

**INTERNATIONAL ASSOCIATION OF HEAT
AND FROST INSULATORS AND ALLIED WORKERS
LOCAL NO. 26 WELFARE PLAN**

SUMMARY PLAN DESCRIPTION

***This Summary Plan Description
Reflects Terms of the Plan
as of January 1, 2010***

International Association of Heat and Frost Insulators and Allied Workers
Local No. 26 Welfare Plan

Summary Plan Description

TABLE OF CONTENTS

INTRODUCTION	1
Section 1 Important Plan Information You Should Know	2
Section 2 Initial Eligibility Requirements for Regular Health Coverage	6
Section 3 Requirements for Continuation of Regular Health Coverage	8
Section 4 Reinstatement of Regular Health Coverage.....	9
Section 5 Health Coverage	9
Section 6 Life, Accident and Disability Coverage	10
Section 7 Continuation of Health Coverage After Regular Health Coverage Ends.....	11
Section 8 Amendment and Termination of the Plan	18
Section 9 Claims Procedure	19
Section 10 Reciprocal Agreements	25
Section 11 Powers of the Trustees	26
Section 12 Your Rights	27

International Association of Heat and Frost Insulators and Allied Workers
Local No. 26 Welfare Plan

Summary Plan Description

INTRODUCTION

The International Association of Heat and Frost Insulators and Allied Workers Local No. 26 (formerly the International Association of Heat and Frost Insulators and Asbestos Workers Local No. 26) and the Master Insulators' Association of Rochester, NY established the International Association of Heat and Frost Insulators and Allied Workers Local No. 26 Welfare Plan (formerly the Asbestos Workers Local No. 26 Welfare Plan), effective July 3, 1952. This Summary Plan Description highlights the features of the Plan as of January 1, 2010.

This Summary Plan Description is not meant to interpret, extend, or change the official Plan documents (including the related insurance policies and contracts). ***If there is any inconsistency between this SPD and official Plan documents (including the related insurance policies and contracts), the official Plan documents, insurance policies and contracts will govern your rights to benefits.***

To prevent misunderstandings, you may wish to review the Plan in its entirety. It is available for review in the Local No. 26 Funds Office at 4515 Culver Road, Suite 104, Rochester, New York 14622, during regular business hours. In addition, the Plan office will provide you with a copy of the Plan document upon your written request. There may be a charge for reproducing the Plan document, but not more than \$0.25 per page.

The information in this SPD may be modified by a "Summary of Material Modification" ("SMM") attached. Check to see if there are any SMMs attached when you refer to this SPD.

Any questions concerning the Plan should be directed to the Joint Board of Trustees.

International Association of Heat and Frost Insulators and Allied Workers
Local No. 26 Welfare Plan

Summary Plan Description

SECTION 1
IMPORTANT PLAN INFORMATION YOU SHOULD KNOW

Plan Name:	International Association of Heat and Frost Insulators and Allied Workers Local No. 26 Welfare Plan
Plan Number:	501
Plan Type:	Welfare Benefit Plan
Plan Year:	Begins on January 1 and ends on December 31
Employee Organization:	International Association of Heat and Frost Insulators and Allied Workers Local No. 26 (the "Union")
Employer Organization:	Master Insulators' Association of Rochester, New York (the "Association")
Tax ID Number:	22-3050907
Plan Sponsor:	Joint Board of Trustees of the International Association of Heat and Frost Insulators and Allied Workers Local No. 26 Welfare Plan 4515 Culver Road, Suite 104 Rochester, NY 14622 (585) 323-2110
Administration:	The Board is the Plan Administrator. The Board consists of six members, three of whom are appointed by the Union and three of whom are appointed by the Association. The current members of the Board are Edward B. Doran, James F. Griffin, III, John Flanagan, Lee Juby, Marjorie Russer, and Brian Urquhart.

International Association of Heat and Frost Insulators and Allied Workers
Local No. 26 Welfare Plan

Summary Plan Description

**Plan Agent for Service
of Legal Process:**

Joint Board of Trustees of the International Association
of Heat and Frost Insulators and Allied Workers
Local No. 26 Welfare Plan
4515 Culver Road, Suite 104
Rochester, NY 14622
(585) 323-2110

**Collective Bargaining
Agreement:**

The Plan is maintained pursuant to a collective bargaining agreement between the Association and the Union. Upon written request to the Board, employees may obtain copies of the collective bargaining agreement. The collective bargaining agreement is also available for inspection at the Plan office.

Funding:

Contributions to the Plan are made by employers pursuant to a collective bargaining agreement, which provides for employers to pay to the Plan a fixed amount for hours worked by an employee. Eligible employees are also required to pay a portion of their health insurance premium. Employees, their spouses and dependents who elect to continue coverage after their regular health coverage expires may be required to pay a greater portion of the premium for their health insurance.

Upon written request, employees may receive information from the Board as to whether a particular employer is a contributing employer and, if so, the contributing employer's address.

All contributions are held by the Trustees in a trust and are used (together with earnings on the contributions) to pay premiums for insurance coverage and the cost of administering the Plan.

International Association of Heat and Frost Insulators and Allied Workers
Local No. 26 Welfare Plan

Summary Plan Description

DEFINITIONS

Agreement means the collective bargaining agreement in effect from time to time between the Union and the Association, or between the Union and an individual Contributing Employer.

Applicable Premium means the monthly premium charged by an Insurer to the Plan for Health Coverage for an Employee, his Spouse and/or Children. The Applicable Premium varies with the type of Health Coverage and the level of Health Coverage (e.g. family, two-person or single Health Coverage).

Association means the Master Insulators' Association of Rochester, New York.

Board means the Joint Board of Trustees of the Plan.

Child means a child of an Employee or retired Employee who satisfies the requirements for coverage under an applicable Policy and the Plan.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985.

COBRA Continuation Coverage means group health coverage made available to an Employee, his Spouse or Child after Regular Health Coverage ends, as required under COBRA.

Contributing Employer means any employer who is required to make contributions to the Plan for hours worked by an Employee pursuant to the Agreement (or another collective bargaining agreement between the Contributing Employer and the Union, or agreement between the Contributing Employer and the Board). It also means the Union, the Plan, and other employee benefit plans sponsored by the Union and the Association, with respect to their own Employees.

Contribution Period means each four consecutive month period beginning on January 1, May 1 or September 1.

