ROOFERS UNION LOCAL 30
COMBINED HEALTH AND WELFARE PLAN

SUMMARY PLAN DESCRIPTION/PLAN DOCUMENT

COMMERCIAL PLAN
FOR COMMERCIAL EMPLOYEES AND FOURTH YEAR COMMERCIAL APPRENTICES

JANUARY 2017

To All Eligible Employees and Eligible Apprentices:

We are pleased to provide you with this updated booklet describing the comprehensive benefits provided to Eligible Employees, Eligible Apprentices, and their Eligible Dependents under the Commercial Plan of the Roofers Union Local 30 Combined Health and Welfare Fund (the "Plan"). We suggest that you read it carefully and become familiar with its contents. Share the information with your family and keep it handy for future reference.

The Plan provides coverage for the exclusive benefit of Eligible Employees, Eligible Apprentices, and their Eligible Dependents. Coverage includes medical and hospital benefits provided through Independence Blue Cross, as well as prescription drug benefits through FutureScripts, Dental Benefits called Concordia FLEX administered by United Concordia and Vision Benefits through Vision Benefits of America. In addition, the Plan provides Life Insurance and Accidental Death and Dismemberment (AD&D) Benefits for Eligible Employees and Eligible Apprentices that is insured by The Amalgamated Life Insurance Company.

This SPD/Plan Document is booklet is not the sole governing instrument of the Plan. The Plan must be interpreted in accordance with the Agreement and Declaration of Trust and the related Collective Bargaining Agreement or insurance contracts that also govern the operation and administration of this Plan.

The Trustees intend to continue the Plan described in this booklet. Nevertheless, they reserve the right to terminate, suspend, amend, or modify the Plan in whole or in part at any time. The Trustees have the exclusive right and discretionary authority to construe the terms of the Plan, to resolve any ambiguities, and to determine any question that may arise in connection with the Plan's application or administration, including but not limited to determination of eligibility for benefits. Please see the chapter entitled "General Plan Information" of this booklet for further details and the chapter entitled "Your ERISA Rights" for your rights under the Employee Retirement Income Security Act of 1974 (ERISA).

The Plan also provides vacation benefits which are described in a separate Summary Plan Description ("Vacation SPD"). Please refer to the Vacation SPD for more information about your Vacation Benefits. If you do not have a copy of the Vacation SPD, please contact the Fund Office.

We urge you to read this Plan booklet and its Appendices so that you are familiar with the benefits to which you and your family may be entitled.

Sincerely,

BOARD OF TRUSTEES

ROOFERS UNION LOCAL 30
COMBINED HEALTH AND WELFARE PLAN
830 Bear Tavern Road
PO Box 1028
West Trenton, NJ 08628
Telephone : (609) 883-6688

BOARD OF TRUSTEES

UNION TRUSTEES	EMPLOYER TRUSTEES
Thomas Pedrick	Richard Harvey
Clark Shiley	David Farragut
Shawn McCullough	Mike Thomas

LEGAL COUNSEL

Jennings Sigmond, P.C.
Susanin, Widman & Brennan, P.C.

CONSULTANTS

The Segal Company

TABLE OF CONTENTS

FOR HELP OR INFORMATION

When you need information, please check this booklet first. If you need further help, call the people listed in the following summary:

SUMMARY OF BENEFITS AND INFORMATION ON CONTACTS AND ADMINISTRATION		
FOR INFORMATION ON:	**YOU SHOULD CONTACT:**	**PLAN BENEFIT**
Eligibility, Enrollment, COBRA and General Plan Information	**Roofers Union Local 30 Combined Health and Welfare Plan Administrative Office** 830 Bear Tavern Road P.O. Box 1028 West Trenton, NJ 08628 609-883-6688 Phone 609-883-7560 Fax	See the beginning of this booklet for information on when you become eligible for benefits, Eligible Dependents, enrollment rules and other information. You may also contact the Administrative Office for information on the Plan's benefits and necessary forms.
Comprehensive Medical Benefits	**Independence Blue Cross** Member Services 215-557-7577 Phone 800-626-8144 Toll-free http://www.ibx.com **Complaints:** Independence Blue Cross General Correspondence 1901 Market Street Philadelphia, PA 19103 **Appeals:** Member Appeals Department P.O. Box 41820 Philadelphia, PA 19101-1820 888-671-5274 Fax: 888-671-5276	For details on Pre-authorization, covered benefits, exclusions, coordination of benefits and other details about your hospital and medical benefits, see the attached Independence Blue Cross and Pennsylvania Blue Shield Booklet attached as **Appendix A.**

SUMMARY OF BENEFITS AND INFORMATION ON CONTACTS AND ADMINISTRATION		
FOR INFORMATION ON:	**YOU SHOULD CONTACT:**	**PLAN BENEFIT**
Prescription Drugs	**FUTURE SCRIPTS** Future Scripts Independence Blue Cross 1901 Market Street Philadelphia, PA 19103-1480 1-800-ASK-BLUE www.ibx.com	A summary of your Prescription Drug Benefits is included in this booklet. For a complete description of the Plan's Prescription Drug Benefits is attached as **Appendix B.**
Dental Benefits	**Concordia FLEX** Dental Benefits are administered by United Concordia Companies, Inc. 4401 Deer Path Road Harrisburg, PA 17110 800-822-3368 Phone www.ucci.com	For details, see the Dental Benefits chapter of this booklet.
Vision Benefits	**Vision Benefits of America** 300 Weyman Plaza Pittsburgh, PA 15236-1588 800-432-4966 Phone www.visionbenefits.com	See the description of Vision Benefits chapter of this booklet.

SUMMARY OF BENEFITS AND INFORMATION ON CONTACTS AND ADMINISTRATION		
FOR INFORMATION ON:	**YOU SHOULD CONTACT:**	**PLAN BENEFIT**
Life Insurance and Accidental Death and Dismemberment Benefits	**The Amalgamated Life Insurance Company** Group Benefits The Amalgamated 730 Broadway New York, New York 10003	See the chapters entitled Life Insurance Benefits and Accidental Death Dismemberment Benefits in this booklet. See the Certificate of Insurance attached as **Appendix C.**
Weekly Accident and Sickness Benefit	**Roofers Union Local 30 Combined Health and Welfare Plan** Administrative Office 830 Bear Tavern Road P.O. Box 1028 West Trenton, NJ 08628 609-883-6688 Phone 609-883-7560 Fax	See the chapter entitled Weekly Accident and Sickness Benefit chapter of this booklet.

IMPORTANT NOTICES

YOU MUST PROVIDE THE ADMINISTRATIVE OFFICE WITH NOTICE OF LIFE EVENTS

You or your Eligible Dependents must promptly furnish to the Administrative Office information regarding any change of name or address, marriage, divorce or legal separation, death of any covered family member, Medicare enrollment or disenrollment, or the existence of other coverage. Failure to do so may cause you or your Dependents to lose certain rights under the Plan.

NOTICE REGARDING RETROACTIVE CANCELLATIONS OF COVERAGE

The Plan Administrator, in its discretion, may retroactively cancel coverage for you and/or your Dependents for the following reasons:

- Fraud or intentional misrepresentation of a material fact;
- Failure to timely pay premiums or required contributions; or
- Untimely notification of a divorce.

For this purpose, enrolling an ineligible individual or otherwise knowingly failing to comply with the Plan's eligibility requirements will constitute an intentional misrepresentation of fact and may trigger a retroactive termination of coverage.

If the retroactive cancellation is due to fraud or an intentional misrepresentation of a material fact, the Plan will provide advance notice at least 30 days before a retroactive termination of coverage and you may appeal the termination under the provisions set forth in the Claims and Appeals section of this booklet. If coverage is retroactively terminated, you and/or your Eligible Dependents may be responsible for repaying any amounts paid by the Plan after the date of termination.

WOMEN'S HEALTH AND CANCER RIGHTS

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with you and your attending physician, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. For more information on WHCRA benefits, the amount of coverage available to you, and co-payment, deductible and maximum amounts, please refer to **Appendix A**. You may also contact Independence Blue Cross Member Services at the toll-free number located on your I.D. card.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION

This Plan complies with the protections afforded under the Newborns' and Mothers' Health Protection Act of 1996, which prohibits restricting 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 and newborn's attending physician, after consulting with the mother, from discharging the mother or her newborn earlier. In any case, the Plan and Independence Blue Cross may not, under Federal law, require that a provider obtain authorization from the Plan or Independence Blue Cross for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NONDISCRIMINATION IN HEALTH CARE

In accordance with Section 2706 of the Public Health Service Act, as amended by the Affordable Care Act, to the extent an item or service is a covered benefit under the Plan, and consistent with reasonable medical management techniques with respect to the frequency, method, treatment or setting for an item or service, the Plan will not discriminate with respect to participation under the Plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. The Plan is not required to contract with any health care provider willing to abide by the terms and conditions for participation established by the Plan or issuer. The Plan is permitted to establish varying reimbursement rates based on quality or performance measures.

ROUTINE PATIENT COSTS IN CONNECTION WITH APPROVED CLINICAL TRIALS

If you are eligible to participate in an Approved Clinical Trial with respect to treatment of cancer or another life-threatening disease or condition, the Plan will:

- Not deny you participation in the trial;
- Not deny, limit or impose additional conditions on the Plan's coverage of routine patient costs for items, services or drugs otherwise covered by the Plan that are furnished in connection with participation in the trial; and
- Will not discriminate against you because of your participation in the trial.

The Plan will deem you eligible to participate in the trial if:

i) Your health care provider is a participating provider in this Plan and that provider has concluded that your participation in the trial would be medically appropriate; or

ii) You provide medical and scientific information establishing that your participation would be medically appropriate.

Routine patient costs do not include the following:

- The investigational item, device, or service, itself;
- Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

If one or more of the Plan's participating providers is participating in a clinical trial, the Plan may require that you participate in the trial through such a participating provider if the provider will accept you as a participant in the trial.

An Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and that is funded or approved by the federal government, conducted under an investigational new drug application reviewed by the federal Food and Drug Administration, or a drug trial exempt from having such an investigational new drug application.

A life-threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

DEFINITIONS

Active Participant means an Eligible Employee or Eligible Apprentice.

Bargaining Unit Alumni means an employee of an Employer signatory to a participation agreement with the Fund provided the employee previously participated in the Fund as a bargaining unit member pursuant to a collective bargaining agreement with the United Union of Roofers, Waterproofers, and Allied Workers Local 30. Bargaining Unit Alumni does not include any self-employed person, sole proprietor, or partner of an unincorporated business organization which is an Employer.

Benefit Period means the six-month period beginning either January 1st or July 1st.

Calendar Year means the 12-month period beginning January 1 and ending December 31.

Covered Employment means employment covered by a collective bargaining agreement between a Contributing Employer and the United Union of Roofers, Waterproofers, and Allied Workers Local 30.

Covered Expenses mean the cost of medically necessary treatments, services, or supplies that are not specifically excluded elsewhere in the Plan and are considered to be Reasonable and Customary or fall within the Plan's scheduled allowances.

Covered Person means any Eligible Employee, Eligible Apprentice, or Eligible Dependent.

Disability/Disabled for purposes of Weekly Accident and Sickness Benefits**,** means an Active Participant's complete inability to perform substantially all of the duties of his or her occupation because of a medically determinable physical or mental impairment, as certified by the Active Participant's Attending Physician. An Attending Physician is the physician who assumes primary responsibility for the care and treatment of the Active Participant. Total Disability is defined for purposes of Life Insurance Benefits in the chapter entitled, "Life Insurance Benefits," beginning on page 44. For purposes of COBRA, Disability means the Social Security Administration has found an Active Participant to be disabled within 60 days of the start of the COBRA continuation coverage period. See the chapter entitled, "Continuation of Coverage" beginning on page 19 for details. For purposes of receiving the Disability Extension (as described on page 9), an Active Participant must be totally disabled as defined by the Pension Plan and be in receipt of Disability Pension.

Eligible Apprentice means a Fourth Year Commercial Apprentice who has met the eligibility requirements detailed in the Eligibility chapter of this booklet and is enrolled for coverage under this Plan.

Eligible Dependents means your Spouse (unless you and your Spouse are living separate and apart) and your Children who meet the requirements of a Dependent as described in this Plan and are enrolled in the Plan.

Eligible Employee means a Commercial Employee who is not an Apprentice who has met the eligibility requirements detailed in the Eligibility chapter of this booklet and is enrolled for coverage under this Plan. Eligible Employee shall also include a Bargaining Unit Alumni.

Eligible Participant means an Eligible Employee or Eligible Apprentice.

Employer or Contributing Employer means an entity that has entered into a collective bargaining agreement with the United Union of Roofers, Waterproofers, and Allied Workers Local 30 or a Participation Agreement requiring contributions to be made into the Roofers Union Local 30 Combined Health and Welfare Fund.

Fund means the Roofers Union Local 30 Combined Health and Welfare Fund.

Illness means a sickness, disorder, or disease that is not employment-related. Pregnancy is treated in the same manner as an Illness under the Plan for you or your eligible Spouse.

Injury means physical damage to you or your Dependent's body caused by an accident, independent of all other causes. Only injuries which are not employment-related are considered for benefits under this Plan, except under Accidental Death and Dismemberment Benefits.

Marriage, Married, Marries, and Marry, wherever used throughout the plan, mean and describe a legal relationship between two individuals of any gender who are lawfully married pursuant to an official marriage license or similar document issued by any state, (meaning any domestic or foreign jurisdiction having the legal authority to sanction marriages), without regard to the law of the state in which the individuals are currently domiciled, but the terms do not include civil unions, domestic partnerships, or any other status unless such status is fully equivalent to marriage under the law of the issuing state.

Medicare means the health insurance program set forth in Parts A, B or D, Title XVIII of the Social Security Act, as amended.

Physician means a person duly licensed as a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.). Also referred to as a Provider or Health Care Provider.

Plan means the group health plan sponsored by the Board of Trustees.

Residential Plan means the Residential Plan of benefits of the Roofers Union Local 30 Combined Health and Welfare Fund.

Spouse means the spouse to whom the Eligible Participant is Married, as defined herein, who is not living separate and apart from the Employee as described on page 7 of the Eligibility chapter. Used generally herein, the term "spouse" means the spouse to whom an individual is married, as defined herein.

Union means the United Union of Roofers, Waterproofers and Allied Workers, Local 30.

There are other terms applicable to this Plan that are defined throughout this booklet and in the attached Appendices.

Whenever a pronoun is used in the masculine, it also includes the feminine, unless the context clearly indicates otherwise.

ELIGIBILITY

ACTIVE PARTICIPANTS (ELIGIBLE EMPLOYEES AND ELIGIBLE APPRENTICES)

Initial Eligibility

If you are a Commercial Employee or a Fourth Year Commercial Apprentice, your eligibility for coverage is based on the number of hours for which a Contributing Employer makes contributions to the Plan on your behalf. The following rules determine your eligibility for coverage under the Plan:

- If you worked at least 625 hours under Covered Employment in the last six months preceding the first day of a Benefit Period (either January 1st or July 1st), you are eligible for that Benefit Period; or
- If you worked at least 1,250 hours under Covered Employment in the last twelve months preceding the first day of a Benefit Period (either January 1st or July 1st), you are eligible for that Benefit Period.

The six-month or twelve-month period used to determine Eligibility is called the "***Look-back Period***." A ***Benefit Period*** is the six-month period beginning either January 1st or July 1st.

Eligible Employees and Eligible Apprentices who meet the above eligibility requirements are eligible for the benefits described in this booklet.

No owner of an Employer, other than a Bargaining Unit Alumni (or an Eligible Dependent of a Bargaining Unit Alumni), shall be eligible to participate in the Plan. An owner includes a stockholder, officer, director, sole proprietor, trustee or beneficiary or other person with an ownership interest or powers similar to officers or directors of a corporation in an incorporated or unincorporated business

The Spouse or child(ren) of an owner of an Employer shall be permitted to participate in the Plan only where the following conditions are satisfied: (i) the spouse or child(ren) is otherwise an Eligible Employee; and (ii) the Employer contributes to the Fund on behalf of such spouse or child(ren) for forty (40) hours per week or the actual hours worked by such spouse or child(ren), whichever is greater.

