ROOFERS UNION LOCAL NO. 70 INSURANCE BENEFITS TRUST

SUMMARY PLAN DESCRIPTION

SECTION I - INTRODUCTION TO THE PLAN

Roofers Union Local No. 70 (“Union") maintains an Insurance Benefit Trust for the benefit of individuals who are covered by the Local No. 70 collective bargaining agreement (“eligible participants”), the employees of Local No. 70 and the Local No. 70 Fringe Benefit Funds. The Trust has been in effect since May 1, 1987. The Trust as amended is for the exclusive benefit of eligible participants and their beneficiaries.

The purpose of this Trust is to reward eligible participants for service by providing them with health, dental, disability and other benefits.

Monthly contributions will be made by the employers whose employees are covered by the union contract, by Local No. 70 for its employees, and by the Local No. 70 Fringe Benefit Funds for its employees ("Employers") based upon the hours worked by you and other eligible participants. During this time, you will be eligible to receive the benefits you are entitled to from the Trust provided you meet the requirements of participation

This Summary Plan Description is a brief description of the Trust and your rights, obligations, and benefits from it. This Summary Plan Description is not meant to interpret, extend, or change the provisions of the Trust in any way. The provisions of the Trust may only be determined accurately by reading the actual Trust document which incorporates any informational pamphlets from insurance carriers or other providers with materials pertinent to the Trust.

A copy of the Trust is on file at the Local's office and may be read by you, your beneficiaries, or your legal representatives at any reasonable time. If you have any questions regarding either the Trust or this Summary Plan Description, you should ask the Plan's Administrator. In the event of any discrepancy between this Summary Plan Description and the actual provisions of the Trust, the Trust will govern.

This Summary and any referenced Insurance Booklets (which are incorporated by reference) contains all information regarding the Trust as of January 1, 2018 or any later effective date that is referenced in the Summary.

SECTION II - GENERAL INFORMATION ABOUT THE TRUST

There is certain general information which you may need to know about the Trust. This information has been summarized for you in this section.

1. General Trust Information

Roofers Union Local No. 70 Insurance Trust is the name of the Trust.

The Local has assigned Plan Number 501 to the Trust.

The amended and restated provisions of the Trust became effective January 1, 2008. Other provisions have varying effective dates.

The Trust's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on January 1st and ends on December 31st.

The contributions made to the Trust will be held and invested by the Board of Trustees.

The Trust will be governed by the laws of the State of Michigan to the extent not pre-empted by Federal law.

2. Sponsor Information

The Sponsor's name, address and identification number are:

Roofers Union Local No. 70
P.O. Box 116
Howell, MI 48844
Phone No. 517-548-6554
Fax No. 517-548-5358
Employer Identification Number: 38-2014021

3. Plan Administrator Information

The name, address and business telephone number of the Plan's Administrator are:

Joint Board of Trustees
P.O. Box 766
Roofers Union Local No. 70
Howell, MI 48844
Phone No: 517-548-7941
Fax No: 517-548-5936

The Plan's Administrator keeps the records for the Trust and is responsible for the administration of the Trust. The Administrator has discretionary authority to construe the terms of the Trust and make determinations on questions which may affect your eligibility for benefits. The Plan's Administrator will also answer any questions you may have about the Trust.

4. Trustee Information

The Trustee is the Joint Board of Trustees which consists of equal numbers of Employer and Union Trustees. At this time there are four trustees.

The Board of Trustees shall collectively be referred to as Trustee throughout this Summary Plan Description.

The principal place of business of the Trustee is:

1451 Old Pinckney Road
Howell, MI 48843

The Trustees have been designated to hold and invest Trust assets for the benefit of you and other participants. The trust fund established by the Trustees will be the funding medium used for the accumulation of assets from which benefits will be paid.

5. Service of Legal process

The name and address of the Trust's agent for service of legal process are:

Roofers Union Local No. 70 Insurance Trust Board of Trustees
P.O. Box 766
Howell, MI 48844
Phone: 517-548-7941

Fax: 517-548-5936

Service of legal process may also be made upon any of the Trustees or the Plan Administrator.

