Roofers Local No. 74/Local No. 203

Welfare Plan

Summary Plan Description

Dated: September 2014

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I
DEFINITIONS

Certain terms used in this Welfare Plan/Summary Plan Description have special meanings. These terms will be capitalized and will have the meaning set forth below.

Calendar Year. The term "Calendar Year" will mean a benefit period commencing January 1 up to and including December 31 of the same year.

Change in Family Status. The term "Change in Family Status" will mean your marriage or divorce, the death of your spouse, the termination of employment of your spouse, or such other change in your spouse's employment status that results in a termination or significant reduction in your health care benefits.

Claim Administrator. The Fund Administrator will also be the "Claim Administrator," exept for prescription drug claims which will be administered by ProAct, Inc.

Code. The term "Code" will mean the Internal Revenue Code of 1986, as amended.

Collective Bargaining Agreement. The term "Collective Bargaining Agreement" will mean any agreement in force and effect between the Union and an Employer, which agreement provides for the payment of periodic contributions to the Fund for health benefits.

Contributions. The term "Contributions" will mean those payments made to the Fund as required by the Collective Bargaining Agreement.

Covered Employment. The term "Covered Employment" will mean employment of a type covered by a Collective Bargaining Agreement and requiring contributions to the Fund for health benefits.

Dependent. The term "Dependent" will mean any of the following individual(s)

- Your lawful spouse, as long as you and your spouse are not living separately pursuant to a written separation agreement or property settlement agreement,

- Your child (children) who have not reached age 26.

For purposes of determining your Dependents, your children shall include stepchildren or legally adopted children who permanently live with you and are dependent upon you for their support.

Disability. The term "Disability" will mean a physical or mental condition resulting from bodily injury, disease or mental condition which renders a person incapable of continuing any gainful occupation and which entitles him to benefits under the New York State Disability Benefits Law or Worker's Compensation Act. Disability shall be determined by the Trustees in their sole and absolute discretion.

Employer. The term "Employer" will mean any Employer who is bound by the terms of the Collective Bargaining Agreement with the Union to contribute to the Fund. The term "Employer" shall also include the Fund, Pension Fund, Security Benefit Fund and the Union, provided that each entity makes Contributions for its Employees at the same rate as other Employers under the Collective Bargaining Agreement.

Fund – Welfare Trust Fund. The term "Roofers Local No. 74/Local No. 203 Welfare Trust Fund" or "Fund" or "Health and Welfare Fund" will mean all contributions made to the Trustees pursuant to and in accordance with the terms of a Collective Bargaining Agreement, together with all income, increments, earnings and profits received by the Trustees, less any expenses paid therefrom.

Hospital. The term "Hospital" will mean an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an in-patient basis at the patient's expense and which fully meets all of the tests set forth in (A) or (B) or (C) below:

(A) It is a Hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations.

(B) It is a Hospital, a psychiatric hospital, or a tuberculosis hospital as those terms are defined in Medicare, which is qualified to participate and eligible to receive payments under and in accordance with the provisions of Medicare.

(C) It is an institution, which fully meets all of the following tests:

1. It maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified physicians; and
2. It continuously provides on the premises 24 hour a day nursing service by or under the supervision of registered graduate nurses; and
3. It is operated continuously with organized facilities for operative surgery on the premises.

Such term shall not include any institution or part thereof which is used principally as a rest facility, nursing home, convalescent home, and place for custodial care or home for the aged.

Hour of Service. The term "Hour of Service" will mean each hour for which an Employee is entitled to payment by an Employer obligated by the terms of the Collective Bargaining Agreement to make Contributions to the Fund. An Employee shall be credited with an Hour of Service for each hour worked regardless of the rate of those Contributions.

Illness. The term "Illness" shall be deemed to include a voluntary sterilization procedure and related charges. Reversal of Sterilization is not covered.

Medically Necessary. The term "Medically Necessary" refers to services and supplies ordered by or under the direction of a physician, as approved by the Plan or its designee and customarily recognized as appropriate diagnosis, care, and treatment of the patient's injury or illness. In order to be considered medically necessary, the services or supplies must be: consistent with the symptom or diagnosis and treatment of the injury or illness; appropriate with regard to standards of good medical practices; not solely for the convenience of a covered person, physician, hospital, health care facility,

or other person or provider; the most appropriate and cost efficient level of service that can be safely provided to the covered person; and safe and effective for the condition for which it is used. The fact that a physician or health care practitioner may order, recommend, or approve a service or supply does not in itself make it medically necessary. The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is medically necessary.

Medicare. The term "Medicare" will mean the health insurance for the aged program under Title XVII of the Social Security Act, and as such program is currently constituted and as it may be later amended.

Participant. The term "Participant" will mean any person employed by an Employer who is covered by a Collective Bargaining Agreement. The term "Participant" shall also include, with the consent of the Trustees, persons who are employed by Roofers Local No. 74/Local No. 203 Pension Fund, Roofers Local No. 74/Local No. 203 Welfare Fund, and the Union if their employer has become an Employer hereunder by making required contributions to the Fund as called for by the Collective Bargaining Agreement.

Plan Administrator. The term "Plan Administrator" will mean the Board of Trustees, or such person or persons as may be designated by the Trustees from time to time.

Retirees. The term "Retirees" will mean the persons who have retired from the bargaining unit of Employees covered by a Collective Bargaining Agreement with Local No. 74 or 203 and are receiving a pension from the Roofers Local No. 74/Local No. 203 Pension Fund.

Trust Agreement. The term "Trust Agreement" will mean the Agreement and declaration of Trust, Roofers Local No. 74 Welfare Trust Fund, dated the 22nd day of October 1958.

Trustees. The term "Trustees" will mean the Board of Trustees of the Fund.

Union. The term "Union" will mean "Roofers Local Union No. 74" "Roofers Local No. 203" and their successors or assigns.

II
GENERAL INFORMATION

This Section contains general information that you may need to know about the Fund.

A. General Fund Information

The name of the Fund is Roofers Local No. 74/Local No. 203, Welfare Trust Fund.

The provisions of the Plan became effective on January 1, 2003, which is called the Effective Date of the Plan.

The Fund's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year is the twelve month period beginning on June 1st and ending on the following May 31st.

B. Plan Administrator

The Plan is sponsored by the Board of Trustees of the Roofers Local No. 74/Local No. 203 Welfare Trust Fund. The Board of Trustees is also the Plan Administrator. The Board of Trustees is responsible for the overall operation and administration of the Fund.

The employer identification number of the plan sponsor is 16-0836163. The Trustees have assigned plan number 501 to the Fund.

The following is a list of individuals that currently comprise the Board of Trustees with their principal place of business address:

Union Trustees

John Bernas
2800 Clinton Street
West Seneca, New York 14224

Paul Johnsen
32 West State Street
Binghamton, New York 13901

Daniel Richardson
32 West State Street
Binghamton, New York 13901

Nicholas Gechell
2800 Clinton Street
West Seneca, New York 14224

Employer Trustees

Anthony Byrne - Chairman
40 Appenheimer Street
Buffalo New York 14214

John Embow
131 Reading Street
Buffalo, New York 14220

Peter Griffiths
P. O. Box 2131
Binghamton, New York 13902

Stephen Sanders
P. O. Box 814
Buffalo, New York 14240

The Board of Trustees has delegated certain day-to-day administrative duties to the Fund Administrator. The Fund Administrator is:

Bernadine I. Magney
2800 Clinton Street
West Seneca, New York 14224
(716) 828-0488 or Toll free # 1 (800) 905-0904

Please remember that no one except the Board of Trustees (and other Plan fiduciaries and individuals to whom the Board of Trustees has delegated responsibility for administration of the Plan) has the authority to interpret this booklet or the other official Plan documents, to make any promises to you about it, or to change the provisions of the Plan. The Board of Trustees (or its duly authorized designee) has the exclusive right and power, in its sole and absolute discretion, to interpret the Plan documents and to decide all matters under the Plan, including, without limitation, the right to make all decisions with respect to eligibility for the amount of benefits payable under the Plan and the right to resolve any ambiguities, inconsistencies or omissions concerning the Fund or

the Plan. All determinations by the Board of Trustees (or its duly authorized designee) are final and binding on all persons and will be given full force and effect.

C. Pharmacy Benefit Manager

The Pharmacy Benefit Manager is ProAct. They are also responsible for administering drug claims. Most claims will be handled automatically by use of your prescription drug card. If necessary, you may contact ProAct's Help Desk at 1-877-635-9545 to obtain a Direct Member Reimbursement form. Once the form is obtained and completed the member should attach any applicable receipts and mail the form to the following ProAct address :

ProAct, Inc.
1230 US HWY 11
Governeur, NY 13642
Attn: DMR Dept.

D. Service of Legal Process

The name and address of the Fund's agent for service of legal process is:

Board of Trustees
Roofers Local No. 74/Local No. 203
Welfare Trust Fund
2800 Clinton Street
West Seneca, New York 14224
(716) 828-0488 or Toll free 1 (800) 905-0904

Legal process may be served on any of the Trustees listed in part (B) of this Section.

E. Type of Plan

This plan is an ERISA health and welfare benefit plan, which provides general health, hospitalization, death and disability income. Your general health, hospitalization, death and disability income benefit is provided on a self-insured basis.

This plan is maintained pursuant to one or more Collective Bargaining Agreements. A copy of such agreement and list of participating Employers may be obtained by participants and beneficiaries upon written request to the Plan Administrator, and is available for examination during regular business hours at the Fund Office.

F. Legal Counsel

Lipsitz, Green, Scime, Cambria LLP
42 Delaware Avenue, Suite 120
Buffalo, New York 14202

III
PARTICIPATION/ELIGIBLITY

Please note that Participant's in both Local No. 74 and Local No. 203 are eligible for medical, prescription, dental and vision care benefits once they have met the eligibility requirements applicable to their Local as described.

Definitions. The following terms have special meanings that pertain to this Section:

Qualifying Period. The term "Qualifying Period" will mean a three (3) month period beginning on the first day of the months of February, May, August and November.

The hours worked during these months are entered in a quarterly period of coverage. It is important to note that the hours must be worked and the paychecks to cover those hours worked must be received within the same time qualifying period.

Example: Hours worked and pay received within the months of:
February, March, April will count towards the June quarterly period of coverage.
May, June, July will count towards the September quarterly period of coverage.
August, September, October will count towards the December quarterly period of coverage.
November, December, January will count towards the March quarterly period of coverage.

Quarterly Period of Coverage. The term "Quarterly Period of Coverage" will mean a three (3) month period beginning on the first day of the months of June, September, December and March.

Once you have qualified for coverage, following the qualifying period guide as listed above, you will be eligible for coverage for the corresponding quarter.

Example: Hours worked and pay received within the months listed above will make you eligible for coverage for the following quarters:
June quarter covers the months of June, July, August
September quarter covers the months of September, October, November
December quarter covers the months of December, January, February
March quarter covers the months of March, April, May

Credited Hours. The term "Credited Hours" means the hours worked for which you have been employed by a contributing Employer. This is based on total hours worked.

Example: If you work a 40 hour week with 2 hours overtime, you will be credited with 42 total hours worked.

ROOFERS LOCAL NO. 74
ELIGIBILITY REQUIREMENTS

Initial Eligibility. To be eligible for benefits provided under the Plan you must first work a total of 1000 hours before your Employer will contribute to the Plan. These are not considered credited hours because no contribution is made to the plan.

Once you have worked the 1000 Hour Requirement, you must accumulate 200 additional Credited Hours before you qualify for benefits. After which your coverage will begin the first day of the next Quarterly Period of Coverage or ninety (90) days thereafter, whichever is sooner.

ROOFERS LOCAL NO. 203
ELIGIBILITY REQUIREMENTS

Initial Eligibility. To be eligible for benefits provided under the Plan you must accumulate 500 Credited Hours. Once you meet this requirement, your coverage will begin on the first day of the next Quarterly Period of Coverage.

CONTINUING ELIGIBILITY
ROOFERS LOCAL NO. 74 and ROOFERS LOCAL NO. 203

Roofers Local No. 74 and Roofers Local No. 203 are subject to the same Continuing Eligibility requirements.

In order to remain eligible for each Quarterly Period of Coverage, your credited hours are calculated based on credited hours worked in previous eligible quarters.

- Within one (1) Qualifying Period, you must have worked at least 250 Credited Hours;
- Within two (2) consecutive Qualifying Periods, you must have worked at least 500 Credited Hours;
- Within three (3) consecutive Qualifying Periods, you must have worked at least 650 Credited Hours; or
- Within four (4) consecutive Qualifying Periods, you must have worked at least 800 Credited Hours.

A "Qualifying Period" is a three (3) month period beginning on the first day of the months of February, May, August and November.

A "Qualifying Period of Coverage" is a three (3) month period beginning on the first day of the months of March, June, September and December.

Current year **QUARTERLY PERIOD OF COVERAGE**	**MARCH** **Apr, May**	**JUNE** **July, Aug**	**SEPTEMBER** **Oct, Nov**	**DECEMBER** **Jan, Feb**
CREDITED HOURS	100	0	0	250
QUALIFYING PERIOD	Nov, Dec, Jan Hours worked Pay received	Feb, Mar, Apr Hours worked Pay received	May, June, July Hours worked Pay received	Aug, Sept, Oct Hours worked Pay received
Previous year **QUARTERLY PERIOD OF COVERAGE**	**MARCH** **Apr, May**	**JUNE** **July, Aug**	**SEPTEMBER** **Oct, Nov**	**DECEMBER** **Jan, Feb**
CREDITED HOURS	0	200	350	350
QUALIFYING PERIOD	Nov, Dec, Jan Hours worked Pay received	Feb, Mar, Apr Hours worked Pay received	May, June, July Hours worked Pay received	Aug, Sept, Oct Hours worked Pay received

Lapse in Service/Termination

A lapse of service (termination) will be incurred whenever you do not meet the requirements for continued coverage.

Re-Instatement of coverage

In the event that you suffer a lapse in service, you may again qualify for coverage under this Plan on of the first day of the Quarterly Coverage Period following the Qualifying Period in which you work at least 250 Credited Hours.

Example: You were credited with 250 during the qualifying period hours worked and paid during August, September, and October. You have met the 250 hours required in one qualifying period for re-instatement of coverage after incurring a lapse in service (termination).

DEPENDENT ELIGIBILITY

Your Dependent will be eligible to participate in this Plan on the later of (a) your eligibility to participate in the Plan or, (b) the date he/she becomes your Dependent.

"SPECIAL ENROLLMENT RIGHTS"

If you decline health and hospitalization coverage from the Plan for yourself or for your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

In addition, if you or your Dependents have been covered by Medicaid or New York's Child Health Plus program, and you or your Dependents lose eligibility for either such coverage, you may be able to enroll under this Plan provided you request enrollment within 60 days after losing such coverage.

"ACTIVE PARTICIPANTS WITH MEDICARE DEPENDENTS"

In the event your Spouse and/or eligible Dependent(s) become entitled to Medicare benefits while you are actively employed with a Contributing Employer such Spouse and/or eligible Dependent shall continue to be eligible for benefits under this Plan. This Plan will be considered primary payor with Medicare being secondary. At the time of your termination (for reasons other than gross misconduct) or loss of eligibility due to insufficient covered hours such Spouse and/or eligible Dependent will be entitled to continue coverage under this Plan on a self-pay basis in accordance with "COBRA Continuation Coverage", of this Plan. If your Spouse and/or eligible Dependent elect COBRA Continuation Coverage then this Plan shall be considered secondary payor with Medicare being considered primary.

In the event that your Spouse and/or eligible Dependent are covered under other health insurance, such other health insurance shall be taken into account when paying a claim. The order in which the claim shall be paid will be made in accordance with "Coordination of Benefits"' of this Plan.

