ASBESTOS WORKERS LOCAL No. 6
HEALTH AND WELFARE FUND
RETIREE HEALTH ALLOWANCE PLAN

SUMMARY PLAN DESCRIPTION

January 1, 2016

ASBESTOS WORKERS LOCAL No. 6
HEALTH AND WELFARE FUND

BOARD OF TRUSTEES

Union Trustees	Employer Trustees
Francis C. Boudrow	Paul M. Camara
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ADMINISTRATOR (FUND OFFICE)

Through March 31, 2016
AliCare, Inc.
529 Main Street
Charlestown, MA 02129

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

Effective April 1, 2016
BeneSys, Inc.
750 Dorchester Avenue
Boston, MA 02125
Telephone: (617) 795-4120

LEGAL COUNSEL
Segal Roitman, LLP

CONSULTANTS AND ACTUARIES
Segal Consulting

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

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

THE TRUSTEES OF THE ASBESTOS WORKERS LOCAL NO. 6 HEALTH AND WELFARE FUND (THE "FUND" OR THE "HEALTH FUND") 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 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 describes the provisions of the Plan in effect on the date this SPD was issued.

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 the Fund without the express authority of the Trustees.

Only the Trustees of the Fund have the authority to determine, among other things, a person's eligibility for benefits and the right to participate in the Retiree Health Allowance Plan, including eligibility for any benefit, discontinuance of benefits, the level of benefits, and the interpretation and application of rules and regulations to a particular claim or application.

To All Participants:

The Board of Trustees of the Asbestos Workers Local No. 6 Health and Welfare Fund (the Fund) is pleased to issue this Summary Plan Description (SPD) which describes the Fund's separate Retiree Health Allowance Plan (the "Plan" or "Retiree Plan") for eligible members and their spouses and dependents effective January 1, 2016. You and your family should read this SPD together so that you will thoroughly understand the Plan. The health and well-being of all of our members is of great importance to us.

We are establishing this separate plan and issuing the accompanying SPD for the Retiree Plan to enable the Fund to continue to maintain its traditionally generous support for our retirees' health insurance needs. As you know, the Fund does not currently provide health coverage to eligible retirees directly. Instead, it provides an allowance to be used to pay health insurance premiums up to a set dollar limit for each calendar year quarter. Due to changes in federal law resulting from the Affordable Care Act (ACA), health plans are no longer permitted to have annual dollar limits. An exception to this rule applies to separate health plans that cover only retirees and their eligible dependents. Therefore, the Trustees have re-structured the Fund's traditional retiree allowance benefit as a separate "retiree-only" health plan to enable the Fund to continue its strong commitment to our members' health insurance needs during their retirement years, without any disruptions.

Please note the Fund's retiree health benefit allowance has not changed; only the way it is being presented to you is different.

For other benefits provided by the Asbestos Workers Local No. 6 Health and Welfare Fund, including retiree life insurance, please refer to the Fund's Summary Plan Description or contact the Fund Office.

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 the SPD.

This SPD supersedes and replaces all discussions and/or descriptions in the Fund's prior SPDs regarding the Fund's retiree allowance for reimbursement of retiree health insurance premiums.

We urge you to read this SPD carefully and make full use of the coverage to which you are entitled. If you have any questions concerning the benefits available to you, or your eligibility for benefits, please feel free to contact the Fund Office.

Sincerely,

THE BOARD OF TRUSTEES

Important Contact Information

If you have questions about the Retiree Health Allowance Plan, including COBRA continuation coverage, contact the Fund Office as indicated below:

ASBESTOS WORKERS LOCAL No. 6
HEALTH AND WELFARE FUND

Through March 31, 2016
AliCare, Inc.
529 Main Street
Charlestown, MA 02129

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

Effective April 1, 2016
BeneSys, Inc.
750 Dorchester Avenue
Boston, MA 02125
Telephone: (617) 795-4120

Table of Contents

NOTE**:** *This booklet serves as the Plan's official rules and regulations that govern the Plan.*

Definitions

"Active" means a participant in the Asbestos Workers Local No. 6 Health and Welfare Fund who is eligible for coverage based on active employment, and not as a COBRA Qualified Beneficiary.

"Benefits" means the allowance to be used for reimbursement of Health Insurance Premiums as described in this Summary Plan Description (SPD).