SECTION III - HOW ELIGIBILITY AND HOURS ARE MEASURED

Throughout this Summary reference is made to hours worked for employers. These hours are very significant under the Trust to determine what benefits an eligible participant is eligible for. Generally you receive credit for an hour for which contributions are required in accordance with the provisions of the Collective Bargaining Agreement ("CBA") between Local No. 70 and the Signatory Employer, or for hours worked for Local No. 70. For the Local No. 70 Fringe Benefit Funds employees, contributions shall be equal to the appropriate monthly premium charge for the employee. In order to be eligible for any benefits you must be an employee of a Signatory Employer covered by the Local No. 70 Collective Bargaining Agreement, or be employed by Local No. 70 or the Local No. 70 Fringe Benefit Funds. In this Summary whenever the term "eligible participant" is used it refers to this requirement.

1. Monthly Hours Reports.

Each signatory contractor and Local No. 70 and the Local No. 70 Fringe Benefit Funds makes monthly contributions to the Insurance Trust. The contributions are based upon hours worked by eligible participants of Local No. 70 for the contractors or Local No. 70. These monthly reports track the hours of employment of each eligible person. The hours are extremely important since they determine eligibility for various benefits of the Trust. For purposes of this Summary all signatory contractors and Local No. 70 and the Local No. 70 Fringe Benefit Funds are referred to collectively as "Employers".

2. Hours required to become covered.

Once you have satisfied the eligibility requirements for a benefit, your next step will be to actually become a participant in that portion of the Trust. You will become a participant (for single or family coverage) on the first day of the month after contributions have been made for 800 hours of service you have performed for Employers.

3. Rolling Twelve Month Hour Bank.

The Plan Administrator will keep a record for each eligible participant of the hours worked by the employee and the dollars contributed by his employer or employers for the eligible participant during the last twelve calendar months. In addition the Plan Administrator will keep a record of the payments made for various insurance premiums for each employee. Any amount contributed (or expended) more than twelve months before the current date will be removed from the record and replaced by the most current twelve month period. If you take a non-union job, all of your banked dollars will expire.

4. Non-Collectively Bargained Employees of contractors.

Any contractor or the Local No. 70 Fringe Funds may elect to have all of their non-collectively bargained employees covered by this Trust. The coverage is available only if the contractor has made all of the contributions to the Trust required by the Insurance Trust Agreement. Coverage will continue only during the period that the contractor pays the required monthly cost for all appropriate coverages. This option is available only if all non-collectively bargained employees of the contractor are covered. Additionally any amount paid by the contractor will first be applied to pay monthly contributions for collectively bargained employees.

5. Self Payments

Eligible participants who would otherwise not be covered because of a period for which insufficient employer contributions are being made to continue coverage, may continue coverage by making self-payments, but not beyond a maximum period of twelve (12) consecutive months, subject to the following:

a. The eligible participant shall make the required contribution to the Fund.

b. The contribution is made not later than the first day of the next succeeding calendar month following notification of the lack of enough hours of the eligible participant. Acceptance of contributions by the Trust is conditioned upon the eligible participant not having enough contributed hours, but available for work during the period covered by the self contributions. In each instance, Local No. 70 shall verify the fact that the eligible participant for whom contributions are made is, in fact, available for work within its jurisdiction. Self pay rates shall be equal to the appropriate monthly premium charge for active eligible participants.

6. Requalification after a lapse in coverage

After the exhaustion of banked hours the participant may continue self payments. If self payments are not continued resulting in a lapse in coverage, the participant will be eligible to reinstate to the Insurance Plan without re-qualifying within 2 calendar months of the end of coverage. After the 2 calendar month grace period the participant will need to re-qualify as stated in Section IV 2.

All insurance cost and bills associated within the time frame during which the participant did not make self-payments for insurance are not covered under the Plan.

Before the end of the 63rd day the Benefits office must have received funds from all sources for the benefit of the participant sufficient to pay for one current monthly payment for insurance coverage.

This reinstatement provision may only be used once during any twelve consecutive month period.

7. Reinstatement after loss of eligibility

If an eligible participant's insurance eligibility is terminated due to insufficient contributions (whether by employer contribution or self-pay), he/she will be reinstated if credited with 400 Hours Employer contributions within a six month period with reinstatement effective on the first day of the month following receipt of the contribution for the month which includes the 400th hour. The reinstatement must occur within 12 months of loss of eligibility. If reinstatement does not occur within the 12 month period from loss of eligibility the eligible participant will be required to meet the initial 800 hours needed for the eligibility requirements for benefits coverage.