Eligibility in Residential Plan for Commercial Employees and Fourth Year Apprentices who Fail to Meet Initial Eligibility

If you do not attain eligibility in this Plan under the above eligibility requirements, you will be eligible to participate in the **Residential Plan**, provided you meet the eligibility requirements for that coverage as described in the SPD/Plan Document of the Residential Plan.

Eligibility for Retirees who Return to Covered Employment

Retirees who are eligible for Retiree Benefits under the Retiree-only Plan and who return to work in Covered Employment will have their eligibility transferred from the Retiree-only Plan to this Plan. Please refer to the Retiree-only SPD for details. Beginning on the first day of the calendar quarter following the calendar quarter in which the Retiree once again ceases working in Covered Employment, a Retiree will no longer be eligible for coverage under this Plan. **This section only**

applies to those Retirees who have not earned coverage based on the Initial Eligibility Requirements described above.

Eligibility for Self-Pay

Additionally, you will be eligible to self-pay or "buy-up" for coverage under this Plan provided you worked a minimum of 500 hours in the sixth months or 1000 hours in the twelve months immediately preceding the Benefit Period. An individual may buy up by paying the difference between the number of hours the individual worked between 500 and 625 or 1000 and 1250 at the applicable collectively bargained contribution rate for welfare plan coverage. . All hours paid by a participant under this buy up provision will be considered as hours worked for the purpose of applying all eligibility rules under the Plan. In order to obtain coverage under the Plan by buying up **full payment must be received by the Plan Administrator within thirty days after the start of the Benefit Period.**

Credit for Disability for Eligible Employees and Apprentices

If you are receiving Weekly Accident and Sickness Benefits from this Plan, you will be credited with up to 160 hours (net of any hours you earn for work in Covered Employment) per month for each month you are receiving such benefits up to a maximum of 26 weeks. If you are receiving Workers' Compensation benefits while covered as an Active Participant in the Plan, you will be credited with up to 160 hours (net of any hours you earn for work in Covered Employment) per month for each month you are receiving such benefits up to a maximum of 12 months beginning with the first month you receive those benefits. You must notify the Administrative Office when you first begin receiving such benefits in order to receive credit. Partial months will be prorated accordingly.

Effective Date of Coverage

Once you meet the Initial Eligibility requirements, your coverage under the Plan becomes effective on the first day of the Benefit Period following the date you meet either of the hours requirements described above. Once you meet the Initial Eligibility requirements, coverage remains in effect for the entire six-month Benefit Period. For example, if you become eligible for benefits as of January 1st, your coverage will be in effect from January 1st through June 30th and if you become eligible for benefits as of July 1st, your coverage will be in effect from July 1st through December 31st.

Rules for Continuing Coverage

Your coverage continues in each Benefit Period provided you continue to meet the Initial Eligibility requirements. If your eligibility for Plan coverage has lapsed because you have not met these requirements, your coverage will terminate and you will be required to meet the requirements for Initial Eligibility to become eligible for Plan coverage.

Benefits for Eligible Participants who become Totally Disabled

If you become totally disabled and are receiving a Disability Pension, as defined in the Pension Plan, from the Roofers Union Local 30 Combined Pension Plan, your coverage under the Plan will be continued for twelve months from the date of your disability. However, to be eligible for this coverage, you must have been eligible for coverage in the Plan at the time you became disabled. You should contact the Fund Office if you become totally disabled to review your eligibility under this provision.

Your Eligible Dependents

Your dependents also are eligible for Plan coverage when you are eligible for Plan coverage. When you lose eligibility, your dependents will lose their coverage also. Your Eligible Dependents include:

- Your legal Spouse;
- Your Child or Children under 26 years of age;
- Children subject to a Qualified Medical Child Support Order (QMCSO) or National Medical Support Order (NMSO).

"Child" includes a natural child, stepchild, a child placed with you for adoption, adopted child, or any child for whom coverage is your responsibility under the terms of a qualified release or court order. This Plan does not cover children of Dependent Children unless the Eligible Participant legally adopts the grandchild.

A child whose coverage would otherwise terminate solely due to reaching the limiting age will continue to be eligible if:

- The child is incapable of self-sustaining employment due to mental or physical incapacitation;
- The child became so incapable prior to age 26 and was eligible for coverage prior to age 26; and
- The child continues to be your Dependent (except for the age requirement) as defined in this section.

You will be required to make an application to the Administrative Office with respect to any such child within 31 days after he attains the limiting age in order for coverage to continue. The Administrative Office may request proof of continuing incapacity from time to time at its request.

A child who becomes incapacitated after reaching age 26 or who is not covered by the Plan when he or she attains age 26 is not eligible as a Dependent under this Plan.

Effective Date of Coverage for Eligible Dependents

If you have Eligible Dependents when you first become eligible for benefits, coverage for your Eligible Dependents is effective the same day as your coverage, subject to the enrollment rules described in the following chapter. If you later add an Eligible Dependent, coverage will be effective when you add your new Dependent, subject to the Special Enrollment rules described in the following chapter.

ENROLLMENT

HOW TO ENROLL

You (the Active Participant) are automatically enrolled for benefits provided by the Plan. This Plan complies with the federal law regarding Special Enrollment for Eligible Participants by virtue of the fact that all Eligible Participants are automatically enrolled in this Plan as soon as the Eligibility requirements of the Plan are met.

The Administrative Office will notify you when you first become eligible for coverage under the Plan and will send you an Enrollment Card. You should submit a completed Enrollment Card to assure that the Administrative Office has the correct information on file for you and to ensure proper enrollment in the Plan. You must enroll your Eligible Dependents in the Plan within 31 days of the effective date of your coverage and provide the Administrative Office with proof of your Dependents' eligibility. The Administrative Office will accept a copy of any of the following documents as proof of dependent status:

- Spouse/Marriage: copy of your certified marriage certificate (you will also need to notify the Administrative Office of other coverage for your Spouse or family, if applicable).
- Child/Birth: copy of your child's certified birth certificate.
- Adoption or placement for adoption: a court order signed by a judge.
- Disabled Dependent Child: Current written statement from the Child's physician, indicating the Child's diagnoses that are the basis for the physician's assessment, that the Child is incapable of self-support because of mental or physical incapacitation and proof that the Child is dependent on you as described under the Eligibility subsection.

If you enroll your Eligible Dependents within 31 days of the effective date of your coverage, coverage for your Eligible Dependents will be effective retroactive to the date you were first eligible.

SPECIAL ENROLLMENT

If you acquire a new Dependent as a result of marriage, birth, adoption, or placement for adoption after your Initial Eligibility, your new Dependents may enroll in the plan. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption and complete the proper enrollment paper work, as described above.

If you decline enrollment or do not enroll your any of your Eligible Dependents because of other health insurance or group health plan coverage, you may be able to enroll your Dependents in this plan if your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your Dependents' other coverage). However, you must request enrollment for your dependents and enroll for benefits as described above, after your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you did not enroll your Eligible Dependents for coverage when they were first eligible, you may enroll your Dependents in this plan if your Dependents have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and your Dependents lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends. You may also enroll your Dependents in this Plan if your Dependents become

eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after your Dependents are determined to be eligible for such assistance.

To request special enrollment or obtain more information, contact the Administrative Office.

LATE ENROLLMENT

If the Administrative Office does not receive the necessary enrollment material for your Dependents within 31 days or 60 days (for special enrollment that applies to CHIP, Medicaid, or a premium assistance program), coverage will not become effective until the beginning of the month following the month in which the Administrative Office receives your completed Enrollment Card and the necessary proof. If you submit claims for your Dependents before you enroll them, they will be denied and will need to be resubmitted once enrollment is complete but such claims will only be paid retroactive to the effective date of coverage.

START OF COVERAGE FOLLOWING SPECIAL ENROLLMENT

For newly added Dependents, if the Administrative Office receives a complete Enrollment Card and the necessary documentation within 31 days of the date of the marriage, birth, adoption, placement for adoption or loss of other group coverage, coverage will be effective:

For newborn child(ren): Retroactive to the date of birth. However, newborn child(ren) are entitled to the benefits provided by the Plan from the date of birth for a period of 31 days regardless of whether you enroll your newborn Child in coverage.

For children placed with you for adoption, or adopted Dependent Child(ren): the date that child is adopted or "placed for adoption" with you, whichever is earlier. A child is "placed for adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt. A child who is placed for adoption with you within 31 days after the child was born will be covered from birth. However, if a child is placed for adoption with you, and if the adoption does not become final, coverage of that child will terminate as of the date you no longer have a legal obligation to support that child.

For Stepchildren: retroactive to the date of your marriage to the Child's biological or adopted parent.

For your new Spouse: retroactive to the date of your marriage.

Special Enrollment opportunity related to Medicaid or a State Children's Health Insurance Program (CHIP): coverage will become effective on the first day of the month following the date of the event that allowed this Special Enrollment opportunity, if the individual requests enrollment within 60 days.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

You may be required to enroll your children in the Plan due to a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Order (NMSO) – a support order of a court or state agency that usually results from a divorce or legal separation. The Administrative Office can provide more details about enrolling your children in such cases.

Notwithstanding any provision of this Plan to the contrary, benefits will be provided to natural Dependent Children and Dependent Children placed with an Eligible Participant for adoption as required by any Qualified Medical Child Support Order ("QMCSO"), in accordance with §609(c)

of ERISA. The Plan will notify the Eligible Participant if a QMCSO is received. You may obtain, free of charge, a copy of the Plan's QMCSO procedures by contacting the Administrative Office.

TERMINATION OF COVERAGE

ELIGIBLE PARTICIPANT

If you are an Eligible Participant, your coverage ends on the earliest of:

- The date this Plan terminates;
- The last day of the Benefit Period preceding the date you fail to meet the eligibility requirements, (for example, you did not work at least 625 hours in last 6 months, or 1,250 hours in the last 12 months immediately preceding the first day of a Benefit Period);
- If you are receiving benefits under the Total Disability extension, the last day of the 12th month following the date your disability begins;
- 31 days after you enter military service (subject to the Leave for Military Service section on page 17).
- The date you first perform Covered Employment for an employer who is not signatory to a collective bargaining agreement with the Union; or
- The date of your death.

ELIGIBLE DEPENDENTS

Coverage for your Eligible Dependents ends on the earliest of the following:

- The date your (the Eligible Participant's) coverage ends;
- The last day of the month following the date they no longer qualify as Dependents (e.g., your Dependent Child reaches age 26 or you and your Spouse divorce); or
- The date of their death.

Fraudulent Claims and Conduct

No benefits are payable on a claim if the person who files the claim or for whom the benefit is claimed, or if the provider of the service that is subject of the claim, attempts to perpetrate a fraud upon or misrepresent a fact to the Plan with respect to that claim.

No benefits will be payable for claims that arise or are submitted to the Plan during a period of time in which a Covered Person on whose account, or by whom, the benefit is claimed enters into or cooperates, either actively or by implied consent, with a Contributing Employer in any arrangement, the purpose of which is or results in the intentional purposeful and fraudulent underreporting and underpayment of contributions to the Plan as required by the Contributing Employer's collective bargaining agreement with the Union. Proof of the actual fraud is not necessary for purposes of this rule. A Covered Person who accepts cash or unreported payments for work performed that is covered by the Union's collective bargaining agreement and for which contributions to this Plan would be normally required by the Contributing Employer shall be presumed to have violated this rule and subject the Covered Person to non-payment of benefits. In addition, any Covered Person who, with or without permission of an employer or Contributing Employer uses equipment and/or material and/or tools and/or vehicles of the Employer to perform

work for his/her own benefit for a customer will be presumed to have violated this provision of the Plan.

Regardless of whether delinquent contributions are ever collected or losses due the Plan are ever recovered, benefits will be suspended for the Eligible Participant and his Eligible Dependents for a period of not more than twelve (12) calendar months after the discovery of the attempted and/or actual fraud, misrepresentation, and/or concealment.

The Plan will also seek restitution for past Plan payments made during the period of the fraud or misrepresentation and/or concealment through any lawful means.

NOTICE TO THE PLAN

You, your Spouse, or any of your Dependent Children ***must*** notify the Plan immediately but no later than 60 days after the date:

- a Spouse ceases to meet the Plan's definition of Spouse (such as in a divorce); or
- a Dependent Child ceases to meet the Plan's definition of Dependent (such as the Dependent Child reaches the Plan's limiting age or the Dependent Child ceases to have any physical or mental Handicap).

Failure to give this Plan a timely notice will cause your Spouse and/or Dependent Child(ren) to lose their right to obtain COBRA Continuation Coverage or will cause the coverage of a Dependent Child to end when it otherwise might continue because of a physical or mental Handicap.

COBRA CONTINUATION OF COVERAGE

See the COBRA section in the Continuation of Coverage chapter for information on continuing your health care coverage when you (or your Dependents') coverage ends.

CERTIFICATION OF COVERAGE WHEN COVERAGE ENDS

When your coverage ends, you and/or your covered Dependents may request a Certificate of Creditable Coverage that indicates the period of time you and/or they were covered under the Plan.

LEAVE OF ABSENCE FOR ACTIVE PARTICIPANTS

If you are an Eligible Employee or Eligible Apprentice, there are certain circumstances where you may be entitled to a leave of absence from Covered Employment.

COVERAGE UNDER SPECIAL CIRCUMSTANCES

Special circumstances may entitle you to continue your eligibility for coverage under the Plan when you are on leave from work due to either family and medical leave reasons or service in the uniformed services of the United States. **Please note that in order to be eligible for continued coverage as provided below, your Employer must properly grant the leave and make the required notification and payment to the Administrative Office. Please contact your Employer to determine whether you are eligible.**

The general rules are set forth below:

Family and/or Medical Leave

The Family and Medical Leave Act of 1993 (FMLA) allows you to take up to 12 weeks of unpaid leave during any 12-month period for any of the following reasons:

- the birth, adoption or placement of a child with you for adoption;
- to provide care for your Spouse, child or parent who is seriously ill; or
- your own serious Illness.

During your leave, you may continue all of your medical coverage and other benefits offered through the Plan. You are generally eligible for leave under FMLA if you:

- worked for an Employer for at least 12 months;
- worked at least 1,250 hours in Covered Employment over the previous 12 months; and
- worked at a location where at least 50 employees are employed by the Employer within 75 miles.
- You may also be entitled to unpaid leave of up to 26 weeks to take care of a military service member who is your spouse, child, parent, or next-of-kin and is undergoing medical treatment or recuperating from serious illness or injuries as a result of their service.

The Plan will maintain your eligibility status until the end of the leave, provided the Employer properly grants the leave under FMLA, makes the required notification, and continues to make contributions to the Plan on your behalf. Please contact your Employer to determine whether you are eligible for FMLA leave.

Leave for Military Service

If you voluntarily or involuntarily leave your employment position to undertake military service, the Uniformed Services Employment and Reemployment Rights Act (“USERRA”) of 1994 requires your employer to grant you unpaid military leave for up to five years and to continue to subsidize your health care coverage for up to 31 days from the first day of your military leave. If your military service exceeds 31 days, you should receive military health care coverage from the U.S.

Government at no cost. However, you may also elect to continue your coverage under this Plan for you and your Eligible Dependents for a maximum period of 24 months from the first day of your military leave. If you elect to continue coverage in this Plan during a period of military service, the Plan will cover the cost of the 24 months of USERRA continuation coverage (at no cost to you). You must notify the Administrative Office at the beginning of your military leave and fill out an election form in order to receive this continuation of coverage.

When your coverage under this Plan terminates because of your reduction in hours due to your military service, you and your Eligible Dependents may also have COBRA rights. See the COBRA chapter of this document for details. In addition, your Dependent(s) may be eligible for health care coverage under TRICARE. This Plan will coordinate coverage with TRICARE.

Coverage will not be offered for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. The Uniformed Services and the Department of Veterans Affairs will provide care for service-connected disabilities.

When you are discharged (not less than honorably) from military service, your full eligibility will be reinstated on the day you return to employment with a Contributing Employer, provided that you return to employment within:

- 90 days from the date of discharge if the period of service was more than 180 days; or
- 14 days from the date of discharge if the period of service was at least 31 days, but less than 180 days; or
- at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of service was less than 31 days.

If you are hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two years.

If you have any questions about how your military service affects your coverage, please contact the Administrative Office. Your USERRA rights are subject to change. Coverage will be provided only as required by law. If the law changes, your rights will change accordingly.

Reinstatement of Coverage after Leaves of Absence

If your coverage ends while you are on an approved FMLA leave or USERRA military service, your coverage will be reinstated on the day you return to active employment (see the Leave for Military Service section above for more details).