"Child" means the Retiree's child or the Retiree's Spouse's child by birth or adoption (including a child placed for adoption), and any child under the Retiree's or Retiree's Spouse's legal guardianship. The Plan will also recognize children for whom the Retiree has received a QMCSO (see definition in the definitions section).

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Code" means the Internal Revenue Code of 1986, as amended.

"Dependent Child" or "Dependent" means: (a) each dependent Child (as defined immediately below) until the last day of the month in which the Child reaches age 26; (b) each Child age 26 or older who is physically or mentally handicapped, provided proof of incapacity is received by the Fund Office within 30 days of the Child's 26th birthday; and (c) the offspring of a dependent identified in (a) or, if unmarried, (b), provided that the Fund Office receives written notice no more than 30 days after the offspring's birth.

Appropriate supporting legal documents must be submitted to the Fund Office for review and approval in order to document the existence of the Dependent Child/Dependent relationship.

"Eligible Retiree" means a Retiree eligible to participate in this Retiree Plan, as provided in this SPD.

"Enrollment Form" means the form provided by the Fund Office or its designee for the purpose of allowing an eligible Retiree to participate in this Plan.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"Participant" means a person who is an Eligible Retiree and who is participating in this Plan.

"Plan" or "Retiree Plan" means the Asbestos Workers Local No. 6 Health and Welfare Retiree Health Allowance Plan as set forth in this SPD.

"Plan Year" means the 12-month period commencing January 1 and ending on December 31.

"QMCSO" means a qualified medical child support order, as defined in ERISA § 609(a).

"Retiree" means an individual who retired from Active service and is collecting a pension from the Asbestos Workers Local No. 6 Pension Fund.

"Health Insurance" means medical coverage through a non-group or group health insurance plan for Retirees (and for their Spouses and Dependents that may be eligible under the terms of the Plan) not sponsored by or associated with the Asbestos Workers Local No. 6 Health and Welfare Fund (other than COBRA).

Examples of eligible Health Insurance coverage include, but are not limited to:

- Harvard Pilgrim Health Care
- Blue Cross Blue Shield
- United Health Care
- Tufts Health Plan

"Health Insurance Premiums" means premiums paid by an Eligible Retiree for qualified Health Insurance.

"Spouse" means an individual who is legally married to a Participant as determined under applicable state law (and who is treated as a spouse for tax purposes under the Code).

"Surviving Spouse" means an individual who was a Spouse on the date of the Retiree's death, and was covered under this Plan on the date of death.

"The Health Fund" means the Asbestos Workers Local No. 6 Health and Welfare Fund.

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

How the Retiree Health Allowance Plan Works

Retirees who are on Active health coverage may purchase Health Insurance coverage on their own when they retire and receive an allowance from the Retiree Plan to apply towards the premium cost for the coverage. Eligibility rules for participating in the Retiree Plan are described later in this SPD.

The Retiree Plan will provide an allowance to help cover the cost, or a portion of the cost, of your health insurance premiums. The allowance is set at a maximum amount as described in this SPD. Life insurance and other non-Health Insurance benefits do not qualify for coverage under this Plan.

In order to ensure continuous coverage, prior to the termination date of your Active health insurance coverage, you, your Spouse, and your Dependent Child(ren) must enroll in other Health Insurance coverage, such as Tufts Health Plan, Harvard Pilgrim Health Care, Blue Cross Blue Shield or any other plan available to you. This other insurance coverage includes COBRA continuation coverage offered by the Health Fund. In addition, if you are able to join your Spouse's health plan, the Retiree Plan will reimburse the cost of your premium for such coverage up to the Retiree Plan's maximum allowance.

You must submit appropriate documentation, satisfactory to the Fund Office, that you (and your Spouse and eligible Dependents, if applicable) are enrolled in Health Insurance coverage under a group or non-group health plan offered outside the Health Fund or in COBRA coverage offered by the Health Fund.

To receive an allowance under the Retiree Plan, you must pay the Health Insurance premiums directly to your health plan and the Retiree Plan will provide a quarterly allowance to reimburse you on a tax-free basis for premiums paid for one health plan per individual (or family) according to the Plan's Schedule of Benefits (see page 9). The allowance is for each quarter of the applicable calendar year, and is provided upon receipt of proof of payment of Health Insurance premiums that is acceptable to the Fund Office.