Employee means (i) an employee of a Contributing Employer who performs services within the jurisdiction of the Union and for whom the Contributing Employer is required under the Agreement to make contributions to the Plan; (ii) any other person working for a Contributing Employer and for whom the Contributing Employer is required under the

International Association of Heat and Frost Insulators and Allied Workers
Local No. 26 Welfare Plan

Summary Plan Description

Agreement (or agreement between the Contributing Employer and the Board) to make contributions to the Plan; and (iii) an employee of the Union, the Plan, or other employee benefit plan sponsored by the Union and the Association, who does not decline Regular Health Coverage.

Health Coverage means Regular Health Coverage, COBRA Continuation Coverage, and/or Retiree Health Coverage, as the context indicates.

Hour of Service means an hour of work performed by an Employee for a Contributing Employer for which the Contributing Employer is required under the Agreement (or agreement between the Contributing Employer and the Board) to make contributions to the Plan.

Insurer means Excellus (d/b/a BlueCross Blue Shield) or Preferred Care with respect to Health Coverage, and Aetna Life Insurance Company with respect to Life, Accident & Disability Coverage.

Life, Accident & Disability Coverage means coverage described in Section 6 and made available to an eligible Employee at no cost to the eligible Employee.

Policy means a policy or contract issued by an Insurer for Health Coverage or for Life, Accident & Disability Coverage.

Plan means the International Association of Heat and Frost Insulators and Allied Workers Local No. 26 Welfare Plan as herein set forth, and any amendment hereof.

Plan Year means each twelve consecutive month period beginning on January 1 and ending on December 31.

Regular Health Coverage means Health Coverage described in Section 5, and made available to an eligible Employee at a cost to the eligible Employee equal to the percentage of the Applicable Premium specified in Section 2.

Retiree Health Coverage means Health Coverage described in Section 5, and made available to a retired Employee at a cost to the retired Employee equal to the percentage of the Applicable Premium specified in Section 7.

International Association of Heat and Frost Insulators and Allied Workers
Local No. 26 Welfare Plan

Summary Plan Description

Spouse means the person to whom an Employee or retired Employee is legally married and who satisfies the requirements for coverage under the applicable Policy.

Union means the International Association of Heat and Frost Insulators and Allied Workers Local No. 26.

SECTION 2
INITIAL ELIGIBILITY REQUIREMENTS FOR
REGULAR HEALTH COVERAGE

An Employee is eligible for Regular Health Coverage on his Initial Eligibility Date. An Employee's Initial Eligibility Date is the first day of a calendar month immediately following any four consecutive calendar month period during which he has at least 200 Hours of Service with at least one Hour of Service in each of those four months. With the consent of the Insurers, the Board may change this 200 Hours of Service requirement when, in the Board's sole judgment, the reserve funds accumulated under the Plan warrant such a change.

Regular Health Coverage may begin on the Employee's Initial Eligibility Date if he is employed by a Contributing Employer on that day and he completes and files the appropriate applications and forms for Regular Health Coverage by that date (or any earlier date required, or later date permitted, by the Insurer). If an Employee does not complete and file the appropriate application and forms for Regular Health Coverage by that date, Regular Health Coverage may not begin until the first day of a Plan Year on which he is employed by a Contributing Employer, has at least 200 Hours of Service during the immediately preceding four calendar months (with at least one Hour of Service in each of those four months), and has timely completed and filed the appropriate forms and applications, unless the Insurer allows Regular Health Coverage to begin as of the first day of an earlier calendar month following four consecutive calendar months during which the Employee has at least 200 Hours of Service (with at least one Hour of Service in each of those four months).

Example: An Employee first begins working for a Contributing Employer in August 2010, and completes a total of 200 Hours of Service during the months of July, August, September, and October (with at least one Hour of Service in each of those months). He is eligible for Regular Health Coverage on November 1, 2010, provided he completes and files any

International Association of Heat and Frost Insulators and Allied Workers
Local No. 26 Welfare Plan

Summary Plan Description

required application or form by November 1, 2010 (or any later date permitted by the Insurer for filing the application or form).

Important Note: It is the Employee's responsibility to request, complete and file the appropriate application and forms required for coverage by the deadlines described above. The required application and forms are available from the Plan Office. Each Employee should keep track of his Hours of Service so he knows when he is eligible for Regular Health Coverage.

If an Employee's Spouse or Child is confined in a hospital, other institution or home, on the date Regular Health Coverage for the Spouse or Child would otherwise begin, coverage for the Spouse or Child may be delayed under the terms of the applicable Policy.

An Employee who satisfies the eligibility requirements in this Section 2 for Regular Health Coverage must pay fifteen percent (15%) of the Applicable Premium in order for his Regular Health Coverage to begin and remain in effect.

Example 1: John is eligible for Regular Health Coverage and elects BlueCross BlueShield EPO J coverage for himself only. Assume the Applicable Premium is \$464.73 per month. John's cost for Regular Health Coverage is \$69.71 per month (15% of \$464.73).

Example 2: Paul is eligible for Regular Health Coverage and elects BlueCross BlueShield EPO J two-person coverage. Assume the Applicable Premium is \$974.80 per month. Paul's cost for Regular Health Coverage is \$146.22 per month (15% of \$974.80).

Example 3: Tom is eligible for Regular Health Coverage and elects BlueCross BlueShield EPO J family no-spouse coverage. Assume the Applicable Premium is \$892.93 per month. Paul's cost for Regular Health Coverage is \$133.94 per month (15% of \$892.93).

Example 4: Gary is eligible for Regular Health Coverage and elects BlueCross BlueShield EPO J family coverage. Assume the Applicable Premium is \$1,488.00 per month. Paul's cost for Regular Health Coverage is \$223.20 per month (15% of \$1,488.00).

International Association of Heat and Frost Insulators and Allied Workers
Local No. 26 Welfare Plan

Summary Plan Description

The due date for payment of an Employee's portion of the Applicable Premium for a month is the last day of the prior month. Invoices are mailed to Employees for their portion of the Applicable Premium approximately two weeks before the due date for the payment. All payments should be mailed to the Local No. 26 Funds Office, 4515 Culver Road, Suite 104, Rochester, NY 14622. If the Funds Office does not receive an Employee's payment for a month by the last day of the prior month, his insurance coverage will be terminated as of the end of the prior month.