If you and your Employer have a dispute regarding your eligibility and coverage under the FMLA, the Plan will not have any direct role in resolving the dispute and your benefits may be suspended while the dispute is being resolved.

COBRA

In General

You can continue your health care coverage temporarily in certain circumstances where coverage would otherwise end. This extended health care coverage is called "COBRA coverage," named for the federal law that sets forth the rules for continuation coverage (the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)). COBRA coverage is identical to the health care coverage provided under this Plan and is available to you and your Eligible Dependents at your own expense provided your coverage is lost due to a "Qualifying Event."

Under the law, only "Qualified Beneficiaries" are entitled to elect COBRA coverage. Depending on the type of Qualifying Event, a Qualified Beneficiary can include any Active Participant or Eligible Dependent who are covered by the Plan when a Qualifying Event occurs. A child who becomes an Eligible Dependent by birth, adoption, or placement for adoption with the Eligible Participant during a period of COBRA coverage is also a Qualified Beneficiary. A person who becomes your Spouse during a period of COBRA coverage is not a Qualified Beneficiary.

If you choose COBRA coverage, you and/or your Dependents may continue the same medical, dental, vision and prescription drug coverage that you had prior to the Qualifying Event. COBRA does not cover Weekly Accident and Sickness, Life Insurance and AD&D Benefits.

COBRA Qualifying Events

To be eligible to elect COBRA coverage, you or your Dependent must ***lose*** coverage due to any one of the following Qualifying Events:

Qualifying Event	Who May Purchase Continuation Coverage?	For How Long?
Voluntary or involuntary termination employment, unless the termination is due to gross misconduct*	Active Participants and Eligible Dependents	18 months*
Loss of eligibility due to a reduction in your work hours*	Active Participants and Eligible Dependents	18 months*
Death	Eligible Dependents	36 months
Divorce or Legal Separation	Eligible Dependents	36 months
Dependent Child is no longer considered an Eligible Dependent under this Plan's definition	Eligible Dependent Child	36 months
Becoming disabled at some time before the 60th day of COBRA coverage and the disability lasts until the end of the 18-month COBRA coverage period	Active Participants and Eligible Dependents	29 months

* May be extended to 29 months in cases of Social Security Administration disability determination. See page 22 for details.

Availability of COBRA Coverage

The Plan will offer COBRA coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. Your Contributing Employer is responsible for notifying the Administrative Office of termination of employment, reduction in hours, death of the Eligible Employee or Eligible Apprentice, or the Contributing Employer's commencement of a bankruptcy proceeding, and the Administrative Office will determine when a the loss of coverage occurs. However, you or your family should also notify the Administrative Office promptly if any such Qualifying Event occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in providing that notice.

You Must Give Notice of Some Qualifying Events and Second Qualifying Events

For all other Qualifying Events, you must notify the Plan Administrator no later than 60 days after the Qualifying Event occurs. The notice of occurrence of any of these events and all Second Qualifying Events (as described in the section "Multiple Qualifying Events While Covered Under COBRA") must be provided to the Administrative Office in writing:

1. You divorce or legally separate from your Spouse. A copy of the court document must be included with the notice.
2. Your Child no longer meets the definition of Child.
3. A Qualified Beneficiary experiences a Second Qualifying Event, as described on the next page.

Failure to provide this notice within the form and timeframe described above may prevent you and/or your Eligible Dependents from obtaining or extending the COBRA coverage.

You must also notify the Plan Administrator when a Qualified Beneficiary is determined by the Social Security Administration to be disabled during a COBRA coverage period or when the Social Security Administration determines that a Qualified Beneficiary is no longer disabled. See the section below entitled, "COBRA Coverage for Disabled Eligible Participants."

How Is COBRA Coverage Provided?

When the Plan Administrator is notified that a Qualifying Event has occurred, the Plan Administrator will then provide you and/or your Eligible Dependents with notice of the date on which your coverage will end, and the information and election form that you will need in order to elect COBRA coverage. Under the law, you and/or your Eligible Dependents will then have only ***60 days*** from the later of the date you ordinarily would have lost coverage because of one of the Qualifying Events described above, or the date you and/or your Eligible Dependents received the notice, to apply for COBRA coverage.

IF YOU AND/OR ANY OF YOUR ELIGIBLE DEPENDENTS DO NOT CHOOSE COBRA COVERAGE WITHIN **60 DAYS** AFTER THE QUALIFYING EVENT (OR, IF LATER, WITHIN 60 DAYS AFTER RECEIVING THAT NOTICE), YOU AND/OR THEY WILL NOT HAVE ANY GROUP HEALTH COVERAGE FROM THIS PLAN AFTER COVERAGE ENDS.

Each Qualified Beneficiary has an independent (separate) right to elect COBRA coverage. COBRA coverage may be elected for some members of the family and not others. In addition, one or more Eligible Dependents may elect COBRA even if the Eligible Participant does not elect

it. However, in order to elect COBRA coverage, the family members must have been covered by the Plan on the date of the Qualifying Event or became an Eligible Dependent by birth, adoption, or placement for adoption during the period of COBRA coverage. An Eligible Participant may elect COBRA coverage on behalf of any or all of his or her Eligible Dependents.

Payment for COBRA Coverage

You are responsible for the entire cost of COBRA coverage and must pay for the coverage on a monthly basis. When you and/or your Eligible Dependents become entitled to this coverage, the Plan Administrator will notify you of the COBRA premium amounts that you must pay. Covered Persons who continue full coverage under COBRA pay 102% of the Plan's cost, except in the case of Social Security disability. (See the section below entitled "COBRA Coverage for Disabled Eligible Participants").

If you elect COBRA coverage, you do not have to send any payment with the Election Form. However, the first COBRA payment must be sent to the Plan Administrator not later than ***45 days*** after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for COBRA in full within 45 days after the date of your election, you will your right to continuation coverage under the Plan.

Payments for subsequent months are due on the first day of the month for which coverage is provided. You will be sent a bill for subsequent months. However, it is your responsibility to make payment by the first of the month whether or not you receive a bill. If you do not remit your payment by the due date or within the grace period for that payment, your COBRA coverage will end regardless of whether or not you were billed in a timely manner.

Grace Period for Payments

Although payments are due on the first day of the month, you will be given a grace period of 30 days after the first day of the month to make each payment. Failure to receive a bill or receipt of a late bill from the Administrative Office will not extend this deadline. If you fail to make your payment before the end of the grace period for that month, you will lose all rights to COBRA continuation coverage under the Plan.

Notice of Unavailability of COBRA Coverage

In the event the Plan is notified of a Qualifying Event but the Administrative Office determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent an explanation indicating why the COBRA coverage is not available. This notice of the unavailability of the COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

COBRA Coverage for Disabled Eligible Participants

If, during an 18-month COBRA coverage period the Social Security Administration determines that you (or a member of your family who is eligible for COBRA coverage) were disabled at some time before the 60th day of COBRA coverage, the disabled person and any Qualified Beneficiary who elected coverage may receive up to 11 additional months of COBRA coverage, for a maximum of 29 months. **You must notify the Plan Administrator of the determination of your disability in writing within 60 days of the date of that determination and before the end of the 18-month period of COBRA coverage**. The notice of disability must be in writing. If the 18-

month period of COBRA Coverage is extended because of Social Security disability, the COBRA premiums for any period of coverage covering the disabled person (whether single or family coverage) may be as high as 150% of the regular premiums for the additional 11 months of coverage.

This extended period of COBRA coverage will end on the earlier of:

- The last day of the month, 30 days after Social Security has determined that you and/or your Eligible Dependent(s) are no longer disabled;
- The end of the 29 months COBRA coverage;
- The date the disabled person becomes entitled to Medicare.

You must notify the Administrative Office in writing within 30 days of a final Social Security determination that you are no longer disabled.

Multiple Qualifying Events While Covered Under COBRA

If, during an 18-month period of COBRA coverage resulting from loss of coverage because of your termination of employment or reduction in hours, you die, become divorced or legally separated, become entitled to Medicare (Part A or B or both), or if an Eligible Dependent Child ceases to be an Eligible Dependent under the Plan, the maximum COBRA continuation period for the affected Spouse and/or child(ren) is extended to 36 months from the date of your termination of employment or reduction in hours.

In no case are you entitled to COBRA coverage for more than a total of 18 months if your employment is terminated or you have a reduction in hours (unless you are entitled to an additional COBRA coverage on account of disability). As a result, if you experience a reduction in hours followed by a termination of employment, the termination of employment is not treated as a second Qualifying Event and COBRA coverage may not be extended beyond 18 months from the loss of coverage due to the initial Qualifying Event.

If your family experiences a Second Qualifying Event, you must notify the Administrative Office of the Second Qualifying Event within 60 days of the event according to the procedures described in the section “You Must Give Notice of Some Qualifying Events and All Second Qualifying Events.”

In no event is anyone entitled to COBRA coverage for more than a total of 36 months.

Termination/Reduction in Hours That Follows Medicare Entitlement

If you become entitled to Medicare and you later have a termination of employment or reduction in hours, your Eligible Dependents who are Qualified Beneficiaries would be entitled to COBRA coverage for a period of: (a) 18 months (29 months if the 11-month Social Security disability extension applies) from your termination of employment or reduction in hours; or (b) 36 months from the date you became entitled to Medicare, whichever is longer.

Special Enrollment Rights

If, while you are enrolled for COBRA coverage, you marry, have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that Eligible Dependent for coverage for the balance of the period of COBRA coverage by doing so within 31 days after the marriage, birth, adoption, or placement for adoption.

You may enroll an Eligible Dependent in COBRA coverage if, while you are enrolled in COBRA coverage, your Eligible Dependent loses coverage under another group health plan provided:

- The Eligible Dependent was eligible for coverage under the terms of the Plan when you enrolled in COBRA coverage and declined coverage for the Eligible Dependent; and

- you enroll your Eligible Dependent within 31 days after the termination of the Eligible Dependent's other group health plan coverage.

Adding an Eligible Dependent may cause an increase in the amount you must pay for COBRA coverage.

Early Termination of COBRA Coverage

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

- Any required payment is not made on time;
- The person receiving the coverage first becomes covered by another group health plan;
- The person receiving the coverage becomes entitled to Medicare; or
- The Plan terminates its group health plan and no longer provides group health insurance coverage to its members.

Notice of Early Termination of COBRA Coverage

The Plan Administrator will notify the Qualified Beneficiary(ies) if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the Qualifying Event that entitled the Qualified Beneficiary(ies) to COBRA coverage. This written notice will explain the reason COBRA terminated. The notice will be provided as soon as practicable after the Plan Administrator determines that COBRA coverage will terminate early.

Confirmation of COBRA Coverage to Providers

Under certain circumstances, federal rules require the Administrative Office to inform your health care providers as to whether you have elected and/or paid for COBRA coverage. This rule only applies in certain situations where the provider is requesting confirmation of coverage and you are eligible for, but have not yet elected COBRA coverage, or you have elected COBRA coverage but have not yet paid for it. In these circumstances, the providers will be given the status of the election and/or payment, and will be given notice that no claims will be paid until the amounts due have been received. They also will be informed that COBRA coverage will terminate effective as of the date of any unpaid amount if payment is not received by the end of the grace period.

If You Have Questions

Questions concerning the Plan or your COBRA coverage rights should be addressed to the Plan Administrator identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

Other Health Coverage Alternatives to COBRA

Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the Health Insurance Marketplace. Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. For more information, visit www.healthcare.gov.

You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a group health plan sponsored by your Spouse's employer) within 30 days after your group health coverage ends because of the qualifying events listed above. You will also have the same special enrollment right at the end of COBRA continuation coverage if you elect COBRA continuation coverage for the maximum time available to you.

Keep the Plan Informed of Address Changes

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

Plan Contact Information

Administrative Office
Roofers Union Local 30
Combined Health and Welfare Plan
830 Bear Tavern Road
P.O. Box 1028
West Trenton, NJ 08628
Telephone: 609-883-6688

Independence Blue Cross Conversion Privilege

You may also have the right to convert your Medical coverage to an individual polity provided by Independence Blue Cross. See the section "Termination of Your Coverage and Conversion Privilege under this Group Coverage" in the attached Independent Group Health Benefits Booklet/Certificate for the Personal Choice Health Benefits Program for details.

MEDICAL COVERAGE

You are covered for Medical coverage based on the following:

ELIGIBLE PARTICIPANTS (ELIGIBLE EMPLOYEES AND ELIGIBLE APPRENTICES)

Comprehensive Medical Benefits – Comprehensive Medical Benefits are insured and provided by Independence Blue Cross ("IBC"). Please refer to Appendix A for details on these benefits including:

- Covered benefits;
- Limitations;
- Exclusions;
- Cost-sharing;
- Extent to which preventive services are covered;
- Medical tests, devices, and procedures;
- provisions governing the use of network providers and out of area services;
- limits on the selection of primary care providers or the providers of specialty medical care;
- limits applicable to emergency care;
- coordination of benefits; and
- provisions regarding pre-authorization or utilization review requirements.

ELIGIBLE DEPENDENTS

Your Eligible Dependents are eligible for the same medical benefits for which you are eligible.

PRESCRIPTION DRUG COVERAGE

The Plan provides you and your Eligible Dependents with coverage for prescription drugs that is self-insured and administered by FutureScripts. You will receive a FutureScripts identification card when you first become eligible for Plan coverage.

To help you understand the program the following explanations may be useful:

Co-payment – this is the amount you (and not the Plan) pay for a prescription drug.

Generic – A generic drug is defined by its official chemical name and is an equivalent to a brand name medication. All drugs, including generics, must meet the same Food and Drug Administration (FDA) standards for quality, strength, purity, effectiveness, stability, and safety.

Formulary Brand Name – A formulary is a list of preferred medications. The list has been put together by doctors and pharmacists and will be regularly updated and maintained by them. The list contains brand name drugs used to treat all illnesses. In fact, many of the drugs you are already taking are probably included on the list.

Non-Formulary Brand Name – A non-formulary drug is a medication that is not listed on the formulary.

If you are taking a drug that is on the Plan's "maintenance" drug list, you must use the mail order program or Preferred Retail Pharmacy for refills, as described at the end of this chapter.

HOW TO OBTAIN YOUR PRESCRIPTION DRUGS

FutureScripts has established a network of more than 60,000 retail pharmacies through which you may fill prescriptions. If you use one of FutureScripts' Participating Pharmacies, your out-of-pocket costs may be lower than if you use a Non-Participating Pharmacy. You may locate a Participating Pharmacy by selecting the *Find a Participating Pharmacy* feature at www.ibx.com or contacting Independence Blue Cross customer service at 1-800-ASK-BLUE.

For service, simply present your identification card and a valid prescription at any Participating Pharmacy for service. The Participating Pharmacy will dispense a prescription and collect the applicable copayment (as described on the next page). You will be asked to sign a signature log to verify that you picked up the medication.

If you purchase a prescription from a Non-Participating Pharmacy, you will have to submit a claim along with the prescription drug receipt to FutureScripts for reimbursement. You must submit the receipts no later than 45 days from the date of purchase in order to receive reimbursement. Please note any difference in the cost of the prescription and the amount allowed by the Plan is your responsibility. It is always to your advantage to use a Participating Pharmacy.

See the "Claims Information and Appeals" chapter of this booklet for information on how to file a prescription drug claim.

Coinsurance and Annual Out-of-Pocket Copayment Maximum

Prescriptions are filled or checked by a registered pharmacist regardless of how you choose to purchase them and you will be required to pay a coinsurance when you receive a prescription. The Plan pays a percentage (80%) of the prescription cost, and you (and **not** the Plan) are responsible for paying the rest - 20% up to a maximum amount as described below. Your 20%

cost-sharing is what is known as *coinsurance*. The maximum amount you pay in coinsurance for any single prescription is known as the *maximum copayment*.

Once the total amount of copayments, deductibles, and coinsurance you and/or your covered dependents pay for prescription drugs (and medical benefits) during the Plan year reaches the annual out-of-pocket maximum, the Plan will pay 100% of your prescription drugs for the remainder of the Calendar year (until December 31st).

