United Union of Roofers, Waterproofers and Allied Workers Local Union No. 154 Welfare Fund

Summary Plan Description

Effective January 2022

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The following information, together with the information contained in the booklets provided by the insurance carriers that the Welfare Fund has chosen for health insurance coverage under the Plan, form the Summary Plan Description as required under the Employee Retirement Income Security Act of 1974 (ERISA). The benefits booklet provided by CIGNA can be found as an Appendix to this document.

1. IMPORTANT INFORMATION

Name and Address of Fund Whose Participants are Covered by the Plan

United Union of Roofers, Waterproofers and Allied Workers
Local Union No. 154 Welfare Fund
c/o Marshall & Moss Administrative Services, Fund Administrator
1400 Old Country Road, Suite 406
Westbury, NY 11590

Telephone No. (516) 209-4016

Employer Identification Number 11-1670612

Plan Number 501

Type of Plan

The Plan is a Welfare Benefit Plan. The benefits under the Plan are those provided by the applicable group policies in accordance with their terms, provisions, and conditions. Detailed schedules of these benefits are available without cost to any member or beneficiary who so requests from the Fund Administrator, at the address listed above.

Type of Funding

Benefits are insured and premiums are paid from the Fund's assets, which are accumulated under the provisions of a collective bargaining agreement and Trust Agreement and held in the Trust fund for the purpose of providing benefits to covered Participants and paying reasonable administrative expenses.

Contribution Source

Pursuant to a collective bargaining agreement, your employer agrees to make contributions weekly/monthly to the Welfare Fund to provide the benefits for your Plan. That portion of the employer's contribution attributable to your vacation benefits is made on an after-tax basis. In some cases, contributions are made by employers pursuant to Participation Agreements.

Plan Year

The Plan Year begins January 1 of each year.

Administration of the Plan

The Plan is administered by a joint board of trustees consisting of an equal number of Union and Employer Trustees. The Trustees have full discretion in construing the terms of the Plan and in the making of benefit determinations under the Plan.

Agent for Service of Legal Process

Any one of the Trustees may be served at his address listed below or service may be made on the Fund Administrator at the address below.

Names and Addresses of the Joint Board of Trustees:

EMPLOYER TRUSTEES

John Martone
L. Martone & Sons
166 Seacliff Avenue
Glen Cove, NY 11542

Wayne Maskiell
Nationwide Contracting Corp.
1150-2 Lincoln Avenue
Holbrook, NY 11741

Tom Martin
Metropolitan Construction Systems, Inc.
234 Union Ave
Holbrook, NY 11741

UNION TRUSTEES

John Keating
Salvatore Giovanniello
Thomas Pedrick

c/o United Union of Roofers,
Waterproofers & Allied Workers
Local Union No. 154
of Nassau & Suffolk Counties
370 Vanderbilt Motor Parkway
Suite 1
Hauppauge, NY 11788-5133

Fund Administrator:
Marshall & Moss
Administrative Services
1400 Old Country Road
Suite 406
Westbury, NY 11590

Accountant:
Wagner & Zwerman LLP
450 Wireless Blvd.
Hauppauge, NY 11788

Fund Counsel:
Virginia & Ambinder LLP
40 Broad Street
New York, NY 10004

Consultant and Actuary:
The McKeogh Company
Four Tower Bridge, Suite 225
200 Barr Harbor Drive
West Conshohocken, PA 19428

2. ELIGIBILITY FOR BENEFITS

If you are a member of one of the following classes, you may be eligible to qualify for benefits under the Plan:

Class 1 All Roofers and Waterproofers who:

a. are in the collective bargaining unit represented by United Union of Roofers, Waterproofers & Allied Workers, Local Union No. 154;
b. have registered with the Welfare Fund; and
c. are in the employ of one or more contributing employers.

Class 2 All Apprentices of the United Union of Roofers, Waterproofers & Allied Workers, Local Union No. 154 who:

a. have registered with the Welfare Fund; and
b. are in the employ of one or more contributing employers.

Class 3 All retired Roofers and Waterproofers under age 65 who receive a pension from the United Union of Roofers, Waterproofers & Allied Workers, Local Union No. 154 Pension Fund.

3. ELIGIBILITY REQUIREMENTS

If you are a member of either Class 1 or Class 2, you will become eligible for benefits:

a. Insurance Coverage During the Winter/Spring

You will receive insurance coverage for the period March 1 to August 31 if you have either: (1) at least **500** hours of covered employment in the preceding six-month period from July 1 to December 31, or (2) at least **1,000** hours of covered employment in the preceding twelve-month period from January 1 to December 31.

b. Insurance Coverage During the Summer/Fall

You will receive insurance coverage for the period September 1 to February 28 if you have either: (1) at least **500** hours of covered employment in the preceding six-month period from January 1 to June 30, or (2) at least **1,000** hours of covered employment in the preceding twelve-month period from July 1 to June 30.

If you are a member of Class 3, you will become eligible for benefits on the date you enter Class 3.

c. Continuation of Eligibility

Self-Pay

If you do not satisfy the minimum number of hours required for insurance coverage during the next coverage period, under certain circumstances you may be able to continue your eligibility by self-paying the premium cost of your coverage.

Class 1 – Participants may continue coverage during the next coverage period by making up the difference between the total hours worked in covered employment and the hours needed (500 or 1,000) to meet the eligibility requirements. This difference in hours is multiplied by 110% of the journeyman hourly contribution rate. It must be paid in full to the Fund prior to the start date of the next coverage period.

To be eligible for self-pay, you must be an active Plan participant, ready and able to go to work. If a participant becomes classified as NOT AVAILABLE FOR WORK, by refusing a referral from the hiring hall, he/she will not be eligible for self-pay. The participant will then be offered Continuation of Health Coverage under Federal Law (COBRA).

Class 2 – Participants may continue coverage during the next coverage period by making up the difference between the total of all contributions for covered employment and the cost of the participant's coverage. This must be paid in full to the Fund prior to the start date of the next coverage period.

To be eligible for self-pay, you must be an active Plan participant, ready and able to work. If a participant becomes classified as NOT AVAILABLE FOR WORK, by refusing a referral from the hiring hall, he/she will not be eligible for self-pay. The participant will then be offered Continuation of Health Coverage under the Federal Law (COBRA).

If you are unable to afford the premiums, New York has a premium assistance program that can help pay for coverage. It uses funds from its Medicaid program to help people who are eligible for employer-sponsored health coverage but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid, you can contact your Medicaid office at 1-800-541-2831 or www.nyhealth.gov/health_care/medicaid/ to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid, and you think you or any of your dependents might be eligible, you can contact your Medicaid office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask if there is a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

4. TERMINATION OF BENEFITS

Your coverage under the Plan will terminate on the earliest of the following:

a. the date the Plan terminates;

b. the date you are no longer a member of an eligible class;

c. the date a change is made in the Plan to terminate insurance for your class;

d. the first day of the month following the date you are inducted into the Military Service of the United States (however, see item 9);

e. the last day of the month following any month within the Coverage Period (March 1 to August 31; or September 1 to February 28) in which you are not available for work with a contributing employer for reasons other than illness, disability or leave of absence authorized by the Trustees of the Fund;

f. the last day of the Coverage Period (March 1 to August 31; or September 1 to February 28) in which the Fund has not received contributions in accordance with Item 3 (a) or (b) during the same period that are necessary to continue coverage;

g. the date you attain age 65 if you are a member of Class 3; or

h. the last day of the month following a two-year period of disability due to injury or illness.