SECTION 3
REQUIREMENTS FOR CONTINUATION OF
REGULAR HEALTH COVERAGE

An Employee's Regular Health Coverage will terminate at the end of a Contribution Period during which he has less than 200 Hours of Service unless he has at least 1,500 Hours of Service during the 12 consecutive months ending just before that Contribution Period.

Example 1: Assume an Employee's Regular Health Coverage begins on November 1, 2010 and he completes at least 200 Hours of Service during the Contribution Period that begins on September 1, 2010 and ends on December 31, 2010. His Regular Health Coverage will remain in effect at least through December 31, 2010.

Example 2: Assume an Employee's Regular Health Coverage begins on November 1, 2010 and he does not complete at least 200 Hours of Service during the Contribution Period that begins on September 1, 2010 and ends on December 31, 2010. However, he have at least 1,500 Hours of Service during the 12 consecutive months ending on December 31, 2010. His Regular Health Coverage will remain in effect at least through December 31, 2010.

Example 3: Assume an Employee's Regular Health Coverage begins on November 1, 2010 and he does not complete at least 200 Hours of Service during the Contribution Period that begins on September 1, 2010 and ends on December 31, 2010, and he does not have at least 1,500 Hours of Service during the 12 consecutive months ending on December 31, 2010. His Regular Health Coverage will terminate effective January 1, 2011.

Summary Plan Description

With the consent of the Insurers, the Board may change this 200 Hours of Service requirement when, in the Board's sole judgment, the reserve funds accumulated under the Plan warrant such a change.

SECTION 4
REINSTATEMENT OF REGULAR HEALTH COVERAGE

If an Employee's Regular Health Coverage terminates, he will not again be entitled to Regular Health Coverage until he again satisfies all of the rules and conditions for Regular Health Coverage set forth in Section 2.

SECTION 5
HEALTH COVERAGE

The Plan pays the difference between the percentage of the Applicable Premium paid by Employees, their Spouses or Children for Health Insurance and the total Applicable Premium. The Plan does not pay or provide actual health benefits. All actual health benefits are paid or provided only by Insurers pursuant to the terms of the applicable Policy. At the times permitted by the Insurers and subject to the terms of the Policies, an Employee who is eligible for Health Coverage may select from the types of coverage available under the Plan and level of that coverage (single, two-person, family no-spouse, or family). As of January 1, 2010, only BlueCross BlueShield EPO J coverage available to eligible Employees and eligible retired Employees under age 65.

Currently, the following types of coverage are available to eligible retired Employees age 65 or older:

- (i) Preferred Care Gold coverage
- (ii) Medicare Blue Choice Platinum coverage
- (iii) if the former Employee lives outside of both the Preferred Care Gold coverage area and the Medicare Blue Choice Platinum coverage area, BlueCross BlueShield Complimentary coverage

Full descriptions of the benefits provided with each type of coverage are contained in booklets issued by the Insurers. The booklets are available from the Insurers or the Plan Office.

International Association of Heat and Frost Insulators and Allied Workers
Local No. 26 Welfare Plan

Summary Plan Description

Excellus (d/b/a BlueCross BlueShield) guarantees benefits and is responsible for processing all claims under BlueCross BlueShield EPO J coverage, BlueCross BlueShield Complimentary coverage, and Medicare Blue Choice Platinum coverage. Preferred Care guarantees benefits and is responsible for processing Preferred Care Gold claims. Their addresses are:

BlueCross BlueShield
165 Court Street
Rochester, New York 14647

Preferred Care
259 Monroe Avenue
Rochester, New York 14607

If an Employee, his Spouse or Child is eligible to receive any benefit provided under a Policy that is also provided under another health plan, group or individual insurance policy or program, the benefit under the Policy will be coordinated with benefits from the other plan, policy or program so that no more than 100% of the benefit will be paid jointly by both the Policy and the other plan, policy or program.

The Board and the Insurers reserve the right to obtain from, and exchange benefit information with, other plans, organizations, carriers and individuals, and to recover any over-payment made to an Employee, his Spouse, or Child as a result of a failure to report other coverage or other reasons.

SECTION 6
LIFE, ACCIDENT & DISABILITY COVERAGE

If an Employee is not classified as an apprentice or pre-apprentice, he will be eligible for Life, Accident & Disability Coverage under the same eligibility rules and conditions as are in Section 2 (applicable for Regular Health Coverage). His Life, Accident & Disability Coverage will start when his Regular Health Coverage starts (provided he has timely completed and filed the appropriate application and forms required by the Insurer).

An Employee classified as an apprentice or pre-apprentice is not eligible for Life, Accident & Disability Coverage until: (i) he completes 1,000 Hours of Service; and (ii) satisfies the same rules and conditions as are in Section 2 (applicable for Regular Health Coverage). His Life, Accident & Disability Coverage will start on the first day of the calendar month after he satisfies all of these requirements (provided he has timely completed and filed the appropriate application and forms required by the Insurer).

Summary Plan Description

Except as noted below, his Life, Accident & Disability Coverage will end when his Regular Health Coverage ends.

Important Note: An Employee must be working within the United States to be eligible for Life, Accident & Disability Coverage. Also, it is the Employee's responsibility to request, complete and file the appropriate application and forms required for coverage by the deadlines described above. The required application and forms are available from the Plan Office. Each Employee should keep track of his Hours of Service to so he knows when he is eligible for Life, Accident & Disability Coverage.

Life, Accident & Disability Coverage is only for Employees, except for: (i) limited life insurance on the life of an Employee's Spouse and Children; and (ii) reduced life insurance on the life a retired Employee who had Regular Health Coverage and qualified for normal or early pension benefits under the Union Pension Plan when he retired. (No accident or disability coverage is provided for an Employee's Spouse or Children, or for a retired Employee.)

All Life, Accident & Disability Coverage benefits are provided by, and are subject to the terms and conditions of, the Policy. A full description of Life, Accident & Disability Coverage benefits is contained in a booklet issued by the Insurer. The booklet is available from the Plan Office.

Note that prior to November 1, 2006, Life, Accident & Disability Coverage was insured by Connecticut General Life Insurance Company under a policy that terminated effective November 1, 2006. The termination of that policy did not affect benefits payable by Connecticut General Life Insurance Company under that policy for a death, accident, or total disability incurred before November 2006.