Summary of Prescription Drug Benefit Coinsurance, Maximum Copayment and Out-of-Pocket Limit		
Medication Type	**Prescriptions from a Retail Pharmacy**	**Prescription from a Mail Order Pharmacy**
Generic Medications	20% coinsurance to a maximum of $20 copayment	20% coinsurance to a maximum of $40 copayment
Formulary Brand Drugs	20% coinsurance to a maximum of $100 copayment	20% coinsurance to a maximum of $200 copayment
Non-Formulary Brand Drugs	20% coinsurance to a maximum of $200 copayment	20% coinsurance to a maximum of $400 copayment
ACA-Required Preventive Medication	The Plan covers ACA preventive medications to you at no cost. For the most up-to-date list of covered medications (including those covered as preventive under the ACA), contact Future Scripts.	
Supply of Medication	Up to a 34-day supply	Up to a 90-day supply
Annual Out-of-Pocket Limit:	Individual: $6,600/Family: $13,200* *integrated with medical benefits	
Using the mail order program saves you money because you receive three months of drugs for two copayments. Please note that you must use the mail order program for any "maintenance drugs", as described below.		

Mandatory Generic Program—If you fill a prescription for a brand name drug for which there is a generic equivalent, the pharmacy or mail order program will dispense the generic equivalent. You may still receive the brand name drug (for instance, if your physician indicates the prescription is to be "dispensed as written") but you will have to pay the difference between the brand name drug and its generic equivalent plus the 20% coinsurance. For ACA-required preventive drugs, brand name drugs are generally payable only if a generic alternative is medically inappropriate.

You may obtain an updated list of Participating Pharmacies by visiting the Future Scripts web site at www.futurescripts.com. You may also call Future Scripts at the number on your ID card.

USE OF THE FORMULARY

FutureScripts has negotiated preferred pricing on certain drugs, included on a list called a Formulary. As a result of this preferred pricing (which is often on drugs by different manufacturers for the same medical condition), lower co-payments can be offered on the formulary drugs. Where possible, you are encouraged to obtain prescriptions for formulary drugs rather than non-formulary drugs, as use of formulary drugs saves both you and the Plan money.

MAIL ORDER PROGRAM AND PREFERRED RETAIL PHARMACY REQUIRED FOR MAINTENANCE DRUGS

The mail order program is designed to be more convenient and less expensive for you to obtain drugs that you use on a long-term basis. If you are taking a drug that is on the Plan's "maintenance" drug list, you must use the mail order program for refills or a Preferred Retail Pharmacy to fill 90-day prescriptions. Maintenance drugs generally include drugs that treat chronic conditions such as high blood pressure or diabetes. You may obtain up to a 90-day supply of medication if indicated by a physician.

You can order prescriptions through the mail order program by telephone, by calling the number listed on the back of your ID card. Or, you may do so by filling out and mailing in the *Mail Order Service Form* available at www.ibxpress.com, along with your prescription to Future Scripts. If you choose to fill your maintenance drugs through a Preferred Retail Pharmacy instead of the Mail Order Program, the Preferred Retail Pharmacies are ShopRite, Pathmark, Superfresh, SuperValu, Rite Aid and Costco.

You should contact FutureScripts to find out if a drug that you are taking is on the maintenance drug list. If it is, you must get any refills filled through the mail order program or at a Preferred Retail Pharmacy.

COVERED PRESCRIPTION DRUGS

Coverage is provided only for those pharmaceuticals (drugs and medicines) that are:

- Approved by the US Food and Drug Administration (FDA) as requiring a prescription;
- FDA approved for the condition, dose, route, duration and frequency for which they are prescribed;
- Preventive medications as required under the ACA including required over-the-counter (OTC) drugs (coverage of preventive medications, including OTC medications, requires a prescription from a licensed health care provider)
- Prescribed by a physician or other health care provider authorized by law to prescribe them; and
- Not otherwise specifically excluded in this chapter.

A number of drugs require Prior Authorization by FutureScripts. FutureScripts maintains the list of drugs that require Prior Authorization and will intervene at the point of service to support appropriate use through pre-established clinical criteria. Contact FutureScripts for information on drugs needing Prior Authorization and for information on which drugs have a limit to the quantity payable by this Plan.

ITEMS THAT ARE NOT COVERED

Prescription drug benefits are not payable for:

- Non-prescription drugs (or non-legend or over-the counter) drugs or medicines except insulin and ACA-required preventive medications (coverage of OTC preventive medications requires a prescription from a licensed health care provider);
- Expenses incurred due to participation in an Approved Clinical Trial that are: (1) the investigational drugs being studied as part of the Approved Clinical Trial; (2) drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) drugs inconsistent with widely accepted and established standards of care for a patient's particular diagnosis;
- Serums, Toxoids and Vaccines;
- Prescriptions for Harvoni, Olysio and Sovaldi. All other Hepatitis C treatments and prescriptions (per the approved formulary) will be covered subject to prior authorization.
- Diagnostic agents;
- Supplies and devices including respiratory therapy supplies, ostomy supplies and peak flow meters;
- Intravenous drugs;
- Rh immune globulin human agents;
- Blood products;
- Vitamin A derivatives (retinoids) for dermatological use are excluded after the patient reaches age 35 (subject to prior authorization before that age)
- Drugs, medicines or devices for:
    - Hair removal or hair growth products (e.g., Propecia, Rogaine, Minoxidil, Vaniqa);
    - Photo-aged skin products;
    - Erectile dysfunction (e.g., Yohimbine).

The Board of Trustees will review this list from time to time, in light of new drugs approved by the FDA and other considerations, and revise the list of covered and non-covered drugs based on criteria established by Future Scripts. Please contact Future Scripts for the most up-to-date information on which drugs are not covered by the Plan.

Prescription Drug Benefits for Active Participants and Their Eligible Dependents Who Are Medicare Eligible

Medicare covers prescription drug benefits under Part D. If you, as an Active Participant, and/or your Eligible Dependent(s) are enrolled in either Part A or B of Medicare, you are eligible for Medicare Part D. For Active Participants and their Eligible Dependents who are Medicare-eligible, this Plan offers "Creditable Coverage." This means that this Plan's prescription drug benefits are expected to pay out, on average, as much or more as the standard Medicare prescription drug benefits will pay. Since this Plan's coverage is as good as Medicare, you do not need to enroll in a Medicare Prescription Drug Plan while you have this Plan's prescription drug coverage as an Eligible Participant in order to avoid a late penalty under Medicare. When you lose coverage under this Plan, you may enroll in a Medicare Prescription Drug Plan either during a special enrollment period or during Medicare's annual enrollment period (November 15-December 31 of each year). For more information about Creditable Coverage see the Plan's Notice of Creditable Coverage that will be mailed to you from the Plan once a year. You may request another copy of this Notice by calling the Administrative Office.

DENTAL BENEFITS

The Plan provides you and your Eligible Dependents with coverage for Dental Benefits that are self-insured and administered by United Concordia Companies, Inc. ("United Concordia"), referred to as Concordia FLEX.

Dental services are offered through Network Providers and from Out-of-Network Providers. United Concordia will provide you with a list of Network Providers when you are first eligible. You are free to select any dentist or dental specialist you wish, whether they are In-Network or Out-of-Network. Each of your Eligible Dependents is free to select the dentist or dental specialist of his/her choice.

You will receive a Concordia FLEX identification card when you first become eligible for Plan coverage. You may call Concordia at 800-332-0366 to request new cards if you lose your card. Show your Concordia FLEX identification card when you go to the dentist.

BENEFIT MAXIMUMS

The Plan Maximum for Dental Benefits is $900 per Covered Person per calendar year. The Plan does not provide coverage for expenses for any Covered Person for dental services exceeding $900 per calendar year. These expenses may be incurred by use of Concordia FLEX Providers, Out-of-Network Providers, or any combination.

The following Class 1 – Covered Diagnostic and Preventive Services do not count toward the Annual Plan Maximum:

- Exams
- X-Rays
- Cleanings
- Flouride Treatments
- Sealants
- Palliative Treatment

IF YOU USE A NETWORK PROVIDER

You and your Eligible Dependents may obtain dental services listed on the Schedule of Dental Procedures payable at 100% of the Maximum Allowable Charge up to $900 per Covered Person per calendar year. Because Network Providers have agreed to accept the Maximum Allowable Charge as payment in full, you will have no out-of-pocket costs for the first $900 you have in covered dental expenses. The Class 1 – Covered Diagnostic and Preventive Services listed in the Benefit Maximum section above will not count toward the annual Plan Maximum.

In order to schedule an appointment with a Network Provider, first check the provider directory or list to assure the provider participates. Then, call the provider's office and identify yourself as being covered under this Plan. You will not have to submit any claims; the Network Provider will

handle all paperwork. Simply complete the patient information and payment authorization section of the provider's claim form, and payment will be made directly to him or her.

If you go to a Network Provider to receive services where the frequency limit for the procedure has been reached, or if you reach your annual limit, you must pay the provider, but his charge will not exceed the Maximum Allowable Charge set by United Concordia which will be lower than the amount most Out-of-Network Providers will charge. If you go to a Network Provider to obtain treatment for a procedure not covered by the Plan, you must pay the provider's charge for that service.

IF YOU USE AN OUT-OF-NETWORK PROVIDER

An Out-of-Network Provider is one that does not have a contract with United Concordia to provide discounted fees for services. If you go to a provider who does not participate in the Concordia FLEX network, you must pay the provider whatever amount he or she charges. You may submit a claim form to the United Concordia to receive reimbursement for the charge. The most you will be reimbursed for any procedure covered under the Plan is up to the Maximum Allowable Charge. You will be responsible for any portion of the provider's charge that exceeds the Maximum Allowable Charge and any amounts that exceed $900 in a Calendar Year. See the "Claims Information and Appeals" chapter of this booklet for information on how to file a dental claim.

United Concordia maintains the Schedule of Dental Procedures and the Maximum Allowable Charge for all Dental procedures it covers. If you would like to know the actual reimbursement level for a particular procedure, please contact United Concordia.

PREDETERMINATION OF BENEFITS

Although you do not have to seek predetermination of benefits before you start treatment, you are encouraged to do so in the case of major dental procedures. A predetermination lets your dentist and you know exactly what your coverage is and how much you will have to pay.

COURSE OF TREATMENT

A course of treatment is a planned program of one or more services or supplies for the treatment of a dental condition. The course of treatment starts as of the date that a dentist first does something to correct or treat the diagnosed dental condition.

ALTERNATE TREATMENT

There are often several ways to treat a dental condition. For example, a filling or a crown can restore a tooth, or a fixed bridge or partial denture can replace missing teeth. United Concordia will authorize treatment for the least expensive procedure; of course, the procedures selected must meet accepted standards of dental treatment. You do not have to accept the less expensive procedure. However, you must pay any additional charges if you choose the more expensive procedure.

EXCLUSIONS

No payment shall be made for:

- Treatment solely for the purposes of cosmetic improvement;

- Replacement of a lost or stolen appliance;
- Replacement of a bridge or denture within three years after the date it was originally installed;
- Replacement of a bridge, crown, or denture which is or can be made usable according to common dental standards;
- Procedures, appliances or restorations (except full dentures) whose main purpose is to
    - change vertical dimension; or
    - diagnose or treat conditions or dysfunctions of the temporomandibular joint; or
    - stabilize periodontally involved teeth.
- Dental services that do not meet common dental standards;
- Services not included as covered dental expenses in the dental schedule; or
- Services for which benefits are not payable according to the "general limitations"

GENERAL LIMITATIONS

No payment will be made for expenses incurred for you or any one of your Dependents:

- In excess of the $900 annual maximum;
- for or in connection with services or supplies resulting from an accidental injury and which are deemed to be the responsibility of a third party;
- for or in connection with an injury arising out of, or in the course of, any employment for wage or profit;
- for or in connection with an Injury or Illness which is covered under any Workers' Compensation, occupational disease, similar law, or work-related;
- for charges made by a hospital owned or run by a federal, state, or municipal agency unless there is a legal obligation to pay such charges whether or not there is any insurance;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which would not have been made if the person had no insurance, including services provided by a member of the patient's immediate family;
- to the extent that they are more than Maximum Amount on the Schedule of Dental Procedures;
- for charges for unnecessary care, treatment or surgery;
- to the extent that you or any of your Eligible Dependents is in any way paid or entitled to payment for those expenses by or through a public program; or
- in connection with experimental procedures or treatment methods not accepted.

COVERED DENTAL SERVICES—CONCORDIA FLEX

The following services are covered at 100% of the Maximum Allowable Charge as set by United Concordia up to the Annual Maximum of $900 per Covered Person.

Diagnostic and Preventive Services

- Exams
- X-Rays
- Cleanings
- Fluoride Treatments
- Sealants
- Palliative Treatment

Basic Services

- Basic Restorative
- Endontics
- Non-surgical Periodontics
- Repairs
- Simple Extractions
- Surgical Periodontics
- Anesthesia
- Complex Oral Surgery (Partial and complete bony impactions or excision of tissue are not covered)

Major Restorative

- Inlays, Onlays, Crowns
- Prosthetics

Orthodontia

- Diagnostic
- Active
- Retention Treatment

VISION BENEFITS

The Plan provides you and your Eligible Dependents with coverage for Vision Benefits that is self-insured and administered by Vision Benefits of America (VBA).

Vision services are offered through Participating Providers or from Non-Participating Providers. To obtain a list of Participating Providers, free-of-charge, you can contact VBA. VBA maintains a network of more than 13,000 Participating Optometrists, Ophthalmologists and retail locations nationwide. If you prefer to use a Non-Participating Provider, the reimbursement is based on the Non-Participating Provider Reimbursement Schedule. See the Schedule on the next page for more information.

VISION BENEFITS

The Plan provides the following Vision Benefits:

- Vision exam once every 12 months which includes a professional examination and an eye refraction including case history, exam for pathological abnormalities of the eyes and lids, ranges of clear single vision and balance and coordination of muscles for far-seeing and near-seeing and special working distances.
- Lenses once every 12 months
- Frames once every 12 months. The Plan offers a wide selection of frames. However, if you select a frame that costs more than the amount allowed by your plan, you will be responsible for any additional charges.
- OR
- Contact Lenses, in lieu of all other benefits, up to an allowance of $150 toward their cost.

HOW TO USE THIS BENEFIT

Before you receive vision care services, you must obtain a validated VBA Benefit Form ("Benefit Form") by doing one of the following:

- Call VBA at 1-800-432-4966; or
- Visit VBA's website at www.visionbenefits.com

If you are eligible, you will be sent a personalized Benefit Form along with an updated provider roster. You must obtain this Benefit Form before you schedule an eye exam. Once you have received the Benefit Form, you may then choose one of the following options for obtaining vision services.

BENEFITS IF YOU USE A VBA PARTICIPATING PROVIDER

Participating Providers (optometrist, ophthalmologists or dispensing optician) have a contract to provide discounted fees to you for services covered under this Vision Benefit. By using the services of a Participating Provider, this Plan covers the benefits described in this chapter at no cost to you if what you select falls within the Plan's allowance. A current list of Participating Providers is available at VBA's website www.visionbenefits.com or by calling VBA at 1-800-432-4966.

When you choose to obtain services from a VBA Participating Provider, this Plan covers the examination, lenses and frames, at no cost to you, if the materials selected fall within your Plan's allowance. Through a VBA Participating Provider, only scratch resistant lenses are covered in full. Any additional care, services and/or materials are not covered by this Plan but may be arranged between you and the provider at your expenses.

1. Choose a VBA Participating Provider and make your appointment for the eye examination.
2. You must present the Benefit Form to the VBA Participating Provider on your first visit. If you do not do this, you will be reimbursed according to the Non-Participating Provider Reimbursement Schedule. When the examination has been completed, the VBA participating provider will have you sign the Benefit Form.
3. The VBA provider will take care of all paperwork for payment. VBA will pay the Participating Provider for the services you received according to VBA's Agreement with the Provider.
4. You will be responsible to pay the VBA Participating Provider for any extra cost or non-covered items, and any amounts in excess of the Plan's allowances.

BENEFITS FROM A NON-PARTICIPATING PROVIDER

Non-Participating Providers do not have a contract with VBA. Services may be received from any licensed ophthalmologist, optometrist, and/or dispensing optician. If you use the services of a Non-Participating Provider, you will need to pay the provider for all services and then submit the bill to Vision Benefits of America. You will be reimbursed up to the amounts listed in the Reimbursement Schedule below. Vision claims submitted beyond one year after the date of service will not be considered for reimbursement. See the "Claims Information and Appeals" chapter of this booklet for information on how to file a vision claim.

