to that covered person; or
5. The Employer that you worked for before the qualifying event has stopped contributing to the Fund, and the Employer establishes one or more group health plans covering a significant number of the Employer's employees formerly covered under the Plan; or the Employer starts contributing to another multiemployer plan that is a group health plan.

If continuation coverage is terminated before the end of the maximum coverage period, the Fund Administrator will send you a written notice as soon as practicable following the Fund Administrator's determination that continuation coverage will terminate. The Notice will set out why continuation coverage will be terminated early, the date of termination, and your rights, if any, to alternative individual or group coverage.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Administrator has been notified that a qualifying event has occurred. When the qualifying event is termination of employment or reduction in work hours, death of the employee, or the employee becoming entitled to Medicare, the employer must notify the Fund Administrator about the qualifying event. You are responsible for notifying the Fund Administrator of certain other qualifying events, as discussed in "How Does the COBRA Election Take Place?" Once the Fund Administrator receives Notice that a qualifying event has taken place, COBRA continuation coverage will be offered to each of the qualified beneficiaries.

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Fund Administrator in a timely fashion, you and your entire family may be entitled to receive up to 11 additional months of COBRA continuation coverage, for a total maximum of 29 months. This disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. See "How Does the COBRA Election Take Place?" for instructions on how to notify the Fund Administrator about a Social Security determination of disability.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage for a maximum of 36 months. This extension may be available to the spouse and dependent children (only) who are receiving continuation coverage if: the employee or former employee dies, becomes entitled to Medicare (under Part A, Part B or both); the former employee gets divorced or legally separated; or the dependent child stops being eligible as a "dependent" under the Plan - but only if the event that occurred would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event (*i.e.*, termination of employment or reduction in work hours), not taken place. Note: Employees or former employees cannot experience "second qualifying events."

How Does The COBRA Election Take Place?

Step 1. As a covered employee or other qualified beneficiary, you are responsible for providing

the Fund Administrator with timely notice of certain qualifying events. You must provide the Fund Administrator with notice of the following qualifying events:

1. The divorce or legal separation of a covered employee from his or her spouse;
2. A beneficiary ceasing to be covered under the plan as a dependent child of a participant;
3. The occurrence of a second qualifying event, as described above, after a qualified beneficiary has become entitled to COBRA with a maximum of 18 (or 29) months.

In addition to these qualifying events, there are two other situations where a covered employee or other qualified beneficiary is responsible for providing the Fund Administrator with notice:

4. When a qualified beneficiary entitled to receive COBRA coverage has been determined by the Social Security Administration (SSA) to be disabled. If the SSA's determination indicates that a qualified beneficiary was disabled at any time during the first 60 days of COBRA coverage, then as noted previously, the individual (and your entire family) may be eligible for an 11-month extension of the 18 months maximum coverage period, for a total of 29 months of COBRA coverage;
5. When the Social Security Administration determines that a qualified beneficiary is no longer disabled.

You must make sure that the Fund Administrator is notified of any of these five occurrences listed above. Failure to provide this notice within the form and timeframes described below may prevent you and/or your dependents from obtaining or extending COBRA coverage.

How Should A Notice Be Provided? Notice of any of the five situations listed above must be provided in writing. You may use the Fund's "COBRA Notice Form for Covered Employees and Other Qualified Beneficiaries" to provide notice to the Fund. You may obtain a copy of this form by contacting the Fund Administrator at (617) 666-3100. Alternatively, you may send a letter to the Fund containing the following information: your name, which of the following events listed above you are providing notice, and the date of the event. You must furnish all other documentation requested by the Fund.

To Whom Should the Notice Be Sent? Notice should be sent to Fund Administrator, Asbestos Workers Local 6 Health and Welfare Fund, c/o AliCare, Inc., P.O. Box 9631, Boston, MA 02114-9631. Notice should be sent by U.S. Postal Service first class mail.

When Should the Notice Be Sent? If you are providing notice due to a divorce or legal separation, a dependent losing eligibility for coverage or a second qualifying event, you must send the Notice no later than **60 days after the later of:** (1) the date of the relevant qualifying event; or (2) the date upon which coverage would be lost under the Plan as a result of the qualifying event.

If you are providing notice of a Social Security Administration determination of disability, Notice must be sent no later than **60 days after the later of:** (1) the date of the disability determination by the Social Security Administration; (2) the date of the qualifying event; or (3) the date on which the qualified beneficiary would lose coverage under the Plan due to the qualifying event.

You should include a copy of Social Security's disability determination letter with your Notice.

If you are providing notice of a Social Security Administration determination that you are **no longer** disabled, Notice must be sent no later than **30 days after** the date of the determination by the Social Security Administration that you are no longer disabled.

Who Can Provide a Notice? Notice may be provided by the covered employee or other qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the covered employee or other qualified beneficiary. Notice from one individual will satisfy the notice requirement for all related qualified beneficiaries affected by the same qualifying event. For example, if an employee, her spouse and her child are all covered by the plan, and the child ceases to be a dependent under the plan, a single notice sent by the spouse would satisfy this requirement.

If you or your dependents have provided Notice to the Fund Administrator of a divorce or legal separation, a beneficiary ceasing to be covered under the Plan as a dependent, or a second qualifying event, but are not entitled to COBRA, the Fund Administrator will send you a written notice stating the reason why you are not eligible for COBRA. This will be provided within 14 days of receiving your notice.

The Fund Office will then send you, your spouse and/or dependent child an election form and information about continuation coverage. **Important: If you don't notify the Fund Office of a Qualifying Event within 60 days of the date of the event, you will lose your right to elect COBRA coverage entirely.**

If you and/or your Eligible Dependents become eligible to self-purchase COBRA coverage due to any other qualifying event, for example, termination of employment or reduction in work hours, the Fund Office will notify you and will send the election form and information within 60 days of the loss of coverage, or the date of the qualifying event, whichever is later.

In order to protect your family's rights, you should keep the Fund Office informed of any changes in address of family members. You should also keep a copy, for your records, of any notices you send to the Fund Office.

Within 60 days of the event that would cause you to lose your health coverage, you must inform the Fund Office that you want to elect COBRA continuation coverage. No evidence of insurability is required. If you do not choose continuation coverage, your group health insurance coverage will end.

Step 2. Once the Fund Office sends you your COBRA election materials, you have **60 days** to make an election.

Each qualified beneficiary with respect to a particular qualifying event has an independent right to elect COBRA continuation coverage. For example, both the employee and the employee's spouse may elect continuation coverage, or only one of them. A parent or legal guardian may elect continuation coverage for a minor child.

Step 3. Once the Fund Office receives your election materials, they will notify you of the amount of retroactive premium you owe. You will have 45 days from the date you made your COBRA election to make payment for all premiums owed for the period. If payment is not received, COBRA coverage will be cancelled retroactively to the date your coverage under the Plan terminated.

Step 4. In addition to the retroactive payment described in Step 3, monthly payments are due. Your monthly payments are due on the 1st day of each month. You will have a 30-day grace period in which to pay. Payments should be mailed to the Fund Office at the address below. If you do not make payment by the end of the grace period, your coverage will be cancelled retroactively to the last day of the previous month.

If you have any questions or need additional information about COBRA coverage, please contact the Fund Administrator at AliCare, Inc., which serves as the Fund Office.

You can contact the Fund Administrator at:

Asbestos Workers Local 6 Health and Welfare Fund
529 Main Street
Charlestown, MA 02129

Mailing Address:
Asbestos Workers Local 6 Health and Welfare Fund
c/o AliCare
P.O. Box 9631
Boston, MA 02114-9631
Telephone (617) 666-3100

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 events 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.

Confirmation of Coverage Before Election or Payment of COBRA Premiums

If a health care provider requests confirmation of coverage and

1. you, your spouse or dependent children have elected COBRA but have not yet paid the premium (and the grace period is still in effect); or
2. you, your spouse or dependent children are within the COBRA election period but have not yet elected COBRA;

COBRA coverage will be confirmed to your health care provider but with notice that the premium has not been paid and that no claims will be paid until the amount due has been received by the Fund. Additionally, your provider will be informed that if the amount due is not received by the end of the grace period, your coverage will terminate retroactively.

What Coverage is Available if I Elect COBRA?

The benefits available to individuals eligible to elect to continue coverage are identical to the benefits available to eligible members and dependents *except for* accidental death and dismemberment coverage and weekly accident and sickness benefits. You may elect medical coverage (including hearing benefits) and life insurance only or *medical coverage together with dental benefits, vision benefits, and life insurance. You may not* elect only dental benefits and vision benefits, and life insurance. More specific information will be provided to you when you become eligible for continuation coverage.

If, during the period of COBRA Continuation Coverage, you marry, have a newborn child, or have a child placed with you for adoption, that Spouse or Dependent child may be enrolled for coverage for the balance of the period of COBRA Continuation Coverage on the same terms available to active Participants. Enrollment must occur no later than 30 days after the marriage, birth or placement for adoption. Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

The Cost

Employees and/or their Eligible Dependents may be required to pay the entire cost of continued group health coverage at group rates. The cost will not exceed 102% of the cost of these benefits to the Fund. Life insurance is provided at no additional cost.

Retirees who elect COBRA will be billed at a rate which is net of the reimbursement they receive from the Fund. Please see Part 9 of this Summary Plan Description for further information on the Fund allowance for retiree health insurance premiums.

Actual employer contributions made on an individual's behalf are credited toward the cost of coverage under the COBRA provision of the Plan.

Specific cost information will be given to you when you become eligible for this type of continuation coverage.

COBRA Continuation Coverage Rights of Appeal

You may appeal any COBRA-related claims that are denied. Please refer to the Fund's claims and appeals procedures beginning on Page 52 of this Summary Plan Description.

Additional COBRA Election Period and Tax Credit in Cases of Eligibility for Benefits Under the Trade Act of 1974

If you are certified by the U.S. Department of Labor (DOL) as eligible for benefits under the Trade Act of 1974, you may be eligible for both a new opportunity to elect COBRA and an individual Health Insurance Tax Credit. If you and/or your dependents did not elect COBRA during your election period, but are later certified by the DOL for Trade Act benefits or receive pensions managed by the Pension Benefit Guaranty Corporation (PBGC), you may be entitled to an additional 60-day COBRA election period beginning on the first day of the month in which you were certified. However, in no event would this benefit allow you to elect COBRA later than six months after your coverage ended under the Plan.

Also under the Trade Act eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp. The Fund Administrator may also be able to assist you with your questions.

For More Information

Questions concerning your Plan or your COBRA continuation coverage rights should be directed to AliCare at the address and telephone number previously indicated. 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 nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available on EBSA's website.)

Certification of Coverage When Coverage Ends

When your medical, dental, vision and hearing coverage ends, the Fund Office will provide you and/or your Eligible Dependents with a Certificate of Coverage that indicates the period of time you and/or they were covered under the Plan. If, within 62 days after your coverage under this Plan ends, you and/or your Eligible Dependents become eligible for coverage under another group health plan, or if you buy, for yourself and/or your Eligible Dependents, a health insurance policy, this certificate may be necessary to reduce any exclusion for Pre-Existing Conditions that may apply to you and/or your Eligible Dependents in that group health plan or health insurance policy. The certificate will indicate the period of time you and/or they were covered under this

Plan, and certain additional information that is required by law.

The certificate will be sent to you (or to any of your Eligible Dependents) by first class mail shortly after your (or their) coverage under this Plan ends. If you (or any of your Eligible Dependents) elect COBRA Continuation Coverage, another certificate will be sent to you (or if COBRA Continuation Coverage is provided only to your Eligible Dependent(s), to the Eligible Dependent(s)) by first class mail shortly after the COBRA Continuation Coverage ends for any reason.

In addition, a certificate will be provided to you and/or any Eligible Dependent upon receipt of a request for such a certificate if that request is received by the Administrator within two years after the later of the date your coverage under this Plan ended or the date COBRA Continuation Coverage ended, if the request is addressed to:

Fund Administrator
Asbestos Workers Local 6 Health and Welfare Fund
529 Main Street
Charlestown, MA 02129

Mailing Address:
Asbestos Workers Local 6 Health and Welfare Fund
c/o AliCare
P.O. Box 9631
Boston, MA 02114-9631

Telephone (617) 666-3100

3. LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Life Insurance

If you die from any cause - on the job or off - while you are insured, the full amount shown in the Schedule of Benefits will be paid to your named beneficiary.

Schedule of Benefits (Active Members Only)

Life Insurance $50,000

Beneficiary

You may name anyone you wish as your beneficiary, and you may change your beneficiary at any time by submitting a completed beneficiary designation form available at the Fund Office. If you die without a completed beneficiary designation form, or your designated beneficiary has predeceased you, the life insurance benefit will be paid to your estate.

Insurance During Total Disability

If you become totally disabled while eligible and before you reach age 60, your life insurance, in the amount shown in the schedule, will be continued at no cost to you as long as you are totally disabled. Totally disabled means that, due to illness or injury, you are completely unable to engage in any business, occupation or employment for wages or profit for at least nine consecutive months.

Your coverage due to disability will begin as soon as you cease to be eligible under the regular eligibility rules and will continue for 12 months, provided you furnish written proof of total disability to Amalgamated Life. Thereafter, your coverage will be continued for successive periods of one year provided you furnish written proof of total disability to Amalgamated Life. Written proof of disability must be furnished within 3 months prior to each anniversary of the date Amalgamated Life received your initial proof of disability.

Conversion to an Individual Policy

You may be able to change your Group Life Insurance, without having to furnish evidence of good health, to an individual life insurance policy provided you apply for conversion and pay the premium during the 31 days following termination of your group coverage. The policy will be effective at the end of the 31-day period, and the premiums will be the same as you would ordinarily pay if you applied for an individual policy at that time. Please contact the Fund Office for additional information.

If you die within this 31-day period, your Group Life Insurance Benefit will be paid whether or not you have applied for an individual policy.