Eligibility to Participate

Once your eligibility for benefits as an Active participant under the Health Fund ends (including eligibility based on banked hours), you, your Spouse and your eligible Dependents will qualify for coverage under this Retiree Plan if:

1. You were eligible for benefits from the Health Fund on the day prior to your retirement;* **and**
2. You are eligible to receive a pension immediately under the Asbestos Workers Local No. 6 Pension Fund; **and**
3. You earned a minimum of three years of vesting service under the Asbestos Workers Local No. 6 Pension Fund (or the Asbestos Workers Local No. 31 Pension Fund before they merged effective January 1, 2015), during the 5-year period prior to receiving payments from the Asbestos Workers Local No. 6 Pension Fund.

Example: You retire on January 1, 2016, and were eligible for Active Health Fund benefits, and you are eligible for a pension from either of the above Pension Funds, **but** you earned only two years of vesting service during the 5-year period from January 1, 2011 through December 31, 2015. *In this situation, you, your Spouse and your eligible Dependents will **not qualify** for coverage under the Retiree Health Allowance Plan.*

***** If you retire on a disability pension, and were not eligible for benefits under the Asbestos Workers Local No. 6 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 Health Allowance Plan as of your retirement date. Contact the Fund Office for more details.

In case of death of the Retiree, the Surviving Spouse and eligible Dependents of a Retiree will continue to be eligible to participate in the Retiree Health Allowance Plan as long as the Retiree otherwise would have met the eligibility rules noted above. Contact the Fund Office for details.

An ex-Spouse will remain eligible for coverage under this Retiree Plan until the re-marriage of either the Retiree or the ex-Spouse, whichever occurs first. In addition, the Surviving Spouse of a Retiree will lose eligibility for Retiree Plan participation upon re-marriage.

Retirees will receive information from the Fund Office regarding their eligibility for the Retiree Plan prior to termination of Active coverage under the Fund.

Benefits and Duration of Coverage

Schedule of Benefits

This Retiree Plan does not provide health coverage for eligible retirees directly. Instead, it provides a quarterly allowance to help you as a Retiree pay the cost of Health Insurance Premiums for health insurance coverage.

The Retiree Plan provides a quarterly allowance (up to a maximum amount) to reimburse all or a portion of the costs of Health Insurance Premiums for health coverage obtained for you, your Spouse, and your eligible Dependents. 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
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 No. 6 Pension Fund. A participant of the Pension Fund may retire on a Regular Pension if he/she 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.

Note: For Medicare-eligible retirees, the Trustees currently maintain a group Medicare Supplement Policy (Medex II). If you choose to participate in this group policy, the Fund will bill you for the difference between the health allowance to which you are entitled and the actual Medex premium. Additional information is available on this option from the Fund Office.

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

The Retiree Plan's Benefits are provided for the lifetime of both the Retiree and Spouse, without regard to when the Retiree dies. In general, eligibility for Benefits under this Plan terminates on the date of the death of the longest surviving marriage partner (*i.e.*, either the Retiree or the Surviving Spouse (if any). However, as previously noted, a Surviving Spouse's benefits terminate at re-marriage.

The Trustees reserve the right to eliminate or modify the allowance for Health Insurance Premiums under the Retiree Plan.

Enrollment

A Retiree who becomes eligible to participate in this Retiree Plan will start participation on the first day of the month after the eligibility requirements have been satisfied, provided an Enrollment Form is submitted to the Fund Office before the first day of the month in which participation begins.

The Enrollment Form will identify the Spouse and Dependents whose health insurance premiums are subject to the allowance amount.

Once enrolled, a Retiree's participation will continue on a month-to-month and year-to-year basis until s/he is no longer eligible to participate in the Plan.

Obtaining Plan Benefits

After receiving a completed Enrollment Form, the Fund Office will establish and maintain a recordkeeping account for you. The purpose of the recordkeeping account is to keep track of the amount of allowance available to reimburse you for your Health Insurance Premiums.

Each quarter of the calendar year, the Retiree Plan will provide you with an allowance to reimburse you for all or a portion of the qualified Health Insurance Premium payments that you have made, as long as you remain eligible for Benefits.