NON-PARTICIPATING PROVIDER REIMBURSEMENT SCHEDULE

The following is a listing of the reimbursement schedule for Non-Participating Providers:

Professional Fees	
Vision Examination, up to	$35.00
Materials	**Pair**
Single Vision Lenses, up to	$30.00
Bifocal Lenses, up to	$40.00
Trifocal Lenses, up to	$60.00
Lenticular Lenses, up to	$80.00
Frames, up to	$35.00

OR

Contact Lenses
In lieu of all other benefits for the benefit period, an allowance of up to $150. You will not receive any additional monies for contact lenses and/or contact lens exam costs that are over the allowance of $150.

Procedures for Receiving Benefits When You Use a Non-Participating Doctor for an Exam and a Participating Provider for Vision Materials

Once you receive your exam from the doctor, pay the doctor for the exam and obtain a receipt for the exam and a prescription for your lenses. You should then call one of the VBA Participating Providers who has an asterisk next to the name make an appointment to get your prescription filled. The asterisk means that the Provider is willing to fill another doctor's prescription. You should then take your Benefit Form and prescription to the VBA Participating Provider on your first visit. The Provider will fit you with your new glasses (or contact lenses) and take care of any further paperwork associated with your glasses. The Participating Provider will be paid by VBA for covered services.

You will need to submit a claim for the exam and you will be reimbursed directly for the expense according to the Reimbursement Schedule (see above). Simply submit the receipt for the exam to VBA, along with a note explaining that you had your prescription filled by a VBA Participating Provider.

If any problems arise with your glasses or contact lenses due to inaccurate prescription written by a Non-Participating Doctor, VBA and the VBA Participating Provider assume no responsibility.

VISION BENEFITS LIMITATIONS AND EXCLUSIONS

The Vision Benefit is designed to cover visual needs rather than cosmetic materials.

EXTRA COST ITEMS

There will be extra cost involved if you select:

- Rimless frames;
- A frame that costs more than the Plan's allowance;
- Polycarbonate lenses (covered if under age 19);
- Progressive or seamless multifocal lenses;
- Contact lenses (in excess of the Plan's allowance);
- Anti-Reflective coated lenses;
- Photochromic lenses; and
- Coated lenses (except 1 year scratch resistant protection).

EXCLUDED ITEMS

There are no benefits for professional services or materials connected with:

- Orthoptics or vision training, subnormal vision aids or non-prescription lenses
- Lost or broken lenses and frames furnished under this program (unless you are eligible for new frames or lenses)
- Medical or surgical treatment of the eyes
- Two pairs of glasses in lieu of bifocals

- Services or materials provided as a result of any Workers' Compensation Law or similar legislation.
- Any eye examination required by an employer as a condition of employment; or any services or materials provided by any other vision care plan or group benefit plan containing benefits for vision care.

LIFE INSURANCE BENEFITS

If you are an Eligible Employee or Eligible Apprentice you are eligible for the Life Insurance Benefits described in this chapter.

The Life Insurance Benefits are insured by Amalgamated Life Insurance Company ("Amalgamated") and the benefits are subject to the terms and provisions of the insurance policy that are described in detail in Amalgamated's Certificate which is attached hereto as Appendix C.

In the event of your death from any cause, on or off the job, while you are covered and upon the Administrative Office's receipt of complete proof of death, your named beneficiary will be entitled to receive Life Insurance Benefits. The amount that will be paid to your beneficiary will equal to the amount listed below. If there are any discrepancies between this summary and Appendix C, the Appendix will govern.

AMOUNT OF LIFE INSURANCE BENEFITS

Eligible Employees	$10,000
Eligible Apprentices	$5,000

NAMING A BENEFICIARY

You may name anyone you wish as your beneficiary by completing the Beneficiary Designation Section of this Plan's Enrollment Card and submitting it to the Administrative Office. Further, you may name more than one beneficiary to receive the proceeds of your Life Insurance Benefits. You can change your beneficiary or beneficiaries at any time by filing a new Enrollment Card. The change becomes effective when the Administrative Office receives a signed copy of your new Enrollment Card with your new Beneficiary Designation. The beneficiary on file at the Administrative Office at the time of your death is the one who will receive the proceeds of your Life Insurance Benefits. If you name more than one beneficiary, each surviving beneficiary will share equally, unless you indicate otherwise. Your death proceeds will be paid in a lump sum to your estate if you die without naming a beneficiary or all of your beneficiaries have died before you. If payment would otherwise be payable to your estate due to the above, Amalgamated has the right to pay all or part of the benefit to the first of the following surviving relatives: your spouse; your children, equally; your parents, equally; or your siblings, equally.

Any payment made by Amalgamated in good faith will fully discharge Amalgamated's liability to the extent of such payment.

OTHER PROVISIONS

The Plan also contains a number of provisions including a waiver of premium benefit for total disability and conversion privileges as well as forms of payment that are all explained in the Amalgamated Life Insurance Company Certificate.

FILING A LIFE INSURANCE CLAIM

See the Claims and Appeals chapter of this document for details on filing a claim for benefits.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

If you are an Eligible Employee or Eligible Apprentice you are eligible for the Accident Death and Dismemberment (AD&D) Benefits described in this chapter.

The Accidental Death and Dismemberment Benefit is insured by Amalgamated and the benefits are subject to the terms and provisions of the insurance policy which are described in detail in Amalgamated's Certificate which is attached as Appendix C. This chapter contains a summary of the Accidental Death and Dismemberment Benefits. If there is a discrepancy between the information in this chapter and the Certificate, the Certificate will control.

An Accidental Dismemberment Benefit is paid to you, or an Accidental Death Benefit is paid to your beneficiary if you have a covered loss due solely to an accident. A covered loss is your loss of life, or your loss of one or more body parts as described below or your loss of sight. The loss must occur within 90 days after the date of the accident. These benefits are *in addition to* any other benefits you may receive.

RECEIPT OF YOUR AD&D BENEFIT

If you have an accident that results in a dismemberment to you, you will receive an Accidental Dismemberment Benefit. If you have an accident that results in your death, your beneficiary will receive an Accidental Death Benefit. See the Life Insurance chapter or the Certificate for details on naming a beneficiary.

AMOUNT OF YOUR AD&D BENEFIT

The full amount of AD&D Benefit is payable according to the following. Depending upon your loss, the Plan will pay either the full benefit or half the benefit, in one lump sum payment, as shown below.

SCHEDULE OF ACCIDENTAL DEATH AND DISMEMBERMENT LOSSES

Loss	Eligible Employee	Eligible Apprentice	Payable to:
Life	$10,000	$5,000	Your beneficiary
Both hands	$10,000	$5,000	You
Both feet	$10,000	$5,000	You
Sight of both eyes	$10,000	$5,000	You
One hand and one foot	$10,000	$5,000	You
One hand and the sight of one eye	$10,000	$5,000	You
One foot and the sight of one eye	$5,000	$2,500	You
One hand	$5,000	$2,500	You
One foot	$5,000	$2,500	You

Sight of one eye	$5,000	$2,500	You

A loss means a permanent loss of a hand or foot that is completely severed at or above the wrist or ankle joint. Loss of sight means that the sight in the eye is completely lost and cannot be restored or recovered.

If you have more than one loss in any one accident, payment is made only for the one loss for which the larger amount is payable. Your benefit will never exceed the amounts listed above.

Exclusions

No benefit is payable under this provision for any loss caused directly or indirectly, wholly or partly, by:

- Riding in or boarding or alighting from any aircraft owned, chartered or leased by or on behalf of the insured participant;
- Riding in or boarding or alighting from any vehicle or device for aerial navigation as a pilot or crew member;
- Declared or undeclared war or an act of either;
- Suicide, a suicide attempt, self-destruction or intentionally self-inflicted injury;
- Medical or surgical treatment of sickness or disease;
- Intoxication or being under the influence of drugs unless taken as prescribed by a Doctor. Intoxication means that which is defined and determined by the laws of the jurisdiction where the loss or cause of loss was incurred;
- Participation in a felony;
- Service in the armed forces of any country. However, orders to active military service for two (2) months or less will not constitute service in the armed forces;
- Sickness or disease, except pyogenic infections which occur through an accidental cut or wound;

FILING AN AD & D CLAIM

See the Claims and Appeals chapter of this document for details on filing a claim for benefits.

WEEKLY ACCIDENT AND SICKNESS BENEFITS

If you are an Active Participant, you are entitled to Weekly Accident and Sickness Benefits described in this Chapter. This section does not apply to Eligible Dependents.

This weekly benefit will be payable to you if, while covered under the Plan, you become disabled and unable to work because of a non-occupational accident or sickness. This benefit is administered through the Administrative Office.

Benefits will begin as of the first day of disability due to an accident or as of the eighth day of disability due to illness. Benefits may continue for any one period of disability up to a maximum of 26 weeks.

Successive periods of disability will be considered as one continuous disability, unless either of the following is true:

- The second period of disability results from causes that are unrelated to the first period of disability, and you were actively at work for at least one full day between the two; or

- You were actively at work at least two consecutive weeks between the first and second periods of disability.

You do not have to be confined to your home to qualify for benefits. However, you must be under the care a legally qualified physician. No disability will be considered to begin more than three days before your first visit to a physician.

If your disability is job-related, any Workers' Compensation claim should be filed with your Employer and not through the Administrative Office.

The Amount of Your Weekly Accident and Sickness Benefit

The weekly benefit amount is $250 for Active Participants. This amount will be prorated accordingly for partial weeks.

Filing A Claim for Weekly Accident and Sickness Benefits

In the event that you become disabled, you should report the disability to the Administrative Office within 30 days from the commencement of disability so that a claim form may be obtained.

The claim form must be fully completed by all parties called for (including a physician statement) and submitted to the Administrative Office as promptly as possible, but in no event more than 90 days after the start of disability. ***Failure to submit a claim form within 90 days of the start of disability will result in denial of the claim.*** Improperly completed forms may cause a delay in the payment of your claim. If disability continues beyond two weeks, intermediate claim forms must be filed as requested but no more frequently than every other week.

In no event will any benefit be paid under this section on any claim for treatment of an Illness or Injury that is work-related. If a determination is made under a Workers' Compensation program that the Illness or Injury is not work-related, a benefit may be payable under this section on a claim for treatment of the Illness or Injury, subject to all Plan provisions, limitations and exclusions.

GENERAL EXCLUSIONS

In addition to the Exclusions set forth in other sections of this booklet and the Appendices, the following exclusions apply:

- Services, supplies, or treatment that are not prescribed as Medically Necessary by a Physician. This exclusion also applies to any hospital confinement (or any part of a confinement) that is not recommended or approved by a Physician;
- Any portion of an expense that exceeds the Reasonable and Customary charges for services, supplies or treatment;
- Cosmetic surgery, unless required because of:
    - An accidental bodily Injury occurring while insured;
    - Reconstructive surgery when service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part; or
    - Reconstructive surgery due to congenital disease or anomaly of a Dependent Child which has resulted in a functional defect;
- An elective abortion, except for charges incurred:
    - Which results directly from complication of an abortion; or
    - For an abortion when the insured female's life would be endangered if the fetus were to be carried to term;
- Services, supplies or treatment furnished on account of Injury or other loss sustained as a result of war, or any act of war, whether declared or undeclared, or by any act of war, whether declared or undeclared, or by any act of international armed conflict involving the armed forces of any international authority;
- Expenses incurred as a result of participation in a felony, riot or insurrection;
- Charges incurred as a result of an accidental bodily Injury arising out of or in the course of your or your Eligible Dependent's employment;
- Charges incurred as a result of an occupational disease. For the purposes of this Plan, "occupational disease" means a disease for which you or your Eligible Dependents are entitled to benefits under the applicable Workers' Compensation law, Occupational Disease law or similar law;
- Charges for services which you or your Eligible Dependent obtains, or is entitled to obtain, under any plan or program without charges, except Medicaid. This will include charges provided or paid for by the federal government at a Veteran's Administration facility for:
    - An Injury or Illness related to military service; or
    - You or your Eligible Dependent, if you are retired from the armed services;
- Any charges which you or your Eligible Dependents are not legally obligated to pay;
- Any service or treatment that you or your Eligible Dependent receives prior to the effective date of your (or your Dependent's) eligibility under this Plan;
- Charges for which benefits are provided under the law of any government (except Medicaid). For example, benefits provided under Medicare or any benefits which are

recovered or recoverable under any mandatory "No-Fault" automobile law are not covered under the Plan;

- Charges for any services, treatment or supplies which are provided by reason of the past or present service of you or your Eligible Dependent in the armed forces of any country;
- Charges for dental care or treatment, or dental X-rays, unless specifically provided;
- Charges incurred for Experimental Procedures, except as specifically set forth in this SPD;
- Charges incurred for recreational or leisure therapy;
- Charges incurred in connection with radial keratotomy or any other surgical procedure performed to correct myopia (near sightedness) or hyperopia (far sightedness);
- Charges incurred for services rendered by any provider who is your or your Eligible Dependent's spouse, parent, child, brother or sister, or who lives in your or your Eligible Dependent's home;
- Charges for hearing aids, eye refractions, eyeglasses or their fitting, unless specifically provided; or
- Charges incurred in connection with any of the following procedures:
    - Artificial insemination; or
    - In vitro fertilization.

COORDINATION WITH OTHER PLANS

This section applies to self-insured benefits described in this booklet. There are specific coordination of benefit rules that apply to your insured medical benefits. These rules are described in Appendix A.

COVERAGE UNDER MORE THAN ONE PLAN

When and How COB Applies

This section describes the circumstances when a Covered Person may be entitled to medical, dental, and/or vision benefits under this Plan and may also be entitled to recover all or part of your medical, dental and/or vision expenses from some other source.

For the purposes of this COB section, the word "plan" refers to any medical or dental policy, contract, or plan, whether insured or self-insured, that provides benefits payable on account of medical, dental, and/or vision services incurred by the Covered Person or that provides medical, dental, and/or vision services to the Covered Person.

Some families are covered by more than one medical or dental plan. If this is the case with your family, ***you must let this Plan know about all your coverages when you submit a Claim.***

COB operates so that one of the plans (called the "primary plan") will pay its benefits first. The other plan (called the "secondary plan") may then pay additional benefits. ***In no event will the combined benefits of the primary and secondary plans exceed 100% of the medical, dental and/or vision expenses incurred.*** Sometimes, the combined benefits that are paid will be less than the total expenses.

Which Plan Pays First: Order of Benefit Determination Rules—The Overriding Rules

This Plan uses the following order of benefit determination rules which are based, in part, on the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC). When two plans cover the same person, the following rules establish which is the primary plan and which is the secondary plan. If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established. These rules are as follows:

Rule 1: Employee

The plan that covers a person as an employee pays first.

Rule 2: Dependent

If the previous rule does not determine the order of benefits, then the plan that covers a person as a Dependent pays first.

If a Dependent Child has coverage under this Plan and also has coverage as a Dependent under his/her Spouse's plan, the Spouse's plan pays first.

When a Dependent Child is covered under this Plan and as a Dependent under another plan through a parent, the plan that covers the parent whose birthday falls earlier in the calendar year

pays first; and the plan that covers the parent whose birthday falls later in the calendar year pays second, if:

1. the parents are married;
2. the parents are not separated (whether or not they ever have been married); or
3. a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage for the child.

If both parents have the same birthday, the plan that has covered one of the parents for a longer period of time pays first; and the plan that has covered the other parent for the shorter period of time pays second.

The word "birthday" refers only to the month and day in a calendar year; not the year in which the person was born.

If the specific terms of a court decree state that one parent is responsible for the Child's health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's current Spouse does, the plan of the Spouse of the parent with financial responsibility pays first. However, this provision does not apply during any Plan Year during which any benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that court decree.

If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and their Spouses (if any) is:

1. The plan of the custodial parent pays first; and
2. The plan of the Spouse of the custodial parent pays second; and
3. The plan of the non-custodial parent pays third; and
4. The plan of the Spouse of the non-custodial parent pays last.

Rule 3: Continuation Coverage

If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member or subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage to that same person pays second.

Rule 4: Longer/Shorter Length of Coverage

If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first; and the plan that covered the person for the shorter period of time pays second.

To determine how long a person was covered by a plan, two plans are treated as one if the person was eligible for coverage under the second plan within 24 hours after the first plan ended.