Filing A Claim

A claim for benefits must be filed with the Fund Office within 90 days of the date of your death. Claim forms may be obtained from the Fund Office.

NOTE: Separate life insurance benefits apply to certain retired members. Please see Page 46 for more information.

Accidental Death And Dismemberment Benefit

This benefit is payable for any of the following losses as the result of an accident occurring on or off the job while you are insured. It is payable regardless of other insurance. This benefit is no longer available when your eligibility for coverage from this Fund as an active participant (not on COBRA) ceases or you retire. This benefit is provided through Amalgamated Life .

Schedule of Benefits (Active Members Only)

Loss of Life ..... Full Principal Sum - $50,000

Loss of:
Both hands .....Full Principal Sum - $50,000
Both feet
Sight of both eyes
One hand and one foot
One hand and sight of one eye, or One foot and sight of one eye

Loss of: .....One-Half of the Principal - $25,000
One hand
One foot, or
Sight of one eye

Filing A Claim

A claim for benefits must be filed with the Fund Office within 90 days of your death or accidental dismemberment. Claim forms may be obtained from the Fund Office.

Not Covered

No Accidental Death and Dismemberment benefits will be paid for losses resulting from or caused directly or indirectly by:

1. Suicide or any attempt at suicide
2. Bacterial infection (except pyogenic infections resulting solely from injury)
3. Medical or surgical treatment (except medical or surgical treatment made necessary solely by injury)
4. War or any act of war
5. Injury sustained while engaged in or taking part in aeronautics and/or aviation of any description or resulting from being in an aircraft except while a fare-paying passenger in any aircraft licensed to carry passengers
6. Committing a felony
7. Intentional self-inflicted injury

4. WEEKLY ACCIDENT AND SICKNESS BENEFITS

You are eligible to receive weekly payments in accordance with the Schedule of Benefits if you are unable to work as the result of:

- any non-occupational accidental bodily injury; or
- any sickness for which no benefits are provided under any worker's compensation law,

but no benefits are payable with respect to any time you are unable to work due to alcohol or substance abuse.

These benefits are not provided by the Fund to retired members, members receiving unemployment benefits or members receiving continued coverage under COBRA.

Schedule of Benefits (Active Members Only)

Weekly Accident and Sickness: In general, for accidents or sickness that commenced on April 1, 2013 or later, the available benefit is $550 per week, up to a maximum of 26 weeks. For accidents or sickness that commenced prior to April 1, 2013, the available benefit is $400 per week, up to the 26-week maximum.

The Fund offers a weekly Accident and Sickness benefit to members who are not eligible for a state-provided weekly temporary disability benefit. However, members who have worked in states that have a temporary disability benefit do not qualify to receive the Fund's $550 or $400 per week (whichever applies) accident and sickness benefit, in addition to a state-provided benefit. Specifically, members who have worked in Rhode Island, New York, New Jersey, California, and/or Hawaii (the five states currently with a temporary disability program) who receive less than $550 (or $400) per week from a state disability benefit, can apply to the Fund for the difference between their state temporary disability benefit amount and the $550 (or $400) Fund benefit.

Benefit Period Commences

For a Covered Accident:

On the *first* day that you are unable to work.

For a Covered Sickness:

On the *eighth* day that you are unable to work or the *first* day you are confined to a hospital (or on which you undergo day surgery requiring a significant period of recovery), whichever occurs first.

Receiving Weekly Accident and Sickness Benefits

In order to receive Weekly Accident and Sickness benefits, you must

- contact the Fund Office for a claim form;

- furnish proof to the Fund Office that you are disabled;
- be under the regular and continuing care of a legally qualified physician before payments commence; and
- not be eligible for or receiving state unemployment benefits or receiving any Fund benefits under COBRA.

Please contact the Fund Office to file a claim for Weekly Accident and Sickness benefits. You will need to verify that you are not eligible for any state temporary disability benefit, or if you are eligible, the state benefit is less than the Fund's $550 or $400 weekly accident and sickness benefit amount, whichever applies. Failure to disclose this information will be considered fraudulent behavior, and appropriate action will be taken.

Successive Disabilities

Successive disabilities separated by less than two weeks of full time work will be considered one disability, unless the subsequent disability is due to a different accident or sickness. The subsequent disabilities must occur after you return to fulltime work.

Proof of Disability

In order to receive Weekly Accident and Sickness benefits,

- you must submit proof to the Fund Office that you cannot perform all of the material duties of your regular occupation. Specifically, you must submit a claim form and physician's statement; and
- your disability must be caused by injury or sickness. *No benefits are payable with respect to any time you are unable to work due to alcohol or substance abuse; and*
- you must certify to the Fund Office that you are not eligible for or receiving state unemployment benefits.

The benefits for disability due to pregnancy, including childbirth and abortion (spontaneous or elective), will be determined in the same manner as for any other sickness.

If you have applied for worker's compensation, you may be able to receive payments in exceptional cases. Please contact the Fund Office for more information.

Withholding

Payments received under this benefit are considered as taxable income and must be reported on your state and federal income tax returns. The Fund Office will arrange to have taxes withheld from your disability payments upon request. FICA payments are automatically withheld.

5. MEDICAL BENEFITS

Your medical benefits are described in detail in the Certificate of Insurance provided by Tufts Health Plan. The following descriptions are only a brief introduction to your benefits.

You must read the Tufts Health Plan Certificate of Insurance in order to determine what services are covered, the exact level of coverage, and what restrictions and exclusions exist.

The Fund pays a premium to Tufts Health Plan in return for providing medical benefits to you.

You will be enrolled in the **CareLink** plan option. Completing a Tufts Health Plan/CareLink application is a requirement for obtaining medical coverage, in addition to meeting all other eligibility requirements under the Health and Welfare Fund.

The CareLink Network

The Board of Trustees has contracted with Tufts Health Plan to provide you and your dependents with a Preferred Provider Organization (PPO) medical plan. A PPO is a network of hospitals, physicians, and other health care providers that have agreed to charge negotiated, reduced rates. Since network providers have agreed to these negotiated rates, you help control health care costs for you and the Fund by using health care providers in the CareLink provider network.

However, this plan gives you flexibility in how you receive your medical care. As explained below, each time you seek medical care, you have a choice of using a network or a non-network provider. It is your decision whether to use a network or a non-network provider. The Fund is not responsible for the care or quality of services rendered by either type of provider. You have the final say about the providers you and your family use.

How the Plan Works

CareLink is an open-access health plan offered by Tufts Health Plan in affiliation with CIGNA HealthCare which provides comprehensive, nationwide coverage at a low cost. As noted previously, with CareLink, health care services are covered at two levels: the in-network level of benefits and the out-of-network level of benefits.

As a CareLink member:

- You can choose to obtain covered services from providers in CareLink's broad nationwide network of more than 700,000 providers and 6,000 hospitals, or from providers outside the CareLink network
- You are not required to select a Primary Care Physician (PCP) – although you are encouraged to do so
- The plan allows you to choose any available physician you wish to receive covered services - no referrals are needed

- Wellness and disease management programs are available to help keep members healthy
- Discounts are available on fitness club memberships, acupuncture, massage and more
- You can choose between two levels of coverage:
    - **In-Network Benefits** – When you receive care from a provider in the CareLink network, you receive a higher level of benefits. In general, you pay a copayment (except for durable medical equipment) when you receive covered health care services at the in-network level.
    - **Out-of-Network Benefits** – When you receive care from a provider who is not in the CareLink network, you pay a deductible and then coinsurance until you reach your out-of-pocket maximum. Once you reach your out-of-pocket maximum, you are covered in full up to the reasonable charge for all out-of-network covered services for the remainder of the calendar year. You may also be responsible for paying any difference between what the plan covers and what the out-of-network provider charges for a service. You may also need to submit a claim form for each covered service you receive.

      * A *deductible* is the amount you must pay first out-of-pocket before any coverage is available out-of-network

      * You must then pay *coinsurance* for these services until you reach the plan's *out-of-pocket maximum*. *Coinsurance* is the percentage of covered medical services you are responsible for paying.

      * The plan's *deductible* and *out-of-pocket maximums* are listed in the Benefits Grid that follows.

Deductible and Out-of-Pocket Maximums (per calendar year)	**Individual**	**Family**
Deductible (applies to out-of-network care only)	$250	$500
Out-of-pocket maximum (includes deductible and out-of-network coinsurance)	$2,250	$4,500
Day surgery co-payment maximum	$500	N/A
Inpatient copayment maximum	$1,000	N/A
Preventive Services	**In-Network**	**Out-of-Network (after deductible)**
Routine Physical Exams (including preventive immunizations, preventive Pap smears and mammograms, well-child care visits, annual gynecological exams, and most preventive screenings	Covered in full	Plan covers 80%
Screening for Colon or Colorectal Cancer in the absence of symptoms	Covered in full	Plan covers 80%
Outpatient Medical Care	**In-Network**	**Out-of-Network (after deductible)**
Non-routine Office Visits (including PCP and specialist consultations, and urgent care)	$20 per visit	Plan covers 80%
Outpatient Maternity Care	Covered in full	Plan covers 80%
Routine eye exams (1 visit every 12 months) – you must use an EyeMed Vision Care provider to be covered at the in-network level of benefits	$20 per visit	Plan covers 80%

Nutritional Counseling (when medically necessary)	$20 per visit	Plan covers 80%
Allergy Injections	Covered in full	Plan covers 80%
Speech Therapy (when medically necessary)	$20 per visit	Plan covers 80%
Short-term Physical and Occupational Therapy (60 visits for each type of service per calendar year)	$20 per visit	Plan covers 80%
Spinal Manipulation (no visit limit)	$20 per visit	Plan covers 80%
Non-preventive Pap Smears and Mammograms	Covered in full	Plan covers 80%
Colonoscopies Generally Associated With Symptoms (Including Family History of Cancer) – without surgical intervention	Covered in full	Plan covers 80%
Colonoscopies Generally Associated with Symptoms (Including Family History of Cancer) – with surgical intervention	$250 per admission	Plan covers 80%
Diagnostic Procedures	Covered in full	Plan covers 80%
Diagnostic Imagining – General Imaging (such as x-rays and ultrasounds)	Covered in full	Plan covers 80%
Diagnostic Imaging – High-Tech Imaging (MRIs, CT/CAT Scans, PET Scans, and Nuclear Cardiology)	$100 per visit	Plan covers 80%
Diagnostic Lab Tests	Covered in full	Plan covers 80%
Day Surgery	$250 per admission	Plan covers 80%
Inpatient Hospital Care (semiprivate room, unless private room is medically necessary)	**In-Network**	**Out-of-Network (after deductible)**
All Hospital Services – Acute Care and Maternity Care	$500 per admission	Plan covers 80%
Skilled Nursing in Skilled Nursing Facility (up to 100 days per calendar year)	Covered in full	Plan covers 80%
Emergency Care		
In Emergency Room (copay waived if admitted	$150 per visit	
Mental Health and Substance Abuse	**In-Network**	**Out-of-Network (after deductible)**
Outpatient care	$20 per visit	Plan covers 80%
Inpatient Care	$500 per admission	Plan covers 80%
Other Health Services	**In-Network**	**Out-of-Network (after deductible)**
Durable Medical Equipment	Plan covers 100% up to $1,500, 70% thereafter	Plan covers 70%
Ambulance Service	Covered in full	Plan covers 80%
Hospice Care	Covered in full	Plan covers 80%
Home Health Care	Covered in full	Plan covers 80%
Pediatric Dental: X-rays (full mouth) once every 5 years, Bitewings, once every 6 months and periapicals as needed. Periodic oral exam, oral prophylaxis and fluoride treatment once every 6 months.	Covered for children under 12	

When you choose to receive care on your own:

You pay a deductible of **$250** per member each calendar year **($500** for all family members covered under the same membership) before benefits are provided. After your deductible, you pay 20% co-insurance for most covered services.

When the money you've paid for your 20% co-insurance equals **$2,250** for a member in a calendar year **($4,500**/family, then your benefits (or your family's benefits) are provided in full, based on the allowed charge, up to any benefit maximums for the rest of that calendar year. Your copayments do not count toward your co-insurance maximum. You must still pay your copayment when it applies.

Emergency Care - Wherever You Are

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call 911 (or the local emergency phone number). There is a **$150** copayment for emergency room services, which is waived if you're admitted to the hospital or for an observation stay.

Newborns' and Mother's Health Protection Act

This Plan complies with federal law that prohibits restricting benefits for a mother or newborn child for any hospital length of stay in connection with childbirth to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a Cesarean section. The law also prohibits a plan from requiring a health care practitioner to obtain authorization from the Fund for prescribing a length of stay **not** in excess of those periods.

Women's Health and Cancer Rights Protection Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was per-formed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the medical plan.

6. PRESCRIPTION DRUGS

The Health Benefits Plan provides prescription drug coverage through Teamsters Rx—an easy-to-use and cost-effective way for you and your family to fill your medically necessary prescriptions. When you become eligible for coverage, you'll receive a Teamsters Rx prescription drug card sent to you by Medco/Express Scripts, Inc. (Medco/ESI).

Retail Pharmacy Benefits

When you fill a prescription at a retail pharmacy that participates in the Teamsters Rx prescription drug plan, simply present your drug card when you request your medication. You pay just $10 for a 30- day supply of generic medication.

Medco/Express Scripts, Inc. Network

The Trustees have arranged for Medco/ESI to provide network prescription drug benefits on a tiered basis, as follows:

Tier 1: Generic

Tier 2: Brand name with no generic available

Tier 3: Medco/Express Scripts non-preferred formulary list of drugs or the patient chooses to obtain a brand name drug when a generic version is available (a "multi-sourced" brand)[1]

Mandatory Generic Drug Policy

To help cut costs, your Prescription Drug Plan has a mandatory generic drug policy in effect. This means that if a generic drug is available, you must receive that drug instead of the brand-name drug to receive full benefits.

If a generic drug is available and your doctor prescribes the brand-name version or you insist on the brand-name drug, you will be responsible for paying the brand-name drug copayment PLUS the difference in cost between the generic and the brand-name drug.