Annual Right to Permanently Opt-Out

Each year you will have the right to permanently opt-out of coverage under this Retiree Plan. The opt-out will be effective on the first day of the next Plan Year.

If you elect to permanently opt-out of coverage under this Plan, you will

- Waive all rights to future Retiree Plan reimbursements (except for "run-out" claims, described later);
- Not be eligible for reinstatement under this Retiree Plan at any time in the future and;
- Not be eligible for continuation coverage under COBRA.

Funding This Plan

The Retiree Plan is funded through contributions made by Contributing Employers to the Health Fund, which then pays the amounts necessary to cover the costs of the Retiree Plan. <u>There are no Participant contributions for Benefits under this Retiree Plan</u>.

No Carryover of Account Balances

There is no carryover of account balances under this Retiree Plan. All claims for the Benefits provided under the Retiree Plan must be filed within **180** days of the date of purchase of the Health Insurance coverage or payment of the Health Insurance Premiums to qualify for the allowance under this Plan.

Deadline for Allowance Requests

Allowances During the Plan Year

You (or your estate) may file a claim for the Retiree allowance to cover the cost of any Health Insurance Premiums paid (up to the maximum allowed) for a quarter during which Health Insurance coverage was obtained. The claim should be filed by the last day of the first calendar year quarter following the quarter for which the Health Insurance coverage was purchased, but no later than **180** days after the date of purchase of the coverage to qualify for reimbursement.

Allowances After End of the Plan Year

The coverage Plan Year is January 1 – December 31. You (or your estate) may file a claim for the allowance to cover the cost of any Health Insurance Premiums (up to the maximum allowed) paid for the final quarter for which Health Insurance coverage was obtained. The claim must be filed by the last day of the first quarter following the quarter for which the coverage was purchased. For example, if a premium was paid for the last quarter of the calendar year, the claim must be filed by you (or your estate) ***by March 31st of the next Plan Year*** (*i.e.,* the claims "run-out" period).

Example*: A claim for Benefits for group or non-group health insurance coverage that you paid between January 1, 2016 and December 31, 2016 must be filed by March 31, 2017.*

Allowances After Termination of Eligibility For Coverage

Eligibility for coverage under the Retiree Plan ends at the death of the longest surviving marriage partner (either the Retiree or Surviving Spouse, but not Dependents). The Retiree Plan will not provide an allowance for any Health Insurance Premium expense incurred after the death of the longest surviving marriage partner (but see the COBRA discussion below).

However, an estate can file a claim for reimbursement for any Health Insurance Premium expense incurred during the quarter of the calendar year in which coverage terminates, as long as the estate files a claim ***by the last day of the next calendar quarter*** (*i.e*., the claims "run-out" period).

***Example**: If Retiree Plan coverage terminated on August 31st, your estate or your Surviving Spouse's estate would have until December 31st – the last day of the next calendar quarter – to file a claim for the allowance to cover all or part of the premiums paid for coverage terminating in August).*

In addition, a Spouse and Dependents (*i.e.*, Qualified Beneficiaries), whose coverage terminates because of a COBRA qualifying event will have the opportunity to continue (on a self-pay basis) the same coverage that he or she had on the day before the qualifying event for the periods of coverage as prescribed by COBRA (subject to all conditions and limitations under COBRA). See COBRA continuation coverage starting on page 17.

Note: Participants who elect to permanently waive coverage under this Plan will not be eligible for COBRA.

Compliance with HIPAA, USERRA, and Other Laws

Benefits under this Retiree Plan will be provided in compliance with HIPAA, USERRA, and all other applicable group health plan laws to the extent required. For more information about your rights under HIPAA and/or USERRA, please refer to your Summary Plan Description for the Asbestos Workers Local No. 6 Health and Welfare Fund or ask the Fund Office for such information.

Coordination of Benefits

In general, Benefits provided under this Retiree Plan are intended to provide an allowance to cover part or all of the cost of Health Insurance Premiums not previously reimbursed or reimbursable elsewhere. To the extent that an otherwise eligible insurance premium is payable or reimbursable from another source, that other source shall pay or reimburse prior to reimbursement from this Retiree Plan.

