ROOFERS UNION LOCAL 30 COMBINED HEALTH AND WELFARE FUND

SUMMARY PLAN DESCRIPTION/PLAN DOCUMENT

RETIREE PLAN

FOR ELIGIBLE RETIREES

Established January 2011

Summary Plan Description stated January 2017

To All Eligible Retirees:

We are pleased to provide you with this updated Summary Plan Description ("SPD")/Plan Document describing the comprehensive benefits provided to Eligible Retirees under the Roofers Union Local 30 Combined Health and Welfare Retiree Plan ("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 Retirees and their Eligible Dependents. Coverage includes medical and hospital benefits as well as insured accidental death and dismemberment and life insurance benefits.

Please note that this Summary Plan Description does not contain the Agreement and Declaration of Trust of the Fund, the related Collective Bargaining Agreement or insurance contracts that also govern the operation and administration of this Plan. The Plan must be interpreted in accordance with these documents.

The Trustees intend to continue the Plan described in this booklet indefinitely. 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 titled "Your ERISA Rights" for your rights under the Employee Retirement Income Security Act of 1974 (ERISA).

We urge you to read this Plan booklet and any attachments carefully so that you are familiar with the benefits to which you are entitled and with the Plan's eligibility requirements.

Sincerely,

BOARD OF TRUSTEES

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

BOARD OF TRUSTEES

UNION TRUSTEES

Thomas Pedrick
Clark Shiley
Shawn McCullough

EMPLOYER TRUSTEES

Richard Harvey
Michael Thomas
David Farragut

LEGAL COUNSEL

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

CONSULTANTS

The Segal Company

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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	**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	Please refer to the appropriate section of this booklet for information on eligibility and enrollment. You may also contact the Administrative Office for information on the Plan's benefits and necessary forms.
Preferred Provider Organization (PPO) Medical and Hospital Benefits **Personal Choice PPO Program** If you live in an area where the Personal Choice PPO Program is not available, you may receive benefits through the Blue Card Program.	**Independence Blue Cross** Member Services 215-557-7577 Phone 800-626-8144 Toll-free http://www.ibx.com Personal Choice PO Box 890016 Camp Hill, PA 17089-001 **Complaints:** Independence Blue Cross General Correspondence 1901 Market Street Philadelphia, PA 19103 **Appeals:** Independence Blue Cross Member Appeals Department PO Box 41820 Philadelphia, PA 19101-1820 888-671-5274 Fax: 888-671-5276	Pre-Medicare Eligible Commercial Retirees are eligible for the medical benefits described in Appendix A. For details on your hospital and medical benefits, see Appendix A.
Basic Benefits	**Independence Blue Cross** Member Services 215-557-7577 Phone 800-626-8144 Toll-free http://www.ibx.com Non-Participating Provider Claims: Highmark Blue Shield	Pre-Medicare Eligible Residential Retirees are eligible for the medical benefits described in Appendix B. For details on pre-authorization, covered benefits, exclusions, coordination of benefits, and other details about your hospital

	PO Box 890062 Camp Hill, PA 17089-0062 **Complaints:** Independence Blue Cross General Correspondence 1901 Market Street Philadelphia, PA 19103 **Appeals:** Member Appeals Department PO Box 41820 Philadelphia, PA 19101-1820 888-671-5274 Fax: 888-671-5276	and medical benefits, see Appendix B.
Major Medical Benefits	**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	Pre-Medicare Eligible Residential Retirees are eligible for the Major Medical Benefits described in this booklet. Major Medical Benefits are generally payable after benefits are paid under the Plan's Basic Benefits. Major Medical benefits are payable for covered medical expenses at 80% after a $100/individual/ $300/family deductible.
Medicare Supplemental Benefits	**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	Medicare-Eligible Retirees are eligible to receive Medicare Supplemental Benefits from the Plan. For more information on these benefits, see page 25 of this SPD.
Prescription Drug Benefits	**Future Scripts** Future Scripts Independence Blue Cross 1901 Market Street Philadelphia, PA 19103-1480 1-800-ASK-BLUE www.ibx.com	All Eligible Retirees are subject to an annual calendar maximum of $625 per Single Retiree and $1250 per family. For Detailed information on Prescription Drug Benefits, see Appendix C.
Dental Benefits	**Concordia FLEX** Dental Benefits are administered by United Concordia Companies, Inc. 4401 Deer Path Road Harrisburg, PA 17110 800-822-3368 www.ucci.com	Commercial Retirees have a $900 per covered person per calendar year maximum on dental benefits. Residential Retirees have a $625 per covered person per calendar year maximum on dental benefits.

		Certain Diagnostic and Preventive services will not count toward the annual maximum. For details, see the Dental Benefits chapter beginning on page 19.
Vision Benefits	**Vision Benefits of America** 300 Weyman Plaza Pittsburgh, PA 15236-1588 800-432-4966 Phone www.visionbenefits.com	The Plan provides for an eye exam, a pair of lenses and frame or contact lenses (in lieu of all other benefits) once every 12 months, paid in full if received in-network or up to the Plan's allowances if received out-of-network. See the description of Vision Benefits beginning on page 22.
Life Insurance and Accidental Death and Dismemberment Benefits	**The Amalgamated Life Insurance Company** Group Benefits The Amalgamated 730 Broadway New York, New York 10003	Payable at $2,500 for Eligible Retirees. See the chapters entitled Life Insurance Benefits and Accidental Death and Dismemberment Benefits. See Appendix D for full details on this benefit.

IMPORTANT NOTICE

You or your Dependents must promptly furnish to the Administrative Office information regarding change of name, address, marriage, divorce or legal separation, death of any covered family member, change in status of a Dependent Child, Medicare enrollment or disenrollment or the existence of other coverage.

The Plan Administrator, in its discretion, may retroactively cancel coverage for a Retiree and/or his Dependents for: fraud or intentional misrepresentation of a material fact; failure to timely pay required cost-sharing payments; or untimely notification of a divorce. If your coverage is cancelled retroactively for any of these reasons, you and/or your Dependents may be required to reimburse the Plan for any benefits the Plan paid on your or your Dependents behalf after the date of cancellation.

DEFINITIONS

Active Plan means the Roofers Union Local 30 Combined Health and Welfare Fund Commercial Plan and the Roofers Union Local 30 Combined Health and Welfare Fund Residential Plan.

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

Child includes a natural child, stepchild, a child placed for adoption, adopted child, or any child whose coverage is your responsibility under the terms of a qualified release or court order.

Claim is a request for a Plan benefit or benefits made in accordance with the procedures described in this Summary Plan Description or in the Appendices, where applicable.

Coinsurance means the portion of Covered Expenses that are paid by the Covered Person in accordance with the provisions of the Plan.

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 Retiree or Eligible Dependent.

Eligible Dependents means your Spouse (unless you and your Spouse are living separate and apart) and your unmarried children who meet the requirements of a Dependent as described on page 4 and are enrolled in the Plan.

Eligible Participant means an Eligible Retiree.

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

Experimental Procedure means:

1. any medical procedure, equipment, treatment or course of treatment, or drug or medicine that is under investigation or is limited to research;
2. techniques that are restricted to use at centers, which are capable of carrying out disciplined clinical efforts and scientific studies;
3. procedures which are not proven in an objective way to have therapeutic value or benefit; or
4. any procedure or treatment whose effectiveness is medically questionable.