IV
MEDICAL BENEFITS

GENERAL HEALTH AND HOSPITALIZATION

Your general health and hospitalization benefit is a self-insured benefit. This means that any benefit you receive is payable from the assets of the Fund. Your general health and hospitalization benefit is administered through the Fund.

REASONABLE & CUSTOMARY CHARGES (R&C)

Covered expenses are the Reasonable and Customary charges, as determined by the Fund, for the medical care, services or supplies listed below and as recommended by a licensed physician. A charge shall be considered Reasonable and Customary to the extent it does not exceed the prevailing charge in a particular geographic area for a similar service performed by a similar provider. The Plan bases its payments on these fees.

BASIC MEDICAL BENEFITS

The plan shall pay 100% of certain procedures (as identified within this document) for an eligible participant or dependent. This type of coverage is classified as basic coverage.

MAJOR MEDICAL BENEFITS

If as a result of accidental injury or sickness an eligible employee or dependent incurs expenses for covered charges in excess of the deductible amount while covered under this Plan, the participant or dependent shall be entitled to Major Medical benefit coverage. After satisfying the deductible amount, the Plan shall pay eighty (80%) percent of the participant or dependent eligible expenses that are incurred during the calendar year. Once the aggregate amount of benefits provided to an participant or dependent reaches $5,000.00 in one calendar year, the Major Medical benefit coverage will pay one hundred (100%) percent of the eligible expenses for the remainder of the calendar year.

Please note that certain procedures are broken out. A portion of the charge is covered at 100%, basic, and then the balance is covered under major medical. All major medical charges are subject to an applicable deductible.

It is recommended that you do not pay any charges at time of visit. The Administrator of our Plan will try to negotiate a discount with the provider on your behalf. This discount will be applied to the total fee charged. After the Plan pays the 80% of the reduced discounted amount, the savings will also be applied to your 20% patient responsibility. This will not take place if you pre-pay.

DEDUCTIBLE

Individual	$250.00
Family (cumulative for all members)	$500.00

Once the maximum deductible has been met on an individual basis or family (cumulative basis) the charges will be paid at 80%.

Deductibles are re-applied at the beginning of each calendar year.

OUT-OF-POCKET MAXIMUM

The aggregate amount of major medical benefits provided to a Participant or dependent is $5,000.00 per calendar year. The plan pays 80% which equals a total of $4,000.00. Therefore the participant or dependents responsibility of 20% equals a total of $1,000.00.

The OUT OF POCKET maximum is $1,000.00. This means that no individual shall be responsible for more than $1,000.00. Once your out-of-pocket maximum is reached the Plan will again pay major medical expenses as basic coverage 100% of any Reasonable & Customary charges thereafter incurred.

Exception: This amount <u>does not</u> include your deductible.

Exception: Expenses incurred for basic coverage, prescriptions, dental, and vision <u>are not</u> applied to the out-of- pocket maximum.

Out-Of-Pocket maximums are re-applied at the beginning of each calendar year.

<u>PLEASE NOTE: Whenever our Plan does not specifically provide for an expense that may reasonably be considered a covered expense (whether that expense is for a drug, device or medical/surgical therapy, treatment or procedure) a benefit may be provided as long as the expense is a covered item under the U.S. Health Care Financing Administration (HCFA) in its instructions for payment under the Federal Medicare Program. In other words, should any questions arise about coverage of a medical expense; their policy will be the determining factor.</u>

V
SUMMARIZATION
"SCHEDULE OF BENEFITS"

<u>FOR EMPLOYEES AND DEPENDENTS</u>

Hospitalization Benefit

Daily room and Board

70 Full Benefit Days ..... 100% of Charges

Standard Semi-Private Room & Miscellaneous Expenses

Daily In-Hospital Physician Benefit ..... $15.00 per day
70 Full Benefit Days
Major medical charges incurred after 80%

Surgical (Surgeon fees) Benefit
Maximum per operation $1,000.00
Major medical charges incurred after 80%

Diagnostic X-Ray and Laboratory Benefit
Maximum per calendar year $300.00
Major medical charges incurred after 80%

Out-Patient Services & Pre-Admission Testing ..... 80% of charges

Ambulance – Transportation Mileage ..... $100.00 per trip

Preventative Care (as described)……..……100% of charges

Maternity…..... 100% of charges

Newborn
Nursery room ..... $775.00 per day
Miscellaneous care …… …. $425.00 per day
Pediatric doctor visit ..... $130.00 per day

Hospice Care…..... 100%
Up to a maximum of 16 days

ACTIVE EMPLOYEE BENEFIT

Weekly Disability Income Benefit – maximum period of benefit 26 weeks
Benefit Payable – on job site injury ..... $ 50.00
Benefit Payable – injury or sickness $100.00

Please contact the Funds office for a medical form.

BENEFIT MAXIMUMS

The following benefits are subject to limited coverage:

Lifetime – Medical Services..... No Limit
(Excludes Prescription, Dental and Vision)

Medical Supplies---------- No Limit

Chiropractic & Massage Therapy (combined).....40 visits per year

Physical Therapy----------No Limit

Alcohol/Substance Abuse inpatient.....No Limit
out-patient ..... No Limit

AIDS related illness .....No Limit

Hearing Aid
Device and related charges $3,000.00
DME – durable medical equipment
Device purchased once every five (5) years.

EMPLOYEE BENEFICIARY BENEFIT

Death Benefit – of an Active Employee - Lump Sum
Based on years of continuous service ..... $1,000.00 - $10,000.00

Death Benefit – of an Active Employee –
Monthly Income……$200.00

Death Benefit – After Employee Termination
Based on 15 years continuous service $5,000.00

Death Benefit – After Employee Termination due to Disability
Based on years of continuous service ..... $1,000.00 - $5,000.00

VI
COVERED MEDICAL EXPENSES

Covered medical expenses are REASONABLE AND CUSTOMARY charges actually incurred for the services and supplies listed on the following pages upon the recommendation and approval of the attending physician.

BASIC COVERAGE = Plan pays 100%

MAJOR MEDICAL = Subject to applicable deductible,
plan pays 80%,
up to your out-of-pocket maximum.

OUT-OF-POCKET = Maximum is $1,000.00.
after which plan pays 100% of charges incurred,
exceptions listed in Out-of-Pocket section on Page 13

HOSPITAL BENEFIT

IN-PATIENT FACILITY AND BENEFITS

If you or your Dependent are admitted to the hospital, due to accidental illness or sickness, the Plan will cover any Reasonable and Customary charges incurred at Basic coverage 100% with the following limitations:

Payment will be made for charges for:

- Room and Board up to the semi-private room rate for up to 70 days.
- Miscellaneous Fees incurred on the days for which the Room and Board benefit is payable include:

  (a) Hospital charges for ancillary Hospital services and supplies, and

  (b) Daily In-Hospital Physician benefit up to 70 days payable. The per day charge will cover the reasonable and customary fee and broken out under basic and major medical.

  The first $15 will be covered at basic coverage 100%, the balance incurred will be covered under major medical, subject to the applicable deductible, and paid at 80% up to your out-of-pocket maximum.

OUTPATIENT HOSPTIAL FACILITY

For services rendered in a Hospital facility, as an out patient, the plan will pay in as major medical, subject to the applicable deductible and paid out at 80% up to your out of pocket maximum.

The plan is subject to pay in accordance with a negotiated contract agreement guideline (per facility) whenever applicable.

SURGERY BENEFITS

SURGEONS

The Plan pays basic coverage 100% up to $1,000 of the Reasonable and Customary charges of surgeon fees and of assistance surgeon fees for surgery performed as the result of an accidental injury or sickness. Any charges incurred thereafter will be covered under major medical, subject to the applicable deductible, and paid at 80% up to your out-of-pocket maximum.

In the event that two or more surgeries are required as a result of the same accidental injury or sickness, the Plan will not pay more than a combined total of $1,000.

Any cutting procedures involving the exposure of bones, tendons, or ligaments and any injections into the joints will be covered procedures. The removal of nail matrix or root will also be a covered procedure.

Surgeon Physician services include: Office Surgery Physician. Specialist Office Surgery, Inpatient Surgery Physician charge, Outpatient and Surgery Physician charge, Inpatient Assistant Surgeon, Outpatient Assistant, Transplant services

Please note a Second Surgical opinion will be covered under major medical, subject to an applicable deductible and paid at 80% up to your out of pocket maximum.

Dental surgery is not covered except for corrections due to an accident. If a Hospital confinement is medically necessary, it will be covered, but not the dental procedure.

SURGICAL FACILITY

Ambulatory Surgery Centers, Free Standing Facility and Observation room are classified as coverage under major medical, subject to an applicable deductible and paid at 80% up to your out of pocket maximum.

Surgical Transplant facility will be covered under basic at 100%

No Surgical Expense Benefits will be paid for procedures or operations performed for cosmetic services or for services rendered by podiatrist or chiropractor.
Exception: Breast Reconstruction, as reference within this plan

DIAGNOSTIC X-RAY AND LABORATORY BENEFIT

This Plan will pay benefits at basic coverage 100% of Reasonable and Customary charges up to a maximum of $300. Then applied to major medical, subject to the applicable deductible and paid at 80% up to your out of pocket maximum.

This benefit is payable each calendar year for any x-ray examination, laboratory tests and analysis recommended by a Licensed Physician provided however, you are not receiving other care or treatment under the Plan, the tests are not made in a national or state hospital and the expense incurred is not payable under any Workmen's Compensation Law or similar legislation. Dental or Eye Examinations are only covered if for diagnosis of an accidental bodily injury.

Diagnostic Testing charges:
Diagnostic test Out Patient Hospital, Diagnostic test office, Diagnostic professional component, diagnostic test In-Patient, Diagnostic Test Facility, Bone Density, Cat Scans, MRI, MRA, Pet Scans, Nuclear Medicine, Contrast Materials, Fetal Stress Test.

Lab Services Diagnostic Tests charges:
Diagnostic Lab home, Diagnostic lab facility, Diagnostic Lab Out-Patient Hospital, Diagnostic Lab office, Diagnostic Lab Prof component

X-RAY Services:
Diagnostic X-Ray facility, Diagnostic X-RAY Out-Patient Hospital, Diagnostic X-RAY office, Diagnostic X-RAY Prof component, Diagnostic X-RAY home

Additional Services:
Routine ancillary services, GYN ancillary charges, Mammogram family history

PHYSICIAN SERVICES

The plan will pay for the following physician services as major medical, subject to the applicable deductible and paid at 80% up to your out of pocket maximum.

All licensed Physician office visits, Specialist office visit, Physician home visit, (not agency employed), Podiatrist office visit, Podiatrist Ancillary charges, Osteopath office visit, Consultation visits

PREVENTIVE CARE

The plan will pay benefits at basic coverage 100% of the Reasonable and Customary charges for the following Preventive Care Expenses.

- Routine care office visits for Participants and spouses. Diagnostic tests which may be prescribed by a physician in connection with those office visits will be covered as specified in the diagnostic X-Ray and Laboratory Benefit section of the Plan.

- Mammograms one baseline exam will be covered per calendar year.

- GYN exam, Specialist GYN and Pap Smear, will be covered per calendar year.

The plan will pay the following preventive care procedures under major medical, subject to the applicable deductible and paid out at 80% up to your out of pocket maximum.

- Prostate Cancer Screening (PSA) One Prostate cancer screening will be covered per calendar year including an annual digital rectal examination and a prostate specific antigen test for men age 50 or over and for men age 40 and over with a family history of prostate cancer.

- Colon Cancer Screening. One colonoscopy will be covered per calendar year for Participants and Spouses age 50 and over, and every 10 years after a normal colonoscopy. In a case where polyps are found, based on a physician's recommendation, a colon cancer screening will be covered before the 10 year normal time limit. Routine screening may start earlier upon physician recommendation due to a first degree relative with colon cancer.

IMMUNIZATIONS:

Routine adult immunizations, Flu vaccinations (adult and dependent), HPV vaccine (adult and dependent), Shingle vaccine, Pneumonia vaccine are covered under major medical, subject to an applicable deductible and paid at 80% up to your out of pocket maximum.

MATERNITY CARE

The Plan will cover the Reasonable and Customary charges incurred at Basic coverage 100%.

Benefits are payable for normal delivery, (Vaginal or Caesarean Section), provided the pregnancy begins while the individual (Employee or Spouse only) is covered. Payments for hospital expenses incurred as a result of pregnancy are limited to the first four (4) consecutive days of hospitalization.

Complications of pregnancy are payable as any other sickness. For administration of this provision, complications of pregnancy means: Conditions (when the pregnancy is not terminated) whose diagnosis are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician prescribed bed rest during a period of pregnancy, morning sickness, hypermesis gravid arum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy constituting a nosologically distinct complication of pregnancy; and Non-elective Caesarean Section, ectopic pregnancy that is terminated, and spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours, as applicable). Federal law does not require a mother who is a Participant or a Beneficiary to give birth in a Hospital or to stay in the Hospital for a fixed period of time following the birth of her child.

Example: Jane goes into labor and gives birth at home by vaginal delivery on July 17th at 1 p.m. After the delivery Jane begins bleeding excessively in connection with the childbirth and is admitted to the Hospital for treatment at 3 p.m. on July 17th. In this example, the 48 hour period will end on July 19th at 3 p.m.

Please note:
There is no coverage for Maternity and Obstetrical benefits, or any charges related to or due to pregnancy for dependent children.

RECONSTRUCTIVE BREAST SURGERY

In accordance with the requirements of a Federal law entitled, the Women's Health and Cancer Rights Act of 1998, since this Plan provides medical and surgical benefits in connection with a mastectomy, the Plan will also provide benefits for certain reconstructive surgery. In particular, in such a case, the Plan will provide to a participant or beneficiary who is receiving (or presents a claim to receive) benefits in connection with such mastectomy, coverage for the following;

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications associated with all stages of mastectomy, including lymph edemas, in a manner determined in consultation between the attending physician and the patient.

This coverage will be subject to an annual deductible and coinsurance provisions applicable to other surgical procedures. You should review these provisions of the Plan carefully and if you should have any questions regarding this coverage, please contact the Plan Administrator.

NEWBORN CARE

Newborn care coverage applied to reasonable and customary charges. Plan pays at basic coverage 100% with the limitations as noted:

ROUTINE NURSERY CARE

Maximum 4 consecutive days .....$775.00 per day

*Miscellaneous
Charges.....$425.00 per day
Up to a maximum of 4 consecutive days, as required.

***Miscellaneous Fees incurred on the days for which the Newborn Care Benefit is payable include Hospital charges for ancillary Hospital services and supplies.**

ROUTINE PEDIATRIC DOCTOR VISIT

Maximum 4 consecutive days.....$130.00 per day

NEWBORN RESUSCITATION $275.00

WELL CHILD COVERAGE

Well child visits are covered under major medical, subject to the applicable deductible and paid at 80% up to your out of pocket maximum.

Well Child Visits

Well child visits in accordance with the guidelines of the American Academy of Pediatrics.

The American Academy of Pediatrics schedule for well child visits is:

- at birth
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 2 years
- 3 years
- 4 years
- 5 years
- 6 years
- 8 years
- 10 years
- 12 years
- 14 years
- 16 years
- 18 years
- once a year up to age 26

Services Covered as Part of the Well Child Visit

Services and immunization typically provided in conjunction with a well child visit will be covered in accordance with the American Academy of Pediatrics standards. In order to remain current in coverage, this Plan will also cover any new approved guidelines and services which have been implemented by the American Academy of Pediatrics standards that are not included below.

Services will include:

- Complete medical histories
- A complete physical exam
- Developmental assessments
- Anticipatory guidance
- Laboratory test ordered at the time of the well child visit in either the practitioner's office or in a clinical laboratory.