Claims and Appeals Procedures

This section describes the procedures for filing claims for Benefits under this Retiree Plan. Also, it describes the procedure you must follow if your claim is denied in whole or in part, and you wish to appeal the decision.

How to File a Claim

In order to file a claim for Benefits offered under this Retiree Plan, you must submit copies of premium invoices and proof of payment or copies of pay stubs that show deductions for health coverage. Simple inquiries about the Retiree Plan's provisions that are unrelated to any specific Benefit claim will not be treated as a claim for benefits.

When Claims Must Be Filed

Claims should be filed within 90 days following the date the insurance premiums were paid. Failure to file claims within the time required will not invalidate or reduce any claim if it was not reasonably possible for you to file the claim within such time. However, in that case, the claim must be submitted as soon as reasonably possible, and in no event later than **180 days** from the date the insurance expenses were incurred.

Where to File Claims

Claims should be filed with the Fund Office at the following address:

Asbestos Workers Local No. 6
Health and Welfare Fund
Retiree Health Allowance Plan

Through March 31, 2016
c/o AliCare, Inc.
529 Main Street
Charlestown, MA 02129

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

Effective April 1, 2016
BeneSys, Inc.
750 Dorchester Avenue
Boston, MA 02125
Telephone: (617) 795-4120

Authorized Representatives

An authorized representative, such as your Spouse, may file a claim for benefits for you if you are unable to do it 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.

Filing a Claim

The following procedures apply to filing claims:

1. Obtain receipts for the period of Health Insurance coverage for which you are filing a claim for Benefits (*i.e.,* either paid invoices or other statements from an independent third party showing that expenses for Health Insurance Premiums have been incurred and paid, showing the dates and amounts of these expenses, or pay stubs showing deductions for Health Insurance coverage.)
2. Sign a statement attesting that the Health Insurance Premiums for which reimbursement is sought have not otherwise been reimbursed and are not reimbursable through any other source.
3. Send your proof of payment and signed statement to the Fund Office at the address listed on the preceding page.

***Note**: The Fund Administrator, in his/her sole discretion, will determine whether a claim for Benefits has been adequately substantiated and may be paid. The Fund Administrator reserves the right to request documentation in addition to that described above to verify the validity of any claim.*

Ordinarily, you will be notified of the decision on your claim within **30 days** from the Plan's receipt of the claim. This period may be extended one time by the Plan for up to **15 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 the earlier of: (a) **45 days**; or (b) the date you respond to the request. The Plan will have **15 days** after the receipt of additional information to make a decision on your claim and notify you of the determination.

How You Receive Your Quarterly Allowance

The Retiree Plan's quarterly allowance will be made by check sent to the Participant's home.

Notice of a Denied Claim

In the event your claim for Benefits is denied, you will be provided with written notice of the denial (whether denied in whole or in part). This notice will state:

- The specific reason(s) for the determination;
- Reference to the specific Plan provision(s) on which the determination is based;
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary;
- A description of the appeal procedures and applicable time limits;
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review; and
- If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge.

Request for Review of Denied Claim – Appeals Process

If your claim is denied, in whole or in part, or if you disagree with the decision made on a claim, you may ask for a review. Your request for review must be made in writing to the Fund Office

Review/Appeals Process

The review/appeals process works as follows:

You have the right to review 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 upon review; 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 claim.

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

Timing of Notice of Decision on Appeal

Your claim will be reviewed and determined by the Fund Office within **30 days** of the receipt of the claim. If your claim is denied, you have the right to a second appeal to the Board of Trustees. Ordinarily, for second level appeals, decisions will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review of the Fund Office's determination.

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 an 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 **five days** after the decision has been reached.

Notice of Decision on Review/Appeal

The decision on any review of your denied claim will be given to you in writing. The notice of a denial of a claim on review will state:

- The specific reason(s) for the determination;
- Reference to the specific Plan provision(s) on which the determination is based;
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge;
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review; and
- If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge.

Limitation on When a Lawsuit May Be Started

You may not start a lawsuit to obtain Benefits until after you have requested a review and a final decision has been reached on the review, or until the appropriate time frame described previously has elapsed after you filed a request for review and you have not received a final decision or a notice that an extension will be necessary to reach a final decision. The law also permits you to pursue your remedies under Section 502(a) of ERISA without exhausting these appeal procedures if the Plan has failed to follow them. No lawsuit may be started more than three years after the end of the year in which the health coverage was purchased.

