ROOFERS' LOCAL NO. 149 SECURITY BENEFIT TRUST FUND

PLAN DOCUMENT

2021

PREFACE

The Board of Trustees of the Roofers Local 149 Security Benefit Trust Fund define its Health Care Plan by this Plan Document. The Fund is intended to be maintained for the exclusive benefit of employees and maintained on an indefinite basis. It is intended that this Plan Document will serve to describe the benefits of the Fund. It is also intended that this Plan Document shall conform to the requirements found in the Employee Retirement Income Security Act of 1974 (ERISA), as amended from time to time, as that Act applies to employee welfare benefit plans. If any portion of this Plan Document does now, or in the future, conflict with ERISA or applicable Federal Regulations, ERISA and/or such regulations will govern.

Although the Trustees expect to continue the Fund indefinitely, they reserve the right to change or terminate the Fund at any time and for any reason, for any group or class of Participants or Dependents, as well as for all such groups. Correspondingly, the Trustees may change the level of benefits provided, impose or raise self-payments, or eliminate an entire category of benefits, at any time and/or for any reason.

The Fund is subject to all terms, provisions and limitations stated on the following pages.

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ARTICLE 1: DEFINITIONS

Accident or Accidental means the Injury caused by external forces under unexpected circumstances.

Active Employee or Employee shall mean an Apprentice, Journeyman, Superintendent, Working Principal, Union Employee, Apprenticeship Fund Employee, or other person on whose account an Employer has made Contributions to the Fund.

Apprentice means a person learning the trade and designated as an Apprentice under the Collective Bargaining Agreement.

Apprenticeship Fund Employee means an instructor or other employee of the Roofers Local 149 – Southeastern Michigan Roofing Contractors Joint Apprenticeship Committee Training Fund or Roofers Local 149 Mid-Michigan Joint Apprenticeship Fund (collectively "Apprenticeship Fund") on whose behalf the Apprenticeship Fund makes Contributions to this Fund.

Association means the Southeastern Michigan Roofing Contractors Association, Inc., or the Professional Roofing Organization Inc.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Calendar Year means January 1 through December 31 of any year.

Children or Child means:

1. Any person up until the first of the month following the month in which he/she turns 26 years of age and either:

   (a) is a Participant's natural or adopted child;

   (b) has been placed with a Participant for adoption; or

   (c) is a Participant's step-child.

2. A person who would qualify as a "child" under paragraph 1 but for the age

limitations, who by reason of mental or physical handicap is incapable of sustaining employment, such handicap accrued prior to the date such person's coverage would otherwise terminate, he/she is claimed as a dependent on the Participant's federal tax returns, and the Participant has submitted proof of such to the Fund within 31 days of the date such Dependent's coverage would have otherwise terminated ; or

3. An alternate recipient under a Qualified Medical Child Support Order of a Participant.

Chiropractic Services and Alternate Therapies means chiropractic, acupuncture, acupressure, therapeutic massage, biofeedback and homeopathy therapy provided by a practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

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

Collective Bargaining Agreement. The term "Collective Bargaining Agreement" means any contract entered into between the Union and the Association or any Employer or other association under which the Employer has agreed to contribute to the Fund.

Contributions shall mean the payments made or required to be made to the Security Benefit Trust Fund by the Employers. Contributions become vested plan assets at the time they become due and owing to the Fund. The Employers shall have no right, title or interest in the Contributions owing to or made to the Fund, and no part of the Fund shall revert to the Employers.

Covered Charge or Allowable Expense is the lesser of the actual charge for services or treatment covered under this Plan, the reasonable and customary charge for such services/treatment, or the maximum benefit provided under the terms of this Plan.

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication, which could normally be self-administered.

Covered Person means a Participant or his/her Dependent.

Dependent means a Participant's Spouse and his/her Children.

Detroit Participant means an Active Employee, Disabled Employee, Pensioner or Surviving Spouse who are covered by the Plan by virtue of present or past contributions received by the Fund pursuant to a Collective Bargaining Agreement covering the Detroit area.

Disability means a physical or mental condition (Occupational or Non-Occupational), which in

the opinion of a physician satisfactory to the Trustees, prevents a person from engaging in any regular occupation or employment as a roofer; however, no person shall be deemed to have a Disability if such incapacity was contracted, suffered or incurred while he was engaged in an illegal activity or from the Armed Forces of any country.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury, and (d) is appropriate for use in the home.

Employer means

1. a member of the Association who is bound by the terms of a Collective Bargaining Agreement between the Union and the Association to make Contributions to the Fund;

2. any other employer or other association engaged in work coming within the jurisdiction of the Union who is obliged, by a Collective Bargaining Agreement or other written agreement satisfying the requirements of the National Labor Relations Act, to make Contributions to the Fund;

3. the Union to the extent, and solely to the extent, that it acts in the capacity of an employer of its business representatives or other employees on whose behalf it makes Contributions to the Fund; and

4. the Roofers' Local 149 Apprenticeship Trust Fund, to the extent and solely to the extent that it acts in the capacity of an employer of employees on whose behalf Contributions are made to the Fund.

Experimental and/or Investigational means services, supplies, care and treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental or nonexperimental standings of specific technologies. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

(1) If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

(2) If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving

a similar function, or if federal law requires such review or approval; or

(3) If evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(4) If evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Extended Care Facility means an institution which is licensed as an extended care facility or long-term nursing facility and which is qualified to participate and is eligible to receive payment under and in accordance with the provisions of the United States Medicare Program, but which is not, other than incidentally, a home for the aged or domiciliary care home.

Flint Participant means an Active Employee, Disabled Employee, Retiree or Surviving Spouse who are covered by the Plan by virtue of present or past contributions received by the Fund pursuant to a Collective Bargaining Agreement covering the Flint area.

Fund means Roofers Local No. 149 Security Benefit Trust Fund, which includes all rights, assets, and liabilities assumed by virtue of the Merger.

Generic Drug means a Prescription Drug that has the equivalency of the brand name drug with the same use and metabolic disintegration.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care means the following items and services furnished to an individual, who is under the care of a Physician, by a Home Health Agency, which except as provided in item (7), are provided on a visiting basis in a covered person's home:

1. part-time or intermittent nursing care provided by or under the supervision of a registered nurse or LPN,

2. physical, occupational, or speech therapy,

3. medical social services under the direction of a Physician,

4. part-time or intermittent services of a home health aide,

5. medical supplies and the use of medical appliances,

6. in the case of a Home Health Agency which is affiliated or under common control with a Hospital, medical services provided by an intern or resident-in-training of such hospital,

7. items 1-6, above, provided on an outpatient basis, under arrangements made by the Home Health Agency, at a Hospital, Extended Care Facility, or a rehabilitation center if such services cannot readily be made available to the Covered Person at his/her home (the cost of transportation to such facility is not included),

8. rental of Durable Medical Equipment used in the patient's home (including an institution used as his home), and

9. dietitian services when ordered by a Physician provided such services are performed by registered dietitian.

Home Health Care does not include general housekeeping services.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, or home care.

Hospice Unit is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises. The definition of "Hospital" also includes the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness or Sickness means a bodily disorder, disease, physical sickness or Mental Nervous Disorder, including Pregnancy.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Inpatient means over 23 consecutive hours in a Hospital.

Intensive Care Unit is defined as a separate, clearly designated service area that is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Journeyman/Journeymen mean persons who have attained journeyman status pursuant to the terms of a Collective Bargaining Agreement.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime means while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Medically Necessary means care, services or treatment recommended or approved by a Physician or Dentist as necessary by reason of Illness or Injury or for the protection of the health of the individual; is consistent with the patient's condition or accepted standards of good medical and dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical and dental services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Nervous Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International

Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Merger means the merger of the Roofers Local 149 Security Benefit Trust Fund and Roofers Local 149 Mid-Michigan Health and Welfare Fund ("Mid-Mich Fund"), which was effective June 1, 2004.

Non-Detroit Participant means a Flint Participant, Upper Peninsula Participant, Port Huron Participant, or Traverse/Northern Lower Michigan Participant.

Non-Occupational means an Injury or Illness that does not arise out of or in the course of employment.

Occupational means an Injury or Illness that arises out of or in the course of employment.

Out-Patient means treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Participant means a Detroit Participant, Flint Participant, Upper Peninsula Participant, Port Huron Participant, or Traverse/Northern Lower Michigan Participant.

Pensioner means a Detroit Participant person entitled to coverage pursuant to the terms of §2.4.

Physician means a doctor of medicine or osteopathy or podiatry or optometry, legally qualified and licensed to practice medicine or perform surgery or provide services at the time and place services are performed. The term "Physician" shall also mean a person who is licensed or certified as a psychologist and who is legally entitled to engage in the private practice of psychology (but not including a person acting within the scope of a partial or limited license or certification). It shall also mean a person who is a member or Fellow of the American Psychological Association if there is no licensure of certification in the jurisdiction where such person renders service.

Plan means this document and any amendments to it.

Plan Office means BeneSys, Inc., 700 Tower Drive, Suite 300, Troy Michigan 48098-2835, (248) 641-4949 or (888) 868-6411.

Plan Administrator means the Trustees of the Fund.

Plan Year means the period of 12 consecutive months beginning June 1 through May 31. This is also the Plan's fiscal/accounting year.

Port Huron Participant means an Active Employee, Disabled Employee, Retiree or Surviving

Spouse who are covered by the Plan by virtue of present or past contributions received by the Fund pursuant to a Collective Bargaining Agreement covering the Port Huron area.

Pregnancy means childbirth and conditions associated with Pregnancy, including miscarriage, or any complications thereof.

Psychiatric Treatment means treatment or care for a mental disease or disorder.

Retiree means an individual entitled to coverage under §2A.4.

Skilled Nursing Facility is a facility that fully meets all of these tests:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

Spouse means the Participant's legal spouse who has met all requirements of a valid marriage contract in the state of marriage of such parties.

Substance Abuse is the condition caused by regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs that results in a chronic disorder affecting physical health and/or personal or social functioning. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Surviving Spouse means that person who was married to the Participant on the date of the Participant's death.

Traverse/Northern Lower Michigan Participant means an Active Employee, Disabled Employee, Retiree, or Surviving Spouse who are covered by the Plan by virtue of present or past contributions received by the Fund pursuant to a Collective Bargaining Agreement covering the

Traverse/Northern Lower Michigan area.

Trust Agreement means the Agreement and Declaration of Trust establishing the Roofers Local No. 149 Security Benefit Trust Fund.

Trustees or **Board of Trustees** means the Trustees as selected pursuant to the terms of the Trust Agreement.

Union means the United Union of Roofers, Waterproofers and Allied Workers Local No. 149.

Union Employee means a business representative or other employee of the Union on whose behalf the Union makes Contributions to the Fund.

Upper Peninsula Participant means an Active Employee, Disabled Employee, Retiree, or Surviving Spouse who are covered by the Plan by virtue of present or past contributions received by the Fund pursuant to a Collective Bargaining Agreement covering the Upper Peninsula.

Working Principal means those persons who are proprietors, partners, or corporate officers of an Employer and who work with the tools of the trade.

ARTICLE 2: ELIGIBILITY RULES FOR DETROIT PARTICIPANTS

2.1. Active Employees

(a) Initial Eligibility

All Active Employees working under the jurisdiction of Roofers Local Union No. 149 who have been employed by a Contributing Employer for 3 consecutive months and for whom contributions have been received for a minimum of 300 hours within the 3 month period with at least 1 hour worked and reported in each of the 3 months will become eligible on the first day of the 5th month following the date contributions were first made in his behalf.

If during the 3 month period in which an Employee must establish initial eligibility he (a) is injured in the course of his employment as a roofer, (b) is unable to continue working due to such injury, (c) receives worker's compensation benefits for such injury, and (d) returns to employment as a roofer within 24 months of the date of such injury, then upon his return to employment the hours which he accumulated prior to his injury shall be counted towards establishing his initial eligibility.

(b) Continuation Of Eligibility

An Employee will continue to be eligible so long as he is credited with 100 hours of contributions per month. An Employee who is credited with less than 100 hours per month may continue his/her eligibility by self-payments. The self-

payment required to maintain eligibility shall be computed as follows: (hourly self-payment rate) multiplied by (100 minus the hours contributed by Employer(s) for the month at issue).

> For example, if an Employer contributes 80 hours in a month on behalf of an Employee, the Employee may self-pay for 20 hours to maintain eligibility. The self-payment rate is currently $3.25 er hour. Therefore, the Employee must pay $65.00 ($3.25 x 20) to maintain eligibility for such month.

The Trustees shall determine the hourly self-payment rate from time to time. To maintain coverage, the Plan Office must receive self-payments by the 25th of the month for which the payment is due.

An Employee's hour bank will only be credited with Employer contributions and not self-payments.

It should be noted that hours of employment for eligibility can only be credited when contributions have been received from the Contributing Employer. In the event an Employee self-pays for continuation of coverage and the Employer subsequently pays on his behalf, the Employee will be refunded the amount of the self-payment when the Employer's contributions have been processed for eligibility.

Eligibility will continue in force without contribution so long as the Employee is credited with an employee hour bank of 1,200 hours during the prior twelve-month period (looking back twelve months each month on the first day of any specific month).

Eligibility will be determined according to the following schedule:

Hours Worked During The Months Below:	Will Provide Eligibility For The Month Of:
July	September
August	October
September	November
October	December
November	January
December	February
January	March
February	April

Hours Worked During The Months Below:	Will Provide Eligibility For The Month Of:
March	May
April	June
May	July
June	August

An Employee must be credited with the required number of hours and/or a self-payment for each and every month. If the Employee is not credited with any contributions in any month, his eligibility and benefits will terminate 2 months thereafter. For example, if no Employer contributions are received for the month of January, eligibility and benefits will terminate the first day of March (see, however, section (c) below regarding the ability to make self-payments).

Notwithstanding the foregoing, an Active Employee forfeits his/her hour bank if he/she:

(1) Works for noncontributing employer: An Active Employee will forfeit his/her hour bank if he/she:

(a) is not on the out of work list, or is on the out of work list but refuses suitable employment when offered, and

(b) works with the tools of the trade for a noncontributing employer, or commences self-employment, in the roofing industry without making contributions to the Fund.

(2) Fails to obey strike notice: An Active Employee will forfeit his/her hour bank if he fails to obey a strike notice issued as a result of failure of an Employer to pay Contributions.

(c) Self-Payment For Continuation Of Eligibility

An Active Employee who is totally or partially unemployed and is registered on the Union's out-of-work list may self-pay to maintain eligibility, provided he has been credited with 120 hours of Contributions in the prior 12 month period (this latter requirements of 120 hours of Contributions in the prior 12 months is waived for the period 1/1/2021-6/30/201)). Notwithstanding, in no event will an Employee be eligible to self-pay in full for a period to exceed 12 consecutive months.

The self-payment amount shall be as established by the Trustees from time to time. Self-payments are not credited to the Active Employee's bank of hours. The Plan Office must receive self-payments by the 25th of the month for which

the self-payment is required to maintain eligibility.

An Active Employee whose eligibility is maintained exclusively by such self-payments is entitled to all benefits provided by the Fund.

Self-payments will no longer be required to maintain eligibility once an Employee has been credited with 100 hours of Employer contributions in a month.

The right to self-pay to maintain eligibility, in whole or in part, is not available to Working Principals, those who are employed by noncontributing employers, or those who fail to obey a strike notice issued as a result of failure of an Employer to pay contributions.

(d) Reinstatement of Eligibility

In the event an Employee's eligibility is terminated, the Employee may be reinstated when he/she has been credited with 300 hours of Employer contributions within 3 consecutive months, with coverage thereafter effective the first day of the 5th month, but only if such reinstatement occurs within 12 months from the loss of eligibility. If such contributions are not received within 12 months of loss of eligibility, the Active Employee must meet the initial eligibility requirements set forth in §2.1(a) in order to be eligible for benefits.

(e) Notice Of Hours Worked

Monthly, the Plan Office will forward to an Active Employee a Monthly Status Statement, which provides a summary of hours worked. The Active Employee is encouraged to compare this summary of hours with his pay stubs. It is the obligation of the Active Employee to report any discrepancy in hours to the Plan Office immediately.

(f) Special Initial Eligibility Rule for Newly Organized Employees

When a Newly Organized Employee commences work under the collective bargaining agreement establishing this Fund, he/she will be eligible for benefits the first day of the second month after he/she has been credited with 100 hours of employer contributions accrued in consecutive months, provided that prior to commencing work under such collective bargaining agreement, he/she had other health care coverage and such coverage remains in effect until eligibility is established. If he/she does not qualify for eligibility under this rule, initial eligibility must be established pursuant to the Initial Eligibility Rules for Active Employees.

(g) Special Initial Eligibility Rule for Employees Formerly Performing Work Under Another United Union of Roofers, Waterproofers and Allied Workers' Collective Bargaining Agreement

When an Employee who commences work under the collective bargaining agreement establishing this Fund has been previously eligible for benefits under a plan established by another United Union of Roofers, Waterproofers and Allied Workers' collective bargaining agreement, he/she will be eligible for benefits the first day of the second month after he/she has been credited with 100 hours of employer contributions accrued in consecutive months, provided that prior to commencing work under such collective bargaining agreement, he/she had other health care coverage and such coverage remains in effect until eligibility is established. If he/she does not qualify for eligibility under this rule, initial eligibility must be established pursuant to the Initial Eligibility Rules for Active Employees.

2.2 Disabled Employees

(a) Continuation of Coverage

(1) Non-Occupational Disability

An Active Employee with a Non-Occupational Disability will remain fully eligible for benefits under the Plan so long as he/she is receiving a Weekly Disability Benefit under §3.2 and:

(i) he/she is credited with an employee hour bank of 1,200 hours during the prior twelve-month period; or

(ii) he/she is not credited with an employee hour bank of 1,200 hours during the prior twelve-month period but makes monthly self-payments pursuant to §2.1(b) and (c).

(2) Occupational Disability

An Active Employee with an Occupational Disability will remain fully eligible for benefits under the Plan if he/she:

(i) either:

has a worker's compensation claim either approved or pending and executes an assignment of benefits to the Fund in order to receive coverage under the Plan, or

is receiving worker's compensation, in which case coverage will be provided under the Plan except for the claims covered by worker's compensation;

and

(ii) either:

is credited with an employee hour bank of 1,200 hours during the prior twelve-month period; or

is not credited with an employee hour bank of 1,200 hours during the prior twelve-month period but makes monthly self-payments pursuant to §2.1(b) and (c).

Coverage for an Occupational Disability under this section may be continued for 78 weeks. This period may be extended:

- an additional 26 weeks (less any extension provided below for pending appeals) upon approval of the Trustees if the participant has a Social Security Disability award and continues to make self-payments as required above; or

- where a participant has timely applied for and is pursuing an appeal for Social Security Disability benefits, upon approval of the Trustees coverage may be extended to the week following the date a decision on such appeal is issued but not to exceed 16 weeks, provided the participant continues to make self-payments as required above.

(b) Social Security Award Prior to Expiration of Coverage

If prior to the expiration of coverage under this section, the Disabled Employee receives a Social Security Award, he/she can continue coverage as a P-1 or P-2 Pensioner if he has the continuous years of participation in this Fund needed to qualify for either P-1 or P-2 coverage and meets the following requirements:

(1) has 10 or more years of Credited Service under the Roofers Local 149 Pension Plan;

(2) does not have a Break in Service under the Roofers Local 149 Pension Plan, or if he does have a Break in Service his Social Security disability award has an effective date prior to the date such Break in Service was incurred;

(3) has not yet reached his Normal Retirement Date under the Roofers Local 149 Pension Plan; and

(4) he/she repays the Fund for any Weekly Disability Benefits received for any period for which he/she also received a Social Security Disability award. In the sole discretion of the Trustees, such amount may be paid via an offset of future benefits.

(c) Conditions for Reinstatement of Coverage Upon Receiving Social Security Disability Award

If a disabled employee has a lapse in coverage and subsequently receives a Social Security disability award certifying he/she was totally disabled as the date coverage lapsed, then he/she will be allowed on a one-time basis only to reinstate coverage if the participant:

(1) has 10 or more years of Credited Service under the Roofers Local 149 Pension Plan ;

(2) does not have a Break in Service under the Roofers Local 149 Pension Plan, or if he does have a Break in Service his Social Security disability award has an effective date prior to the date such Break in Service was incurred;

(3) has not yet reached his Normal Retirement Date under the Roofers Local 149 Pension Plan;

(4) as of the date coverage lapsed, he had the continuous years of participation in this Fund needed to qualify for either P-1 or P-2 coverage;

(5) he/she applies for benefits under this Plan within 30 days of receipt of his/her Social Security Disability Award; and

(6) he/she repays the Fund for any Weekly Disability Benefits received for any period for which he/she also received a Social Security Disability award. In the sole discretion of the Trustees, such amount may be paid via an offset of future benefits.

If these conditions are met, (a) a participant who had the continuous years of participation in this Fund needed to qualify for P-1 coverage under (4), above, will be reinstated as P-1; and (b) a participant who had the continuous years of participation in this Fund needed to qualify for P-2 coverage under (4), above, will be reinstated as P-2.