Immunizations

The following immunizations will be covered:

Immunization	Protects Against
Hepatitis B (Hep B)	Hepatitis B virus that may cause serious liver disease including cancer.
Diphtheria (DTaP)	A potentially fatal throat and wind pipe infection
Tetanus	Lockjaw
Pertussis	Whooping cough

▪ H. Influenzae type b (HIB)	Haemophilus influenza type b. This bacterium is a major cause of meningitis, pneumonia and other serous infections.
▪ Inactivated Polio (IVP)	Polio, which can cause paralysis or death.
▪ Pneumococcal Conjugate (PCV)	Pneumococcal bacteria, which can cause meningitis, pneumonia, and serious infections in the brain, blood stream and ears.
▪ Measles, Mumps, Rubella (MMR)	Measles, Mumps and Rubella (German Measles)
▪ Varicella (VAR)	Chickenpox, which can cause serious complications such as bacterial skin infections, pneumonia and infections of the brain.

Based on the American Academy of Pediatrics schedule, the frequency of the immunizations will be:

- Hep B - 1st Dose Birth to 2 months
  2nd Dose 1 to 4 months
  3rd Dose 6 to 18 months

If your child did not receive this vaccination when recommended above or if it was missed then he/she should receive this vaccination between 11 to 12 years old.

- DTaP – at months 2, 4, 6, 15-18 & 4-6 years.
- TD (Tetanus – Diphtheria) - at 11-12 years as long as 5 years have lapsed since last dose of DTaP.
- HIB –at months 2, 4, 6 & 12-15.
- IPV – at months 2, 4, 6 & 12-15.
- PCV – at months 2, 4, 6 & 12-15.
- MMR – 12-15 months, 4-6 years.

If your child did not receive the 2nd dose of the MMR vaccination when recommended above or if it was missed then he/she should receive this vaccination between 11 to 12 years old.

- VAR – 12-18 months.

Any child who lacks a reliable history of chickenpox (as judged by a health care provider) and who have not received the VAR vaccination when recommended above should receive 2 doses within 4 weeks apart at 13 years of age or older.

Eligible Providers

Services must be provided by or under the supervision of a physician or other professional licensed under Article 139 of the Education law. Article 139 refers to registered nurses, licensed practical nurses and certified nurse practitioners.

THERAPY SERVICES

Therapy services are covered as major medical, subject to the applicable deductible and paid at 80% up to your out of pocket maximum.

Occupational therapy -
Occupational therapy Outpatient Hospital, Occupational Therapy other places of service

Resp Therapy -
Resp Therapy Outpatient Hospital, Resp Therapy other places of service

Speech Therapy –
Speech Therapy Outpatient Hospital, Speech Therapy other places of services

Chemotherapy –
Chemotherapy Outpatient Hospital, Chemotherapy Office

Radiation Therapy –
Radiation Therapy Outpatient Hospital, Radiation Therapy Office

Dialysis –
Dialysis Outpatient Hospital, Dialysis other location

IV Therapy –
IV Therapy Hospital, IV Therapy Office, IV Therapy Home

REHAB
Cardiac Rehab Outpatient Hospital, Cardiac Rehab other place of service

REHAB Facility is paid as basic coverage at 100%.

PHYSICAL THERAPY, CHIROPRACTIC MASSAGE THERAPY

PHYSICAL THERAPY of the type and duration prescribed by the attending physician, and performed by a duly qualified licensed physical therapist.

CHIROPRACTIC SERVICES, MASSAGE THERAPY – These two (2) combined services are limited to an annual maximum benefit of 40 visits per calendar year.

Massage therapy must be administered with prescription from physician, indicating the specified area to be worked on. Example: back, neck, arm, etc. It does not include body massages.

MENTAL AND NERVOUS CONDITION

IN-PATIENT

In-patient confinements for the treatment of mental/nervous disorders shall be paid at basic 100% of any Reasonable and Customary charges with the following limitations:

Payment will be made for charges for:

- Room and Board up to the semi-private room rate for up to 70 days.
- Miscellaneous Fees incurred on the days for which the Room and Board benefit is payable include:

  (a) Hospital charges for ancillary Hospital services and supplies, and

  (b) Daily In-Hospital Physician benefit up to 70 days payable. The per day charge will be broken out under basic and major medical.

  The first $15 will be covered at basic coverage 100%, the balance incurred will be covered under major medical, subject to the applicable deductible, and paid at 80% up to your out-of-pocket maximum.

Timothy's Law Adult and Dependent
..... Facility will be covered under basic at 100%
Timothy's Law Adult and Dependent
..... Physician services will be covered under major medical, subject to the applicable deductible and paid at 80% up to your out of pocket maximum.

OUT-PATIENT

Out-patient Hospital, Physician services, Office visits, Therapy services for the treatment of a mental/nervous disorder will be covered under major medical at 80% of reasonable and customary allowances. Major medical charges are subject to an applicable deductible.

For purposes of this Section the following terms have special meanings:

Mental or Nervous Condition. The phrase "Mental or Nervous Condition (Disorder)" will mean a neurosis, psychoneurosis, pyschopathy, psychosis, mental or emotional disease.

Specialized Treatment Facility. The term "Specialized Treatment Facility" as applied to the treatment of alcoholism or drug abuse will mean an institution (or distinct part thereof) which meets fully every one of the following tests:

(A) It is primarily engaged in providing, for compensation from its patients and on a full-time in-patient basis, a program for diagnosis, evaluation, and "effective treatment" of alcoholism or drug abuse, whichever condition is being treated.

(B) It provides all medical detoxification services necessary as an adjunct to its effective treatment program continuously on a 24 hour basis.

(C) It provides all normal infirmary-level medical services required for the treatment period, whether or not related to the alcoholism or drug abuse, continuously on a 24-hour daily basis. Also, it provides, or has an agreement with a Hospital in the area to provide, any other medical services that may be required during the treatment period.

(D) On a continuous 24-hour daily basis, it is under the supervision of a staff of physicians and provides skilled nursing services by licensed nursing personnel under the direction of a full-time registered graduate nurse.

(E) It prepares and maintains a written individual plan of treatment for each patient based on a diagnostic assessment of the patient's medical, psychological and social needs with documentation that the Plan is under the supervision of a physician.

(F) It meets any applicable licensing standards established by the jurisdiction in which it is located.

ALCOHOL / SUBSTANCE ABUSE

IN-PATIENT

In-patient confinements for the treatment of alcohol and drug abuse, in a Hospital or Specialized Treatment Facility, along with Physician and De Tox care will be paid at basic 100% of any Reasonable and Customary Charges.

OUT-PATIENT

Out-patient Hospital, Physician services along with Family therapy for the treatment of alcohol and drug abuse, will be covered under major medical at 80% of reasonable and customary allowances and subject to the applicable deductible.

Please also refer to Page 16 for in-patient information.

EMERGENCY ROOM MEDICAL CARE

A Medical Emergency is a medical condition of sudden, unexpected onset, whereby if immediate care is not given, the person's life might be in danger or there might be a serious impairment to a bodily function.

Acceptable Emergency room services are covered under major medical, subject to the applicable deductible and paid at 80% up to your out of pocket maximum.

Eligible participants and dependents shall be entitled to reimbursement for emergency medical care rendered by a licensed physician in his/her office or in the outpatient department of a hospital or clinic, provided such care is administered within 72 hours of an accident or the sudden onset of any of the following conditions:

- Acute allergic reactions - (except allergy tests)
- Acute attack of asthma
- Atelectasis
- Choking
- Convulsions and/or Seizures
- Severe Cyanosis
- Diabetic coma
- Drug reaction
- Eclampsia
- Severe fecal impaction
- Frostbite
- Heart attack
- Heat prostration
- Hemorrhage
- Hysteria
- Insulin shock
- Paroxysm
- Tachycardia
- Poisoning
- Pulmonary embolism
- Sunstroke
- Unconsciousness
- Acute urinary retention
- Sudden onset of vision loss
- Stroke
- Spontaneous pneumothorax

HOSPICE BENEFITS

Covered hospice charges will include charges made by a hospice or other facility under the direction of hospice.

The following benefits will be payable at basic 100% of Reasonable and Customary charges for a maximum of 16 days.

A. **COVERED CHARGES WHEN BILLED BY HOSPICE**

- Charges for in-patient hospice care at the Hospital's most common semi-private room rate.
- Charges for physician's services in-patient and out-patient care.
- Charges for home care of skilled nursing services.
- Charges for Laboratory exams, x-rays, chemotherapy and radiation therapy as needed to control symptoms.
- Charges for physical, respiratory or speech therapy.
- Charges for drugs, medication, and medical supplies.
- Charges for Home Health Aide services for respite care.
- Charges for emotional support services.
- Charges for ambulance service between covered person's home and the Hospice facility or a Hospital and person's home where Hospice care will be administered..
- Charges for bereavement services.

B. **HOSPICE CARE WILL BE PROVIDED ONLY IF THE FOLLOWING REQUIREMENTS ARE MET:**

- Terminal illness with a prognosis of a 6 month life expectancy if certified by a physician. The patient need not be homebound, and no prior Hospitalization is necessary to receive benefits for Hospice care.
- Palliative care (to lessen pain) is appropriate.
- The patient and physician consent to the Hospice Program.

EXCLUSIONS

Covered Hospice charges do not include charges:

- Not approved or ordered by the attending doctor.
- For which the family unit would not legally have to pay in the absence of coverage.
- Private Duty Nursing.

OTHER COVERED MEDICAL EXPENSES

Other than those previously detailed, covered medical expenses shall include allowable charges actually incurred for the services and supplies listed below if they are:

- provided upon the recommendation and approval of the attending physician, and
- required for the treatment of you or your covered dependent, and
- provided such services and supplies are medically necessary.

Unless otherwise noted, the following expenses will be covered under major medical, subject to the applicable deductible and paid at 80% up to your out-of-pocket maximum. All procedures or services are subject to reasonable and customary fees. Certain coverage may have limitations attached.

1. **AIDS (Acquired Immune Deficiency Syndrome)**

2. **ALLERGY** injection, serum, testing and office visit

3. **AMBULANCE** EMERGENCY SERVICE by a professional ambulance to and from the Hospital or by regular scheduled airline, railroad or air ambulance to the nearest Hospital qualified to provide necessary treatment, and other medical necessary ambulance transportation to and from a medical facility. This Plan shall pay for the transportation charges incurred for mileage up to a maximum of $100.00 under basic coverage 100%. The Plan will pay for care administered under major medical at 80%, up to your out-of-pocket maximum.

4. **ANESTHESIA:** Office anesthesia, Inpatient and Outpatient anesthesia, Transplant anesthesia

5. **BLOOD OR BLOOD PLASMA**

6. **DURABLE MEDICAL EQUIPMENT (SUPPLIES)**

   - DURABLE MEDICAL EQUIPMENT, but only to the extent that any rental (up to the purchase price) otherwise purchase must be pre-approved in writing by the Trustees, or by such person designated by the Trustees.
   - Surgical supplies and Ostomy supplies including bandages, dressings, and appliances to replace physical organs or parts or to aid in their functions.
   - OXYGEN and rental (up to the purchase price) of equipment for its administration.
   - Prosthetics to replace functioning body part
   - Foot orthotics, Orthopedic Shoe and appliance
   - Diabetic supplies and Orthotics
   - Wigs after Chemo

7. **EDUCATIONAL SERVICES** Diabetic education and Nutritional counseling

8. **FAMILY PLANNING:** covers Early Intervention Services at major medical.

VOLUNTARY STERILIZATIONS (Vasectomy and Tubal Ligation) are covered under the Plan for Participants only. The surgeon is covered under basic 100% up to $1000.00. The balance would be covered under major medical, subject to an applicable deductible, paid at 80% up to your out of pocket maximum. The facility is covered under major medical, subject to an applicable deductible, paid at 80%, up to your out of pocket maximum.

9. **HEARING AID**: this Plan will pay 80% up to a maximum of $3000.00 (considered durable medical equipment) for related charges incurred in obtaining a hearing device. However, the plan will only pay for a device (or two if needed in both ears) once every five (5) years.

10. **HOME HEALTH CARE** by an agency. This does not include custodial care.

11. **HOSPITAL CLINIC**: includes both the clinic facility and clinic physician.

12. **MISCELLANEOUS SERVICES:** Acupuncture, Biofeedback, Genetic Testing, Pre-Admission Testing, Handling Charge, Injections, Enteral Formula, Modified Food Product, Accidental Injury to teeth, Sleep studies, Cataract..

13. **NURSE PRACTITIONER**, who is licensed or certified to practice and provides services normally covered under this plan.

13. **SKILLED VISITING NURSING** medical care provided at home. This care does not include custodial service. A physician visit Skilled Nursing Facility and a Skilled Nursing Inpatient Facility are covered at major medical

14. **SMOKING CESSATION SUPPLIES** pills, patches, and gum. These items are subject to a combined maximum limit of $1,000.00 per calendar year. A physician prescription must be submitted at time of purchase.

15. **URGENT CARE:** includes both the Urgent care facility and Urgent care physician.

<u>The following items are covered under major medical; however each is subject to review as these are considered high dollar items.</u>

<u>Transplants, Experimental/Investigational, Durable Medical Equipment, Bone Density Studies, Braces/Splints/Orthotics, Compression Hose, CPAP Machine, Cryotherapy Rental, Erectile Dysfunctional Drugs, Insulin Pumps, MRI, Oxygen, Home therapy, Sleep Studies, TENS Unit.</u>

<u>Any claims that pose a medical necessity are also subject to review.</u>

VII
MEDICAL PLAN EXCLUSIONS

No payment shall be made under any benefit of the medical plan in any event for:

1. Charges in connection with an injury or illness for which benefits are payable in accordance with the provisions of any Worker's Compensation or similar law.

2. Charges incurred while you or your Dependents are confined in a Hospital operated by the United States of America or any agency thereof, or charges, which you would not be required to pay if there were no medical coverage.

3. Charges on account of a dependent for any expense incurred during or in connection with a Hospital confinement, which commenced prior to the date the dependent, became covered under the policy.

4. Charges for education, training, and bed and board while you or your dependents are confined in an institution which is primarily a school or institution for training, a place of rest, a place for the aged or a nursing home.

5. Charges for custodial care.

6. Except as noted previously for preventive care, charges incurred for immunizations and medical examinations or tests or any kind not incidental or medically necessary to the treatment of a covered injury, sickness or pregnancy.

7. Charges for medical care resulting from suicide, attempted suicide, or a self-inflicted injury, unless due to a health related factor as defined in the Health Insurance Portability and Accountability Act of 1996.

8. Eye refraction, eyeglasses or dental prosthetic appliances, except as required on account of accidental injury.

9. Services rendered by an individual in the participant's family or in the participant's spouse's family.

10. Cosmetic or reconstructive surgery or treatment, unless necessitated by an accidental injury, congenital malformation or breast reconstruction as a result of mastectomy. It does not matter if such surgery is for psychological or emotional reasons.

11. Charges for experimental and/or investigational procedures. Any treatment must be judged as non-experimental or non-investigational by BOTH (a) the Medicare Guidelines and (b) the American Medical Association or the appropriate medical-specialty society or board.

12. Treatment of Temporomandibular Joint Dysfunction Syndrome (TMJ).

13. Charges for routine examinations except as outlined elsewhere in this Plan.

14. Charges incurred as a result of court ordered therapy or treatment, or expenses incurred as a result of the commission of a felony, or DWI (driving while intoxicated).