In-Network Retail Pharmacy Prescription Drug Copayments

Tier 1: Generic - $10 copayment for a 30-day supply

Tier 2: Brand Name - $25 copayment for a 30-day supply

[1] The patient's physician must request the brand name drug

Tier 3: Non-Preferred Formulary/Multi-Sourced Brand - $45 copayment for a 30-day supply; brand name when a generic is available - $45 copayment plus the difference between the brand name and the generic drug.

The Mail-Order Program

The Medco/ESI mail order pharmacy program is a convenient and less expensive way for you to receive your medication—particularly "maintenance prescriptions"—or drugs that you require on an on-going basis. Examples of maintenance drugs include those you take for high blood pressure, heart conditions or diabetes.

Mail-Order Prescription Drug Copayments

Tier 1: Generic - $20 copayment for a 90-day supply

Tier 2: Brand Name - $50 copayment for a 90-day supply

Tier 3: Non-Preferred Formulary/Multi-Sourced Brand - $90 copayment for a 90-day supply; brand name when a generic is not available – not offered under the mail order program.

Using the Mail-Order Program

Because you know in advance that you need your maintenance medication, it's easy to establish a routine of filling these prescriptions by mail. You are eligible to receive medication for up to a 90-day supply through the mail-order program.

To have your medications filled by the Medco/ESI Mail-Order pharmacy please:

1. Contact Teamsters Rx at www.TeamstersRx.com or call 1-866-888-0103 for instructions.
2. You will be supplied with a Patient Profile form and a Credit/Debit Card Authorization form for your copayments. Attach the original prescription(s) to the completed Patient Profile form and send along with the Credit/Debit Card Authorization form to:

   Teamsters Rx Mail Order Pharmacy
   51 Goffstown Road, P.O. Box 5242,
   Manchester, NH 03108;

   OR

3. Ask your doctor to call the Medco/ESI Mail Order pharmacy at 1-888-327-9791 for instructions on how to provide a prescription drug order to Medco/ESI. Your doctor should fax or call in new prescriptions for a 90-day supply, with three refills, to the Medco/ESI Mail Order pharmacy. Faxed prescriptions must originate from the doctor's office. Your prescription(s) will be sent to you via US Mail or UPS.

To reorder, you simply call Teamsters Rx, 24 hours a day, at 1-866-888-0103 and follow the instructions. Your prescription(s) will be refilled, copays charged to your credit/debit card and the order shipped to you. Check or money orders are accepted.

This is a very simple way in which you can contribute to containing health care costs for you and for the Plan.

7. DENTAL BENEFITS

This is a brief description of your Dental Blue Freedom Plan. It should be used only as a guide. It does not contain complete details of the Plan. The *Dental Blue Freedom (with Orthodontics) Summary of Benefits* and any applicable riders define the terms and conditions, including limitations and exclusions, of your dental care coverage in detail. If questions arise concerning coverage, the Summary of Benefits and any riders will govern. You can get copies of the Summary of Benefits and riders from the Fund Office.

Please Note: Members (and their eligible dependents) who are residents of the State of Maine are enrolled in Dental Blue Program 2. These members receive the same benefits as members enrolled in the Dental Blue Freedom Plan. However, the *Dental Blue Program 2 (with Orthodontics) Summary of Benefits* and any applicable riders define the terms and conditions, including limitations and exclusions, of your dental coverage in detail. If questions arise concerning coverage, the Summary of Benefits and any riders will govern. You can get copies of the *Dental Blue Program 2 Summary of Benefits* and riders from the Fund Office.

Your Dentist

There are more than 5,000 participating Dental Blue dentists/locations that participate with Blue Cross Blue Shield of Massachusetts. Dentists that participate with Blue Cross Blue Shield of Rhode Island and out-of-area dentists who participate in the DenteMax Network of Dentists are also available to Dental Blue members.

If you already have a dentist and want to know if he or she participates with Blue Cross Blue Shield of Massachusetts or Blue Cross Blue Shield of Rhode Island, you may call the dentist, refer to the most current dental provider directory, or call Member Service at the toll-free number shown on your Dental Blue ID card.

If you need to choose a dentist, you may call the Physician Selection Service at **1-800-821-1388**. You can also access the online dental provider directory at www.bluecrossma.com.

Your Dental Benefits

Dental coverage, exclusive of orthodontia, is subject to a $2,000/person maximum benefit per calendar year, with an exception for pediatric dental services that are deemed essential health benefits under the Affordable Care Act (ACA). Pediatric dental services that are deemed essential health benefits under the ACA will be provided to individuals under age 19 with no calendar year maximum limit. There is a $2,500 general lifetime limit on orthodontics covered by the Plan, but this limit does not apply to pediatric, medically necessary orthodontics.

Many of the covered services have specific time limits or age limits associated with them. For example:

- Cleanings are provided only once each six months.

- Fluoride treatments are provided only for members under age 19.

Your Orthodontic Benefits

Your orthodontic benefits are covered based on the allowed charges. Benefits are available on or after your effective date under this dental plan. You will be responsible for any charges beyond your lifetime benefit maximum of $2,500. If your orthodontic treatment began before you were covered under Dental Blue, a monthly fee will be paid for your remaining orthodontic visits until either your treatment is completed or the lifetime benefit maximum is exhausted, whichever comes first.

Note: The lifetime benefit limit on orthodontic benefits does not apply to pediatric, medically necessary orthodontics.

Dental Blue Freedom Plan (with Orthodontics)

Preventive Benefits

No deductible, full coverage based on 100% of Usual and Customary Charges

Diagnostic

- One comprehensive initial oral evaluation, including initial dental history and charting of the teeth and supporting structures
- Full mouth X-rays, seven or more films, or panoramic X-ray with bitewing X-rays once each 60 months
- Bitewing X-rays once each six months
- Single tooth X-rays as needed
- Study models and casts used in planning treatment once each 60 months
- Periodic or routine oral exams once each six months
- Emergency exams

Preventive

- Routine cleaning, scaling and polishing of the teeth once each six months
- Fluoride treatment (members under age 19) once each six months
- Sealants on permanent pre-molar and molar surfaces (members under age 14)
  - one application per bicuspid or molar surface each 48 months
- Space maintainers needed due to premature tooth loss (members under age 19)

Basic Benefits

No deductible, full coverage based on 100% of Usual and Customary Charges

Restorative

- Amalgam (silver) fillings (limited to one filling for each tooth surface in a 12-month period)
- Composite resin (tooth color) fillings on all teeth (limited to one filling for each tooth surface in a 12-month period
- Pin retention for fillings
- Stainless steel crowns on baby teeth and on first permanent adult molars (members under age 16)

Oral Surgery

- Tooth extraction
- Root removal
- Biopsies

Periodontics (gum and bones)

- Periodontal scaling and root planing once per quadrant each 24 months
- Periodontal surgery once per quadrant each 36 months
- Periodontal maintenance following active periodontal therapy once each three months

Endodontics (roots and pulp)

- Root canal therapy on permanent teeth, once in a lifetime for each tooth
- Retreatment root canal therapy on permanent teeth, once in a lifetime for each tooth
- Therapeutic pulpotomy on primary or permanent teeth (members under age 16)
- Other endodontic surgery intended to treat or remove dental root

Prosthetic Maintenance

- Repair of partial or complete dentures, crowns, and bridges once each 12 months
- Adding teeth to an existing complete or partial denture
- Rebase or reline of dentures once each 36 months
- Recementing of crowns, inlays, onlays, and fixed bridgework once each 12 months

Other Covered Services

- Occlusal adjustments once each 24 months
- Services to treat root sensitivity
- Emergency dental care to treat acute pain or to prevent permanent harm to a member
- General anesthesia when administered in conjunction with covered surgical services

Major Benefits

No deductible, 80% of Usual and Customary Charges

Prosthodontics (teeth replacement)

- Complete or partial dentures (including services to fabricate, measure, fit, and adjust them) once each 60 months for each arch
- Fixed bridges (including services to fabricate, measure, fit, and adjust them) once each 60 months for each tooth
- Replacement of dentures and bridges once each 60 months when the existing appliance can't be made serviceable
- Adding teeth to an existing bridge
- Temporary partial dentures to replace any of the six upper or six lower front teeth (only covered if they are installed immediately following the loss of teeth and during the period of healing)
- Endosteal implants to replace permanent teeth through the first molars (once per lifetime, per tooth for members age 18 or older). Limited to $5,000 lifetime benefit maximum. Certain restrictions apply.

Major Restorative (Members age 16 or older)

- Crowns, once each 60 months for each tooth
- Metallic, porcelain, and composite resin inlays. Benefits are provided for an amalgam filling toward the cost of a metallic, porcelain, or composite resin inlay, once each 60 months for each tooth. You pay any balance.
- Metallic, porcelain, and composite resin onlays, once each 60 months for each tooth
- Replacement of crowns, once each 60 months for each tooth
- Replacement of metallic, porcelain, and composite resin inlays. Benefits are provided for an amalgam filling toward the cost of a metallic, porcelain, or composite resin inlay, once each 60 months for each tooth. You pay any balance.
- Replacement of metallic, porcelain, and composite resin onlays, once each 60 months for

each tooth

- Post and core or crown buildup, once each 60 months for each tooth
- Single-tooth dental endosteal implants (the fixture and abutment portion) in addition to the allowance for the crown for the implant, once each 60-month period, when the implant replaces permanent teeth through the second molars (members age 16 and older)

Orthodontic Benefits

No deductible, full coverage of Usual and Customary Charges

Orthodontics

- Complete orthodontic exam
- Comprehensive or limited active orthodontic treatment including appliances

Maximum Benefits

As previously noted, for Adult Preventive, Basic, and Major Benefits, the maximum calendar year benefit payable for services provided to each eligible member or dependent is $2,000, exclusive of orthodontia. There is no calendar year benefit maximum on pediatric dental services that are considered essential health benefits under the ACA provided to eligible dependent children under age 19. There is a $2,500 lifetime limit on orthodontia. However, this limit does not apply to pediatric, medically necessary orthodontia provided to eligible dependent children under age 19.

Pre-Treatment Estimates

If your dentist expects that your dental treatment will involve covered services that will cost more than $250, he or she should send a copy of the "treatment plan" to Blue Cross Blue Shield before services are rendered. A treatment plan is a detailed description of the procedures that the dentist plans to perform and includes an estimate for the charges for each service.

Once the treatment plan is reviewed, you and your dentist will be notified of the benefits available for those services.

Remember, the payment estimate is based on your eligibility status and the amount of your calendar-year (or lifetime) benefit maximum at the time the estimate is received and reviewed. (The actual payment may differ if your available calendar-year (or lifetime) benefit maximum or eligibility status has changed.)

Multi-Stage Procedures

Your dental plan provides benefits for multi-stage procedures (these are procedures that require more than one visit, such as crowns, dentures, and root canals) as long as you are enrolled under the plan on the date the multi-stage procedure is completed. A participating dentist will send a claim for a multi-stage procedure to Blue Cross Blue Shield for processing only after the completion date of the procedure. You will be responsible for all charges for multi-stage procedures if your coverage under the plan has been cancelled before the completion date of the procedure.

Limitations and Exclusions

Examples of when Dental Blue does not provide benefits include:

- A service or procedure that is not necessary and appropriate as determined by Blue Cross Blue Shield.
- Services that are rendered due to the requirements of a third party, such as an employer or school.
- An illness or injury that Blue Cross Blue Shield determines arose out of and in the course of your employment.
- An illness or injury for which any benefits are available through a government program (local, state, national, or foreign) which provides or pays for health services, not including Medicaid or Medicare.
- A method of treatment more costly than is customarily provided. Benefits

  will be based on the least costly, but acceptable methods of treatment.
- Consultations when the dentist who renders the consultation provides treatment.
- A service to treat disorders of the joints of the jaw (temporomandibular joints).
- Services that are meant primarily to change or improve your appearance or solely for convenience.
- Replacement of dentures, bridges, or space maintainers, due to theft, misplacement, or loss.
- Duplicate dentures and bridges.
- Laboratory or bacteriological tests.
- Occlusal guards.
- Drugs, pharmaceuticals, biologicals or other prescription agents or products.

How Dentists are Paid

Dental Blue Freedom (with Orthodontics)

Preferred Dentists

You will receive the greatest value if you visit a preferred dentist, because you will maximize the amount of benefits you receive under the plan.

Payments are calculated based on the provisions of the Blue Cross Blue Shield preferred dentist payment agreement and the dentist's allowed charge in effect at the time the covered dental service is furnished. Preferred dentists agree to accept the allowed charge as payment in full. You pay your co-insurance and all charges beyond your calendar-year or lifetime benefit maximum.

Participating Dentists

For dentists who participate with Blue Cross Blue Shield, but do not have a Blue Cross Blue Shield preferred provider contract, benefits are calculated based on the provisions of the participating dentist's payment agreement and the dentist's allowed charge. These dentists agree to accept the allowed charge as payment in full. You pay your co-insurance and any charges beyond your calendar-year or lifetime benefit maximum.

Non-Participating Dentists

For dentists who do not participate with Blue Cross Blue Shield, benefits are calculated based on the 90^{th} percentile of Blue Cross Blue Shield's Fair Health data. You are responsible for the co-insurance, any difference between the maximum allowance and the dentist's actual charge, and all charges beyond your calendar-year or lifetime benefit maximum.

Dental Blue Program 2 (with Orthodontics)

Participating Dentists

Dentists that participate with Blue Cross Blue Shield of Massachusetts, Blue Cross Blue Shield of Rhode Island, or out-of-area dentists that are in the DenteMax Network of Dentists accept the lesser of either the dentist's actual charge or the allowed charge as payment in full for covered services. You pay only your co-insurance and charges beyond your calendar-year (or lifetime) benefit maximum.

In Massachusetts, benefits are usually only provided when covered services are furnished by a participating dentist. The exceptions are described in your plan description.