8. Special Reinstatement Rule for loss of eligibility due to Apprenticeship Block Training

If an eligible participant's Insurance eligibility is terminated due to insufficient contributions while attending Apprenticeship Block Training he or she may be reinstated in the Plan after receiving contributions for 110 Hours if the following conditions are met:

a. The eligible participant must have been insured at the time of commencement of the training.
b. The loss of coverage must be due to lack of hours and no self payment.
c. Reinstatement occurs upon receiving contributions for 110 Hours worked within a 12 month period following loss of coverage. The reinstatement will occur on the first day of the month following receipt of the contributions for the 110th hour.
d. The eligible participant must provide proof from the Apprenticeship School that the Block Training course was successfully completed.

9. Surviving Spouse

The surviving spouse of a deceased active participant who expires with an existing dollar bank, who would not otherwise be covered upon the death of the active participant, may continue coverage in the Medical portion of the Plan only, subject to the following:

a. The surviving spouse must notify the Plan Administrator of his or her desire to continue coverage

b. The remaining dollar bank of the deceased participant used by the surviving spouse shall be calculated in the same manner as for active Participants under this Section. The rate used for premiums shall be equal to the self pay rate that is periodically established by the Trustees. If the remaining dollar bank is not sufficient to pay for a full month's self-payment then continuation of coverage will terminate at that date and the surviving spouse will be offered continuation of coverage under COBRA.

10. Notice of Plan Changes

The Fringe Office must be notified of any change as follows:

Marriage. To add a spouse to coverage, the marriage must be reported within 30 days. A copy of the certificate of marriage must be filed in the Fund Office. If timely reported, coverage for such Spouse will be effective from the date of marriage. If not timely reported, coverage for such Spouse will be effective the first day of the month following the month in which the Fringe Office was notified of the marriage.

New Babies. To add a baby to coverage, birth must be reported within 30 days. A copy of the birth certificate must be filed in the Fringe Office. The baby will be covered from the moment of birth, as provided herein, subject to the filing of the Birth Certificate. If not timely reported, coverage for such child will be effective the first day of the month following the month in which the Fringe Office was notified of the birth.

Adoptions/Placement for Adoption. Adoption or placements for adoption of a child must be reported within 30 days to add the child as an eligible dependent and a copy of the legal adoption papers or court order must be filed in the Fringe Office. Coverage is effective from the date of adoption or placement for adoption. If not timely reported, coverage for such child will be effective the first day of the month following the month in which the Fringe Office was notified of the adoption or placement for adoption.

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

Deaths. Deaths of any person covered by the Insurance Plan should be reported immediately. A certified copy of the death certificate is required.

Divorce. **Divorce must be reported immediately by a Participant and his former Spouse and a copy of the Judgment of Divorce must be filed in the Fund Office including any applicable Qualified Domestic Relations Order (QDRO).** A former spouse is not eligible for benefits commencing on the date of the divorce, except as provided under the Continuation of Coverage (COBRA) Provision. Eligible Children will continue to be covered.

26th Birthday. Children are removed from coverage at midnight on the last day of the month in which they turn 26.

11. EXPLANATION OF COBRA RIGHTS

Introduction

This Notice is included in this Summary because you either continue to be covered or have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

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

If you are a Local No. 70 eligible participant, or an employee of Local No. 70 or the Local No. 70 Fringe Funds, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or

- The child stops being eligible for coverage under the plan as a "dependent child."

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice in writing to the Fringe Funds Office.

How is COBRA Coverage Provided?

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must give written notice to the Fringe Funds Office with a copy of the Social Security determination within 30 days of the determination.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the

spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

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

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator 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 Plan Administrator.

Plan Contact Information

Roofers Union Local No. 70 Fringe Funds Office
P.O. Box 766
Howell, MI 48844
517-548-7941

SECTION IV - PARTICIPATION IN THE HEALTH INSURANCE PORTION OF THE TRUST

Before you become an eligible participant or a “participant” in the Health Insurance portion of the Trust, there are certain eligibility and participation rules which you must meet. These rules are explained in this section.

1. Eligibility Requirements

You will be eligible to become a participant in the Health Insurance Trust if you are an eligible participant as defined in Section III.

2. Participation Requirements

Once you have satisfied the Trust’s eligibility requirements, your next step will be to actually become a “participant” in the Trust. You will become a participant (for single or family coverage) on the first day of the month after contributions have been made for 800 hours of service you have performed for Employers.