15. Charges for an elected termination of pregnancy except when it is medically necessary.

16. In-vitro fertilization, embryo transfers procedure, or artificial insemination.

17. Services related to treatment of or in connection with transsexual surgery.

18. Reversal of sterilization.

19. Any loss or portion thereof for which mandatory Automobile no-fault benefits are recovered or recoverable.

20. Charges for services or supplies, which are furnished, paid for or otherwise provided for by reason of the past or present service or any person in military services of a government.

21. Services for treatment of obesity, Surgery, Anesthesia, Facility, Non-Surgical. Except for surgical treatment of morbid obesity in life threatening circumstances. This will be subject to review, as other means must have been tried in order to lose the weight.

22. Diet and Weight reduction programs or treatments including Liposuction. Except for counseling services directly related to the treatment of diabetes.

23. Chelation therapy, except to treat heavy metal poisoning.

24. Family Planning, Miscellaneous contraceptives, IUD, Depo Provera, Contraceptive Management

25. Private Duty Nursing Facility (not hospital), Private Duty Nursing Home care, Private Duty Nursing Inpatient Hospital services.

26. Maternity benefits and other charges related to maternity care for dependent children.

27. Personal comfort items, such as, health spas, health gyms, exercise equipment, television, telephone, furniture, air conditioners, air filters, and all other equipment which are not exclusively for medical treatment even when prescribed as medically necessary by a physician.

28. Charges that are not reasonable and customary

29. Charges for services or supplies related to an injury, condition or disease resulting from, or incurred while committing an unlawful act, or resulting from being engaged in an unlawful act. If your are convicted of committing or engaging in an unlawful act, then such conviction will serve proof that you committed or engaged in the unlawful act. However, for purposes of this exclusion, you will also be deemed to have committed or engaged in an unlawful act to the extent that the Trustees determine that you committed or engaged in such unlawful act, based on the facts and circumstances involved even if a criminal prosecution does not result, or it does result and you are found guilty.

30. Services or supplies that is experimental or investigational. Services or supplies will be considered "experimental or investigational" as follows:

    If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;

    If "Reliable Evidence" shows that the drug, device or medical treatment or procedure is the subject of on-going Phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with the standard means of treatment or diagnosis;
    If "Reliable Evidence" shows that the consensus of opinion among experts regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to

determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with the standard means of treatment or diagnosis.

"Reliable Evidence" means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as experimental or investigational.

31. Late filing claims. Claims that are received after one (1) year from date of service will be considered late filing and denied payment.

    This includes claims in cases where a participant neglects to notify their provider with the proper insurance information, participant neglects to notify Fund office that claim(s) are not being paid, claims that were held in collections and claims where a provider fails to file in a timely manner.

    Late filed claims will become the responsibility of the participant.

    This item also applies to: Section XX, Additional Plan Information D. Claims Process

V
DENTAL BENEFITS

This Plan will pay eighty (80%) percent up to a maximum of $1,000 per calendar year. This service is not subject to a deductible. The following covered procedures for expenses incurred in connection with dental treatments and services or supplies ordered by a Licensed Physician or Dentist are:

Routine oral examinations. Benefits are payable for expenses incurred for diagnosis, x-rays and prophylaxis. You are limited to one (1) routine exam every six (6) months.

Extractions, root canal therapy and periodontal treatment.

Oral Surgery.

Extended prophylactic procedures prescribed by a Licensed Dentist or Physician.

Multi-stage procedures, which require dental work over an extended period of time will be covered, provided your coverage under this Plan is in effect when the first stage is performed.

Dentures and bridge work to the following extent:

The initial installation of full or partial dentures or bridgework, or additions to full or partial dentures or bridgework, to replace one or more injured or diseased natural teeth extracted while covered,

The replacement or alteration of full or partial dentures or bridgework when due to either (1) an accidental injury (while covered) including oral surgical treatment, or (2) oral surgical treatment (while covered) to reposition muscle attachments or remove a tumor, cyst, torus or redundant tissue. The replacement or alteration must be completed within twelve (12) months after the injury described in (1), and

The replacement of a full denture because of structural change in the mouth, if it is done more than five (5) years after the installation of the denture, provided you have been covered under this Plan for at least two (2) years.

Repair of dentures or bridgework.

Drugs and Medicines. Drugs and Medicines that are prescribed by a Licensed Physician or Dentist which are dispensed at a drug store and are needed as a result of covered dental work.

Inlays, crowns, fillings, and implants

X-rays every six (6) months (including panoramic x-rays)

<u>Children's Dental Benefit.</u> The annual dollar limit on dental benefits for dependent Children under 19 is also $1,000.00 . Orthodontic and cosmetic dental work are excluded.

You have the option to opt out of dental benefits under the Plan by written notice to the Fund Administrator. This election may be made at any time.

EXCLUSIONS

This Plan will not cover charges in connection with any of the following:

1. Orthodontic work, or prosthetic appliance

2. Surfaces, supplies or treatment you received from a family member, from a dental or medical department, clinic or office maintained by an Employer, a mutual benefit association, labor union, trustee or similar type of groups.

3. Replacement of dentures or bridgework due to loss or theft.

4. Treatment required as a result of war, occupational injury or sickness.

5. Dental work for cosmetic purposes

VI
VISION COVERAGE

You and/or your Dependents will be eligible to receive a maximum benefit of $150.00 per calendar year for any of the following:

- Eye exam,
- Frames,
- Lenses,
- Contacts,
- Safety glasses

Vision Care expenses do not include and no payment shall be made for expenses caused by, incurred or resulting from:

1. Accidental bodily injuries or sickness arising out of or in the course of employment.

2. Accidental bodily injury or sickness caused by war or by an act of war, declared or undeclared, or by participating in a riot, or as the result of committing a felony.

3. Charges made by a state or federally operated institution.

4. Intentionally inflicted injury, while sane or insane.

5. Eye examinations without commitment refraction test.

6. Sunglasses, plain or prescription.

7. The duplication or replacement of existing lenses, contact lenses, or frames, unless a change in prescription is required.

8. Charges that are eligible expenses under the medical benefits of this plan.

You have the option to opt out of vision benefits under the Plan by written notice to the Fund Administrator. This election may be made at any time.

VII
PRESCRIPTION DRUG BENEFITS

WHAT IS COVERED?

This Plan provides benefits for medicine which by law may not be dispensed without a prescription, for injectable medication, insulin syringes and for compound medications of which at least one ingredient is a prescription legend drug.

Eligible medicines are covered when they are ordered by a licensed physician and provided by a licensed pharmacy. Refills will be covered for up to 12 months after the original prescription date, unless the number of refills is specified in the physician's order. The quantity of prescription drugs dispensed with the original prescription and each refill is limited to a 30-day supply.

BENEFITS PROVIDED FOR PRESCRIPTION DRUGS

At the Pharmacy:

When you or your eligible Dependents receive covered drugs from a pharmacy there is no deductible and you pay a co-payment charge of $15.00 for generic drugs or $30.00 for brand name drugs for each prescription and refill. The prescription drug program will pay the remaining charges.

HOW BENEFITS ARE PROVIDED

When you receive prescription drug service from a pharmacy just present your ID card and pay the co-payment charge. The pharmacy will bill the Fund for the balance.

THE PRESCRIPTION DRUG PROGRAM DOES NOT COVER

- Non-legend drugs (those that do not require a prescription), other than insulin.
- Vitamins except those, which by law require a prescription.
- Prescriptions dispensed by a doctor, Hospital, nursing home, or other treatment institution during confinement or otherwise.
- Benefits obtainable under any other prescription drug program.
- Drugs for conditions or services not covered under your medical plan.
- Immunizing agents.
- Rogaine.
- Retin-A (for persons over age 30)
- Chemstrips, these are covered under the major medical part of this healthcare plan.
- Contraceptives and therapeutic devices or appliances.

XI
MEDICAL REIMBURSEMENT ACCOUNT

This benefit entitles an eligible participant to a Medical Reimbursement. You will be reimbursed for amounts spent out of pocket for eligible expenses on behalf of yourself, your spouse and your eligible dependent(s). The Internal Revenue Service maintains a list of expenses that may be reimbursed tax-free under this benefit, which are found in IRS Publication 502.

The Plan Administrator will maintain a "personal account" on your behalf. Each account will include a record of contributions received from your contractor. The dollar amount received is established in the collective bargaining agreement of your participating Local. Also recorded is the benefit paid out to you. You do not have a vested right to the balance in the account; your account is only used to determine your eligibility for benefits, actual contributions and withdrawals.

Your expenses may be reimbursed under the medical reimbursement benefit providing; they are filed within one (1) year after the date in which you have paid for the eligible out of pocket expense, and providing the expense has not been covered under this plan or any other insurance plan. It is important to note that medical expenses are to be processed through the plan first. After which this benefit will cover out of pocket patient responsibility items (Example – deductibles, major medical balances, non-covered items, denials, etc.). However certain medical items listed in the IRS Publication 502 such as over the counter items (bandages, cough syrup, etc.) do not have to be processed through the plan first.

As a result of the health care reform law, expenses incurred for medicines or drugs (other than insulin) on or after January 1, 2011, are subject to an additional requirement. Those expenses may be reimbursed on a tax-free basis only if the medicine or drug is prescribed, even if the medicine or drug is an over-the-counter (OTC) medicine or drug that may be purchased without a prescription. For purposes of the new restrictions, a prescription for a

medicine or drug must be a written or electronic order that satisfies the legal requirements for a RX in your state (including that it be issued by someone authorized to issue prescriptions in that state). The restrictions do not apply to OTC items other than medicines and drugs (e.g. equipment, supplies, and medical devices, including items such as crutches, bandages, Blood sugar test kits, and eyeglasses).

All claims received will be date stamped and processed within a sixty (60) day period. The claim form can be used for more than one eligible family member and include several different eligible expenses. Each claim form submitted between the months of January through November is subject to a seventy-five ($75.00) dollar minimum amount. However there will be no minimum amount applied to claims submitted during the month of December or in the case of an eligible retiree who is zeroing out his/her account.

All claims submitted to the fund must be accompanied by adequate documentation; which is the appropriate claim form accompanied with actual receipts, showing that you have already paid for the expense. A list of adequate documentation can be found on the claim form. The Plan Administrator may ask you to provide other documentation to show that your medical expense is otherwise eligible for reimbursement. A claim form must be completed accurately or it will be returned to you for lacking information or wrong addition when forwarding several expenses on one claim. Neither the Fund Administrator nor any fund office employee is allowed to make any adjustments on your form, even if you request the change to be entered on your behalf. This will prevent any possible error being entered on your claim through miscommunication.

If you die and there is still a balance in your account, your spouse and/or eligible dependents, can continue to draw on the account for their eligible medical expenses. If you die and do not have a surviving spouse and/or eligible dependents, the balance in the account will be forfeited. Should you terminate your service as an active participant (leave the union to work elsewhere) or be terminated from a service program (apprenticeship program) or retire, you, your spouse and/or eligible dependents can continue to draw on the account until the balance is zeroed out.

If you have any balance in your Medical Reimbursement Account, you are prohibited from receiving a premium assistance tax credit to purchase health insurance coverage through the new health insurance marketplace. You may wish to forfeit the Medical Reimbursement Benefit under your account if the premium assistance tax credit is more valuable. You have the option each year to opt out of the Medical Reimbursement Benefit. You will also have the option upon your retirement to permanently opt out of the Medical Reimbursement Benefit. If you opt out of the Medical Reimbursement coverage at retirement, your entire Medical Reimbursement Account will be forfeited.

Please note that health insurance coverage under Tricare, Indian Health Services, Medicare, or Medicaid is not considered group health insurance.

The Affordable Care Act prohibits "stand-alone" healthcare accounts. Stand-alone health care accounts are accounts that provide medical reimbursement benefits without being offered in connection with group health insurance.

Therefore, beginning July 1, 2014, you will not be entitled to medical reimbursement benefits under your Medical Reimbursement Account unless you are enrolled in health insurance coverage through the Roofers 74/203 Plan or through your spouse's or parent's employer.

If you are enrolled in your spouse's or parent's plan, that plan must provide "Minimum Value". A health plan provides Minimum Value if the health plan's share of the total allowed cost of benefits is at least 60 percent (i.e., has an actuarial value of at least 60 percent). If you do not enroll in coverage under the Plan, you will be eligible to use your Health Care Account only if you present your enrollment card in your spouse's or parent's group health plan and provide a copy of the plan's Summary of Benefits and Coverage (SBC) indicating that it meets the Minimum Value standard.

Any Employer contributions that were credited to your Medical Reimbursement Account prior to December 31, 2013 are "grandfathered" and may continue to be used as before.

XII
RETIREE COVERAGE

If you retired with a pension from the Roofers Local No. 74/Local No. 203 Pension Fund on or after September 1, 1998 you, your Spouse and eligible dependent may continue coverage under this Plan for a maximum of five (5) years or if earlier until you or your Spouse's entitlement to Medicare benefits. Provided however, you were at least 60 years old when you retired, you were already eligible for medical benefits under this Plan and you did not incur a break in service in any of the five (5) years preceding your retirement. Once you have exhausted the five (5) years of coverage or, if earlier, your entitlement to Medicare you will be entitled to continue coverage, on a self-pay basis, in accordance with Section XII of this Plan.

If you do not meet the requirements stated above and you retired with a pension from the Roofers Local No. 74/Local No. 203 Pension Fund on or after age 47, while active and eligible for medical benefits under the Plan, you and your Spouse will be eligible for medical benefits (pursuant to the Schedule of Retiree Medical Benefits listed below) until you become eligible for Medicare. In lieu of this Retiree medical coverage, you and/or your Spouse may elect to continue full coverage under the Plan on a self-pay basis. The guidelines for continuing coverage on a self-pay basis are detailed in Section XVIII, "COBRA Continuation Coverage", of this Plan. The amount required for self-payment may be obtained from the Plan Administrator.

SCHEDULE OF "RETIREE" MEDICAL BENEFITS

HOSPITALIZATION BENEFIT

Daily Room and Board
70 Full Benefit Days $100.00

*Miscellaneous Fees/includes Hospital charges for ancillary Hospital services and supplies.
Up to $1,000.00 ..... 100% of Charges
$1,000.01 to $3,000.00 ..... 75% of Charges

SURGICAL BENEFIT

Maximum per operation..... $900.00

DAILY IN-HOSPITAL PHYSICIAN BENEFIT

70 Full Benefit Days ..... $10.00 per day

DIAGNOSTIC X-RAY AND LABORATORY BENEFIT

Maximum per Calendar Year..... $200.00
(This benefit is payable regardless if incurred when an out-patient or in-patient)

"MEDICARE REIMBURSEMENT" BENEFIT
Premium Reimbursement

If you retire on or after January 1, 2009 and are otherwise eligible for benefits under this Plan at your retirement, you will be entitled, upon becoming eligible for Medicare to reimbursement for Part B Medicare premium charges for you and your spouse. If you retired prior to January 1, 2009, were not yet eligible for Medicare at your retirement, and were otherwise eligible for benefits under this Plan at your retirement, you will be entitled, upon becoming eligible for Medicare to reimbursement for Part B Medicare premium charges for you and your spouse. The amount of the reimbursement will be $100.00 for both you and your spouse. The benefit is granted only at the time you and your spouse initially became eligible and apply for the Medicare B benefit. Proof of acceptance and payment of Medicare Part B must be presented.

This benefit is reimbursed by means of a direct deposit method only.

"MEDICARE DEDUCTIBLE" REIMBURSEMENT BENEFIT

Once you or your Spouse become entitled to Medicare benefits, you will be eligible to receive reimbursement for Part "A" Hospitalization and Part "B" Medical Coverage deductibles for a maximum of two (2) Part "A" deductibles and one (1) Part "B" deductible per person per calendar year for the rest of your life. Provided, however, you were eligible for benefits under this Plan as of your retirement date.