Supplemental Coverage

The Fund has also purchased supplemental coverage to provide benefits for covered services furnished in Massachusetts by non-participating dentists. You may be responsible for the co-insurance, any difference between the maximum allowance and the dentist's actual charge, and all charges beyond your calendar-year benefit maximum. Contact the Fund Office for details and claim filing information.

Non-Participating Dentists Outside of Massachusetts

For covered services by non-participating dentists, you may be responsible for the co-insurance, any difference between the Blue Cross Blue Shield payments and the dentist's actual charge, and charges beyond your calendar year (or lifetime) maximum.

If You Have to File a Claim

Participating dentists will send claims to Blue Cross Blue Shield for you. Just show them your Dental Blue ID card. The payment will be sent directly to your dentist when claims are received within one year of the completed service.

If you receive emergency care in Massachusetts by a non-participating dentist because a participating dentist was not available, you or the dentist may file an Attending Dentist's Statement. If you file, send the Attending Dentist's Statement with the original itemized bills. Any benefit payment will be sent to you. You can get Attending Dentist's Statements from Member Service or the Fund Office.

Send all claims to Blue Cross Blue Shield of Massachusetts, P.O. Box 986030, Boston, MA 02298. All member-submitted claims must be submitted within two years of the date of service.

8. VISION BENEFITS

General Information About Your Vision Benefits

Vision benefits are provided through Davis Vision on a self-funded basis. You may choose to obtain services through a Davis Vision provider and receive full coverage, or obtain services outside the network and receive benefits in accordance with a fixed reimbursement schedule.

This benefit is not provided by the Fund to retired members or their dependents, except when an eligible retired member or dependent elects to continue his benefit. See Part 2 of this SPD.

Schedule Of Benefits

Benefits Provided by a Participating Davis Vision Provider

1. **Eye Examinations** - Covered in full, once every 12 months, including dilation as professionally indicated. A complete analysis of the eyes and related structures to determine the presence of vision problems.
2. **Eyeglasses/Frames** - Covered in full, once every 12 months. A Davis Vision provider will order, and verify the accuracy of, the proper corrective lenses. You may choose any Fashion or Designer level frame from Davis Vision's Frame Collection, covered in full. Premier frames are available once every 12 months for a $25 co-payment. If you select another frame in the network provider's office, a $100 credit will be applied toward that frame. This credit also applies at retail locations that do not carry the Davis Vision Frame Collection. Members are responsible for any amount over $100.

   Once every 12 months, the following lenses are also available:

Lens Options	**Member Copay**	
	Dress	**Safety**
Premier Frame	$25	Included
Anti-Reflective Coating		
Standard	$20	N/A
Premium	$48	N/A
Ultra	$60	N/A
Plastic Photosensitive Lenses	$30	$65
High Index Lenses	$30	N/A
Ultraviolet (UV) Coating	$10	Included
Polarized Lenses	$40	$75
Polycarbonate Lenses	$15	Included
Glass Photochromic Lenses	Included	N/A
Progressive Addition Multifocal		
Standard types	$25	$50
Premium types	$45	$90
Didymium lenses	N/A	Included

3. **Contact Lenses –** In lieu of eyeglasses, you may select contact lenses. These are covered once every 12 months, with a required member co-payment of $35. Any contact lenses from Davis Vision's Contact Lens Collection will then be covered in full, per the number indicated below. Your evaluation, fitting and follow-up care will also be covered:

   Standard/Daily Wear……..One pair of lenses

   Disposable……..Four boxes/multi-packs

   Planned Replacement…….Two boxes/multi-packs

   In lieu of the Davis Vision contact lenses, member may use their $45 credit towards their provider's own supply of contact lenses, evaluation, fitting and follow-up care. This credit would also apply towards all contact lenses received at participating retail locations.

4. **Safety Eyeglasses –** Available to members only, once every 12 months. Covered in full in-network. Safety frame from the Premier Safety Collection available at network provider's offices in conjunction with the dress benefit.

5. **Which lenses/coatings are included?**

   - Plastic or glass single vision, bifocal, or trifocal lenses, in any prescription range
   - Glass grey #3 prescription lenses
   - Oversize lenses
   - Post-cataract lenses
   - Fashion, sun or gradient tinted plastic lenses
   - Polycarbonate lenses (under specific circumstances)
   - Didymium lenses for safety eyewear
   - Scratch-resistant coating
   - Blended invisible bifocals

6. **How do I receive services from a network provider?**

   To find a network provider, please access Davis Vision's website at www.davisvision.com and use the "Find a Doctor" feature, or call 1-800-999-5431 to access our Interactive Voice Response Unit. Then, call the network provider of your choice and schedule an appointment. Identify yourself as a Davis Vision and Asbestos Workers Local 6 Fund member or dependent. You will need to provide your member number and the name and date of birth of any covered dependent needing services to schedule an appointment.

Eyeglasses and contact lenses are **not** covered in the same benefit cycle, that is, eyeglasses **or** contact lenses will be covered as described above once every 12 months.

Non-Participating Reimbursement Schedule*

If you choose to obtain the services and materials from a non-Davis Vision provider, you will be reimbursed by Davis Vision up to the maximum shown in the following schedule:

PROFESSIONAL FEES	
Vision Examination	$20.00
MATERIALS	(pair)
Single Vision Lenses	$20.00
Bifocal Lenses	$30.00
Trifocal Lenses	$40.00
Lenticular Lenses	$60.00
Frames	$25.00

* Individuals (including covered dependents) under age 19 are **not** eligible to receive vision benefits from a non-participating provider. Eligible individuals under age 19 receive the Davis Vision in-network benefits described previously. **NOTE:** Reimbursement for the services and materials listed above are payable once every 12 months and are in place of benefits received from a participating Davis Vision practitioner. Eyeglasses and contact lenses are **not** covered in the same benefit cycle, that is, eyeglasses **or** contact lenses are covered as described above once every 12 months.

How to Receive Benefits

When vision care services are needed, you should call a network provider and identify yourself as a member or Eligible Dependent of the Asbestos Workers Local 6 Health and Welfare Fund. As noted earlier, you must provide the office with the member's ID number and the date of birth of the covered individual needing services. The provider's office will verify your eligibility for services with Davis Vision. There are no claim forms or I.D. cards required.

For the Services of a Participating Davis Vision Provider

If you receive services from a Davis Vision provider, the provider is responsible for all of the paperwork. Davis Vision will pay the provider directly in accordance with the Schedule of Benefits.

For the Services of a Non-Participating Davis Vision Provider

1. Make an appointment and receive the necessary services from the non-Davis Vision provider. Pay the full fee and obtain an itemized receipt which must contain the following information:

    - Your name
    - Date services began
    - The services and materials you received
    - The type of lenses you received (single vision, bifocal, trifocal, etc.)

NOTE: Only one claim per service may be submitted for reimbursement each benefit cycle. To request claim forms, please visit the Davis Vision website at www.davisvision.com or call 1-800-999-5431.

2. Mail your vision care claim form and receipt to:

Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

3. You will then be reimbursed directly according to the non-Davis Vision Reimbursement Schedule shown previously.

NOTE: All services must be received at one time from either a network or a non-network provider.

Exclusions

The following items are not covered by this vision program:

- Medical treatment of eye disease or injury
- Vision therapy
- Special lens designs or coatings, other than those previously described
- Replacement of lost eyewear
- Non-prescription (plano) lenses
- Services not performed by licensed personnel
- Contact lenses and eyeglasses in the same benefit cycle.

If you're not sure whether a procedure or item is covered by this program, or you need more information, please visit Davis Vision's website at www.davisvision.com or call Davis Vision at 1-800-999-5431.

9. HEARING BENEFITS

General Information About Your Hearing Benefits

The hearing aid benefit is provided to all eligible active members and dependents by the Asbestos Workers Local 6 Health and Welfare Fund. If an authorized facility determines that an eligible member or dependent requires a hearing evaluation examination, the charges for all testing and a hearing aid, if recommended, will be paid in full by the Fund. In order to receive benefits, you must use an authorized facility.

This benefit is not provided by the Fund to retired members or their dependents.

How to Receive Benefits

You must contact the Fund Office at (617) 666-3100 to receive authorization for the initial hearing examination. After you receive the voucher from the Fund Office, you may contact an authorized facility for an appointment. Subsequent treatment and testing will be arranged by an authorized facility. Contact the Fund Office for information on an authorized facility

Schedule of Benefits

Initial Hearing Examination

You will be provided with an initial hearing examination to determine if you have a hearing loss. The initial screening will be performed by an otolaryngologist or audiologist at an authorized facility.

Hearing Evaluation Examination

If a hearing loss is detected, you will be given further audiological testing. Your hearing loss will be evaluated, and the need for a hearing aid will be determined. Coverage for a hearing evaluation examination will be provided once every two years.

Hearing Aid

If testing indicates the need for a hearing aid, it will be paid in full only when dispensed by an authorized facility. The Fund will cover conventional Analog Hearing Devices, Advanced Programmable or Digital Hearing Aid technology, as indicated and approved. Coverage will be provided for up to $1,500 for Advanced Programmable or Digital Hearing Aid technology or up to $900 for Analog Hearing Devices, per ear, once every five (5) years for adults and once every three (3) years for eligible dependents through age 18. There may be an additional charge not covered by the Fund for completely in-the-canal style hearing aids.

Follow-Up

If you are provided with a hearing aid, all follow-up visits, educational materials, and

adjustments to the hearing aid will be paid in full, provided you use an authorized facility.

HEARING BENEFITS WILL BE PROVIDED ONLY BY AN AUTHORIZED FACILITY.

Other Important Information

1. In order to receive hearing benefits, you must use an authorized facility.
2. The hearing aid must be dispensed by an authorized facility as specified above.
3. Eligible dependents under age 18 must first be seen by an otolaryngologist associated with an authorized facility. Contact the Fund Office before scheduling an appointment.

10. ASBESTOS SCREENING BENEFITS

If you are a benefits-eligible active member of Asbestos Workers Local 6 Health and Welfare Fund or you are currently receiving a pension from the Asbestos Workers Local 6 Pension Fund or the Asbestos Workers Local 31 Pension Fund, you are eligible for certain asbestos screening benefits at specific locations designated by the Plan. Asbestos screening benefits are available once each 12-month period.

The Fund Office maintains a list of medical facilities where you may receive these benefits. To make an appointment for asbestos screening, contact the Fund Office. Please be sure to tell your designated screening provider that you are a member (or retired member) of Local 6 and the bills should be sent to the Fund Office.

NOTE: THE FUND WILL NOT COVER ASBESTOS SCREENING AT ANY FACILITIES OTHER THAN THOSE DESIGNATED BY THE PLAN. FOR MORE INFORMATION, CONTACT THE FUND OFFICE.

11. RETIREE HEALTH AND LIFE INSURANCE

If you are eligible based upon reported hours when you retire, full benefits, except for life insurance, accidental death and dismemberment and weekly accident and sickness benefits, will continue for you and your eligible dependents until the end of the current eligibility period. If you have hours in the hour bank, you may continue to receive group health benefits based on banked hours. After you have exhausted the hours in your hour bank, you and your eligible dependents will be eligible for the coverages described in this Part 9 if:

1. you were eligible for benefits from the Health and Welfare Fund on the day prior to your retirement;* **and**
2. you are eligible to receive a pension immediately under the Asbestos Workers Local 6 Pension Fund or are age 62 and eligible to receive a pension from the Asbestos Workers Local 31 Pension Fund; **and**
3. you earned a minimum of 3 Years of Vesting Service during the 5-year period prior to receiving payments from the Asbestos Workers Local 6 Pension Fund or the Asbestos Workers Local 31 Pension Fund.

For example: You retire on January 1, 2011 and were eligible for Health and Welfare Fund benefits and you are eligible for a pension from the Pension Fund, **but** you earned only 2 Years of Vesting Service during the 5-year period from January 1, 2006 through December 31, 2010. *You and your eligible dependents will **not** be eligible for the Fund's retiree health and life insurance coverages.*

*** If you retire on a disability pension, and were not eligible for benefits from the Health and Welfare Fund on the day before your retirement date because of a delay in receiving an award of disability retirement benefits from the Social Security Administration, you may be eligible for the retiree allowance as of your retirement date.**

Health Coverage

The Fund does not provide health coverage for eligible retirees directly. Instead, it provides a quarterly allowance to be used to pay health insurance premiums. The amount of the allowance depends on:

- your family status (individual, two persons, or family);
- the type of pension you are receiving (Regular**, Disability or Early); and
- the amount you actually pay for coverage.

The current allowance amounts are:

Type of Pension	Individual	2 Persons	Family
Regular or Disability.	$300	$600	$750

Type of Pension	Individual	2 Persons	Family
Early	$225	$450	$600

or, if less, the amount you actually pay for coverage.

** A Regular Pension is defined under the terms of the Asbestos Workers Local 6 Pension Fund. A participant of the Pension Fund may retire on a Regular Pension if he has attained age 62 and has at least 5 years of Vesting Service or 5 Pension Credits, as those terms are defined by the Pension Fund.

Effective April 1, 2013, if you are receiving a pension from the Asbestos Workers Local 31 Pension Fund, you must have attained age 62 at the time you retired to receive or continue to receive the Regular Pension allowance amount shown above. If you were under age 62 at the time you retired, and did not retire on a Disability Pension, you will receive the Early Pension allowance amount (*i.e.*, $225 for an individual) starting April 1, 2013. If you are the surviving spouse of a participant who retired from the Asbestos Workers Local 31 Pension Fund who is currently receiving the retiree health allowance, your deceased spouse must have attained age 62 at the time s/he retired for you to receive or continue to receive the Regular Pension allowance amount shown above. If your spouse was younger than age 62 at the time of retirement, and did not receive a Disability Pension, you will receive the Early Pension allowance amount (*i.e.*, $225 for an individual) as of April 1, 2013.