3. Family Coverage

After you have become eligible for coverage, family coverage is available for your spouse, minor children and qualified adult children. Any adult child is eligible to enroll for continuation of coverage until the last day of the month during which the adult child reaches age 26. Your parental relationship may be by birth, marriage, legal adoption, or guardianship. You do not need to be providing any financial support to your child. The adult child does not need to be living in your household. The adult child does not need to be attending school. The adult child may be any marital status (single,

married, divorced, or separated). However, this coverage is not available if the adult child is eligible to enroll in his or her own employer sponsored health insurance

Finally, you may continue to cover any "Domestic Partner" that was covered prior to January 1, 2008. After January 1, 2008 no new Domestic Partners may be covered under the Trust. For purposes of this Trust, Domestic Partners are unmarried individuals who sign an affidavit that states:

a. The cohabitators are living together,
b. Neither cohabitator is married to any other individual, and
c. The cohabitation has been for a period of at least one year.

4. Benefits available to Participants

Currently the Health Insurance coverage is provided by Blue Cross Blue Shield of Michigan. The benefits available to all Participants are described in detail in the Blue Cross Blue Shield pamphlet that is distributed upon initial eligibility and subsequently on an annual basis. From time to time the applicable co-pays, maximum out of pocket amounts and qualifying expenses may change. Should any of these items change, you will be notified in writing. If the insurance carrier changes, you will be notified of the change and will be provided a new summary of benefits from the new carrier.

5. Excluded Benefits

No benefits will be paid for any expenses incurred as a result of a work related injury or an automobile accident. The determination of whether the expenses are as a result of either of these events shall be made by the Plan Administrator based upon all available information.

6. Health Reimbursement Account.

The Health Reimbursement Account Plan provides an amount that you can use for Health Care Expenses that are not covered by insurance or any other reimbursement plan. In order to be eligible for any benefits you must be an eligible participant.

Using the Plan Account you can pay your out of pocket Health Care Expenses. Any out of pocket health care expenses can be submitted to the Plan Administrator for reimbursement. Generally these expenses are any expense not covered by the Local No. 70 Insurance Plan that would be deductible on your federal income tax return without taking into account the 7.5% of income threshold. The request for reimbursement must be submitted no later than two years after the later of the date the services were performed or the date of the EOB for the services.

The maximum amount of reimbursement that you are eligible for depends upon your contributions to the Roofers Union Local No. 70 Insurance Trust by contractors with collective bargaining agreements with Local No. 70. Currently 25 cents per hour will be contributed by contractors beginning with your first hour of work covered by the Local No. 70 Collective Bargaining Agreement. This amount can be changed by the Trustees. If it is changed you will be notified. The amount will accumulate without interest in a bookkeeping account maintained by the Local No. 70 Fringe Benefit Office. There is no requirement that this amount be maintained in a separate trust or account. You will be kept informed of the balance in your account on your monthly status report.

The balance of your account will be forfeited upon the earlier of the first anniversary of the termination of your eligibility or after twenty four (24) consecutive months of no eligibility in the Roofers Union Local No. 70 Insurance Trust.

Upon the death of the eligible participant any balance in the Plan Account will be available to the surviving spouse of the eligible participant for the reimbursement of any out of pocket Health Care Expenses.

The attached Information Sheet contains the procedures that must be followed to receive reimbursements from this account.

SECTION V - PARTICIPATION IN THE DENTAL INSURANCE PORTION OF THE TRUST

Before you become an eligible participant or a "participant" in the Dental Insurance portion of the Trust, there are certain eligibility and participation rules which you must meet. These rules are explained in this section.

1. Eligibility Requirements

You will be eligible to become a participant in the Dental Insurance portion of the Trust if you are an eligible participant as defined in Section III.

2. Participation Requirements

Once you have satisfied the Trust's eligibility requirements, your next step will be to actually become a participant in the Trust. You will become a participant after you meet the hours requirement for health insurance coverage and have completed any necessary enrollment forms.

3. Family Coverage

After you have become eligible for coverage, family coverage is available for your spouse; children up to age 26 and qualified dependents. Qualified Dependents include your or your spouse's children that reside with you, are claimed as a dependent on your federal income tax return, and are totally and permanently disabled under the Social Security Act.

4. Benefits available to Participants

Currently the Dental Insurance coverage is provided by Delta Dental PPO. The benefits available to all Participants are described in detail in the Delta Dental pamphlet that is distributed upon initial eligibility. From time to time the applicable co-pays, maximum out of pocket amounts and qualifying expenses may change. Should any of these items change, you will be notified in writing. If the insurance carrier changes, you will be provided a new summary of benefits from the new carrier.