If such coverage is reinstated, benefits will be paid prospectively only, in other words no benefits will be paid for the period of time that coverage was not in effect.

(d) Expiration of Coverage

At the expiration of his/her coverage under this section, if the Disabled Employee is not otherwise eligible for continued coverage under the Plan, he/she may maintain coverage by way of self-payments (if eligible to do so) or, if not, will be offered COBRA continuation coverage.

2.3. Dependents

(a) Effective Date of Coverage

Dependents become eligible for benefits when the Participant of whom they are dependent is eligible.

(b) Proof of Dependent Status

Birth Certificates for Children and Marriage Certificates for Spouses are required to establish proof of Dependent status. In the event either a Birth Certificate or Marriage Certificate is not filed and a claim is received, the Plan Office will request and obtain proof of Dependent status prior to processing the claim.

In the case of stepchildren, a copy of the Judgment of Divorce of the parents of the stepchild is required in order to determine payment of benefits pursuant to the Coordination of Benefit provisions of Article 6.

(c) Initial Enrollment for New Dependents

A new Participant or a Participant with a new Dependent must complete an Enrollment Card, available at the Plan Office, within 30 days. If timely submitted, eligibility of a Spouse is effective the date of marriage and eligibility of a Child is effective from the date such person met the definition of Child, as set forth in Art. I. If not timely submitted, eligibility shall be effective the date such enrollment was completed. For purposes of this provision, a "new Dependent" is an individual who would have qualified for Dependent coverage no earlier than 12 months prior to the request for enrollment.

(d) Open Enrollment

During the open enrollment period of May 1 to May 31, Participants will have the opportunity to enroll eligible Dependents who were not previously enrolled, or who are not eligible for enrollment under section (b) above. Coverage shall become effective the following June 1. If a Dependent is not timely enrolled, he/she will not be able to enroll until the next open enrollment period, except as set forth below.

If during open enrollment the Participant states in writing that the reason for declining coverage for a Dependent is because such Dependent has Other Coverage, then if the Other Coverage involuntarily terminates during the Plan Year, the Dependent may enroll in the Plan the first of the month following the date a request to enroll is received, provided this request is made within 30 days of such termination. For purposes of this section:

(1) Coverage involuntarily terminates when:

(A) the other coverage was COBRA coverage and it has been exhausted; or

(B) the other coverage was non-COBRA coverage and it has been terminated as a result of loss of eligibility for the coverage (including due to legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, termination of the plan for similarly situated individuals, or cessation of dependent status or employer contributions toward such coverage were terminated.

(2) Other Coverage is coverage under a group health plan or health insurance coverage, which does not include accident or disability only policies, coverage issued as a supplement to liability insurance, liability insurance, workers compensation or similar insurance, automobile medical payment insurance, credit only insurance, coverage for on-site medical clinics, or other similar insurance under which benefits for medical care are secondary or incidental to other insurance benefits.

(e) Effect of Children's Other Employer Provided Coverage

Notwithstanding anything in the Plan to the contrary, for Plan Years beginning before January 1, 2014, Children are not eligible for coverage if they are eligible for health coverage provided by their own employer or their spouse's employer.

(f) Effect of Divorce on Dependent Coverage

If a Participant divorces from his/her Spouse, the Participant and his former Spouse have a duty to inform the Plan Office of the divorce so coverage for the Participant's Child/Children and former Spouse can be properly determined. A Participant's former Spouse is only entitled to continue his/her coverage under the Fund pursuant to COBRA Continuation Coverage. In the event that the Judgment of Divorce requires the Participant to provide health insurance coverage for his/her former Spouse, it is the Participant's responsibility to arrange for this coverage. A divorced Spouse cannot be covered as a Dependent under the Fund.

(g) Limitation of Coverage: Dependent coverage does not include Pregnancy

Benefits.

(h) **Extension of Deadlines:** The Plan will disregard the period from March 1, 2020, until the earlier of (1) 1 year from the date a Participant or Beneficiary becomes eligible for an extended deadline or (2) until 60 days after the announced end of the National Emergency or such other date announced by the applicable federal agency (the "Outbreak Period") for all participants and dependents in determining the 30-day period (or 60-day period, if applicable) to request special enrollment.

2.4 Pensioners

Two categories of Pensioners are entitled to coverage under the Fund, Class P-1 and Class P-2.

(a) Class P-1

An Active Employee who retires with 20 or more years of continuous participation in the Fund immediately prior to retirement, up to and including the day before his/her retirement, and is receiving a pension benefit from the Roofers Local 149 Pension Fund as a "Detroit Participant," as that term is defined in the Roofers Local 149 Pension Fund Plan document, will be eligible for benefits as a Pensioner as set forth in this Plan, provided he/she makes a monthly self-payment for coverage in an amount as determined by the Trustees from time to time. Self-payment must be made by way of an assignment of a portion of the benefit that the Pensioner is receiving or will receive from the Roofers Local 149 Pension Fund. This assignment is voluntary and revocable at any time; however, coverage will be lost upon such revocation. If a Pensioner chooses not to make such an assignment, he/she will be offered COBRA continuation coverage.

(b) Class P-2

An Active Employee who retires with 5 or more years of continuous participation in the Fund immediately prior to retirement, up to and including the day before his/her retirement, and is receiving a pension benefit from the Roofers Local 149 Pension Fund as a "Detroit Participant," as that term is defined in the Roofers Local 149 Pension Fund Plan document, will be eligible for benefits as a Pensioner as set forth in this Plan provided he/she makes a monthly self-payment for coverage in an amount as determined by the Trustees from time to time. Self-payment must be made by way of an assignment of a portion of the benefit that the Pensioner is receiving or will receive from the Roofers Local 149 Pension Fund. This assignment is voluntary and revocable at any time; however, coverage will be lost upon such revocation. If a Pensioner chooses not to make such an assignment, he/she will be offered COBRA continuation coverage.

(c) Lapse in Coverage

In the event a Pensioner loses eligibility as a Pensioner, voluntarily or otherwise, he/she will **NOT** be eligible to enroll again at a later date. In the event a Dependent of a Pensioner loses eligibility, voluntarily or otherwise, he/she will **NOT** be eligible to enroll again at a later date.

(d) Effect of Medicare Eligibility

In order for any Pensioner, or his/her Spouse, who is age 65 years or older to obtain maximum health benefits, he or she must apply for and obtain Parts A and B of Medicare. (Part A is for hospitalization benefits and is provided by Medicare automatically. Part B is for medical insurance and must be elected and paid for by the Pensioner or his Spouse.) This is because upon attainment of age 65, even if Medicare has not been obtained, coverage under the Fund is limited as set forth in §3.3(e) or Article 18. **Thus, it is strongly recommended that a Pensioner, his Spouse, or an Active Employee contemplating retirement, contact the Social Security Administration at least 4 months before they will reach age 65.**

A Pensioner who is disabled becomes eligible for Medicare, regardless of age, after receiving Social Security disability benefits for 2 years. Such a Pensioner is required to obtain Medicare coverage as soon as he/she becomes eligible for it. A Spouse who becomes entitled to Medicare due to disability is also required to obtain Medicare coverage upon eligibility. **Once Medicare eligibility could have been obtained, even if Medicare has not been obtained, coverage under the Fund is limited as set forth in §3.3(e) or Article 18. Thus, it is strongly recommended that the Social Security Administration be contacted as soon as possible regarding eligibility for Medicare due to disability.**

When a Pensioner or his/her Spouse becomes eligible for Medicare, the Plan Office must be notified immediately. Any covered person who fails to notify the Plan Office of his/her eligibility for Medicare will be required to reimburse the Fund for all claims paid in excess of the amount the Fund would have paid had it known of the Covered Person's Medicare eligibility. **THUS, IT IS EXTREMELY IMPORTANT THAT PENSIONERS AND THEIR SPOUSES COMMUNICATE THEIR ELIGIBILITY FOR MEDICARE IMMEDIATELY.**

(e) Dependent Coverage

Those individuals who were enrolled and eligible as Dependents at the time of the Pensioner's retirement will maintain eligibility as his/her Dependent. However, a Pensioner may not add a Dependent after his/her retirement.

In the event a Pensioner divorces his previously eligible spouse, such spouse may

not, at a later date, be reinstated as a Dependent.

(f) Returning to Work

In the event a Pensioner returns to work as a roofer for an Employer contributing to the Fund, he/she shall remain eligible as a Pensioner until he/she has been credited with sufficient hours to be eligible as an Active Employee, at which time the rules regarding Active Employees will govern. If a Pensioner returns to work as a roofer for an employer who does not contribute to the Fund, his/her eligibility shall immediately terminate and he/she will not be entitled to reinstatement. If a Pensioner returns to work in any other capacity, his/her Employer's health plan shall be primary and the benefits provided by the Fund shall be secondary.

The Trustees reserve the right to require any Pensioner to provide a copy of his/her Income Tax Return to establish continued eligibility in the Plan.

A Pensioner who returns to work and re-establishes eligibility as an Active Employee will not be eligible for the Weekly Disability Benefit.

Upon return to Pensioner status, eligibility will be maintained as an Active Employee until the Pensioner depletes the eligibility accrued as an Active Employee.

2.5 Surviving Spouses

(a) Surviving Spouses of Active Employees

A Surviving Spouse and Children of a deceased Active Employee who were eligible for coverage at the time of death, will remain eligible at no cost for a period of 6 months immediately following the death of the eligible Active Employee.

For the second six-month period following the death of the eligible Active Employee, the Surviving Spouse, and the Children of the deceased Active Employee, can maintain coverage by making a self-payment at 50% of the Surviving Spouse self-payment rate. Thereafter, coverage can be continued by payment of the full Surviving Spouse self-payment rate. The amount of the self-payment will be as determined by the Trustees from time to time.

(b) Surviving Spouses of Pensioners

The Surviving Spouse of a Pensioner will be required to make a self-payment to maintain coverage immediately following the death of the Pensioner. The amount of the self-payment will be the amount determined by the Board of Trustees from time to time. Self-payment must be made by way of an assignment of a portion of the benefit that the Surviving Spouse is receiving or will receive from the Roofers

Local 149 Pension Fund. This assignment is voluntary and revocable at any time; however, coverage will be lost upon such revocation. If a Surviving Spouse chooses not to make such an assignment, he/she will be offered COBRA continuation coverage.

(c) Dependents of Surviving Spouses

Dependents of Surviving Spouses are eligible for coverage only if such person was eligible as a Dependent of the deceased Active Employee or Pensioner at the time of the Active Employee or Pensioner's death, with the exception that Children born to a Surviving Spouse within 9 months of the death of the Active Employee or Pensioner will also be eligible for coverage.

Due to health care reform, a special enrollment period was provided to Surviving Spouses. During this special enrollment period, from May 15 to June 15, 2011, Surviving Spouses were permitted to enroll adult children who were not covered at the time of the Active Employee or Pensioner's death due to age limitations. If during this special enrollment period a Surviving Spouses did not enroll his/her adult children or provide proof that such children were not being enrolled due to other coverage, they cannot be added at a later date.

(d) Medicare Eligibility

Coverage is limited for all Participants and Dependents who are Medicare eligible. See, e.g., §2.4(d), 3.3(e), and Article 18 which apply also to Surviving Spouses, as do all the limitations related to Medicare eligibility/coverage set forth in this Plan.

2.6 Termination of Coverage

(a) Participant Coverage

Participant coverage will terminate on the earliest of these dates:

(1) The date the Plan is terminated.

(2) His/Her eligibility terminates under the terms of this Plan.

(3) The date he becomes a full-time member of the armed forces of any country, unless he/she elects self-payments under Art. 11.

(b) Dependent Coverage

A Dependent's coverage will terminate on the earliest of these dates:

(1) The date the Plan or Dependent coverage under the Plan is terminated.

(2) The date that the Participant's coverage under the Plan terminates.

(3) The date a Spouse loses coverage due to loss of dependency status (e.g. divorce).

(4) On the day that a Dependent child ceases to be a Child as defined by the Plan.

(5) The date a Dependent enters the armed forces of any country.

(6) For Plan Years prior to January 1, 2014, the date a Dependent Child becomes eligible for health coverage provided by his own employer or his/her spouse's employer.

ARTICLE 2A: ELIGIBILITY RULES FOR NON-DETROIT PARTICIPANTS

2A.1 Active Employees

(a) Initial Eligibility

To establish initial eligibility, an Employee must have a minimum of 400 hours of Employer Contributions (348 hours for Upper Peninsula Participants) remitted to the Fund in his behalf for work performed within a 4 consecutive month period. Only employer contributions can be counted in meeting the initial eligibility provisions. Self-payments are not permitted to establish initial eligibility.

Eligibility commences on the first day of the sixth month following the month in which such Contributions were first received by the Fund.

(b) Continuation of Eligibility

An Employee will continue to be eligible so long as he is credited with 100 hours of contributions per month, or 87 hours of contributions per month for Employees who are Upper Peninsula Participants. An Employee who is credited with less than the required hours may continue his/her eligibility by making self-payments for the hours by which he/she is short of the minimum required hours.

> For example, for a Non-Detroit Participant, other than Upper Peninsula Participants, the self-payment required to maintain eligibility shall be computed as follows: (hourly self-payment rate) multiplied by (hours short of required 115 hours).

The self-payment hourly rate is currently the same as the required Employer Contribution rate. The Trustees may change the hourly self-payment rate from time to time. The Plan Office must receive self-payments within 30 days of

notice to the Participant that self-payments may be made to continue eligibility.

It should be noted that hours of employment for eligibility can only be credited when Contributions have been received from the Contributing Employer. In the event an Employee self-pays for continuation of coverage and the Employer subsequently pays on his behalf, the Employee will be refunded the amount of the self-payment when the Employer's contributions have been processed for eligibility.

Eligibility will be determined according to the following schedule:

Hours Worked During The Months Below:	Will Provide Eligibility For The Month Of:
July	September
August	October
September	November
October	December
November	January
December	February
January	March
February	April
March	May
April	June
May	July
June	August

If the Employee is not credited with any contributions in any month, his eligibility and benefits will terminate 2 months thereafter. For example, if no Employer contributions and no self-payments are received for the month of January, eligibility and benefits will terminate the first day of March.

Notwithstanding the foregoing, eligibility will continue in force without Contribution or self-payment so long as the Employee is credited with an employee hour bank of 1,200 hours (1,044 hours for Employees who are Upper Peninsula Participants) during the prior twelve-month period (looking back twelve months each month on the first day of any specific month).

If an Employee whose Employer Contributions are insufficient to provide him with continued eligibility fails to remit the necessary self-payment for continued eligibility, he will be required to follow the procedures for Reinstatement of

Eligibility, as set forth below.

Notwithstanding the foregoing, an Active Employee forfeits his/her hour bank if he/she:

(1) Works for noncontributing employer: An Active Employee will forfeit his/her hour bank if he/she:

(a) is not on the out of work list, or is on the out of work list but refuses suitable employment when offered, and

(b) works with the tools of the trade for a noncontributing employer, or commences self-employment, in the roofing industry without making contributions to the Fund.

(2) Fails to obey strike notice: An Active Employee will forfeit his/her hour bank if he fails to obey a strike notice issued as a result of failure of an Employer to pay Contributions.

(c) Self-Payment for Continuation Of Eligibility

As set forth above, an Active Employee who is totally or partially unemployed and is registered on the Union's out-of-work list may self-pay to maintain eligibility for a period of 12 months.

The Plan Office must receive self-payments by the 25th of the month for which the self-payment is required to maintain eligibility.

An Active Employee whose eligibility is maintained exclusively by such self-payments is entitled to all benefits provided by the Fund.

The right to self-pay to maintain eligibility, in whole or in part, is not available to Working Principals, those who are employed by noncontributing employers, or those who fail to obey a strike notice issued as a result of failure of an Employer to pay contributions.

(d) Reinstatement of Eligibility

In the event an Employee's eligibility is terminated, the Employee may be reinstated when he/she has been credited with 200 hours of Employer Contributions for work performed in 2 consecutive calendar months (87 hours in one month for Upper Peninsula Participants), with coverage thereafter effective the first day of the fourth month (first day of the third month for Upper Peninsula Participants) following the initial receipt of such Contributions, but only if such reinstatement occurs within 12 months from the loss of eligibility.

If such Contributions are not received within 12 months of loss of eligibility, the Active Employee must meet the initial eligibility requirements set forth in §2A.1(a) in order to be eligible for benefits.

(e) Notice Of Hours Worked

Quarterly, the Plan Office will forward to an Active Employee a "Notice of Hours Worked," which provides a summary of hours worked during the most recent 3-month period. The Active Employee is encouraged to compare this summary of hours with his pay stubs. It is the obligation of the Active Employee to report any discrepancy in hours to the Plan Office immediately.

(f) Special Initial Eligibility Rule for Newly Organized Employees

When a Newly Organized Employee commences work under the collective bargaining agreement establishing this Fund, he/she will be eligible for benefits the first day of the second month after he/she has been credited with 100 hours of employer contributions accrued in consecutive months, provided that prior to commencing work under such collective bargaining agreement, he/she had other health care coverage and such coverage remains in effect until eligibility is established. If he/she does not qualify for eligibility under this rule, initial eligibility must be established pursuant to the Initial Eligibility Rules for Active Employees.

(g) Special Initial Eligibility Rule for Employees Formerly Performing Work Under Another United Union of Roofers, Waterproofers and Allied Workers' Collective Bargaining Agreement

When an Employee who commences work under the collective bargaining agreement establishing this Fund has been previously eligible for benefits under a plan established by another United Union of Roofers, Waterproofers and Allied Workers' collective bargaining agreement, he/she will be eligible for benefits the first day of the second month after he/she has been credited with 100 hours of employer contributions accrued in consecutive months, provided that prior to commencing work under such collective bargaining agreement, he/she had other health care coverage and such coverage remains in effect until eligibility is established. If he/she does not qualify for eligibility under this rule, initial eligibility must be established pursuant to the Initial Eligibility Rules for Active Employees.

(h) Nonbargaining Unit Employees

Upon approval of the Trustees (as evidenced by the approval and execution of a participation agreement), Nonbargaining Unit Employees of an Employer are eligible for coverage under the Fund under the following terms and conditions:

(1) The Employer for whom such Nonbargaining Unit Employees work must execute a participation agreement with the Fund.

(2) The Employer must contribute on behalf of all Nonbargaining Unit Employees of the Employer, including the owner(s), unless any such Nonbargaining Unit Employee has health care coverage that meets the minimum value standard under the Affordable Care Act (Excluded Employee).

(3) If an Excluded Employee loses his/her other health coverage, or experiences another qualifying event such as death, marriage, birth of a child or adoption, the Excluded Employee may be enrolled within 30 days of such event. If not enrolled within 30 days of loss or coverage, an Excluded Employee who no longer has other coverage must be enrolled in the next open enrollment period, which is May 1-31 of each year.

(4) Newly hired Employees are eligible for enrollment in the Fund on the first of the month following 30 days of employment. New employees not enrolled when first eligible must be enrolled in the next open enrollment.

(5) The Employer must contribute on behalf of each Nonbargaining Unit Employee Contributions for 40 hours per week, 52 weeks of the year, at the prevailing Journeyman hourly fund contribution rate as determined by the Collective Bargaining Agreement which obligates the Employer to contribute to the Fund for other Active Employees.

(6) Coverage under the Plan terminates for Nonbargaining Unit Employees upon earliest of the following events:

(A) the Employer fails make contributions as required by sec. (5), above;

(B) the Employer becomes delinquent in contributions for Active Employees for whom it has an obligation to contribute under a Collective Bargaining Agreement;

(C) participation is otherwise terminated due to the terms of the applicable participation agreement;

(D) the Plan is amended to eliminate coverage for Nonbargaining Unit Employees; or

(E) the Office Employee's employment with the Employer is terminated.

COBRA coverage will only be offered upon the termination of coverage

due to the events listed in (E), above, or as otherwise required by law. See Article 8 of the Plan Document.

(7) Notwithstanding anything to the contrary, Nonbargaining Unit Employees may not maintain coverage by way of self-payments and are not eligible for weekly disability or retiree coverage.

2A.2 Disabled Employees

(a) Continuation of Coverage during Short Term Disability

An Active Employee with a Disability will have his/her hour bank credited with Disability Hours so long as he/she is eligible for payment of Weekly Disability under §3A.2 or is receiving undisputed workers compensation benefits, or has a workers compensation claim pending and executes an assignment of benefits, and has provided the Fund Office requested proof of same.

Disability Hours will be credited in the amount of 5.75 hours (4.35 hours for Upper Peninsula Participants) for each full day of such Disability for a maximum of 26 weeks:

(1) For any single period of Disability, or

(2) For any continuous twelve calendar month period.

All Active Employees may self-pay the difference between the credited Disability Hours and those necessary to maintain eligibility.

All Disability absences will be considered a single Disability unless:

(1) The Active Employee returns to active covered employment for at least one day and submits evidence satisfactory to the Trustees that the cause(s) of the latest Disability absence cannot be connected with the cause(s) of any prior Disability absences, or

(2) The Active Employee returns to active covered employment for at least two weeks even though a connection can be established between the cause(s) of two successive Disability absences.

The Trustees have the right to have the Disabled employee medically examined by a physician of their own choice at the Plan's expense to determine whether a disability qualifies under this Rule.