The start of a new plan does not include a change:

1. in the amount or scope of a plan's benefits;
2. in the entity that pays, provides or administers the plan; or

3. from one type of plan to another (such as from a single employer plan to a multiple employer plan).

The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the plan presently in force.

How Much This Plan Pays When It Is Secondary

When this Plan pays second, it will pay 100% of "**Allowable Expenses" less** whatever payments were actually made by the plan (or plans) that paid first. In addition, when this Plan pays second, it will never pay more in benefits than it would have paid during the Plan Year had it been the plan that paid first.

"Allowable Expense" means a health care service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any of the plans covering the person, except as provided below or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not Allowable Expenses:

- The difference between the cost of a semi-private room in a hospital or specialized health care facility and a private room, unless the patient's stay in a private hospital room is Medically Necessary.

- If the coordinating plans provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an Allowable Expense.

- If the other coordinating plan determines benefits on the basis of Usual and Customary Charges, this Plan will use the Negotiated Amount as the Allowable Expense.

- When benefits are reduced by a primary plan because a Covered Person did not comply with the primary plan's provisions, such as the provisions related to Utilization Management in this Plan and similar provisions in other plans, the amount of those reductions will not be considered an Allowable Expense by this Plan when it pays second.

Allowable Expenses do ***not*** include expenses for services received because of an occupational sickness or Injury, or expenses for services that are excluded or not covered under this Plan.

Administration of Coordination of Benefits

To administer Coordination of Benefits, this Plan reserves the right, in accordance with the HIPAA Privacy Rules, to:

- exchange information with other plans involved in paying Claims;

- require that you or your Health Care Provider furnish any necessary information;

- reimburse any plan that made payments this Plan should have made; or

- recover any overpayment from any hospital, physician, dentist, other health care provider, other insurance company, you or your Eligible Dependent.

If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount this Plan's Administrator or its designee determines to be proper under this provision. Any amounts so paid will be considered to be benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.

To obtain all the benefits available to you, you should file a Claim under each plan that covers the person for the expenses that were incurred. However, any person who claims benefits under this Plan must provide all the information the Plan needs to apply COB.

This Plan follows the customary coordination of benefits rule that the medical program coordinates with only other medical plans or programs, and not with any dental plan or program and the dental program coordinates only with other dental plans or programs and not with any other medical plan or program. Additionally, the vision program coordinates only with other vision plans or programs. Therefore, when this Plan is secondary, it will pay secondary medical benefits only when the coordinating primary plan provides medical benefits, and it will pay secondary dental or vision benefits only when the primary plan provides dental or vision benefits.

If this Plan is primary, and if the coordinating secondary plan is an HMO, EPO, or other plan that provides benefits in the form of services, this Plan will consider the reasonable cash value of each service to be both the allowable expense and the benefits paid by the primary plan. The reasonable cash value of such a service may be determined based on the prevailing rates for such services in the community in which the services were provided.

If this Plan is secondary, and if the coordinating primary plan does not cover health care services because they were obtained out-of-network, benefits for services covered by this Plan will be payable by this Plan only to the extent they would have been payable if this Plan were the primary plan.

If this Plan is secondary, and if the coordinating plan is also secondary because it provides by its terms that it is always secondary or excess to any other coverage, or because it does not use the same order of benefit determination rules as this Plan, this Plan will not relinquish its secondary position. However, if this Plan advances an amount equal to the benefits it would have paid had it been the primary plan, this Plan will be subrogated to all rights the Covered Person may have against the other plan, and the Covered Person must execute any documents required or requested by this Plan to pursue any Claims against the other plan for reimbursement of the amount advanced by this Plan.

COORDINATION WITH MEDICARE

Entitlement to Medicare Coverage: Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income Benefits is also entitled to Medicare coverage (generally after a waiting period).

Active Participants Who Become Eligible for Medicare While Actively Working May Retain or Cancel Coverage Under This Plan

If an Active Participant under this Plan is actively working and becomes covered by Medicare, Part A, B, or D, whether because of end-stage renal disease (ESRD), disability or age, that Active Participant may either retain or cancel coverage under this Plan. If the Active Participant under this Plan is covered by both this Plan and by Medicare, and as long as the Active Participant remains actively employed, that Active Participant's medical coverage will continue to provide the same benefits, and contributions for that coverage will remain the same. In that case, this Plan pays first and Medicare pays second.

If an Active Participant under this Plan is covered by Medicare and cancels coverage under this Plan, coverage of his/her Eligible Dependent(s) will terminate, but they may be entitled to COBRA Continuation Coverage. See the Continuation of Coverage chapter for further information about COBRA Continuation Coverage. If any of the Active Participant's Dependents are covered by Medicare, and the Active Participant cancels that Eligible Dependent's coverage under this Plan, that Dependent will not be entitled to COBRA Continuation Coverage. The choice of retaining or canceling coverage under this Plan of a Medicare beneficiary is the responsibility of the Active Participant. Neither this Plan nor the Active Participant's Employer will provide any consideration, incentive or benefits to encourage cancellation of coverage under this Plan.

Coverage Under Medicare and This Plan When Totally Disabled: If an Active Participant under this Plan who is actively working becomes Totally Disabled and entitled to Medicare because of that disability, the Active Participant will no longer be considered to remain actively employed. As a result, once entitled to Medicare because of that disability, Medicare pays first and this Plan pays second.

Coverage Under Medicare and This Plan for End-Stage Renal Disease: If, while actively employed, an Active Participant under this Plan becomes entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the earlier of the month in which Medicare ESRD coverage begins; or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

Those who are no longer working in Covered Employment, but are currently receiving benefits based on hours accumulated when they were working, are considered to be actively working. As a result, this Plan pays first, and Medicare pays second.

How Much This Plan Pays When It Is Secondary to Medicare

When Covered by Medicare Parts A or B: When an Eligible Dependent is covered by Medicare Parts A and B and this Plan is secondary to Medicare, this Plan pays the Part A deductible and coinsurance and the Part B coinsurance amounts not payable by Medicare. Benefits payable by this Plan are based on the fees allowed by Medicare and not on the Usual and Customary Charges of the health care provider.

When Covered by Medicare Part D: If an Eligible Participant or Eligible Dependent enrolls in a Medicare Prescription Drug Plan (PDP) or Medicare Advantage Plan with prescription drugs (MA-PD), this PDP or MA-PD pays first and this Plan pays second. This Plan will pay any balances not paid by the Part D.

Why you enter into a Medicare Private Contract: Under the law, a Medicare beneficiary is entitled to enter into a Medicare private contract with certain health care providers under which he or she agrees that no claim will be submitted to or paid my Medicare for health care services

and/or supplies furnished by that provider. If you or an Eligible Dependent enters into such a contract, this Plan will NOT pay any benefits for any health care services and/or supplies you receive pursuant to it.

COORDINATION WITH OTHER GOVERNMENT PROGRAMS

Medicaid: If an individual is covered by both this Plan and Medicaid, this Plan pays first and Medicaid pays second.

TRICARE/CHAMPUS: If an Eligible Dependent is covered by both this Plan and the TRICARE/Civilian Health and Medical Program of the Uniformed Service (CHAMPUS), the program that provides health care services to dependents of active armed services personnel, this Plan pays first and TRICARE/CHAMPUS pays second. For an Active Participant called to active duty for more than 30 days, TRICARE is primary and this plan is secondary.

Veterans Affairs Facility Services: If an Eligible Participant or Eligible Dependent under this Plan receives services in a U.S. Department of Veterans Affairs hospital or facility on account of a military service-related illness or injury, benefits are not payable by the Plan. If a Covered Person under this Plan receives services in a U.S. Department of Veterans Affairs hospital or facility on account of any other condition that is not a military service-related illness or injury, benefits are payable by the Plan to the extent those services are medically necessary and the charges are Usual and Customary.

Motor Vehicle Coverage Required by Law: If an Eligible Participant~~,~~ or Eligible Dependent under this Plan is covered for benefits by both this Plan and any motor vehicle coverage, including but not limited to no-fault, uninsured motorist, underinsured motorist or personal injury protection rider to a motor vehicle liability policy, that motor vehicle coverage pays first, and this Plan pays second.

If an Active Participant under this Plan is covered for loss of earnings by both this Plan and any motor vehicle coverage that is required by law, including no-fault, uninsured motorist or underinsured motorist, the benefits payable by this Plan on account of disability will be reduced by the benefits available to you for loss of earnings pursuant to the motor vehicle coverage.

Other Coverage Provided by State or Federal Law: If an Eligible Participant or Eligible Dependent under this Plan is covered by both this Plan and any other coverage (not already mentioned above) that is provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this Plan pays second.

THIRD PARTY RECOVERY (SUBROGATION)

The purpose of these recovery policies is similar to coordination of benefits rules and rules excluding work-related injuries. If a Covered Person can look to another source to pay medical bills for a particular injury, the Plan saves the money and the Covered Person's costs are covered. Of course, any savings to the Plan will benefit all Covered Persons. There are specific subrogation rules that apply to your insured medical benefits which are described in detail in Appendix A.

ADVANCE PAYMENTS ON ACCOUNT OF PLAN BENEFITS

The Plan does not cover expenses for services or supplies for which a third party would be liable in the absence of Plan benefits. The Plan will advance payment on account of benefits paid by the Plan (an "Advance"), as long as this does not prevent the Plan from being reimbursed by the third party to the full extent of any Advance payment for a Covered Person if and when there is any recovery from any third party:

- Except as otherwise expressly agreed by the Plan in writing and in its sole discretion, the Plan will be entitled to recovery from you, your Spouse, your Dependent Child or the third party;
- Even if the recovery is not characterized in a settlement or judgment as being paid on account of any benefits for which the advance was made;
- Even if the recovery is not sufficient to make the Covered Person whole pursuant to state law or otherwise; and
- Without any reduction for legal or other expenses incurred by any ill or injured person in connection with the recovery against the third party or that third party's insurer.

The Plan's rules with regard to third party liability expressly prohibit the application of the make-whole rule and common fund doctrine. In addition, these rights apply equally to each Covered Person, and their legal guardians or representatives, and the Plan reserves the right to seek recovery even though payments are directed to someone other than the Covered Person.

REIMBURSEMENT AND/OR SUBROGATION AGREEMENT

A Covered Person must advise the Plan of any actual or contemplated third-party action and must prudently pursue such claims and cooperate with the Plan on third-party recovery in order to be entitled to an Advance. Upon receipt of information concerning a third-party, the Plan may request the Covered Person to sign and deliver a written reimbursement and/or subrogation agreement (hereafter called the "Agreement") in a form provided by or on behalf of the Plan. If the ill or injured person is a minor or incompetent to execute that agreement, that person's parent (in the case of a minor) or Spouse or legal representative (in the case of an incompetent adult) must execute the Agreement on request by or on behalf of the Plan. The Plan may, in its sole discretion, decline an Advance in the absence of a signed Agreement if it determines, in its sole discretion, that the absence of such an agreement may, either legally or practically, impair its ability to recover an Advance on a cost-effective basis.

The Agreement will be delivered to any lawyer or other party representing the Covered Person and provide for direct re-payment to the Plan of an Advance from any recovery. The failure to sign such an Agreement will not waive, compromise, diminish, release, or otherwise prejudice any of

the Plan's rights. The Plan may notify any such representative of an Advance and its rights notwithstanding the failure of the Covered Person to sign the Agreement.

SUBROGATION

By accepting an Advance, the Covered Person agrees that the Plan will be subrogated to his/her or their right of recovery from a third party or that third party's insurer for the entire Advance from any amounts payable to the Covered Person, including any payments actually made for such injury or loss even if paid to another person on a related claim, such as loss of consortium, and that such amounts will be held in trust for the Plan by the Covered Person and any lawyer, executor, trustee, guardian or other representative for the Covered Person. This means that, in any legal action against a third party who may have wrongfully caused the injury or illness that resulted in the Advance, the Plan may be substituted in place of the Covered Person, to the extent of the amount of the advance. Any balance remaining after repayment of the advance may be retained by the Covered Person.

Under its subrogation rights, the Plan may, at its discretion, start any legal action or proceeding it deems necessary to protect its subrogation rights, and try or settle that action or proceeding in the name of and with the full cooperation of the Covered Person; or intervene in any claim, legal action, or Plan proceeding started by the Covered Person against any third party or third party's insurer on account of any alleged negligent or wrongful action that may have caused or contributed to the injury or illness that resulted in the Advance. In such actions, the Plan will not represent, or provide legal representation with respect to damages that exceed any Advance.

REIMBURSEMENT

The Plan is also entitled to a right of reimbursement to the full extent of any Advance or any amounts payable by the Plan to or on behalf of a Covered Person. By accepting an Advance, the Covered Person recognizes and agrees to the Plan's right of reimbursement.

The Plan's right of reimbursement applies in situations where the Plan makes an Advance to a Covered Person, who subsequently receives a full or partial recovery from any third party for any illness or injury resulting in the Advance. When this happens, the Plan is entitled to an immediate first right to reimbursement to the full extent of the amount of the Advance from amounts payable to the Covered Person, at or within 30 days from the time that a recovery is received from a third party. Any balance then remaining from the subsequent recovery may be retained by the Covered Person.

REMEDIES AVAILABLE TO THE PLAN UNDER ITS SUBROGATION AND REIMBURSEMENT RIGHTS

All Covered Persons are obligated to cooperate with the Plan in its efforts to enforce is subrogation and reimbursement rights and to refrain from any action which interferes with those efforts. This duty of cooperation includes but is not limited to the obligation to sign a reimbursement and/or subrogation agreement in the form prescribed by the Plan.

The Plan has the right to take all appropriate actions necessary to enforce its subrogation and reimbursement rights if an Eligible Participant and/or ill or injured Spouse or Dependent Child does not reimburse the Plan as required by this section on a timely basis, refuses to sign a reimbursement and/or subrogation agreement, or takes any action inconsistent with the Plan's subrogation or reimbursement rights. The Plan's options include, but are not limited to the following remedies:

- The Plan may offset any future Plan benefits that may become payable on behalf of the Covered Person against the amount not reimbursed;
- Obtain a judgment against the Covered Person or his representatives from a court for the amount for the Advance that is not reimbursed on a timely basis and place a lien or execute on such judgment in accordance with applicable law; and/or
- Deny eligibility and Plan benefits to a Covered Person who fails to comply with the Plan's requirements on third-party claims or the conditions for an Advance even though no Advance was paid or the benefits thereby denied exceed the amount of any Advance.

Claims and Appeals

To obtain benefits from the Plan, you (or in some instances, your provider) will file Claims for benefits. In the event your Claim for benefits is denied (an "adverse benefit determination"), federal law gives you the right to appeal the determination, subject to certain procedures.

As described in this SPD, the Plan offers a combination of insured and self-insured Medical Benefits, self-insured Prescription Drug Benefits, Dental Benefits, Vision Benefits, Accidental Death and Dismemberment Benefits, and Life Insurance Benefits. The below chart includes the applicable addresses for filing a claim or appeal.

	File claim with:	File appeal with:
Insured Medical Benefits	Independence Blue Cross Non-Participating Provider claims: Independence Blue Cross General Correspondence 1901 Market Street Philadelphia, PA 19103	Independence Blue Cross Member Appeals Department PO Box 41820 Philadelphia, PA 19101-1820 888-671-5276 Fax: 888-671-5274
Prescription Drug Benefits	FutureScripts Dept. #0382 PO Box 419019 Kansas City, MO 64141	Member Appeals Department P.O. Box 41820 Philadelphia, PA 19101-1820 Phone: 888-671-5276 Fax: 888-671-5274
Dental Benefits	Customer Service-Concordia FLEX United Concordia Companies, Inc. 4401 Deer Path Road Harrisburg, PA 17110	Board of Trustees 830 Bear Tavern Road P.O. Box 1028 West Trenton, NJ 08628
Vision Benefits	Vision Benefits of America 300 Weyman Plaza	Vision Benefits of America 300 Weyman Plaza

	Pittsburgh, PA 15236-1588	Pittsburgh, PA 15236-1588
Accidental Death and Dismemberment Benefits and Life Insurance Benefits	The Amalgamated Life Insurance Company Group Benefits The Amalgamated 730 Broadway New York, New York 10003	The Amalgamated Life Insurance Company Group Benefits The Amalgamated 730 Broadway New York, New York 10003

CLAIMS PROCEDURES

IN GENERAL

Generally, all Claims for benefits provided under the Plan are subject to certain federal minimum requirements which depend on whether your Claim is categorized as a pre-service Claim, an urgent care Claim, a concurrent Claim, or a post-service Claim. Below is a summary of these requirements.