SECTION VI - PARTICIPATION IN THE OPTICAL PORTION OF THE TRUST

Before you become an eligible participant or a "participant" in the Optical portion of the Trust, there are certain eligibility and participation rules which you must meet. These rules are explained in this section.

1. Eligibility Requirements

You will be eligible to become a participant in the optical portion of the Trust if you are an eligible participant as defined in Section III.

2. Participation Requirements

Once you have satisfied the Trust's eligibility requirements, your next step will be to actually become a participant in the Trust. You will become a participant after you meet the hours requirement for health insurance coverage and have completed any necessary enrollment forms.

3. Family Coverage

After you have become eligible for coverage, family coverage is available for your spouse; children up to age 26 and qualified dependents. Qualified Dependents include your or your spouse's children that reside with you, are claimed as a dependent on your federal income tax return, and are totally and permanently disabled under the Social Security Act.

4. Benefits available to Participants

Currently the Optical coverage is provided by N.V.A. National Vision. The benefits available to all Participants are described in detail in the National Vision Administrators, LLC pamphlet that is distributed upon initial eligibility. From time to time the applicable co-pays, maximum out of pocket amounts and qualifying expenses may change. Should any of these items change, you will be notified in writing. If the insurance carrier changes, you will be provided a new summary of benefits from the new carrier.

SECTION VII - PARTICIPATION IN THE HEARING BENEFIT PORTION OF THE TRUST

Before you become an eligible participant or a "participant" in the Hearing Benefit portion of the Trust, there are certain eligibility and participation rules which you must meet. These rules are explained in this section.

1. Eligibility Requirements

You will be eligible to become a participant in the hearing benefit portion of the Trust if you are an eligible participant as defined in Section III.

2. Participation Requirements

Once you have satisfied the Trust's eligibility requirements, your next step will be to actually become a participant in the Trust. You will become a participant after you meet the hours requirement for health insurance coverage and have completed any necessary enrollment forms.

3. Family Coverage

After you have become eligible for coverage, family coverage is available for your spouse; children up to age 26 and qualified dependents. Qualified Dependents include your or your spouse's children that reside with you, are claimed as a dependent on your federal income tax return, and are totally and permanently disabled under the Social Security Act.

4. Benefits available to Participants

Currently the hearing benefit coverage is self funded by the Trust. The benefits available to all Participants are one hearing exam performed by a certified medical doctor during each 24 consecutive month period and one set of hearing aids during any 48 consecutive month period. The maximum amount of benefit is $3,000 during any 48 month period. From time to time the applicable co-pays, maximum out of pocket amounts and qualifying expenses may change. Should any of these items change, you will be notified in writing. If the self funding arrangement is changed to an insured product, you will be provided a summary of benefits from the insurance carrier.

SECTION VIII - LIFE INSURANCE

1. Eligibility Requirements

You will be eligible for life insurance benefits for you, your spouse and your qualified dependents (referred to as eligible participants) from the Insurance Trust if you are an Eligible participant and have met the Participation Requirements described below. Qualified dependents include your or

your spouse's children that reside with you, are claimed as a dependent on your federal income tax return, and are one of the following:

a. under the age of nineteen (19),
b. are totally and permanently disabled, or
c. full time students under age 25 with proper documentation.

2. Participation Requirements

Once you have become an eligible participant of Local No. 70, your next step will be to actually become eligible for the applicable life insurance benefits. You will become eligible for the life insurance benefits for eligible participants after you have performed 400 hours of service for contractors covered by a collective bargaining agreement. You remain eligible for life insurance benefits for eligible participants if you have performed 800 hours of service for contractors covered by a collective bargaining agreement during the last twelve (12) months.

3. Life Insurance Benefits.

The beneficiary of any eligible participant shall be eligible to receive the following amounts upon the death of the eligible participant:

Eligible participant:	$40,000
Eligible participant's Spouse:	$20,000
Dependent Child:(six months and older)	$5,000
Dependent Child:(less than six months)	$1,000

The beneficiary will be required to supply the Administrator with an official copy of the eligible participant's death certificate.

The eligible participant shall be allowed to name the beneficiary of the life insurance benefits on a form supplied by the Administrator. If no beneficiary is named, the beneficiary shall be the surviving spouse in the case of the death of eligible participant and the eligible participant in the case of the death of a spouse or dependent child.