Exceptions

Your coverage will not be terminated under Item 4(f) if the Fund failed to receive contributions in accordance with Item 3 (a) or (b) from one or more contributing employers during a coverage period because of a disability due to either an injury or illness (see Item 4(h)) or if you make the required contributions under Item 3(c). If you are out of work due to an injury or illness, you will be credited with 35 hours per week for up to a maximum of 26 weeks in order to maintain eligibility upon your return to work.

If you or one of your dependents are a disabled Medicare beneficiary under age 65 and you are considered to be active, your hospital and medical benefits will be provided first from this Plan and secondarily from Medicare for any services or supplies rendered until the earlier to occur of the following:

- You are no longer considered by your employer to be an active employee; or
- The disability ends.

5. SCHEDULE OF BENEFITS

This Plan is administered in compliance with all applicable laws and regulations. The benefits listed below are provided in accordance with the terms of the insurance carrier. Specific benefit information for health insurance may be found in the booklet provided by the insurance carrier. Vacation benefits are described in item 20.

An Eligible Dependent is defined as the legal spouse or child of the participant. A child is defined as the natural child, stepchild or adopted child of the participant regardless of the marital status and financial dependency status of the child. A child will cease to be an eligible dependent upon the attainment of age 26.

FOR CLASS 1:

Benefits for Roofers and Waterproofers and their Eligible Dependents
Hospital/Medical/Major Medical
Prescription Drug
Dental Care

FOR CLASS 2:

Benefits for Registered Apprentices Only
Hospital/Medical/Major Medical
Prescription Drug
Dental Care

Benefits for Registered Apprentices and their Eligible Dependents
Hospital/Medical/Major Medical
Prescription Drug

FOR CLASS 3:

Benefits for Retired Roofers and Waterproofers
Prior to the Attainment of Age 65
Hospital/Medical/Major Medical
Prescription Drug
Dental Care

There are no benefits for eligible dependents in Class 3.

6. CHANGING YOUR COVERED DEPENDENTS

You may add or drop dependents once each year during our Open Enrollment period unless you have a Change in Status.

Change in Status

You are allowed to change (within 30 days of the change) the number of dependents and level of coverage during the year for certain Changes in Status. These are:

- Events that change your legal marital status including marriage, divorce, death of spouse, legal separation or annulment;
- Events that change your number of dependents (as defined in Internal Revenue Code section 152), including birth, adoption, placement for adoption or death of a dependent;
- Events that change your employment status, or the employment status of your spouse or dependent, including a termination or commencement of employment, a strike or lockout, a commencement of, or return from, an unpaid leave of absence, or a change in worksite;
- Events that significantly change the medical benefits available to you or your spouse through your employment, or to your spouse, through his or her employer; or
- Events that change your dependency status, causing a dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstance.

You may revoke your election during the year only if the election is consistent with your Change in Status.

For example, if you recently had a baby, you may not change your election during the year from family to individual coverage. That election would be inconsistent with the event.

If you are dropping a dependent because he or she is no longer your dependent, you must immediately contact the Fund Administrator, as these former dependents, must, by law, be given the opportunity to continue insurance coverage at their own expense under COBRA (see “Continuation of Benefits” below).

7. CONTINUATION OF BENEFITS

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

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

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

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

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

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan due to the attainment of age 26.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to United Union of Roofers, Waterproofers and Allied Workers Local Union No. 154

Welfare Fund, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

Electing COBRA after a Leave under FMLA

If you take a leave of absence under the Family and Medical Leave Act (FMLA) and do not return to work at the end of the leave, you (and your spouse and dependent children, if any) will be entitled to elect COBRA if:

- They were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and
- They will lose Plan coverage within 18 months because of your failure to return to work at the end of the leave. COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment or reduction of hours. (See "How is COBRA Coverage Provided?" below).

When COBRA Coverage Is Available

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Administrator is notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the commencement of a proceeding in bankruptcy with respect to the employer, your employer must notify the Fund Administrator of the qualifying event. You are responsible for notifying the Fund if you become entitled to Medicare benefits (under Part A, Part B, or both).

You Must Give Notice of Some Qualifying Events

For all other qualifying events (divorce or legal separation of you and your spouse, eligibility for Medicare, or your child's losing eligibility for coverage), **you must notify the Fund Administrator within 60 days after the qualifying event occurs**.

How COBRA Coverage Is Provided

When the Fund Administrator is notified that one of these events has happened, you will, in turn, be notified that you have the right to choose COBRA continuation coverage. You have 60 days to inform the Fund Administrator that you want continuation coverage. This 60-day election period begins on the later of the date you would lose coverage (due to the qualifying event) or the date the Fund Administrator provides the notice of the right to elect COBRA.

You and/or your spouse and children may elect COBRA continuation coverage for all qualifying members. However, each qualified beneficiary has an independent right to elect continuation coverage. Thus, both you and your spouse may elect continuation coverage, or only one of you may do so. You may also elect to continue coverage on behalf of your children only.

COBRA continuation coverage is a **temporary** continuation of coverage. The COBRA coverage periods described below are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage for several reasons, which are described below in the item below entitled Termination of COBRA Coverage Before the End of the Maximum Coverage Period.

When the qualifying event is your death, your becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a child's losing eligibility, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of your hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. The 18-month period may be extended to 36 months under the New York State Continuation Coverage Extension provisions. However, when the qualifying event is the end of employment or reduction of your hours of employment, and you became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than yourself lasts until 36 months after the date of Medicare entitlement.

For example, if you become entitled to Medicare 8 months before the date on which your employment terminates, COBRA continuation coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

There are two additional ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

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

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

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your spouse and dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Fund Administrator. This extension may be available to your spouse and any dependent children receiving continuation coverage if you die, become entitled to Medicare benefits (under Part A, Part B, or both), get divorced or legally separated, or if your dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused your spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Paying for COBRA Continuation Coverage

You must pay the cost of COBRA continuation coverage. The cost of coverage is determined by the Board of Trustees and is subject to change periodically as the actual cost of providing benefits changes.

Generally, the amount of the premium for COBRA coverage will not exceed 102 percent of the cost of providing benefits to a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage. In the case of an extension of COBRA continuation coverage due to a disability, the amount of the premium will not exceed 150 percent of the cost of coverage.

Your first payment must be made within 45 days of the date that the COBRA election was made. After the initial payment is made, all other premiums are due on the first day of the month to which such premium will apply, subject to a 30-day grace period. If the full amount of the premium is not paid by the due date or within the 30-day grace period, COBRA continuation coverage will be cancelled retroactively to the first day of the month for which no payment was received and all COBRA rights are forfeited.

Termination of COBRA Coverage Before the End of the Maximum Coverage Period

Your continuation coverage may be shortened for any of the following reasons:

a. the Fund no longer provides group health coverage to any of its participants;

b. the premium for your continuation coverage is not paid;

c. you become covered under another group health plan that does not have a pre-existing condition limitation. Even if the other plan's coverage is less valuable than the continuation coverage, continuation coverage will cease;
If the other group health plan has a pre-existing condition limitation, coverage will not end provided the beneficiary provides evidence of the pre-existing limitation from the other group health plan's policy, document or Summary Plan Description.

d. you become eligible for Medicare;

e. for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

f. in the case of extended COBRA coverage due to disability:

- after Social Security determines that the individual is no longer disabled; or
- when the disabled individual becomes eligible for Medicare (even if it is before the 29 months has expired).