At the expiration of his/her coverage under this provision, if the Active Employee is not otherwise eligible for continued coverage under the Plan, he/she may

maintain coverage by way of self-payments (if eligible to do so), or, if not, will be offered COBRA continuation coverage.

(b) Continuation of Coverage During Long Term Disability

An Employee who is Totally and Permanently Disabled, at the end of eligibility for short term disability as set forth in (a), above, may continue to make self-payments to maintain eligibility provided:

(1) The Disabled Employee must be Totally and Permanently Disabled on the date he would otherwise lose eligibility under the Eligibility Rules of the Plan, and

(2) Have had a minimum of 4,350 hours remitted to the Fund in the 5 years of continuous eligibility immediately prior to the Participant's Total Disability, and

(3) Is eligible for Social Security disability benefits.

Eligibility under this provision will continue for the participant and his/her dependents until the earlier of:

(1) The date the Disabled Employee is no longer Totally and Permanently Disabled; or

(2) The date the Disabled Employee becomes eligible for Medicare; or

(3) The date he is denied Social Security Disability benefits after timely exhausting all appeals, or the date he has failed to timely pursue Social Security Disability benefits; or

(4) The date the Disabled Employee becomes eligible in any other group health care plan.

Employees whose coverage is continued by this long term disability provision are not eligible for the Weekly Accident and Sickness Benefits (Loss of Time) benefit.

2A.3 Dependent Coverage

(a) Effective Date of Coverage

Dependents become eligible for benefits when the Participant of whom they are dependent is eligible.

(b) Proof of Dependent Status

Birth certificates for Children and marriage certificates for Spouses are required to establish proof of Dependent status. In the event either a birth certificate or marriage certificate is not filed and a claim is received, the Plan Office will request and obtain proof of Dependent status prior to processing the claim.

In the case of stepchildren, a copy of the Judgment of Divorce of the parents of the stepchild is required in order to determine payment of benefits pursuant to the Coordination of Benefit provisions of the Plan.

(c) Initial Enrollment for New Dependents

A new Participant or a Participant with a new Dependent must complete an Enrollment Card, available at the Plan Office, within 30 days. If timely submitted, eligibility of a Spouse is effective the date of marriage and eligibility of a Child is effective from the date such person met the definition of Child. If not timely submitted, eligibility shall be effective the date such enrollment was completed. For purposes of this provision, a "new Dependent" is an individual who would have qualified for Dependent coverage no earlier than 12 months prior to the request for enrollment.

A self-payment may be required to cover the Spouse or Child of an Early Retiree, Retiree, or Totally and Permanently Disabled Retiree. The Trustees shall determine the monthly self-payment rate from time to time. If such self-payments are not timely received, eligibility shall terminate.

(d) Open Enrollment

During the open enrollment period of May 1 to May 31, Participants will have the opportunity to enroll eligible Dependents who were not previously enrolled, or who are not eligible for enrollment under section (b) above. Coverage shall become effective the following June 1. If a Dependent is not timely enrolled, he/she will not be able to enroll until the next open enrollment period, except as set forth below.

If during open enrollment the Participant states in writing that the reason for declining coverage for a Dependent is because such Dependent has Other Coverage, then if the Other Coverage involuntarily terminates during the Plan Year, the Dependent may enroll in the Plan the first of the month following the date a request to enroll is received, provided this request is made within 30 days of such termination. For purposes of this section:

(1) Coverage involuntarily terminates when:

(A) the other coverage was COBRA coverage and it has been exhausted; or

(B) the other coverage was non-COBRA coverage and it has been terminated as a result of loss of eligibility for the coverage (including due to legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, termination of the plan for similarly situated individuals, or cessation of dependent status or employer contributions toward such coverage were terminated.

(2) Other Coverage is coverage under a group health plan or health insurance coverage, which does not include accident or disability only policies, coverage issued as a supplement to liability insurance, liability insurance, workers compensation or similar insurance, automobile medical payment insurance, credit only insurance, coverage for on-site medical clinics, or other similar insurance under which benefits for medical care are secondary or incidental to other insurance benefits.

(e) Effect of Children's Other Employer Provided Coverage

Notwithstanding anything in the Plan to the contrary, for Plan Years beginning before January 1, 2014, Children are not eligible for coverage if they are eligible for health coverage provided by their own employer or their spouse's employer.

(f) Effect of Divorce on Dependent Coverage

If a Participant divorces from his/her Spouse, the Participant and his former Spouse have a duty to inform the Plan Office of the divorce so coverage for the Participant's Child/Children and former Spouse can be properly determined.

A Participant's former Spouse is only entitled to continue his/her coverage under the Fund pursuant to COBRA Continuation Coverage. In the event that the Judgment of Divorce requires the Participant to provide health insurance coverage for his/her former Spouse, it is the Participant's responsibility to arrange for this coverage. A divorced Spouse cannot be covered as a Dependent under the Fund.

(g) Eligibility Upon Death of Participant

If an Active or Retired Participant dies while eligible for benefits, his/her eligible Dependents may continue to be eligible, without self payments, so long as they continue to meet the definition of Dependent until the later of:

(1) The normal eligibility termination date based on Fund records as if death

had not occurred; or

(2) The last day of the third calendar month following the month in which the Participant dies;

(3) As long as the dependent remits the required self-payments to maintain eligibility; or

(4) Dependent Spouse remarries.

(h) Extension of Deadlines: The Plan will disregard Outbreak Period for all participants and dependents in determining the 30-day period (or 60-day period, if applicable) to request special enrollment.

2A.4 Retired Participants

(a) Early Retiree Self-Payment Program

Active Employees who retire prior to the age of 65, are considered Early Retirees under the Fund until such time as they attain age 65 and become eligible for Medicare. Early Retirees are eligible to receive all of the same benefits as Active Employees, except for the Weekly Disability and Accidental Death and Dismemberment benefits.

To be eligible for coverage as an Early Retiree, the Early Retiree must meet all of the following requirements:

(1) Have earned at least 4,500 contribution hours within the 10 years prior to application for coverage as an Early Retiree;

(2) Be eligible by Employer Contributions, self-payments, or use of banked hours on the date of retirement and begin coverage as an Early Retiree immediately upon termination of coverage as an Active Employee;

(3) Retire from the trade;

(4) Be between the ages of 50 and 65; and

(5) Make required self-payments on time.

Once an Early Retiree or his/her Spouse become Medicare eligible, he/she will be eligible for supplemental Medicare benefits only. Medicare must be timely applied for and obtained to secure maximum coverage.

(b) Totally and Permanently Disabled Retiree Self-Payment Program

Active Employees who become Totally and Permanently Disabled prior to the age of 65 may continue benefits for themselves under the Totally and Permanently Disabled Retiree Self-Payment Program.

Totally and Permanently Disabled Retirees are eligible to receive the same benefits as Active Employees, except for the Loss of Wage benefits and Accidental Death and Dismemberment benefits.

To be eligible for coverage as Totally and Permanently Disabled Retiree, the individual must meet all of the following requirements:

(1) Be Totally and Permanently Disabled and receiving disability pension benefits from the Roofers Local 149 Pension Fund as a "Mid-Michigan Participant," as that term is defined in the Roofers Local 149 Pension Fund Plan document, or National Roofing Industry Pension Plan, or disability benefits from the Social Security Administration;

(2) File an application for Total and Permanent Disability benefits;

(3) Be eligible by Employer Contributions, self-contributions, or use of banked hours on the date of retirement and begin coverage as a Totally and Permanently Disabled Retiree immediately upon termination of coverage as an Active Employee;

(4) Agree to submit to an examination, and subsequent examinations while eligible under these provisions, by a physician approved and paid by the Fund; and

(5) Make required self-payments on time.

Eligibility for Plan benefits begins on the first day of the month in which your application for Total and Permanent Disability benefits is approved by the Trustees.

If the Totally and Permanently Disabled Participant and/or his Spouse is eligible for Medicare, he/she will be eligible for supplemental Medicare benefits only. Medicare must be timely applied for and obtained to secure maximum coverage.

(c) Retiree Self-Payment Program

(1) Eligibility

This coverage is available to those retired Participants and/or Spouses who are age 65 or over and eligible for Medicare. In order to participate in this Program, the Retired Participant must meet the following requirements:

(1) Have earned at least 4,500 contribution hours within the 10 years prior to retirement;

(2) Retired from the trade;

(3) Age 65 or older;

(4) Coverage based upon employer contributions or banked hours has terminated; and

(5) Make required self-payments.

The Retiree and/or his Spouse are required to obtain both Parts A and B when they are eligible for such coverage through Medicare. A Participant or Spouse who fail to apply for Medicare when eligible will be treated as if such benefits had been timely applied for and obtained.

(d) Effect of Medicare Eligibility

In order for any Retiree, or his/her Spouse, who is age 65 years or older to obtain maximum health benefits, he or she must apply for and obtain Parts A and B of Medicare. (Part A is for hospitalization benefits and is provided by Medicare automatically. Part B is for medical insurance and must be elected and paid for by the Pensioner or his Spouse.) This is because upon attainment of age 65, even if Medicare has not been obtained, coverage under the Fund is limited as set forth in §3A.3(e) or Article 18. **Thus, it is strongly recommended that a Retiree, his Spouse, or an Active Employee contemplating retirement, contact the Social Security Administration at least 4 months before they will reach age 65.**

A Retiree who is disabled becomes eligible for Medicare, regardless of age, after receiving Social Security disability benefits for 2 years. Such a Retiree is required to obtain Medicare coverage as soon as he/she becomes eligible for it. A Spouse who becomes entitled to Medicare due to disability is also required to obtain Medicare coverage upon eligibility. **Once Medicare eligibility could have been obtained, even if Medicare has not been obtained, coverage under the Fund is limited as set forth in §3A.3(e) or Article 18. Thus, it is strongly recommended that the Social Security Administration be contacted as soon as possible regarding eligibility for Medicare due to disability.**

When a Retiree or his/her Spouse becomes eligible for Medicare, the Plan Office must be notified immediately. Any covered person who fails to notify the Plan Office of his/her eligibility for Medicare will be required to reimburse the Fund for all claims paid in excess of the amount the Fund would have paid had it known of the Covered Person's Medicare eligibility. **THUS, IT IS EXTREMELY IMPORTANT THAT RETIREES AND THEIR SPOUSES COMMUNICATE THEIR ELIGIBILITY FOR MEDICARE IMMEDIATELY.**

(e) Dependent Coverage

Those individuals who were enrolled and eligible as Dependents at the time of the Pensioner's retirement will maintain eligibility as his/her Dependent. However, a Pensioner may not add a Dependent after his/her retirement. Please see §2A.3(b) regarding enrollment of dependents.

Due to health care reform, a special enrollment period was provided to Pensioners. During this special enrollment period, from May 15 to June 15, 2011, Pensioners were permitted to enroll adult children who were not covered at the time of their retirement time due to age limitations. If during this special enrollment period a Pensioner did not enroll his/her adult children or provide proof that such children were not being enrolled due to other coverage, they cannot be added at a later date.

(f) Self-Payments/Lapse in Coverage

The amount of the monthly self-payment is established by the Trustees and may be changed from time to time. Current self-payment rates can be obtained from the Fund Office.

Self-payments are due in the Fund Office on the 1st day of the month for which payment is being made. The Trustees shall determine the monthly self-payment rate from time to time. If such self-payments are not timely received, eligibility shall terminate. If the Retired Participant is receiving a pension benefit from the Roofers Local 149 Pension Fund, self-payment must be made by way of an assignment of a portion of such benefit. This assignment is voluntary and revocable at any time; however, coverage will be lost upon such revocation.

In the event any Retired Participant loses eligibility as a Retiree, voluntarily or otherwise, he/she will **NOT** be eligible to enroll again at a later date. In the event a Dependent of a Retiree loses eligibility, voluntarily or otherwise, he/she will **NOT** be eligible to enroll again at a later date.

(g) Returning to Work

In the event a Retiree returns to work as a roofer for an Employer contributing to the Fund, he/she shall remain eligible as a Retiree until he/she has been credited with sufficient hours to be eligible as an Active Employee, at which time the rules regarding Active Employees will govern. Prior to re-establishing eligibility as an Active Employee, the full Retiree self-payment rate must be remitted to maintain eligibility.

If a Retiree returns to work as a roofer for an employer who does not contribute to the Fund, his/her eligibility shall immediately terminate and he/she will not be entitled to reinstatement. If a Retiree returns to work in any other capacity, his/her Employer's health plan shall be primary and the benefits provided by the Fund shall be secondary.

The Trustees reserve the right to require any Retiree to provide a copy of his/her Income Tax Return to establish continued eligibility in the Plan.

A Retiree who returns to work and re-establishes eligibility as an Active Employee will not be eligible for the Weekly Disability Benefit.

Upon return to Retiree status, eligibility will be maintained as an Active Employee until the Retiree depletes the eligibility accrued as an Active Employee.

It is the responsibility of the Retired Participant to notify the Fund Office, in writing, if he returns to work and to again notify the Fund Office, in writing, when he again retires.

2A.5 Surviving Spouses

(a) Surviving Spouses of Active Employees

A Surviving Spouse and Children of a deceased Active Employee who were eligible for coverage at the time of death, will remain eligible at no cost until the later of:

(1) The remaining hours in the Participant's hour bank are no longer sufficient to maintain eligibility; or

(2) The last day of the third calendar month following the month in which the Participant died.

After such time, a self-payment will be required for continued coverage.

(b) Surviving Spouses of Retirees

The Surviving Spouse of a Retiree will be required to make a self-payment to maintain coverage immediately following the death of the Retiree. The amount of the self-payment will be the amount determined by the Board of Trustees from time to time. If the Surviving Spouse is receiving a pension benefit from the Roofers Local 149 Pension Fund, self-payment must be made by way of an assignment of a portion of such benefit. This assignment is voluntary and revocable at any time; however, coverage will be lost upon such revocation.

(c) Dependents of Surviving Spouses

Dependents of Surviving Spouses are eligible for coverage only if such person was eligible as a Dependent of the deceased Active Employee or Retiree at the time of the Active Employee or Retiree's death, with the exception that Children born to a Surviving Spouse within 9 months of the death of the Active Employee or Retiree will also be eligible for coverage.

Due to health care reform, a special enrollment period was provided to Surviving Spouses. During this special enrollment period, from May 15 to June 15, 2011, Surviving Spouses were permitted to enroll adult children who were not covered at the time of the Active Employee or Pensioner's death due to age limitations. If during this special enrollment period a Surviving Spouses did not enroll his/her adult children or provide proof that such children were not being enrolled due to other coverage, they cannot be added at a later date.

(d) Medicare Eligibility

Coverage is limited for all Participants and Dependents who are Medicare eligible. See, e.g., §2A.4(d), 3A.3(e), and Article 18, which apply also to Surviving Spouses, as do all the limitations related to Medicare eligibility/coverage set forth in this Plan.

2A.6 Termination of Coverage

(a) Participant Coverage

Participant coverage will terminate on the earliest of these dates:

(1) The date the Plan is terminated.

(2) His/Her eligibility terminates under the terms of this Plan.

(3) The date he becomes a full-time member of the armed forces of any country, unless he/she elects self-payments under Art. 11 of the Plan document.

(b) Dependent Coverage

A Dependent's coverage will terminate on the earliest of these dates:

(1) The date the Plan or Dependent coverage under the Plan is terminated.

(2) The date that the Participant's coverage under the Plan terminates.

(3) The date a Spouse loses coverage due to loss of dependency status (e.g. divorce).

(4) On the day that a Dependent child ceases to be a Child as defined by the Plan.

(5) The date a Dependent enters the armed forces of any country.

(6) The date a Surviving Spouse remarries.

(7) For Plan Years prior to January 1, 2014, the date a Dependent Child becomes eligible for health coverage provided by his own employer or his/her spouse's employer.

2A.7 Definitions

Unless otherwise provided below, all terms used in this Article 2A and Article 3A have the same meaning as the terms as used in Article 1, with the exception of the following terms:

Active Employee or Employee means an Active Employee who is a Flint Participant, Upper Peninsula Participant, Port Huron Participant, or Traverse/Northern Lower Michigan Participant, or Nonbargaining Unit Employee.

Children or Child means:

1. Any person up until the end of the calendar year in which he/she turns 26 years of age who either:

   (a) is a Participant's natural or adopted child;

   (b) has been placed with a Participant for adoption; or

   (c) is a Participant's step-child.

2. A person who would qualify as a "child" under paragraph 1 but for the age limitations, who by reason of mental or physical handicap is incapable of

sustaining employment, such handicap accrued prior to the date such person's coverage would otherwise terminate, he/she is claimed as a dependent on the Participant's federal tax returns, and the Participant has submitted proof of such to the Fund within 31 days of the date such Dependent's coverage would have otherwise terminated ; or

3. An alternate recipient under a Qualified Medical Child Support Order of a Participant.

Disability means a physical or mental condition (Occupational or Non-Occupational), which in the opinion of a physician satisfactory to the Trustees, prevents a person from engaging in any regular occupation or employment as a roofer; however, no person shall be deemed to have a Disability if such incapacity was contracted, suffered or incurred while he was engaged in an illegal activity or from the Armed Forces of any country.

Nonbargaining Unit Employee means an Active Employee who is eligible for benefits pursuant to a duly adopted participation agreement between his/her Employer and the Fund.

Participant means a Flint Participant, Upper Peninsula Participant, Port Huron Participant, or Traverse/Northern Lower Michigan Participant.

Retiree or Retired Participant means an individual who has retired who is a Flint Participant, Upper Peninsula Participant, Port Huron Participant, or Traverse/Northern Lower Michigan Participant.

Totally Disabled and Total Disability, unless otherwise specifically defined, means a disability resulting solely from a sickness or accidental bodily injury which prevents an Employee from engaging in any occupation or employment for compensation or profit or prevents a Dependent from engaging in substantially all the normal activities of a person of like age and sex in good health and the person is eligible for Social Security Disability Benefits, or is receiving a disability pension benefit from the Roofers Local 149 Pension Fund. A copy of the Social Security Administration Award Letter is required for proof of total disability. Notwithstanding the foregoing, no person shall be deemed to be Totally and Permanently Disabled if such incapacity was contracted, suffered or incurred while he was engaged in an illegal activity or from the Armed Forces of any country.

ARTICLE 3: BENEFITS FOR DETROIT PARTICIPANTS

3.1. Life and Accidental Death and Dismemberment Benefits

This section summarizes the coverage provided pursuant to a group term life insurance policy purchased by the Fund. Additional information regarding such coverage, including limitations and exclusions, can be found in the certificates of insurance issued by the insurance company. A copy of the life insurance policy is available at the Plan Office upon request. See Article 19 for contact information.

Notwithstanding, life insurance coverage for Pensioner's Spouses and Surviving Spouses, in the amount set forth below, is self-insured. Additionally, the difference in benefits set forth below is self-insured from 1/1/2017-3/1/2017. For example, the benefit for active employees under the age of 65 is self-insured in the amount of $5,000 for the period 1/1/2017 to 3/31/2017.

(a) Life Insurance Coverage

Active Employee:

Age	Benefit prior to 1/1/2017	Benefit effective 1/1/2017
Under age 65	$15,000.00	$20,000
Age 65-69	9,750.00	13,000
Age 70-74	6,750.00	9,000
Age 75-79	6,750.00	9,000
Age 80-84	3,000.00	4,000
Age 85 and over	3,000.00	4,000

Spouse: $1,500.00
Dependent Child: $1,500.00

Pensioner:

Age	Benefit prior to 1/1/2017	Benefit effective 1/1/2017
Under age 65	$4,000	$5,000
Age 65-69	4,000	5,000
Age 70-79	4,000	5,000
Age 80 and over	4,000	5,000

Spouse: $1,500.00 (self-insured)
Surviving Spouse: $1,500.00 (self-insured)

(b) Accidental Death and Dismemberment Benefit (AD&D) – Active Employees Only

Please refer to the life insurance policy for terms and conditions of payment of AD&D benefits, which cover Active Employees only.

(c) Beneficiary Designation

A Participant entitled to the above insurance coverages must complete a beneficiary designation form. Beneficiary designation forms are available upon

request. Benefits shall be paid to the designated beneficiary upon the death of the Participant. Beneficiary designations must be received by the Plan Office or insurance company prior to death to be effective. If more than one beneficiary is designated, and in such designation the Participant has failed to specify their respective interest, the beneficiaries will share equally. If no beneficiary has been designated, or the designated beneficiary has predeceased the Covered Person, then beneficiary shall mean, in the following order: (1) Spouse; (2) Children; (3) Parents; (4) Siblings, or the insurance carrier may choose to pay your Estate. A Participant must change the beneficiary so designated if he/she wants to change the beneficiary.

Notwithstanding the above, upon a divorce, any prior designation of the ex-spouse as Beneficiary shall be null and void unless such designation in favor of the ex-spouse is made subsequent to the divorce.

In the event of any conflict between the provisions of this Plan and the insurance policy, including the proper determination of the beneficiary, the terms of the insurance policy and the determination by the insurance company controls.