**SECTION 7
CONTINUATION OF HEALTH COVERAGE
AFTER REGULAR HEALTH COVERAGE ENDS**

The Plan will make COBRA Continuation Coverage available to Employees, Spouses and Children who are eligible for COBRA Continuation Coverage at a cost equal to the Applicable Premium plus a two percent (2%) administrative fee. (Note that COBRA Continuation Coverage consists of only Health Coverage.) In addition, under the special rules below, the cost to an Employee, his Spouse and/or Child for COBRA Continuation Coverage may be less than the Applicable Premium, and Retiree Health Coverage may be

International Association of Heat and Frost Insulators and Allied Workers
Local No. 26 Welfare Plan

Summary Plan Description

available at a lower cost and for a period longer than the maximum period required for COBRA Continuation Coverage.

None of the rules in this Section:

- (i) apply to an Employee, Spouse or Child who does not otherwise qualify for COBRA Continuation Coverage;
- (ii) prevent an Employee, Spouse or Child from exercising his right to elect and receive COBRA Continuation Coverage for the maximum period required under COBRA; or
- (iii) require an Employee, Spouse or Child to pay more for COBRA Continuation Coverage or Retiree Health Coverage than the Plan is permitted to charge under COBRA.

(A) Lower Cost in the Event of Partial Employment or Temporary Employment in Another Jurisdiction

If an Employee does not complete the minimum number of Hours of Service for continued Regular Health Coverage during a Contribution Period, but at the beginning of that Contribution Period he is employed by a Contributing Employer in the jurisdiction of the Union, or is temporarily employed in the jurisdiction of a plan with a reciprocal agreement with this Plan (see Section 10), then the Employee, his Spouse and his Children may elect COBRA Continuation Coverage during that Contribution Period at a cost equal to:

- (i) the difference between (i) the contributions the Plan would have receive on behalf of the Employee if he had worked at least 200 Hours of Service during the immediately preceding Contribution Period in the jurisdiction of the Union, and (ii) the contributions owed to the Plan for the Employee's actual hours during the immediately preceding Contribution Period; plus
- (ii) 15% of their Applicable Premium.

This special rule will apply until the earlier of the date: (i) the Employee is no longer partially employed by Contributing Employers in the jurisdiction of the Union or is no

International Association of Heat and Frost Insulators and Allied Workers
Local No. 26 Welfare Plan

Summary Plan Description

longer temporarily employed in the jurisdiction of a plan with a reciprocal agreement with this Plan; or (ii) the maximum period for COBRA Continuation Coverage ends.

(B) Lower Cost in the Event of Disability

If an Employee does not complete the minimum number of Hours of Service for continued Regular Health Coverage because he is totally disabled, for the first 26 weeks of his disability the Employee, his Spouse and Children may elect COBRA Continuation Coverage at a cost equal to 15% of their Applicable Premium and, thereafter, at a cost equal to 65% of their Applicable Premium.

This special rule will apply until the earlier of the date: (i) the Employee is no longer totally disabled; or (ii) the maximum period for COBRA Continuation Coverage ends.

For purposes of the Plan, an Employee will be considered totally disabled when he qualifies for disability benefits under this Plan.

(C) Lower Cost in the Event of Death

The Spouse and Children of an Employee who dies while eligible for Regular Health Coverage may elect COBRA Continuation Coverage for two years following the Employee's death at a cost equal to 15% of their Applicable Premium and, thereafter, at a cost equal to 65% of their Applicable Premium.

This special rule will apply until the earlier of the date: (i) the Spouse remarries; or (ii) the maximum period for COBRA Continuation Coverage ends.

(D) Retiree Health Coverage

If an Employee qualifies for normal or early pension benefits under the Union Pension Plan when he retires, then in lieu of COBRA Continuation Coverage, the retired Employee, his Spouse and Children may continue Health Coverage for four months at a cost equal to 15% of their Applicable Premium and, thereafter, at a cost equal to 65% of their Applicable Premium. This Health Coverage is referred to as "Retiree Health Coverage."

If a retired Employee with Retiree Health Coverage dies before the end of the 36 month period following his retirement date, his surviving Spouse and Children will be entitled to

International Association of Heat and Frost Insulators and Allied Workers
Local No. 26 Welfare Plan

Summary Plan Description

continue Health Coverage through the end of that 36 month period only. Their cost for Health Coverage after the retired Employee's death will be the cost under this special rule unless the surviving Spouse remarries during that 36 month period (in which case the cost will increase to 100% of their Applicable Premium plus a two percent (2%) administrative fee). If a retired Employee dies after he has had 36 months of Retiree Health Coverage, his Spouse and Children will no longer be entitled to Health Coverage under the Plan.

If a retired Employee with Retiree Health Coverage divorces his Spouse before the end of the 36 month period following his retirement date, that Spouse will be entitled to continue Health Coverage through the end of that 36 month period only. Her cost for Health Coverage after the divorce will be 100% of her Applicable Premium plus a two percent (2%) administrative fee. If a retired Employee divorces his Spouse after he has 36 months of Retiree Health Coverage, that Spouse will no longer be entitled to Health Coverage under the Plan.

COBRA Continuation Coverage

Introduction

COBRA Continuation Coverage is a temporary extension of Health Coverage under the Plan. The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA Continuation Coverage may become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family when they would otherwise lose your group health coverage. Below is a summary of COBRA Continuation Coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

What is COBRA Continuation Coverage?

COBRA Continuation Coverage is a continuation of Health Coverage when Health Coverage 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 because of the qualifying event. Under the Plan, qualified

International Association of Heat and Frost Insulators and Allied Workers
Local No. 26 Welfare Plan

Summary Plan Description

beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage.

If you are an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- (1) Your hours of employment are reduced; or
- (2) Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- (1) Your Spouse dies;
- (2) Your Spouse's hours of employment are reduced;
- (3) Your Spouse's employment ends for any reason other than his or her gross misconduct;
- (4) Your Spouse becomes enrolled in Medicare (Part A, Part B, or both); or
- (5) You become divorced or legally separated from your Spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- (1) The parent-Employee dies;
- (2) The parent-Employee's hours of employment are reduced;
- (3) The parent-Employee's employment ends for any reason other than his or her gross misconduct;
- (4) The parent-Employee becomes enrolled in Medicare (Part A, Part B, or both);
- (5) The parents become divorced or legally separated; or
- (6) The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA Continuation Coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of

International Association of Heat and Frost Insulators and Allied Workers
Local No. 26 Welfare Plan

Summary Plan Description

the Employee, or the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the Employee and Spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Local No. 26 Funds Office, 4515 Culver Road, Suite 104, Rochester, NY 14622. The notice must be in writing, and must contain your name and address, the name and address of any affected dependents, a description of the qualifying event, and the date of the qualifying event. You may be asked to provide additional documentation or information after you have submitted the notice.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA Continuation Coverage will be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their Spouses, and parents may elect COBRA Continuation Coverage on behalf of their children.