Other Coverage Options Besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Enrolling in Medicare Instead of COBRA Continuation Coverage

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still working, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of the month after your employment ends or the month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare even if you are not enrolled in Medicare. For more information, visit www.medicare.gov/medicare-and-you.

Trade Act Rights

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation ("PBGC") (eligible individuals). Under these tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA continuation coverage. If you have questions about these tax provisions, you may call Health Coverage Tax Credit Customer Contact Center toll-free 1-866-628-4282. TTD/TTY callers may call toll-free 1-866-626-4282. More information about the Trade Act is also available at http://www.doleta.gov/tradeact/benefits.cfm.

Keep Your Plan Informed of Marital Status and Address Changes

In order to protect your family's rights, you should keep the Fund Administrator informed of any changes in your marital status or to your address or the addresses of family members that are eligible for coverage. You should also keep a copy, for your records, of any notices you send to the Fund Administrator.

If You Have Questions

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

8. FAMILY AND MEDICAL LEAVE

The Family and Medical Leave Act of 1993 (the Act) requires covered employers to provide up to 12 weeks of unpaid leave to eligible employees for certain family and medical reasons.

Employees are considered eligible for this leave if:

a. the employee has worked for the covered employer for at least 12 months (months need not be consecutive);

b. the employee has worked 1,250 or more hours over the previous 12 months; and

c. there are at least 50 employees within 75 miles of your workplace.

Unpaid leave may be granted to an eligible employee for any of the following reasons:

a. to care for the employee's child after birth, or placement for adoption or foster care;

b. to care for the employee's spouse, child, or parent who has a serious health condition; or

c. for a serious health condition that makes the employee unable to perform the Employee's job.

NOTE: At the employer's option, certain kinds of paid leave may be substituted for or used prior to using unpaid leave (i.e., accrued vacation or sick leave). If employers do not require the use of unpaid leave, the employee retains the option of choosing to use paid leave prior to any unpaid leave.

The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if the following requirements are not met:

a. The employee ordinarily must provide 30 days advance notice when the leave is "foreseeable;" or

b. The employers may require medical certification to support a request for leave because of a serious health condition and may require second or third opinions (at the employer's expense) as well as a fitness for duty report to return to work.

The Family and Medical Leave Act also provides job and benefit protection to employees by mandating certain administrative compliances. For example:

a. For the duration of the approved leave, the employers must maintain the employee's health coverage under any "group health plan." If the employee normally makes contributions toward the cost of the "group health plan," the employers may require the employee to continue to make the contributions while on leave. The method and timing of these contributions will be determined by mutual agreement between the employers and employee.

b. Upon return from the approved leave, most employees must be restored to their original, or equivalent, positions with equivalent pay, benefits, and other employment terms.

c. The use of the approved leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

d. The Family and Medical Leave Act makes it unlawful for any employer to:

1) Interfere with, restrain, or deny the exercise of any right provided under the act;

2) Discharge or discriminate against any person for opposing any practice made unlawful by the act, or for involvement in any proceeding under or relating to the act.

The U.S. Department of Labor is authorized to investigate and resolve complaints of violations under the Act. An eligible employee may bring a civil action against an employer for violation.

This Act does not affect any Federal or State law prohibiting discrimination or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FOR ADDITIONAL INFORMATION: Contact the nearest office of the Wage and Hour Division, listed in most telephone directories under U.S. Government, Department of Labor *or* contact the office of the Fund Administrator.

9. THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

USERRA provides for continuation coverage for employees who leave employment to serve in the military. For additional information, please contact the Fund Administrator.

10. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) enacted portability requirements for group health plans and health insurance issuers.

Certificate of Coverage

One of the goals of HIPAA was to make it easier for people changing jobs to qualify for health insurance, regardless of their health status. The Plan, upon request, will give you a certificate after you lose coverage (whether regular coverage or COBRA continuation coverage) under the Plan, which shows the type of coverage you had (e.g., employee only, employee plus spouse, etc.) and how long the coverage lasted. Certificates apply to Plan participants and their qualified beneficiaries. The Plan will provide a certificate for you (or your dependents) upon request if you make the request within 24 months after your coverage terminates. The Fund Administrator can give you forms to make such a request.

In accordance with federal law, the Certificate of Coverage will only show your coverage under this Plan on or after July 1, 1996. Contact the Fund Administrator for information about confirming any coverage you had before that date.

11. THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

One of the most important changes provided under the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) relates to the time a mother and newborn child can spend in the hospital in connection with the birth of a child.

NMHPA provides that group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

12. THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act (WHCRA) includes important protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy. The WHCRA requires all group health plans, insurance companies, individuals with insurance policies and HMOs that provide coverage for medical and surgical benefits for mastectomies to provide coverage for the following:

1. All stages of reconstruction of the breast on which the mastectomy was performed;
2. Surgery for reconstruction of the other breast to produce symmetrical appearance; and
3. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas.

Each year, either the Fund Administrator or the group health insurance company (or HMO) is required to furnish a notice to all group health plan participants describing the availability of benefits for the treatment of mastectomy-related services indicated above, and information on how to obtain a detailed description of the mastectomy-related services available under the plan.

13. QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

Simply stated, a Medical Child Support Order (MCSO) is any judgment, decree or order issued by a court or through an administrative process established under state law that provides for child support payments related to health benefits with respect to a child of a group health plan participant, or requires health benefit coverage of the child in such a plan. You may receive a detailed description of the QMCSO administrative procedures (at no charge) from the Fund Administrator.

14. PATIENT PROTECTION AND AFFORDABLE CARE ACT AND THE HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010 (PPACA)

In accordance with PPACA, our plan provides coverage for all children up to age 26, regardless of their marital, student or financial status. In addition, for most benefits there are no lifetime or calendar year maximum benefits.

15. MEDICAL BENEFITS

Medical coverage is provided to you through an insurance contract with Cigna Health and Life Insurance. The benefits outlined below are a summary. If you would like a complete schedule of benefits, including all terms and conditions outlined in the policy please contact the Fund Administrator or Cigna Health and Life Insurance.

Cigna Health and Life Insurance
P.O. Box 182223
Chattanooga, TN 37422-7223
1-800-Cigna24
Policy # 3333560-DHMO

Benefit	In-Network
Lifetime Maximum	Unlimited
Deductible	$0
Out-of-pocket Maximum Combined medical/pharmacy out-of-pocket maximum	$1,000 for an individual $2,000 for a family
Physician Services	
Physician Office Visit	$25 Primary Care Physician (PCP) copay or $35 Specialist Copay
Surgery performed in Physician's Office	$25 PCP copay or $35 Specialist copay
Allergy Treatment/Injections	$25 PCP copay, $35 Specialist copay, or actual charge (if less)

Benefit	In-Network
Allergy Serum (dispensed by the physician in the office)	Your plan pays 100%
Preventative Care	
Preventative Care (includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplement the standard Preventative Care benefit)	Your plan pays 100%
Immunizations	Your plan pays 100%
Mammograms, PAP, and PSA Tests	Your plan pays 100%
Diagnostic Testing	
Lab and X-ray performed in a physician's office or emergency room/urgent care facility	Your plan pays 100%
Lab and X-ray performed in an independent lab or outpatient facility	Your plan pays 90%
Advanced Radiology Imaging performed in a physician's office or emergency room/urgent care facility	Your plan pays 100%
Advanced Radiology Imaging performed in an outpatient facility	Your plan pays 90%
Emergency Care	
Emergency Room Care	$100 copay (copay waived if admitted)
Emergency Outpatient Professional Services	Your plan pays 100%
Ambulance	Your plan pays 90% (ambulance services used as non-emergency transportation are not covered)
Urgent Care	$75 copay
Inpatient	
Inpatient Hospital Facility (semi-private room, private rooms and special care units are limited to the negotiated rate)	Your plan pays 90%
Inpatient Hospital Physicians Visit/Consultation	Your plan pays 90%
Inpatient Professional Services (services performed by Surgeons, Radiologists, Pathologists, and Anesthesiologists)	Your plan pays 90%