For Medicare-eligible retirees, the Trustees currently maintain a group Medicare Supplement Policy. If you choose to participate in this group policy, the Fund will bill you for the difference between the health allowance and the actual Medex premium. Additional information is available at the Fund Office.

You may instead choose to use the allowance to pay for other health insurance coverage.

The Trustees reserve the right to eliminate or modify the allowance for retiree health insurance premiums.

Retiree Life Insurance (Self-Funded Benefit)

Effective January 1, 2013, the Life Insurance benefit for eligible retirees is $12,000. (Prior to January 1, 2013, the benefit amount was $7,500.)

Accidental Death and Dismemberment benefits will not continue beyond the date on which you retire. (If you remain eligible for the life insurance benefits available to active employees as the result of becoming totally disabled while eligible, you will *not* also be eligible for retiree life insurance.)

> NOTE: The amount of Life Insurance paid to your beneficiary is determined by your work status. Banked hours cannot be used to continue life insurance coverage.

IMPORTANT: If you are currently receiving a pension from the Asbestos Workers Local 6 Pension Fund or the Asbestos Workers Local 31 Pension Fund, you are also eligible for certain asbestos screening benefits. Please see Part 10 of this SPD for further details.

12. COORDINATION OF BENEFITS

Medical Benefits

See your Tufts Health Plan or Medicare Supplement Subscriber Certificate.

Dental, Vision, and Hearing Benefits

Members of a family are often covered by more than one group health insurance plan. As a rule, two or more plans are paying for the same expense. To avoid this costly problem, your Plan provides a Coordination of Benefits provision. This provision affects all of your health coverages.

How Does Coordination of Benefits Work?

If you or your eligible dependents are also covered under another group plan, the total amount received from all plans will never be more than 100% of Allowable Expenses. Benefits are reduced only to the extent necessary to prevent any person from making a profit on his health coverage.

Allowable Expenses are any reasonable and necessary expenses for services, treatment or supplies, covered by one of the plans under which you or your eligible dependents are insured.

A plan is considered to be any group insurance plan providing coverage for medical treatments or services on an insured or uninsured basis. This includes group blanket or franchise insurance, group pre-payment coverage, labor-management trusteed plans, union welfare plans, employer organization plans, any coverage under governmental programs and any coverage required or provided by law, including state no-fault auto insurance.

This Coordination of Benefits provision shall not apply to any coverage for which you pay the entire premium.

Which Plan Pays First?

If both plans have a Coordination of Benefits provision, the plan that insures you as an employee pays first. If you are insured as an employee under two plans, the plan which has insured you longer is primary. If one plan does not have a Coordination of Benefits provision, that plan is always primary.

Rule 1. Non-Dependent/Dependent

The plan that covers a person as an employee, retiree, member or subscriber (that is, other than as a dependent) pays first; and the plan that covers the same person as a dependent pays second. There is one exception to this rule. If the person is also a Medicare beneficiary, and Medicare is:

1. Secondary to the plan covering the person as a dependent; and
2. Primary to the plan covering the person as other than a dependent (that is, the plan covering the person as a retired employee); then

The order of benefits is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

Rule 2. Dependent Child Covered Under More than One Plan.

If a dependent child is covered under two plans, the birthday rule will be used. Under this rule, the plan of the parent whose birthday falls earlier in the year is primary.

However, if the parents are divorced or separated, the plan of the parent with custody pays benefits first. If the parent with custody remarries, the order of payment is as follows:

1. Parent with whom child resides;
2. Step-parent with whom child resides; and
3. Parent not having custody of the child.

If both parents have joint custody, the birthday rule will be used.

This order of payment can change if the divorce decree directs one of the parents to be financially responsible for the medical, dental or other health care expenses of the child.

Rule 3. Continuation Coverage.

If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member or subscriber (or as that person's dependent) pays first and the plan providing continuation coverage to that same person pays second.

13. EMPLOYEE ASSISTANCE PROGRAM

This benefit is available to eligible members and their dependents. Modem Assistance Programs, Inc. is the Fund's provider for your Employee Assistance Program (EAP). A description of the benefit follows:

Coverage

All members and eligible dependents who are eligible for health benefits under the Plan are covered by the Employee Assistance Program.

Description

The Employee Assistance Program (EAP) provides confidential, professional counseling to members and eligible dependents who want help dealing with alcohol dependency or drug abuse. Modem Assistance Programs, Inc. (the EAP) will develop an outpatient treatment plan and will recommend a list of counselors for the treatment of alcohol and substance abuse.

Pre-admission certification is mandatory for ALL hospital admissions for alcohol and substance abuse and/or rehabilitation. It must be obtained from Modern Assistance Programs, Inc.

If you or your eligible dependent want confidential assistance, call the personnel at the EAP office (telephone number (617) 849-2004) to make an appointment to discuss the situation. Whatever is discussed with the EAP representative is absolutely confidential. No information can be released by the provider without written permission of the person receiving counseling. This is a state and federal law!

Counseling for Alcohol Dependency and Drug Abuse

Counseling for alcohol dependency and drug abuse for eligible members and their dependents is handled directly by Modem Assistance Programs, Inc. (MAP). MAP will help develop an outpatient plan and will recommend a list of counselors. Every effort will be made to continue any pre-existing counseling relationships.

When initial counseling and referral are provided on an outpatient basis with representatives of MAP, services are covered in full.

*Remember, all members or eligible dependents **must** be pre-approved by MAP before they are hospitalized for alcohol dependency or drug abuse.*

If you feel there is a life-threatening emergency and you cannot reach a MAP representative, you should have the eligible person treated in the emergency ward of a general hospital as you would in any other emergency.

The treatment period is adjustable to each individual's needs as determined by Modern Assistance Programs, Inc.

Subsequent use of this benefit will be based upon the completion of the medically recommended inpatient stay and the completion of the aftercare plan recommended by the inpatient facility or Modern Assistance Programs, Inc.

The Fund does not pay weekly accident and sickness benefits for illnesses related to alcohol or substance abuse.

Here is How to Use the Program

There are two ways that a member may use the EAP-self-referral or at the suggestion of your business agent, steward or foreman. When your business agent, steward or foreman suggests you contact an EAP representative, **IT IS NOT MANDATORY** for you to do so. Your employer and supervisor are interested in your total well-being. Getting the right kind of help early may keep a minor problem from becoming a serious problem.

Dependents

Eligible dependents of members may call Modern Assistance Programs, Inc. directly for an appointment.

Representatives of MAP may be reached 7 days a week. For an appointment call:

(617) 774-0331 or 1-800-878-2004

If you live outside the metropolitan area, collect calls will be accepted by MAP.

14. CLAIMS, APPEALS AND GENERAL INFORMATION

Claims Review and Appeals Procedures

1. Tufts Health Plan

See the Tufts Health Plan Certificate of Insurance for details on claims and appeals procedures. The appeals procedures contained therein are the only appeals procedures available to you for medical benefits.

2. Amalgamated Life Insurance Claims Review and Appeals

You should contact the Fund Office to obtain the appropriate claim form. In the event a claim has been denied in whole or in part, you or your beneficiary can request a review of your claim by Amalgamated Life. This request for review should be sent to Group Insurance Claims Review at the address of Amalgamated Life's office which processed the claim.

3. Claims And Appeals Procedures For Weekly Accident and Sickness Benefits, Dental Benefits, Hearing Benefits, Vision Benefits, the Employee Assistance Program and the Asbestos Screening Program, and Medical/Dental Eligibility

This section describes the procedures for filing claims for certain benefits from the Plan. **This section applies only to Weekly Accident and Sickness Benefits, Prescription Drug Benefits, Dental Benefits, Hearing Benefits, Vision Benefits, the Asbestos Screening Program, and for claims denied based on eligibility under the medical and dental plans.** For claims and appeals procedures for your medical benefits for any reason other than eligibility issues, please refer to your Tufts Health Plan Certificate of Insurance. It describes the procedures for you to follow if your claim is denied in whole or in part and you wish to appeal the decision. A claim for benefits is a request for Plan benefits made in accordance with the Plan's reasonable claims procedures. Simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim will not be treated as a claim for benefits. In addition, a request for prior approval of a benefit that does not require prior approval by the Plan is not a claim for benefits.

Elimination of Conflict of Interest: To ensure that the persons involved with adjudicating claims and appeals (such as claims adjudicators and dental/vision experts) act independently and impartially, decisions related to those persons' employment status (such has decisions related to hiring, compensation, promotion, termination) or retention will not be made on the basis of whether that person is likely to support a denial of benefits.

Claims Process

When Claims Must Be Filed

Claims should be filed within one year from the date the charges were incurred.

Who May File Claims?

You, as the individual who obtained a service or item that you believe is a benefit covered by the Plan, or your health care provider on your behalf, may file a claim. You may also file a claim for a service or item that you believe is a benefit provided by the Plan that is provided to your unemancipated minor.

An authorized representative, such as your spouse, also may complete the claim form for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. A form can be obtained from the Fund Office to designate an authorized representative. The Plan may request additional information to verify that this person is authorized to act on your behalf.

How and Where To File Claims

Weekly Accident and Sickness (Disability) Benefits

In order to file a claim for Weekly Accident and Sickness (Disability) Benefits, you must submit a completed claim form. Claim forms may be obtained from the Fund Office at the address listed below.

Your claim will be considered to have been filed as soon as it is received at the Fund Office. Claim forms should be filed and mailed to the Fund Office at the following address:

Asbestos Workers Local 6 Health and Welfare Fund
c/o AliCare
P.O. Box 9631
Boston, MA 02114-9631

Prescription Drugs, Dental, Hearing and Vision Benefits

For Prescription Drugs: When you need a prescription filled at a retail pharmacy, you should locate a participating pharmacy by calling Teamsters Rx at 1-866-888-0103 or visiting their website at www.TeamstersRx.com. At the time that you fill your prescription, present your Teamsters Rx prescription drug card and pay the applicable copayment. You do not have to complete any claim forms; your claims are filed electronically.

When you are filling prescriptions for medications that you take on an ongoing basis (known as maintenance medications), you should use the mail order program. Maintenance medications are

medicines you take on a long-term basis for ongoing conditions. The mail order program offers you the convenience of having prescriptions delivered to your home and it saves you money. See "The Mail Order Program" on Page 28 for more information.

For Dental Benefits, participating dentists will send claims to Blue Cross Blue Shield for you. You will need to show them your Dental Blue ID card. The payment will be sent directly to your dentist when claims are received within one year of the completed service.

If you receive emergency care in Massachusetts by a non-participating dentist because a participating dentist was not available, you or the dentist may file an Attending Dentist's Statement. If you file, send the Attending Dentist's Statement with the original itemized bills. Any benefit payment will be sent to you. You can get Attending Dentist's Statements from Member Service or the Fund Office.

Send all claims to Blue Cross Blue Shield of Massachusetts, P.O. Box 986030, Boston, MA 02298. All member-submitted claims must be submitted within two years of the date of service.

For Hearing Benefits, you must file and mail a completed claim form to the **Asbestos Workers Local 6 Health and Welfare Fund** address above, and your claim will be considered filed as soon as it is received at the Fund Office. Claim forms may be obtained from the Fund Office. Be sure to check the claim form to be certain that all applicable portions of the form are completed and that you have submitted all itemized bills. By doing so, you will speed the processing of your claim. If the claim forms have to be returned to you for information, delays in payment will result.

For Vision Benefits, when you utilize an in-network Davis Vision provider, your claim will automatically be sent to Davis Vision by the provider. There are no claim forms for you to complete. If you use an out-of-network vision provider, you must pay the provider directly. Save a copy of your bill and receipt. You must request a claim form from Davis Vision and complete the claim form and submit it with the receipt to Davis Vision at the following address:

Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

To request a claim form, visit the Davis Vision web site at www.davisvision.com or call 1-800-999-5431. Please note that out-of-network reimbursements will be made in accordance with the terms of the schedule of benefits and the Plan.

If you are not literate in English, depending on the county in which you reside, you may be eligible for assistance in the non-English language in which you are literate. Call the Fund Office at (617) 666-3100 for more information.

Types of Health Care Claims (*i.e.*, Prescription Drugs, Dental, Hearing and Vision Benefits)

There are four basic types of health care claims:

Pre-Service. A pre-service claim is a claim for benefits where prior authorization is required. The Plan will not deny benefits for these procedures or services if:

- It is not possible for you to obtain prior authorization; or
- The prior authorization process would jeopardize your life or health.

Urgent Care. An urgent care claim is a type of a pre-service care claim. An urgent care claim is a claim for medical care or treatment that:

- Would seriously jeopardize your life or health or your ability to regain maximum function if normal pre-service standards were applied; or
- Would subject you to severe pain that cannot be adequately managed without the care or treatment for which approval is sought, in the opinion of a Physician with knowledge of your condition.

Post-Service. A post-service claim is a claim for Plan benefits that is not a pre-service claim. When you file a post-service claim, you have already received the services in your claim. A claim regarding rescission of coverage will be treated as a post-service claim.

Concurrent Care. A concurrent care claim is a claim that is reconsidered after it is initially approved (such as recertification of the number of days of an inpatient hospital stay) and the reconsideration results in:

- Reduced benefits; or
- A termination of benefits.

While other claims have certain deadlines throughout the claim and appeal process, there is no formal deadline to notify you of the reconsideration of a concurrent claim. However, you will be notified as soon as possible and in time to allow you to have an appeal decided before the benefit is reduced or terminated. If you request an extension of approved urgent care treatment, the Plan will act on your request within 24 hours after receiving it, as long as your claim is received at least 24 hours before the expiration of the approved treatment.

If a claim for post-service or concurrent care is approved, payment will be made and the payment will be considered notice that the claim was approved. However, for urgent care and pre-service claims, you will be given written notice of a decision about your claim.

Timing and Form of Claims Decisions

Weekly Accident And Sickness (Disability) Benefits

An **adverse benefit determination** (*i.e.,* a "denial") for an accident and sickness benefit (disability) claim is a denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in the Plan.