Formulary means a list of drugs on which the prescription benefit manager obtained preferred pricing. See Appendix C for a detailed description.

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 your 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.

Medically Necessary means any service, supply, treatment, or hospital confinement (or part of a hospital confinement) which:

1. is essential for the diagnosis or treatment of the Injury or Illness for which it is prescribed or performed;
2. meets generally accepted standards of medical practice;
3. is not educational or experimental in nature;
4. is not rendered solely for the purpose of medical research; and
5. is ordered by a Physician.

The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make it medically necessary or make the expense a covered charge. Independence Blue Cross ("IBC") maintains a detailed definition of Medical Necessity, Experimental and provider/physician that are defined in the attached IBC booklet.

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.). The term "Physician" shall include a duly licensed or certified practitioner, as required by state law for services that are:

1. within the scope of the license or certificate; and
2. a Covered charge under this Plan.

Also referred to as a Provider or Health Care Provider.

Plan means the small group health plan as defined in Section 732(a) of the Employee Retirement Income Security Act ("ERISA") sponsored by the Board of Trustees and called the Retiree Plan for Eligible Retirees.

Reasonable means the usual charge made by a person, a group, or an entity that renders or furnishes the services, treatments or supplies that are covered under this Plan. In no event does it mean a charge in excess of the general level of charges made by others who render or furnish such services, treatments or supplies to persons: (a) who reside in the same area; and (b) whose Illness or Injury is comparable in nature and severity. The term "area" means a county or such greater area that is necessary to obtain a representative cross section of the usual charges made.

Retiree or Eligible Retiree means a former Eligible Employee who meets this Plan's Retiree Eligibility rules and is enrolled for Retiree Benefits under this Plan. **Eligible Employee** means a Commercial or Residential Employee who has met the eligibility requirements of the Active Plan and is enrolled for coverage under that Plan. As used herein, **Residential Retiree** means an Eligible Retiree who was an Eligible Employee in the Roofers Union Local 30 Combined Health and Welfare Fund Residential Plan. **Commercial Retiree** means an Eligible Retiree who was an Eligible Employee in the Roofers Union Local 30 Combined Health and Welfare Fund Commercial Plan.

Spouse means the spouse to whom the Eligible Retiree is married who is not living separate and apart from the Eligible Retiree as described on page 4 of the Eligibility chapter. As used herein, marriage, married, marries, and marry, whenever 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.

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 appendices.

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

ELIGIBILITY

Initial Eligibility

You become eligible for benefits under this Retiree-only Plan ("Retiree Benefits") if you meet the following eligibility requirements:

- you "retire" (as defined in the Roofers Union Local 30 Combined Pension Plan) at or after age 50 and commence benefit payments as described in Section 5.4(B) of the Roofers Union Local 30 Combined Pension Plan;
- you have at least ten years of "continuous service" (as defined in the Roofers Union Local 30 Combined Pension Plan) in the Roofers Union Local 30 Combined Pension Fund;
- you had Active Plan coverage as an Eligible Employee and/or a COBRA beneficiary continuously for the three years immediately preceding the date on which you retire;
- you enroll for Retiree Benefits when your coverage as an Eligible Employee ends under the Active Plan. You will be given the chance to enroll in Retiree Benefits or choose COBRA within sixty (60) days after your coverage as an Eligible Employee ends. See page 5 for details on how to enroll for Retiree Benefits.

To determine the medical benefits to which you are entitled, please refer to Page 18.

Effective Date of Retiree Benefits

Benefits for Eligible Retirees become effective on the first day of the month after coverage as an Eligible Employee ends under the Active Plan, provided you enroll in Retiree coverage and pay the applicable premiums. If your benefits as an Eligible Employee would end less than six months after your retirement date, you will continue to receive benefits under the Active Plan for the balance of six months from your retirement date. If you do not enroll for coverage within 60 days of your loss of coverage as an Eligible Employee under the Active Plan, you will not be eligible for Retiree Benefits (see pages 6 and 9 for details and the few exceptions to this rule).

Premiums for Retiree Benefits

If you are eligible for and enroll in Retiree Benefits, you are required to pay a monthly premium for the coverage, following the run-out of your Active Benefits or the six-month Active Plan grace period described above. If your retirement date (or re-retirement date, if applicable) with respect to which you are electing Retiree Benefits is on or after January 1, 2015, your required premium will be 50% of the Plan's total cost of providing the coverage. If your retirement date with respect to which you are electing Retiree Benefits is before January 1, 2015, your required annual premium is calculated as a percentage of the total cost of coverage based on your years of service and your age at the time of retirement. The percentage of the premium that you are responsible for is equal to 100% minus 50% of the "Fund Contribution Percentage". The Fund Contribution Percentage is equal to the product of:

(a) 3.6% times completed service, and

(b) 100% less the product of:
- 4%; and
- the number of years between your age as of the date of your retirement and age 62

You may elect to pay your monthly premiums through a deduction to your pension check. If your premium amount exceeds the amount of your pension benefit, you will be billed for the remainder of the premium amounts owed. Benefits and premiums differ depending on whether or not you are Medicare-Eligible and whether you have Dependent coverage. The Administrative Office will notify you of the exact amount of Retiree premiums and send you enrollment information when you retire. See the chapter on Retiree Benefits beginning on page 13 for a complete description of Retiree Benefits.

Eligible Retirees Returning to Covered Employment

If you initially met this Plan's Retiree Eligibility rules and enrolled for benefits, your coverage will terminate under this Plan at the end of any six-month calendar period in which you return to work in Covered Employment (i.e. January 1 to June 30 or July 1 to December 31). You are obligated to notify the Plan Administrator as soon as practicable regarding your return to Covered Employment. Advance notice is required when feasible under the circumstances. The Plan Administrator will also review contribution and remittance reports to determine whether any Eligible Retirees are working in Covered Employment; however this does not relieve you of your obligation to provide notice to the Plan Administrator.

Eligible Retirees who return to Covered Employment will have their coverage transferred to the Commercial Plan. You will be required to pay a monthly premium for that coverage which is equal to the amount you would pay for Pre-Medicare Retiree Coverage under this Plan. **If you fail to pay the required premiums for the Commercial Plan during your return to work in Covered Employment, you will not be eligible to re-enroll in this Plan when you once again cease working in Covered Employment.**

You are obligated to notify the Plan Administrator as soon as practicable when you once again cease working in Covered Employment. Advance notice is required when feasible under the circumstances. The Plan Administrator will also review contribution and remittance reports to determine whether you have ceased working in Covered Employment; however this does not relieve you of your obligation to provide notice to the Plan Administrator.

When you once again cease working in Covered Employment, your coverage under the Commercial Plan will terminate and you coverage under this Retiree-only Plan will be reinstated subject to payment of applicable premiums. **If you enroll in COBRA coverage from the Commercial Plan in lieu of being reinstated in this Retiree-only Plan, you will no longer be eligible to continue coverage in this Plan.**

Unless specifically stated otherwise in this SPD, all limits, annual maximums, out-of-pocket maximums, deductibles, restrictions, and other similar provisions will apply on a Plan Year basis and will not be reset should you transfer to the Commercial Plan for a portion of the Plan Year as provided above. For example, if you are enrolled in this Plan during the first six-month period of the Plan Year and utilize $250 of your $1250 family prescription drug maximum, you will have $1000 of the maximum available if your coverage is reinstated during a later portion of that Plan Year (i.e. the maximum does not reset).

