ROOFERS' LOCAL NO. 149
SECURITY BENEFIT TRUST FUND

SUMMARY PLAN DESCRIPTION

NON-DETROIT PARTICIPANTS

2015

PREFACE

Este folleto contiene un resumen en inglez de sus derechos y beneficios del fi deicomiso obrero designado *Roofers Local 149 Security Benefit Trust Fund* (Fondo de Beneficios de Seguridad) Si tiene preguntas o comentarios sobre la informacion inclusa, o, si tiene dificultad en entender alguna parte de este folleto, por favor llamar al fi deicomisario, *BeneSys, Inc.,* localizado en 700 Tower Drive, Suite 300, Troy, Michigan 48098-2835. El telefono de la oficina es (248) 641-4949 o (888) 868-6411. Las horas de la empresa son de 7:30 a.m. a 4:30 p.m., Lunes a Viernes.

The Board of Trustees of the Roofers Local 149 Security Benefit Trust Fund (the "Fund") is pleased to present this Summary Plan Description. As a Summary Plan Description, this document summarizes the terms of the Roofers Local 149 Security Benefit Trust Fund Plan (the "Plan"). The Plan itself comprehensively sets forth the benefits, eligibility rules, exclusions, limitations, and other provisions of the medical and other benefits provided by the Fund. The Plan is available for inspection at any time at the Plan Office. If there is any conflict between this summary and the Plan, the Plan controls.

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 Trustees may raise, impose, or otherwise change self-payments for coverage at any time.

Grandfathered Status

By law, we are required to provide this notice to you: It is believed that the Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on essential health benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Board of Trustees Roofers Local 149 Security Benefit Trust Fund Plan, c/o BeneSys, Inc., P.O. Box 396, Troy, Michigan 48099-0396, telephone number (248) 641-4949 or (888) 868-6411. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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ARTICLE 1: DEFINITIONS

Only some of the terms used in the Plan are defined below. For those terms not specifically defined below, the definitions used in the Plan are controlling. You are always welcome to review the entire Plan at the Plan Office.

Active Employee or Employee means 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.

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.

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.

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

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.

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.

Covered Person means a Participant or his/her Dependent.

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

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.

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.

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) 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; and (b) 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.

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.

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

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.

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

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

Plan means the Plan 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 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.

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.

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 form 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.

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.

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

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 NON-DETROIT PARTICIPANTS

2.1 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 on his behalf for work performed within a four 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 Month of:	Provides 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 two 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 12-month period (looking back 12 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 two 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 §2.1(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 three-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 through a family member's employer.

(3) 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.

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

(A) the Employer fails to make contributions as required by §3, 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 event listed in (E), above, or as otherwise required by law. See Article 8 of the Plan Document.

2.2 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 §3.2 or is receiving undisputed workers compensation benefi ts, or has a workers compensation claim pending and executes an assignment of benefi ts, and has provided the Fund Offi ce 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 five 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.

2.3 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.

2.4 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 seligible 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 §3.3(e) or Article 16. **Thus, it is strongly recommended that a Retiree, his Spouse, or an Active Employee contemplating retirement, contact the Social Security Administration at least four 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 §3.3(e) or Article 16. 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 §2.3(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.

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 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 Spouse 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 16, 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 Article 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.

ARTICLE 3 – BENEFITS FOR NON-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. The life insurance carrier is the United of Omaha Life Insurance Company, Mutual of Omaha Plaza, Omaha, Nebraska 68175, (800)-775-8805. 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. Coverage is available in the amounts set forth below:

(a) Life Insurance Coverage

Active Employee:

Age	Benefit
Under age 65	$15,000.00
Age 65-69	9,750.00
Age 70-74	6,750.00
Age 75-79	6,750.00
Age 80-84	3,000.00
Age 85 and over	3,000.00

Pensioner:

Age	Benefit
Under age 65	$4,000
Age 65-69	4,000
Age 70-79	4,000
Age 80 and over	4,000

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

(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 and file it with the Plan Office. Beneficiary designation forms are available upon request. Benefits shall be paid to the designated beneficiary upon the death of the Participant. 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) Siblings; (4) Estate. A Participant must change the beneficiary so designated if he/she wants to change the beneficiary.
- 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 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 the 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.