Timing of Notice of Claim Denial

The Plan will make a decision on the claim and notify you of the decision within *45 days*. If the Plan requires an extension of time due to matters beyond the control of the Plan, the Plan will notify you of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the *45-day period*. A decision will be made within *30 day*s of the time the Plan notifies you of the delay. The period for making a decision may be delayed an additional *30 days*, provided the Fund Administrator notifies you, prior to the expiration of the first *30-day extension period*, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision.

If an extension is needed because the Plan needs additional information from you, the extension notice will specify the information needed. In that case, you will have *45 days* from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either *45 days* or until the date you respond to the request (whichever is earlier). Once you respond to the Plan's request for the information, you will be notified of the Plan's decision on the claim within *30 days*.

Notice of Denial for Accident and Sickness (Disability) Benefit Claims

If your claim for Accident and Sickness Benefits is denied, the Plan will provide you with written notice of the claim (whether denied in whole or in part). This notice will*:*

1. State the specific reasons for the denial, and refer to the specific plan provisions on which the denial based;
2. Explain your right, upon request and free of charge, to access and receive copies of any documents, records and other information that are "relevant" to the claim for benefits, and your right to submit comments, documents, records and information relating to your claim for benefits;
3. If relevant, include a description of any additional information or material needed from you to perfect the claim and an explanation of why such additional information or material is necessary;
4. If the denial was based on an internal rule, guideline, protocol, or similar criteria, contain a

statement that the rule, guideline, protocol or criteria was relied upon and that a copy will be provided to you upon request at no charge;

5. If the denial was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge;
6. Describe the Plan's claims and appeals procedures, including this Plan's voluntary appeals procedures; and
7. Contain a statement of your right to bring a civil action under ERISA Section 502(a) following a denial on appeal, but note that, in general, such civil action only may be brought after the Plan's appeals procedures have been exhausted.

If A Claim Is Denied (Prescription Drugs, Dental, Hearing and Vision Claims)

An **adverse benefit determination** (*i.e.*, a "denial") of a prescription drug, dental, hearing or vision claim 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, termination or failure to provide or make a payment that is based on:
   (a) a determination of an individual's eligibility to participate in a Plan, or
   (b) a determination that a benefit is not a covered benefit;
2. A reduction in or denial of a benefit resulting from the application of any utilization review decision, preexisting condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits 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/or
3. Any rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions.

Timing of Notice of Denial of Health Care Claims

The deadlines differ for the different types of claims as shown in the following paragraphs:

- **Urgent Care Claims.** An initial determination will be made within 72 hours from receipt of your claim. Notice of a decision on your urgent care claims may be provided to you orally as soon as possible, but no later than 72 hours and then will be confirmed in writing within three days after the oral notice. If additional information is needed from you to process your claim, you will be notified as soon as possible, but no later than 24 hours after receipt of your claim. You will then have up to 48 hours to respond. You will then be notified of the Plan's benefit determination on the urgent care claim as soon as

possible, but no later than 24 hours after the earlier of the receipt of the information or the end of the period of time allowed to you in which to provide the information.

- **Pre-Service Claims.** An initial benefit determination will be made within 15 calendar days from receipt of your pre-service claim. If additional time is necessary to make a benefit determination on your pre-service claim due to matters beyond the control of the Plan, the Plan may take up to 15 additional calendar days to make a benefit determination. You will be informed of the extension within the initial 15-day deadline. If additional information is needed from you to process your claim, you will be notified as soon as possible, but no later than 15 days after receipt of your claim. You will have up to 45 days to provide the requested information. You will then be notified of the Plan's benefit determination on the pre-service claim as soon as possible, but no later than 15 days after the earlier of the receipt of the information, or the end of the 45-day time period allowed to you in which to provide the information.
- **Post-Service Claims.** Ordinarily, you will be notified of the decision on your Post-Service Claim within *30 days* from the Plan's receipt of the claim (including notice from Blue Cross Blue Shield for dental claims, and from Davis Vision for vision claims). This period may be extended one time by the Plan for up to *15 additional days* if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

  If an extension is needed because the Plan needs additional information from you, the extension notice will specify the information needed. In that case, you will have *45 days* from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either *45 days* or until the date you respond to the request (whichever is earlier). The Plan then has *15 days* to make a decision on a Post-Service Claim and notify you of the determination.
- **Concurrent Care Claims.** While other claims have certain deadlines throughout the claim and appeal process, there is no formal deadline to notify you of the reconsideration of a previously approved claim. However, you will be notified as soon as possible and in time to allow you to have an appeal decided before the benefit is reduced or terminated. If you request an extension of approved urgent care treatment, the Plan will act on your request in the same manner as urgent care claims.

Notice of Claim Denial (Prescription Drugs, Dental, Hearing and Vision Benefits)

If your claim is denied, you will be provided with written notice of a denial of a claim (whether denied in whole or in part). Depending on the type of benefit involved with the claim, this notice will either come from the Fund Administrator, Teamsters Rx, Blue Cross Blue Shield or Davis Vision. This notice will*:*

1. Include information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable);
2. State that, upon your request and free of charge, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, will be provided. However, a request for this information will not be treated as a request for an internal appeal or external review;
3. State the specific reason(s) for the denial, including the denial code and its corresponding meaning, as well as any Plan standards used in denying the claim;
4. Reference the specific Plan provision(s) on which the determination is based;
5. If relevant, describe any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary;
6. Provide a description of the Plan's internal appeal procedures (including voluntary appeals) and external review processes, along with the applicable time limits and information on how to initiate an appeal;
7. If the denial was based on an internal rule, guideline, protocol, or similar criteria, contain a statement that the rule, guideline, protocol or criteria was relied upon and that a copy will be provided to you upon request at no charge;
8. If the denial was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge;
9. Contain a statement of your right to bring a civil action under ERISA Section 502(a) following a denial on appeal; and

Disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with their internal claims and appeals and external review processes. The Plan will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of denial of appeal is required to be provided to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan can deny your claim on appeal based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of denial on appeal is required to be provided to give you a reasonable opportunity to respond prior to that date.

Internal Appeals Process

Accident and Sickness (Disability) Benefits

If your claim for Accident and Sickness Benefits is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for an appeal of the claim. Your request for

appeal must be made in writing to the Fund Office within *180 days* after you receive the notice of denial.

Appeals must be submitted in writing to;

The Board of Trustees
Asbestos Workers Local 6 Health and Welfare Fund
c/o AliCare
P.O. Box 9631
Boston, MA 02114-9631

The appeal will be reviewed by The Board of Trustees, who are named fiduciaries of the Plan, and processed as follows:

Upon request, and without charge, you have the right to reasonable access to and copies of documents relevant to your claim. A document, record or other information is relevant if it was relied upon by the Plan in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon); it demonstrates compliance with the Plan's administrative processes for ensuring consistent decision-making; or it constitutes a statement of plan policy regarding the denied treatment or service.

You have the right to submit written comments, documents, records and other information relating to your claim. The review will take into account all such information submitted by you, without regard to whether that information was submitted or considered in the initial claim denial.

A different person/entity will review your claim than the one who originally denied the claim. The reviewer will not be the subordinate of the person/entity who originally denied the claim. The reviewer will not give deference to the initial denial. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine, and who is neither an individual who was consulted in connection with the initial denial nor a subordinate of any such individual, will be consulted. You will be provided with the identification of medical or vocational experts, if any, that gave advice to the Plan on your claim, without regard to whether their advice was relied upon in deciding your claim.

Timing of Appeals Decision

Decisions on Accident and Sickness Benefits claim appeals will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly

scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

Notice of Decision on Appeal

You will receive a notice of the appeal determination. If that determination is a denial, it will include:

- Identification of the claim involved, including date of service, provider, claim amount, and a statement with denial codes and their respective meanings;
- The specific reason(s) for the adverse appeal review decision;
- Reference the specific Plan provision(s) on which the determination is based;
- A statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
- A statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal ;
- A statement of the voluntary Plan appeal procedures;
- If the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
- If the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;
- Disclosure of the availability of, and contact information for, any applicable ombudsman established under the Affordable Care Act of 2010 to assist individuals with internal claims and appeals and external review processes for external claims; and
- The following statement: "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency."

Appeals of Prescription Drug, Dental, Hearing or Vision Benefits

Request for Appeal of a Denied Claim for Prescription Drug Benefits

If your claim for Prescription Drug Benefits is denied by Teamsters Rx in whole or in part, or if you disagree with the decision made on a claim, you may ask for an appeal of the claim. Your request for appeal must be made in writing to Teamsters Rx within 180 days of the date of the denial.

Please send your appeals of denied prescription drug benefits to:

Teamsters Rx
51 Goffstown Road
Manchester, NH 03102

Request for Appeal of a Denied Claim for Dental Benefits

You have the right to a review when you disagree with a decision by Blue Cross and Blue Shield to deny payment for dental services, or if you have a complaint about the service you received from Blue Cross and Blue Shield or a dentist who has a payment agreement to furnish dental services to members. Blue Cross and Blue Shield refers to such appeals as "grievance reviews."

How to Request a Grievance Review

To request a formal review from the *Blue Cross and Blue Shield* internal Member Grievance Program, you (or your authorized representative) have three options:

- **Write or Fax.** The preferred option is for you to send your grievance in writing to: **Member Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126**. Or, you may fax your grievance to **1-617-246-3616**. *Blue Cross and Blue Shield* will let you know that your request was received by sending you a written confirmation within 15 calendar days.
- **E-mail.** Or, you may send your grievance to the *Blue Cross and Blue Shield* Member Grievance Program internet address **grievances@bcbsma.com**. *Blue Cross and Blue Shield* will let you know that your request was received by sending you a confirmation immediately by e-mail.
- **Telephone Call.** Or, you may call the *Blue Cross and Blue Shield* Member Grievance Program at **1-800-472-2689**.

Request for Appeal of a Denied Claim for Vision Benefits

If all or part of a vision claim was not covered, you have a right to appeal or grieve a coverage decision.

Please send your appeal of denied vision benefits to:

Davis Vision
Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

Before sending a formal appeal, you may also ask a question about a denied vision benefit by calling Davis Vision directly at 1-800-999-5431.

Request for Appeal of a Denied Claim for Hearing Benefits

If your claim for Hearing Benefits is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for an appeal of the claim. Your request for appeal must be made in writing to the Board of Trustees within 180 days of the date of the denial. Please send your appeals of denied hearing benefits to:

The Board of Trustees
Asbestos Workers Local 6 Health and Welfare Fund
c/o AliCare
P.O. Box 9631
Boston, MA 02114-9631

Appeals Process (Prescription Drugs, Dental, Vision, and Hearing Benefits)

As noted above, your appeal related to the denial of a prescription drug benefit will be made by Teamsters Rx, dental benefit appeals will be determined by Blue Cross and Blue Shield, and the denial of a vision benefit will be determined by Davis Vision. The Board of Trustees will determine your appeal for hearing benefits. The appeals process for each of these benefits will work as follows:

Upon request, and without charge, you have the right to reasonable access to and copies of documents relevant to your claim. A document, record or other information is relevant if it was relied upon by the Plan in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon); it demonstrates compliance with the Plan's administrative processes for ensuring consistent decision making; or it constitutes a statement of plan policy regarding the denied treatment or service. You have the right to submit written comments, documents, records and other information relating to your claim. The review will take into account all such information submitted by you, without regard to whether that information was submitted or considered in the initial benefit determination.

A different person/entity will review your claim than the one who originally denied the claim. The reviewer will not be the subordinate of the person/entity who originally denied the claim. The reviewer will not give deference to the initial denial. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine, and who is neither an individual who was consulted in connection with the initial denial nor a subordinate of any such individual, will be consulted. You will be provided with the identification of medical or vocational experts, if any, that gave advice to the Plan on your claim, without regard to whether their advice was relied upon in deciding your claim.

Timing of Appeal Decision

The Plan's determination of its decision on your appeal will be made within certain timeframes. The deadlines differ for the different types of claims, as shown in the following paragraphs:

Urgent Care Claims: A determination will be made as soon as possible, but not later than 72 hours after receipt of your appeal.

Pre-Service Claims: A determination will be made within 30 calendar days from receipt of your appeal.

Post Service Claims: Decisions on post-service hearing benefit claim appeals will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 30 days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

Concurrent Care Claims: A determination will be made before termination of your benefit.

Notice of Decision on Appeal

The decision on any review of your appeal will be given to you in writing. The notice of a denial of an appeal will include:

1. Information sufficient to identify the claim, including the date of the service, the health care provider, the claim amount (if applicable);
2. A statement that, upon your request and free of charge, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning will be provided to you. However, a request for this information will not be treated as a request for a voluntary appeal or external review;
3. A statement that you are entitled to receive, upon request and free of charge, access to copies of documents relevant to your claim;
4. The specific reason(s) for the denial, including the denial code and its corresponding meaning, as well as any Plan standards used in denying the claim;
5. Reference to the specific Plan provision(s) on which the determination is based;
6. If relevant, any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary;
7. A description of the Plan's internal appeal procedures (including voluntary appeals) and external review processes, along with the applicable time limits and information on how to

initiate an appeal;

8. A statement of your right to bring a civil action under ERISA Section 502(a) following a denial on appeal;
9. If the denial was based on an internal rule, guideline, protocol, or similar criteria, contain a statement that the rule, guideline, protocol or criteria was relied upon and that a copy will be provided to you upon request at no charge;
10. If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge;
11. The following statement: "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local US Department of Labor Office and your State insurance regulatory agency."
12. Disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with their internal claims and appeals and external review processes.

NOTE: The Plan will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of denial of the appeal is required to be provided to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan can issue a denial on appeal based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of denial on appeal is required to be provided to give you a reasonable opportunity to respond prior to that date.

Limitation On When A Lawsuit or External Review May Be Started

You may not seek external review or start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on appeal, or until the appropriate time frame described above has elapsed since you filed a request for appeal and you have not received a final decision or notice that an extension will be necessary to reach a final decision. However, the law also permits you to pursue your remedies under Section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them. No lawsuit may be started more than three (3) years after the end of the year in which dental or vision services were provided.