You should be aware that the majority of pre-service, expedited/urgent care, and concurrent Claims will arise through benefits provided through IBC or Medicare. For benefits provided through IBC, you should refer to the applicable appendix for information on submitting a Claim. If any of the below procedures conflicts with the information contained in the applicable appendix, the procedures set forth in the appendix will control. Additionally, vision benefits and life insurance benefits are insured and are subject to the claims procedures set forth in their respective policies.

For purposes of the below procedures, you may designate an authorized representative to pursue a claim or appeal on your behalf. To the extent you do so, all references to "you" below shall be interpreted to include your authorized representative.

A. Pre-Service Claims

A pre-service Claim is a Claim for a benefit for which the Plan requires approval of the benefit (in whole or in part) before medical care is obtained.

In the case of a pre-service Claim, you will be notified within 15 days from receipt of the Claim, unless additional time is needed. The time for response may be extended up to 15 days if necessary due to matters beyond the control of the Plan. In such circumstances, you will be notified within the initial 15-day period of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If you fail to follow proper procedures in filing a pre-service Claim, you will be notified of the proper procedures to be followed as soon as possible but not later than 5 days after receipt of the Claim. This notification may be oral, unless you specifically request written notification. The notification described herein will be provided only if the Claim was received and the claim included (i) your name, (ii) the specific medical condition or symptom, and (iii) a specific treatment, service or product for which approval is requested. A Claim that is improperly filed as set forth in this section will not constitute a Claim unless and until the Claim is refiled properly.

If an extension is necessary because the Plan needs additional information to decide the Claim, the extension notice will specify the information needed. In that case, you have at least 45 days from receipt of the notification to supply the additional information. The normal period for making a decision on the Claim is suspended until the date of response to the request. Within 15 days of receipt of the additional information, you will be notified of the determination. You have the right to appeal a denial of a pre-service Claim.

B. Expedited/Urgent Care Claim

An urgent care Claim (or expedited Claim) is any Claim for medical or dental treatment with respect to which the application of the time periods for making non-urgent care Claim determinations:

1. Could seriously jeopardize the patient's life or health or ability to regain maximum function, or
2. In the opinion of a Physician with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.

Whether a Claim is an urgent care claim is determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Alternatively, any Claim that a Physician with knowledge of the patient's medical condition determines is an urgent care Claim within the meaning described above, shall be treated as an urgent care Claim.

You will be notified of a decision on an urgent care Claim (adverse or not) as soon as possible according to your particular medical circumstances, but no later than 72 hours after receipt of the Claim. If the Plan needs more information to decide the urgent care Claim, it will request the additional information no later than 24 hours after receipt of the Claim. You will then have 48 hours in which to produce the requested additional information. You will be notified of the Plan's decision no later than 48 hours after the earlier of the Plan's receipt of the information or the end of the time period allowed for supplying the additional information.

C. Concurrent Claims

A concurrent Claim is a Claim where the Plan has approved an ongoing course of treatment to be provided over a specific period of time or a number of treatments and:

1. A reconsideration of such ongoing course of treatment (other than by Plan amendment or termination) before the end of the period of time or number of treatments results in a reduction or termination of a benefit; or
2. You request an extension of the period of time or number of treatments (e.g. an inpatient hospital stay is originally certified for three days and is reviewed at three days to determine if additional days are appropriate).

In these situations, a decision to reduce, terminate or extend treatment is made concurrently with the provision of treatment.

In the case of a reduction or termination of a benefit, you will be notified of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

In the case of concurrent Claim requesting that the Plan extend the course of treatment beyond the period of time or number of treatments, the Plan will take into account the medical exigencies and will notify you of the determination within 24 hours after receipt of the Claim, provided that any such Claim is made at least 24 hours before the expiration of the prescribed period of time or number of treatments.

D. Post-Service Claim

A post-service Claim is a Claim submitted for payment after health services and treatment have been obtained and is not a pre-service Claim.

You will be notified of a decision on a post-service Claim within 30 days from receipt of the Claim. This period may be extended one time for up to 15 days if the extension is necessary due to matters beyond the control of the organization responsible for making the Claims determination. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which the organization expects to render a decision.

If an extension is needed because additional information is needed from you, the extension notice will specify the information needed. In that case, you will have at least 45 days from receipt of the notification to supply the additional information. The normal period for making a decision on the Claim will be suspended until the date you respond to the request. You will be notified of its decision with 15 days of receipt of the additional information, or within 15 days of the expiration of the time for providing such additional information.

E. Content of Claim Decision

In the case of an adverse benefit determination (e.g., a benefit denial) on claims subject to these procedures, you will be provided with written notification of the denial written in a manner you should be able to understand. The notification will include the following:

- The specific reasons for the adverse benefit determination including information sufficient to identify the claim involved;

- Reference to the specific Plan provision on which the determination was based;

- A description of any additional material or information necessary for the claimant to complete the Claim (if additional material is needed) and an explanation of why such material or information is necessary;

- A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following the adverse benefit determination on review;

- If an internal rule, guideline, protocol, or other criterion was relied upon in the decision-making, either (1) a copy of such rule, guideline, or protocol, or (2) a statement that a copy of such rule, guideline, or protocol will be provided free of charge to the claimant upon request;

- If the adverse benefit determination was based on a Medical Necessity or experimental treatment or similar exclusion or limit, either (1) an explanation of the scientific or clinical

judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or (2) a statement that such explanation will be provided free of charge upon request.

- Information for contacting the appropriate state agency for health insurance consumer assistance or the Department of Labor to assist with the claims and appeals process.

For the Plan's self-insured prescription drug benefits and the IBC Insured Medical Benefits, to the extent a claimant resides in a county where ten percent or more of the population is literate only in the same non-english language, the IBC or Future Scripts will include contact information indicating how to access a person fluent in the non-english language to assist you with your claim or appeal and, upon your request, will provide you with a copy of the notice in the non-english language upon your request.

CLAIMS PROCEDURES APPLICABLE TO SPECIFIC PLAN BENEFITS

- **IBC Insured Medical Benefits** Claims for insured medical benefits provided through IBC are subject to procedures set forth in the IBC Booklet attached as Appendix A for filing Claims (including pre-certification and pre-authorization procedures). Please refer to the applicable appendix for information on submitting claims.

- **Claims for Prescription Drug Benefits** Claims for self-insured Prescription Drug Benefits provided through FutureScripts are subject to procedures set forth in Appendix B. Please refer to Appendix P for information on submitting a Claim.

- **Claims for Life Insurance Benefits and Accidental Death and Dismemberment (AD&D) Benefits** To file a Claim for Life Insurance Benefits and/or AD&D Benefits offered under this Plan, you or your beneficiary must contact the Administrative Office. A **Life Insurance Benefits Claim** is any Claim made by your beneficiary on the occasion of your death. An **Accidental Death and Dismemberment (AD&D) Claim** is any Claim for loss as specified in Appendix C. The following procedure applies to these Claims:

    - You or your beneficiary, as applicable, must call the Administrative Office at 888-339-9209 (toll-free) to obtain a claim form from the Administrative Office.

    - Complete the claim form.

    - Attach proof of death (i.e., certified death certificate) or dismemberment to the claim form.

    - Return the completed claim form and all necessary documentation to the Administrative Office. The Administrative Office will forward all claims to The Amalgamated Life Insurance Company for processing.

    - Claim payments for loss of life or for a covered loss under the AD&D policy will be paid within 60 days after receipt of satisfactory proof of claim or loss by Amalgamated, except as stated in Appendix L. Please refer to Appendix L for more details on claims and appeals.

- **Claims for Dental Benefits** You do not need claim forms when using a Network Provider. When you use a Network Provider under the terms of this Plan, that request is not considered a Claim under these procedures. However, if your request is denied in whole or in part, you may file a claim using the procedures for filing an Out-of-Network Claim described below.

    - To file a claim for Out-of-Network benefits, send a copy of your dental bill along with a written request for reimbursement to Customer Service-Concordia FLEX at the address listed in chart on page 43.

      Be sure to include your name, address and social security number. Your Claim will be processed within 30 days from the date it is received by the Concordia FLEX. If you have any questions, you may call Concordia FLEX at 800-822-3368. Claims should be filed within 12 months of the date of service.

- **Claims for Vision Benefits** You do not need claim forms when using a Participating Provider. When you use a Participating Provider under the terms of this Plan, that request is not considered a Claim under these procedures. However, if your request is denied in whole or in part, you may file a Claim under the procedures for filing a Claim for Non-Participating Provider benefits described below.

    - To file a Claim for Non-Participating Provider benefits, send a copy of the bill along with a benefit form request for reimbursement to Vision Benefits of America at the address listed in the chart on page 43. Be sure to include your name, address, and social security number.

    - If you have any questions, you may call the Customer Service Department at 800-432-4966.

    - **Claims must be filed within 12 months of the date of service.**

APPEALS PROCEDURES

INTERNAL APPEALS IN GENERAL

If payment for your Claim is denied or reduced, you will receive a written explanation of the reason for the denial or reduction in the manner set forth in the above section. You have the right to appeal any Claim that is denied in whole or in part, or any determination regarding eligibility.

Generally, all appeals of adverse benefit determinations are subject to certain federal minimum requirements which differ based on whether you are appealing the denial of a pre-service Claim, an urgent care Claim, a concurrent Claim, or a post-service Claim. Below is a summary of these requirements.

Please note that only appeals for Dental Benefits are filed with the Board of Trustees. To the extent your appeal is filed with an entity other than the Board of Trustees as provided in the chart on page 38 and herein, if any of the below procedures conflicts with the procedures set forth in the applicable appendix, the procedures set forth in the applicable appendix will control.

For purposes of the below, you may designate an authorized representative to pursue a Claim or appeal on your behalf. To the extent you do so, all references to "you" below shall be interpreted to include your authorized representative.

A. Time for Filing Appeal

You may appeal the denial in writing within 180 days after you receive the denial. You have the right to submit a written statement in support of your claim. In addition, you will be provided upon request and free of charge, reasonable access to, and copies of, all documents records, and other information relevant to the Claim.

B. Information Appeal Must Include

An appeal must set out the reasons for the appeal and your dissatisfaction or disagreement with the Plan's decision. Any evidence, comments, or documentation to support your position should be submitted with your written appeal. Any appeal that does not involve an urgent care claim must be in writing, and can be made by you or a duly authorized representative.

C. Review of Appeal

A different person will review your Claim than the one who originally denied the Claim. The reviewer will not give deference to the initial adverse benefit determination. The review will be conducted by an appropriately named fiduciary who is neither the individual nor the subordinate of the individual who made the initial adverse determination. All comments, documents, records, and other information submitted by the claimant relating to the Claim will be considered on appeal, regardless of whether or not such information was submitted or considered in the initial adverse benefit determination.

If an appeal involves medical judgment, including determinations with regard to medical necessity and whether a particular treatment, drug, or other item is experimental or investigational, the Plan will consult with an independent health care professional with appropriate training and experience in the field of medicine involved. This health care professional will be someone who was neither an individual who was consulted in the initial adverse benefit determination nor the subordinate of such individual. All medical or vocational experts whose advice was obtained in the initial adverse benefit determination will be identified by the Plan, regardless of whether or not the individual's advice was relied upon in making the initial adverse determination. The Plan may request additional information to clarify any matters it deems appropriate.

D. Timing of Decision

If your Claim is an **urgent care Claim or is a concurrent care Claim,** it will be subject to an expedited review process. In such circumstances, an appeal of the initial adverse benefit determination may be submitted orally *or* in writing and any necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, e-mail or any other similarly expeditious method. Your appeal of an urgent care Claim will be decided as soon as possible, but in no event more than 72 hours after receipt of your request for review of the initial adverse benefit determination.

If you appeal a **pre-service Claim**, you will be notified of the determination within 30 days after receipt of your request for review.

If the Board of Trustees is responsible for the determination of an appeal of a **post-service Claim**, it will make its determination at its regular meeting scheduled at least 30 days after the appeal is received absent other notice. Special circumstances may require an extension of time for consideration of an appeal to no later than the third meeting of the Board following the Plan's receipt of the review request. You will be notified in writing of any such extension prior to the commencement of the extension. This notice will include the special circumstances for which the extension is required and the date by which the Plan expects to render a decision on the appeal. You will be notified of the Plan's decision on an appeal in writing as soon as possible but not later than 5 days after the determination is made.

If an entity other than the Board of Trustees is responsible for the determination of an appeal of a post-service Claim, that entity will make its determination within 60 days of the appeal request.

E. Content of Decision

If your appeal is denied, you will be provided with written notification of the denial written in a manner you should be able to understand. The notification will include the following:

- the specific reasons for the denial;
- reference to the specific Plan provision on which the decision was based;
- the claimant's right to request access to or copies of all information relevant to the claimant's Claim
- the claimant's right to bring a civil action under Section 502(a) of ERISA following the adverse benefit determination on review;
- if an internal rule, guideline, protocol, or other criterion was relied upon in the decision-making, either (1) a copy of such rule, guideline, or protocol, or (2) a statement that a copy of such rule, guideline, or protocol will be provided free of charge to the claimant upon request;
- if the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either (1) an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or (2) a statement that such explanation will be provided free of charge upon request.
- The availability of and contact information for the appropriate state agency for health insurance consumer assistance and/or the Department of Labor to assist with the claims and appeals process.

For the Plan's self-insured prescription drug benefits and the IBC Insured Medical Benefits, to the extent a claimant resides in a county where ten percent or more of the population is literate only in the same non-english language, the IBC or Future Scripts will include contact information indicating how to access a person fluent in the non-english language to assist you with your claim or appeal and, upon your request, will provide you with a copy of the notice in the non-english language upon your request.

INTERNAL APPEALS PROCEDURES FOR SPECIFIC PLAN BENEFITS

- **IBC Insured Medical Benefits:** The final right of appeal for Claims for IBC Insured Medical Benefits is to IBC. Please refer to Appendix A for information on submitting an appeal of a denied Claim.

- **Prescription Drug Benefits:** The final right of appeal for Claims for self-insured Prescription Drug Benefits provided through FutureScripts is to IBC. Please refer to the procedures set forth in Appendix B for information on submitting an appeal of a denied Claim.

- **Life Insurance and AD&D Benefits:** The final right of appeal for Claims for Life Insurance and AD&D Benefits is to the Amalgamated Life Insurance Company. Please refer to Appendix C for information on submitting an appeal of a denied Claim.

- **Vision Benefits:** The final right of appeal for Vision Benefits is to VBA. Please refer to Appendix DV for information on submitting an appeal of a denied Claim.

- **Dental Benefits:** The final right of appeal for Dental Benefits is with the Board of Trustees and is subject to the procedures and timeframes set forth herein.

EXTERNAL APPEALS FOR PRESCRIPTION DRUG BENEFITS AND IBC INSURED MEDICAL BENEFITS

Federal law gives you the right to file an external appeal of certain denials of benefits if the denial is upheld after the Internal Appeals process. The below procedures are not applicable to the Plan's Dental, Vision, Life Insurance and AD & D benefits.

Federal law also gives you the right to an external appeal after an initial claim denial but only if the appeal involves a medical condition for which the timeframe for completion of an expedited internal appeal (72 hours) would seriously jeopardize your life or health or your ability to regain maximum function. You must expressly request an expedited external review if this option applies to you. If your claim is not eligible for expedited external review, as discussed below, you must complete the internal appeal process before seeking external review.

Subject to the above requirements and limitations, you will have the right to pursue an external appeal with an Independent Review Organization (IRO). To exercise this right, you must request an external appeal in writing within four months after receiving a final internal appeal decision regarding your claim. The notice provided after an initial denial and final internal appeal decision will provide full details regarding the process that must be followed to request and obtain an external review. A small filing fee may be required. If so, it will be noted in the notice.

If the process for obtaining this review is successfully completed, and your claim is deemed eligible, you will be notified and your appeal will be assigned to an IRO. Once it is assigned, the IRO will notify you about any additional steps that must be taken to complete your appeal. Once all of these additional steps are completed, the IRO will review all of the information in your case as if it were new. The IRO is not bound by any decisions or conclusions that were reached during the internal appeals process.