Benefit	In-Network
Outpatient	
Outpatient Facility Services	Your plan pays 90%
Outpatient Professional Services (services performed by Surgeons, Radiologists, Pathologists, and Anesthesiologists)	Your plan pays 90%
Short Term Rehab • Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy and Occupational Therapy - 90 days maximum per Contract Year • Chiropractic Care – Unlimited	$25 PCP copay or $35 Specialist copay
Short-Term Rehabilitation • Cardiac Rehabilitation - 36 days maximum per Contract Year	$25 PCP copay or $35 Specialist copay
Other Health Care Facilities	
Home Health Care • Unlimited days per Contract Year • 16 hours maximum per day	Your plan pays 90%
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility • Unlimited days per Contract Year	Your plan pays 90%
Durable Medical Equipment • Unlimited maximum per Contract Year	Your plan pays 90%
Breast-Feeding Equipment & Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician • Includes related supplies	Your plan pays 100%
External Prosthetic Appliances (EPA) • $200 EPA annual deductible per Contract Year	Your plan pays 90%
Routine Foot Disorders (services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary)	Not Covered

Exclusions and Expenses Not Covered

1. Treatment of an Injury or Sickness which is due to war, declared, or undeclared.

2. Cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Dependent child which has resulted in functional defect.

3. Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet.

4. Treatment provided in a government hospital.

Exclusions

1. Benefits provided under Medicare or other governmental program (except Medicaid), any State or Federal workers' compensation, employers' liability or occupational disease law.

2. Services rendered and separately billed by employees of hospitals, laboratories or other institutions.

3. Services performed by a member of the covered person's immediate family.

4. Dental care or treatment, except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly.
5. Hearing aids.

6. Eyeglasses and examination for the prescription or fitting thereof.

7. Rest cures and custodial care.

8. Expenses incurred outside the United States, its possessions or the countries of Canada and Mexico, other than expenses for Medically Necessary urgent or emergent Care while temporarily traveling abroad.

Exclusions and Expenses Not Covered Unless Medically Necessary

1. Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.

2. Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.

3. Hearing aids, including but not limited to semi-implantable hearing devices, audient bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.

4. Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.

5. Dental implants for any condition.

6. For or in connection with experimental, investigational, or unproven services. However, Cigna will cover an experimental or investigational treatment approved by an external appeal agent. If the external appeal agent approved coverage of an experimental or investigational treatment that is part of a clinical trial, Cigna will only cover the costs of services required to provide treatment to you according to the design of the trial. Cigna shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or the costs which would not be covered under this plan for nonexperimental or non-investigational treatments provided in such clinical trial.

7. Experimental, investigational, and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:

    a. Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;

    b. Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;

c. The subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) of this plan; or

d. The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.

8. Charges made for drugs and implanted/injected devices for contraception.

9. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.

10. Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.

11. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.

Limitations of Coverage

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

1. Medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.

2. Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, and elastic stockings.

3. Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.

4. Expenses denied by a Primary Plan because treatment was received from a nonparticipating provider.

5. To the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.

6. To the extent that payment is unlawful where the person resides when the expenses are incurred.

7. For charges which would not have been made if the person had no insurance.

8. Expenses for supplies, care, treatment, or surgery that are not Medically Necessary, except as specified in any certification requirement shown in this plan.

16. PRESCRIPTION BENEFITS

Prescription coverage is provided to you through an insurance contract with Cigna Health and Life Insurance. The benefits outlined below are a summary. If you would like a complete schedule of benefits, including all terms and conditions outlined in the policy please contact the Fund Administrator or Cigna Health and Life Insurance.

Cigna Health and Life Insurance
P.O. Box 182223
Chattanooga, TN 37422-7223
1-800-Cigna24
Policy # 3333560-DHMO

Tier	In-Network	Out-of-Network
Generic	Retail (30-day supply): $10/prescription Home Delivery (90-day supply): $20/prescription	Not Covered
Preferred Brand	Retail (30-day supply): $30/prescription Home Delivery (90-day supply): $60/prescription	
Non-Preferred Brand	Retail (30-day supply): $50/prescription Home Delivery (90-day supply): $100/prescription	

Out-of-Pocket-Maximum

Your Plan includes a combined Medical/Pharmacy Out-Of-Pocket maximum. You will be subject to an individual Out-of-Pocket Maximum of $1,000 or a family Out-of-Pocket Maximum of $2,000. All copayments, deductibles and coinsurance amounts apply towards your Out-of-Pocket Maximum.

Pharmacy Cost Management Program

Step Therapy is a prior authorization program that may require you to try other medications available to treat the same condition before “Step Therapy” medication is covered. All possible Step Therapy medications are identified on the Cigna Prescription drug list with an “ST” suffix. To determine if a specific drug is subject to Step Therapy for you plan, please call Customer Service at the phone number listed on your ID card or visit the Prescription Drug Price Quote tool on www.myCigna.com

Exclusions and Expenses Not Covered

1. Treatment of an Injury or Sickness which is due to war, declared, or undeclared.

2. Cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Dependent child which has resulted in functional defect.
3. Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet.

4. Treatment provided in a government hospital.

Exclusions

1. Benefits provided under Medicare or other governmental program (except Medicaid), any State or Federal workers' compensation, employers' liability, or occupational disease law.

2. Services rendered and separately billed by employees of hospitals, laboratories, or other institutions.

3. Services performed by a member of the covered person's immediate family.

4. Dental care or treatment, except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly.

5. Hearing aids.

6. Eyeglasses and examination for the prescription or fitting thereof.

7. Rest cures and custodial care.

8. Expenses incurred outside the United States, its possessions or the countries of Canada and Mexico, other than expenses for Medically Necessary urgent or emergent Care while temporarily traveling abroad.

Exclusions and Expenses Not Covered Unless Medically Necessary

1. Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.

2. Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.

3. Hearing aids, including but not limited to semi-implantable hearing devices, audient bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.

4. Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.

5. Dental implants for any condition.

6. For or in connection with experimental, investigational, or unproven services. However, Cigna will cover an experimental or investigational treatment approved by an external appeal agent. If the external appeal agent approved coverage of an experimental or investigational treatment that is part of a clinical trial, Cigna will only cover the costs of services required to provide treatment to you according to the design of the trial. Cigna shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or the costs which would not be covered under this plan for nonexperimental or non-investigational treatments provided in such clinical trial.

7. Experimental, investigational, and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:

    a. Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;

b. Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;

c. The subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) of this plan; or

d. The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.

8. Charges made for drugs and implanted/injected devices for contraception.

9. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.

10. Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.

11. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.

Limitations of Coverage

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

1. Medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.

2. Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, and elastic stockings.

3. Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.

4. Expenses denied by a Primary Plan because treatment was received from a nonparticipating provider.

5. To the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.

6. To the extent that payment is unlawful where the person resides when the expenses are incurred.
7. For charges which would not have been made if the person had no insurance.