Voluntary Claims Appeal Procedures for Prescription Drug, Dental and Vision Benefits

If you are dissatisfied with the decision of Teamsters Rx, Blue Cross Blue Shield or Davis Vision, you may, but are not required, to file a voluntary appeal to the Board of Trustees. The Board of Trustees is the Fund Administrator, and has discretionary authority regarding payment

of claims, subject only to external review and/or judicial review. The Board is composed of six Trustees, three of whom are appointed by the Union and three of whom are contributing employers.

In the event that you choose to file a voluntary appeal with the Board of Trustees, you may do so by making a written request for review of your claim and mailing it the Fund Office at the following address:

Asbestos Workers Local 6 Health and Welfare Fund
c/o AliCare
P. O. Box 9631
Boston, MA 02114-9631
Telephone (617) 666-3100

In the event the Board of Trustees receives an appeal, it will obtain the entire claims record from Teamsters Rx for prescription drug benefits, Blue Cross Blue Shield, for dental benefits, or from Davis Vision, for vision benefits, including the reasons Teamsters Rx, Blue Cross Blue Shield or Davis Vision denied the claim, together with all information which you submitted in support of your claim. In addition, the Trustees will consider any other evidence that you may wish to present, including written documents, or if you desire, you or your representative may appear before the Board of Trustees to explain your position.

If you file a voluntary appeal with the Board of Trustees, neither the Plan nor Teamsters Rx, Blue Cross Blue Shield or Davis Vision will assert in a court a failure to exhaust administrative remedies if you fail to complete (exhaust) the voluntary appeal process. We will also agree that any defense based upon timeliness or statute of limitations will be tolled during the time that your voluntary appeal is pending.

This voluntary appeal procedure is at no cost to you. You are welcome at any time during the voluntary appeal process to have access to all documents relevant to your claim and to present any additional material or information that you believe is appropriate or necessary. Moreover, this appeal will not have any effect on your right to any other benefits under the Plan.

You may request this voluntary appeal only after all other internal appeals pursuant to the Plan have been completed. If you request this appeal, the appeals process outlined previously for hearing and accident and sickness benefits will be followed.

The Plan is managed by the Trustees, who will act as the final decision-makers in this voluntary appeal process. The Trustees have no personal financial stake in the outcome of the claim appeal process or the claim appeal. Their obligation is to administer the Plan in the best interests of all participants and according to the terms of the Plan.

If you have any further questions relating to the voluntary appeal procedure, please contact the Fund Office at the above address.

External Review of Health Claims

This External Review process is intended to comply with the Affordable Care Act's external review requirements.

If you are not literate in English, depending on the county in which you reside, you may be eligible for assistance in the non-English language in which you are literate. Call the Fund Office at (617) 666-3100 for more information.

If your appeal of a claim is denied, whether it's a pre-service, post-service, or urgent care claim, you may request further review by an independent review organization ("IRO") as described below. In the normal course, you may only request external review after you have exhausted the internal review and appeals process described above.

Note that external review is only available for the following types of denials of claims:

- A denial that involves medical judgment, including but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational. The IRO will determine whether a denial involves a medical judgment; and
- A denial due to a rescission of coverage (retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time.

External review is not available for any other types of denials, including if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan. In addition, external review is not available for Accident and Sickness (Disability) Claims.

External Review of Prescription Drug, Dental, Hearing and Vision Claims

Your request for external review of a denial must be made, in writing, within four (4) months of the date that you receive the denial. Because the Plan's internal review and appeals process generally must be exhausted before external review is available, typically external review of claims will only be available for denials of appeals (and not initial claim denials).

1. Preliminary Review

   (a) Within five (5) business days of the Plan's receipt of your external review request for a claim, the Plan will complete a preliminary review of the request to determine whether:

   - You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
   - The denial does not relate to your failure to meet the requirements for eligibility under the terms of the Plan;
   - You have exhausted the Plan's internal claims and appeals process (except, in

limited, exceptional circumstances); and

- You have provided all of the information and forms required to process an external review.

(b) Within one (1) business day of completing its preliminary review, the Plan will notify you in writing as to whether your request meets the threshold requirements for external review. If applicable, this notification will inform you:

- If your request is complete and eligible for external review, or
- If your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)), or
- If your request is not complete, in which case the notice will describe the information or materials needed to make the request complete, and allow you to perfect the request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

2. Review By Independent Review Organization

If the request is complete and eligible, the Plan will assign the request to an Independent Review Organization or "IRO." The IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Plan has contracted with more than one IRO, and generally rotates assignment of external reviews among the IROs with which it contracts.

Once the claim is assigned to an IRO, the following procedure will apply:

(a) The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim (generally, such information must be submitted within ten (10) business days).

(b) Within five (5) business days after the assignment to the IRO, the Plan will provide the IRO with the documents and information it considered in making its denial determination.

(c) If you submit additional information related to your claim, the assigned IRO must within one (1) business day forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its denial that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its denial, it will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

(d) The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo (as if it is new) and will

not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s), unless such requirements are inconsistent with applicable law.

(e) The assigned IRO will provide written notice of its final external review decision to you and the Plan within 45 days after the IRO receives the request for the external review.

(f) The assigned IRO's decision notice will contain the following information, unless such information is inconsistent with applicable current law:

- A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, and the reason for the previous denial);
- The date that the IRO received the assignment to conduct the external review and the date of the IRO decision;
- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available to you or the Plan under applicable State or Federal law;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Services Act to assist with external review processes.

Expedited External Review of Claims

You may request an expedited external review if:

- You receive an initial claim denial that involves a medical condition for which the timeframe for completion of a non-expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or
- You receive a denial from an appeal that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or, you receive a denial from an appeal that concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility.

Preliminary Review

Immediately upon receipt of the request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review set forth above, in Section 1(a), are met. The Plan will immediately notify you as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information described above in Section 1(b).

Review By Independent Review Organization

Upon a determination that a request is eligible for expedited external review following the preliminary review, the Plan will assign an IRO. The Plan will expeditiously provide or transmit to the assigned IRO all necessary documents and information that it considered in denying the claim.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review, above at Section 2. In reaching a decision, the assigned IRO must review the claim de novo (as if it is new) and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, unless such requirements are inconsistent with applicable law.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth above in Section 2.(f), as expeditiously as your medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within forty-eight (48) hours after the date of providing that notice, the IRO must provide written confirmation of the

decision to you and the Plan.

After External Review

If, upon external review, the IRO reverses the Plan's denial, upon the Plan's receipt of notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

If the final external review upholds the Plan's denial, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

General Information

No Medical Examination

If you are eligible, you will be insured under this Plan without medical examination and regardless of your age.

Change in Family Status

After your insurance becomes effective, you must notify the Fund Office of any change in your family status by reason of marriage, birth, adoption or legal guardianship of a child, death, divorce or legal separation. Failure to file the required information may delay payment of benefits.

Medicare

An active employee, age 65 or older and eligible for Part A of Medicare, and an active employee's spouse, age 65 or older and eligible for Part A of Medicare, may continue to have the Fund pay claims as the primary carrier (if the employee's spouse is still working and covered under another plan, that plan is primary to Medicare and this Plan is tertiary). Medicare would then consider a claim for any remaining expenses (provided you registered for Part A and enrolled in Part B).

This Plan is also the primary payor and Medicare is the secondary payor of benefits for an active employee, or the dependent of an active employee who is under age 65 and eligible for Medicare benefits.

If you are actively employed and you or any of your covered dependents become entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the **earlier** of:

- the month in which Medicare ESRD coverage begins; or
- the first month in which the individual receives a kidney transplant. Then, starting with the

31st month, Medicare pays first and this Plan pays second.

Any Covered Charges incurred by such disabled individual should be submitted to this Plan for payment. Afterward, any unpaid balance should be submitted to Medicare, for their consideration.

Third Party Liability

Advance on Account of Plan Benefits

The Plan does not cover expenses for services or supplies for which a third party pays due to any recovery, whether by settlement, judgment or otherwise,(see the exclusion regarding Expenses for Which a Third Party Is Responsible in the Exclusions chapter), but it will advance payment on account of Plan benefits (hereafter called an **"Advance"**), subject to its right to be reimbursed to the full extent of any Advance payment from the covered Employee and/or Dependent(s) if and when there is any recovery from any third party. The right of reimbursement will apply:

(a) even if the recovery is not characterized in a settlement or judgment as being paid on account of the medical [or dental] expenses for which the Advance was made; and

(b) even if the recovery is not sufficient to make the ill or injured employee and/or dependent(s) whole pursuant to state law or otherwise (sometimes referred to as the "make-whole" rule); and

- without any reduction for legal or other expenses incurred by the employee and/or dependent(s) in connection with the recovery against the third party or that third party's insurer pursuant to state law or otherwise (sometimes referred to as the "common fund" rule); and
- regardless of the existence of any state law or common law rule that would bar recovery from a person or entity that caused the illness or injury, or from the insurer of that person or entity (sometimes referred to as the "collateral source" rule);

(c) even if the recovery was reduced due to the negligence of the covered Employee or covered dependent (sometimes referred to as "contributory negligence"), or any other common law defense.

Reimbursement [and/or Subrogation] Agreement

The covered Employee and/or any covered Dependent(s) on whose behalf the Advance is made, must sign and deliver a reimbursement [and/or subrogation] agreement (hereafter called the **"Agreement"**) in a form provided by or on behalf of the Plan. If the ill or injured Dependent(s) is a minor or incompetent to execute that Agreement, that person's parent (in the case of a minor dependent child) or spouse or legal representative (in the case of an incompetent adult) must execute that Agreement upon request by the Fund Administrator or its designee.

If the Agreement is not executed at the Fund Administrator's request, the Plan may refuse to make any Advance, but if, at its sole discretion, the Plan makes an Advance in the absence of an

Agreement, that Advance will not waive, compromise, diminish, release, or otherwise prejudice any of the Plan's rights.

Cooperation with the Plan by All Covered Individuals

By accepting an Advance, regardless of whether or not an Agreement has been executed, the covered Employee and/or covered Dependent(s) each agree:

(a) to reimburse the Plan for all amounts paid or payable to the covered Employee and/or covered Dependent(s) or that third party's insurer for the entire amount Advanced; and

(b) that the Plan has the first right of reimbursement from any judgment or settlement

(c) to do nothing that will waive, compromise, diminish, release, or otherwise prejudice the Plan's reimbursement [and/or subrogation] rights; and

(d) to not assign the right of recovery to any third party without the specific consent of the Plan

(e) to notify and consult with the Fund Administrator or designee before starting any legal action or administrative proceeding against a third party alleged to be responsible for the injury or illness that resulted in the Advance, or entering into any settlement Agreement with that third party or third party's insurer based on those acts; and

(f) to inform the Fund Administrator or its designee of all material developments with respect to all claims, actions, or proceedings they have against the third party.

Subrogation

By accepting an Advance, the covered Employee and/or covered Dependent's jointly agree that the Plan will be subrogated to the covered employee and/or covered dependent's right of recovery from a third party or that third party's insurer for the entire amount Advanced, regardless of any state or common law rule to the contrary, including without limitation, a so-called collateral source rule (that would have the effect of prohibiting the Plan from recovering any amount). This means that, in any legal action against a third party who may have been responsible for the injury or illness that resulted in the Advance, the Plan may be substituted in place of the covered Employee and/or covered Dependent(s), but only to the extent of the amount of the Advance. The Plan is subrogated in any and all actions against third parties for the portion of all recoveries that the Plan is entitled.

Under its subrogation rights, the Plan may, at its discretion:

- start any legal action or administrative proceeding it deems necessary to protect its right to recover its Advances, and try or settle that action or proceeding in the name of and with the full cooperation of the covered Employee and/or covered Dependent(s), but in doing so, the Plan will **not** represent, or provide legal representation for the covered Employee and/or covered Dependent(s) with respect to their damages that exceed any Advance; or

- intervene in any claim, legal action, or administrative proceeding started by the covered Employee or covered Dependent(s) against any third party or third party's insurer concerning the injury or illness that resulted in the Advance.

Lien and Segregation of Recovery

By accepting the Advance the covered Employee and/or covered Dependent agrees to the following:

(a) The Plan will automatically have an equitable lien, to the extent of the Advance, upon any recovery, whether by settlement, judgment, or otherwise, by the covered Employee and/or covered Dependent. The Plan's lien extends to any recovery from the third party, the third party's insurer, and the third party's guarantor and to any recovery received from the insurer under an automobile, uninsured motorist, underinsured motorist, medical or health insurance or other policy. The Plan's lien exists regardless of the extent to which the actual proceeds of the recovery are traceable to particular funds or assets.

(b) The Plan holds in a constructive trust that portion of the recovery that is the extent of the Advance. The covered Employee, covered Dependent, and those acting on their behalf shall place and maintain such portion of any recovery in a separate segregated account until the reimbursement obligation to the Plan is satisfied. The location of the account and the account number must be provided to the Plan.

(c) Should the covered Employee, covered Dependent, or those acting on their behalf, fail to maintain this segregated account, or comply with any of the Plan's reimbursement requirements, they stipulate to the entry of a temporary or preliminary injunction requiring the placement and maintenance of any reimbursable or disputed portion of any recovery in an escrow account until any dispute concerning reimbursement is resolved and the Plan receives all amounts that must be reimbursed.

Remedies Available to the Plan

In addition to the remedies discussed above, if the covered Employee or covered Dependent(s) does not reimburse the Plan as required by this provision, the Plan may, at its sole discretion:

(a) apply any future Plan benefits that may become payable on behalf of the covered Employee and/or covered Dependent(s) to the amount not reimbursed; or

(b) obtain a judgment against the covered Employee and/or covered Dependent(s) for the amount Advanced and not reimbursed, and garnish or attach the wages or earnings of the covered Employee and/or covered Dependent(s), to the extent permitted by law.