4. Benefits available to Participants

Currently the Life Insurance coverage is provided by Aetna. The benefits available to all Participants are described in detail in the Aetna pamphlet that is distributed upon initial eligibility. From time to time the applicable coverage amounts and available benefits may change. Should any of these items change, you will be notified in writing. If the insurance carrier changes, you will be provided a new summary of benefits from the new carrier.

SECTION IX - DISABILITY BENEFITS UNDER THE TRUST

1. Eligibility Requirements

You will be eligible for disability benefits from the Insurance Trust if you are covered by the Local No. 70 Collective Bargaining Agreement and have met the Participation Requirements described below.

Participation Requirements

Once you have become covered by the Local No. 70 Collective Bargaining Agreement, your next step will be to actually become eligible for disability benefit coverage. You will become an eligible for disability benefit coverage after you have performed 800 hours of service for contractors or Local No. 70. You remain eligible for disability benefit coverage if you have performed 800 hours of service for contractors or Local No 70 during the last twelve (12) months.

2. Disability Benefits.

Any covered individual eligible to receive disability benefits shall receive disability benefits for any period of time that he is unable to perform his normal duties by reason of physical or mental illness as defined in 4 below. The disability must be determined by a licensed medical practitioner that is acceptable to the Trustees. The Trustees may require an examination by a practitioner of their choice in order to verify disability. The amount payable is $350 per week for journeymen and $250 per week for apprentices. Benefits shall be payable only after the disability has prevented the covered individual from working for a period of at least seven days. The benefit shall be payable for a maximum period of twenty six (26) weeks. During this period of disability you will be responsible for payment of any health insurance premiums. See the Section regarding Self Payments (Section III, No. 4) in the Summary Plan Description. The maximum number of weeks of disability benefits (whether a single disability event or multiple disability events) shall be 26 weeks during any 52 week period.

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

- is under the regular care of a Physician and has submitted a Physician's statement attesting to his/her Disability (such statement must be submitted initially and at intervals as requested by the Trustees);
- is not on the Out-of-Work List and/or available for work in or outside the jurisdiction of the Roofers Local Union No. 70 because of such Non-Occupational Disability;
- is not eligible for similar benefits under another plan of insurance (provided such benefits are equal to the benefits provided by this Plan);
- is not disabled due to alcohol or substance abuse, unless he/she is receiving in- patient treatment at an approved facility;
- at the time the Disability commenced, was eligible for benefits as an Active Employee by virtue of hours in his/her hour bank or active self-payments; and
- was not Disabled in a motor vehicle accident or by an act of war (declared or undeclared) or while in the armed forces of any country.

For those with an Occupational Disability, the Disabled Employee must have a Workers' Compensation claim pending and execute an assignment of benefits to the Fund in order to receive this benefit as described in No. 6 below.

4. **Pre-existing Condition Rules.**
The covered individual will not be eligible for the disability benefit if the physical or mental illness causing the disability commenced within the six months preceding the covered individual's eligibility date unless and until after the date of eligibility either the condition has been under treatment for a period of 24 months during which it has not prevented the covered individual from working, or the covered individual continues working for a period of 12 months during which no treatment for the condition is necessary.

5. **Disability covered by Worker's Compensation Benefits**
If the covered individual's disability is for a condition covered by Worker's Compensation Benefits, such individual shall not be eligible for disability benefits unless the individual has a Worker's Compensation claim pending and has executed an assignment of benefits to the Local No. 70 Trust.

6. **Successive Periods of Disability**
An active covered individual shall not be eligible for benefits for the same or a new disability unless he has returned to work and has received credit for at least 80 hours.

7. **Re-Certification of Disability.**
In order to continue receiving disability benefits beyond 13 weeks you must be reexamined by a physician designated by the Trustees. This physician must re-certify to the Trustees that you continue to be disabled as defined in the Trust.

SECTION X - POST RETIREMENT MEDICAL BENEFITS

1. Purpose

The purpose of this Plan is to encourage and help provide full and complete medical care for each retired eligible participant of Roofers Union Local No. 70 (“Local 70") and his or her spouse if he or she meets various eligibility standards.