The Plan grants its fiduciaries discretionary authority to determine eligibility for benefits and to construe the Plan's terms. Consequently, if you file a lawsuit, the issue will be limited to whether or not the Board of Trustees (or its delegate(s), as may apply) acted arbitrarily or capriciously in making a decision.

COBRA Continuation Coverage

If your Spouse or Dependent(s) loses coverage because of a "Qualifying Event" (see below), that individual may be eligible to continue coverage in the Retiree Plan under COBRA.

Note: Only your Spouse or Dependent can qualify for COBRA under this Retiree Plan. Participants are not eligible for COBRA under this Plan because as a Retiree, you cannot experience a Qualifying Event of termination of employment or loss of eligibility due to a reduction in work hours.

Qualifying Events

To be eligible for COBRA continuation coverage, your Spouse or Dependent(s) must lose coverage due to any one of the following Qualifying Events:

Qualifying Event	**Who May Purchase Continuation Coverage**	**Maximum Period of Coverage**
Participant dies	Spouse and/or Dependent children	36 months
Participant is divorced or legally separated from Spouse*	Spouse and/or Dependent children	36 months*
Child is no longer considered a Dependent child under this Plan's definition	Dependent child	36 months

*__Note__: A Retiree's ex-Spouse's Retiree Plan coverage will terminate on the last day of the month in which either the Retiree or the ex-Spouse re-marries.

Qualified Beneficiaries

Under the law, only "Qualified Beneficiaries" are entitled to COBRA continuation coverage. Qualified Beneficiaries are the following if they were covered under the Retiree Plan on the day before the Qualifying Event:

- Your Spouse; and
- Your Dependent Child.

A child who becomes a Dependent Child by birth, adoption or placement for adoption with you (but not an individual who becomes your Spouse) during a period of COBRA continuation coverage is also a Qualified Beneficiary.

One or more of your family members may elect COBRA. However, in order to elect COBRA continuation coverage, the members of the family must have been covered by the Retiree Plan on the date of the Qualifying Event. A parent may elect or reject COBRA continuation coverage on behalf of minor Dependent children.

Notifying the Fund Office/Electing COBRA Continuation Coverage

In order to elect COBRA continuation coverage, you (or your Spouse or Dependent) must notify the Fund Office when certain Qualifying Events occur. You (or your Spouse or Dependent) must notify the Fund Office in case of divorce, legal separation, or a Child losing Dependent status under the Retiree Plan. Failure to provide the proper notice within the required time frames may prevent your Spouse or Dependent from obtaining or extending COBRA coverage.

The notice must be mailed via U.S. First Class mail and postmarked no later than 60 days after the later of the date:

- of the Qualifying Event; or
- coverage was lost under the Plan because of the Qualifying Event.

Notice from one individual will satisfy the notice requirement for all individuals affected by the same Qualifying Event.

In order to notify the Plan of these Qualifying Events, you or your Spouse or Dependent must send a COBRA Notice of Qualifying Event (form available upon request from the Fund Office) to the Fund Office. Alternatively, you or your Spouse or Dependent must send a notice to the Fund Office containing the following information: the Participant/Retiree's name, the Qualified Beneficiary's name, the type of Qualifying Event for which the individual is providing notice, and the date of the event. In the event of divorce or legal separation, you must also submit a copy of the divorce decree or court statement that documents the legal separation.

Within fourteen (14) days after receiving timely notice of a Qualifying Event, the Fund Office will mail the Qualified Beneficiary a COBRA Election Notice and form, as well as information about COBRA and the date on which coverage will end.

Under the law, to elect COBRA coverage your covered Spouse and/or Dependent(s) have 60 days from the later of the date:

- Coverage would have been lost because of the Qualifying Event; or
- Your covered Spouse and/or Dependents received the election form and COBRA information.

If your covered Spouse, and/or your covered Dependent(s) do not elect COBRA **within 60 days** of the Qualifying Event (or, if later, within 60 days after receiving the COBRA Election Notice), then your covered Spouse and/or your covered Dependent(s) will not have any group health coverage under this Retiree Plan and any rights to COBRA will be permanently waived.