3.3 Medical Benefits

(a) Networks

- The Fund has entered into an agreement with Health Alliance Plan ("HAP"), 2850 W. Grand Blvd., Detroit, MI 48202, (800) 422-4641 or (313) 872-8100, a preferred provider organization. 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 charged. 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

- 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 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 Plan Year for in-network services, and $2,600 per Covered Person or $5,200 per family per Plan Year for out-of-pocket services. (these limits do not include co-payments or deductibles)
- **Annual Limit:** Effective June 1, 2011, the Fund imposed an annual limit on benefits of $1,000,000. Effective June 1, 2012, it was increased to $1,250,000, effective June 1, 2013, this limit was increased to $2,000,000, and effective June 1, 2014, this limit will be eliminated.

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

Benefit	In-Network Provider	Out-of-Network Provider
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. For Spouses of Active Employees only 2. 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 ServiceService 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, Pensioners, Spouses, and Surviving Spouses	100%	Not Covered

Benefit	In-Network Provider	Out-of-Network Provider
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

Benefit	In-Network Provider	Out-of-Network Provider
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	90%, not subject to Annual Deductible.	70% of R&C
Sterilization (no reversal)	90%	70% of R&C
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

Benefit	In-Network Provider	Out-of-Network Provider
Colonoscopy	100%, not subject to deductible, once every 5 years. Additional medically necessary colono-scopies within the 5 year limit are covered: (a) 90% if performed inpatient, subject to deductible, or (b) 100% out-patient, subject to deductible.	70% of R&C, subject to the deductible

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.

(44) Examination, preparation, fitting or procurement of hearing aids.

(e) Medicare Eligibility

In the event coverage is not yet in place under Article 18 of the Plan document, 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 §§ 3.3(b) and (d).

(B) For those benefits provided by Medicare Part B (medical insurance), Medicare, as the primary insurer, will pay 80% of Medicare's approved allowance. 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).

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.

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 four months before they will reach age 65.

(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 coordinated with Medicare as 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.

3.4 Vision Benefits

(a) Benefits: The Fund provides the following self-insured vision benefits 24 months unless otherwise indicated:

COVERED SERVICES	BENEFIT
Complete Examination:	
Ophthalmologist (M.D.)	$ 35.00*
Optometrist	$ 25.00*
Lens, Pair:	
Single Vision Rx	$ 45.00
Bi-Focal Rx	$ 49.00
Tri-Focal Rx	$ 79.00
Lenticular	$ 75.00
Frames (once every two years)	$ 45.00
Contact Lenses:	$ 88.00

*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 agreements with SVS Vision, 140 Macomb Place, Mt. Clemens, MI 48043, (800) 787-4600; Henry Ford OptimEyes, (800) 393-2273; Co/Op Optical, 2424 East 8 Mile Road, Detroit, MI 48234, (866) 733-2667; and Davis Vision, 660 Woodward Ave., Suite 1525, Detroit, MI 48226, (877) 923-2847, whereby providers in these respective networks have agreed to provide vision services to Covered Persons at reduced fees. A list of participating providers is available upon request at the Plan Office. 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. Regardless of the provider chosen, benefits paid by the Fund will not exceed those amounts set forth in Paragraph (a), above.

(d) Opt-Out: At any time a Participant may decline all vision benefits under Section 3.4(a).

3.5 Dental/Orthodontic Benefits

(a) Preferred Provider Organization

The Fund has entered into an agreement with DenteMax, 25925 Telegraph Road, Suite 400, Southfield, MI 48033, (800) 752-1547, a preferred dental provider organization, 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 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 §3.3(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 §3.3(d) apply to dental and orthodontic benefits.

(d) Opt-Out

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

3.6 Prescription Drug Benefits

(a) Provider Network/Prescription Drug Card

The Fund has contracted with a prescription drug service: Envision Pharmaceutical Services, Inc., 2181 East Aurora Road., Suite 201, Twinsburg, Ohio 44087, (800) 361-4542, for the administration of the prescription drugs for Participants and their Dependents. 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 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
- Injectible Bee Sting Kits
- Injectible Immunizations

(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
- Contraceptive Devices
- Oral and Injectible 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 Immunodulators (subject to §3.6(d)(2). 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 Injectable Immunomodulators

The following Injectable 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 Injectable Immunomodulators are excluded from coverage.