3.2 Weekly Disability

(a) Eligibility

An Active Employee with a Non-Occupational Disability which prevents him/her from working as a roofer is entitled to weekly disability benefits for a period of 50 if he/she:

(1) is under the regular care of a Physician and has submitted a Physician's statement attesting to his/her Disability (such statement must be submitted initially and at intervals as requested by the Trustees);

(2) is not on the Out-of-Work List and/or available for work in or outside the jurisdiction of the Roofers Local Union No. 149 because of such Non-Occupational Disability;

(3) is not eligible for similar benefits under another plan of insurance (provided such benefits are equal to the benefits provided by this Plan);

(4) is not disabled due to alcohol or substance abuse, unless he/she is receiving in- patient treatment at an approved facility;

(5) at the time of the Disability commenced, was eligible for benefits as an Active Employee by virtue of hours in his/her hour bank or active self-payments; and

(6) was not Disabled in a motor vehicle accident or by an act of war (declared

or undeclared) or while in the Armed Forces of any country.

For those with an Occupational Disability, the Disabled Employee must have a worker's compensation claim pending and execute an assignment of benefits to the Fund in order to receive this benefit.

For any Disability extending beyond 26 weeks, if requested by the Trustees the Disabled Employee must submit to a physical conducted by a physician selected by the Trustees. The Fund will pay for any such physical.

Upon request to and approval of the Board of Trustees, coverage will be extended for an additional 26 weeks (for a total of 78 weeks) as follows:

(1) For Occupational illnesses or injuries, the Disabled Employee has timely applied for and pursued workers compensation benefits and is awaiting a decision; or

(2) For Non-Occupational illnesses or injuries, the Disabled Employee (a) has timely applied for Social Security disability benefits and is awaiting a decision, (b) if approved for Social Security disability benefits would meet the requirements of section 2.2(b)(2) and (3), and (c) has executed an assignment of benefits for such additional 26 week period of benefits and coverage under §2.2 in favor of the Fund.

For purposes of the above, to "timely apply" for workers compensation benefits means to file a claim for Workers Compensation benefits within 14 days of execution of the assignment to the Fund, as set forth above. To "timely apply" for Social Security disability benefits means to apply within the first 6 months following the date the Disability began.

An additional 26 week extension (i.e. beyond 78 weeks) is available upon request and approval of the Trustees only if:

(1) the Disabled Employee is confirmed Disabled by an Independent Medical Examination conducted by a physician selected by the Trustees prior to receiving such extension;

(2) the Disabled Employee meets the requirements of Section 2.2(b)(1)-(3); and

(3) the Disabled Employee agrees to repay the Fund for any Weekly Disability Benefits received for any period for which he/she also received(receives) a Social Security Disability award. In the sole discretion of the Trustees, such amount may be paid via an offset of future benefits.

(b) Benefit

The weekly disability benefit shall commence with the first day of Disability due to Injury, first day of outpatient surgery or inpatient Hospital admission, or eighth day of Illness.

The amount of the weekly disability benefit is as follows:

Journeyman:	$370.00
Eighth Period Apprentice:	$350.00
Seventh Period Apprentice:	$350.00
Sixth Period Apprentice:	$350.00
Fifth Period Apprentice:	$330.00
Fourth Period Apprentice:	$310.00
Third Period Apprentice:	$290.00
Second Period Apprentice:	$270.00
First Period Apprentice:	$250.00
New Apprentice:	$230.00

Weekly disability benefits are payable Monday-Friday only. Payment for one weekday is therefore 1/5 of weekly disability benefit due and owing. No benefits are payable for Saturdays and Sundays.

Weekly disability benefits are not payable during a strike unless the Disability commenced prior to the effective date of the strike and while the Employee was still actively employed by an Employer.

Weekly disability benefits are wages subject to appropriate withholding.

(c) Successive Periods of Disability

An Active Employee will not be entitled to benefits for a successive period of Disability due to a different cause unless he has returned to active work for one full day.

An Active Employee will not be entitled to benefits for a successive period of Disability due to the same cause unless he has returned to active work for at least 2 full weeks. Under no circumstance will an Active Employee be entitled to more than 104 weeks of weekly disability benefits as a result of a Disability due to the same or related cause.

3.3 Medical Benefits

(a) Networks

The Fund has entered into an agreement with a preferred provider organization.

See Article 19 for contact information. This agreement provides that Hospitals, Physicians, and other health care providers in the preferred provider organization network will charge reduced fees to Covered Persons. Providers in the preferred provider organization are referred to as Participating Providers, or in network providers. The Fund reimburses a higher percentage of in network provider charges than out of network provider charges. However, it is always the Covered Person's choice as to which Provider to use.

A list of Participating Providers will be given to Plan Participants upon request and is available for inspection at the Plan Office.

Treatment at an in-network facility utilizing a non-network provider will be covered as in-network benefits.

Claims incurred by an Active Employee or his/her dependents while such Active Employee is working outside the jurisdiction of the Union for a contributing Employer will be covered as in-network claims.

(b) Benefits

The chart below summarizes the benefits provided by the Fund, subject to the following:

Co-payment: The amount of money paid by the Covered Person each time a particular service is received from a Provider.

Annual Deductible: A deductible is an amount that must be paid by the Covered Person before any benefits are payable. The Annual Deductible is $250 per Covered Person, $500 Two Person, or $750 Three or more Covered Persons (i.e. Family) per Calendar Year. **All benefits are subject to these deductibles, whether received in or out of network, unless otherwise stated in the benefit chart set forth below.** Covered expenses which were applied toward the Annual Deductible in October, November, and December will be applied toward the Annual Deductible in the following calendar year.

R&C: This refers to "Reasonable and Customary," which means the lesser of (a) a charge which is not higher than the general level of charges accepted by most providers of like service in the same area, considering the nature and severity of the condition being treated, medical complications or unusual circumstances; or (b) the actual charge billed.

Co-insurance: The chart below indicates the percentage of a covered expense paid by the Fund. If the percentage is less than 100%, the Covered Person is responsible for the remainder. For instance, for in-patient in-network surgery, the Fund pays 90%. This means that the Covered Person is responsible for paying the remaining 10%. The annual out of pocket

maximum for co-insurance (in network and out of network claims combined) is $1500 per Covered Person and $3000 per family per Calendar Year. This limit does not include co-payments or deductibles, or any benefits not subject to the co-insurance maximum as noted in the benefit chart set forth below.

The benefits set forth below are subject to the exclusions set forth below and in ¶(d), which follows this chart.

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
INPATIENT (a person is "inpatient" when he/she has spent over 23 consecutive hours in a Hospital)		
Inpatient/Hospital Room and Board Limited to ward or semi-private rooms.	90%	70% of R&C, after $75 co-payment
Surgery and Anesthesia (in hospital)	90%	70% of R&C
Technical Surgical Assistant Provided only where the complexity of the surgery warrants a surgical assistant	20% of the surgical procedure allowance at 100%	20% of the R&C surgical procedure allowance at 100%
Special care units (e.g. burn, cardiac, intensive care)	90%	70% of R&C
Physician Visits in Hospital	90%	70% of R&C
Physical Therapy	90%	70% of R&C
Diagnostic Lab, testing, and X-ray	90%	70% of R&C
Organ Transplants	90%	70% of R&C
Hemodialysis	90%	70% of R&C
MATERNITY		
Eligibility: Maternity benefits are only available as follows: 1. Active Employees 2. For Spouses of Active Employees 3. For Surviving Spouses of Active Employees for 9 months following death of such Active Employee		
Office Visits Includes pre-natal office visits, post-natal office visits, related laboratory/diagnostic testing, etc. in conjunction with a maternity course	90%, after $15 co-payment on first visit only. Not subject to deductible.	70% of R&C
In-Patient Hospital See Special Notice following this chart	90%	70% of R&C, with $75 co-payment upon admission If the mother has a cesarean section and her son has a circumcision during the same in-patient stay, then only one $75 co-payment will be charged

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
In-Patient Birthing Center See Special Notice following this chart	90%	70% of R&C, with $75 co-payment upon admission If the mother has a cesarean section and her son has a circumcision during the same in-patient stay, then only one $75 co-payment will be charged
Nurse-Midwifery Service Limited to care from a nurse-midwife who is a licensed registered nurse, has successfully completed formal advanced specialty training as a nurse-midwife in a program accredited by the American College of Nurse-Midwives; and is certified by the American College of Nurse-Midwives. The nurse-midwifery benefit will be paid for normal care surrounding the birth of a child. Services also include a week of visits with the mother. The American College of Nurse-Midwives must confirm that an individual is certified by that organization.	90%	70% of R&C
Routine In-Patient Well Newborn Care Limited to well newborn care services rendered during the first 7 days after birth while the newborn is Hospital confined.	90%	70% of R&C (if mother admitted, no additional deductible charged for newborn)
OUTPATIENT		
Physician Visits (Office visit)	$15 co-payment, then 100%. Not subject to deductible.	70% of R & C, after $15 copayment
Physical Exam for Active Employees, Pensioners, Spouses, and Surviving Spouses	100% Not subject to deductible.	80% of R & C after $10 copayment, only if participant does not reside in Michigan. No benefit for Michigan residents.
Well Baby Care for Children up to age 5	100%, less $15 co-payment. Not subject to deductible.	No benefit; in-network benefit only
Urgent Care Facility	100%, after $25 co-payment. Not subject to deductible.	70% of R & C, after $25 co-payment

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Emergency Room Visits	90%, after $100 co-payment The co-insurance requirement is waived if (1) the Covered Person is admitted as a bed patient, or (2) the purpose of the emergency room visit is to treat an Injury resulting from an Accident that occurred no more than 24 hours prior to the emergency room visit.	70% of R&C, after $100 co-payment The co-insurance requirement is waived if (1) the Covered Person is admitted as a bed patient, or (2) the purpose of the emergency room visit is to treat an Injury resulting from an Accident that occurred no more than 24 hours prior to the emergency room visit.
Immunizations for Children up to age 19	90%, not subject to deductible	No benefit – In-network benefit only
Immunizations for Children over age 19	90%, not subject to deductible	Not to exceed in-network allowance
Diagnostic X-ray, Lab & Supplies in Doctor's Office or Outside Facility	90%, after $15 co-payment per billing statement, not subject to deductible	70% of R&C
Surgery/Anesthesia: Physician's Office or surgical facility	100%, subject to the deductible.	70% of R&C
Assistant Surgeon	20% of the surgical procedure allowance at 100%	20% of the R&C surgical procedure allowance at 100%
Second Surgical Opinion	90%	70% of R&C
Speech Therapy	90%, after $15 co-payment, not subject to deductible	70% R&C
Physical Therapy	90%, after $15 co-payment, not subject to deductible	70% R&C
Hemodialysis Must be approved program of hemodialysis in an approved outpatient facility or home. Reasonable and necessary expenses for installation, maintenance and repair of equipment and supplies used in the home are covered. Includes related physician services when covered person is receiving treatment in approved facility.	100%, limited to 120 days per Calendar Year – Fund will pay pursuant to Medicare Secondary Payer Rules	80% R&C, limited to 120 days per Calendar Year– Fund will pay pursuant to Medicare Secondary Payer Rules
OTHER PROVISIONS		
Psychiatric And Substance Abuse Treatment	90% coverage	80% coverage of R&C
Allergy Injections	90%, after $15 co-payment, not subject to deductible	70% R&C
Diabetic Teaching Class	Cost of class covered at 100%. Covers one class only per Participant or Dependent per lifetime. Not subject to deductible.	Cost of class covered at 100%. Covers one class only per Participant or Dependent per lifetime. Not subject to deductible.
Radiation and Chemotherapy	90%	70% R&C
Durable Medical Equipment (equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury, and (d) is appropriate for use in the home)	90%	70% of R & C

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Ambulance	90%, after $50 co-payment per trip; paid at 100% if admitted as bed patient	70% of R&C, after $50 co-payment per trip; paid at 80% if admitted as bed patient
Home Health Care	90%	70%
Hospice Care	90%, up to $90 per day, 90 day combined in-patient and out-patient limit	70%, up to $80 per day, 80 day combined in-patient and out-patient limit
Family Counseling	80%, after $50 co-payment and $500 maximum benefit. Maximum co-insurance limitation does not apply.	80%, after $50 co-payment and $500 maximum benefit. Maximum co-insurance limitation does not apply.
Family Bereavement Counseling	80%, after $50 co-payment, with maximum benefit of $250 for maximum of 90 days. Maximum co-insurance limitation does not apply.	80%, after $50 co-payment, with maximum benefit of $250 for maximum of 80 days. Maximum co-insurance limitation does not apply.
Skilled Nursing Facility	90%	70%
Chiropratic Services and Alternate Therapies - chiropractic, acupuncture, acupressure, therapeutic massage, biofeedback and homeopathy therapy provided by a practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license	90%, after $15 co-payment, limited to $1,000 per year (including x-rays and related physical therapy)	70%, after $15 co-payment, limited to $1,000 per year (including x-rays and related physical therapy)
TMJ/Jaw Joint	90%	70% R&C
Hearing Aids Limited to $3000 every three years, including repairs.	80%	80% R&C
Mammograms Limited 1 per year	100%, not subject to deductible	70% R&C
Annual Preventive GYN/Routine Pap Limit 1 per year	100% not subject to Annual Deductible	80% R&C after $10 copayment, only if participant does not reside in Michigan. No benefit for Michigan Residents
Sterilization (no reversal)	100%, up to $300.00 maximum benefit (one-time only). Deductible does not apply.	100% R&C, up to $300.00 maximum benefit (one-time only). Deductible does not apply.
Dental Surgery Surgery for multiple extractions or removal of unerupted teeth under general anesthesia where a concurrent hazardous medical condition exists, or surgery necessitated by an accident that occurred while eligible for coverage.	90%	70% of R & C

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Colonoscopy Cologuard Screening Preauthorization Required.	100%, not subject to deductible, once every 5 years. Additional medically necessary colonoscopies within the 5 year limit are covered: (a) 90% if performed inpatient, subject to deductible, or (b) 100% outpatient, subject to deductible. 100%, not subject to deductible, once every 3 years.	70% of R&C, subject to the deductible 100%, not subject to deductible, once every 3 years.
Gene Therapy – Pre-certification required to avoid possible non-payment or denial of claim. You must contact Health Plan Advocate to obtain pre-certification, which will enable the Plan to determine if a particular treatment is medically necessary.	90% after deductible.	70% R&C.
COVID-19 Testing/Facility Charges – Includes: (1) Diagnostic tests to detect COVID-19, approved by the FDA, including the administation of such tests; and (2) Items and services furnished during office visits, urgent care center vists, and emergency room vists that result in an order for a COVID-19 diagnostic test, provided items and services relate to the provision of the test or evalution of whether a test is needed.	100%	100% of the negotiated rate (if applicable) or the Provider's posted Cash Price on the Provider's public internet website (as requred to be posted by the CARES Act).
COVID-19 Vaccines approved for distribution and use by the FDA	100%	Not covered.
Flu Vaccine	100%	Not covered.
Telehealth visits through MDLIVE	100%	100%

Special Notice Regarding Maternity Benefits: Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans may not, under Federal law, require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

(c) Utilization Management and Review

The Fund has contracted with a company to provide the following services:

(1) Utilization management in program, entailing:

- Hospital Preadmission Review;
- Concurrent Review;
- Discharge Planning;
- Identification of Large Case Management;
- Second Surgical Opinion Program;
- Medical Information Help Line.

(2) Large Case and Disease Management Program.

(d) Exclusions and Limitations

In addition to and not in lieu of other restrictions to coverage set forth in this Plan, the following services and benefits are not covered by the Plan:

(1) Services provided before the effective date of coverage.

(2) Services provided after the effective date of termination of coverage.

(3) Charges that are not Reasonable and Customary.

(4) Services or supplies that are not Medically Necessary.

(5) Services or supplies provided mainly as a rest cure, maintenance or custodial care.

(6) Charges related to donating an organ or tissue to an individual other than a Covered Person.

(7) Services for educational or vocational testing or training.

(8) Exercise programs for treatment of any condition, except for Physician supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

(9) Charges for travel outside the United States without Plan approval if the sole purpose is to obtain medical services, supplies or drugs.

(10) Care, treatment or supplies furnished by, or available from, a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

(11) Care and treatment of hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a physician (however, wigs will be covered for persons undergoing chemotherapy).

(12) Expenses for cosmetic surgery; unless (1) treatment is rendered by a

Physician for injuries sustained in an accident and such treatment is begun within ninety days after such accident; (2) treatment is for a congenital anomaly for a Covered Person under 12 years of age, unless a Physician certifies that such treatment could not have been undertaken prior to age 12; (3) treatment is rendered for reconstruction of the breast, surgery and reconstruction of the other breast for symmetrical appearance, or prostheses and physical complications in all stages of mastectomy; or (4) such surgery is incidental to any other covered illness.

(13) Charges for use of any treatment, supply, device or facility that (a) does not have required governmental approval, or (b) is Experimental, investigative or not a generally accepted medical practice.

(14) Services that are not health care services (e.g. personal and convenience, completion of forms, cost of transportation, except covered ambulance services, in hospital television and telephone, etc.).

(15) Services, care, supplies or devices not prescribed by a Physician and not directly related to the diagnosis or treatment of Illness or Injury.

(16) Services not rendered by a Physician.

(17) Expenses in connection with dental work or TMJ (temporomandibular joint syndrome), other than set forth in the benefits chart, above.

(18) Charges for services rendered by Participant's or Dependent's immediate family or (i.e., spouse, brother, sister, parent, or child) or regular member of the Participant's or Dependent's immediate household.

(19) Services for which a charge would not have been made had no coverage existed; services that the Participant or Dependent is not legally obligated to pay.

(20) Services provided by Employer facilities.

(21) An Occupational Injury or Illness and or an Injury or Illness for which the Covered Person is eligible for benefits under any workers' compensation plan.

(22) Any Injury or Illness arising from a motor vehicle accident.

NOTE: "Motor vehicle" means a vehicle, including a trailer, operated or designed for operation upon a public highway by power other than muscular power which has more than 2 wheels. "Motor vehicle accident" means a loss involving the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle regardless of whether the

accident also involves the ownership, operation, maintenance, or use of a motorcycle as a motorcycle. Consequently, all Covered Persons are expected to cover themselves for motor vehicle claims under their individual insurance policies.

(23) Expenses incurred for family planning, semen analysis, fertility and infertility analysis, treatment or diagnosis.

(24) Charges for treatment of obesity.

(25) Custodial care.

(26) Expenses incurred for treatment of Injuries, Illnesses, or Disability incurred while the Covered Person was engaged in an illegal activity. This exclusion does not apply if the Covered Person was not the aggressor.

(27) Expenses incurred as a result of being under the influence of any narcotic, drug, chemical, alcoholic beverage or any other substance, or in consequence of the use thereof, unless administered or prescribed by a legally qualified physician.

(28) Any Injury or Illness resulting from war, whether or not a declared war.

(29) Expenses in connection with care rendered within a facility of, or provided by, the United States Veterans' Administration or other government Hospital for care for disabilities resulting from military service for which government benefits are reasonably available to the Covered Person.

(30) Expenses incurred for treatment of self-inflicted injuries, unless they were the result of a physical or mental condition.

(31) For surcharge or admission privilege fee levied by community hospitals.

(32) For any operation involving 2 or more surgical procedures, the maximum amount shall be determined on the following basis:

(A) When two or more surgical procedures are performed through the same incision, the maximum amount payable under the Plan shall be that for the major procedure only.

(B) When two or more surgical procedures are performed in the same general area, the maximum amount payable under the Plan shall be that for the major procedure plus one-half the maximum amount for the secondary procedure. The maximum amount shall not be further increased for additional procedures.

(C) When two or more surgical procedures are performed in different areas, the maximum amount payable under the Plan shall be that for the major procedure, plus one-half the maximum amount for each additional procedure.

(D) For a bilateral operation, the maximum amount payable under the Plan shall be 1½ times the maximum amount for a unilateral operation.

(E) When two or more procedures are performed through two or more separate incisions by two or more Specialists in different fields, the maximum amount payable under the Plan shall be the sum of the maximum amounts for each of the procedures.

(33) Expenses incurred for vision services including eye refractions, the fitting of eyeglasses or contact lenses.

(34) Orthopedic evaluation or training.

(35) Reversal of sterilization procedures.

(36) Insertion or removal of intra-uterine devices, or complications arising from the use of such devices or for any type of birth control.

(37) Treatment of injury, resulting from causes other than Illness or Injury. Injuries occurred in a fight will not be covered, unless the Covered Person was the victim and did not provoke the fight. In case of questionable claims of this type, the Trustees will require a copy of the police report and full details describing the altercation.

(38) Installation of air conditioning units, humidifiers for environmental controls, whirlpools, air filters, bathroom rails, special toilet seats, commodes, chair lifts, sun lamps or any non-essential home-installed conveniences even when prescribed by a physician, including ergometers and exercycles, bicycles, etc.

(39) Court ordered hospital confinements and treatment required by court orders, even when recommended by a Physician.

(40) Voluntary abortions. Abortions will be covered only to protect the health of the Covered Person.

(41) Growth Hormones.

(42) Aromatherapy, art therapy, phototherapy, hypnosis, herbal therapies,

spiritual therapies, nutritional therapy, yoga, bee sting venom therapy, aura therapy, or touch therapy.

(43) Transsexual surgery.