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 if you are married on the effective date of your Retiree Coverage;
- Your unmarried children provided your children are under 19 years of age on the effective date of your Retiree coverage;
- Your unmarried children over age 19 but under age of 23, if they are full-time students in an accredited college or university (you must provide the Plan with proof of student status each semester) and such children are your Dependents on the effective date of your Retiree coverage.
- Children subject to a Qualified Medical Child Support Order (QMCSO) or National Medical Support Order (NMSO) if such children are your Dependents on the effective date of your Retiree coverage.

A Child will be considered your Dependent (as a "qualifying relative") if he or she is dependent upon you for over one half of his or her support and is not a "qualifying child" of any other taxpayer as defined in IRC Section 152(c). If your Dependents include stepchildren, you must provide the Plan with either your 1040 IRS certified tax form or a qualified release or formal court order. This Plan does not cover children of Dependent Children unless the Eligible Retiree has legally adopted the grandchild, the child is a Dependent as defined in this Plan, and you provide proof of such dependency to the Administrative Office.

A Dependent Child that does not reside with an Eligible Retiree may be considered an Eligible Dependent only if:

- The child's parents are: (1) divorced or legally separated under a decree of divorce or separate maintenance; (2) separated under a written separation agreement; or (3) lived apart at all times during the last six (6) months of the Calendar Year;
- The child's parents provide over one-half of the child's support; and
- The child is in the custody of one or both of his or her parents for more than one-half of the Calendar Year.

An unmarried 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 19 and was eligible for coverage prior to age 19; 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 (which will include written evidence of such incapacity) either to the Administrative Office with respect to any such child within 31 days after he or she 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 19 or who is not covered by the Plan when he or she attains age 19 is not eligible as a Dependent under this Plan.

Effective Date of Coverage For Eligible Dependents

The Plan covers your Spouse (and Dependent Children) if you are married (and have Dependent Children) on the effective date of your Retiree coverage. You may not add a Spouse or other Dependents after your effective date of Retiree coverage.

ENROLLMENT

The Administrative Office will notify you when you are eligible for coverage under the Plan and will send you an enrollment card.

HOW TO ENROLL

If you are an Eligible Retiree, you must enroll in this Plan within 60 days of the date your coverage as an Eligible Employee ends. You will be sent enrollment material by the Administrative Office when you are first eligible for benefits under this Plan. If you are a Retiree, the Plan covers your Eligible Dependents on the effective date of your Retiree Coverage based on records on file with the Fund for purposes of Active Plan coverage. You may not add a Spouse or other Dependents you acquire after your retirement date.

Eligible Retirees are required to elect coverage under this Plan when first eligible and may not enroll late unless the Eligible Retiree has other group health plan coverage when he or she first becomes eligible for Retiree Coverage. For instance, if an Eligible Retiree has group health plan coverage through his Spouse's employer when he first becomes eligible for coverage under this Plan, he may enroll in this Plan if he loses coverage through his Spouse's group health plan.

Notwithstanding the above, if you do not enroll for Retiree Benefits when your coverage as an Eligible Employee ends under the Active Plan, and you subsequently receive a Social Security Disability award, you may elect coverage for Retiree Benefits provided:

- the Injury or Illness that causes your disability occurred or began while you were covered by the Active Plan;
- you apply for coverage from this Plan within three months following receipt of your Social Security Disability award;
- you are age 50 or older on the effective date of your Social Security Disability award;
- you had Active Plan coverage as an Eligible Employee and/or a COBRA beneficiary continuously for the three years immediately preceding the date on which you last worked in Covered Employment (provided that you ceased working in Covered Employment due to the disability that forms the basis of your Social Security Disability award); and
- you have at least ten years of "continuous service" (as defined in the Roofers Union Local 30 Combined Pension Plan) in the Roofers Union Local 30 Combined Pension Fund.

Coverage will be effective on the later of the first of the month following the receipt of the award or your completed enrollment material.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

According to federal law, you might be requested 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 QMSCO 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

If you are covered under the Plan as an Eligible Retiree, your coverage ends:

- on the last day of the month for which you make the required monthly cost-sharing payment to the Plan;
- The date the Plan terminates;
- On the last day of the month following the date you become eligible for benefits under another group health plan;
- The date of your death; or
- The first day of the six-month period following the six-month period in which you return to Covered Employment or otherwise become a current employee under Section 732 (a) of ERISA.

If you lose Retiree Benefits, you cannot reenroll in the Plan (except as provided in the section of this SPD titled "Eligible Retirees Returning to Covered Employment" above). Please refer to the SPD for the Active Plan for information on your eligibility for Active Plan coverage upon returning to Covered Employment after retirement.

If you lose your Retiree Benefits because you became eligible for coverage under another group health plan, you may reenroll in this Plan when you lose that other coverage. In order to reenroll, you must notify the Administrative Office of the loss of other coverage within 31 days of the loss, fill out an enrollment form and provide proof of the other coverage during the periods you opted out of this Plan.

In the event of an Eligible Retiree's death, the surviving Spouse will continue to be eligible for Retiree Benefits provided the Spouse was covered by the Plan at the time of the Retiree's death. This coverage may continue for the surviving Spouse until the earliest of the date the Spouse: (1) dies; (2) remarries; (3) becomes eligible for coverage under another group health plan; or (4) ceases to make the required cost-sharing contributions to the Plan.

ELIGIBLE DEPENDENTS

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

- The date your Retiree coverage ends;
- The last day of the month following the date they no longer qualify as Dependents (e.g., your Dependent Child reaches the limiting age under the Plan or you and your Spouse divorce); or
- The date the Eligible Dependent enters active military service.

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 attempts to perpetrate a fraud upon or misrepresent a fact to the Plan with respect to that Claim. Furthermore, no benefits are payable on a Claim if the provider of the service that is the subject of the Claim attempts to perpetrate a fraud upon or misrepresent a fact to the Plan with respect to that Claim.

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 the 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 Eligible Dependents' health care coverage when their coverage ends.

CONTINUATION OF COVERAGE

COBRA

In General

Under this Plan, your Eligible Dependents can continue their health care coverage temporarily in certain circumstances where their 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 your Eligible Dependents at their own expense provided their 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 Eligible Dependent who is covered by the Plan when a Qualifying Event occurs.

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

Eligible Retirees and COBRA Continuation Coverage

If you are an Eligible Retiree, please be aware that, when you retire, you have the option of electing COBRA continuation of the coverage you had as an Eligible Employee instead of coverage for Eligible Retirees. If you do not elect COBRA continuation coverage when you retire within the timeframes described in the COBRA election notice, you will no longer have any rights to COBRA continuation coverage, even if you lose your Retiree Benefits. However, if your Spouse and/or Dependent Child(ren) who are covered by this Plan experience a COBRA Qualifying Event while receiving such benefits (for example, if you die or get divorced), they will be entitled to continue coverage in accordance with COBRA for a period of up to 36 months from the date of the loss of that coverage.

Please refer to the section of this SPD titled "Eligible Retirees Returning to Covered Employment" for information regarding the opportunity to elect COBRA following a period of re-employment and its impact on your continued eligibility for benefits from this Retiree-only Plan.