"MEDICARE SUPPLEMENTAL COVERAGE" BENEFIT

If you retire while active and eligible for Welfare coverage under the Plan and are covered by both Medicare Parts A and B, you and your spouse may be entitled to contribute a monthly premium to the Plan for coverage under the Medicare Supplemental Benefit. However, effective January 1, 2006, in order to be eligible for the Medicare Supplemental Benefit, you also must be at least sixty-five (65) years of age. The premium for this coverage is subject to increase at any time pursuant to the discretion of the Plan Trustees. The Trustees may determine that a higher monthly premium is necessary to sustain coverage under the Plan.

This benefit option is offered as a supplement to Medicare only. In addition, this benefit shall be subject to all other limitations contained in this Plan, as well as any other Plan provisions governing coverage under the Roofers Local No. 74/Local No. 203 Welfare Plan. Medicare will continue to be the primary payor with respect to your medical benefits. In no case can the Medicare Supplemental Benefit be used to pay for any medical expenses currently covered by Medicare. This coverage excludes Prescription, Dental and Vision.

XIII

DEATH BENEFITS

BENEFICIARY OF AN ACTIVE EMPLOYEE LUMP-SUM

Initial Eligibility. Once you have accumulated at least 1,000 Credited Hours within the twelve month period of May 1st through April 30th ("Qualifying Period") your Designated Beneficiary will be eligible to receive a lump-sum death benefit (upon your death) during the twelve month period of June 1st through May 31st ("Coverage Period") in accordance with the following schedule:

SCHEDULE OF SURVIVOR BENEFITS

Years of Eligibility	Amount of Death Benefit
1 year	$1,000.00
2 years	$2,000.00
3 years	$3,000.00
4 years	$4,000.00
5 years	$5,000.00
6 or more years	$10,000.00

Continuing Eligibility. Once you have accumulated the 1,000 Credited Hours you will remain eligible for this lump-sum death benefit during that entire Coverage Period. You will remain eligible for this benefit in the next Coverage Period provided you accumulate 700 Credited Hours in the next Qualifying Period. If you fail to accumulate the required 700 Credited Hours your coverage will terminate. You will not be covered under this benefit until you again accumulate 700 Credited Hours in a Qualifying Period, provided no more than three (3) Qualifying Periods have elapsed. If three Qualifying Periods have passed since you were covered under this lump-sum death benefit you will be required to accumulate 1,000 hours in the next Qualifying Period to again be eligible, and your prior years of eligibility will be lost for purposes of determining the amount of your death benefit.

Example: John accumulates 1,000 Credited Hours between 5/1/01 and 4/30/02 ("Qualifying Period"). Coverage under this death benefit will be effective 6/1/02 and end on 5/31/03. If John accumulates an additional 700 Credited Hours between 5/1/02 and 4/30/03 his coverage will not end on 5/31/03, it will continue until 5/31/04. John's coverage under this benefit will continue in the same manner described provided he accumulates at least 700 Credited Hours between 5/1 and 4/30 of any given year. If John fails to accumulate the 700 Credited Hours his coverage will terminate. John will be eligible for coverage once he accumulates 700 Credited Hours between 5/1 and 4/30, provided not more than three Qualifying Periods have passed. If three (3) Qualifying Periods have passed, John will need to accumulate 1,000 Credited Hours between 5/1 and 4/30 to again be eligible.

	John must accumulate this # of Credited Hours	**Within this Qualifying Period**	**In order to qualify for benefits in this Quarterly Period of Coverage**
Initial Eligibility	1000	5/1/01- 4/30/02	6/1/02 – 5/31/03
Continuing Eligibility	700	5/1/02 – 4/30/03	6/1/03 – 5/31/04

MONTHLY INCOME

Initial Eligibility. Once you have met the eligibility requirements for a Lump-Sum Death Benefit, and maintained your eligibility for four (4) consecutive Coverage Periods (6/1 – 5/31) for a total of five (5) years your Designated Beneficiary will be eligible to receive a Monthly Income Death Benefit (upon your death prior to age 65) in an amount of $200.00. Payment will be made on the first of the month following the date of your death and will be payable in accordance with the following schedule:

If your Designated Beneficiary is your …	**Your Monthly Death Benefit will be Payable until…**	**Payable for…**
Spouse	The month you would have reached age 65	No more than 30 years, but not less than 10 years
Children	The youngest child is age 21	Not less than 10 years
*Parent	N/A	10 years
Brother or Sister	Until age 21	Not less than 10 years
Any other Designated Beneficiary	N/A	10 years

* In the event of the death of your designated parent, any remaining payments will be payable to your surviving parent.

Continuing Eligibility. You will remain eligible for this Monthly-Death Benefit provided you accumulate at least 700 Credited Hours during the Qualifying Period (5/1 – 4/30) immediately preceding the Coverage Period (6/1 – 5/31) for any given year after you have met the initial eligibility requirements. If you fail to accumulate 700 Credited Hours your coverage will terminate. You will not be covered under this benefit until you once again become eligible for the Lump-Sum Death Benefit as described above.

AFTER TERMINATION

In the event of your death after your termination (for any reason) or retirement, your Designated Beneficiary will be eligible to receive a lump-sum death benefit in the amount of $5,000 provided you completed at least fifteen (15) years of continuous service prior to your termination or retirement.

TOTALLY AND PERMANENTLY DISABLED

In the event you become totally and permanently disabled prior to your retirement or termination, and you remain totally and permanently disabled until your death, your Designated Beneficiary will be entitled to a death benefit provided, you meet the following requirements:

- You become totally and permanently disabled prior to your 60th birthday;
- You were eligible to receive benefits under this Plan prior to your total and permanent disability, and

- You have submitted a Social Security Disability Award Certificate to the Trustees as proof of your disability.

  * Your Designated Beneficiary will be entitled to receive this benefit if you are between the ages of 60 and 65 and your death has occurred within one year after your termination of employment.

If you meet the requirements listed above, your Designated Beneficiary will be entitled to a death benefit in accordance with the following schedule:

SCHEDULE OF SURVIVOR BENEFITS

Years of Continuous Service	Amount of Benefit
1 year	$1,000.00
2 years	$2,000.00
3 years	$3,000.00
4 years	$4,000.00
5 years	$5,000.00

For purposes of this section "Continuous Service" shall mean a year of service, as defined in the Roofers Local No. 74 Pension Plan, without suffering a break-in-service. If you incur three (3) consecutive plan years of less than five-hundred (500) hours of service, your prior years of continuous service will be lost.

XIV
DISABILITY INCOME BENEFIT

Active Employee
Eligibility:

If you become disabled because of an injury or a serious illness and are not able to work in your trade, you will be entitled to a weekly disability benefit. The disability must begin while you are a covered participant of the plan. Successive periods of disability are considered as one unless they are due to unrelated causes and are separated by complete recovery and return to active full time work.

Payment of Benefits:

You must request, complete and return the disability application form. For verification a section of this form must be completed and signed by your physician. Therefore, you must be under the care of a legally qualified licensed physician while you are disabled.

There are two (2) disability income benefits.

One Hundred Dollars ($100.00) for an illness or accidental injury. Your benefits will begin on the 8th day of disability. Illness or accidental injuries involve a seven (7) day waiting period.

Fifty Dollars ($50.00) for an on-job site injury. Your benefits will begin on the first (1st) day of the disability if due to on-job site injury.

The applicable benefit will be paid for a maximum period of twenty-six (26) weeks. However, if you are age 65, or over, the maximum period is 13 weeks for all disabilities during any 12 consecutive months.

Credited Hours:

You will be credited with six (6) hours per day for the maximum of twenty-six (26) weeks. (Saturdays and Sundays are not applicable) The credited hours will be applied towards your Health and Welfare benefit.
The maximum amount credited to your Health and Welfare would be 780.
Calculation: 26 weeks maximum equals 130 days, times 6 credits per day resulting in 780 credits.

Please note that the same calculation applies to the Pension benefit. However only 501 hours are applied towards the Pension benefit. Those hours will be credited for purposes of determining your vested service. You will not earn an accrual.

For purposes of this Section, you shall be entitled to this benefit if New York State Disability, Workers' Compensation or the Federal Social Security Act deems you disabled. Furthermore, your disability must have occurred while you were eligible for coverage under this Plan and you must be under the care of a legally qualified physician. Disability due to self-inflicted injury, substance abuse, or war is not covered.

XV
COORDINATION OF BENEFITS (COB)

Coordination of Coverage. This Plan has been designed to help the Employee meet the cost of sickness or injury. It is not intended that the Employee receive greater benefits then the actual covered expenses incurred. Therefore, any coverage he has under "other plans" will be taken into account in determining the amount of benefits payable under this Plan; that is, the benefits under this Plan will be coordinated with the benefits of the other plans (excluding life and disability income).

Order of Claim Determination. This Plan will always pay either its regular benefits in full, or it will pay a reduced amount which, when added to the benefits payable and the cash value of any services provided by the "other group plans" will equal 100% of the "Allowable Expenses" incurred by the person for whom the claim is being made. "Allowable Expenses" means any necessary and

reasonable medical expense, part or all of which is covered under any of the "other plans" covering the person for whom the claim is made.

Allowable expenses do not include any expenses listed in the benefits or services not provided. To administer this provision properly, and to determine whether this Plan will reduce its regular benefit, it is necessary to determine the order in which the various group plans will pay benefits. The rules for establishing the order of all claim determinations are as follows:

(a) A plan with no provision for coordination of other benefits will be considered to pay its benefits before a plan, which contains such a provision.

(b) A plan, which covers a person other than as a Dependent, will be considered to pay its benefits before a plan, which covers the individual as a Dependent.

(c) Where both parents' plans cover Dependents, the primary plan becomes the plan of the parent whose birthday (month and day only) falls earlier in the Calendar Year.

(d) Where (a), (b) and (c) above do not establish the order of payment, the plan under which the person has been covered for the longer period of time will be considered to pay its benefits before the other.

(e) When the parents are separated or divorced and the parent with the custody of the child has not remarried, the benefits of a plan which covers the child as a Dependent of the parent with custody of the child will be utilized before the benefits of a plan which covers the child as a Dependent of the parent without custody.

(f) When the parents are divorced and the parent with custody of the child has remarried:

(i) The benefits of a plan, which covers the child as a Dependent of the parent with custody shall be utilized before the benefits of a plan, which covers the child as a Dependent of the stepparent.

(ii) The benefits of a plan, which covers that child as a Dependent of a stepparent, will be utilized before the benefits of a plan, which covers that child as a Dependent of the parent without custody.

(iii) A court decree assigning financial responsibility overrides the previous rules. The Fund has the right to release or obtain any information or make or recover any payments it considers necessary in order to administer this provision.

Other Plans. The term "Other Plans" means:

(a) Any group insurance, franchise, Blue Cross/Blue Shield, or other service or prepayment plan arranged through any employer, trustee, union or Employee benefit association,
(b) Any Federal, State, City or other governmental plan or law, or
(c) Any automobile insurance coverage under which benefits are payable pursuant to a "no fault" motor vehicle law. This definition does not include individual policies. When a plan provides benefits in the form of services, rather than cash payments, the reasonable cash value of each

service rendered shall be deemed to be both a covered expense and a benefit paid. Benefits payable under other plans include the benefits that would have been payable had the claim been duly made.

XVI
AMENDMENT AND TERMINATION

The Trustees may amend, modify or terminate the Plan, in whole or in part, at any time for any reason. Any amendment may reduce or eliminate any benefit provided under the Plan. There are no circumstances in which you will become vested or have a non-forfeitable right to any Plan benefit discussed herein.

The Trustees have established this Plan with the intent that it will be maintained for an indefinite period of time. However, the funding for the Plan is conditioned on a Collective Bargaining Agreement remaining in effect that provides for continued Employer Contributions to the Fund. Therefore, the Trustees reserve the right to terminate the Plan, in whole or in part, at any time.

XVII
FAMILY AND MEDICAL LEAVE ACT (FMLA)

If you are eligible for, and granted leave by your Employer, under the Family and Medical Leave Act of 1993 (FMLA) you shall be entitled to health and hospitalization insurance coverage under this Plan for the duration of the leave. You shall receive the type of coverage (i.e., family or single) you were receiving immediately prior to your leave. Your Employer agrees to certify to your eligibility for FMLA leave and shall provide the Trustees with such additional information as they may reasonably request to verify your eligibility for continued health coverage hereunder, including any medical certifications as may be requested by your Employer under the FMLA and regulations thereunder. FMLA allows up to twelve weeks of unpaid leave and requires your Employer to maintain health care coverage during that time.

If you fail to return to work after your FMLA leave entitlement has been exhausted or expires, your Employer may request reimbursement for the cost of maintaining your insurance, unless the reason you do not return is due to:

(a) The continuation, recurrence, or onset of a serious health condition, which would entitle you to leave under FMLA; or

(b) Other circumstances beyond your control.

XVIII
COBRA CONTINUATION COVERAGE

Continuation Coverage. In 1986, a Federal Law was enacted (Public Law 99-272, Title X) — the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA") — requiring that most employers sponsoring group heath plans offer Employees and their families the

opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end (called "qualifying events"). This notice is intended to inform you, in a summary fashion, of your rights and obligations with respect to continuation coverage under the Plan.

You should review the following information carefully and share it with your covered Dependents. Please remember that COBRA rights are provided only as required by law. Your rights may change in the event that the COBRA law changes.

1. When Are You Eligible for COBRA Coverage

You have a right to choose continuation coverage if you lose your eligibility for group health coverage by virtue of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an Employee covered by the Plan, you have the right to choose continuation coverage for yourself if you lose group health coverage under the Plan for any of the following reasons:

- the death of your spouse;
- a termination of your spouse's employment (for reasons other than gross misconduct) or a reduction in your spouse's hours of employment;
- divorce or legal separation from your spouse; or
- your spouse becomes entitled to Medicare (Part A or Part B).
- If you are the Dependent child of an Employee covered under the Plan, you have the right to choose continuation coverage if you lose group health coverage under the Plan for any of the five following reasons:
- the death of the Employee-parent;
- the termination of the Employee-parent's employment (for reasons other than gross misconduct) or a reduction in the Employee-parent's hours of employment with the Employer;
- parents' divorce or legal separation;
- the Employee-parent becomes entitled to Medicare (Part A or Part B); or
- you cease to be an eligible Dependent child under the terms of the Plan.

For purposes of this Section, a termination of employment (for reasons other than gross misconduct) will be considered a Qualifying Event as of the date your coverage is actually lost under the Plan.

2. What You Must Do to Obtain COBRA Coverage

Under the law, the Employee or family member has the responsibility to inform the Fund Office of a divorce, legal separation or a child losing Dependent status under the Plan within 60 days of the date of the event or the date on which coverage would end under the Plan because of the event, whichever is later.

Your Employer has the responsibility to notify the Fund Office of your death, termination of employment, reduction in hours of employment or Medicare entitlement. (However, you or your

family should also notify the Fund Office if such an event occurs in order to avoid confusion as to your status.)

When the Fund Office is notified that a qualifying event has happened, the Fund Office will notify you and/or your spouse or Dependent children of the right to choose continuation coverage and the manner in which to do so.

Under the law, if your (or your family member's) coverage will terminate because of an event described above, you (or your family members) must inform the Fund Office that you want continuation coverage within 60 days from the later of (i) the date you ordinarily would have lost coverage because of one of the events described above, or (ii) the date of the notice of your right to elect continuation coverage. If you (or your family members) do not properly and timely choose continuation coverage, your group health insurance coverage under the Plan will end.

Under the law, you may have to pay all or part of the premium for your continuation coverage. During the initial 18 or 36-month period of continuation coverage, you will have to pay 102% of the applicable premium for your continuation coverage. However, during the additional 11 months of continuation coverage for disability, the Plan may charge up to 150% of the applicable premium for such continuation coverage.