COBRA Continuation Coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), divorce or legal separation, or loss of a child's eligibility as a dependent child, COBRA Continuation Coverage lasts for up to total of 36 months. When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA Continuation Coverage for qualified beneficiaries other than the Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA Continuation Coverage for his Spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). Otherwise, when the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA Continuation Coverage

International Association of Heat and Frost Insulators and Allied Workers
Local No. 26 Welfare Plan

Summary Plan Description

generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA Continuation Coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. The 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. You must provide this notice to the Local No. 26 Funds Office, 4515 Culver Road, Suite 104, Rochester, NY 14622. The notice must be in writing, and must contain your name and address, the name and address of the disabled qualified beneficiary, and the date the disability was determined to have begun. You must also attach a copy of the Social Security Administration's determination. You may be asked to provide additional documentation or information after you have submitted the notice.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the Spouse and dependent children in your family may be entitled to up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the Spouse and any dependent children receiving continuation coverage if the Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the Spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. You must provide this notice to the Local No. 26 Funds Office, 4515 Culver Road, Suite 104, Rochester, NY 14622. The notice must be in writing, and must contain your name and address, the name and address of any affected dependents, a description of the second qualifying event, and the date of the second qualifying event. You may be asked to provide additional documentation or information after you have submitted the notice.

International Association of Heat and Frost Insulators and Allied Workers
Local No. 26 Welfare Plan

Summary Plan Description

If You Have Questions

Questions concerning your Plan or your COBRA Continuation Coverage rights should be addressed to the contract or contracts identified below. 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.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator 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 Plan Administrator.

Plan Contact Information

Funds Manager, Local No. 26 Funds Office, 4515 Culver Road, Suite 104, Rochester, NY 14622 (Tel. No. (585) 323-2110).

SECTION 8
AMENDMENT AND TERMINATION OF THE PLAN

The Board may amend the Plan at any time when it deems it necessary or advisable, including any amendment that reduces or eliminates benefits for active employees, retirees, or any other group or class of employees or former employees. However, no amendment may provide for the use of the Trust funds for any purpose other than the exclusive benefit of Employees, their Spouses and Children. It is expected the Plan will continue indefinitely but the Plan may be discontinued at any time if maintenance of the Plan is no longer called for under the Agreement or any other collective bargaining agreement, or the Board determines that funding of the Plan is insufficient to provide benefits.

Summary Plan Description

SECTION 9
CLAIMS PROCEDURE

Health Claims

If you have questions about eligibility for Health Coverage or the cost of Health Coverage, you should contact the Plan Office. Each Insurer is responsible for paying the specific benefits under the Health Coverage that it provides through its Policies. You should contact the appropriate Insurer directly if you have questions concerning your specific health benefits at the following address:

BlueCross BlueShield
165 Court Street
Rochester, New York 14647

Preferred Care
259 Monroe Avenue
Rochester, New York 14607

The Insurer's are responsible for processing claims and paying benefits. If you believe you are entitled to specific benefits you should submit a benefit claim directly to the appropriate Insurer at the address above.

The claim procedures are different for "concurrent claims," "pre-service claims," "post-service claims," and "urgent claims." A concurrent claim is a request for an extension of health treatment (i.e., treatment provided over a period of time or a number of treatments). A pre-service claim is a claim requiring advance approval to receive all or part of the benefit. A post-service claim is any claim that is not a pre-service claim. An urgent claim is any claim for medical care or treatment that, if non-urgent claim procedures were followed, could seriously jeopardize the life or health of the patient or his ability to regain maximum function, or in the opinion of a physician with knowledge of the patient's medical condition would subject the patient to severe pain that cannot be adequately managed without the care or treatment requested.

You may appoint someone to file a claim and act on your behalf; provided you give the Plan signed written notification of the appointment. In the case of an urgent claim, a health care professional with knowledge of your medical condition will be permitted to act as your representative.

Post-service claims must be filed within 24 months after the service or expense claimed was incurred. All claims must be filed on forms provided by the Insurer and submitted

International Association of Heat and Frost Insulators and Allied Workers
Local No. 26 Welfare Plan

Summary Plan Description

by mail, except urgent claims may be made orally and information may be transmitted by telephone or by facsimile at the following numbers, provided that any necessary written forms are later completed and filed.

BlueCross BlueShield
Telephone (585) 454-4810
Facsimile (585) 238-3659

Preferred Care
259 Monroe Avenue
Rochester, New York 14607

If you make a request for benefits that does not comply with the Plan's procedure for pre-service claims, you will be notified of the proper procedure within 24 hours if it involves an urgent pre-service claim, or within five days if it involves a non-urgent pre-service claim. (This notification may be oral, unless you request written notification.)

If a claimant fails to submit sufficient information for a determination on an urgent claim, he will be notified of the specific information necessary to complete the claim within 24 hours after the Plan receives the claim. He may then submit the additional information within 48 hours, and will be notified of the determination on his claim within 48 hours after the earlier of the receipt of the additional information or the end of the period the additional information could have been submitted.

A claimant will be notified of the determination on his claim within: 24 hours in the case of a concurrent claim involving urgent health care if the request is received at least 24 hours before the scheduled expiration of the treatments; 72 hours in the case of any other urgent claim (or earlier if possible); 15 days in the case of a non-urgent pre-service claim; or 30 days in the case of a post-service claim. However, if an extension to make a determination on a non-urgent claim is necessary due to reasons beyond the Plan's control, the time to make the determination may be extended for up to another 15 days. In that case, the claimant will receive written notice of the reasons for the extension, any additional information required from him to make the determination, and the date the determination is expected. Also, if the extension is necessary because additional information is needed from the claimant, the claimant will be given 45 days from the date he receives the notice to provide the information.