COBRA Qualifying Events

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

Qualifying Event	Who May Purchase Continuation Coverage?	For How Long?
You die	Eligible Dependents	36 months
You become legally separated or divorced from your Spouse	Eligible Dependents	36 months
Your Dependent Child is no longer considered a Dependent under this Plan's definition (e.g., he or she reaches the maximum age limit or marries)	Eligible Dependent Child	36 months

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.

You must provide the Administrative Office notice of the following Qualifying Events:

1. When an Eligible Participant divorces or legally separates from his or her Spouse, notice must be sent no later than 60 days after the date upon which coverage would be lost under the Plan as a result of the Qualifying Event. A copy of the court document must be included with the notice.
2. When a Qualified Beneficiary ceases to be covered under the Plan as a Dependent Child of an Eligible Participant, notice must be sent no later than 60 days after the date upon which coverage would be lost under the plan as a result of the Qualifying Event.

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. Notice may be provided by the Eligible Participant or Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the Eligible Participant or Qualified Beneficiary. Notice from one individual will satisfy the notice requirement for all related Qualified Beneficiaries affected by the same Qualifying Event.

How Is COBRA Coverage Provided?

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

IF 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), 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 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. A parent may elect or reject COBRA coverage on behalf of Dependent Children living with him or her.

Payment for COBRA Coverage

Your Eligible Dependents are responsible for the entire cost of COBRA coverage and can pay for the coverage on a monthly basis. When your Eligible Dependents become entitled to this coverage, the Plan Administrator will notify them of the COBRA premium amounts that they must pay. Covered Persons who continue full coverage under COBRA pay 102% of the Plan's cost.

If your Eligible Dependents elect COBRA coverage, they 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 their election. (This is the date the Election Notice is post-marked, if mailed.) If they do not

make their first payment for COBRA in full within 45 days after the date of their election, they will lose all continuation coverage rights under the Plan.

Payments for subsequent months are due on the first day of the month for which coverage is provided. Your Eligible Dependents will be sent a bill for subsequent months. However, it is their responsibility to make payment by the first of the month whether or not they receive a bill. If payment is not remitted 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 coverage period to make each payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. Failure to receive a bill or receipt of a late bill from the Administrative Office will not extend this deadline. If your Eligible Dependents fail to make your payment before the end of the grace period for that coverage period, they will lose all rights to COBRA continuation coverage under the Plan.

Maximum Coverage Period

The maximum time period for COBRA continuation coverage depends upon the Qualifying Event that causes the termination of coverage. Please refer to the "What is A Qualifying Event" section above to determine how long the coverage will last.

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.

If You Have Questions

Questions concerning the Plan or COBRA coverage rights should be addressed to the Plan Administrator identified below. For more information about 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.

You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a 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

If you have insured coverage through IBC (i.e. you are a Pre-Medicare Eligible Retiree) you may have the right to convert your medical coverage to an individual policy provided by IBC. See the section "Termination of Your Coverage and Conversion Privilege under this Group Coverage" in the applicable Appendix.

MEDICAL COVERAGE

Medical Coverage for Pre-Medicare Eligible Retirees

If you are an Eligible Retiree, you and your Eligible Dependents, who are not yet age 65 and/or not otherwise eligible for Medicare, are eligible for benefits which are substantially similar to the benefits provided by the Active Plan to Eligible Employees. These benefits are described in the Benefits for Pre-Medicare Eligible Retirees Section of this SPD. Please note that these benefits are different depending on whether you are a Commercial or Residential Retiree.

If you are a Pre-Medicare Eligible Retiree, you are eligible for medical benefits for Pre-Medicare Eligible Commercial Retirees described in Appendix A provided that you were enrolled in the Roofers Local Union 30 Combined Health and Welfare Commercial Plan for at least six (6) of the ten (10) benefit periods that immediately precede the date of your retirement. All Pre-Medicare Eligible Retirees that were not enrolled in the Roofers Local Union 30 Combined Health and Welfare Commercial Plan for at least six (6) of the ten (10) benefit periods will be treated as Pre-Medicare Eligible Residential Retirees.

Pre-Medicare Eligible Commercial Retirees

If you are an Eligible Commercial Retiree who is not otherwise eligible for Medicare, your medical benefits are described in the IBC booklet attached as Appendix A. See the attached booklet for details.

Information in Appendix A includes a description of:

- covered benefits;
- limitations;
- exclusions;
- cost-sharing provisions;
- extent to which preventive services are covered;
- medical testing, 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.

Pre-Medicare Eligible Residential Retirees

If you are an Eligible Residential Retiree who is not otherwise eligible for Medicare, you are eligible for Basic Benefits provided through the Comprehensive Blue Cross Hospital Plan and Highmark Blue Shield Medical-Surgical Benefits ("Basic Benefits") and Major Medical Benefits which are administered by the Administrative Office.

Your Basic Benefits are described in Appendix B.

Information in Appendix B includes a description of:

- covered benefits;
- limitations;
- exclusions;
- cost-sharing provisions;
- extent to which preventive services are covered;
- medical testing, 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.

Your Major Medical Benefits are described in the section titled Major Medical Benefits for Pre-Medicare Eligible Residential Retirees.

Medicare Coverage for Medicare Eligible Retirees

If you are an Eligible Retiree and/or an Eligible Dependent of an Eligible Retiree and are Medicare-Eligible, you are eligible for the self-funded Medicare Supplemental Benefits which are described on page 23.

The Medicare Supplemental Program for Medicare-Eligible Retirees and Eligible Dependents is administered by the Administrative Office. Benefits are described beginning on page 23.

Eligible Dependents

Your Eligible Dependents that are not Medicare-Eligible, are eligible for the same Retiree Benefits for which you are eligible prior to attaining eligibility for Medicare (for example, if you are a Commercial Retiree, your Eligible Dependents that are not Medicare-Eligible are entitled to benefits provided to Pre-Medicare Eligible Commercial Retirees). Your Eligible Dependents that are Medicare-Eligible are eligible for Medicare Supplemental Benefits.

MAJOR MEDICAL BENEFITS FOR PRE-MEDICARE ELIGIBLE RESIDENTIAL RETIREES

Major Medical Benefits are intended to help you and your Eligible Dependents meet the expenses associated with a serious Illness. Benefits are payable under the Major Medical portion of the Plan after benefits are payable under the Plan's Basic Benefits. Major Medical benefits are only payable after the Basic Benefits have been paid. No benefits are payable under the Major Medical portion of the Plan if the service or supply is denied for any reason by IBC. Benefits will not be available for services to a greater extent or for a longer period than is medically necessary, as determined by the Plan. The amount of benefits for any covered service will not be more than the amount charged by the health care provider and will not be greater than any maximum amount or limit described or referred to in Appendix B.

ANNUAL DEDUCTIBLE

Before you are eligible for Major Medical Benefits, you are required to meet a deductible. The Annual deductible is the amount of Covered Medical Expenses which must be paid before you or your Eligible Dependents are entitled to medical benefits.

The annual deductible is $100 per individual and $300 per family (three individual deductibles, collectively). The deductible applies only once in any Calendar Year even though an Eligible Retiree or Eligible Dependent may be treated for several different covered Illnesses. If two or more members of your family are injured in the same accident, you are only required to pay one deductible for all charges in connection with that accident.

COINSURANCE

Once you've met your annual deductible, the Plan generally pays a percentage of the Covered Medical Expenses and you, and not the Plan, are responsible for paying the rest. The part you pay is called the Coinsurance. Under the Major Medical Benefits, the Plan pays 80% of the balance of Covered Medical Expenses up to the allowance maintained by the Plan. You are responsible for 20%.