You will be required to make the first premium payment retroactive to the date your benefits ended under the Plan. Your first payment must be made within 45 days after you elected to continue coverage. All subsequent payments will be due on the first of each month for that month's coverage. The Fund Office will notify you if the monthly premium amount changes. If payment of amounts due is not timely made, continuation of coverage will cease as of the end of the last month for which you timely paid. You may apply your Medical Reimbursement Account to the payment of monthly Cobra premiums until you have exhausted your account. You can then continue Cobra coverage for the allowable period of time on a self-pay basis.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under the law is provided subject to your eligibility for coverage under the Plan. The Plan Administrator reserves the right to terminate your continuation coverage retroactively if you are determined to be ineligible.

Continuation coverage may be elected for some members of the family and not others. In addition, one or more eligible Dependents may elect COBRA even if the Employee does not elect it. However, in order to elect COBRA Continuation Coverage, the members of the family must have been covered by the Plan on the date of the qualifying event (except in certain cases of added Dependents, see the following section). A parent may elect or reject COBRA Continuation Coverage on behalf of Dependent children living with him or her. However, Dependent children have an independent right to elect COBRA Continuation Coverage if the parent does not elect coverage for the child.

3. Acquiring a New Dependent(s) while Covered by COBRA

Qualified COBRA beneficiaries are entitled to exercise the same rights to enroll Dependents under the Plan as are similarly situated active Employees who have not had a qualifying event.

In addition, if you acquire a new Dependent through marriage while you are enrolled in COBRA continuation coverage, you may add the spouse to your coverage for the balance of the COBRA period. For example, if you have five months of COBRA left and you get married, you can enroll your new spouse for up to five months of COBRA coverage. You must notify the Plan within 30 days of acquiring the new spouse.

In addition, a child who is born to or placed for adoption with a covered Employee during the period of the Employee's continuation coverage is a "qualified beneficiary" and generally is eligible to be enrolled immediately for COBRA continuation coverage under the Plan. You must notify the Fund Office within 30 days after you acquire a new Dependent. Once the child is enrolled pursuant to the Plan's rules, he or she will be treated like all other COBRA qualified beneficiaries with respect to the same qualifying event. The maximum coverage period for such a child is measured from the same date as for other qualified beneficiaries with respect to the same qualifying event (and not from the date of the birth or adoption).

If COBRA coverage ceases for you before the end of the maximum 18, 29, or 36-month COBRA coverage period, COBRA coverage also will end for any newly added spouse. However, since newborn children or children newly placed for adoption are qualified beneficiaries in their own right, COBRA coverage can continue for such children of an Employee until the end of the maximum COBRA coverage period if the required premiums are timely paid. Check with the Fund Office for more details on how long COBRA coverage can last for these children.

To enroll your new Dependent for COBRA coverage, you must notify the Fund Office in writing. There may be a change in your COBRA premium amount in order to cover the new Dependent.

4. Benefits Under and the Duration of COBRA Coverage

Coverage may continue for:	If:	Maximum length of COBRA coverage:
You and your eligible Dependents	Your employment ends for any reason (except for gross misconduct)	Up to 18 months (29 months if you or your eligible Dependent is disabled)*
You and your eligible Dependents	You no longer meet the Fund's eligibility requirements due to insufficient covered hours	Up to 18 months (29 months if you or your eligible Dependent is disabled)*
Your eligible Dependents	You die	Up to 36 months
Your eligible Dependents	You are divorced or legally separated	Up to 36 months
Your eligible Dependents	You become eligible for Medicare	Up to 36 months
Your covered Dependent children	Your covered Dependent child no longer qualifies as an eligible Dependent under the Plan	Up to 36 months

* See below for more specific information regarding extensions of the COBRA period on account of disability.

This chart provides basic information regarding COBRA continuation coverage. Important details regarding such coverage are set forth in this section.

If you choose continuation coverage, you are entitled to coverage that is identical to the coverage being provided under the Plan to similarly situated non-COBRA beneficiaries for the types of benefits for which COBRA coverage is available. If group health coverage is lost because of a termination of employment or reduction in hours of employment, the law requires that qualified beneficiaries be afforded the opportunity to maintain continuation coverage for up to 18 months from the date of the initial qualifying event. In the case of other qualifying events, qualified beneficiaries will be afforded the opportunity to maintain continuation coverage for up to 36 months from that time. These maximum COBRA periods may be extended or reduced as described below.

5. Extension of the COBRA Coverage Period

An 18 month period of continuation coverage may be extended for up to 11 months (up to 29 months in total) if the qualified beneficiary has been determined to be disabled (under Title II or XVI of the Social Security Act) as of the date of the Employee's termination, reduction in hours or within the first 60 days of continuation coverage (or, in the case of a newborn child or child newly placed for adoption, within 60 days of birth or placement for adoption) and if the Fund Office is

timely notified within 60 days of such determination (and within the initial 18 month continuation coverage period).

This 11-month extension applies to all disabled and non-disabled qualified beneficiaries entitled to COBRA continuation coverage as a result of the same qualifying event, subject to the above notice requirements.

Additional qualifying events can occur while continuation coverage is in effect. Such events may extend an 18 or 29 month period of continuation coverage to a period of up to 36 months, but in no event will coverage extend beyond 36 months after the time coverage would otherwise have terminated as a result of the initial qualifying event. This extended coverage is not available to anyone who became your spouse after the termination of employment or reduction in hours. However, it is available to children born to, adopted by or placed for adoption with you (the active Employee) during the initial 18-month period of continuation coverage.

Subsequent termination of employment following reduction in hours of employment will not be treated as a second qualifying event. You should notify the Fund Office immediately if a second qualifying event occurs during your continuation coverage period.

6. Why Your COBRA Coverage May End Early

The law also provides that your continuation coverage may be cut short prior to the expiration of the 18, 29 or 36 month period for any of the following five reasons:

- The Plan no longer provides group health coverage.
- The premium for your continuation coverage is not timely paid. In such case, your coverage will terminate as of the last day of the last period for which a contribution was timely paid.
- The individual first becomes covered, after electing COBRA coverage, under another group health plan (as an Employee or otherwise) that (i) does not contain any preexisting condition exclusion or limitation applicable to the individual, or (ii) contains a preexisting condition exclusion or limitation, but it does not apply to the individual because he or she has been credited with prior creditable coverage for the duration of the exclusion or limitation period.
- The individual becomes entitled to Medicare Part A or Part B (provided that such entitlement occurs after the COBRA election).
- Coverage has been extended for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled. You are required to notify the Fund Administrator within 30 days of any such final determination. In such case, coverage will end as of the month that begins at least 30 days following such determination.

Once your continuation coverage terminates for any reason, it cannot be reinstated.

XIX
UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Purpose. Congress enacted the Uniformed Services Employment and Reemployment Rights Act (USERRA) on December 12, 1994. The purpose of USERRA is to encourage non-career service in the Uniformed Services, to provide for the prompt reemployment of persons who serve in the uniformed services and to prohibit discrimination against such persons.

Definitions. The terms listed below have special meanings relevant to this section.

Service in the Uniformed Services. The phrase "Services in the Uniformed Services" will mean the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

Uniformed Services. The term "Uniformed Services" will mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

Health Care Coverage. In the event that you are absent from work due to Service in the Uniformed Services you will be entitled to continue your health care coverage for you, your spouse and your eligible Dependent's for the lesser of –

- 24 months beginning on the day your absence of employment begins;
- the day after you fail to notify your Employer of your intent to return to work; or
- the day after you fail to return to a position of employment.

Premiums. If you choose to continue coverage for the length of your Service in the Uniformed Services you will be required to pay 102% of the full premium under the Plan. You will not be required to pay such premium if your length of service is less than 31 days. For detailed information on premium amounts and application for such coverage, please contact the Fund Administrator.

Notification of Intent to Return to Work. It is important that you notify your employer of your intent to return to work within specified time periods. The time periods and notification requirements are specified below:

LENGTH OF SERVICE	NOTIFICATION REQUIREMENTS
30 days or less	Notification must occur no later than the beginning of your first full, regularly scheduled workday. Under special circumstances this time period may be extended to as soon as possible after the expiration of eight (8) hours of your first full, regularly scheduled workday.
31 days – 180 days	Notification must occur no later than 14 days after the completion of your length of service. Under special circumstances this time may be extended.
181 days or more	Notification must occur no more than 90 days after the completion of your length of service.

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ADDITIONAL PLAN INFORMATION

A. Medical Child Support Orders.

The Plan will provide benefits to a Dependent child pursuant to the requirements of any court order (including a National Medical Child Support Notice) that the Plan Administrator determines meets the requirements of a qualified medical child support order as defined in Section 609 of the Employee Retirement Income Security Act of 1974. A copy of the Plan's procedure for dealing with these orders is available for your review at the Fund office.

B. Certificates of Creditable Coverage.

When you (and your covered Dependents') coverage under the Plan ends, the Plan will issue a Certificate of Creditable Coverage to each individual or family member whose coverage under the Plan ends. The Certificate provides the documentation of prior coverage and/or waiting periods that you and/or your family may need to reduce pre-existing condition limitations when enrolling in a new employer-sponsored health plan.

The Plan must provide you with a Certificate:

- when you lose coverage under the Plan or COBRA continuation coverage terminates; or
- if requested, before losing coverage or within 24 months of losing coverage.

The Certificate of Creditable Coverage indicates:

- if you and/or your family had up to 18 months of creditable coverage under the Plan;
- the coverage start date (along with any eligibility waiting period); and
- the coverage end date under the Plan.

If, within 62 days after your coverage under the Plan ends, you and/or your eligible Dependents become eligible for coverage under another group health plan, or if you buy an individual insurance policy, the Certificate of Coverage may be necessary to reduce a pre-existing limitation or limitation period that may apply under that plan.

For a copy of your and/or your eligible Dependent's Certificate of Creditable Coverage, contact the Plan Administrator.

C. Your Rights Under ERISA

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites 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 Pension and Welfare Benefit Administration.

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 administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under the Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from the Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a 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 materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits, 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 form the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

D. Claims Process

You or your Provider must submit a claim form before reimbursement for an eligible expense can be paid. Claim forms are available from the Fund Office.

When submitting a claim form, include:

(1) The Fund's name, and
(2) Your name, and
(3) Your Alternate Identification Number from your Benefit Identification Card or your Social Security Number, and
(4) The full name of the individual receiving treatment, and
(5) An itemized bill reflecting a diagnosis, and
(6) When the claim is the result of an accident, note the time and date of the accident and include a one or two sentence description of the circumstances.
(7) When you or your Dependent is covered under more than one health plan, and medical coverage under the other plan is primary, submit the claim to the other plan first. Then, submit a copy of the "explanation of benefits" from the other plan when submitting the claim to the Claim Administrator.

Payments will be made directly to Preferred Providers. All other payments will be made to you unless there is an assignment of benefits on the claim. Submit claim forms to the Fund Administrator at:

2800 Clinton Street
West Seneca, New York 14224
(716) 828-0488 / (800) 905-0904

KEEPING THE CLAIM FILE CURRENT

To avoid delays in processing claims notify the Fund Office at once:

(1) Of an additional eligible Dependent, or
(2) If a Dependent(s) is no longer eligible, or
(3) If there is a change of address, or
(4) If other coverage is elected or lost, or
(5) If a Dependent Student is registered (every semester) for full-time attendance, or
(6) If a Dependent Student or Child becomes incapable of self-sustaining employment.

Effective January 1, 2003 the following claims procedures shall apply. You should follow these procedures for any claim you submit to the Fund Administrator on or after January 1, 2003.

All of the benefits under this Plan are considered self-insured and are paid directly from the assets of the Fund. Each type of claim, as well as, the procedures to follow when filing a claim is as follows:

Disability and Death Benefit Claims

Claims for benefits shall be made to the Fund Administrator in writing and shall set forth the basis of the claim and shall authorize the Fund Administrator to conduct such examinations as may be necessary to facilitate the payment of any benefits to which you may be entitled under the terms of the Plan.

The Fund Administrator shall notify you within forty-five (45) days after receipt of a claim for disability benefits if the claim has been denied or modified. If the Fund Administrator determines that an extension of time is necessary for processing the claim (due to circumstances beyond the control of the Fund), the 45-day period will be extended for an additional 30 days, if additional time is still needed to make a determination, there may be an additional extension of 30 days. In such case the Fund Administrator must notify you (within the initial 45-day period or prior to the expiration of the first 30-day extension) of the circumstances requiring the extension, the date by which the Plan expects to render a determination, the standard, on which entitlement to benefits is based, the unresolved issues that prevent a decision on the claim and additional information needed to resolve those issues. You will have 45 days from receipt of the notice to provide the Fund Administrator with any additional information needed.

Prescription Drug Claims

You should present your health care identification card whenever you go to the pharmacy. This will ensure the pharmacy has the correct information to submit your prescription claim. When the pharmacy does not file the claim for you, the charges should be submitted directly to ProAct, using the form provided.

Claims are due within 12 months of the date of service. Claims received after the one-year period will be denied unless you can show that it was not possible to provide such notice of claim within the required time and that the claim was filed as soon as reasonably possible.

ProAct provides written notice of the appeal procedure to you every time coverage is denied or when it determines that a requested benefit is not covered under the terms of the plan.

This written notice explains the process for filing an appeal, the timeframes within which an appeal decision must be made, what information is necessary to render a decision on an appeal, and your right to designate a representative to file an appeal on your behalf.

Contact information for ProAct together with the address for filing a claim, are set forth in Article II.C., above.

The claims procedure is as follows:

Health Benefit Claims

Under ERISA §503 health benefit claims are divided into four categories. Different time lines and processing apply to each category. Listed below is a description of each category and the procedures to follow when filing a claim. All claims, no matter what category they are in, shall be made to the Claims Administrator in writing and shall set forth the basis of the claim and shall authorize the Claims Administrator to conduct such examinations as may be necessary to facilitate the payment of any benefits to which you may be entitled under the terms of the Plan.

Urgent Care Claims

The term "Urgent Care Claim" means a claim for medical treatment or care, which, if denied could seriously jeopardize your health or life or your ability to regain maximum function, or, in the opinion of a physician who has knowledge of your medical condition would subject you to severe pain that cannot be adequately managed without the care or treatment that is subject to the claim.

The Claims Administrator will notify you of the determination (whether adverse or not) within 72 hours after receipt of your claim, provided there is sufficient information to make a determination. In such case the Claims Administrator will notify you of your failure to provide sufficient information within 24 hours after he/she receives your claim. You will have 48 hours from receipt of this notice to provide the information needed. Once a determination is made, the Claims Administrator will notify you of the determination no later than 48 hours after receipt of the required information or, if you fail to provide the required information, the end of the 48-hour period you were given to provide such information. The Claims Administrator may orally notify you of the determination. If notification is provided orally, you will receive written notification within 3 days after such oral notification.

Pre-Service Claims

The term "Pre-Service Claim" means any claim for benefits that is made prior to receiving medical care or treatment.

The Claims Administrator will notify you of the determination (whether adverse or not) within 15 days after receipt of your claim. Under special circumstances this time frame may be extended one time for an additional 15-day period. In such case the Claims Administrator will notify you of the extension prior to the end of the initial 15-day period. Such notification will include the special circumstances requiring the extension and the date by which the Plan expects to render a determination. If extension of time is needed because of your failure to provide sufficient

information to make a determination, the Claims Administrator will notify you of your failure no later than 5 days after receipt of your claim. Such notification may be oral, unless you or your authorized representative request it in writing, and will specify all information needed to make a determination. You will have 45 days from the date you receive notification to provide the required information.

Post-Service

The term "Post-Service Claim" means any thing other than a Pre-Service Claim.