If an adverse determination is made, the claimant will be sent a notice containing: (i) the specific reasons for the adverse determination; (ii) references to the specific Plan provisions on which it is based; (iii) the names of any medical or vocational experts whose advice was obtained by the Plan in connection with the determination; (iv) a

International Association of Heat and Frost Insulators and Allied Workers
Local No. 26 Welfare Plan

Summary Plan Description

description of any additional material or information necessary to complete the claim and an explanation of why it is necessary; (v) a description of the Plan's review procedures and time limits; (vi) a statement that the claimant has a right to sue under the Employee Retirement Income Security Act of 1974 following an adverse determination upon review; (vii) if the Plan relied upon an internal rule, guideline, protocol or similar criterion in making the determination, either the criterion relied upon or a statement that the Plan relied upon such criterion and that a copy of the criterion is available free of charge upon request; (viii) if the determination was based upon a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to the claimant's medical circumstances), or a statement that such explanation will be provided free of charge upon request; and (ix) for urgent claims, a description of the expedited review procedure for such claims. This notice may be provided orally for an urgent claim, but will then be sent to the claimant in writing within three days after oral notification.

Within 180 days after receiving an adverse determination, a claimant may file a written appeal to the Insurer for a full and fair review of the claim and determination. He may submit written comments, documents and other information relating to the claim, and may have reasonable access to, and copies of, all documents, records, and other information relevant to the claim. For an urgent claim, the claimant may request, in writing or orally, an expedited review of the initial determination, and information may be transmitted by telephone or by facsimile at the following numbers.

BlueCross BlueShield
Telephone (585) 454-4810
Facsimile (585) 238-3659

Preferred Care
259 Monroe Avenue
Rochester, New York 14607

A reduction or termination of health treatment (other than by Plan amendment or termination) will be treated as an adverse determination, and the participant or beneficiary will be notified sufficiently in advance to allow him to appeal before the reduction or termination occurs.

The review on appeal will take into account all documents, records and information submitted by the claimant, and will be conducted by an appropriate named fiduciary who did not make the initial determination and who is not a subordinate of the person who did. For a claim based on medical judgment (e.g., whether a treatment or drug is

International Association of Heat and Frost Insulators and Allied Workers
Local No. 26 Welfare Plan

Summary Plan Description

experimental, investigational, or medically necessary or appropriate), the person conducting the review will consult with a state licensed or certified independent health care professional with appropriate training and experience in the field who was not consulted in connection with the initial determination and is not a subordinate of any health care professional who was consulted.

The claimant will be notified of the determination on review within 72 hours after the Plan receives the request for review of an urgent claim (or earlier if possible), 30 days after the Plan receives a request for review of a non-urgent pre-service claim, or 60 days after the Plan receives a request for review of a post-service claim.

The notice of an adverse determination on review will contain: (i) the specific reasons for the adverse determination; (ii) reference to the specific Plan provisions on which the determination is based; (iii) a statement that, upon request, the claimant is entitled free of charge to reasonable access to, and copies of, all documents and records relevant to the claim; (iv) if the Plan relied upon some internal rule, guideline, protocol, or similar criterion in making the determination, either the criterion relied upon or a statement that the Plan relied upon such criterion and a copy of the criterion is available free of charge upon request; (v) if the determination is based upon a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and (vi) a statement that the claimant has a right to sue under the Employee Retirement Income Security Act of 1974; (vii) the following statement: "You and your Plan may have other voluntary alternative 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."

Life, Accident and Disability Benefit Claims

The Insurer is responsible for paying Life, Accident and Disability Coverage benefits under its Policy. If you believe you are entitled to Life, Accident and Disability Coverage benefits, you should submit a benefit claim to the Plan Office at the address below:

International Association of Heat and Frost Insulators and Allied Workers
Local No. 26 Welfare Plan

Summary Plan Description

International Association of Heat and Frost Insulators and Allied Workers
Local No. 26 Welfare Plan
4515 Culver Road, Suite 104
Rochester, NY 14622

You should also contact the Plan Office if you have questions about eligibility for Life, Accident and Disability Coverage or about specific Life, Accident and Disability Coverage benefits.

You may appoint someone to file a claim and act on your behalf; provided you give the Plan signed written notification of the appointment. The claim procedures are different for Life and Accident Coverage benefits and for Disability Coverage Benefits.

For Life and Accident Coverage Benefits

A claimant will be notified of the determination on his claim within 90 days. However, if an extension to make a determination is necessary due to reasons beyond the Plan's control, the time to make the determination may be extended for up to another 90 days. In that case, the claimant will receive written notice of the reasons for the extension, any additional information required from him to make the determination, and the date the determination is expected.

If an adverse determination is made, the claimant will be sent a notice containing: (i) the specific reasons for the adverse determination; (ii) references to the specific Plan provisions on which it is based; (iii) a description of any additional material or information necessary to complete the claim and an explanation of why it is necessary; (iv) a description of the Plan's review procedures and time limits; and (v) a statement that the claimant has a right to sue following an adverse determination upon review.

Within 60 days after receiving an adverse determination, a claimant may file a written appeal to the Fund Office for a full and fair review of the claim and determination. He may submit written comments, documents and other information relating to the claim, and may have reasonable access to, and copies of, all documents, records, and other information relevant to the claim. The review on appeal will take into account all documents, records and information submitted by the claimant. The claimant will be notified of the determination on review within 60 days after the Plan receives a request for review. However, if an extension to make a determination on review is necessary due to reasons beyond the Plan's control, the time to make the determination may be

International Association of Heat and Frost Insulators and Allied Workers
Local No. 26 Welfare Plan

Summary Plan Description

extended for up to another 60 days. In that case, the claimant will receive written notice of the reasons for the extension, any additional information required from him to make the determination, and the date the determination is expected.

The notice of an adverse determination on review will contain: (i) the specific reasons for the adverse determination; (ii) reference to the specific Plan provisions on which the determination is based; and (iii) a statement that, upon request, the claimant is entitled free of charge to reasonable access to, and copies of, all documents and records relevant to the claim; and (iv) a statement that the claimant has a right to sue under the Employee Retirement Income Security Act of 1974.

For Disability Coverage Benefits

A claimant will be notified of the determination on his claim within 45 days. However, if an extension to make a determination is necessary due to reasons beyond the Plan's control, the time to make the determination may be extended for up to two additional 30 days periods. In that case, the claimant will receive written notice of the reasons for the extension(s), any additional information required from him to make the determination, and the date the determination is expected.