If the claim or appeal involves experimental or investigational treatments, the IRO will ensure that adequate clinical and scientific experience and protocols are taken into account as part of the external review process.

If your appeal is not an expedited request, the IRO's decision will be communicated to you in writing within 45 calendar days after its receipt of the appeal. In the event your external appeal request was handled on an expedited basis due to your medical circumstances, the IRO will notify you of its decision as soon as possible, but no later than 72 hours following receipt of your request. In both circumstances, the written decision issued by the IRO will include complete information regarding your appeal and the rationale for the decision. The decision will also include a statement that the IRO's decision is binding on both the Plan and you, except to the extent that other remedies may be available to you or the Plan pursuant to state or federal law. The decision will also advise you about other resources that may be available to you for additional assistance.

- **IBC Insured Benefits**

You will have a right to external review of certain adverse benefit determinations IBC makes with respect to your insured medical benefits. For more information on filing an external appeal with IBC, please refer to Appendix A.

- **Self-insured Prescription Drug Benefits**

For self-insured prescription drug claims, participants may file external appeals only for adverse benefit determinations relating to a rescission of coverage or a matter of medical judgment: e.g. determinations of medical necessity, appropriateness, place of treatment, level of care, effectiveness of covered benefits, or whether the applicable treatment is a non-eligible experimental treatment. If the denial of benefits does not relate to any of the above, the claim will be deemed ineligible for external review. You may not use the external review process to appeal a denial, reduction, termination, or failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility set forth in this SPD. For more information on your external appeal rights, see your prescription drug benefit booklet at Appendix B.

YOUR ERISA RIGHTS

As Covered Person in the Roofers Union Local 30 Combined Health and Welfare Plan, you are entitled to certain rights and protections under Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Covered Persons shall be entitled to:

- Receive information about your Plan and benefits.
- Examine, without charge, at the Administrative Office and other specified locations such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the public disclosure room of the Employee Benefits Security Administration (EBSA).
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Eligible Participant with a copy of the summary annual report.
- Continue health coverage for yourself, Spouse, and Eligible 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.

Prudent Actions by Plan Fiduciaries. In addition to creating rights for Eligible 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 Eligible Participants and beneficiaries. No one, including your Employer, your union or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights. If your claim for a welfare benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (EBSA), U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

GENERAL PLAN INFORMATION

The following information, together with the information provided in other portions of this booklet, forms the Summary Plan Description under the Employee Retirement Income Security Act of 1974 (ERISA):

NAME OF PLAN

Roofers Union Local 30 Combined Health and Welfare Commercial Plan.

TYPE OF PLAN

This Plan is an employee welfare benefit plan that provides medical and hospital, prescription drug, Vision, Dental, Weekly Accident and Sickness, Life Insurance, and Accidental Death and Dismemberment Benefits.

PLAN IDENTIFICATION NUMBERS

Employer Identification Number: 23-2258631

IRS Plan Number: 501

PLAN YEAR

The Plan's fiscal records are kept on a Calendar Year basis beginning on January 1 and ending on December 31.

NAME OF PLAN SPONSOR AND PLAN ADMINISTRATOR

The Board of Trustees of the Roofers Union Local 30 Combined Health and Welfare Fund is the Plan Sponsor and Plan Administrator. The Health and Welfare Fund is administered by a joint of Board of Trustees comprised of an equal number of union representatives and representatives of Contributing Employers. All communications to the Plan Sponsor should be sent to:

Board of Trustees
c/o Roofers Union Local 30 Combined Health and Welfare Plan
830 Bear Tavern Road
P.O. Box 1028
West Trenton, NJ 08628

Certain day-to-day duties (including determining eligibility for benefits and enrollment) of the Plan have been delegated to the Administrative Office that can be reached at:

Administrative Office
Roofers Union Local 30 Combined Health and Welfare Plan
830 Bear Tavern Road
P.O. Box 1028
West Trenton, NJ 08628

NAMED FIDUCIARY UNDER ERISA

The named fiduciary of the Plan is the Board of Trustees.

PLAN BOARD OF TRUSTEES

Union Trustees	Employer Trustees
Thomas Pedrick Roofers Union Local No. 30 6447 Torresdale Avenue Philadelphia, PA19135	**Richard Harvey** Roofing Contractors Association 414 Rector Street Philadelphia, PA19128
Clark Shiley Roofers Union Local No. 30 6447 Torresdale Avenue Philadelphia, PA19135	**David Farragut** United States Roofing Corp. 910 East Main Street, Suite 300 Norristown, PA19401
Shawn McCullough Roofers Union Local No. 30 6447 Torresdale Avenue Philadelphia, PA19135	**Michael Thomas** Thomas Company, Inc. 6587 Delilah Road Egg Harbor Township, NJ 08234

A complete list of the Employers and employee organizations sponsoring the Plan may be obtained upon written request to the Plan Administrator or the Administrative Office, and is available for examination. In addition, you may receive from the Plan Administrator or the Administrative Office, upon written request, information as to whether a particular employer or employee organization is a Contributing Employer and the address.

AGENT FOR SERVICE OF PROCESS

Legal process may be served on any individual Trustee at the below address:

Board of Trustees
Roofers Union Local 30 Combined Health and Welfare Plan
830 Bear Tavern Road
P.O. Box 1028
West Trenton, NJ 08628
Phone: 609-883-6688

For disputes arising under those portions of the Plan insured by IBC, service of legal process may be made upon IBC. For disputes arising under those portions of the Plan insured by Amalgamated, service of legal process may be made upon the Amalgamated.

TYPES OF BENEFITS AND ADMINISTRATION

The medical and hospital benefits are provided in accordance with the provisions of the group policies issued by QCC Insurance Company, a subsidiary of Independence Blue Cross. The medical and hospital benefits are subject to the complete terms, conditions, limitations, and exclusions of the Certificates and contracts issued by QCC Insurance Company, 1901 Market Street, Philadelphia, PA 19103. The Life Insurance and AD&D Benefits are subject to the complete terms, conditions, limitations, and exclusions of the Certificates of Insurance and contracts issued by Amalgamated.

The prescription drug benefits are self-insured and administered by FutureScripts 1901 Market Street Philadelphia, PA 19103-1480.

The Dental Benefit is self-insured and administered by United Concordia Companies, Inc. ("Concordia Flex"), 4401 Deer Path Road, Harrisburg, PA 17110.

The Vision Benefit is insured and administered by Vision Benefits America, 300 Weyman Plaza, Pittsburgh, PA 15236-1588.

The Life Insurance Benefits and AD&D Benefits are provided in accordance with the provisions of the group policies issued by Amalgamated Life Insurance Company, 730 Broadway, New York, New York 10003.

The Weekly Accident and Sickness Benefit is self-insured and administered through the Administrative Office, 830 Bear Tavern Road, P.O. Box 1028, West Trenton, NJ 08628.

The Plan also provides vacation benefits which are described in a separate Summary Plan Description ("Vacation SPD"). Please refer to the Vacation SPD for more information about your Vacation Benefits. If you do not have a copy of the Vacation SPD, please contact the Fund Office.

INSURANCE CONTRACT GOVERNS

The medical, hospital, Life Insurance, and Accidental Death and Dismemberment benefits are subject to the complete terms, conditions, limitations, and exclusions of the contracts issued by IBC and Amalgamated to the Plan. If a difference exists between the information in this booklet, the Certificates and the actual contracts, the contracts govern. Please consult the Appendices for more information.

COLLECTIVE BARGAINING AGREEMENTS AND SOURCE OF FINANCING

Benefits are provided pursuant to Collective Bargaining Agreements. The Plan is maintained under Collective Bargaining Agreements between Contributing Employers and the United Union of Roofers, Waterproofers and Allied Workers Local 30. A copy of any such agreement or agreements may be obtained by Eligible Participants and beneficiaries upon written request to the Plan Administrator at the Administrative Office and is available for examination by Eligible Participants and beneficiaries.

Contribution Source: All contributions to the Plan are made by Contributing Employers in accordance with their Collective Bargaining Agreements. The Administrative Office will provide you, upon written request, information as to whether a particular employer is contributing to this Plan on behalf of Active Participants working under the Collective Bargaining Agreement. The Administrative Office will also provide you, upon written request, a list of Contributing Employer's and employee organizations.

The Collective Bargaining Agreements require contributions to the Plan at fixed rates per hours worked. You may request in writing, a copy of the Collective Bargaining Agreement from the Administrative Office.

Funding Medium: Benefits are provided from the Fund's assets that are accumulated under the provisions of the Collective Bargaining Agreement and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to Covered Persons and defraying reasonable administrative expenses.

The Fund's assets are invested by various investment advisors.

PLAN AMENDMENTS OR TERMINATION

The Trustees reserve the right to change or discontinue (1) the types and amounts of benefits under the Plan and (2) the eligibility rules, even if extended eligibility has already been accumulated. Resolution to amend the Plan are made by the Board of Trustees and become effective on the date as specified in the document or resolution amending the Plan.

Plan benefits and eligibility rules for Covered Persons:

- are not guaranteed or otherwise vested;
- may be changed or discontinued by the Board of Trustees;
- are subject to the rules and regulations adopted by the Board of Trustees;
- are subject to the Trust Agreement which establishes and governs the Fund's operations; and
- are subject to the provisions of the group insurance policy purchased by the Trustees.

The nature and amount of Plan benefits are always subject to the actual terms of the Plan, as it exists at the time the claim occurs.

If the Plan terminates, the Trustees will apply the assets of the Fund to provide benefits or otherwise carry out the purposes of the Fund in an equitable manner until the entire remainder of the Fund has been dispersed.

If the Plan is changed or discontinued, it will not affect your or your beneficiary's right to any insured benefit to which you have already become entitled.

RIGHT TO OFFSET

In the event any payment is made by the Plan to an individual who is not entitled to payment, the Plan shall have the right to reduce future payments payable to such individual by the amount of any erroneous payment. This right of offset, however, shall not limit the right of the Plan to recover overpayments in any other manner.

DISCRETIONARY AUTHORITY OF THE BOARD OF TRUSTEES AND ITS DESIGNEES

In carrying out their respective responsibilities under the Plan, the Board of Trustees, the Plan Administrator and other individuals with delegated responsibility for the administration of the Plan, will have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

NO LIABILITY FOR THE PRACTICE OF MEDICINE

The Fund, the Board of Trustees and their designee(s) are not engaged in the practice of medicine, and have no control over any diagnosis, treatment, care or lack thereof, or any health

care services provided or delivered to you by any physicians or other health care providers. Covered Persons should select a provider or course of treatment based on all appropriate facts, only one of which should be coverage by the Plan. Neither the Plan, Administrator, nor any of their designees, will have any liability whatsoever for any loss of injury caused to a Covered Person by any physician or health care provider by reason of negligence, by failure to provide care or treatment, or otherwise.

NO ASSIGNMENT OF BENEFITS

You may not assign your benefits under the Plan, except that you may direct that benefits payable to you be paid to an institution or providers of medical care. However, the Plan is not legally obligated to accept such a direction from you, and no payment by the Plan to a provider can be considered as recognition by the Plan that it has a legal duty to pay the provider, except to the extent that it chooses to do so. Notwithstanding the foregoing, the Board of Trustees shall provide benefits in accordance with the applicable requirements of a Qualified Medical Child Support Order.

SAVINGS CLAUSE

Should any provision of this Plan be held to be unlawful, or unlawful as to any person or instance, such fact shall not adversely affect other provisions of this Plan or the application of any provisions to any other person or instance unless such illegality shall make impossible the functioning of this Plan.

TITLES

The title of any Chapter, Section, Subsection, or provision of this Plan is for convenience and reference only and is not to be considered in interpreting the terms and conditions of this Plan.

CONSTRUCTION OF WORDS

Any words used in this Summary Plan Description/booklet in the masculine gender shall be construed as though they also are used in the feminine gender in all situations where they would so apply. Any words used in this Summary Plan Description/booklet in the singular form shall be construed as though they also are used in the plural form in all situations where they would so apply, and vice-versa.

HIPAA: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Effective April 14, 2003, a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans like the Plan to maintain the privacy of your personally identifiable health information (called Protected Health Information or PHI).

- The term **"Protected Health Information" (PHI)** includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.

- **PHI does not include** health information contained in employment records held by your employer in its role as an employer, including but not limited to health information on disability, work-related illness/injury, sick leave, and Family and Medical leave (FMLA).

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was previously distributed to you and is also available from the Plan Administrator. Information about HIPAA in this document is not intended and cannot be construed as the Plan's Notice of Privacy Practices.

The Plan, and the Plan Sponsor (*Board of Trustees*), will not use or further disclose information that is protected by HIPAA ("protected health information or PHI") except as necessary for treatment, payment, health care operations and Plan administration, or as permitted or required by law. **In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor**. The Plan may disclose PHI to the Plan Sponsor for the purpose of reviewing a benefit claim, appeal or for other reasons related to the administration of the Plan.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Plan will use protected health information to the extent and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations.

"Payment" includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- Determination of eligibility, coverage, and cost sharing amounts (e.g. cost of a benefit, Plan maximums, and copayments as determined for an individual's claim);
- Coordination of benefits;
- Adjudication of health benefit claims (including appeals and other payment disputes);
- Subrogation of health benefit claims;
- Establishing employee contributions;
- Establishing contribution rates for Contributing Employers, including risk adjusting amounts due based on enrollee health status and demographic characteristics;
- Billing, collection activities and related health care data processing;
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes;
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- Responding to Covered Persons' (and their authorized representatives') inquiries about claims;
- Medical necessity reviews, or reviews of appropriateness of care or justification of charges;
- Utilization review, including precertification, preauthorization, concurrent review and retrospective review;
- Disclosure to consumer reporting agencies related to collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, social security number, payment history, account number, and name and address of the provider and/or health Plan); and

- Reimbursement of individual overpayments to the Plan.

Health Care Operations include, but are not limited to, the following activities:

- Quality Assessment;
- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions;
- Rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities,
- Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care reinsurance (including stop-loss and excess of loss insurance);
- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies;
- Business management and general administrative activities of the entity, including, but not limited to:
    - Management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification,
    - Customer service, including the provision of data analyses for policyholders, Plan sponsors, or other customers,
    - Resolution of internal grievances, and
    - Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity;
- Business Compliance with and preparation of all documents as required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500s, SARs, and other documents. The Plan will use and disclose PHI as required by law and as permitted by authorization of the Covered Person. With an authorization, the Plan will disclose PHI to the following: the trustees for use in disability appeals, the Plan staff when processing a claim for pension benefits, Contributing Employers, the Union, workers' compensation carriers, and the pension and disability insurers.
- For purposes of this section, the Board of Trustees of the Roofers Union Local 30 Combined Health and Welfare Fund is the Plan Sponsor. The Fund will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions:

With respect to PHI, the Plan Sponsor agrees to:

- Reasonably and appropriately safeguard PHI created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan,

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI that it creates, receives, maintains, or transmits on behalf of the Plan,
- Not use or further disclose the information other than as permitted or required by the Plan Document or as required by law,
- Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Fund agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information,
- Not use or disclose the information for employment-related actions and decisions unless authorized by the individual,
- Not use or disclose the information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual,
- Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware,
- Make PHI available to the individual in accordance with the access requirements of HIPAA,
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA,
- Make available the information required to provide an accounting of disclosures,
- Make internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of HHS for the purposes of determining compliance by the Fund with HIPAA, and
- If feasible, return or destroy all PHI received from the Plan that the Plan 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. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible,
- Maintain adequate separation between the Plan and the Plan Sponsor. Therefore, in accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:
  - The Plan Administrator; and
  - Staff designated by the Plan Administrator based on their job title and function. Plan staff have access to individually identifiable health information in the Plan's computer system. Access is restricted by the use of individual passwords.

  The persons described above may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If the persons described above do not comply with this Plan Document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

For purposes of complying with the HIPAA privacy rules, this Plan is a "Hybrid Entity" because it has both health plan and non-health plan functions. The Plan designates that its health care components that are covered by the privacy rules include only health benefits and not other Plan functions or benefits.

APPENDIX A – INSURED MEDICAL BENEFITS

APPENDIX B – PRESCRIPTION DRUG BENEFITS

APPENDIX C – LIFE AND ACCIDENTIAL DEATH AND DISMEMBERMENT BENEFITS