8. Expenses for supplies, care, treatment, or surgery that are not Medically Necessary, except as specified in any certification requirement shown in this plan.

17. DENTAL BENEFITS

Dental coverage is provided to you through an insurance contract with Cigna Health and Life Insurance. The benefits outlined below are a summary. If you would like a complete schedule of benefits, including all terms and conditions outlined in the policy please contact the Fund Administrator or Cigna Health and Life Insurance.

Cigna Health and Life Insurance
P.O. Box 182223
Chattanooga, TN 37422-7223
1-800-Cigna24
Policy # 3333560-DHMO

Your Cigna Dental Care Patient Charge Schedule is attached as an appendix to this document. This document lists the dental procedures covered under your dental plan. Some dental procedures are covered at no charge to you. For other covered services the Patient Charge Schedule lists the fees you must pay when you visit your dental office. Your dental office is the Network General Dentist that you and your eligible dependents must select when you enroll in the dental plan. For a list of Network General Dentist please visit www.myCigna.Com or call the Dental Office Locator at 1-800-Cigna24.

There are no deductibles and no annual dollar limits for services covered by your Dental Plan.

Limitations on Covered Services

Listed below are limitations on services when covered by your Dental Plan:

1. Frequency – The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.

2. Pediatric Dentistry – Coverage for treatment by a Pediatric Dentist ends on your child's 7th birthday. Effective on your child's 7th birthday, dental services must be obtained from a Network General Dentist; however, exceptions for medical reasons may be considered on an individual basis.

3. Oral Surgery – The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your Patient Charge Schedule lists any limitations on oral surgery.

4. Periodontal (gum tissue and supporting bone) Services - Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule. Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.

5. Clinical Oral Evaluations - When this limitation is noted on the Patient Charge Schedule, periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under 3 years of age are limited to a combined total of 4 evaluations during a 12 consecutive month period.

6. Surgical Placement of Implant Services – When cover on the Patient Charge Schedule, surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant are limited to one per year with replacement of a surgical implant frequency limitation of one every 10 years.

7. Prosthesis Over Implant – When covered on the Patient Charge Schedule, a prosthetic device, supported by an implant or implant abutment is considered a separate distinct service(s) from surgical placement of an implant. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only covered if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

Exclusions

Services Not Covered Under Your Dental Plan Listed below are the services or expenses which are NOT covered under your Dental Plan, and which are your responsibility at the dentist's Usual Fees. There is no coverage for:

1. services not listed on the Patient Charge Schedule.

2. services provided by a non-network Dentist without Cigna Dental's prior approval (except in emergencies).

3. services related to an injury or illness paid under workers' compensation, occupational disease, or similar laws.

4. services provided or paid by or through a federal or state governmental agency or authority, political subdivision, or a public program, other than Medicaid.

5. services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.

6. cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless the service is specifically listed on your Patient Charge Schedule.

7. for or in connection with an Injury arising out of, or in the course of, any employment for wage or profit.

8. for charges which would not have been made in any facility, other than a Hospital or a Correctional Institution owned or operated run by the United States Government or by a state or municipal government if the person had no insurance.

9. due to injuries which are intentionally self-inflicted.

10. prescription medications.

11. procedures, appliances, or restorations if the main purpose is to: change vertical dimension (degree of separation of the jaw when teeth are in contact); or restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction; or restore the occlusion.

12. replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.

13. surgical placement of a dental implant, repair, maintenance or removal of a dental implant, implant abutment(s), or any services related to the surgical placement of a dental implant, unless specifically listed on your Patient Charge Schedule.

14. services considered to be unnecessary or experimental in nature.

15. procedures or appliances for minor tooth guidance or to control harmful habits.

16. hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for network Dentist charges for covered services performed at a hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination.)
17. the completion of crowns, bridges, dentures, or root canal treatment already in progress on the effective date of your Cigna Dental coverage.

18. the completion of implant supported prosthesis (including crowns, bridges, and dentures) already in progress on the effective date of your Cigna Dental coverage, unless specifically listed on your Patient Charge Schedule.

19. crowns, bridges and/or implant supported prosthesis used solely for splinting.

20. resin bonded retainers and associated pontics.

Pre-existing conditions are not excluded if the procedures involved are otherwise covered in your Patient Charge Schedule.

Should any law require coverage for any particular service(s) noted above, the exclusion or limitation for that service(s) shall not apply.

18. VACATION BENEFITS

Vacation Benefits are paid twice annually in the following manner:

a. Summer Vacation Benefits:

    1. A Summer Vacation Benefit shall be paid to each participant for whom contributions are made by a contributing employer to the Fund.

    2. As soon as practicable, after March 31 of each year, the Joint Board of Trustees will determine and fix the amount of each participant's summer vacation benefit. The amount of each vacation benefit is equal to the amount of contributions actually made on behalf of the participant attributable to employment in the preceding twelve (12) month period and received by the Fund prior to March 31 in the year in which the vacation benefit amount is being determined.

3. The fact that vacation benefits are paid, or that they are determined as of March 31, shall not give any participant or any other person any right, title or interest in the Fund or its assets except at the time(s) and upon the terms and conditions set forth in the Plan.

4. As soon as practicable, after May 1 of each year, the Board of Trustees shall distribute to each participant for whom a vacation benefit was established, the amount determined as set forth in paragraph 2 (above).

   Such distribution shall be made by check and mailed to the last known street address of the participant on file with the Fund Administrator.

b. Winter Vacation Benefits

1. A Winter Vacation Benefit shall be paid to each participant for who contributions are made by a contributing Employer to the Fund.

2. As soon as practicable, after September 30 of each year, the Board of Trustees will determine and fix the amount of each participant's winter vacation benefit. The amount of each vacation benefit is equal to the amount of contributions actually made on behalf of the participant attributable to employment in the preceding twelve (12) month period and actually received by the Fund prior to September 30 in the year in which the vacation benefit amount is being determined.

3. The fact that vacation benefits are paid, or that they are determined as of September 30, shall not give any participant or any other person any right, title or interest in the Fund or its assets except at the time(s) and upon the terms and conditions set forth in the Plan.

4. As soon as practicable, after November 1 in each year, the Board of Trustees shall distribute to each participant for whom a vacation benefit was established, the amount determined as set forth in paragraph 2 (above).

   Such distribution shall be made by check and mailed to the last known street address of the employee on file with the Fund Administrator.

In the event a participant dies at a time when there is in existence a vacation benefit payable, payment thereof shall be made to the deceased participant's designated beneficiary. The designated beneficiary shall be the person designated on a form supplied by the Fund and which is actually on file with the Fund Administrator. In the event that there is no designated beneficiary, then payment will be made to the deceased participant's estate.

Procedure After Distribution of Vacation Checks:

A participant may request the Board of Trustees to review his/her vacation benefit amount within 60 days after receipt of the vacation check if the participant believes the amount received does not reflect the amount of hours worked. The Board of Trustees will review any material or written statement a claimant may wish to submit in support of his claim.

19. LOSS OF BENEFITS

The Board of Trustees may change or eliminate benefits under the Plan and may terminate, amend, or alter the entire Plan or any portion of it. Any claims for benefits resulting from charges incurred before any change or elimination of benefits will be paid according to the coverages in effect prior to such change or elimination of benefits. Plans provided under insurance policies and/or contracts may also be terminated by the insurer for non-payment of premiums or failure to meet certain participation requirements. Your coverage terminates when your employment is terminated, when you leave active service due to disability (except as previously noted), layoff, leave of absence, strike, or retirement after age 65. Coverage also terminates when you are no longer in an eligible class (as determined in the Eligibility for Benefits item 2), when you fail to make any required contributions or when any benefit is terminated.