(3) All specialty drugs must be filled at Orchard Specialty Pharmacy, 7835 Freedom Avenue NW, North Canton, Ohio 44720, (866) 909-5170.

(4) Certain drugs require prior authorization or are subject to step therapy before coverage will be approved. The list of drugs subject to these requirements is available by contacting the Fund Office or EnvisionRxOptions Customer Service Help Desk at 1-800-361-4542. 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. Contact the Fund Office or EnvisionRxOptions Customer Service Help Desk at 1-800-361-4542 for further information.

(6) Certain drugs are subject to quantity limits. The list of drugs subject to these limits is available by contacting the Fund Office or EnvisionRxOptions Customer Service Help Desk at 1-800-361-4542. 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 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 §§ 3.6(d)(2), above, for special co-payments pertaining to Injectable 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.

3.7 Employee Assistance

The Fund has contracted with New Alternatives, Inc., Assessment and Counseling Services, 26120 Van Dyke, Suite B, Center Line, MI 48015, to provide screening, assessment, and counseling for Participants and their Dependents related to alcoholism, drug addiction, and certain mental/nervous disorders. Please contact the Plan Office for more information, (248) 641-4949, or call New Alternatives, Inc. at (586) 755-3550. You may also log onto the New Alternatives' website for more information, www.newalternativescounseling.com.

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

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 to 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.

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) 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 is permitted if the 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.

(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; and, if the denial was based on medical necessity, experimental nature of treatment or similar matter, an explanation of same.

(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.

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; a statement of the Claimant's right to bring a civil action under ERISA; the internal rule or similar guideline relied upon in denying the claim; and, if the denial was based on medical necessity, experimental nature of treatment or similar matter, an explanation of same.

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 five (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 to recover benefits allegedly due under the terms of the Plan more than 180 days following the Notice of Decision on Appeal.

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:

- **Change of Address.** Any change of address, or name change, shall be reported immediately.
- **Deaths.** Deaths should be reported immediately. A certified copy of the death certificate is required.
- **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):

(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)).

(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

- Where coverage was provided as a result of fraud or an intentional misrepresentation of a material fact by a Participant or Dependent, or an individual seeking coverage on behalf of such Participant or Dependent, the Plan will rescind coverage. Failure to inform the Fund Office of a divorce or any other event which makes a Dependent ineligible for coverage is considered fraud or intentional misrepresentation of a material fact. A 30-day notice of rescission will be provided.
- Rescission means the retroactive cancellation of coverage. 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 days 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.

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.

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 eight 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 eight 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.

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.

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

In accordance with §609 of ERISA, the Plan shall provide benefits as required by a Qualified Medical Support Order ("QMSCO"). In general, a QMSCO is a medical child support order which creates or recognizes the right of an alternate recipient (i.e. a child of the Participant) to receive benefits under a group health plan. A QMSCO must meet certain requirements and cannot require a 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. Procedures for determining the qualified status of medical support orders are available, without charge, from the Plan Office.

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 reemployment 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: MEDICARE ELIGIBLE PARTICIPANTS AND DEPENDENTS

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. 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 Article 3.

Coverage under the Medicare Policy may be limited if such person has not timely applied for and obtained Medicare. It is the Participant's or Dependent's responsibility to timely obtain Medicare coverage. If he/she does not do so, he/she is responsible for the costs of medical expenses that otherwise would have been covered by Medicare or the Medicare Policy.

All Medicare eligible Participants and Dependents will automatically be enrolled in the Medicare Policy at the earliest enrollment opportunity after Medicare eligibility is obtained. 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 17: OTHER PROVISIONS

The following information is required to be provided by law:

A. Type of Administration/Plan Administrator/Plan Sponsor/Counsel: The Board of Trustees of the Roofers Local 149 Security Benefit Trust Fund is the Plan Administrator and Plan Sponsor. As such, the Trustees are responsible for overall Plan administration. There are 5 Trustees appointed by the Union and 5 Trustees appointed by the Association. The current Trustees are:

Union Trustees	Employer Trustees
Mark Peterson, Secretary Roofers Local 149 1640 Porter Street Detroit, MI 48216	Roger LaDuke, Chairman LaDuke Roofing & Sheet Metal 10311 Capital Street Oak Park, MI 48237
Brian Gregg Roofers Local 149 10621 Capital Street Oak Park, MI 48237	Gary Sova National Roofing & Sheet Metal G-4130 Flint Asphalt Drive Burton, MI 48529
William Leon Roofers Local 149 1640 Porter Street Detroit, MI 48216	Paul Schick Newton Crane Roofing 353 North Cass Lane Pontiac, MI 48342
Michael Chilcott Roofers Local 149 1640 Porter Street Detroit, MI 48216	Brian Moore Schreiber Roofing 29945 Beck Road Wixom, MI 48393
Ronald Inman Roofers Local 149 4659 Abela Road Millington, MI 48746	[to be appointed]

LEGAL COUNSEL FOR THE PLAN

Jacqueline A. Kelly, Esq.
Sullivan, Ward, Asher & Patton, P.C.
25800 Northwestern Highway, Suite 1000
Southfield, MI 48075
(248) 746-0700

The day-to-day responsibilities for Plan administration are performed by the Plan Office, BeneSys, Inc., 700 Tower Drive, Suite 300, Troy, Michigan 48098, telephone number (248) 641-4949 or (888) 868-6411.

B. Effective Date of Plan: September 22, 1952.

C. Year End Date: The date of the end of the year for purposes of maintaining the plan's fiscal records is May 31.

D. Agent for Service of Legal Process: Service of process should be made upon the Plan Office, BeneSys, Inc., 700 Tower Drive, Suite 300, Troy, Michigan 48098, telephone number (248) 641-4949. Service of legal process may also be made upon any Trustee.

E. Type of Plan/Employer Identification Number: The Plan is a Welfare Benefit Plan. The employer identification number assigned by the IRS is 38-2481614. The Plan Number is 501.

F. Collective Bargaining Agreements: The Plan is maintained pursuant to collective bargaining agreements. Copies of such agreements may be obtained upon written request to the Plan Office, or are available for examination by participants and beneficiaries at the Plan Office. Alternatively, within 10 days of a written request, such agreements will be made available at the Union hall or at any employer establishment where at least 50 or more participants are customarily working. The Plan may impose a reasonable charge for such copies.

G. Source of Plan Contributions: The primary source of financing for the benefits provided under the Plan and for the expenses of the Plan operations are employer contributions. The rate of contribution is set forth in the Collective Bargaining Agreement, or other written agreement requiring contributions to the Fund. A complete list of the employers contributing to the Plan may be obtained upon written request to the Plan Office and may be examined at the Plan Office. Additionally, plan assets are invested which results in investment income to the Plan.

H. Welfare Trust Assets and Reserves: The Board of Trustees holds all assets in trust for the purpose of providing benefits to eligible participants and defraying reasonable administrative expenses.

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

Receive Information About Your Plan and Benefits:

- Examine, without charge, at the Plan Office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage:

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, 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. The procedure for requesting a certificate of creditable coverage is as follows:

a. A covered person may contact the Fund Office, BeneSys, Inc., P.O. Box 396, Troy, Michigan 48099-0396, (248) 641-4949, by phone (ask for a representative of the Roofers Local 149 Security Benefit Trust Fund) or in writing to request a certificate of creditable coverage.

b. The requested certificate shall be provided by the earliest date that the Plan Administrator, and the Plan's third party administrator, BeneSys, acting in a reasonable and prompt fashion, can provide the certificate. In that regard, the parties shall use best and reasonable efforts to process and mail (first class, postage paid) the requested certificate of creditable coverage to the requesting party within five business days of receipt by BeneSys, Inc.

c. The above applies to requests for certificates made by a covered person before losing coverage or within 24 months after losing coverage.

d. This procedure is in addition to the automatic issuance of certificates of creditable coverage to covered persons upon termination of coverage.

Prudent Actions by Plan Fiduciaries: In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights: If your claim for a pension benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions: If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington,

D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

This Summary Plan Description is not intended to cover every detail of the Plan or every situation that might occur. It is simply a summary. The complete Plan is available for inspection at any time at the Plan Office. If there is any conflict between this summary and the Plan, the Plan controls. For a more detailed statement of your rights and obligations consult the Plan document.

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