If your Post-Service Claim is denied in whole or in part, the Claims Administrator will notify you in writing within 30 days after receipt of your claim. Under special circumstances this time may be extended one time for an additional 15-day period. The Claims Administrator will notify you of the extension in writing prior to the expiration of the initial 30-day period. Such notification will include the special circumstances requiring the extension and the date by which the Plan expects to render a determination. If extension of time is needed because of your failure to provide sufficient information to make a determination, the notification will specify all required information. You will have 45 days from your receipt of the notification to provide such information.

Concurrent Care Claims

In the event that the Plan has approved a benefit for ongoing care or treatment (Concurrent Care) and later notifies you that your benefits are going to be terminated or reduced (for reasons other than by Plan amendment or termination) the Plan will notify you of such adverse benefit determination prior to the reduction or termination of your benefit.

If you would like to extend the course of treatment you are receiving beyond the approved period of time or number of treatments, for claims involving urgent care, you may submit a claim to the Claims Administrator at least 24 hours prior to the expiration of the approved period of time or number of treatments. The Claims Administrator will make a determination as soon as possible but no later than 24 hours after receipt of your claim.

Notification Requirements

The Claims Administrator will notify you of the determination of your claim within the specified time limits mentioned above. With regards to all initial benefit claims such notification can be oral (with regards to an urgent care claim), in writing or electronically transmitted and contain the following information:

- The specific reason or reasons for the adverse benefit determination;
- Reference to the specific Plan provisions on which the determination is based;
- A description of any material or information necessary for you to perfect the claim and an explanation of why such information is necessary;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of the Act following an adverse benefit determination on review.

- If an internal rule, guideline, protocol, or other similar criteria was used in making the adverse benefit determination; specify what was used and that it will be provided to you free of charge upon request; and

- If adverse benefit determination is based on a medical necessity or experimental treatment, the Plan must provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;

- If an adverse benefit determination concerning an urgent care claim, the Plan must include the expedited review process in the notice.

E. Claims Review Procedure

Effective January 1, 2003 the following claims review procedures shall apply. You should follow these procedures when filing an appeal on a decision regarding your benefit determination on or after January 1, 2003.

Disability and Death Benefit Claims

If your claim is denied (in whole or in part), you shall thereafter have one hundred eighty (180) days within which to appeal the Claims Administrator's determination to the Trustees. Such appeal shall be in writing, shall be delivered to the Trustees, and shall specify in detail the basis for the objection to the Claims Administrator's determination. The Board of Trustees shall thereby afford you or your duly authorized representative the opportunity to review (free of charge) all documents, records and other information pertinent to the claim, to submit issues and comments in writing and discuss such documents and issues with the Trustees; and

The Trustees shall act upon the appeal as soon as possible but no later than the date of the first Board meeting following the date the Plan receives a request for review, unless the request for review is filed within thirty (30) days prior to the date of such meeting. In such case, a determination will be made no later than the date of the second Board meeting following the date the Plan receives a request for review. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, the Claims Administrator shall notify you in writing describing the special circumstances and the date by which a determination will be rendered. The determination shall be rendered no later than the date of the third Board meeting following the date the Plan receives a request for review. The Claims Administrator shall notify you of the Trustees determination as soon as possible but no later than five (5) days after the determination is made.

Health Benefits

Urgent Care

Within 180 days after your claim is denied, you may request a review of your claim through oral or written communication to the Claims Administrator.

Any such request may be made orally or in writing and should be accompanied by documents or records in support of your appeal. You or your authorized representative may review pertinent documents free of charge and submit pertinent issues and comments orally, in writing, through facsimile or other electronic means. The Claims Administrator will notify you of the determination within 72 hours after receipt of your appeal.

Pre-Service Claims

Within 180 days after your claim is denied, you may submit your claim for reconsideration to the Claims Administrator.

Any such request should be made in writing and accompanied by documents or records in support of your appeal. You or your authorized representative may review pertinent documents free of charge and submit pertinent issues and comments in writing. The Trustees will review the appeal and provide you with their determination no later than 30 days after receipt of your appeal.

Post-Service Claims

Within 180 days after denial, you or your authorized representative may submit a written request for reconsideration of your claim to the Claims Administrator.

Any such request should be made in writing and accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents free of charge and submit pertinent issues and comments in writing. The Trustees will review the claim and provide, as soon as possible but no later than the date of the first Board meeting following the date the Plan receives your request for review, a determination. If your request for review is filed within thirty (30) days prior to the date of such meeting a determination will be made no later than the date of the second Board meeting following the date the Trustees receive your request for review. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, the Claims Administrator will notify you in writing describing the special circumstances and the date by which a determination will be rendered. The determination will be made no later than the date of the third Board meeting following the date the Trustees receive your request for review. The Claims Administrator will notify you in writing of the Trustees determination as soon as possible but no later than five (5) days after the determination is made. In this response, the Trustees will explain the specific reason for the determination, with specific reference to the provisions of the Plan on which the decision is based.

Concurrent Care Decisions

In the event that your appeal is with regards to a concurrent care decision, you will follow the procedures listed above as they apply. For instance if you are appealing a claim concerning urgent care you would follow the appeals procedures for urgent care claims.

In rendering a determination of your appeal the Trustees will consult with a health care professional that has appropriate training and experience in the field of medicine pertinent to your claim. Such health care professional will not have been involved in the determination of your initial claim for benefits. The Trustees will make their determination based in whole or in part on such health care professionals' medical judgment. If the Trustees make and adverse benefit determination with regards to your appeal, you have the right to request the identification of any

medical or vocational expert whose advice was obtained, without regard to whether or not the Trustees relied on this advice to make their determination.

Notification Requirements

The Claims Administrator will notify you of the determination of your claim within the specified time limits mentioned above. Such notification shall include all of the information described in **E.** above, as well as a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents. In addition to this requirement, notification with regards to an appealed claim shall also include the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance agency."

F. Cooperation

Every claimant will furnish to the Trustees all such information in writing as may be reasonably requested by them for the purpose of establishing, maintaining and administering the Plan, the failure on the part of the claimant to comply with such requests promptly and in good faith will be sufficient grounds for delaying payment of benefits. The Trustees will be sole judges of the standard of proof required in any case, and they may from time to time adopt such formulae, methods and procedures, as they consider advisable.

G. Right to Reclaim Overpayment or to Offset

If this Fund has benefits in excess of the amount required under the terms of the Plan, then it may recover the overpayment from you and/or your Dependent(s), or any relevant person, company, or organization. In such a case, you and your Dependent(s) must sign any document which the Trustees determine is needed to help the Fund recover its over-payment and otherwise make good faith attempts to assist the Fund in such recovery. Additionally, if the payment is made to you or your Dependent (or on your behalf) in error, you or your Dependant must repay the amount of the erroneous payment to the Fund. If the Fund owes you or your Dependent a payment for other claims incurred, then it has the right to subtract the amount you or your Dependent owe it from any payment it owes you or your Dependent.

H. RESPONSIBILITIES OF THE FUND ADMINISTRATOR

Named Fiduciaries: The named fiduciaries of this Plan shall be:

(1) The Trustees, and
(2) The Fund Administrator.

The named fiduciaries shall have separate authority to control and manage the operation and administration of the Plan. Every fiduciary and other person who handles funds or other property of this Plan shall be bonded in accordance with Section 412 of ERISA.

Advisors to Fiduciaries: A named fiduciary or his/her delegate may employ actuaries, attorneys, accountants, brokers, employee benefit consultants, and other specialists to give advice concerning any responsibility such fiduciary has under this Plan.

Appointment of Fund Administrator: The Fund Administrator is appointed by the Trustees.

Duties of the Fund Administrator: The Fund Administrator has the authority and responsibility to:

(1) Determine if an individual is eligible for benefits under the Plan and the amount of those benefits, and
(2) Call and attend the meetings at which this Plan's contribution policy is established and reviewed, and
(3) Establish the policies, interpretations, practices and procedures of this Plan, except to the extent such responsibility has been allocated to the Claim Administrator or retained by the Trustees, and
(4) Hire the Claim Administrator and all persons providing services to the Plan, and
(5) Authorize payment of the Plan's administrative expenses, and
(6) Transmit written instructions to the Trustees concerning the management (including the acquisition or disposition) of insurance policies acquired to provide stop-loss coverage for the benefits provided under the Plan. The Fund Administrator shall be under no obligation to acquire such coverage on behalf of the Plan, and
(7) Act as this Plan's agent for the service of legal process, and
(8) Perform all other responsibilities allocated to the Fund Administrator in the instrument appointing the Fund Administrator, and
(9) Comply with the requirements imposed upon the Fund Administrator under the COBRA continuation coverage provisions and applicable regulations, and
(10) Comply with ERISA's reporting and disclosure requirements, and
(11) Receive all disclosures required of fiduciaries and other service providers under ERISA or any other federal or state law.
(12) Comply with the HIPAA Privacy Regulation to ensure compliance with regard to the use and disclosure of any Covered Family Member's Protected Health Information.

Discretion of Named Fiduciaries:

(1) The Fund Administrator and the Trustees shall have the absolute authority and discretion to construe any uncertain or disputed term or provision in the Plan. This includes, but is not limited to, the following:

    (A) Determining whether an individual is eligible for benefits under this Plan, and
    (B) Determining the amount of benefits, if any, an individual is entitled to under this Plan, and
    (C) Interpreting all of the provisions of this Plan, and
    (D) Interpreting all of the terms used in this Plan.

(2) The Named Fiduciaries' exercise of this discretionary authority shall:

    (A) Be binding upon all interested parties, including, but not limited to, the Covered Family Member, the Covered Family Member's estate, any beneficiary of the Covered Family Member and the Employer, and

(B) Be entitled to deference upon review by any court, agency or other entity empowered to review the Fund Administrator's decisions, to the fullest extent permitted by law, and

(C) Not be overturned or set aside on such review, unless found to be arbitrary and capricious, or made in bad faith.

Funding Policy: The Fund Administrator and Employer shall establish a funding policy and method consistent with the objectives of the Plan and the requirement of Title I of ERISA. The funding policy and method shall be reviewed at the Trustees' discretion. In establishing and reviewing the funding policy and method, the responsible persons attending the meeting shall endeavor to determine the Plan's short-term and long-term objectives and financial needs, taking into account the need for liquidity to pay benefits. All actions taken pursuant to this section and the reasons for such action shall be recorded in the minutes of any meeting. Such minutes shall be filed with the Trustees.

Fund Administrator Indemnity: To the extent permitted by ERISA and the Code in the event and to the extent not insured by any insurance company, the Trustees shall indemnify and hold harmless the Fund Administrator and any assistants or representatives from any and all claims, demands, suits or proceedings in connection with the Plan that may be brought by Employees, Dependent(s), or their beneficiaries or legal representatives, or by any other person, corporation, entity, or government agency thereof; provided, however, that such indemnification will not apply to any such person for such person's acts of willful or grossly negligent misconduct in connection with the Plan, or for breaches of their fiduciary obligations or duties, as described under ERISA.

Co-Fiduciary Liability: No fiduciary shall have any liability for a breach of fiduciary duty of another fiduciary, unless he participates knowingly in such breach, knowingly undertakes to conceal such breach, has actual knowledge of such breach and fails to take action to remedy such breach, or, through his negligence in performing his own specific fiduciary responsibilities, he has enabled such other fiduciary to commit a breach of the latter's fiduciary duty.

I. RESPONSIBILITIES OF THE CLAIM ADMINISTRATOR

Appointment of the Claim Administrator: The Claim Administrator shall be appointed by the Trustees.

Claim Administrator's Responsibilities: A Claim Administrator's authority and responsibility shall be limited to that portion of the Plan that it has been authorized by the Trustees to administer. The Claim Administrator shall have the authority and responsibility to:

(1) Interpret this Plan's provisions relating to coverage except where the Claim Administrator requests an interpretation or the Plan Administrator exercises its authority on its own volition. In said case, the Plan Administrator shall interpret the Plan and shall communicate in writing to the Claim Administrator the appropriate interpretation of the Plan.

(2) Administer this Plan's claim procedure.

(3) Pay benefits under the Plan by drawing checks against the claim account.
(4) Advise or otherwise assist the Trustees in connection with the purchase of stop-loss coverage, if any, for the benefits provided under the Plan.
(5) File claims with the insurance companies, if any, who issue stop-loss insurance policies to the Trustees
(6) Perform all other responsibilities delegated to the Claim Administrator in the instrument appointing the Claim Administrator.
(7) Adhere to the HIPAA Privacy Regulation applicable to a Business Associate by complying with the provisions of the Business Associate agreement.

J. Third Party Liability Cases

NOTE: This provision applies to all Employees and Retirees and their covered Spouses and Dependents, with respect to all of the benefits provided under this Plan. For the purpose of this provision, the term "Claimant" refers to all Employees, Retirees, covered Spouses, and covered Dependents.

1. General

Occasionally, a third party may be liable for a Claimant's medical expenses. This may occur when a third party is responsible for causing a Claimant's illness or injury or is otherwise responsible for the medical bills. The rules in this Section govern how this Plan pays benefits in such situations.

These rules have two purposes. First, the rules insure that the Claimant's benefits will be paid promptly. Often, where there is a question of third party liability, many months pass before the third party actually pays. These rules permit this Plan to advance the Claimant's covered expenses until his dispute with the third party is resolved.

Second, the rules protect this Plan from paying the full expenses in situations where a third party is liable. Under these rules, once a settlement, judgment or agreement is reached or it is determined that a third party is liable in any way for the injuries giving rise to these expenses, the Plan must be reimbursed for the relevant benefits advanced to the Claimant out of <u>any</u> recovery whatsoever that he receives that is in any way related to the event which caused him to incur the medical expenses.

Reimbursement to the Plan shall take place regardless of whether the recovery is characterized as being for medical expenses for which benefits were paid. Any amounts received must be applied first to reimburse the Fund for the amount of medical expenses paid on behalf of the Claimant. Where the recovery is partial or incomplete, the Fund's right to reimbursement takes priority over the Claimant's right to recovery, regardless of whether the claimant has been made whole for his or her injuries or losses. Except to the extent required by law, the Fund's right to reimbursement is not reduced by any attorneys' fees, court costs or disbursements that a Claimant might incur in a recovery action. You and/or your attorney must notify and consult with the Fund Administrator before commencing any legal action or administrative proceeding that may relate to or involve any recovery of any payments of Plan benefits and must subsequently keep the Fund Administrator apprised in writing of the status of (and material developments with respect to) the third-party action. Additionally, you and/or your attorney agree that, prior to any settlement of the third-party matter; the Fund must consent to the terms of the settlement. Your attorney must agree

that no attorney's fees, expenses or costs of any kind will reduce the Fund's lien in this matter.

2. Rights of Subrogation and Reimbursement

By law, the Plan automatically acquires any and all rights which the claimant may have against the third party. If the claimant incurs covered expenses for which a third party may be liable, he is required to advise the Plan of that fact.

In addition to its subrogation rights, the Plan has the right to be reimbursed for payments made on the Claimant's behalf under these circumstances. The Plan must be reimbursed from any settlement, judgment, or any other payment that he obtains from the liable third party, before any other expenses, including attorneys' fees, are taken out of the payment.

No Plan Benefits will be advanced unless the Claimant (or his authorized representative if he is a minor or if he can not sign), and his attorney (if any) sign a lien form acceptable to the Plan Administrator, in its sole and absolute discretion. If litigation is commenced, the Claimant must give five (5) days' prior notice to the plan of any pretrial conference, and the Plan has the right to attend any such conference. The Claimant must also notify the Plan before he retains another attorney or an additional attorney since that attorney must also execute the form. IN NO EVENT SHALL THE FAILURE OF THE TRUSTEES TO REQUIRE EXECUTION OF THE LIEN FORM DIMINISH OR BE CONSIDERED A WAIVER OF THE PLAN'S RIGHTS OF SUBROGATION AND REIMBURSEMENT.