OUT-OF-POCKET MAXIMUM

Once you or one of your Eligible Dependents reaches $2,000 in out-of-pocket expenses, including the deductible, under the Major Medical benefits in any Plan year, the Plan will pay 100% of Covered Medical Expenses (as described on the next page) for the remainder of the Calendar Year for that individual. The following expenses are not considered Eligible Medical Expenses and will not be reimbursed by the Plan and will not count toward your out-of-pocket maximum.

- Expenses for medical services or supplies that are not covered in whole or part by the Basic Benefits, unless otherwise noted in this Chapter;
- Charges in excess of the allowance maintained by the Plan;
- Charges in excess of any limitation of the Plan, as discussed in this document and in Appendix B.

PHYSICIAN VISITS

Outpatient physician visits are reimbursed at $10 then payable under the Major Medical Benefits.

SUBSTANCE ABUSE TREATMENT

Benefits for substance abuse treatment are subject to the deductible and coinsurance.

OUTPATIENT MENTAL AND NERVOUS TREATMENT

Benefits for outpatient treatment of mental and nervous conditions are payable at 80% of the Plan's Allowance (after the $10 benefit is paid).

The Physician must be licensed or otherwise duly qualified with the state in which he/she practices.

Coverage is limited to individual counseling only and does not include family or group counseling.

COVERED MEDICAL EXPENSES PAYABLE UNDER MAJOR MEDICAL BENEFITS

Covered Medical Expenses covered under Major Medical Benefits include the following medical expenses that exceed your Basic Benefits for:

- Surgical procedures
- Emergency transportation service by professional ambulance or Mobile ICU to the nearest hospital
- X-ray and laboratory examinations
- Radiation therapy by X-ray, radium, and radioactive isotopes
- Chemotherapy
- Anesthetics, oxygen, and their administration, but only if performed with a surgical procedures
- Medical supplies for bandages, surgical dressings, splints, casts, braces, trusses, and other devices used in reductions of fractures and dislocations
- The initial charges for prosthetic appliances (such as artificial limbs and eyes) to replace any organ or part of an organ in its natural bodily function
- Rental, up to the purchase price, of durable medical equipment such as: a wheelchair, hospital type bed, for temporary use for restorative purposes
- Services performed at Minor Emergency Clinics
- Blood or blood plasma that has not been donated or replaced
- At-home private duty nursing services by a Registered Nurse, Licensed Practical Nurse, or Licensed Vocational Nurse, up to 240 hours per calendar year
- Physical and occupational therapy – treatment by a physiotherapist or occupational therapist
- Speech therapy when its purpose is to restore or rehabilitate any speech loss or impairment caused by Injury or Illness.

MAJOR MEDICAL EXCLUSIONS AND LIMITATIONS

The following expenses are not covered under Major Medical Benefits:

- Expenses for medical services or supplies that are not covered in whole or in part by the Basic Benefits, unless otherwise noted in this Chapter
- Expenses for in-patient and out-patient hospital services, ambulatory service facility/center, skilled nursing facility, home health care services and hospice care services
- Care and treatment of the teeth and gums, except when treatment is the result of accidental Injury to natural teeth and has been pre-approved by the Plan
- Eye refraction, eyeglasses, hearing aids, or dental prosthetic appliances
- Services and supplies in connection with Injury caused by war, whether declared or undeclared, that starts after the person's coverage starts, or by international armed conflict

- Expenses for services provided by any Physician or other health care provider who is a close relative (the parent, spouse, sibling (by birth or marriage) or child) of or resides in the home of the patient or Eligible Retiree
- Cosmetic procedures and cosmetic surgery, except for the repair of accidental injuries or a congenital abnormality (i.e., birth defect) for Dependent Child at birth
- Prescription drugs not provided as inpatient hospital charges
- Charges for services performed by a licensed or otherwise duly-qualified psychologist not acting or practicing within the scope or authority of his or her license or qualifications
- Charges incurred prior to the effective date of coverage under this Plan or after coverage is terminated
- Charges which would be covered under any Workers' Compensation or Occupational Disease Law, or any similar law
- Charges which you are not legally obligated to pay or for which you would not have been charged if you were not covered by this Plan
- Routine physical examinations, check-ups, medical observation, or diagnostic study, other than in a case where a specific Illness or Injury is revealed or where a demonstrable symptomatic condition was present
- Custodial care in a skilled nursing facility or elsewhere
- Charges incurred in connection with services and supplies which are not Medically Necessary for the diagnosis and treatment of an active Illness or Injury or charges which are in excess of the allowance maintained by the Plan and are not prescribed and approved by a Physician
- Charges for hospitalization for hydrotherapy, convalescent or rest care, or any routine physical examinations or test not connected with an actual Illness or Injury
- Charges for a Physician's fees or any treatment which is not rendered by or in the physical presence of a Physician
- Charges incurred for treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or alveolar processes
- Charges for the surgical treatment of obesity or weight reduction, including liposuction, unless it is Medically Necessary and is payable under the Basic Benefits
- Charges resulting from weak or unstable or flat feet, or bunions, unless an open cutting operation is performed, or for treatment of corns, calluses or toenails, unless at least part of the nail root is removed and orthopedic shoes or devices are prescribed; charges for orthopedic shoes are not covered

PRESCRIPTION DRUG COVERAGE

PRESCRIPTION DRUG BENEFITS FOR ELIGIBLE RETIREES AND THEIR ELIGIBLE DEPENDENTS

If you are an Eligible Retiree, the Plan provides you and your Eligible Dependents with coverage for prescription drugs that is self-insured by the Fund and administered by FutureScripts, an affiliate of IBC. Your Prescription Drug Benefits are described in detail in Appendix C.

The Prescription Drug Benefits offered to Eligible Retirees and their Eligible Dependents is subject to an annual maximum benefit of $625 per single person and $1,250 per family per Calendar Year.

WHEN YOU ARE COVERED BY MEDICARE PART D

You cannot be covered by both the Plan's Prescription Drug Benefit and the Medicare Part D Prescription Drug Benefit at the same time. *If you do choose to enroll in the Plan's prescription drug benefit or were already enrolled in the Plan's prescription drug benefit prior to attaining age 65 or otherwise becoming eligible for Medicare*, you must decide whether or not you will keep the Plan's prescription drug coverage or purchase Medicare Part D. *If you cease receiving prescription drug benefits from the Plan or you fail to make timely payment for such benefits, you will no longer be eligible to receive prescription drug benefits from the Plan or otherwise reenroll in such benefits at any time.* If you or your Eligible Dependent decides to purchase Medicare Part D, prescription benefits will terminate for you and your Eligible Dependents. However, eligibility for all of your other Retiree Benefits will continue for you and your Eligible Dependents and your monthly premiums will reflect medical-only coverage.

Please keep the following information in mind when you make your decision: for Eligible Retirees and their Eligible Dependents, the coverage offered by this Plan is **NON-CREDITABLE COVERAGE.** This means that this Plan is not expected to pay out as much in drug benefits as the standard Medicare prescription drug plan will pay out. This is important, because, for most people, failure to enroll in Medicare prescription drug coverage when they are first eligible means that they will have to pay a penalty in the form of a higher premium for Medicare prescription drug coverage if they decide to enroll in the coverage later. For more information about Non-Creditable Coverage see the Plan's Notice of Non-Creditable Coverage that will be/has been mailed to you from Plan. You may request a copy of the Notice by contacting the Administrative Office.

