FIRST AMENDMENT TO THE ROOFERS LOCAL 149
SECURITY BENEFIT TRUST FUND PLAN DOCUMENT DATED DECEMBER 1, 2013

WHEREAS, the Trustees of the Roofers Local 149 Security Benefit Trust Fund Plan desire to amend the Plan Document adopted by the Trustees on October 1, 2017, (the "Plan");

WHEREAS, the Plan and Trust authorize the Trustees to amend the Plan from time to time; and

NOW THEREFORE, the Roofers Local 149 Security Benefit Trust Fund Plan Document dated October 1, 2017, is amended as follows effective April 1, 2018:

1. **Article 4, Section 4.1, Types of Claims Covered is amended by the addition of the following paragraph:**

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

2. **Article 4, Section 4.4(b) is amended as follows:**

(b) 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.

Before the Fund can issue an initial benefit determination 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 the benefit denials is required to be provided, above, to give the Claimant a reasonable opportunity to respond prior to that date.

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 to give the claimant a reasonable opportunity to respond prior to that date.

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

(i) 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.

(ii) 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.

(iii) The 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.

2. **Article 4, Section 4.6 , Notice of Decision on Appeal, is amended as follows:**

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; 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 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.

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 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 that date.

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

(a) an explanation of the basis for disagreeing with any of the following:

(i) the health care professionals that treated the Claimant;

(ii) the advice of the health professional obtained by the Plan; or

(iii) a disability determination from the Social Security Administration.

(b) 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.

3. Article 4, is amended by the addition of the following:

4.9 Failure to Follows 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 section 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 days, 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 impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters 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.

The Board of Trustees has adopted this Amendment to the Roofers Local 149 Security Benefit Trust Fund Plan Document dated October 1, 2018, on 4/10, 2018.

UNION TRUSTEES

EMPLOYER TRUSTEES

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