20. PLAN AMENDMENT AND TERMINATION

The Fund intends to maintain the benefit Plan on a permanent basis. However, the right is reserved in the Plan for the Board of Trustees to terminate, suspend, withdraw, amend, or modify the Plan in whole or in part at any time, subject to the applicable provisions of the group insurance policies. The Board of Trustees shall make any amendments to the Plan, which may be needed for compliance with the Employee Retirement Income Security Act (ERISA) of 1974, and pertinent sections of the Internal Revenue Code of 1986.

If You Have Questions

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

Questions regarding PPACA and which protections apply, and which protections do not apply to a grandfathered health plan and what might cause a plan to change

from grandfathered health plan status can be directed to the Fund Administrator. You may also contact the EBSA at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

21. ERISA RIGHTS

ERISA (the Employee Retirement Income Security Act of 1974) protects your benefit rights as an employee. It does not require an employer to have benefit plans for employees. However, it does require that, when an employer provides such a plan, it must follow certain rules.

ERISA also mandates that you receive the information included in the Summary Plan Description. This section outlines your rights under the United Union of Roofers, Waterproofers and Allied Workers Local Union No. 154 Welfare Fund benefit plan, explains how to appeal claims and describes how the plan is administered.

The Plan Sponsor of the benefit plan is:

Board of Trustees of the United Union of Roofers, Waterproofers and Allied Workers Local Union No. 154 Welfare Fund c/o Marshall & Moss Administrative Services, Fund Administrator 1400 Old Country Road, Suite 406 Westbury, NY 11590 (516) 209-4016

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants are entitled to:

- Examine without charge, during normal business hours at the Fund Administrator's office, all official plan documents. These documents may include insurance contracts, trust agreements, annual reports, and plan descriptions filed by the plan with the U.S. Department of Labor (DOL).

- Obtain copies of plan documents and other plan information upon written request to the Fund Administrator. The administrator may make a reasonable charge for the copies.

- Receive a summary of the plan's annual financial report.

- 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 (including the individual group health plan's insurance booklet) and any other 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 your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing 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 those responsible for the operation of employee benefit plans. The people who administer your plan, called plan "fiduciaries", have a duty to do so prudently and in the interests of you and other plan participants and beneficiaries. No one including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your ERISA rights.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Furthermore, if you disagree with the plan's decision or lack thereof, concerning a Qualified Medical Child Support Order (QMCSO), you may sue the plan.

Every effort has been made to see that you receive all the benefits to which you are entitled. If you have a question about the Plan or problem regarding your benefits, you should contact the Fund Administrator.

Assistance with Your Questions

If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Fund Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also go to www.dol.gov/dol/ebsa for more information.

22. CLAIMS PROCEDURES AND APPEALS PROCEDURES

ALL CLAIMS FOR BENEFITS MUST BE MADE WITHIN ONE YEAR OF THE DATE THE EXPENSE WAS INCURRED. A CLAIM FILED MORE THAN ONE YEAR AFTER THE EXPENSE WAS INCURRED WILL BE AUTOMATICALLY DENIED.

Claim Inquiries

If you have a question regarding coverage for services not specifically described in the Summary Plan Description, contact the Fund Administrator.

Timeframes

The claims procedures contain various timeframes within which the claimant must file a claim or appeal and within which the Fund or the Board of Trustees must issue a decision on such claim or appeal.
The Fund or the Board of Trustees may agree to extend the time limits applicable to a claim and the claimant may agree to extend any time limit within which the Fund or the Board of Trustees must issue a decision. Any agreement to extend an applicable time limit must be knowing, explicit and confirmed in writing before such time period expires.

Applicable Definitions

In order to understand how your claim or appeal will be processed, it is important you understand how claims are categorized. A definition or explanation of each category the Plan will use is set forth below:

- A pre-service claim is a claim for a benefit that requires prior approval under the terms of the plan, such as inpatient admission pre-certification and other pre-certifications described in the summary plan description.

- An urgent care claim is a type of pre-service claim which, if the regular time periods for handling pre-service claims were followed: (1) could seriously jeopardize your life or health or your ability to regain maximum function or (2) would, in the opinion of a health care provider with knowledge of your condition, subject you to severe pain that could not be adequately managed without the care or treatment that is the subject to the claim.
- A post-service claim is a claim for a benefit that does not require prior approval under the terms of the plan. A post-service claim involves a claim for payment or reimbursement for medical care or supplies that have already been received.

Submitting Initial Claims for Benefits

Pre-service and urgent care claims. A pre-service claim, including an urgent care claim, will be considered submitted when a request for pre-certification is received by CIGNA.

Post-service claims. Providers will generally submit their claims for payment directly to CIGNA. If you obtain services from a provider who is not affiliated with CIGNA, you must pay for the services and submit a claim for reimbursement.

Initial Claims Determinations

The timeframes for making the initial decision regarding a claim and the procedures for notifying you about that decision depend on the type of claim.

Urgent care claims. You will be notified whether your urgent care claim has been approved or denied as soon as possible, but in no event later than 72 hours after the claim is received. If more information is needed in order for a determination to be made, you will be advised of the specific information necessary to complete the claim within 24 hours after receipt of the claim. You will be allowed at least 48 hours to provide the necessary information. You will be notified of the determination within 48 hours after the earlier of: (1) the plan's receipt of the requested information or (2) the end of the period you were given in which to provide the information. If you do not provide the requested information within the specified timeframe, your claim will be decided without that information.

Pre-service claims. You will be notified whether your pre-service claim has been approved or denied within a reasonable period of time appropriate to the medical circumstances involved, but in no event more than 15 days after the claim is received. The 15-day period may be extended an additional 15 days if the extension is necessary due to matters beyond the control of the plan and you are notified of the extension before the initial 15-day period expires. If the extension is required because you failed to submit information necessary to decide the claim, the extension notice will specifically describe the information needed to complete the claim. You will be given at least 45 days from the time you receive the notice to provide the requested information. The timeframe for deciding the claim will be

suspended from the date the notice of extension is sent until the date on which you respond to the notice. If you provide the requested information within the specified timeframe, your claim will be decided within the time specified in the extension notice. If you do not provide the requested information within the specified timeframe, your claim will be decided without that information.

Previously approved treatments

- If the Plan previously approved an ongoing course of treatment that was to be provided over a period of time or that involved a specified number of treatments and you wish to extend the course of treatment beyond that which had been approved, you may request an extension.

- If the claim involves urgent care, you will be notified whether the extension has been approved or denied no more than 24 hours after your request for the extension is received, provided that you make such request at least 24 hours before the end of the previously approved period of time or before you received all of the previously approved treatments. If the request for an extension is made less than 24 hours before the expiration of the prescribed period of time or number of treatments, the request will be treated as a new urgent care claim and decided under the general timeframe applicable to urgent care claims. If the claim does not involve urgent care, the extension request will be treated as a new pre-service claim and will be decided within the timeframe applicable to pre-service claims as described above.

- If the Plan previously approved an ongoing course of treatment that was to be provided over a period of time or that involved a specified number of treatments, any decision by the plan to reduce or terminate that course of treatment (other than by plan amendment or termination) before the end of such period of time or before all approved treatments have been received will be considered a benefit denial. You will be notified sufficiently in advance of such reduction or termination to allow you to appeal and obtain a determination on the appeal before the benefit is reduced or terminated.