DENTAL BENEFITS

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

Dental services are available through Network Providers or 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. You should show your Concordia FLEX identification card when you go to the dentist.

BENEFIT MAXIMUMS

The Plan Maximum for Dental Benefits for Commercial Retirees 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 of both.

The Plan Maximum for Dental Benefits for Residential Retirees is $625 per Covered Person per Calendar Year. The Plan does not provide coverage for expenses for any Covered Person for dental services exceeding $625 per Calendar Year. These expenses may be incurred by use of Concordia Flex Providers, Out-of-Network Providers, or any combination of the two.

The following do not count toward the Plan Maximum and are covered at 100% of the Maximum Allowable Charge as set by United Concordia:

- Exams
- X-Rays
- Cleanings
- Fluoride 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 the applicable Plan Maximum. 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 applicable benefit maximum described above that you have in covered dental expenses.

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 the applicable Plan Maximum 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 purposes 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 the "General Limitations" section.

GENERAL LIMITATIONS

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

- in excess of the applicable Plan Maximum described in this section;
- 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 Allowable Charge on the schedule of dental procedures;
- for charges for unnecessary care, treatment or surgery;
- to the extent that you or any of your 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 applicable Annual Maximum.

Basic Services

- Basic Restorative
- Endodontics
- 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 insured by Vision Benefits of America (VBA). 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 the 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 by doing one of the following:

- Calling VBA at 1-800-432-4966; or

- Visiting 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 these Vision Benefits. 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 the 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.

To obtain services through a VBA Participating Provider:

1. Choose a VBA Participating Provider and make your appointment for the eye examination.
2. 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 Provider for the services you received according to VBA's Agreement with the Provider.

4. You will be responsible to pay the VBA 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 Provider 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 to 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 above Reimbursement Schedule. 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 Provider, 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.
- Lenses and frames furnished under this program, which are then lost or broken. These will not be replaced unless you are eligible for frames or lenses at that time.
- 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.

MEDICAL SUPPLEMENTAL BENEFITS FOR MEDICARE ELIGIBLE RETIREES

Medicare Supplemental Benefits—Medical Benefits for Medicare-Eligible Retirees and Dependents

For Eligible Retirees or Eligible Dependents of Eligible Retirees who are age 65 or older and/or are eligible for Medicare, this Plan supplements Medicare benefits. This section provides a brief description of how Medicare works and the benefits the Plan pays. For more details on how this Plan coordinates with Medicare, see the section, "Coordination with Medicare" beginning on page 38.

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 after a waiting period.

Medicare has three parts, A, B, and D. In general, Part A covers hospital services, skilled nursing facilities, hospice, and some home health care services. Part B covers medical services such as physician visits, physical and occupational therapy and diagnostic testing. In general, your Retiree Benefits through this Plan supplements Part A and covers the Part A deductible and coinsurance amounts. This Plan also supplements Part B coverage and covers the Part B coinsurance amounts. Part D – only if purchased – covers outpatient prescription drugs. Medicare does not cover dental or vision expenses.

When You Are Covered by a Medicare Advantage Plan *(formerly called Medicare + Choice or Part C)*

This Plan provides benefits that supplement the benefits you receive from Medicare. If you are covered by a Medicare Advantage plan and you obtain medical services or supplies in compliance with the rules of that program, including, without limitation, obtaining all services In-Network when the Medicare Advantage plan requires it, this Plan will reimburse all applicable copayment amounts and will pay the same benefits provided for Medicare-Eligible Retirees less any amounts paid by the Medicare Advantage plan.

However, if you do not comply with the rules of the Medicare Advantage plan, including, without limitation, approved referral, preauthorization, case management or utilization of Participating Provider requirements, this Plan will NOT provide any health care services or supply or pay any benefits for any services or supplies that you receive.

When You are Not Covered by Medicare Part A or B

You should understand that not enrolling in Medicare Parts A and B will have a significant impact on the expenses for which you will be responsible. This is because if you and/or your Eligible Dependent(s) are eligible for (e.g., because you are age 65), but are not enrolled in, Medicare Parts A and B, this Plan pays benefits as if it were coordinating with Medicare Parts A and B. Therefore, you will only receive the benefits the Plan would have paid had Medicare Part A or B paid benefits first (generally the applicable Medicare coinsurance for a particular service or supply). This means that if you do not sign up for Medicare Parts A and B, you will be responsible for the amounts that Medicare would have paid if you had Medicare Parts A and B.

This provision does not apply for prescription drug benefits (Medicare Part D).

Hospital Benefits for Medicare-Eligible Retirees and Medicare-Eligible Dependents Supplemental to Medicare Part A

For any inpatient stay in a short-term general hospital that does not begin during an already existing period of Illness, you are entitled to the following to supplement Medicare Part A benefits:

Medicare Benefits	**For each day during a period of Illness that you receive inpatient benefits under Part A of Medicare for services provided in a participating hospital or a non-participating hospital, the Plan pays:**
Medicare covers 60 days of inpatient hospital care per period of Illness, subject to an initial deductible.	The lesser of (i) the amount of the inpatient hospital deductible as determined under Medicare, and (ii) the hospital's regular charges for the hospital service rendered.
Medicare covers 61-90 days of inpatient hospital benefits per period of Illness subject to a per day Coinsurance amount.	The Coinsurance amount as determined by Medicare.
For the 91st -150th days of inpatient hospital benefits, you have a 60-day lifetime reserve of additional benefit days provided by Part A of Medicare, subject to a per day Coinsurance amount.	The Coinsurance amount as determined by Medicare. After you have exhausted the 90 days and your 60 reserve days, the Plan will provide benefits in full for an additional 365 days during your lifetime.
Medicare covers the first 20 days of inpatient care in a Skilled Nursing facility in full. For days 21-100, you are subject to a per day Coinsurance.	The Coinsurance amount for the 21st-100th day. You are also entitled to an additional 365 lifetime days (in lieu of the 365 days listed above and not in addition to them).
Inpatient hospice respite care in a Medicare approved facility	The Coinsurance amount as determined by Medicare

Outpatient Hospital Care

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Medicare Part A does not cover outpatient services for emergency care, minor surgery, diagnosis, or therapy. Medicare Part B generally pays 80% for these services after you have paid an annual deductible applying to all your covered medical services during a Calendar Year.

The Plan pays 20% of the balance that would be owed by you for covered emergency care, minor surgery, diagnosis or therapy in the hospital's outpatient department during a Calendar Year. If you do not have Medicare Part B, then you will be responsible for the 80% that Medicare would have paid.

Professional Services

When rendered by hospital staff personnel, the Plan will pay reasonable and customary charges for X-ray, laboratory, and anesthesia services when performed in the hospital up to the extent not covered by Medicare Part B.

Care in Foreign Countries

When the patient who is a United States resident is hospitalized in any foreign country, the Plan pays for all the hospital benefits normally offered under Medicare – in addition to those provided under this Plan.