2. Eligibility

All eligible participants shall be eligible to participate in the Post Retirement Medical Benefits portion of the Plan provided they meet the following eligibility requirements:

a. A covered individual with ten (10) years of active service during a period of continuous covered employment who have attained age 65,
b. Covered Individuals with twenty (20) years of active service during a period of continuous covered employment who have attained age 60,
c. Covered Individuals with thirty (30) years of active service during a period of continuous covered employment who have attained age 55.
d. Employees of Local No. 70 or Local No. 70 Fringe Funds employed as of January 1, 2019 that remain employed and covered by the Local No. 70 Insurance Plan through the later of age 65 or actual retirement shall be eligible if eligible for Medicare Parts A and B.

A Local No. 70 covered participant shall earn one Year of Active Service for each calendar year during which he or she has 600 hours worked for Local No. 70 Employers.

If the eligible participant takes any job in the construction industry in the geographical jurisdiction of Local No. 70, which would be covered by the Local No. 70 Collective Bargaining Agreement if the employer was a signatory contractor (generally known as using the tools of the trade), benefits are suspended for any period the individual is working such job, and the individual is no longer considered retired from Local No. 70. A position with Local No. 70 or as a Local No. 70 Apprenticeship Instructor shall not be considered a job using the tools of the trade regardless of whether or not the job is or would be covered under the Local No. 70 Collective Bargaining Agreement.

Eligibility for post retirement benefits upon any return to employment covered by the Local No. 70 collective bargaining agreement is determined from the return date with no credit for prior years until covered employment is maintained for ten years. If the job is a job in the Local No. 70 geographical jurisdiction covered by the collective bargaining agreement, and the eligible participant continues in a job covered by the collective bargaining agreement, prior years will count after receiving credit for two years of service as provided in this Section.

3. Participation

Each eligible participant who is eligible to participate in the Plan under Section 2 (an “Eligible participant”) shall become a participant in the Plan (a “Participant”) on the effective date of the Plan if on the effective date he or she has met the eligibility requirement of Section 2. Each other Eligible participant shall become a Participant on the first day of the month immediately following the later of the month in which he or she has met the eligibility requirements of Section 2 and is no longer an active participant in the Plan. Post retirement coverage must commence as soon as it is available. Upon termination of an Eligible participant’s membership with Local No. 70, all rights of such Participant (and/or spouse of the Participant) to receive benefits for claims incurred after the termination date shall be forfeited. Such Participant (and his or her spouse) shall, however, retain the right to coverage hereunder for claims incurred prior to the termination of membership. For this purpose, a claim will be considered to be incurred when the services relating to such claim have been rendered.

If any eligible participant fails to pay his or her share of the monthly cost, he or she shall be dropped from coverage. Payment is due on the first day of each month. Any termination of coverage shall be permanent.

Spousal coverage for any eligible participant shall only be available during the time the eligible participant is eligible for benefits. Upon the loss of coverage by the eligible participant for any reason (including death) the coverage of the spouse shall cease.

4. Benefits

The Plan shall provide funds toward coverage to each Participant equal to the basic health benefit provided to each active eligible participant of Local No. 70 subject to the following:

a Any recipient eligible for Medicare Part A and B and D coverage must apply for all Medicare coverage. The coverage of this Plan in conjunction with the Medicare coverage shall be substantially equal to that of active Local No. 70 eligible participants.

b The amount provided towards the coverage shall be 70% of the cost of active eligible participant with a maximum monthly amount of $500.00. This amount shall be in effect unless a change is expressly approved by the Trustees. The amount provided towards two person coverage shall be 50% of the cost of active eligible participants with a maximum monthly amount of $500.00. The only coverage available shall be either single or two person coverage for the eligible participant and the eligible participant's spouse at the date of commencement of coverage.

c The Trustees have the right to provide the benefit in any manner available including any insurance product that has coverage substantially similar to the coverage offered by the Plan to active Local No. 70 eligible participants.

d Local 70 employees or Local 70 Fringe Funds employees post retirement coverage shall only cover a spouse that is Medicare Part A and B eligible. If the spouse at the time of commencement of coverage is not Medicare Part A and B eligible, such spouse may not be added to coverage at a later date.

5. Benefits from Another Source

Coverage under this Plan shall be provided only in the event, and to the extent, that similar coverage for medical care is not provided by any insurance policy or under any other plan of Local No. 70 or another employer or under any federal or state law. If there is such a policy, plan or law in effect providing for such coverage or payment for coverage in whole or in part, then, to the extent of the coverage under such policy, plan or law, this Plan and Local No. 70 shall be relieved of any and all liability hereunder.