Post-service claims. You will be notified of the decision on your post-service claim within a reasonable period of time, but not later than 30 days after the claim is received. This time period may be extended for an additional 15 days when necessary due to matters beyond the control of the plan or if your claim is incomplete. You will be advised in writing of the need for an extension during the initial 30-day period and a determination will be made no more than 45 days after the date the claim was submitted. If the extension is needed because your claim is incomplete, the notice will specifically describe the information needed to complete the claim and you will be allowed 45 days from receipt of the notice to provide the information. The timeframe for deciding the claim will be suspended from the date the notice of extension is sent until the date on which you respond to such notice. If you provide the requested information within the specified timeframe, your claim will be decided within the time specified in the extension notice. If you do not provide

the requested information within the specified timeframe, your claim will be decided without that information.

If Your Claim Is Denied

If your claim for a benefit is denied in whole or in part, you will receive a written notice that will provide:

- The specific reason or reasons for the denial.
- Reference to specific plan provisions on which the determination was based.
- A description of any additional material or information necessary to complete the claim and an explanation of why such material or information is necessary.
- A description of the steps you must follow (including applicable time limits) if you want to appeal the denial of your claim, including:
  - Your right to submit written comments and have them considered,
  - Your right to receive (upon request and free of charge) reasonable access to, and copies of, all documents, records, and other information relevant to your claim, and
  - Your right to bring a civil action under Section 502 of ERISA if your claim is denied on appeal.
- If an internal rule, guideline, protocol, or other similar criterion was relied on in denying your claim:
  - A description of the specific rule, guideline, protocol or criterion relied on, or
  - A statement that a copy of such rule, guideline, protocol or criterion will be provided free of charge upon request.
- If the basis for the denial was medical necessity or a determination of experimental or investigational treatment or similar exclusion or limit:
  - An explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your circumstances, or
  - A statement that such an explanation will be provided free of charge upon request.
- In the case of a denial of an urgent care claim, a description of the expedited review process applicable to such claim.

Review of Denied Claims

You have 180 calendar days after receiving notice that your claim has been denied in whole or in part in which to appeal the determination.

Urgent care and pre-service claims. Appeals of decisions involving urgent care claims and pre-service claim appeals (e.g., claims pertaining to pre-certification for admission to hospital, rehabilitation facilities, skilled nursing facilities or for case management, etc.) should be submitted to CIGNA.

Post-service claims and disability claims. Appeals of decisions involving post-service claims should be submitted to the Board of Trustees.

Appeals of urgent care claims and first-level pre-service claim appeals may be submitted in writing or orally. Appeals of post-service claims must be in writing.

Your appeal should set out the reasons you believe that the claim should not have been denied and should also include any additional supporting information, documents, or comments that you consider appropriate.

At your request, you will be provided with reasonable access to, and copies of, all documents, records, and other information relevant to the claim, free of charge. You may also request the plan to identify any medical or vocational expert from whom it received advice in connection with the benefit determination, regardless of whether it relied on such advice in making the initial benefit determination.

Expedited procedures for urgent care claims. You may request an expedited appeal of a denial involving an urgent care claim. This request may be oral or in writing. Under these expedited procedures, all necessary information, including the determination on appeal, may be transmitted by telephone, facsimile, or other available similarly expeditious method. The phone number for initiating an expedited appeal is provided above.

Determinations on Appeal

The timeframe for making a decision on the appeal depends on the type of claim:

Urgent care claims. You will be notified of the determination on appeal as soon as possible, taking into account the medical urgency of the situation, but in no event more than 72 hours after your appeal is received.

Pre-service claims. You will be notified of the decision on appeal within a reasonable period of time but no longer than 15 days after it is submitted. If you are not satisfied with the decision, you have the right to file a second level appeal with the Board of Trustees.

Your second level appeal request must be submitted within 60 days from receipt of first level appeal decision and must be in writing. Appeals should be submitted to the Board of Trustees. You will be notified of the decision on your second-level appeal no more than 15 days it is submitted.

Post-service claims. The Board of Trustees or a designated subcommittee of the Trustees will review and decide your appeal at the quarterly meeting immediately following receipt of your appeal unless your appeal was received by the Fund Administrator within 30 days of the date of the meeting. In that event, your appeal will be reviewed at the second quarterly meeting following receipt of the appeal. You may wish to contact the Fund Administrator concerning the date of the next meeting so that you may submit your appeal in time to be heard at that meeting. If special circumstances require a further extension of time for review, the decision on appeal will be rendered not later than the third Trustees' meeting following receipt of your appeal. You will be notified in writing prior to the extension of the circumstances requiring the extension and the date by which the Trustees expect to reach a decision. You will receive written or electronic notice of the decision of the trustees after review by the Trustees within 5 days of the date the decision is made. If the Trustees need more information from you, their time for making a decision on your appeal will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request.

The review on appeal will take into account all comments, documents, records, and other information relating to the claim that you submit without regard to whether such information was submitted or considered in the initial benefit determination or at a lower level of appeal. The review will not give deference to the initial denial or, if there is more than one level of appeal, to the decision at a lower level of appeal. In addition, the individual who decides your appeal will not be the same individual who initially decided your claim or made a decision at a lower level of appeal and will not be that individual's subordinate.

A health professional may be consulted in deciding your appeal, except that any health professional consulted in connection with your appeal will not have been involved in the initial benefit determination or at a lower level of appeal nor be a subordinate of the health professional who was involved.

Except in instances in which notice is provided pursuant to the expedited procedures for urgent care claims described above, you will be notified in writing of the decision on appeal. If the decision upholds the denial of your claim, the notification will provide:

- The specific reason or reasons for the denial.
- Reference to specific plan provisions on which the determination was based.
- A description of your right to receive (upon request and free of charge) reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

- If the denial was based on medical necessity or a determination of experimental or investigational treatment or similar exclusion or limit:
  - An explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your circumstances; or
  - A statement that such an explanation will be provided free of charge upon request.
- If an internal rule, guideline, protocol, or other similar criterion was relied on in denying your claim:
  - A description of the specific rule, guideline, protocol or criterion relied on, or
  - A statement that a copy of such a rule, guideline, protocol or criterion will be provided free of charge upon request.
- A statement of your right to bring a civil action under Section 502 of ERISA.

External Appeals Process

If you wish to appeal a claim which is eligible for external review, please refer to the CIGNA Benefit Booklet in the Appendix of this document.

Designation of An Authorized Representative

You may authorize someone else to file and pursue a claim or file an appeal on your behalf. Generally, this authorization must be in writing and signed by you; however, in the case of an urgent care claim, a physician or other health care professional who is licensed, accredited, or certified to perform specified health services consistent with state law and who has knowledge of your medical condition will be acknowledged as your authorized representative even if no written designation is submitted. Any reference in these claims procedures to "you" is intended to include your authorized representative.

An assignment to a health care provider for purposes of payment does not constitute appointment of an authorized representative under these claims procedures.

Fraudulent Claims

If a fraudulent claim is knowingly submitted, all benefits claimed will be denied. If any benefits are paid in connection with a fraudulent claim, the Participant and his dependents will not receive further benefits under the Fund until the money improperly obtained is returned to the Fund. The Participant will be advised by mail of any action taken with regard to a fraudulent claim.