Exclusions for Medicare Supplemental Benefits

The Plan does not provide:

- Benefits in hospitals that do not participate in the Medicare program (except for foreign hospitals)
- Care for any person not entitled to benefits under Medicare
- Routine physical examinations
- Inpatient accommodations when admission for diagnosis, diagnostic study, or medical observation could have been performed on an outpatient basis
- Services not Medically Necessary for diagnosis or treatment of an Illness or Injury
- Convalescent, custodial, rest cures or intermediate nursing home care
- Services covered by programs created by federal or state laws or regulations, such as Medicaid, Medicare, or the Veteran's Administration; or, benefits paid or payable under a policy of motor vehicle insurance, through the Catastrophic Loss Trust Fund for accidents occurring on or before June 1, 1989; or through qualified self-insurance
- Services furnished for a condition arising in the course of employment for which coverage is or was available under Workers' Compensation or similar laws
- Services for which the cost may be recoverable by the Covered Person from or in any action at law or by compromise or settlement of any Claim except as prohibited by the "Health Care Services Malpractice Act"
- Non-hospital or non-skilled nursing facility services
- Private duty nurses
- Ambulance services except as provided and billed for by hospitals or skilled nursing facilities
- Drugs and medications not administered while an inpatient in a hospital or skilled nursing facility during an outpatient visit to a hospital
- Blood or blood plasma to the extent donated or replaced without cost to the Covered Person
- Cosmetic surgery except as related to accidental Injury that occurred after the Covered Person's effective date of retirement
- Purchase or rental of durable medical equipment, except as otherwise specifically provided herein
- Care of gums, teeth or extraction of teeth
- Personal comfort or convenience items
- Professional services and other outpatient services which are provided under Medicare Part B

- Any benefit paid for by Medicare, or benefits excluded under Medicare other than those outlined here

Medical Benefits for Medicare-Eligible Retirees and Medicare-Eligible Dependents of Retirees Supplemental to Medicare Part B

Under Part B of Medicare, you are entitled to medical services that include physician visits, diagnostic x-ray and laboratory and durable medical equipment subject to an annual deductible and Coinsurance, which is generally 20% of the Medicare allowance after the annual deductible.

This Plan does not reimburse the annual Medicare deductible amount. In general, the Plan will reimburse you the 20% Medicare Coinsurance, based on what Medicare allows. If Medicare excludes a benefit, the Plan will not consider it for payment.

If you are enrolled under Medicare Part B, a Medicare claim form must be submitted to the Medicare Part B carrier in the state where the services were performed. After Medicare Part B makes its payment, the balance not covered is processed by this Plan. Please send the Explanation of Medicare Benefits (EOMB) that you receive to the Administrative Office for processing.

In-hospital and outpatient services that are covered:

- Surgeon's charges
- Provider's fee for anesthesia
- Provider's hospital visits
- Provider's fee for radiation treatments
- Provider's fee for X-ray examinations
- Provider's fee for laboratory tests
- Dentist's fee for dental surgery (See exclusions below)
- Provider's fee for diagnostic tests
- Charges for braces, artificial legs, arms, eyes
- Medical consultation by Providers
- Physical therapy and other therapy services by a licensed physical therapist
- Hemodialysis services associated with chronic kidney disease

Services in the Provider's office that are covered:

- Visits to the Provider's office
- Surgical dressings, splints, casts
- Drugs administered by a Provider
- Professional services and examinations such as X-ray, electrocardiograms and pathological tests; radiation treatments and podiatry services

Services in your home that are covered:

- Provider's visits
- Diagnostic X-ray services
- Surgical dressings, splints, casts
- Rental or purchase of durable equipment such as wheelchair, hospital bed, oxygen tent, etc.
- Drugs administered by a Provider
- Charges for braces, artificial legs, arms, eyes

Exclusions for the Medicare supplemental benefits

- Routine physical examinations
- Eye examinations, refractions, eyeglasses, hearing examinations or hearing aids
- Dental services such as the care, filling, removal or replacement of teeth, or treatment of gum areas. However, services involving surgery of the jaw or related structures or setting of fractures of the jaw or facial bones are covered
- Routine foot care, treatment of flat feet and partial dislocations of the joints of the feet, orthopedic shoes or other supportive devices for the feet except those which are a part of leg braces
- Immunization (unless directly related to immediate risk of infection from injury)
- Prescription drugs and drugs the subscriber can administer himself (such as insulin)
- Medical expenses for which the subscriber is not legally obligated to pay
- Services provided and billed for by skilled nursing care facilities
- Care for any person not covered by Medicare Part B
- Benefits excluded under Medicare Part B other than those outlined in this booklet
- Benefits for services occurring prior to the effective date of your coverage
- Payment of charges not deemed Reasonable by Medicare Part B
- Any benefit paid for by Medicare Part A or B
- Payment of the Medicare Part B Calendar Year deductible amount

There is more information on Medicare in the "Coordination with Medicare" section of the booklet.

LIFE INSURANCE BENEFITS

If you are an Eligible Retiree, you are eligible for Life Insurance Benefits. **Your Life Insurance Benefits are subject to the terms and provisions of the insurance policy that are described in Appendix D.** The following is a summary of the Life Insurance Benefits insured through the Amalgamated Life Insurance Company ("Amalgamated").

In the event of your death from any cause while you are covered as an Eligible Retiree 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 be equal to the amount listed below.

AMOUNT OF LIFE INSURANCE BENEFITS

Eligible Retirees	$2,500

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 out 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 if 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.

FILING A LIFE INSURANCE CLAIM

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

All provisions of this benefit are subject to the terms and conditions of the Certificate of Insurance attached as Appendix D.

Accidental Death And Dismemberment Benefits

This Plan provides Accidental Death and Dismemberment (AD&D) Benefits to Eligible Retirees. The AD&D benefit is insured by Amalgamated and is subject to the terms and conditions described in Appendix D. This chapter contains a summary of the AD&D 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 caused by an accident. A covered loss is your loss of life, or your loss of one or more body parts or your loss of sight as described below in the Schedule of Losses. The covered loss must occur within 365 days after the date of the accident. These benefits are in addition to any other benefits you may receive.

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 the following amounts, in one lump sum payment, as shown below.

SCHEDULE OF ACCIDENTAL DEATH AND DISMEMBERMENT LOSSES

Loss	Eligible Retiree	Payable to:
Life	$2,500	Your beneficiary
Both hands	$2,500	You
Both feet	$2,500	You
Sight of both eyes	$2,500	You
One hand and one foot	$2,500	You
One hand and the sight of one eye	$2,500	You
One foot and the sight of one eye	$1,250	You
One hand	$1,250	You
One foot	$1,250	You
Sight of one eye	$1,250	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.

Other Provisions

The Plan also contains a number of provisions that pertain to this benefit that are explained in Appendix D. See the Claims and Appeals chapter for details on filing a Claim.

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 result 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 unless it arises as a result of a physical or mental health condition or as a result of domestic violence;
- 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, 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;
- 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 dental care or treatment, or dental X-rays, unless specifically provided in the Dental Benefits Section of this SPD on page 19;

- Charges incurred for Experimental Procedures;

- 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 in the Vision Benefits Section of this SPD on page 19; or

- Charges incurred in connection with any of the following procedures: artificial insemination; or in vitro fertilization.

COORDINATION WITH OTHER PLANS

As set forth on page 14, you are not eligible for Retiree Benefits if you are or become eligible for coverage under another group health plan. However, from time to time, it may be necessary to coordinate the Dental, Vision, Major Medical Benefits, and Supplemental Medicare Benefits described in this SPD with other coverage. The IBC Insured Medical Benefits contain their own Coordination of Benefits ("COB") provisions which are described in Appendix A and Appendix B.