If an adverse determination is made, the claimant will be sent a notice containing: (i) the specific reasons for the adverse determination; (ii) references to the specific Plan provisions on which it is based; (iii) the names of any medical or vocational experts whose advice was obtained by the Plan in connection with the determination; (iv) a description of any additional material or information necessary to complete the claim and an explanation of why it is necessary; (v) a description of the Plan's review procedures and time limits; (vi) if the Plan relied upon an internal rule, guideline, protocol or similar criterion in making the determination, either the criterion relied upon or a statement that the Plan relied upon such criterion and that a copy of the criterion is available free of charge upon request; (vii) if the determination was based upon a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to the claimant's medical circumstances), or a statement that such explanation will be provided free of charge upon request; and (viii) a statement that the claimant has a right to sue following an adverse determination upon review.

Within 180 days after receiving an adverse determination, a claimant may file a written appeal to the Fund Office for a full and fair review of the claim and determination. He

International Association of Heat and Frost Insulators and Allied Workers
Local No. 26 Welfare Plan

Summary Plan Description

may submit written comments, documents and other information relating to the claim, and may have reasonable access to, and copies of, all documents, records, and other information relevant to the claim. The review on appeal will take into account all documents, records and information submitted by the claimant. The claimant will be notified of the determination on review within 45 days after the Plan receives a request for review. However, if an extension to make a determination on review is necessary due to reasons beyond the Plan's control, the time to make the determination may be extended for up to another 45 days. In that case, the claimant will receive written notice of the reasons for the extension, any additional information required from him to make the determination, and the date the determination is expected.

The notice of an adverse determination on review will contain: (i) the specific reasons for the adverse determination; (ii) reference to the specific Plan provisions on which the determination is based; (iii) if the Plan relied upon an internal rule, guideline, protocol or similar criterion in making the determination, either the criterion relied upon or a statement that the Plan relied upon such criterion and that a copy of the criterion is available free of charge upon request; (iv) if the determination was based upon a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to the claimant's medical circumstances), or a statement that such explanation will be provided free of charge upon request; (v) a statement that, upon request, the claimant is entitled free of charge to reasonable access to, and copies of, all documents and records relevant to the claim; and (vi) a statement that the claimant has a right to sue under the Employee Retirement Income Security Act of 1974

SECTION 10
RECIPROCAL AGREEMENTS

From time to time, the Plan may enter into reciprocal agreements providing for the exchange of contributions made for Employees who normally work in the jurisdiction of another employee welfare benefit plan, or otherwise elect to participate in the reciprocal exchange of contributions with another employee welfare benefit plan. An Employee will not receive credit for Hours of Service if the contributions received by the Plan for those hours are remitted, or are required to be remitted, to another plan pursuant to a reciprocal agreement. The following rules apply to Hours of Service attributable to contributions remitted by another plan to this Plan pursuant to a reciprocal agreement.

Summary Plan Description

- Hours of Service attributable to contributions remitted to this Plan are credited under this Plan when the contributions are actually received by this Plan.
- When contributions are remitted to the Plan for hours worked by one or more Employees, the Hours of Service credited to each such Employee under the Plan will equal the total contributions remitted multiplied by a fraction, the numerator of which is the amount of contributions that should have been remitted for that Employee's hours and the denominator of which is the total amount of contributions that should have been remitted for all such Employees' hours.

An Employee may request from the Board a list of employee welfare benefit plans with which the Plan has a reciprocal agreement.

SECTION 11
POWERS OF THE TRUSTEES

In addition to the other powers conferred upon it by law, subject to the rights of the Insurers, the Board has the power and discretion to:

- Establish, amend or revoke any rule, term or provision of the Plan, at any time, provided that no such amendment or revocation may provide or result in the use of the trust fund assets for any purpose other than the exclusive benefit of the participants and their beneficiaries and to pay necessary and reasonable expenses for the administration of the Plan.
- Administer the Plan in all of its details, including the authority to: (i) decide any issues of fact relevant to the eligibility of any person to participate in the Plan; (ii) interpret the terms of the Plan; (iii) supply any omission, interpret any ambiguous or uncertain provisions of the Plan, and reconcile any inconsistency that may appear in the Plan; and (iv) make and enforce such rules and regulations as it deems necessary or proper for the administration of the Plan.

SECTION 12
YOUR RIGHTS

USERRA Participation Rights

The Uniformed Services Employment and Reemployment Rights Act (“USERRA”) also gives an employee who is absent from work due to service in the uniformed services (including active or reserve duty, whether voluntary or involuntary, and time off for training or instruction) the right to continuation coverage under the Plan if the employee is covered under the Plan when the period of military service begins, and certain other requirements are satisfied. For example, the period of military service generally cannot exceed five years, and the employee (or an appropriate officer) must give advance oral or written notice of the absence to the employee’s employer as early as is reasonable under the circumstances, unless notice is prevented by military necessity or is otherwise impossible or unreasonable under the circumstances.

An employee entitled to USERRA continuation coverage may elect continuation coverage (for him/herself and his/her covered dependents) for a period of up to 24 months. However, USERRA continuation coverage will terminate if the employee’s military service ends because of: (i) separation from service with a dishonorable or bad-conduct discharge; (ii) separation from service under certain less-than-honorable conditions; or (iii) for a commissioned officer, dismissal in connection with a court-martial or, in time of war, by the President, or dropping of the commissioned officer from the rolls as a result of an unauthorized absence for at least three months or as a result of a sentence imposed after a court-martial or a conviction in another court. USERRA continuation coverage will also terminate if the employee fails to report back to work or apply for reemployment within the time period required under USERRA after completion of military leave.

All election and premium payment procedures, rules and deadlines for USERRA continuation coverage under the Plan are the same as the COBRA continuation coverage election and premium payment procedures, rules and deadlines described in the SPD, except to the extent any of those procedures, rules or deadlines conflict with USERRA regulations (e.g., if compliance with any particular procedure, rule or deadline is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances).

International Association of Heat and Frost Insulators and Allied Workers
Local No. 26 Welfare Plan

Summary Plan Description

An employee also has the right to reinstatement in the Plan, without any exclusions or waiting periods due to the military leave, when he/she timely returns to work after a military leave, assuming he/she is otherwise eligible for Plan coverage. If the employee timely returns to work after a military leave before the maximum USERRA continuation coverage period but the employee is not reinstated in the Plan because he/she is not eligible for coverage at that time (for reasons unrelated to the military leave), then the employee has a right to continuation coverage for the entire 24 month USERRA continuation coverage period (or, if sooner, the date he/she is reinstated).

Information concerning your USERRA rights is available from the Local No. 26 Funds Office at 4515 Culver Road, Suite 104, Rochester, New York 14622.