SECTION XI - CONTRIBUTIONS TO THE TRUST

The Participating Employers' contributions will be placed into a trust fund for the payment of insurance premiums and other Trust benefits. The Administrator of the Trust maintains a bookkeeping account for all participants as described in Section III, No 1.

SECTION XII - CLAIMS BY PARTICIPANTS AND BENEFICIARIES

Unless otherwise required by an Insurance Carrier or by the Trust, benefits will be paid to participants and their dependents without the necessity of formal claims. You or your beneficiaries, however, may make a request for any Trust benefits to which you may be entitled. Any such request must be made in writing, and it should be made to the Administrator. (See Section II)

Your request for Trust benefits shall be considered a claim for Trust benefits, and it will be subject to a full and fair review. If your claim is wholly or partially denied, the Administrator will furnish you with a written notice of this denial. This written notice must be provided to you within a reasonable period of time (generally 90 days) after the receipt of your claim by the Administrator. The written notice must contain the following information:

a. the specific reason or reasons for the denial;
b. specific reference to those Trust provisions on which the denial is based;
c. a description of any additional information or material necessary to correct your claim and an explanation of why such material or information is necessary; and
d. appropriate information as to the steps to be taken if you or your dependent wishes to submit your claim for review.

If notice of the denial of a claim is not furnished to you in accordance with the above within a reasonable period of time, your claim will be deemed denied. You will then be permitted to proceed to the review stage described in the following paragraphs.

If your claim has been denied, and you wish to submit your claim for review, you must follow the Claims Review Procedure.

The Claims Review Procedure

a. Upon the denial of your claim for benefits, you may file your claim for review, in writing, with the Administrator.

b. YOU MUST FILE THE CLAIM FOR REVIEW NO LATER THAN 60 DAYS AFTER YOU HAVE RECEIVED WRITTEN NOTIFICATION OF THE DENIAL OF YOUR CLAIM FOR BENEFITS.

c. You may review all pertinent documents relating to the denial of your claim and submit any issues and comments, in writing, to the Administrator.

d. Your claim for review must be given a full and fair review. If your claim is denied, the administrator must provide you with written notice of this denial within 60 days after the Administrator's receipt of your written claim for review. There may be times when this 60 day period may be extended. This extension may only be made, however, where there are special circumstances which are communicated to you in writing within the 60 day period. If there is an extension, a decision shall be made as soon as possible, but not later than 120 days after receipt by the Administrator of your claim for review.

e. The Administrator's decision on your claim for review will be communicated to you in writing and will include specific references to the pertinent Trust provision on which the decision was based.

f. If the Administrator's decision on review is not furnished to you within the time limitations described above, your claim will be deemed denied on review.

g. If benefits are provided or administered by an insurance company, insurance service, or other similar organization which is subject to regulation under the insurance laws, the claims procedure relating to these benefits may provide for review. If so, that company, service, or organization will be the entity to which claims are addressed. If you have any questions regarding the proper person or entity to address claims, you should ask the Administrator.

SECTION XIII - STATEMENT OF ERISA RIGHTS

Explanation of Your ERISA Rights

As a participant in this Trust you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, also called ERISA. ERISA provides that all Trust participants are entitled to:

a. examine, without charge, all Trust documents, including:

    1. insurance contracts;
    2. collective bargaining agreements; and
    3. copies of all document filed by the Trust with the U.S. Department of Labor, such as detailed annual reports and Trust descriptions.

This examination may take place at the Administrator's office and at other specified employment locations of the Employer. (See Section II);

b. obtain copies of all Trust documents and other Trust information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies;

c. receive a summary of the Trust's annual financial report. The Administrator is required by law to furnish each participant with a copy of this summary annual report;

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

If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Administrator review and reconsider your claim. (See Section X)

Under ERISA, there are steps you can take to enforce the above rights. for instance, if you request materials from the Trust 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 Administrator to provide the materials and pay you up to $110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

If the Trust's fiduciaries misuse the Trust'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 if, for example, it finds your claim is frivolous.

If you have any questions about this statement, or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

SECTION XIV - AMENDMENT AND TERMINATION OF THE TRUST

1. **Amendment**

The Trustees have the right to amend the Trust at any time. In no event, however, will any amendment authorize or permit any part of the Trust assets to be used for purposes other than the exclusive benefit of participants or their dependents.

2. **Termination**

The Trustees have the right to terminate the Trust at any time. Upon termination, all amounts in the Trust will be used to pay benefits until exhausted.