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

This plan provides supplemental benefits for Medicare-Eligible Retirees. The following rules apply to Medicare-Eligible Retirees and their Medicare-Eligible Dependents.

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). It is important that you or your Eligible Dependent visit an office of the Social Security Administration during the three-month period prior to your or his/her 65th birthday to learn about Medicare. For questions on coverage by this Plan, or help in comparing benefits offered by this Plan and Medicare, please contact the Administrative Office.

Coverage Under Medicare When a Covered Person is a Medicare-Eligible Retiree

If a Covered Person is not actively working (e.g. retired) and is covered by Parts A, B and/or D of Medicare, as well as this Plan, Medicare pays first and this Plan pays second. Those enrolled in any Part of Medicare may either retain or cancel coverage under this Plan. The choice of retaining or canceling coverage under this Plan is the responsibility of the Eligible Retiree. This Plan will not provide any consideration, incentive or benefits to encourage cancellation of coverage under this Plan.

How Much This Plan Pays When It Is Secondary to Medicare

When Covered by Medicare Parts A or B: When a Covered Person 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: Those enrolled in Medicare Part D or a Medicare Advantage Plan that provides prescription drug coverage (MA-PD) and their Eligible Dependents **ARE NOT** eligible to receive any prescription drug benefits from this Plan. They may not re-enroll in the Plan if they discontinue their Medicare Part D coverage in the future.

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 by 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 a Covered Person 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 Eligible Dependent called to active duty for more than 30 days, TRICARE is primary and this plan is secondary.

Veterans Affairs Facility Services: If a Covered Person 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 a Covered Person has benefits under 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.

Other Coverage Provided by State or Federal Law: If a Covered Person has coverage under 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 the 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 for the Medical Benefits insured through IBC that can be found in the applicable appendix.

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 the Covered Person 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 Covered 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 the Covered Persons 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 action, the Plan may request the Covered Person and any other injured party to sign and deliver a written reimbursement and/or subrogation and trust agreement (hereafter called the "Agreement") in a form provided by or on behalf of the Plan. If the Covered Person is a minor or unable to execute the Agreement due to incompetence, 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 Covered Person. The Plan may 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 or other injured party 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 or her 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 Plan proceeding it deems necessary to protect its subrogation rights, and litigate 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 of 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 is 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 a Covered Person 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 of 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 Benefits for Pre-Medicare Eligible Residential and Commercial Retirees	Independence Blue Cross Commercial Retirees: Personal Choice PO Box 890016 Camp Hill, PA 17089-001 Residential Retirees: Non-Participating Provider claims: Highmark Blue Shield PO Box 890062 Camp Hill, PA 17089-0062 Other Benefits: 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
Major Medical Benefits and Medicare Supplemental Benefits	Administrative Office Roofers Union Local 30 Combined Health and Welfare Plan 830 Bear Tavern Road P.O. Box 1028 West Trenton, NJ 08628	Board of Trustees 830 Bear Tavern Road P.O. Box 1028 West Trenton, NJ 08628
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 Pittsburgh, PA 15236-1588	Vision Benefits of America 300 Weyman Plaza 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;
- 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.

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 applicable appendix 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 C. Please refer to Appendix C 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 D. 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 D. Please refer to Appendix D for more details on claims and appeals.

- **Claims for Major Medical Benefits and Medicare Supplemental Benefits** Claims for Major Medical Benefits and Medicare Supplemental Benefits must be filed within 12 months of the date of service.

    - To file a Claim for **Major Medical Benefits** you must first file a Claim with IBC. After you have received an Explanation of Benefits ("EOB") from IBC, you should submit a Claim along with a copy of the EOB to the Administrative Office.

    - To file a Claim for **Medicare Supplemental Benefits** you must submit a copy of the Medicare Explanation of Benefits along with a copy of the provider's itemized statement to the Administrative Office.

- **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

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 Major Medical Benefits, Medicare Supplemental Benefits and 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.

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 the applicable appendix 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 C 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 D 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 the Vision Benefits section of this booklet for information on submitting an appeal of a denied Claim.
- **Major Medical Benefits, Medicare Supplemental Benefits and Dental Benefits:** The final right of appeal for Major Medical Benefits, Medicare Supplemental Benefits and Dental Benefits is with the Board of Trustees and is subject to the procedures and timeframes set forth above.

YOUR ERISA RIGHTS

As a Covered Person in the Retiree Plan of the Roofers Union Local 30 Combined Health and Welfare Fund, you are entitled to certain rights and protections under the 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.
- Continued health coverage for your Eligible Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. 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 Covered Persons, 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 Covered Persons. No one, including your former Employer, your Union or any other person may 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 Retiree Plan

TYPE OF PLAN

This Plan is an employee welfare benefit plan that provides medical and hospital, prescription drug, Vision, Dental, Life Insurance, and Accidental Death and Dismemberment Benefits. The plan is a small group health plan as defined in Section 732(a) of ERISA.

PLAN IDENTIFICATION NUMBERS

Employer Identification Number: 23-2258631

IRS Plan Number: 502

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 Fund
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 Fund Administrator at the Administrative Office that can be reached at:

Administrative Office
Roofers Union Local 30 Combined Health and Welfare Fund
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 Fund
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 IBC. The Life Insurance and AD&D Benefits are insured by Amalgamated and 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 are administered by FutureScripts, 1901 Market Street Philadelphia, PA 19103-1480.

The Dental Benefit is self-insured and is administered by United Concordia Companies, Inc. (“United Concordia”), 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 insured by The Amalgamated Life Insurance Company, 730 Broadway, New York, New York 10003 .

INSURANCE CONTRACT GOVERNS

The medical, hospital, Vision, Life Insurance, and Accidental Death and Dismemberment benefits are subject to the complete terms, conditions, limitations, and exclusions of the contracts issued by IBC, VBA, and Amalgamated to the Plan. If a difference exists between the information in this booklet and the certificates and the actual contracts, the certificate or contracts govern.

COLLECTIVE BARGAINING AGREEMENTS AND SOURCE OF FINANCING

The Fund 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 are available for examination by Eligible Participants and beneficiaries.

Contribution Source: All contributions to the Fund 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 Fund on behalf of active employees working under the Collective Bargaining Agreement. The Administrative Office will also provide you, upon written request, a list of Contributing Employers and employee organizations.

The Collective Bargaining Agreements require contributions to the Fund at fixed rates per hours worked. You may request in writing, a copy of the Collective Bargaining Agreements 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 of this Plan and the Active Plan.

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

PLAN AMENDMENTS OR TERMINATION

The Trustees reserve the right to change or, with approval of the Union and the Association, terminate (1) the types and amounts of benefits under the Plan and (2) the eligibility rules, even if extended eligibility has already been accumulated. Resolutions 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.

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 make findings of fact, interpret the terms of the Plan, and determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination will be final and binding, 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 or 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 Roofers Union Local 30 Combined Health and Welfare Retiree Plan (hereafter referred to as the "Plan"), 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 Eligible Retirees' and their Eligible Dependents (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 Eligible Retiree or beneficiary. 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 FOR COMMERCIAL RETIREES

APPENDIX B

INSURED MEDICAL BENEFITS FOR RESIDENTIAL RETIREES

APPENDIX C

PRESCRIPTION DRUG BENEFITS

APPENDIX D

LIFE INSURANCE & AD & D BENEFITS