**New York Extended Dependent Child Coverage
and New York Continuation Coverage**

Under New York law, if a child has reached the maximum age for dependent child coverage under the Plan he may be entitled to extended health insurance coverage until he reaches age 29 (“New York extended dependent child coverage”). This coverage is provided directly by the insurer providing health coverage under the Plan for the child’s parent, and the cost for this coverage is billed by the insurer directly to the child.

To be eligible for New York extended dependent child coverage, the child must be unmarried and satisfy certain other requirements. If you have reached, or are about to reach, the maximum age for dependent child coverage under the Plan and are interested in New York extended dependent child coverage, you should contact the insurer providing your parent’s health coverage for more information.

Under New York law, if the maximum period a person is entitled to federal COBRA continuation coverage is less than 36 months and he receives federal COBRA continuation coverage through that period, he may be entitled to continued health insurance coverage under New York law (“New York continuation coverage”). The maximum period of combined federal COBRA continuation coverage and New York continuation coverage is 36 months. For example, if your maximum federal COBRA continuation coverage period is 18 months, the longest New York continuation coverage would be available is another 18 months. Note that the same circumstances and events that would trigger termination of a person’s federal COBRA continuation coverage also trigger termination of New York continuation coverage. The cost for New York

Summary Plan Description

continuation coverage is equal to 102% of the full premium for insured health coverage and must be paid by the person receiving the New York continuation coverage.

Family and Medical Leave Act Leave

If you are eligible for and take a leave of absence under the Family and Medical Leave Act (“FMLA Leave”), you may continue Plan coverage during the FMLA Leave, provided you would have been continuously employed during the entire FMLA Leave and you pay the participant cost for Plan coverage during the FMLA Leave. Plan coverage will continue as if you were actively employed by your Contributing Employer until the earlier of the date (1) the FMLA Leave ends, or (2) you notify your Contributing Employer that you will not return to work. If you choose not to continue Plan coverage during an FMLA Leave, you may resume Plan coverage when you return to work (provided you return when the FMLA Leave expires), and any pre-existing condition exclusion rules under the Plan will be waived.

You are also eligible to elect COBRA Continuation Coverage after the FMLA Leave if you:

- were covered under the Plan on the day before the FMLA Leave,
- do not return to work at the end of the FMLA Leave, and
- would otherwise lose coverage under the Plan.

You also may be able to elect COBRA Continuation Coverage even if you choose not to continue regular Plan coverage during the FMLA Leave, or you stop paying your cost for Plan coverage during the FMLA Leave.

Information concerning your right to and obligations during a leave is available from your Contributing Employer.

Women’s Health And Cancer Rights Act

The Plan provides coverage in connection with a mastectomy (in the manner determined by the attending physician and the patient) for:

- reconstruction of the breast on which the mastectomy is performed,
- surgery and reconstruction of the other breast to produce symmetrical appearance, and

Summary Plan Description

- prostheses and physical complications at all stages of the mastectomy, including lymphedema.

The Plan may not deny eligibility to enroll, renew or continue group health plan coverage to avoid providing coverage for breast reconstruction or mastectomy complications. Deductible and co-payment amounts for covered care will be consistent with those established for other Plan benefits. In addition, the law prohibits penalizing or otherwise reducing or limiting the reimbursement of an attending provider for the required care, or providing any incentive (monetary or otherwise) to induce the attending provider to provide care that would be inconsistent with the law.

If you have any questions about this coverage, please contact your Plan Administrator.

Newborn Mothers and Minimum Maternity Stay

The Plan generally may not restrict benefits 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 caesarian section, or require that a health care provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order (QMCSO) is an order by a court for one parent to provide a child or children with health coverage. If the Plan receives a QMCSO for your child or children, you will be contacted about the procedure for the QMCSO.

Certificates of Coverage

If you lose regular Plan Coverage or COBRA Continuation Coverage, you will receive a "Certificate of Coverage." This Certificate generally shows the level of coverage you had under the Plan and how long it was in effect. The purpose of the Certificate is to allow you to prove the amount of "creditable coverage" that may reduce or eliminate any pre-existing condition requirement under new health coverage you may acquire. The Plan will also make reasonable efforts to provide separate Certificates of Coverage for a Spouse or dependent when it has reason to know the Spouse or dependent is no longer covered under the Plan.

International Association of Heat and Frost Insulators and Allied Workers
Local No. 26 Welfare Plan

Summary Plan Description

In addition, the Plan will provide a Certificate of Coverage to you, your Spouse or dependent (or their authorized representative) upon request made within 24 months after Plan coverage terminates. Contact the Plan Office to request a Certificate of Coverage.

HIPAA Privacy Rules

The Plan has responsibilities under Health Insurance Portability and Accountability Act (“HIPAA”) regarding the use and disclosure of your protected health information (“PHI”). Your PHI is any information that: (i) identifies you or may reasonably be used to identify you; (ii) is created or received by a health care provider, health plan, employer or health care clearinghouse; and (iii) relates to your past, present or future physical or mental health or condition, or the provision of or payment for health care. The Plan is required maintain the privacy of your PHI. It is also required to provide you with a notice of its legal duties and privacy practices, and to follow the terms of the privacy notice. However, the Plan is also permitted by law to use and disclose your PHI in certain ways, which are described in the privacy notice.

If you believe your PHI has been impermissibly used or disclosed, or that your privacy rights have been violated in any way, you may file a complaint with the Plan or with the Secretary of United States Department of Health and Human Services. If you want a copy of the Plan’s privacy notice or more information about the Plan’s privacy practices, or you want to file a privacy violation complaint, please contact the Plan Office.

Your Rights Under ERISA

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

Receive Information About Your Plan and Benefits

This includes the ability to:

- Examine, without charge, at the Plan Administrator's 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), if applicable, filed by the Plan with the U.S.

International Association of Heat and Frost Insulators and Allied Workers
Local No. 26 Welfare Plan

Summary Plan Description

Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit 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), if applicable, and updated Summary Plan Description. The Plan 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, if applicable.

Continue Group Health Plan Coverage

You may have a right to 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.

You may have a right to a reduction or elimination of exclusionary periods of coverage for preexisting conditions under the Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from the Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in 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 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

International Association of Heat and Frost Insulators and Allied Workers
Local No. 26 Welfare Plan

Summary Plan Description

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 Plan Administrator. If you have a claim for benefits that 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 the Employee Benefits Security Administration.