If any disability benefits are paid by the Plan, Section 227 of the New York Workers' Compensation Law requires that the Claimant give notice to the Plan within ninety (90) days of the commencement of any action against the liable third party. The Claimant is also required to obtain the written consent of the Plan prior to the compromise of any cause of action.

3. Right of Future Subrogation and Reimbursement

In addition to satisfaction of the existing lien from any recovery received by the participant, spouse and/or Dependent, the Fund is also entitled to future credit for future related Plan expenses equal to the monies received by the participant, spouse and/or Dependent. As such, the participant, spouse and/or Dependent must spend the net recovery on related plan expense until the amount of said net recovery is exhausted. It is only at that point that the participant's spouse's and/or Dependent's claim for the related Plan benefits will again be the responsibility of the Fund pursuant to the terms of the Plan. The Fund Office will determine the net monies available for future credit.

Under certain circumstances, the Trustees may decide that you should assign your entire claim against the third party to the Fund. If the Fund recovers from the third party any amount in excess if the benefits paid to you plus the expenses incurred in making the recovery, the excess will be paid to you.

If you have any questions, please contact the Administrator.

K. No Liability for the Practice of Medicine

None of the Fund, the Plan, the Plan Administrator, nor any of their designees are engaged in the practice of medicine; nor does any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you or your Dependents by any health care provider; nor will any of them have any liability whatsoever for any loss or injury caused to you or your Dependents by any health care provider by reason of negligence, failure to provide care or treatment, or otherwise.

L. Facility of Payment

Every person receiving or claiming benefits through the Plan will be presumed to be mentally and physically competent and of age. However, in the event the Plan Administrator (or its designee) determines that the covered person is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the covered person has not provided the Fund Office with an address at which he or she can be located for payment, the Fund may pay any amount otherwise payable to such person to his spouse, relative or any other person or entity determined by the Plan Administrator (or its designee), in its sole and absolute discretion, to be equitably entitled thereto. Any such payment will discharge entirely the obligation of the Fund.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that, in part, requires group health plans to protect the privacy and security of your confidential information. As an employee welfare benefit plan under ERISA, the Roofers Local No. 74/No. 203 Welfare Plan will not use or disclose your protected health information (PHI) without your authorization, except for purposes of treatment, payment, health care operations, Plan administration or as required or permitted by law. A description of the Plan's uses and disclosures of your PHI and your rights and protections under the HIPAA privacy rules is set forth in the Plan's Notice of Privacy Practices, which is furnished to all Plan participants and can also be accessed on the Plan's internet site at: www.roofersloc74-203funds.com

A. Adequate Separation between Plan and Plan Sponsor

The Plan Sponsor will allow Fund employees access to PHI. No other persons will have access to PHI. These employees will only have access to and use of PHI to the extent necessary to perform the plan administration functions needed for successful operation of the Plan. In the event that any of these specified employees does not comply with the provisions of this Section, that employee will be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor's employee discipline and termination procedures.

The Plan Sponsor will ensure that the provisions of this section A. are supported by reasonable and appropriate security measures to the extent that the persons designated above create, receive, maintain, or transmit Electronic PHI on behalf of the Plan.

B. Conditions of Disclosure for Plan Administration Purposes

The Plan Sponsor agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR § 164.508 45 CFR § 164.508, which are not subject to these restrictions) disclosed to it by the Plan, Plan Sponsor will:

not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;

ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan, agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI;

not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

report to the Plan any use or disclosure of the PHI of which it becomes aware that is inconsistent with the uses or disclosures provided for;

make available PHI to comply with HIPAA's right to access in accordance with 45 CFR §164.524 45 CFR §164.524;

make available PHI for amendment, and incorporate any amendments to PHI, in accordance with 45 CFR § 164.526 45 CFR § 164.526;

make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528 45 CFR § 164.528;

make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;

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, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

ensure that the adequate separation between Plan and Plan Sponsor (i.e., the firewall), required by 45 CFR § 504 45 CFR § 504(f)(2)(iii), is established.

Plan Sponsor further agrees that if it creates, receives, maintains, or transmits any Electronic PHI (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508 45 CFR §164.508, which are not subject to these restrictions) on behalf of the Plan, it will:

implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

ensure that the adequate separation between the Plan and Plan Sponsor (i.e., the firewall), required by 45 CFR § 504(f)(2)(iii) 45 CFR § 504(f)(2)(iii) is supported by reasonable and appropriate security measures;

ensure that any agent, including a subcontractor, to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and

report to the Plan any security incident of which it becomes aware, as follows: Plan Sponsor will report to the Plan, with such frequency and at such times as agreed, the aggregate number of unsuccessful, unauthorized attempts to access, use, disclose, modify, or destroy Electronic PHI or to interfere with systems operations in an information system containing Electronic PHI; in addition, Plan Sponsor will report to

the Plan as soon as feasible any successful unauthorized access, use, disclosure, modification, or destruction of Electronic PHI or interference with systems operations in an information system containing Electronic PHI.

Roofers Local Union No. 74/No. 203 Welfare Plan

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This HIPAA Notice of Privacy Practices (the "**Notice**") contains important information regarding your medical information. Our current Notice is posted at 2800 Clinton Street, West Seneca, NY. You also have the right to receive a paper copy of this Notice and may ask us to give you a copy of this Notice at any time. If you received this Notice electronically, you are entitled to a paper copy of this Notice. If you have any questions about this Notice please contact the person listed in Part 8, below.

The Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**") imposes numerous requirements on employer health Plan regarding how certain individually identifiable health information – known as protected health information or PHI – may be used and disclosed. This Notice describes how the Roofers Local Union No. 74/No. 203 Welfare Plan (the "**Plan**"), and any third party that assists in the administration of the Plan, may use and disclose your protected health information for treatment, payment or health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your protected health information. "Protected health information" is information that is maintained or transmitted by the Plan, which may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you and will use it to the minimum necessary to accomplish the intended purpose of the use, disclosure or request of it. We create a record of the health care claims reimbursed under the Health Care Account for the Plan's administration purposes. This Notice applies to all of the medical records we maintain. Your personal doctor or health care provider may have different policies or notices regarding their use and disclosure of your medical information.

We are required by law to abide by the terms of this Notice to:

- Make sure that medical information that identifies you is kept private.

- Give you this Notice of our legal duties and privacy practices with respect to medical information about you.

- Follow the terms of the Notice that is currently in effect.

1. How We May Use And Disclose Medical Information About You. **HIPAA** generally permits use and disclosure of your health information without your permission for purposes of health care treatment, payment activities and health care operations. These uses and disclosures are more fully described below. Please note that this Notice does not list every use or disclosure, instead it gives examples of the most common uses and disclosures.

- **Treatment:** When and as appropriate, we may use or disclose medical information about you to facilitate medical treatment or services by providers. We may disclose medical information about you to health care providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about you with physicians who are treating you.

- **Payment:** When and as appropriate, we may use and disclose medical information about you to determine your eligibility for the Plan's benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility and coverage under the Plan, or to coordinate your coverage. For example, we may disclose information about your medical history to a physician (including your physician) to determine whether a particular treatment is experimental, investigational, or medically necessary or to decide if the Plan will cover the treatment. Additionally, we may share medical information with another entity to assist with the adjudication or subrogation of health claims or with another health plan to coordinate benefit payments.

- **Health Care Operations:** When and as appropriate, we may use and disclose medical information about you for the Plan's operations, as needed. For example, we may use medical information in connection with: conducting quality assessment and administration improvement; underwriting, premium rating and other activities relating to coverage; submitting claims for stop loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services and fraud and abuse detection programs; business planning and development such as cost management; and business management and general administrative activities of the Plan. For example, we may use your information to

review the effectiveness of wellness programs or in negotiating new arrangements with our current or new insurers. We will not use or disclose your genetic information for underwriting purposes.

We will always try to ensure that the medical information used or disclosed will be limited to a "Designated Record Set" and to the "Minimum Necessary" standard, including a "limited data set," as defined in HIPAA and ARRA (as defined in Part 3, below) for these purposes. We may also contact you to provide information about treatment options or alternatives or other health-related benefits and services that may be of interest to you.

OTHER PERMITTED USES AND DISCLOSURES

- **Disclosure to Others Involved in Your Care:** We may disclose medical information about you to a relative, a friend or to any other person you identify, provided the information is directly relevant to that person's involvement with your health care or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim and asks us to help verify the status of a claim, we may agree to help them confirm whether or not the claim has been received and paid.

- **Disclosure to Health Plan Sponsor:** Information may be disclosed to another health plan maintained by the Board of Trustees for purposes of facilitating claims payments under that plan. In addition, medical information may be disclosed to the Fund's personnel solely for purposes of administering benefits under the Plan.

- **Workers' Compensation:** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work related injuries or illness.

- **To Comply with Federal and State Requirements:** We will disclose medical information about you when required to do so by federal, state or local law. For example, we may disclose medical information when required by the U.S. Department of Labor or other government agencies that regulate us; to federal, state and local law enforcement officials; in response to a judicial order, subpoena or other lawful process; and to address matters of public interest as required or permitted by law (for example, reporting child abuse and neglect, threats to public health and safety and for national security reasons). We are required to disclose medical information about you to the Secretary of the U.S. Department of Health and Human Services if the Secretary is investigating or

determining compliance with HIPAA or to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law. We may disclose your medical information to a health oversight agency for activities authorized by law (such as audits, investigations, inspections and licensure).

- **To Avert a Serious Threat to Health or Safety:** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose medical information about you in a proceeding regarding the licensure of a physician.

- **Military and Veterans:** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

- **Business Associates:** We may disclose your medical information to our business associates. We have contracted with entities (defined as "business associates" under HIPAA) to help us administer your benefits. We will enter into contracts with these entities requiring them to only use and disclose your health information as we are permitted to do so under HIPAA.

- **Other Uses:** If you are an organ donor, we may release your medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation. We may release your medical information to a coroner or medical examiner. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your information to the correctional institution or law enforcement official.

Uses and disclosures other than those described in this Notice will require your written authorization. Your written authorization is required for: most uses and disclosures of psychotherapy notes; uses and disclosures of PHI for marketing purposes; and disclosures that are a sale of PHI. **You may revoke your authorization at any time, but you cannot revoke your authorization if the Plan has already acted on it.**

The privacy laws of a particular state or other federal laws might impose a stricter privacy standard. If these stricter laws apply and are not superseded by federal preemption rules under the Employee Retirement Income Security Act of 1974, the Plan will comply with the stricter law.

2. Your Rights Regarding Medical Information About You. You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy:** You have the right to inspect and obtain a copy of your medical information that may be used to make decisions about your benefits under the Plan.

  If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

  We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. If the Plan does not maintain the health information, but know where it is maintained, you will be informed of where to direct your request.

- **Your Right to Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

  In addition, you must provide a reason that supports your request.

  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend any of the following information:

  - Information that is not part of the medical information kept by or for the Plan.
  - Information that was not created by us, unless the person or entity that created the information is no longer available to make the amendment.
  - Information that is not part of the information which you would be permitted to inspect and copy.
  - Information that is accurate and complete.

- **Your Right to an Accounting of Disclosures:** You have the right to request an "accounting of disclosures" (that is, a list of certain disclosures the Plan has made of your health information). Generally, you may receive an accounting of disclosures if the disclosure is required by law, made in connection with public health activities, or in similar situations as those listed above as "Other permitted uses and disclosures". You do not have a right to an accounting of disclosures where such disclosure was made:

    - For treatment, payment, or health care operations.
    - To you about your own health information.
    - Incidental to other permitted disclosures.
    - Where authorization was provided.
    - To family or friends involved in your care (where disclosure is permitted without authorization).
    - For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances.
    - As part of a limited data set where the information disclosed excludes identifying information.

    To request this list or accounting of disclosures, you must submit your request, which shall state a time period, which may not be longer than six years and may not include dates before **April 14, 2003**. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

    Notwithstanding the foregoing, you may request an accounting of disclosures of any "electronic health record" (that is, an electronic record of health-related information about you that is created, gathered, managed and consulted by authorized health care clinicians and staff), provided that you must submit your request and state a time period which may be no longer than three years prior to the date on which the accounting is requested. In the case of any electronic heath record created on your behalf on or before January 1, 2009, this paragraph shall apply to

disclosures made on or after January 1, 2014. In the case of any electronic health record created on your behalf after January 1, 2009, this paragraph shall apply to disclosures made on or after the later of January 1, 2011 or the date we acquired the electronic health record.

- **Your Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

  We are not required to agree to your request. If the Plan does agree to a request, a restriction may later be terminated by your written request, by agreement between you and the Plan (including orally), or unilaterally by the Plan for health information created or received after the Plan have notified you that they have removed the restrictions and for emergency treatment.

  To request restrictions, you must make your request in writing and must tell us the following information:

  - What information you want to limit.
  - Whether you want to limit our use, disclosure or both.
  - To whom you want the limits to apply (for example, disclosures to your spouse).

  Effective February 17, 2010 (or such other date specified as the effective date under applicable law) we will comply with any restriction request if: (1) except as otherwise required by law, the disclosure is to the Plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full.

- **Right to Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

You must make any of the requests described above, to the person listed in Part 8, below.

3. Breach Notification. Pursuant to changes to HIPAA required by the Health Information Technology for Economic and Clinical Health Act of 2009 and its implementing regulations (collectively, "**the HITECH Act**") under the American Recovery and Reinvestment Act of 2009 ("**ARRA**"), this Notice also reflects new federal breach notification requirements imposed on the Plan in the event that your "unsecured" protected health information (as defined under the HITECH Act) is acquired by an unauthorized party.

We understand that medical information about you and your health is personal and we are committed to protecting your medical information. Furthermore, we will notify you following the discovery of any "breach" of your unsecured protected health information as defined in the HITECH Act (the "**Notice of Breach**"). Your Notice of Breach will be in writing and provided via first-class mail, or alternatively, by e-mail if you have previously agreed to receive such notices electronically. If the breach involves:

- 10 or more individuals for whom we have insufficient or out-of-date contact information, then we will provide substitute individual Notice of Breach by either posting the notice on the benefits web site on the [PLAN SPONSOR] intranet or by providing the notice in major print or broadcast media where the affected individuals likely reside.

- Less than 10 individuals for whom we have insufficient or out-of-date contact information, then we will provide substitute Notice of Breach by an alternative form.

Your Notice of Breach shall be provided without unreasonable delay and in no case later than 60 days following the discovery of a breach and shall include, to the extent possible:

- A description of the breach.

- A description of the types of information that were involved in the breach.

- The steps you should take to protect yourself from potential harm.

- A brief description of what we are doing to investigate the breach, mitigate the harm, and prevent further breaches.

- Our relevant contact information.

Additionally, for any substitute Notice of Breach provided via web posting or major print or broadcast media, the Notice of Breach shall include a toll-free number for you to contact us to determine if your protected health information was involved in the breach.

4. Changes To This Notice. We can change the terms of this Notice at any time. If we do, the new terms and policies will be effective for all of the medical information we already have about you as well as any information we receive in the future. We will send you a copy of the revised notice.

5. Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact the person listed in Part 8, below.

All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

6. Other Uses Of Medical Information. Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you grant us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we may be required to retain our records related to your benefit determinations and enrollment.

7. Effective Date. The effective date of this Notice is September 16, 2013.

8. Contact Information. All correspondences relating to the contents of this Notice should be directed as follows:

Bernadine Magney, Fund Administrator
Roofers Local No. 74/No. 203 Welfare Trust Fund
2800 Clinton Street
West Seneca, New York 14224
(716) 828-0488