(e) Medicare Eligibility

In the event coverage is not yet in place under Article 18, coverage for Medicare eligible Participants and Dependents is provided as set forth in this section.

The Fund provides limited benefits intended to complement Medicare coverage for Medicare eligible Participants and Dependents. In the event either a Medicare eligible Participant/Dependent does not obtain Medicare coverage or Medicare does not cover a particular claim, this Plan will not pay more than the limited benefits set forth below. In other words, this Plan pays only the limited benefits set forth below as if Medicare coverage is available, even if it is in fact not available.

(1) Pensioners, Spouses and Surviving Spouses

For Medicare eligible Pensioners, Spouses and Surviving Spouses ("Medicare Eligible Participants"), Medicare is primary. For those items covered by Medicare Part A (hospitalization), the Fund will only reimburse the Medicare inpatient deductible. For those benefits covered by Medicare Part B (medical insurance), the Fund will pay 20% of Medicare's approved allowance and the Medicare calendar year deductibles. Subject to the terms of this section 3.3(e)(1), prescription drugs will be covered under the same terms as coverage is provided for non-Medicare eligible participants.

The Fund only coordinates benefits with Medicare, as set forth above.

The Fund will not pay for any service, item, or expense that is not a Medicare eligible expense, including claims incurred outside of the United States (see paragraph (4), below).

All claims will be processed as if the Medicare Eligible Participant has obtained Medicare Parts A and B, even if such coverage is not in place. Thus, it is strongly recommended that a covered person contact the Social Security Administration at least 4 months before they will reach age 65.

This complementary coverage will terminate when with reasonable diligence, as determined in the sole and exclusive discretion of the Trustees, the covered person should have Medicare Parts A and B in

effect, but in no event more than 12 months after the date such coverage could have been obtained. If a covered person fails to obtain Medicare Parts A and B within this time frame, he/she will lose all coverage (medical, prescription drug, dental, life, employee assistance, and vision) under the Fund and will not be allowed at any time in the future to reinstate coverage.

(2) Permanent and Total Disability Employees

A Participant suffering from a disability becomes eligible for Medicare, regardless of age, after receiving Social Security Disability payments for 2 years. Such a Participant is required to apply for Medicare benefits as soon as he becomes eligible for them. A Spouse who becomes entitled to Medicare due to disability is also required to enroll in Medicare Parts A and B upon eligibility. Once Medicare eligibility could have been obtained, even if it is not, coverage under the Plan will be limited and coordinated with Medicare subject to all the provisions set forth in paragraph (1), above. In other words, the Plan will not pay for benefits which would have been paid for by Medicare had it been timely applied for and obtained. Thus, it is strongly recommended that the Social Security Administration be contacted as soon as possible regarding Social Security Disability payments.

(3) Dialysis Patients

After a period of time, Medicare becomes the primary insurer for an individual who needs a regular course of dialysis treatment or a kidney transplant because of renal disease. Any Covered Person receiving such treatment should contact the Social Security Administration as soon as possible to obtain information regarding Medicare eligibility and take appropriate steps to become eligible for Medicare benefits. Once eligibility could have been obtained, even if it is not, the Plan will be primary (i.e. will provide benefits) only to the extent required by the Medicare's Secondary Payer rules.

(4) Claims Incurred by Medicare Participants Outside of United States

Medicare does not pay for claims incurred outside of the United States and, therefore, the Fund will not provide coverage either. If a Participant or Dependent is traveling outside of the United States, he/she must obtain a private short term insurance policy to ensure coverage.

(5) Medicare Secondary Payer Rules

To the extent that Medicare Secondary Payer Rules are applicable to a Medicare eligible individual who has coverage by virtue of current

employment status or is Medicare eligible due to End Stage Renal Disease, please see §6.2(e), below.

(f) Benchmark Plan for purposes of defining Essential Health Benefits.

The Plan is a grandfathered health plan under the Patient Protection and Affordable Care Act, PPACA, Pub. L. No. 111-148 §1251(a) and 10103 (2010) as amended by HCERA, Pub. L. No. 11-152 (2010). Grandfathered health plans are prohibited from imposing annual and lifetime dollar limits on any essential health benefits they offer. PPACA, Pub. L. No. 111-148 §1251(a)(4)(A)(ii) - (B)(i) (2010). Therefore, the Plan adopts the Utah state benchmark plan for purposes of defining essential health benefits.

3.4 Vision Benefits

(a) Benefits

The Fund provides the following self-insured vision benefits per year unless otherwise indicated below:

Coverage with a VSP Provider		
Benefit	**Description**	**Copay**
Well Vision Exam – every 12 months	• Overall wellness exam.	$10.00
Prescription Glasses		
Frames – every 24 months	• $150 allowance for frames. • $170 allowance for featured brand frames. • 20% discount on amount over the above-specified allowance. • $80 Costco frame allowance.	Included in Prescription Glasses
Lenses – every 12 months	• Single vision, lined bifocal, and lined trifocal lenses.	Included in Prescription Glasses
Lens Enhancements – every 12 months	• Standard progressive lenses. • Premium progressive lenses. • Custom Progressive Lenses.	$0 $95.00 - $105.00 $150.00 - $175.00
Contacts (instead of glasses) – every 12 months	• $150 allowance for contacts; copay does not apply. • Contact lens exam (fitting and evaluation)	Up to $60.00
Diabetic Eyecare Plus Program	• Services related to diabetic eye diseases, glaucoma and	$20.00

Coverage with a VSP Provider		
Benefit	**Description**	**Copay**
	age-related macular degeneration (AMD). Retinal screening for eligible participants.	
ProTec Safety (Participant-only. Not available to Dependents)		
Frame – every 24 months	• Fully covered if frame is chosen from VSP Provider's ProtTec Eyewear Collection	Combined with exam.
Lenses – every 12 months	• Prescription single vision, lined bifocal, and lined trifocal	Combined with exam.
Out-of-Network Provider		
Exam	Up to $45.00	
Prescription Glasses		
Frame	Up to $70.00	
Single Vision Lenses	Up to $30.00	
Lined Bifocal Lenses	Up to $50.00	
Lined Trifocal Lenses	Up to $65.00	
Progressive Lenses	Up to $50.00	
Contacts	Up to $105	

*These limits will not apply to covered persons age 18 and under.

(b) Limitations

No benefits shall be paid for the following:

(1) Sunglasses, unless they are prescribed to be worn at substantially all times.

(2) Glasses with tinted lenses, unless prescribed by an Ophthalmologist (M.D.) for medical reasons.

(3) Routine yearly examinations required by an employer in connection with the occupation of the individual.

(c) Providers

The Fund has entered into an agreement with Vision Service Plan (VSP) to provide vision benefits to its participants. A list of in-network providers is available upon request by calling VSP directly. See Article 18 for contact information. A Covered Person does not have to use one of these providers, as it is always the Covered Person's choice as to which vision service provider to use. Please be advised that if you visit and out-of-network Provider for vision services, you will be responsible for the entire cost of that service out-of-pocket. You will

be able to submit the cost to VSP for reimbursement up to the specified amount listed above.

(d) Opt-Out

At any time a Participant may decline all vision benefits under Section 3.4(a)

3.5 Dental/Orthodontic Benefit

(a) Preferred Provider Organization

The Fund has entered into agreements with preferred dental provider organizations, which provide that the preferred provider organization network will charge reduced fees to Covered Persons. The Fund reimburses a higher percentage of in network provider charges than out of network provider charges. However, it is always the Covered Person's choice as to which Provider to use.

A list of Participating Providers will be given to Plan Participants upon request and is available for inspection at the Plan Office.

(b) Benefits

(1) Dental Benefit

The total benefits payable for all Dental Benefits (Routine Oral Examination Benefit and Basic Dental Benefit) shall not exceed $1,200.00 per Covered Person per dental benefit year, which is September 1 through August 31 (this is referred to as the "Maximum Dental Benefit"). The $1,200.00 maximum will not apply to covered persons age 18 and under.

Subject to the Maximum Dental Benefit and the exclusions set forth in ¶3.5(c), which follows this chart, the following chart summarizes the dental benefits provided. The percentages refer to the percentage of the cost for a particular benefit that will be paid by the Fund; the balance is the Covered Person's responsibility. "R&C" means "Reasonable and Customary," as defined in §3.3(b).

Routine Oral Examination Benefit

In Network: 50%
Out of Network: 50% R&C

- Exams: Limited to one diagnostic oral examination and related consultations every 6 months. This includes the cleaning and scaling of teeth.
- Fluoride Applications: Limited to one application every 6 months.
- Prophylaxis: Limited to one application every 6 months.
- X-Rays - Dental: Full month or panoramic x-ray (or an equivalent) is

covered only once every 3 years. Bitewing x-rays, extraoral x-rays and occlusal interoral x-rays are each limited to 2 sets every 6 months.

Basic Dental Benefit 50% Out of Network: 50% R&C • Initial Complete Dentures • Replacement of complete dentures. No replacement shall be allowed for stolen/lost dentures. No benefits will be paid for the replacement of dentures that were paid for, in whole or in part, by this Plan, unless five years have elapsed from such treatment. • Fillings • Crowns • Partial Dentures and Bridges • Extractions and other oral surgery • Periodontal Treatment • Root Canal Therapy
Core Vent Implants In Network: 100%, to maximum lifetime benefit of $5000* Out of Network: First $1000 reimbursed 100% of R&C, and then at 75% of R&C to maximum lifetime benefit of $5000* *These limits will not apply to covered persons age 18 and under.

(2) Orthodontic Benefit

This benefit is for Active Employees and their Dependents only. Benefits are payable as follows after submission of a treatment plan:

In-Network Provider:	75% of Covered Charges
Out of Network Provider:	75% of reasonable and customary charges
Lifetime Maximum per person:	$2,000

Orthodontic Benefits are paid on a monthly basis as the expense is incurred. An allowance will not be made for advance payments, except for the initial fee or for the fitting of appliances.

(c) Exclusions and Limitations

The exclusions and limitations for medical benefits in §3.3(d) apply to the dental/orthodontic benefits.

(d) Golden Dental Plan

In lieu of the self-funded dental coverage set forth above, Participants may

alternatively elect insured dental coverage under a policy issued by Golden Dental Plans DMO, pursuant to which dental services will only be covered if the Covered Person receives treatment from a dentist in the Golden Dental Plan DMO network. See Article 19 for contact information. The maximum benefit is $1800 per year per Covered Person, and a lifetime orthodontic benefit of $2000 is available. Please refer to the applicable Golden Dental Plans DMO summary of benefits for a description of the benefits available, and exclusions and limitations to coverage. Any such election is binding for one year on the Participant and his/her Dependents. As this benefit is fully insured, all claims and appeals regarding such benefits shall be determined by the procedures set forth in the Golden Dental Plans summary of benefits, not pursuant to Article 4, below.

(e) Opt-Out

At any time a Participant may decline all dental/orthodontic benefits under Section 3.5(b) and Article 3.5(d).

3.6 Prescription Drug Benefits

(a) Provider Network/Prescription Drug Card

The Fund has contracted with a prescription drug service for the administration of the prescription drugs. See Article 19 for contact information. To receive coverage, a Covered Person must obtain prescription drugs at a pharmacy in the service provider network (a "Participating Pharmacy"). A list of such pharmacies is available at the Plan Office. Participants must present their identification card at participating pharmacies for benefits.

(b) Covered Drugs

The following drugs are covered under this program:

Federal Legend Drugs
Insulin/Insulin Syringes/Diabetic Supplies (Blood/Urine sugar testing equipment (i.e. Chemstrips, Lancets)
Compounds
Retin-A (only if the Covered Person submits documentation from his/her Physician verifying that it has not been prescribed for wrinkles and is Medically Necessary for the treatment of an Illness)
Miscellaneous Injectible Drugs (including imitrex), with a $100.00 co-payment for each 34-day supply
Prescription Vitamins
Injectable Bee Sting kits
COVID-19 vaccines approved for distribution and use by the FDA and Flu vaccines (COVID-19 vaccines and Flu vaccines covered 100% in-network

only).

(c) Excluded Drugs

The following Drugs are excluded under this program:

Cosmetic Drugs
Over the Counter products
Injectable Growth Hormones
Injectable Allergens
Smoking Cessation Drugs
Oral and Injectible Fertility Agents
Viagra
Non-insulin syringes
Contraceptive Devices
Oral and Injectable Contraceptives (unless medically necessary for treatment of a medical condition, with the understanding that the prevention of pregnancy in and of itself is not a "medical condition" for purposes of this exception)
Anti-obesity agents
Appliances (for example, canes, crutches, wheelchairs, braces, splints, bandages, dressings, heat devices, etc.)
Injectable Immunomodulators (subject to section 3.6(d)(3), below)
Singulair, unless the Covered Person presents a letter from his or her physician stating that the Singulair is prescribed for the treatment of asthma or for the treatment of symptoms in conjunction with cancer treatment
Raptiva
Levitra
Cialis
Bulk powders

(d) Additional Limitations

(1) All limitations for medical benefits, set forth at §3.3(d), apply to the prescription drug benefits.

(2) **Special Limitations Regarding Injectible Immunomodulators**

The following Injectible Immunomodulators will be covered only under a specialty pharmacy program, with a $100.00 co-payment for each 34-day supply:

Interferon/Intron-A	Enbrel
Pegasys/Peg-Intron	Remicade
Orencia	Revlimid
Humira	Mitoxantron/Novantrone
Kineret	Thalomid

All other Injectible Immunomodulators are excluded from coverage.

(3) **Special Coverage for Proton Pump Inhibitors**

Proton Pump Inhibitors (PPIs) will be covered only as follows: Subject to a $15 co-payment, the Plan will pay $50 per prescription, whether the prescription is filled through a retail or mail order pharmacy. The remainder of the cost of the drug is the Participant's responsibility.

The following over the counter PPIs will be covered subject to a $15 co-payment and physician prescription:

Prilosec OTC and generic equivalents
Pepcid AC and generic equivalents
Pepcid Complete
Zantac and generic equivalents
Prevacid OTC

(4) All specialty drugs must be filled at Orchard Specialty Pharmacy.

(5) Certain drugs require prior authorization or are subject to step therapy before coverage will be approved. This list of drugs is subject to change from time to time in the sole discretion of the Trustees.

(6) Compound drugs costing over $200 require letters of medical necessity before coverage will be approved.

(7) Certain drugs are subject to quantity limits. This list of drugs, and quantity limits, are subject to change from time to time in the sole discretion of the Trustees.

(e) Co-Payments

Drugs may be filled at a retail pharmacy for a 34-day supply for a $15.00 co-pay for Generic drugs and a $40.00 co-pay for Brand Name drugs (regardless of whether a Generic is available). If a Covered Person receives a Brand Name Drug for a drug that has a Generic equivalent, in addition to the $40.00 co-payment, he/she must pay the difference in the cost between the Brand Name and Generic drugs.

Drugs may be filled via mail order or at a retail pharmacy for a 90-day supply, for a $30.00 co-pay for Generic drugs and a $100.00 co-pay for Brand Name drugs (regardless of whether a Generic is available). If a Covered Person receives a Brand Name Drug for a drug that has a Generic equivalent, in addition to the $100.00 co-payment, he/she must pay the difference in the cost between the

Brand Name and Generic drugs.

If a Participant or Dependent pays cash for a drug that is covered by the Plan, the Fund will reimburse the Covered Person, excluding any applicable co-payment. Request for reimbursement must be submitted to the prescription drug service within 90 days of payment.

See §§3.6(d)(3) and (4), above, for special co-payments pertaining to Injectible Immunomodulators and Proton Pump Inhibitors.

(f) Medicare Eligible Participant or Dependent

Any Medicare eligible Participant or Dependent who enrolls in Medicare Part D will lose prescription drug coverage provided by the Fund.

3.7 Employee Assistance

The Fund provides an Employee Assistance Program to provide screening, assessment, and counseling for Participants and their Dependents related to alcoholism, drug addiction, and certain mental/nervous disorders. See Article 19 for contact information.

ARTICLE 3A – BENEFITS FOR NON-DETROIT PARTICIPANTS

3A.1 Life and Accidental Death and Dismemberment Benefits

Non-Detroit Participants are eligible for the Life and Accidental Death and Dismemberment Benefits set forth in Article 3, §3.1, above.

3A.2 Weekly Disability

(a) Eligibility

An Active Employee with a Non-Occupational Disability which prevents him/her from working as a roofer is entitled to weekly disability benefits for a period of 26 weeks if he/she:

(1) is under the regular care of a Physician and has submitted a Physician's statement attesting to his/her Disability (such statement must be submitted initially and at intervals as requested by the Trustees);

(2) is not on the Out-of-Work List and/or available for work in the jurisdiction of the Roofers Local Union No. 149 because of such Non-Occupational Disability;

(3) is not eligible for similar benefits under another plan of insurance (provided such benefits are equal to the benefits provided by this Plan);

(4) is not disabled due to alcohol or substance abuse, unless he/she is receiving in- patient treatment at an approved facility;

(5) at the time of the Disability commenced, was eligible for benefits as an Active Employee by virtue of hours in his/her hour bank or active self-payments; and

(6) was not Disabled in a motor vehicle accident or by an act of war (declared or undeclared) or while in the Armed Forces of any country.

Pursuant to the above, an individual may not receive a Weekly Disability benefit at the same time he/she is receiving a disability pension benefit from the Roofers Local 149 Pension Fund. In the event a Weekly Disability benefit is paid for a period of time for which the Disabled Employee is awarded a disability pension benefit from the Roofers Local 149 Pension Fund, such amount paid for Weekly Disability must be repaid to the Fund.

For those with an Occupational Disability, the Disabled Employee must have a workers' compensation claim pending and execute an assignment of benefits to the Fund in order to receive this benefit.

(b) Benefit

The weekly disability benefit shall commence with the first day of Disability due to Injury, first day of outpatient surgery or inpatient Hospital admission, or eighth day of Illness.

The amount of the weekly disability benefit is $250 per week.

Weekly disability benefits are payable Monday-Friday only. Payment for one weekday is therefore 1/5 of weekly disability benefit due and owing. No benefits are payable for Saturdays and Sundays.

Weekly disability benefits are not payable during a strike unless the Disability commenced prior to the effective date of the strike and while the Employee was still actively employed by an Employer.

Weekly disability benefits are wages subject to appropriate withholding.

(c) Successive Periods of Disability

An Active Employee will not be entitled to benefits for a successive period of Disability due to a different cause unless he has returned to active work for one full day.

An Active Employee will not be entitled to benefits for a successive period of

Disability due to the same cause unless he has returned to active work for at least 2 full weeks. Under no circumstance will an Active Employee be entitled to more than 26 weeks of weekly disability benefits as a result of a Disability due to the same or related cause.

3A.3 Medical Benefits

(a) Networks

See Article 3, §3.3(a) for a description of networks.

(b) Benefits

Benefits are available to eligible Participants and their Dependents.

The chart below summarizes the benefits provided by the Fund. As used in this chart, the following terms have the following meanings:

Deductible: The amount that must be paid by the Covered Person before any benefits are payable. The annual deductible is $325 per Covered Person or $650 per family per Plan Year for in-network services, and $650 per Covered Person or $1,300 per family per Plan Year for out-of-network services.

Co-payment: The amount of money paid by the Covered Person each time a particular service is received from a Provider.

Annual Deductible: As indicated in the chart below, a number of benefits are subject to an Annual Deductible. This means that before any benefits will be paid for these benefits, the Annual Deductible must be paid by the Participant. Annual deductibles will be calculated on a Calendar Year basis. Covered expenses which were applied toward the Annual Deductible in October, November, and December will be applied toward the Annual Deductible in the following calendar year.

R&C: This refers to "Reasonable and Customary," which means the lesser of (a) a charge which is not higher than the general level of charges accepted by most providers of like service in the same area, considering the nature and severity of the condition being treated, medical complications or unusual circumstances; or (b) the actual charge billed.

Co-insurance: The chart below indicates the percentage of a covered expense paid by the Fund. If the percentage is less than 100%, the Covered Person is responsible for the remainder. For instance, for in-patient out-of-network surgery, the Fund pays the physician's fee at 70% of R&C. This means that the Covered Person is responsible for paying the remaining 30%. The annual out of pocket maximum for co-insurance is $1,300 per Covered Person or $2,600 per family per Calendar Year for in-network services, and $2,600 per Covered Person or $5,200

per family per Plan Year for out-of-network services. (These limits do not include co-payments or deductibles.)

The benefits set forth below are subject to the exclusions set forth below and in ¶(d), which follows this chart.