Paying for COBRA Continuation Coverage

The Qualified Beneficiary is responsible for the entire cost of COBRA continuation coverage. When your Spouse or Dependent(s) becomes eligible for this coverage, the Fund Office will notify the individual(s) of the COBRA premium amounts that must be paid.

COBRA premiums may be up to 102% of the Plan's cost of coverage.

The Qualified Beneficiary must make timely payments so that COBRA coverage is continuous. To prevent a lapse in coverage, the first payment to the Fund Office must be made within 45 days from the date COBRA coverage is elected.

Payments for subsequent months are due on the first day of the month for which coverage is provided.

If COBRA coverage is chosen within the election period but after the date your Spouse's and/or Dependent's eligibility ended, your Spouse and/or Dependent must pay the required COBRA premiums retroactively to cover the elapsed period.

Termination of COBRA Continuation Coverage

COBRA continuation coverage will terminate on the last day of the maximum period of coverage unless it is cut short for any of the following reasons:

- Any required payment is not made on time;
- The person receiving the coverage becomes covered by another group health plan;
- The person receiving the coverage becomes entitled to Medicare for the first time;
- The Retiree Plan is terminated and no longer provides reimbursement for health insurance premiums to any of its Participants;
- The employer that you worked for before the Qualifying Event has stopped contributing to the Fund;
- The employer establishes one or more group health plans covering a significant number of the employer's employees formerly covered under this Plan; or
- The employer starts contributing to another multiemployer plan, other than the Fund, that is a group health plan.

Name, Address and Telephone Number of the Party Responsible for COBRA Administration

Asbestos Workers Local No. 6
Health and Welfare Fund
Retiree Health Allowance Plan

Through March 31, 2016
c/o AliCare, Inc.
529 Main Street
Charlestown, MA 02129

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

Effective April 1, 2016
BeneSys, Inc.
750 Dorchester Avenue
Boston, MA 02125
Telephone: (617) 795-4120

Notice of Unavailability of Coverage

If notice is provided to the Fund Office of a Qualifying Event, but the individual is not entitled to COBRA, the Fund Office will send a written notice stating the reason why that person is not eligible for COBRA. This will be provided within the same time frame that the Fund Office is required to provide an election notice.

Notice of Termination of COBRA

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

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Keep the Fund Office Informed of Address Changes

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

If You Have Questions

Questions concerning your Plan or COBRA continuation coverage rights should be addressed to the Fund Office. 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 through EBSA's website.)

Your ERISA Rights

As a participant in this Retiree Plan, you are entitled to certain rights and protections under ERISA. Under ERISA, all Plan participants are entitled to:

- Receive information about your Plan and Benefits;
- Examine, without charge, at the Fund Office and at other specified locations, such as worksites and 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 Fund 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; and
- Receive a summary of the Plan's annual financial report. The Fund Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You are entitled to continue health care coverage for your Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Spouse or Dependents will have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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 this 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 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 Fund 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 domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan or ERISA rights, you should first contact the Fund Administrator. If you have further questions about your rights under ERISA, or if you need assistance in obtaining documents from the Fund Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at: (866) 444-3272.

Plan Facts

Legal Name of the Plan	Asbestos Worker Local No.6 Retiree Health Allowance Plan
Board of Trustees' Employer Identification Number	04-6374403
Plan Number	TBD
Fiscal Year End Date	December 31
Fund Administrator (until March 31, 2016)	AliCare, Inc.
Fund Administrator (effective April 1, 2016)	BeneSys, Inc.
Plan Sponsor and Plan Administrator	The Board of Trustees
Consultants and Actuaries	Segal Consulting
Legal Counsel	Segal Roitman, LLP

The Fund Office

If you would like detailed information about payments of any claim, you should call the Fund Office and the appropriate representative will assist you. Any person calling the Fund Office must be able to supply the Participant's name and Unique Identifying or Social Security Number.

General Information About the Retiree Health Allowance Plan

The Retiree Plan is a self-insured ERISA group health and welfare plan. AliCare, Inc., a third party administrator, will administer the Plan and provide services to members and dependents until March 31, 2016. You can contact AliCare at the following address:

Asbestos Workers Local No. 6
Health and Welfare Fund
Retiree Health Allowance Plan
c/o AliCare, Inc.
P. O. Box 9631
Boston, MA 02114-9631
Telephone: (617) 666-3100

Effective April 1, 2016, the Board of Trustees has hired a new third party administrator, BeneSys, Inc., to administer the Plan and provide services to members and dependents. BeneSys' contact information will be announced.