15. ADMINISTRATIVE INFORMATION

The following additional information concerning your Plan is being provided to you in accordance with government regulations.

Name of Plan

Asbestos Workers Local 6 Health and Welfare Fund

Plan Sponsor

The Board of Trustees of the Asbestos Workers Local 6 Health and Welfare Fund is the plan sponsor of the Health and Welfare Plan of the Asbestos Workers Local 6 (commonly known as the Asbestos Workers Local 6 Health and Welfare Plan). The plan sponsor's mailing address is:

Board of Trustees
Asbestos Workers Local 6 Health and Welfare Fund
c/o AliCare
P. O. Box 9631
Boston, MA 02114-9631

Plan Administrator

A joint Board of Trustees, consisting of three Union representatives and three Employer representatives, is the administrator of the Plan. The Trustees are listed at the back of this booklet. You may also contact any of them at the above address.

Fund Administrator

The Board of Trustees has hired AliCare, Inc., a third party administrator to administer the Health Fund and provide services to members and dependents. You can contact AliCare at the following address:

AliCare, Inc.
P. O. Box 9631
Boston, MA 02114-9631
Telephone: (617) 666-3100

Employer Identification Number and Plan Number

Board of Trustees' Employer Identification No.: 04-6374403

Plan Number: 501

Plan Year

The Plan's fiscal year is January 1 through December 31.

Discretionary Authority of the Plan Administrator and Its Designees

In carrying out their respective duties under the Plan, the Plan Administrator and any other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated, will have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination under such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Type of Plan

The Plan is a health and welfare plan. The Plan is maintained pursuant to Collective Bargaining Agreements. Copies of such Collective Bargaining Agreements can be obtained upon request. The Collective Bargaining Agreements are also available for examination as required by Department of Labor Regulation 29 CFR §§ 2520.1046-1 and 2520.1046-30.

Funding Medium

Benefits are provided from the Fund's assets which are accumulated under the provisions of Collective Bargaining Agreements between contributing employers and the Unions and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses. The Fund's assets and reserves are invested in accordance with the instructions of the Board of Trustees.

Some of the benefits are fully insured and are provided through the payment of insurance premiums from fund assets to insurance companies. The Fund’s insurance companies are listed under the Section "Insurance Policies and Plan Regulations." Other benefits are self-insured, as described below.

The Fund maintains an agreement with Davis Vision to provide vision benefits and administration services to members and dependents. The benefits provided by Davis Vision are self-insured, which means Davis Vision administers the benefit and the Fund pays the bill provided by Davis each month. Davis Vision's address and telephone number is:

Davis Vision Corporate Headquarters
159 Express Street
Plainview, NY 11803
Member Services Telephone: 1-800-999-5431

The Fund also maintains an agreement with Blue Cross Blue Shield of Massachusetts to provide self-insured dental benefits.

The address and telephone number for Blue Cross Blue Shield of Massachusetts is:

Blue Cross Blue Shield of Massachusetts
Landmark Center
401 Park Drive
Boston, Massachusetts 02215-3326
Member Services Telephone: 1-800-241-0803

The Fund maintains an agreement with Teamsters Rx to administer self-insured prescription drug benefits. The address and telephone number for Teamsters Rx is:

Teamsters Rx
51 Goffstown Road
Manchester, NH 03102
Telephone: 1-866-888-0103

Source of Contributions

All contributions to the Plan are made by Employers in accordance with Collective Bargaining Agreements between the Asbestos Workers Local 6 and employers in the industry. The collective bargaining agreements require contributions to the Plan at fixed rates per hour worked. You are not required or permitted to contribute to the Plan.

The Fund Office will provide you, upon written request, with information as to whether a particular employer is contributing to this Plan on behalf of Participants working under the Collective Bargaining Agreement and, if so, with that employer's address.

Agent for the Service of Legal Process

The Board of Trustees has been designated as the agent for the service of legal process. Process may be served at the Fund Office address. You may also serve legal process upon any of the Trustees individually.

Plan Information

The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility, or denial or loss of benefits are described in this SPD in Part 1: Eligibility Rules (beginning on Page 1) and Part 14, Claims, Appeals and General Information (beginning on Page 52).

Insurance Policies and Plan Regulations

The complete terms of the insured benefits are set forth in the insurance policies or contracts with the following organizations:

Medical Benefits

Tufts Health Plan, 705 Mt. Auburn Street, Watertown, Massachusetts 02472

Life Insurance and Accidental Death and Dismemberment Benefits

Amalgamated Life Insurance Company
333 Westchester Avenue
White Plains, New York, 10604

The complete terms of the self-insured hearing care benefits are in Part 9 beginning on Page 42 and the complete terms of the self-insured retiree life insurance benefits are in Part 11 beginning on Page 45 of this Summary Plan Description.

For specific information on retiree life insurance, please see Page 46 of this Summary Plan Description.

PROTECTED HEALTH INFORMATION USE OR DISCLOSURE

Effective April 14, 2004, the Fund and the Fund's Board of Trustees ("Plan Sponsor") may only use and/or disclose Protected Health Information (as such term is defined in 45 C.F.R. &164.501) as permitted by the "Standards for Privacy of Individually Identifiable Health Information" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), P.L. 104-191, and applicable guidelines (the "Rule").

Fund's Use and Disclosure Of Protected Health Information

Under HIPAA and the Rule, the Fund will be permitted by law to make certain types of uses or disclosures of your dental and vision information, without your authorization, for payment, treatment and health care operations, as those terms are defined in HIPAA and the Rule. After April 14, 2004, you will have certain rights to request restrictions on certain uses and disclosure of this information, request an amendment of the information, and request an accounting of disclosures, among other things. More detailed information about permitted uses and disclosures of dental and vision information by the Fund, including examples of permitted uses and disclosures, is contained in the Fund's Notice of Privacy Practices.

Plan Sponsor's Use and Disclosure Of Protected Health Information

Use and Disclosure

In accordance with HIPAA and the Rule, effective April 14, 2004, the Plan Sponsor will:

1. Not use or further disclose Protected Health Information other than as permitted or required by this plan document or as required by law;
2. Ensure that any agents, including a subcontractor to whom it provides Protected Health Information received from the Fund, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
3. Not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
5. Report to the Fund any use or disclosure of the Protected Health Information that is inconsistent with the uses or disclosures permitted by the Rule of which it becomes aware;
6. Make available Protected Health Information based on HIPAA's access requirements in accordance with 45 C.F.R. 164.524;
7. Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. 164.526;
8. Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528;

9. Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Fund available to the Secretary of Health and Human Services for purposes of determining compliance by the Fund with the Rule;

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

11. Ensure that adequate separation of the Fund and Plan Sponsor is established as required by 45 C.F.R. 164.504 (f)(2)(iii), as described below.

The Fund, or a health insurance issuer or HMO with respect to the Fund, may disclose Summary Health Information to the Plan Sponsor, provided such Summary Health Information is only used by the Plan Sponsor for the purpose of: (a) obtaining premium bids from health plan providers for providing health insurance coverage under the Fund; or (b) modifying, amending or terminating the Fund.

Certification of Plan Sponsor

Effective April 14, 2004, the Fund (or a health insurance issuer with respect to the Fund) shall disclose Protected Health Information to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Plan has been amended to the conditions of disclosure set forth above. The Fund shall not disclose and may not permit a health insurance issuer to disclose Protected Health Information to a Plan Sponsor as otherwise permitted herein unless the statement required by 45 C.F.R. 164.520 (b)(1)(iii)(C) is included in the appropriate notice.

Separation of Plan and Plan Sponsor

Effective April 14, 2004, only the following types of persons and employees under the control of the Plan Sponsor will be given access to the Protected Health Information: Fund Trustees, Fund Legal Counsel, Fund Consultant, Fund Administrator, Fund Privacy Official and Fund Account Executive ("Permitted Persons" or "Permitted Employees"). Despite the foregoing, any employee or person not described above who receives Protected Health Information relating to payments under, health care operations of, or other matters pertaining to the Fund in the ordinary course of business, will also be included in the definition above of Permitted Persons or Employees. The Permitted Employees or Persons may only use the Protected Health Information for Fund administrative functions that the Plan Sponsor performs for the Fund.

Important Notice *for participants and beneficiaries of the Asbestos Workers Local No. 6 Health and Welfare Plan:*

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE NOTICE CAREFULLY

This notice of privacy practices describes how the Asbestos Workers Local 6 Health and Welfare Plan (referred to after this as "We" or the "Plan") may use and disclose your protected health information to carry out treatment, payment or health care operations, and for other purposes that are permitted or required by law. Protected health information is information about you, including demographic information, that may identify your present or past physical or mental health or condition. This notice applies only to protected health information received by the Plan. It does not apply to your medical or other information that the Plan does not receive, and it does not pertain to how your medical providers, including your treating physician, may use, disclose or protect such information.

We may share protected health information with any of our affiliates as necessary to carry out payment, treatment or health care operations. Some examples of sharing information for these purposes are provided as follows; the examples listed are not an exhaustive list. With respect to payment, We may use protected health information about you to obtain or make payment for your health services, to determine your eligibility or coverage for benefits under the plan, to coordinate benefits with other plans under which you may have coverage, to obtain payment of contributions from you or your employer, and to determine whether benefits provided to you are covered by the plan.

With respect to treatment, we may disclose protected health information to a provider, such as the identity of your primary care physician, if We have the information, it is requested and is for treatment purposes. With respect to health care operations, We may disclose protected health care information in auditing the accuracy of claims adjudications, investigating a complaint regarding a reported violation of your privacy rights, training a new claims processor under close supervision, or evaluating the quality of care that you receive. We may not, however, use or disclose protected health care information that is genetic information for underwriting purposes.

We may use or disclose identifiable protected health information about you without your authorization for several other reasons. Subject to certain requirements, We may give out health information without your authorization for public health purposes, for health oversight and auditing purposes, for research studies, and for emergency treatment. We provide information when otherwise required by law, such as for law enforcement in specific circumstances or pursuant to court order or subpoena. We may also, in limited circumstances, disclose payment information to the spouse or personal representative of a patient.

In any other situation, We will ask for your written authorization before using or disclosing any

identifiable protected health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop any future uses and disclosures at any time.

The types of uses and disclosures that require your authorization include: (1) the use and disclosure of psychotherapy notes, except for use by the originator of the notes for treatment; the use or disclosure by the Plan for its own supervised training programs; or the use of disclosure by the Plan to defend itself in a legal proceeding; (2) the use and disclosure of protected health care information for marketing, except if the communication is in the form of a face to face communication by the Plan to an individual or a promotional gift of nominal value made by the Plan; and (3) the disclosure of protected health care information which is a sale of protected health care information, as defined by the HIPAA regulations.

There may be instances where services are provided to us through contracts with third party business associates. Whenever a business associate arrangement involves the use or disclosure of your health information, We will have a written contract that requires the business associate to maintain the same high standards of safeguarding your privacy that We require of our own employees and affiliates.

Finally, there may be situations where We disclose certain types of health information about you to the Plan's Board of Trustees. We may disclose to the Board of Trustees whether or not you are enrolled in, participate in, or have disenrolled from this plan. We may provide the Board of Trustees with "summary health information," which includes claims history and totals without any personal identification except your zip code, for either obtaining health insurance premium bids from other plans, or to consider changing or terminating the plan.

Your Rights

In most cases, you have the right to look at and get a copy of health information about you that We use to make decisions about you. If you request copies, We will charge you $0.05 (5 cents) for each page. You have the right to **ask** us, in writing, to communicate with you using an alternate means or at an alternate location. We will consider your request but are not legally required to accept it unless disclosure of the information could endanger you.

You also have the right to receive a list of instances where We have disclosed health information about you for reasons other than treatment, payment or related administrative purposes where you did not give your consent or authorization. If you believe that information that We maintain in your record is incorrect or if important information is missing, you have the right to request that We correct the existing information or add the missing information.

You may request in writing that We restrict the use or disclosure of your protected health information to carry out treatment, payment and administrative purposes, except as specifically authorized by you, when required by law or in emergency circumstances. Your request must state the specific restriction requested and to whom you want the restriction to apply. We will consider your request but are not legally required to accept it unless, effective September 23, 2013, the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the protected health information pertains solely to a health care

item or service for which you have paid the Plan in full.

Notice of Breach

If We experience a breach of unsecured protected health information, We will notify affected individuals within 60 days of discovery of the breach. We will also notify the U.S. Department of Health and Human Services and local media outlets if the breach affects 500 or more individuals.

Complaints

If you are concerned that We have violated your privacy rights, or you disagree with a decision We made about access to your records, you have the right to file a complaint with us (see contact information below) or with the U.S. Department of Health and Human Services at: Office for Civil Rights, U.S. Department of Health and Human Services, J.F.K. Federal Building, Room 1875, Boston, MA 02203. Telephone: (617) 565-1340. All complaints must be submitted in writing. You will not be retaliated against or otherwise penalized for filing a complaint.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

We may change our policies at any time. Before We make a significant change in our policies, We will change our notice and provide you with a copy of the new policy. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Contact Information:

If you have any questions or complaints, please contact Privacy Officer Asbestos Workers Local 6 Health and Welfare Fund, c/o AliCare, P.O. Box 9631, Boston, MA, 02114-9643; Telephone (617) 666-3100. You may also contact Chief Privacy Officer, Davis Vision, P.O. Box 1416, Latham, NY 12110-1416, phone 1-800-571-3366, with a question or complaint related to Davis Vision.

Effective Date

This Notice originally became effective on April 14, 2004 and this Notice as revised is effective July 1, 2013.

STATEMENT OF RIGHTS UNDER EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

Your Rights Under ERISA:

As a participant in the Asbestos Workers Local 6 Health and Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security act of 1974. ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as union halls, 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 Benefits 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 or 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 of your coverage.

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 listed in your telephone directory or the Division of Technical Assistance and inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of Employee Benefits Security Administration.

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SPD Date: September 2013