Benefit	In-Network Provider	Out-of-Network Provider
INPATIENT (a person is "inpatient" when he/she has spent over 23 consecutive hours in a Hospital)		
Inpatient/Hospital Room and Board Limited to ward or semi-private rooms.	90%	70% of R&C
Surgery and Anesthesia (in hospital)	90%	70% of R&C
Technical Surgical Assistant Provided only where the complexity of the surgery warrants a surgical assistant	20% of the surgical procedure allowance	20% of the R&C surgical procedure allowance
Special care units (e.g. burn, cardiac, intensive care)	90%	70% of R&C
Physician Visits in Hospital	90%	70% of R&C
Physical Therapy	90%	70% of R&C
Diagnostic Lab, testing, and X-ray	90%	70% of R&C
Organ Transplants	90%	70% of R&C
Hemodialysis	90%	70% of R&C
MATERNITY		
Eligibility: Maternity benefits are only available as follows: 1. Active Employees 2. For Spouses of Active Employees only 3. For Surviving Spouses of Active Employees for 9 months following death of such Active Employee		
Office Visits Includes pre-natal office visits, post-natal office visits, related laboratory/diagnostic testing, etc. in conjunction with a maternity course	$10 copayment on first visit, then 100%	70% of R&C
In-Patient Hospital See Special Notice following this chart	90%	70% of R&C
In-Patient Birthing Center See Special Notice following this chart	90%	70% of R&C

Benefit	In-Network Provider	Out-of-Network Provider
Nurse-Midwifery Limited to care from a nurse-midwife who is a licensed registered nurse, has successfully completed formal advanced specialty training as a nurse-midwife in a program accredited by the American College of Nurse-Midwives; and is certified by the American College of Nurse-Midwives. The nurse-midwifery benefit will be paid for normal care surrounding the birth of a child. Services also include a week of visits with the mother. The American College of Nurse-Midwives must confirm that an individual is certified by that organization.	100%	90% of R&C
Routine In-Patient Well Newborn Care Limited to well newborn care services rendered during the first 7 days after birth while the newborn is Hospital confined.	90%	70% of R&C
OUTPATIENT		
Physician Visits (Office visit or consultation)	$15 co-payment, then 100%	70% of R&C
Physical Exam for Active Employees, Retirees, Spouses, and Surviving Spouses	100%	Not Covered
Well Baby Care for Children	100% as follows: • 6 visits birth through 12 mos. • 6 visits 13 mos. through 23 mos. • 2 visits 24 mos. through 35 mos. • 2 visits 36 mos. through 47 mos. • 1 visit per year thereafter through age 15	Not Covered.
Urgent Care Facility	**Sickness** - $15 co-payment, then 100% **Injury** – 100%	**Sickness** - $15 co-payment, then 90% of R&C **Injury** – 100% of R&C
Emergency Room Visits	**Sickness** - $65 co-payment, then 90%, no deductible **Injury** – 100%	**Sickness** - $65 co-payment, then 80% of R&C, no deductible **Injury** – 100% of R&C
Immunizations for covered persons up to age 16	100%	Not Covered.
Diagnostic X-ray, Lab & Supplies in Doctor's Office or Outside Facility	90%	70% of R&C
Surgery/Anesthesia: Physician's Office or surgical facility	90%	70% of R&C
Assistant Surgeon	20% of the surgical procedure allowance	20% of the R&C surgical procedure allowance
Physical, Occupational and Speech Therapy	90%, subject to 60 combined visit limit per calendar year	70% of R&C, subject to 60 combined visit limit per calendar year

Benefit	In-Network Provider	Out-of-Network Provider
Hemodialysis Must be approved program of hemodialysis in an approved outpatient facility or home. Reasonable and necessary expenses for installation, maintenance and repair of equipment and supplies used in the home are covered. Includes related physician services when covered person is receiving treatment in approved facility.	90%. Fund will pay pursuant to Medicare Secondary Payor Rules	70% R&C. Fund will pay pursuant to Medicare Secondary Payor Rules
OTHER PROVISIONS		
Psychiatric	In patient and out patient: 90%	In patient and out patient: 70% of R&C.
Substance Abuse Treatment	In patient and out patient: 90%	In patient and out patient: 70%, of R&C
Allergy Injections	90%	70% of R&C
Radiation and Chemotherapy	90%	70% of R&C
Durable Medical Equipment (equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury, and (d) is appropriate for use in the home)	90%	90% of R&C
Ambulance	90%, after $65 co-payment per trip; paid at 100% if admitted as bed patient	80% of R&C, after $65 co-payment per trip; paid at 100% if admitted as bed patient
Home Health Care	90%	90% of R&C
Hospice Care	100%, up to $100 per day, 90 day combined in-patient and out-patient limit	100%, up to $100 per day, 90 day combined in-patient and out-patient limit
Skilled Nursing Facility	90%	70% of R&C
Chiropratic Services and Alternate Therapies - chiropractic, acupuncture, acupressure, therapeutic massage, biofeedback and homeopathy therapy provided by a practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license	100%, after $15 co-payment, limited to $1,000 per year (including x-rays and related physical therapy)	90%, after $15 co-payment, limited to $1,000 per year (including x-rays and related physical therapy)
TMJ/Jaw Joint – Limited to surgery directly related to the jaw joint, X-rays (including MRI), and arthrocentesis	90%	70% of R&C
Mammograms Limit 1 per year	100%, not subject to Annual Deductible.	70% of R&C
Annual Preventive GYN/Routine Pap Limit 1 per year	100% not subjec to Annual Deductible	Not covered.
Sterilization (no reversal)	90%	70% of R&C

Benefit	In-Network Provider	Out-of-Network Provider
Dental Surgery Surgery for multiple extractions or removal of unerupted teeth under general anesthesia where a concurrent hazardous medical condition exists,. or surgery necessitated by an accident that occurred while eligible for coverage. In patient only.	90%	70% of R&C
Colonoscopy Cologuard Screening Preauthorization Required.	100%, not subject to deductible, once every 5 years. Additional medically necessary colonoscopies within the 5 year limit are covered: (a) 90% if performed inpatient, subject to deductible, or (b) 100% outpatient, subject to deductible. 100%, not subject to deductible, once every 3 years.	70% of R&C, subject to the deductible 100%, not subject to deductible, once every 3 years.
Gene Therapy – Pre-certification required to avoid possible non-payment or denial of claim. You must contact Health Plan Advocate to obtain pre-certification, which will enable the Plan to determine if a particular treatment is medically necessary.	90% after deductible.	70% R&C.
COVID-19 Testing/Facility Charges – Includes: (1) Diagnostic tests to detect COVID-19, approved by the FDA, including the administation of such tests; and (2) Items and services furnished during office visits, urgent care center vists, and emergency room vists that result in an order for a COVID-19 diagnostic test, provided items and services relate to the provision of the test or evalution of whether a test is needed.	100%	100% of the negotiated rate (if applicable) or the Provider's posted Cash Price on the Provider's public internet website (as required to be posted by the CARES Act).
COVID-19 Vaccines approved for distribution and use by the FDA	100%	Not covered.
Flu Vaccine	100%	Not covered.
Telehealth through MDLive Online	100%	100%

Special Notice Regarding Maternity Benefits: Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans may not, under Federal law, require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of

48 hours (or 96 hours).

(c) Utilization Management and Review

See Article 3, §3.3(c) for a description of Utilization Management and Review.

(d) Exclusions and Limitations

All Exclusions and Limitations set forth at Article 3, §3.3(d) apply to benefits provided under this Article 3A, as well as all other restrictions to coverage set forth in this Plan. In addition, the following is not covered by this Plan:

Examination, preparation, fitting, or procurement of hearing aids.

(e) Medicare Eligibility

In the event coverage is not yet in place under Article 18, coverage for Medicare eligible Participants and Dependents is provided as set forth in this section.

The Fund provides limited benefits intended to complement Medicare coverage for Medicare eligible Participants and Dependents. In the event either a Medicare eligible Participant/Dependent does not obtain Medicare coverage or Medicare does not cover a particular claim, this Plan will not pay more than the limited benefits set forth below. In other words, this Plan pays only the limited benefits set forth below as if Medicare coverage is available, even if it is in fact not available.

(1) Retirees, Spouses and Surviving Spouses

For Medicare eligible Retirees, Spouses and Surviving Spouses ("Medicare Eligible Participants"), Medicare is primary and the Fund will pay for supplemental Medicare coverage only as set forth below:

(A) For those items covered by Medicare Part A (hospitalization), the Fund will only reimburse the Medicare inpatient deductible and daily co-insurance. Fund will cover up to 275 additional days in hospital not covered by Medicare subject to terms and limitations set forth above in §§3A.3(b) and (d).

(B) For those benefits covered by Medicare Part B (medical insurance), the Fund will pay 20% of Medicare's approved allowance and the Medicare calendar year deductibles, with the exception that the Fund will not pay any amount for physician office services (office visits, home visits, and office consultations). Subject to the terms of this section 3A.3(e)(1), prescription drugs will be covered under the same terms as coverage is provided for

non-Medicare eligible participants.

The Fund only coordinates benefits with Medicare, as set forth above.

The Fund will not pay for any service, item, or expense that is not a Medicare eligible expense, including claims incurred outside of the United States (see paragraph (4), below).

All claims will be processed as if the Medicare Eligible Participant has obtained Medicare Parts A and B, even if such coverage is not in place. Thus, it is strongly recommended that a covered person contact the Social Security Administration at least 4 months before they will reach age 65.

This complementary coverage will terminate when with reasonable diligence, as determined in the sole and exclusive discretion of the Trustees, the covered person should have Medicare Parts A and B in effect, but in no event more than 12 months after the date such coverage could have been obtained. If a covered person fails to obtain Medicare Parts A and B within this time frame, he/she will lose all coverage (medical, prescription drug, dental, life, employee assistance, and vision) under the Fund and will not be allowed at any time in the future to reinstate coverage.

(2) Permanent and Total Disability Employees

A Participant suffering from a disability becomes eligible for Medicare, regardless of age, after receiving Social Security Disability payments for 2 years. Such a Participant is required to apply for Medicare benefits as soon as he becomes eligible for them. A Spouse who becomes entitled to Medicare due to disability is also required to enroll in Medicare Parts A and B upon eligibility. Once Medicare eligibility could have been obtained, even if it is not, coverage under the Plan will be limited and coordinated with Medicare subject to all the provisions set forth in paragraph (1), above. In other words, the Plan will not pay for benefits which would have been paid for by Medicare had it been timely applied for and obtained. Thus, it is strongly recommended that the Social Security Administration be contacted as soon as possible regarding Social Security Disability payments.

(3) Dialysis Patients

After a period of time, Medicare becomes the primary insurer for an individual who needs a regular course of dialysis treatment or a kidney transplant because of renal disease. Any Covered Person receiving such treatment should contact the Social Security Administration as soon as

possible to obtain information regarding Medicare eligibility and take appropriate steps to become eligible for Medicare benefits. Once eligibility could have been obtained, even if it is not, the Plan will be primary (i.e. will provide benefits) only to the extent required by the Medicare's Secondary Payer rules.

(4) Claims Incurred by Medicare Participants Outside of United States

Medicare does not pay for claims incurred outside of the United States and, therefore, the Fund will not provide coverage either. If a Participant or Dependent is traveling outside of the United States, he/she must obtain a private short term insurance policy to ensure coverage.

(5) Medicare Secondary Payer Rules

To the extent that Medicare Secondary Payer Rules are applicable to a Medicare eligible individual who has coverage by virtue of current employment status or is Medicare eligible due to End Stage Renal Disease, please see §6.2(e), below.

(f) Benchmark Plan for purposes of defining Essential Health Benefits.

The Plan is a grandfathered health plan under the Patient Protection and Affordable Care Act, PPACA, Pub. L. No. 111-148 §1251(a) and 10103 (2010) as amended by HCERA, Pub. L. No. 11-152 (2010). Grandfathered health plans are prohibited from imposing annual and lifetime dollar limits on any essential health benefits they offer. PPACA, Pub. L. No. 111-148 §1251(a)(4)(A)(ii) - (B)(i)(2010). Therefore, the Plan adopts the Utah state benchmark plan for purposes of defining essential health benefits.

3A.4 Vision Benefits

(a) Benefits

The Fund provides the vision benefits set forth at Article 3, §3.4 for Non-Detroit Participants and their Dependents.

(b) Opt-Out

At any time a Participant may decline all vision benefits under Section 3A.4(a).

3A.5 Dental Benefits

(a) Preferred Provider Organization

The Fund has entered into agreements with preferred dental provider

organizations, which provide that the preferred provider organization network will charge reduced fees to covered persons. The Fund reimburses a higher percentage of in network provider charges than out of network provider charges. However, it is always the Covered Person's choice as to which Provider to use.

A list of Participating Providers will be given to Plan Participants upon request and is available for inspection at the Plan Office. See Article 19 for contact information.

(b) Benefits

(1) Dental Benefit

The total benefits payable for all Dental Benefits (Routine Oral Examination Benefit and Basic Dental Benefit) shall be $1,200 per Covered Person per calendar year. Subject to this $1,200 maximum and the exclusions in paragraph (3), below, the following chart summarizes the dental benefits provided. The percentages refer to the percentage of the cost for a particular benefit that will be paid by the Fund; the balance is the Covered Person's responsibility. "R&C" means "Reasonable and Customary" charges, as defined in §3A.3(b). The $1,200 annual maximum will not apply to covered persons age 18 and under.

Routine Oral Examination Benefit

In Network: 50%
Out of Network: 50% R&C

- Exams: Limited to one diagnostic oral examination and related consultations every 6 months. This includes the cleaning and scaling of teeth.
- Fluoride Applications: Limited to one application every 6 months.
- Phrophylaxis: Limited to one application every 6 months.
- X-Rays - Dental: Full month or panoramic x-ray (or an equivalent) is covered only once every 3 years. Bitewing x-rays, extraoral x-rays and occlusal interoral x-rays are each limited to 2 sets every 6 months.

Basic Dental Benefit

In Network: 50%
Out of Network: 50% R&C

- Initial Complete Dentures
- Replacement of complete dentures. No replacement shall be allowed for stolen/lost dentures. No benefits will be paid for the replacement of dentures that were paid for, in whole or in part, by this Plan, unless five years have elapsed from such

treatment. • Fillings • Crowns • Partial Dentures and Bridges • Extractions and other oral surgery • Periodontal Treatment • Root Canal Therapy
Core Vent Implants In Network: 100%, to maximum lifetime benefit of $5000* Out of Network: First $1000 reimbursed 100% of R&C, and then at 75% of R&C to maximum lifetime benefit of $5000* *These limits will not apply to covered persons age 18 and under.

(2) Orthodontic Benefit

This benefit is for Active Employees and their Dependents only. Benefits are payable as follows after submission of a treatment plan:

In-Network Provider:	75% of Covered Charges
Out of Network Provider:	75% of R&C
Lifetime Maximum per person:	$2,000

Orthodontic Benefits are paid on a monthly basis as the expense is incurred. An allowance will not be made for advance payments, except for the initial fee or for the fitting of appliances.

(c) Exclusions and Limitations

All exclusions and limitations set forth in 3A.3(d) apply to dental and orthodontic benefits.

(d) Opt-Out

At any time a Participant may decline all dental/orthodontic benefits under §3A.5(b).

3A.6 Prescription Drug Benefits

(a) Provider Network/Prescription Drug Card

The Fund has contracted with a prescription drug service for the administration of the prescription drugs for Participants and their Dependents. See Article 19 for contract for information. To receive coverage, a Covered Person must obtain prescription drugs at a pharmacy in the service provider network (a "Participating

Pharmacy"). A list of such pharmacies is available at the Plan Office. Covered persons must present their identification card at participating pharmacies for benefits.

(b) Covered Drugs

The following drugs are covered under this program:

Federal Legend Drugs
Insulin/Insulin Syringes/Diabetic Supplies (Blood/Urine sugar testing equipment (i.e. Chemstrips, Lancets))
Compounds
Retin-A (only if the Covered Person submits documentation from his/her Physician verifying that it is has not been prescribed for wrinkles and is Medically Necessary for the treatment of an Illness)
Miscellaneous Injectible Drugs (including Imitrex), with a $100.00 co-payment for each 34-day supply
Prescription Vitamins, including injectible B-12
Injectable Bee Sting kits
COVID-19 vaccines approved for distribution and use by the FDA and Flu vaccines (COVID-19 vaccines and Flu vaccines covered 100% in-network only).

(c) Excluded Drugs

The following Drugs are excluded under this program:

Cosmetic Drugs
Over the Counter products
Injectible Growth Hormones
Injectible Allergens
Smoking Cessation Drugs
Oral and Injectible Fertility Agents
Viagra
Non-insulin syringes and glucose monitors
Contraceptive Devices
Oral and Injectable Contraceptives (unless medically necessary for treatment of a medical condition, with the understanding that the prevention of pregnancy in and of itself is not a "medical condition" for purposes of this exception)
Anti-obesity agents
Appliances (for example, canes, crutches, wheelchairs, braces, splints, bandages, dressings, heat devices, etc.)
Injectable Immunomodulators (subject to section 3A.6(d)(3), below)
Singulair, unless the Covered Person presents a letter from his or her physician stating that the Singulair is prescribed for the treatment of asthma or for the treatment of symptoms in conjunction with cancer treatment

Raptiva
Allergy serum
General anesthetic
Levitra
Cialis
Bulk powders

(d) Additional Limitations

(1) All limitations for medical benefits, set forth at §3A.3(d), apply to the prescription drug benefits.

(2) **Special Limitations Regarding Injectible Immunomodulators**

The following Injectible Immunomodulators will be covered only under a specialty pharmacy program, with a $130.00 co-payment for each 34-day supply:

Interferon/Intron-A	Enbrel
Pegasys/Peg-Intron	Remicade
Orencia	Revlimid
Humira	Mitoxantron/Novantrone
Kineret	Thalomid

All other Injectible Immunomodulators are excluded from coverage.

(3) All specialty drugs must be filled at Orchard Specialty Pharmacy.

(4) Certain drugs require prior authorization or are subject to step therapy before coverage will be approved. This list of drugs is subject to change from time to time in the sole discretion of the Trustees.

(5) Compound drugs costing over $200 require letters of medical necessity before coverage will be approved.

(6) Certain drugs are subject to quantity limits. This list of drugs, and quantity limits, are subject to change from time to time in the sole discretion of the Trustees.

(e) Co-Payments

Drugs may be filled at a retail pharmacy for a 34-day supply for a $15.00 co-pay for Generic drugs and a $25.00 co-pay for Brand Name drugs (regardless of whether a Generic is available). If a Covered Person receives a Brand Name Drug for a drug that has a Generic equivalent, in addition to the $25.00 co-payment, he/she must pay the difference in the cost between the Brand Name and

Generic drugs.

Drugs may be filled via mail order or at a retail pharmacy for a 90-day supply, for a $25.00 co-pay for Generic drugs and a $50.00 co-pay for Brand Name drugs (regardless of whether a Generic is available). If a Covered Person receives a Brand Name Drug for a drug that has a Generic equivalent, in addition to the $50.00 co-payment, he/she must pay the difference in the cost between the Brand Name and Generic drugs.

If a Participant or Dependent pays cash for a drug that is covered by the Plan, the Fund will reimburse the Covered Person, excluding any applicable co-payment. Request for reimbursement must be submitted to the prescription drug service within 90 days of payment.

See section 3A.6(d)(3), above, for special co-payments pertaining to Injectible Immunomodulators.

(f) Medicare Eligible Participant or Dependent

Any Medicare eligible Participant or Dependent who enrolls in Medicare Part D will lose prescription drug coverage provided by the Fund.

3A.7 Employee Assistance

Please refer to section 3.7 for a description of benefits.

3A.8 Definitions

See section 2A.7 for definitions applicable to this Article 3A and Article 2A.

ARTICLE 4: CLAIMS SUBMISSION AND APPEAL PROCEDURE

4.1 Types of Claims Covered

These procedures are to be used for all benefits available under the Fund, except life insurance benefits. Appeals for life insurance benefits must be resolved pursuant to the procedure set forth in the life insurance policy.

Urgent health claims: claims that require expedited consideration in order to avoid jeopardizing the life or health of the Claimant or subjecting the Claimant to severe pain;

Pre-service health claims: for example, pre-certification of a hospital stay or predetermination of dental coverage;

Post-service health claims: for example, Claimant or his Physician submits a claim after claimant receives treatment from Physician;

Concurrent claims: claims for a previously approved ongoing course of treatment subsequently reduced or terminated, other than by plan amendment or plan termination; and

Disability Claims: initial claims for disability benefits or any rescission of coverage of a disability benefit.

4.2 Initial Submission of Claims

Eligible expenses will be reimbursed for the Plan Year in which they were incurred, even if submission of a claim occurs following that Plan Year. Claims must be submitted within 12 months of the date incurred. However, when a Participant or Dependent's coverage terminates for any reason, written proof of claim must be submitted within 90 days of the date of termination of coverage.

Most expenses will be submitted by the provider directly to the Fund. In the event it is not, a claimant must complete a claim form and submit it Roofers Local 149 Security Benefit Trust Fund Plan Office, P.O. Box 396, Troy, Michigan 48099-0396, (248) 641-4949 or (888) 868-6411. Claim forms are available at the Plan Office. All claims must include (1) a written statement from an independent third party verifying that a medical expense in a specified amount has been incurred, and (2) a written statement from the Participant that the expense has not been reimbursed by or is not reimbursable under any other health plan coverage.

The Plan will disregard the Outbreak Period for purposes of determine the date within which a Claimant must file a benefit claim.

4.3 Notice That Additional Information is Needed to Process Claim

After the claim is submitted, the Plan deadline to provide notice to Claimant that the claim is incomplete (with explanation of additional information is necessary to process claim) is:

For Urgent Health Claims – 24 hours after receiving improper claim
For Pre-Service health claims – 5 days after receiving improper claim.