The Board of Trustees has been designated as the agent for the service of legal process. Legal process may be made upon a Plan Trustee or the Fund Administrator.

The Board of Trustees consists of employer and union representatives who serve without compensation. The number of Trustees may be increased or reduced to such number as the Trustees determine. However, in the event that there is not an equal number of employer and union Trustees,

the voting strength of the employer Trustees and the union Trustees will always be equal (*e.g*., if there are three employer Trustees and two union Trustees, each employer Trustee's vote shall be counted as two-thirds (2/3) and each union Trustee's vote shall be counted as one (1)).

All contributions for the Plan are made by employers in accordance with Collective Bargaining Agreements. You may examine the Collective Bargaining Agreements at the Fund Administrator's office upon ten days' advance written request. In addition, you may obtain copies of any such agreements, for a reasonable charge, upon written request to the Fund Administrator.

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

Benefits are provided from the Fund's assets that are accumulated under the provisions of the Collective Bargaining Agreement 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 Retiree Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility, or denial or loss of any benefits are fully described beginning on page 8 of this descriptive booklet.

The Board of Trustees reserves the right, in its sole discretion, at any time and from time to time, to:

- Amend or terminate either the amount or condition with respect to the payment of any Benefit, regardless of employment or retirement status, or illness, injury, condition or disability suffered prior to the effective date of amendment or termination; alter or postpone the method of payment of any Benefit;
- Amend or terminate the right to continue coverage on a self-payment basis; or
- Amend or terminate any other provisions of the Plan for any class of Participants, Spouses or Dependents.

In no event, however, may any amendment or termination cause any part of the Plan to revert to an employer.

In the event of a Plan termination, only claims for Benefits incurred prior to the termination date will be paid in accordance with the Plan. Payment will be made from the assets remaining in the Fund for the purpose of providing Benefits. If there are not enough assets remaining to pay all outstanding claims, the Trustees will decide the manner in which the remaining assets will be used. In no event will the Board of Trustees or any individual Trustee, contributing employer, union or other individual or entity be liable to provide the payment of Benefits over and beyond the Plan assets in the Fund available for such purpose.

Fraudulent Use of the Plan

If you or your Spouse or Dependent receive Benefits as a result of any sort of misleading representation, false information or other fraudulent representation to the Plan, you or he or she is liable to repay all Benefits paid by the Plan and all costs of collection, including interest and attorney's fees.

In addition, the Trustees reserve the right to deny payment for any subsequent claims you or your Spouse or Dependents incur for a time period or in an amount determined by the Trustees. If this happens, you will be notified of the time period of denial and amount.

When you add a Spouse or Dependent to the Plan, you will be required to provide a marriage certificate or birth certificate, as appropriate, before the individual will be eligible for coverage.

Claims for Benefits should be filed by the last day of the first calendar year quarter following the quarter for which the Health Insurance coverage was purchased, but no later than **180** days after the date of purchase of the coverage to qualify for reimbursement.

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

No local union, local union officer, business agent, local union employee, employer, employer representative, Fund Office personnel, consultant or attorney is authorized to speak for, or on behalf of, or to commit the Trustees of the Fund on any matter relating to this Plan without the express authority of the Trustees.

Only the Trustees of the Fund have the authority to determine eligibility for Benefits and the right to participate in this Plan, including the manner in which eligibility for coverage or for any Benefit is determined; discontinuance of Benefits; status as a covered or non-covered Participant, Spouse or Dependent, the level of Benefits, and the interpretation and application of this Summary Plan Description to a particular claim or applicant.

BOARD OF TRUSTEES

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Dorchester, MA 02122·

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25 Kenwood Circle, Suite H
Franklin, MA 02038

ASBESTOS WORKERS LOCAL No. 6
HEALTH AND WELFARE FUND

Through March 31, 2016
AliCare, Inc.
529 Main Street
Charlestown, MA 02129

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

Effective April 1, 2016
BeneSys, Inc.
750 Dorchester Avenue
Boston, MA 02125
Telephone: (617) 795-4120