After receipt of notice from Plan that claim is incomplete, this is the Claimant's deadline to supply the Plan the information requested to complete claim:

For Urgent Health Claims – 48 hours after receiving notice
For Pre-Service Health Claims – 45 days after receiving notice
For Post-Service Health Claims – 45 days after receiving notice
For Disability Claims – 45 days after receiving notice.

4.4 Initial Decision On A Claim

(a) Additional Evidence

(1) The Fund must provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Fund (or at the direction of the Fund) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of the adverse benefit determination is required to be provided under (b), below, to give the Claimant a reasonable opportunity to respond prior to that date; and

(2) Before the Fund can issue an initial benefit determination based on a new or additional rationale, the Claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of the adverse benefit determination is required to be provided under (b), to give the claimant a reasonable opportunity to respond prior to that date.

(b) The Plan Deadline For Making An Initial Decision On A Claim

For Urgent Health Claims – 72 hours after receiving initial claim, if it was complete; or 48 hours after receiving completed claim or after the 48-hour claimant deadline for submitting information needed to complete claim, whichever is earlier.

For Pre-Service Health Claims – 15 days after receiving the initial claim. A 15-day extension permitted is Plan needs more information and it has provided notice of same to Claimant during initial 15 day period. Plan deadline for responding is tolled while awaiting requested information from Claimant.

For Post-Service Health Claims – 30 days after receiving initial claim. A 15-day extension permitted if Plan needs more information and has provided notice of same to claimant during initial 30 day period. Plan deadline for responding is tolled while awaiting requested information from Claimant.

For Disability Claims – 45 days after receiving the initial claim. A 30-day extension permitted if Plan needs more information and has provided proper notice of same to Claimant. An additional 30-day extension is permitted if the Plan needs more information and has provided notice of same to claimant during first 30-day extension. Plan deadline for responding is tolled while awaiting additional information from Claimant.

(c) Information to be Included in Benefit Denials

Notice of a benefit denial will include:

- the specific reasons for the denial;
- the specific Plan provision or provisions on which the decision was based;
- if applicable, what additional material or information is necessary to complete the claim and the reason why such material or information is necessary;
- a description of the Plan's appeal procedures (including a statement of the Claimant's right to bring a civil action after a further denial on appeal);
- the internal rule or similar guideline relied upon in denying the claim or, if applicable, a statement that such rules or guidelines do not exist; and,
- if the denial was based on medical necessity, experimental nature of treatment or similar matter, an explanation of same.

With respect to benefit denials for disability claims only, the benefit denial must also include the following:

- an explanation of the basis for disagreeing with any of the following:
  - The health care professionals that treated the Claimant;
  - The advice of the health professional obtained by the Plan; or
  - A disability determination from the Social Security Administration.

- a statement that the Claimant is entitled to receive, free of charge and upon request, reasonable access to copies of all documents, records, and other information relevant to the claims for benefits.
- The benefit denial must be in a culturally and linguistically appropriate manner.

(c) Approved Ongoing Course of Treatment

Benefits for an approved ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review.

4.5 Submission of Appeals

An appeal is a written request to the Trustees setting forth issues to consider related to the benefit denial, along with any additional comments the claimant may have. A Claimant, free of charge and upon request, shall be provided reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Claimants are entitled to two appeals. The first appeal ("Level 1 Appeal") is to be submitted to the Plan Manager at P.O. Box 396, Troy, Michigan 48099-0396. The second and final appeal ("Level 2 Appeal"), is to be submitted to the Board of Trustees at

the same address.

The reviews on appeal shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. In deciding the second appeal, the Trustees will not provide deference to the decision of the Plan Manager on the first appeal.

Level 1 Appeals must be submitted in the time frames set forth below:

For Urgent Health Claims – 180 days after receiving denial.

For Pre-Service Health Claims - 180 days after receiving denial.

For Post-Service Health Claims – 180 days after receiving denial.

For Concurrent Claims – Claimant must be given enough time to appeal decision before termination effective.

For Disability Claims – 180 days after receiving denial.

Level 2 Appeals must be submitted within 60 days of a denial of the Level 1 Appeal.

ALL APPEALS MUST BE TIMELY SUBMITTED. A CLAIMANT WHO DOES NOT TIMELY SUBMIT AN APPEAL WAIVES HIS/HER RIGHT TO HAVE THE BENEFIT CLAIM SUBSEQUENTLY REVIEWED BY THE PLAN OR IN A COURT OF LAW.

The Plan will disregard the Outbreak Period for purposes of determining the date within which a Claimant must file an Appeal.

4.6 Notice of Decision on Appeal

The notice of a decision on appeal will include:

- The specific reasons for the denial;
- The specific Plan provision or provisions on which the decision was based;
- A statement that the Claimant is entitled to receive, free of charge, copies of all documents and other information relevant to the claim for benefits;
- if the denial was based on medical necessity, experimental nature of treatment, or similar matter, an explanation of same;
- The internal rule or similar guideline relied upon in denying the claim or, if applicable, a statement that such rules or guidelines do not exist;
- A statement of the Claimant's right to bring a civil action under ERISA;
- A statement describing any contractual limitation period that applies to a Claimant's right to bring an action under ERISA §502(a) and the calendar date on

which such contractual limitation expires;

- 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."

Before the Fund can issue a notice of decision on appeal with respect to disability benefits based on new or additional evidence, the Fund must provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Fund (or at the direction of the Fund) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of decision on appeal is required to be provided, above, to give the Claimant a reasonable opportunity to respond prior to that date.

Before the Fund can issue a notice of decision on appeal with respect to disability benefits based on a new or additional rationale, the Claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of the adverse benefit determination is required to be provided to give the Claimant a reasonable opportunity to respond prior to the date.

In addition, a notice of decision on appeal pertaining to a claim for disability benefits will include the following:

- An explanation of the basis for disagreeing with any of the following:
  - The health care professionals that treated the Claimant;
  - The advice of the health professional obtained by the Plan; or
  - A disability determination from the Social Security Administration.
- The benefit denial must be in a culturally and linguistically appropriate manner.

The deadline for deciding Level 1 Appeals is:

For Urgent Health Claims – 72 hours after receiving appeal.

For Pre-Service Health Claims – 15 days after receiving the appeal.

For Concurrent Claims – Prior to termination of previously approved course of treatment.

For Post-Service Health Claims – 30 days after receiving the appeal.

For Disability Claims – 30 days after receiving the appeal.

The deadline for deciding Level 2 Appeals is:

For Urgent Health Claims – 72 hours after receiving appeal.

For Pre-Service Health Claims – 15 days after receiving the appeal.

For Concurrent Claims – Prior to termination of previously approved course of treatment.

For Post-Service Health Claims – The Trustees shall decide the appeal at a Board Meeting.*

For Disability Claims – The Trustees shall decide the appeal at a Board Meeting.*

* Reference to decisions made at a Trustee Board Meeting means the appeal will be decided at the first meeting following receipt of an appeal, unless the appeal is filed within 30 days preceding the date of such meeting. In such case, the decision may be made no later than the date of the second Board Meeting following the Trustees receipt of the appeal. If special circumstances require a further extension, upon due notice to the Claimant, the decision shall be made no later than the third board meeting following receipt of appeal. The Plan shall notify the Claimant of the Trustees decision on appeal no later than 5 days after the decision is made.

4.7 Discretion of Trustees

The Trustees have full discretionary authority to determine eligibility for benefits, interpret plan documents, and determine the amount of benefits due. Their decision, if not in conflict with any applicable law or government regulation, shall be final and conclusive.

4.8 Limitations of Actions

No action may be brought if a Claimant has failed to exhaust the claims and appeal procedures set forth herein. No action may be brought to recover benefits allegedly due under the terms of the Plan more than 180 days following the Notice of Decision on Appeal.

4.9 Failure to Follow Claims Procedures

If the Plan fails to follow claims procedures with respect to any claim for benefits, the Claimant is deemed to have exhausted administrative remedies and is entitled to pursue all remedies under ERISA §502(a) on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits.

In addition to the above, if the Plan fails to strictly adhere to all procedures with respect to a claim for disability benefits and the Claimant chooses to pursue remedies under ERISA §502(a), the claim is deemed denied on review without the exercise of discretion by the Trustees.

Notwithstanding the above, the internal claims and appeals process will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant.

The Claimant may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within 10 day, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted.

If an external reviewer or a court rejects the Claimant's request for immediate review on the basis that the Plan met the standards for the exception to the deemed exhaustion rule, the Claimant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed ten days), the Plan shall provide the Claimant with the notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon Claimant's receipt of such notice.

4.10 Avoiding Conflicts of Interest

The Fund must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartially of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matter with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

ARTICLE 5: NOTICE OF CHANGES

In addition to other notice requirements set forth in the Plan, the Plan Office must be notified of any change as follows:

5.1 **Change of Address**. Any change of address, or name change, shall be reported immediately.

5.2 **Deaths**. Deaths should be reported immediately. A certified copy of the death certificate is required.

5.3 **Divorce**. Divorce must be reported immediately by a Participant and his former Spouse and a copy of the Judgment of Divorce must be filed in the Fund Office. A former spouse is not eligible for benefits commencing on the date of the divorce, except as provided under the Continuation of Coverage (COBRA) Provision. Eligible dependent Children will continue to be covered if they continue to be legal dependents.

ARTICLE 6: COORDINATION OF BENEFITS

6.1 Application

(a) This provision shall apply in determining the benefits for an Allowable Expense, if the sum of:

(1) the benefits that would be payable under the Plan in the absence of this provision; and

(2) the benefits that would be payable under any other plan in the absence of a coordination of benefits provision, would exceed such Allowable Expense payable under this Plan.

(b) As to any Plan Year to which this provision is applicable, the benefits that would be payable under the Plan in the absence of this provision shall be reduced to the extent necessary so that the sum of such reduced benefits and the benefits payable for such Allowable Expenses under another plan(s) shall not exceed the total Allowable Expenses under this Plan. Benefits payable under another plan include the benefits that would have been payable had the claim been duly filed under that plan.

(c) Notwithstanding anything in this section to the contrary, a Participant or Dependent will never receive less if covered by two or more plans than he would receive if covered by this Plan alone; provided, however, that this Plan will pay no more than an amount which would bring total coverage up to the amount which would have been provided under this Plan.

(d) For the purpose of coordination of benefits with other plans, as allowed by applicable law the Plan Administrator shall retain the right, without the consent of or notice to any person, to release or to obtain from any insurance company or other organization or person, any information, with respect to any Participant or Dependent, which the Plan Administrator deems to be necessary for the purpose of implementing this provision. Any person claiming benefits under the Plan shall furnish to the Plan Administrator such information as may be necessary to administer this provision and as allowed by applicable law.

(e) Whenever payments have been made by the Plan with respect to Allowable Expenses in a total amount which is at any time in excess of the maximum amount of payment necessary at that time to satisfy the requirements of this provision, the Fund the right to recover such excess payments from among one or more of the following: any persons to or for, or with respect to whom such payments were made; any insurance companies; or any other organizations.

6.2 Coordination

Another plan without a coordinating provision shall always be deemed to be the primary Plan. If another plan has a provision that makes this Plan primary, then:

(a) The plan covering the patient directly as an insured, employee or retiree, rather than as a dependent, is primary and the other is secondary.

(b) If a child is covered under both parents' plans, the plan that covers the parent whose birthday occurs earlier in the calendar year shall be considered the primary plan.

(c) If neither 1 nor 2 applies, the plan covering the patient longest is primary.

(d) With respect to dependents of divorced parents, the above shall not apply and the following shall replace it:

(1) if there is a court decree, the plan that covers the dependent of the parent with responsibility to do so pursuant to such decree shall be primary;

(2) if (1) does not apply, the plan covering the parent with custody of the dependent shall be considered the primary plan;

(3) the plan covering the spouse, if any, of the parent with custody of the dependent will be secondarily liable;

(4) the plan covering the parent without custody shall be considered last;

(5) if none of the foregoing apply, coordination of benefits shall be determined in accordance with the Michigan Coordination of Benefits Act (MCL 550.251, et seq.), or any successor law.

(e) Benefits will be coordinated with Medicare according to the Medicare Secondary Payer (MSP) Rules when applicable.

The following addresses specific situations where MSP Rules are applicable and benefits are being provided by the Fund under §§3.3(e) or 3.3A(e):

(1) Coordination with Coverage By Virtue of Current Employment Status

In the event a Medicare-eligible Covered Person is eligible under one plan as a dependent (for example, a dependent of an actively employed spouse) and another plan other than as a dependent (for example, a Pensioner under this Plan), and as a result of the Medicare Secondary Payer Rules, Medicare is

(A) Secondary to the plan covering the Covered Person as a dependent, and

(B) Primary to the plan covering the Covered Person other than as a dependent,

then benefits of the plan covering the Covered Person as a dependent are primary to those of the plan covering the Covered Person other than as a dependent. For example, if a Pensioner is covered as a dependent under a plan covering his/her Spouse as an active employee, then the benefits of the Spouse's plan are primary to the benefits provided by this Plan (and in no event will this Plan pay more than the complementary Medicare coverage set forth in §3.3(e) or §3.3A(e)).

(2) End Stage Renal Disease

After a period of time, Medicare becomes the primary insurer for an individual who needs a regular course of dialysis treatment or a kidney transplant because of renal disease. Any Participant or Dependent receiving such treatment should contact the Social Security Administration as soon as possible to obtain information regarding Medicare eligibility and take appropriate steps to become eligible for Medicare benefits. Once eligibility could have been obtained, even if it is not, the Plan will be primary (i.e. will provide benefits) only to the extent required by Medicare's Secondary Payer rules.

(f) With respect to a Participant or Dependent on COBRA Continuation of Coverage from any other plan, this plan will be secondary.

(g) If a Covered Person is primarily covered by a health maintenance organization, preferred provider organization or similar plan, and such plan requires that health care services only be obtained from certain providers and/or organizations, then benefits will be provided by this Plan only if the Covered Person has complied with any such rules. In other words, the Covered Person must comply with all rules of the Plan under which he/she is primarily covered in order to receive any benefits from this Plan. If he/she fails to do so, this Plan will not provide any coverage, even on a secondary basis.

(h) This Plan will only pay secondary for benefits arising from a motorcycle accident where the patient is covered under any policy providing benefits for injuries arising from such accidents.

6.3 Right to Receive and Release Necessary Information

For the purposes of determining the applicability of and implementing the terms of this Article of this Plan or any provision of similar purpose of any other Plan, consistent with applicable law the Fund may release to or obtain from any other insurance company or

other organization or person any information, with respect to any Covered Person, which the Fund deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Fund such information as may be necessary to implement this provision.

6.4 Right of Recovery

Whenever payments have been made by the Fund with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payable under this section, the Fund shall have the right to recover such payments to the extent of such excess, from one or more of the following as the Fund shall determine: any persons on whose behalf such payments were made; any person or entity to whom such payments were made; any other insurance companies; or any other organizations.

ARTICLE 7: SUBROGATION AND RECOUPMENT

7.1 In General

Subrogation means the Plan has the right to recover from a Covered Person those amounts paid by the Plan for medical care or other expenses due to an injury caused by a third party (for example, another person or company). To the extent benefits are paid by the Plan to a Covered Person for medical, dental, wage loss, or other expenses arising out of such an injury, the Plan is subrogated to any claims the Covered Person may have against the third party who caused the injury.

The Plan's right of subrogation applies to any amounts recovered, whether or not designated as reimbursement for medical expenses or any other benefit provided by the Plan. The right of subrogation applies regardless of the method of recovery, i.e. whether by legal action, settlement or otherwise.

The Plan's right to subrogation applies regardless of whether the injured Participant or Dependent has been fully compensated, or made whole, for his or her losses and/or expenses by the third party or insurer, as the Plan's right to subrogation applies to any full or partial recovery. This provision is intended to make it clear that this provision shall apply in lieu of the "make whole" doctrine. The Plan has first priority to any funds recovered by the injured Covered Person from the third party or insurer.

The Plan also has a lien on any amounts recovered by a Participant or Dependent due to an injury caused by a third party, and such lien will remain in effect until the Plan is repaid in full for benefits paid because of the injury.

7.2 Conditions to Payment of Benefits

If a Covered Person sustains an injury caused by a third party, the Plan will pay benefits related to such injury (provided such benefits are otherwise properly payable under the terms and conditions of the Plan), provided all the following conditions are met:

(a) As soon as reasonably possible, the Covered Person must notify the Plan Office that he or she has an injury caused by a third party.

(b) Prior to the receipt of benefits for such injury, the injured Covered Person must assign to the Plan his or her rights to any recovery arising out of or related to any act or omission that caused or contributed to the injury. If such assignment is not made before the receipt of benefits, then the receipt of benefits automatically assigns to the Plan any rights the Participant or Dependent may have to recover payments from any third party or insurer. (If the recovery so assigned exceeds the benefits paid by the Plan, such excess shall be delivered to the Covered Person or other person as required by law.)

(c) The Covered Person does not take any action that would prejudice the Plan's subrogation rights.

(d) The Covered Person cooperates in doing what is necessary to assist the Plan in any recovery, which includes but is not limited to executing and delivering all necessary instruments and papers.

7.3 Right to Pursue Claim

The Plan's subrogation rights allows the Plan to directly pursue any claims the Covered Person has against any third party, or insurer, whether or not the Covered Person chooses to pursue that claim.

7.4 Enforcement

If it becomes necessary for the Plan to enforce this provision by initiating any action against the Covered Person, the Covered Person agrees to pay the Plan's attorney's fees and costs associated with the action regardless of the action's outcome.

At the Plan's option, it may enforce this provision by deducting amounts owed from future benefits.

7.5 Rescission of Coverage

The Fund will rescind the coverage of any person who defrauds the Plan or makes an intentional misrepresentation of material fact. A 30-day notice of rescission will be provided, but termination of coverage will be retroactive to the date coverage should or would have been terminated if the fraud or intentional misrepresentation had not occurred (Date of Rescission). The intent of this provision is to rescind coverage to the full extent allowed by federal law.

Providing false information to maintain or obtain coverage, or knowingly cooperating in any actions designed to provide false information to maintain or

obtain coverage, is an example of a fraud or intentional misrepresentation of material fact. Examples of fraud or intentional misrepresentation of material fact also include, but are not limited to, failing to inform the Fund Office of: (1) a divorce or legal separation, (2) lapsed Union membership, which is required to maintain Retiree coverage, (3) a Surviving Spouse has remarried or become eligible for other coverage, (4) a Participant or Dependent is covered under another health plan, (5) employment with a noncontributing employer, (5) any other event which makes a Participant or Dependent ineligible for coverage, or (6) continuing to use the benefit cards after eligibility is terminated.

In the event coverage is rescinded, in addition to any legal and equitable means of recovery available, the Plan has the right to pursue the Participant or Dependent, jointly and severally, for the full amount paid for such coverage from the date of cancellation, including all costs and attorney's fees, expended in collecting the amount owed. At the Plan's sole option, it may enforce this provision by offsetting future benefits until the amount owed has been recovered.

Nothing in this section limits the rights of the Plan to prospectively terminate coverage where such coverage was previously provided as a result of a mistake, intentional misrepresentation, or fraud. Further, nothing in this section limits the rights of the Plan to cancel coverage retroactively for failure of a Participant or Dependent to make a self-payment, where there has been a reasonable delay in terminating coverage due to administrative recordkeeping.

ARTICLE 8: COBRA

8.1 Introduction

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to participants and their dependents when they would otherwise lose group health coverage.

8.2 Nature of COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A participant, his spouse, and dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

A participant will become a qualified beneficiary if coverage is lost under the Plan because either one of the following qualifying events happens:

(1) Hours of employment are reduced such that hours are insufficient to maintain eligibility, or

(2) Employment ends for any reason other than gross misconduct.

The spouse of a participant will become a qualified beneficiary if coverage is lost under the Plan because any of the following qualifying events happens:

(1) Death of spouse;

(2) Spouse's hours of employment are reduced such that hours are insufficient to maintain eligibility;

(3) Spouse's employment ends for any reason other than his or her gross misconduct;

(4) Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

(5) Divorce or legal separation from the participant.

Dependent children become qualified beneficiaries if coverage is lost under the Plan because any of the following qualifying events happens:

(1) The parent-participant dies;

(2) The parent-participant's hours of employment are reduced such that hours in the hour bank are insufficient to maintain eligibility;

(3) The parent-participant's employment ends for any reason other than his or her gross misconduct;

(4) The parent-participant becomes entitled to Medicare benefits (under 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."

8.3 When COBRA Coverage Is 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 death of the participant, the employer must notify the Plan

Administrator of this qualifying event within 30 days of the death. The Plan Administrator will monitor whether a qualifying event has occurred due to reduction in hours, termination of employment, or Medicare eligibility.

8.4 Participant/Spouse Obligation to Give Notice to Plan of Certain Qualifying Events

In the event of divorce or a dependent child loses eligibility for coverage as a dependent child (for example, exceeds age limitations), or if after COBRA coverage is elected a qualified beneficiary becomes covered under another group health plan, the participant and his spouse both have an obligation to notify the Plan Administrator of such event within 60 after this qualifying event occurs. This notice must include: the name of the participant, the social security number of the participant, the name of the qualified beneficiaries (for example, a former spouse after divorce or a child no longer eligible for coverage as a dependent), the qualifying event (for example, the date of a divorce), and the date on which the qualifying event occurred. If timely notice is not provided, the right to COBRA coverage is forfeited.

Further, failure to timely notify the Plan of a divorce or a child losing eligibility gives the Plan the right to hold the participant and his/her spouse separately and fully liable for any benefits paid by the Plan which would not have been paid had the Plan received timely notification of such event. At its sole election, the Plan may suspend the payment of future benefits until such amount has been recovered.

The Plan will disregard the Outbreak Period for all participants and dependents in determining the date by which individuals must notify the plan of a qualifying event or disability.

8.5 How COBRA Coverage Is Provided

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries within 14 days. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered participants may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

The COBRA notice will contain information regarding the premium that must be paid for COBRA coverage, which is 102% of the cost to the Plan for such coverage. If the period of COBRA coverage is extended due to disability, discussed below, the premium is 150% of the cost to the Plan.

Coverage under the Plan will be terminated upon the occurrence of a qualifying event and will be retroactively reinstated to the date of the qualifying event once a qualified beneficiary elects COBRA continuation coverage and pays the applicable premium. See §8.7 below regarding the election period for COBRA coverage.

The Plan will disregard the Outbreak Period for all participants and dependents in determining the date by which the Plan must provide the COBRA election notice.

8.6 Duration of COBRA Coverage

COBRA continuation coverage is a temporary continuation of coverage, as follows:

(1) When the qualifying event is the death of the participant, the participant's becoming entitled to Medicare benefits (under Part A, Part B, or both), divorce, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

(2) When the qualifying event is the end of employment or reduction of the participant's hours of employment, and the participant became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the participant lasts until 36 months after the date of Medicare entitlement.

For example, if a participant becomes entitled to Medicare 8 months before the date on which his eligibility 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 8 months).

(3) In all other events, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage 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.

(A) Disability Extension

If the qualified beneficiary or anyone in his family covered under the Plan is determined by the Social Security Administration to be disabled and notifies the Plan Administrator in a timely fashion, all covered family members may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. To obtain this extension, 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.

The Plan Administrator must be notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage.

The Plan Administrator must also be notified of any subsequent determination by the Social Security Administration that the qualified beneficiary is no longer disabled. This notice must be provided within 30 days of such determination.

(B) Second Qualifying Event Extension

If another qualifying event occurs while receiving 18 months of COBRA continuation coverage, the covered spouse and dependent children can get 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 participant or former participant dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced, or if the dependent child stops being eligible under the Plan as a dependent child, but only if such event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

The Plan Administrator must be notified of this second qualifying event within 60 days of such event.

8.7 The Election Period for COBRA Continuation

Qualified beneficiaries have 60 days after receipt of the Election Notice, which will be sent to each qualified beneficiaries' last known address, to elect COBRA continuation coverage. Each qualified beneficiary has an independent right to elect COBRA continuation coverage.

The Plan will disregard the Outbreak Period for all participants and dependents in determining the election period for COBRA continuation coverage.

8.8 Premium Payment for COBRA Coverage

Following an election, a qualified beneficiary has 45 days to pay the initial COBRA premium. If this is not timely paid, coverage will not be reinstated and the qualified beneficiary will not be given a second chance to reinstate coverage.

Payments are thereafter due on the first day of the month of coverage. The postmark will serve as proof of the date paid. There is a 30-day grace period to make such payment. If payments are not made within this period, coverage will terminate and the qualified beneficiary will not be given an opportunity to reinstate coverage.

If, for whatever reason, the Plan pays medical benefits for a month in which the premium was not timely paid, the qualified beneficiary will be required to reimburse the Plan for such benefits.

The premium equals the cost to the Plan of providing coverage plus a 2% administration fee. In the event of extended coverage as a result of a disability for the 19th – 29th months of coverage, the Plan will charge 150% of the cost of providing coverage.

The Plan will disregard the Outbreak Period for all participants and dependents in determining the date by which COBRA premium payments must be made.

8.9 Scope of Coverage

COBRA coverage only pertains to health benefits available under the Plan. Coverage for such benefits under COBRA is the same as those the qualified beneficiary had the day before coverage initially terminated. Coverage may change while on COBRA coverage due to Plan amendments that affect all participants in the plan. A qualified beneficiary may also be able to elect different coverage options during the period of time he is on COBRA coverage, provided such a right is available to similarly situated active employees.

8.10 Enrollment of Dependents During Period of COBRA Coverage and Coverage Options

A child born to, adopted by, or placed for adoption with a Participant during a period of COBRA coverage is considered to be a qualified beneficiary, provided that the Participant has elected continuation coverage for himself/herself. If a Participant desires to add such a child to COBRA coverage, he must notify the Plan Office within 30 days of the adoption, placement for adoption, or birth.

During the COBRA coverage period, a Participant may add an eligible dependent who initially declined COBRA coverage because of alternative coverage and later lost such coverage due to certain qualifying reasons. If a Participant desires to add such a child to COBRA coverage, he must notify the Plan Office within 30 days of the loss of coverage.

8.11 Qualified Medical Child Support Orders

If a Child is enrolled in the Plan pursuant to a qualified medical child support order while the Participant was an active employee under the Plan, he is entitled to the same rights under COBRA as any dependent Child.

8.12 Termination of COBRA Coverage

COBRA continuation coverage terminates the earliest of the last day of the maximum coverage period, the first day timely payment (including payment for the full amount due) is not made, the date upon which the Plan terminates, the date after election of COBRA that a qualified beneficiary becomes covered under any other group health plan, or the date after election if a qualified beneficiary becomes entitled to Medicare benefits

and such entitlement would have caused the qualified beneficiary to lose coverage under the Plan had the first qualifying event not occurred.

In the case of a qualified beneficiary entitled to a disability extension, COBRA continuation coverage terminates the later of: (a) 29 months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination from Social Security that the qualified beneficiary is no longer disabled, whichever is earlier; or (b) the end of the maximum coverage period that applies to the qualified beneficiary without regard to the disability extension.

8.13 Keep the Plan Informed of Address Changes

A participant or his spouse must keep the Plan Administrator informed of any changes in the addresses of family members and is advised to keep a copy of any notices sent to the Plan Administrator.

8.14 Exclusions from COBRA Coverage

Notwithstanding anything in this Article to the contrary:

(a) COBRA coverage will not be offered to a Working Principal (i.e., proprietors, partners, or corporate officers of an Employer and who work with the tools of the trade); or (b) the spouse, child, parent, or sibling of a Working Principal, if the reason for loss of coverage is failure of the Employer to remit required contributions; and

(b) No Participant, or Spouse or Child of such Participant, not included in (a), above, will be allowed to continue coverage by way of COBRA if the Participant fails to obey a strike notice issued as a result of failure of an Employer to pay contributions.

ARTICLE 9: QUALIFIED MEDICAL SUPPORT ORDER

As set forth below, and in accordance with §609 of ERISA, this Plan shall provide benefits as required by a Qualified Medical Support Order.

9.1 Qualified Medical Child Support Order ("QMCSO")

A QMCSO means a medical child support order-

(a) which creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a participant or beneficiary is eligible under a group health plan, and

(b) clearly specifies

(1) the name and the last known mailing address (if any) of the Participant and the name and mailing address of each alternate recipient (i.e. child/ren) covered by the order (except that, to the extent provided in the order, the name and mailing address of an official of a State or a political subdivision thereof may be substituted for the mailing address of any alternate recipient);

(2) a reasonable description of the type of coverage to be provided to each alternate recipient, or the manner in which such type of coverage is to be determined;

(3) the period to which such order applies; and

(4) the plan to which the order applies.

9.2 A medical child support order will fail to be a QMCSO if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of 42 U.S.C. 1396g-1.

9.3 Procedures for Determining Qualified Status of Medical Support Orders.

Upon receipt of a medical child support order, the following procedures will be used when determining whether it is a Qualified Medical Child Support Order pursuant to the terms of ERISA:

(a) The Participant and any potential Alternate Recipients and/or their designated representatives will be immediately notified in writing that the Order has been received by the Fund and has been referred to legal counsel for determination of its status within forty-five (45) days, such notice to include a provision permitting an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the alternate recipient with respect to a medical child support order and a copy of the plan's procedures for determining the qualified status of the order.

(b) The Order will be simultaneously referred to the Fund Attorneys for review and a determination of its status. This determination will be made within forty-five (45) days after receipt of the Order or within any time period that may be established by federal regulations in the future.

(c) After determining the status of an Order, the Participant and Alternate Recipients and/or their designated representatives will be notified in writing. If the QMCSO is acceptable, the Alternate Recipients and/or their designated representative will be informed of the Alternative Recipient's health benefits and of the Plan's procedures to provide benefits.

(d) If the Funds' legal counsel determines that an Order is not a QMCSO, legal

counsel will suggest necessary modifications. During this interim period, the Fund may either provide coverage or wait and provide retroactive coverage once the QMCSO is approved.

Once a child is enrolled in the Fund pursuant to a QMCSO, the Fund cannot disenroll or eliminate coverage unless the Fund is provided with written evidence that the Court or Administrative Order is no longer in effect or that the child will be enrolled in comparable health insurance through another insurer effective no later than the date of the disenrollment.

9.4 National Medical Support Notice Deemed to be a QMCSO

(a) If the Plan receives an appropriately completed National Medical Support Notice and the Notice meets the requirements of §9.1, the Notice shall be deemed to be a QMCSO.

(b) In any case in which an appropriately completed National Medical Support Notice is issued in the case of a child of a participant plan who is a noncustodial parent of the child, and the Notice is deemed under §9.4(a) to be a qualified medical child support order, the Plan Office, within 40 business days after the date of the Notice, shall –

(1) notify the State agency issuing the Notice with respect to such child whether coverage of the child is available under the terms of the plan and, if so, whether such child is covered under the plan and either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent (or by the official of a State or political subdivision thereof substituted for the name of such child pursuant to §9.1(b)(1)) to effectuate the coverage; and

(2) provide to the custodial parent (or such substituted official) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

(c) Nothing in this subparagraph shall be construed as requiring the Plan, upon receipt of a National Medical Support Notice, to provide benefits under the Plan (or eligibility for such benefits) in addition to benefits (or eligibility for benefits) provided under the terms of the Plan as of immediately before receipt of such Notice.

9.5 Any payment for benefits made by the Fund pursuant to a QMCSO in reimbursement for expenses paid by an alternate recipient or an alternate recipient's custodial parent or legal guardian shall be made to the alternate recipient or the alternate recipient's custodial parent or legal guardian.

9.6 The Plan will comply with any other requirements of §609 of ERISA regarding QMCSO.

ARTICLE 10: FAMILY AND MEDICAL LEAVE ACT

Certain Employers are required to continue to make contributions to the Fund on behalf of an employee while such employee is on a medical leave of absence pursuant to the federal Family and Medical Leave Act ("FMLA"). Details concerning FMLA leave are available from the Participant's Employer. Requests for FMLA leave must be directed to such Employer; the Plan cannot determine whether or not a person qualifies for FMLA leave. If a dispute arises between a Participant and his Employer concerning eligibility for FMLA leave, the Participant may continue health coverage by making COBRA payments. If the dispute is resolved in the Participant's favor, the Plan will refund COBRA payments made by the Participant upon receipt of the FMLA-required contributions from the Employer. .

If the Employer continues a Participant's coverage during an FMLA leave and the Participant fails to return to work, he may be required to repay the Employer for all contributions paid to the Plan for such coverage during the leave. Failure to return to work at the end of a FMLA Leave may constitute a Qualifying Event under COBRA.

ARTICLE 11: ABSENCE DUE TO MILITARY DUTY

If coverage under the Plan is terminating due to military service, a Participant may elect to continue the health coverage under the Plan for up to 24 months after the absence begins, or for the period of military service, if shorter. The Participant must notify the Plan Administration Office as soon as he volunteers for or is called to active duty. The maximum premium that will be charged is 102% of the full premium for the coverage. However, if the military service is for 30 or fewer days, the maximum premium will be the self-payment amount.

Upon termination for military duty, a Participant's eligibility shall be frozen, with reinstatement under that same status upon his/her discharge from the military. Exclusions and waiting periods will not be imposed upon re-employment provided coverage would have been afforded had the person not been absent for military service, unless there are disabilities that the Veterans Administration determines to be service related. For these benefits to apply, however, the period of service must be less than 5 years and a Participant must return to work as a Roofer under the Collective Bargaining Agreement within the following time frames:

> For uniformed service of less than 31 days, by the next work day after the end of service plus eight hours, or as soon as possible after the end of the eight-hour period if reporting earlier is impossible through no fault of the Participant.
>
> For service of more than 30 days but less than 181 days, within 14 days of completing the service, or the next full calendar day if returning earlier is impossible through no fault of the Participant.
>
> For service of more than 180 days, within 90 days after completion of the service.

ARTICLE 12: INTERPRETATION OF PLAN DOCUMENTS

The Trustees have full discretionary authority to determine eligibility for benefits, interpret plan documents, and determine the amount of benefits due. Their decision, if not in conflict with any applicable law or government regulation, shall be final and conclusive.

ARTICLE 13: AMENDMENT OF THE PLAN

The Trustees reserve the right to change or terminate the Fund and/or Plan at any time and for any reason, for any group or class of Participants or Dependents, as well as for all such groups. Correspondingly, the Trustees may change the level of benefits provided, impose or raise self-payments, or eliminate an entire category of benefits, at any time and/or for any reason.

ARTICLE 14: TERMINATION OF THE PLAN

If the Plan is terminated, plan assets shall be used to pay eligible claims and expenses incurred prior to termination and expenses incident to the termination. The Trustees will, in their discretion, allocate any remaining assets in a manner which best effectuates the purposes of the Trust. In no event will plan assets revert to or inure to the benefit of contributing employers or the Association.

ARTICLE 15. HIPAA PLAN SPONSOR PROVISIONS

15.1 Effective April 14, 2003, Protected Health Information ("PHI"), as defined in HIPAA, shall only be disclosed to the Plan Sponsors in accordance with the following procedures:

PHI will only be disclosed to Plan Sponsors when and if necessary to carry out the Fund's payment and health care operations. In particular, it is anticipated that such disclosures may be necessary to verify eligibility or to make a decision on appeal. All such disclosures will be made in accordance with HIPAA and its corresponding regulations.

The Plan Sponsors agree to:

(a) Not use or further disclose the information other than as permitted or required by the plan documents or as required by law;

(b) Ensure that any agents, including a subcontractor, to whom it provides protected health information received from the Plan, agree to the same restrictions and conditions that apply to the plan sponsor with respect to such information;

(c) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor;

(d) Report to the group health plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(e) Provide individuals access to protected health information as required by the privacy rules;

(f) Provide individuals the right to amend protected health information maintained in a designated record set as required by the privacy rules;

(g) Make available the information required to provide an accounting of disclosures or protected health information as required by the privacy rules;

(h) Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the group health plan available to the Director of the Secretary of Health and Human Services, or its designee, for purposes of determining compliance by the group health plan with this subpart;

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

(j) Provide for adequate separation between the group health plan and the plan sponsor. To do so:

(1) Only those employees of the Plan Sponsor who are also Trustees of this Fund shall be given access to the protected health information;

(2) Access to PHI for such individuals shall be limited to the plan administration functions that the Plan Sponsor performs for the group health plan; and

(3) Any issue of noncompliance by such persons with these provisions shall be referred to the Trustees for resolution and appropriate action.

15.2 Effective April 20, 2005, the Plan and the Plan Sponsor will comply with the security regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160, 162 and 164 (the "Security Regulations"). The following provisions apply to Electronic Protected Health Information ("ePHI") that is created, received, maintained or transmitted by the Plan Sponsor on behalf of the Plan, except for ePHI (1) it receives pursuant to an appropriate authorization (as described in 45 C.F.R. §164.504(f)(1)(ii) or (iii)), or (2) that qualifies as Summary Health Information and that it receives for the purpose of either (a) obtaining premium bids for providing health insurance coverage under the Plan, or (b) modifying, amending or terminating the Plan (as authorized under 45 C.F.R. §164.508). If other terms of the Plan conflict with the following provisions, the following provisions shall control. The Security Regulations are incorporated herein by reference. Unless defined otherwise in the Plan, all capitalized terms herein have the definition given to them by the Security Regulations.

The Plan Sponsor shall, in accordance with the Security Regulations:

(a) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that it creates, receives, maintains or transmits on behalf of the Plan.

(b) Ensure that "adequate separation" is supported by reasonable and appropriate security measures. "Adequate separation" means the Plan Sponsor will use ePHI only for Plan administration activities and not for employment-related actions or for any purpose unrelated to Plan administration. Any employee or fiduciary of the Plan or Plan Sponsor who uses or discloses ePHI in violation of the Plan's security or privacy policies and procedures or this Plan provision shall be subject to the Plan's disciplinary procedure.

(c) Ensure that any agent or subcontractor to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the information.

(d) Report to the Plan any Security Incident of which it becomes aware.

ARTICLE 16 - RECIPROCITY

The Fund may enter into reciprocity agreements. Reciprocated money received by the Fund under such agreements will be allocated pursuant to policies and procedures adopted by the Trustees.

ARTICLE 17 – OBTAINING CERTIFICATE OF CREDITABLE COVERAGE

You will be provided a certificate of creditable coverage, free of charge, from the Plan Office when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage (see Article 8), when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. You may request a certificate of creditable coverage by contacting the Plan Office, Benesys, Inc., 700 Tower Drive, Suite 300, Troy, Michigan 48098, telephone number (248) 813-9800.

ARTICLE 18 - MEDICARE ELIGIBLE PARTICIPANTS AND DEPENDENTS (DETROIT AND NON-DETROIT)

Medicare eligible Participants and Dependents are provided coverage via a fully insured Medicare coordinated policy (Medicare Policy) and will be enrolled in the Medicare Policy. See Article 19 for contact information. The terms and conditions of such coverage are set forth in the

Medicare Policy. Non-Medicare eligible dependents of Medicare eligible Participants are covered under the Fund's self-insured medical and drug plan set forth in Articles 3 and 3A.

All Medicare eligible Participants and Dependents will automatically be enrolled in the Medicare Policy at the earliest enrollment opportunity after Medicare eligibility is obtained, subject to the terms of section 3.3(e) and 3A.3(e), as applicable. However, by law the Medicare Policy carrier must provide Participants/Dependents with the opportunity to opt out of, i.e. decline, coverage under the Medicare Policy. If a Participant/Dependent opts out of coverage under the Medicare Policy he/she will lose all coverage (medical, prescription drug, dental, life, employee assistance, and vision) under the 149 Fund and will not be allowed at any time in the future to reinstate coverage.

If a Participant has other coverage under a Spouse's plan or any other type of medical plan (Other Coverage), he/she must contact the Fund Office so benefits can be properly coordinated. If he/she does not do so, he/she may be responsible for the costs of medical expenses that otherwise would have been paid by the Other Coverage.

ARTICLE 19 – SERVICE PROVIDERS

Third Party Administrator/ Fund Office BeneSys, Inc. 700 Tower Drive, Ste. 300 Troy, MI 48098-2808 (248) 831-9800	**Legal Counsel** AsherKelly 25800 Northwestern Highway, Suite 1100 Southfield, MI 48075 (248) 746-2710
Medical PPO Network Preferred Health Plan HAP PPO 2850 West Grand Boulevard Detroit, MI 48202 (800) 957-4325 www.hap.org	**Vision Network** Vision Service Plan (VSP) 3333 Quality Drive Rancho Cordova, CA 95670 (800) 877-7195 www.vsp.com
Dental DenteMax 25925 Telegraph Rd., Ste. 400 Southfield, MI 48033 (800) 752-1547 www.dentemax.com Golden Dental 29377 Hover Rd. Warren, MI 48093 (800) 451-5918 www.goldendentalplans.com	**Prescription Network** EnvisionRx Options 2181 E. Aurora Rd., Ste. 201 Twinsburg, OH 44087 (800) 361-4542
Medicare Advantage Plan	**Specialty Pharmacy Savings Plan**

Humana 485 Metro Place South, Ste. 500 Dublin, OH 43017 (800) 733-9064 www.humana.com	Elixir Rx Solutions, LLC 2181 E. Aurora Rd., Ste. 201 Twinsburg, OH 44087 (800) 361-4542 www.elixirsolutions.com
Employee Assistance Program Encompass EAP 100 N. Pennsylvania Avenue Wilkes-Barre, PA 18701 (844) 871-3577 www.encompass.us.com	**Life Insurance** MetLife Group Life Claims P.O. BOX 6100 Scanton, PA 18505-6100 (800) 638-6420 lifeclaimsubmit@metlife
Precertification Health Plan Advocate 1550 E. Beltline SE, Ste. 175 Grand Rapids, MI 49506 (866) 942-1394	**Telehealth** MDLive 3350 SW 148th Avenue, Ste. 300 Miramar, FL 33027 (888) 850-3896 www.MDLIVE.com/roofers149

THIS PLAN IS ADOPTED May 11 **, 2021.**

UNION TRUSTEES:

EMPLOYER TRUSTEES:

W2456701/RL9/110597