Review of Fund Policies, Determinations, Or Actions Not Involving Claims for Benefits

If you disagree with a policy, determination, or action of the Fund that does not involve a claim for benefits, you may request the Board of Trustees to review the Fund policy, determination or action with which you disagree by submitting a written

appeal to the Trustees. You must state the reason for your appeal and submit any supporting documentation. Your written appeal must be submitted within 60 days after you learn of a Fund policy, determination or action with which you disagree, and which is not a benefits denial. The Board of Trustees will have sole authority and discretion to interpret and apply Fund policy, determination or action.

You may review pertinent documents in the Fund Office after making appropriate arrangements or you may request that documents be provided to you. The Fund may charge you $.25 per page to provide documents to you, and this amount must be paid in advance.

The Trustees or a designated Committee of the Trustees will review your appeal at their quarterly meeting immediately following receipt of your appeal unless your appeal was received by the Fund Office within 30 days of the date of the meeting. In this case, your appeal will be reviewed at the second quarterly meeting following receipt of the appeal.

You may wish to contact the Fund Administrator concerning the date of the next meeting so that you may submit your appeal in time to be heard at that meeting. If special circumstances require an extension of the time for review for the Trustees or Committee, you will be notified in writing.

23. REIMBURSEMENT AND SUBROGATION

The Plan's Reimbursement Rights

The Plan's reimbursement provisions apply when you or another covered person receives any amounts by settlement, verdict or otherwise, including payment under an insurance policy, for an injury, illness or other condition caused by a third party, or for an on-the-job injury, illness or other condition covered by workers' compensation. Examples are if you are injured in an automobile accident and the other driver is at fault, or if you are injured on the job and receive a workers' compensation recovery.

The amounts that you receive on account of the liability of a third party or the employer, or on account of a workers' compensation recovery are referred to here as a "recovery". If you or another covered person receives a recovery, the Plan will subtract the amount of the recovery from the benefits it would otherwise pay for treatment of that injury, illness or other condition.

If the Plan has already paid benefits for treatment of the injury, illness or other condition, such payment will be considered to be an "advance" only and you or the covered person must promptly reimburse the Plan from any recovery received for the amount of benefits so advanced by the plan. Reimbursement must be made regardless of whether the covered person is fully compensated ("made whole") by the recovery and regardless of whether or not such proceeds are characterized in

the settlement or judgment as being paid on account of the medical or dental expenses for which benefits were paid, and without any reduction for any legal or other expenses incurred by any covered person in connection with the recovery against the third party, that third party's insurer, the employer or a workers' compensation insurer, except as may be expressly agreed to by the Plan at its sole discretion. By accepting the advance of benefits from the Plan, all covered persons are deemed to agree to this repayment provision.

Covered persons may be required to execute an agreement under which they jointly and severally:

- Grant the Plan a first priority lien against the proceeds of any recovery received;
- Assign to the Plan any benefit they may have under any insurance policy or other coverage, and
- Agree to hold the proceeds of any recovery received in trust for the plan.

Payments of future benefits under the Plan may be conditioned on execution of this agreement.

Each covered person is obligated to cooperate with the Plan and its agents in order to protect the plan's reimbursement rights. Cooperation means promptly signing, and having your legal counsel sign and deliver any subrogation and reimbursement agreement, providing the plan or its agents with any relevant information requested, signing and delivering any documents as the plan or its agents reasonably request, keeping the plan fully informed as to the status of any litigation or settlement efforts in pursuing a recovery, obtaining the written consent of the Plan or its agents before releasing any party from liability, taking actions as the plan or its agents reasonably request to assist the plan in making a full recovery and taking no action that may prejudice the Plan's rights. Failure to cooperate may be grounds for the termination of all future benefits under the Plan.

The Plan is only responsible for those legal costs to which it agrees in writing and will not otherwise bear the legal costs of covered persons.

If you or any person whom you cover under the Plan fails to reimburse the Plan as required by this section, the Plan may apply any future benefits that may become payable to you or your family members to the amount not reimbursed. Alternatively, the Plan may enforce its rights through garnishment, attachment of wages, liens on assets or any other legal or equitable means.

Future Medical Expenses

A recovery may include compensation for injury-related medical expenses that a covered person may incur in the future. If the settlement or judgment does not set out the amount of the recovery allocated for future medical expenses, you and the Fund will attempt to agree on the amount. If there is no agreement, the amount attributable to future medical expenses will be determined by the Fund in its sole and absolute authority.

The Plan will not cover future medical expenses for which a covered person is being compensated. Expenses that are compensated by the recovery will not be covered or applied to the deductible or co-payment requirements of the plan until they exceed the amount that the covered person has received, or is entitled to receive, as compensation for future medical expenses.

In some instances, the third party may compensate the covered person for both past and future medical expenses through an insurance policy. In that event, only expenses that are not paid by the insurance policy will be eligible for reimbursement by this Plan.

The Plan's Subrogation Rights

The Plan's subrogation provisions apply when another party or the employer (including an insurance carrier or workers' compensation carrier) is or may be liable for a covered person's injury, illness or other condition and the plan has already paid benefits for treatment of the injury, illness or other condition. "Subrogation" refers to the right of the Plan to be substituted in place of the covered person with respect to that person's lawful claim, demand, or right of action against a person who may have wrongfully caused, or is otherwise liable for the covered person's injury or illness that resulted in the payment of benefits by the plan.

In exercising its subrogation rights, the Plan at its discretion may start any legal action or administrative proceeding it deems necessary to protect its right to recover any amount it has advanced as benefits, and it may try or settle any such action or proceeding in the name of and with the full cooperation of the covered persons. However, in doing so, the Plan will not represent or provide legal representation for any covered person with respect to that covered person's damages to the extent those damages exceed the amount of plan benefits.

In addition, the Plan may, at its discretion, intervene in any claim, legal action, or administrative proceeding started by any covered person against any person or employer or that person's or employer's insurer on account of any alleged negligent, intentional, or otherwise wrongful action, or on account of a work related injury covered by workers' compensation law, that may have caused or contributed to the covered person's injury or illness that resulted in the payment of benefits by the plan.

Each covered person is obligated to cooperate with the Plan and its agents in order to protect the plan's subrogation rights.

Cooperation means providing the Plan or its agents with any relevant information requested, promptly signing, and having your legal counsel sign and deliver any subrogation and reimbursement agreement, signing and delivering any documents as the Plan or its agents reasonably request, keeping the plan fully informed as to the status of any litigation or settlement efforts in pursuing a recovery, obtaining the written consent of the Plan or its agents before releasing any party from liability, taking actions as the Plan or its agents reasonably request to assist the Plan in making a full recovery and taking no action that may prejudice the Plan's rights.

Failure to cooperate or taking actions that prejudice the Plan's subrogation rights may be grounds for the termination of all future benefits under the Plan.

The Plan's legal costs in subrogation matters will be borne by the Plan. The legal costs of covered persons will be borne by such covered persons.

24. HIPAA PRIVACY AND SECURITY

The Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule, as amended by the Health Information Technology for Clinical and Economic Health Act ("HITECH"), requires Covered Entities to take specific steps to safeguard individuals' Protected Health Information ("PHI") and to notify individuals of their rights to control the use and disclosure of their PHI.

Your Rights Regarding Your Medical Information

You have the right to inspect and copy your medical information, to request corrections of your medical information and to obtain an accounting of certain disclosures of your medical information.

Summary of Privacy Practices

This Summary of Privacy Practices summarizes how medical information about you may be used and disclosed by the **United Union of Roofers, Waterproofers and Allied Workers Local Union 154 Welfare Fund of Nassau & Suffolk Counties** ("Fund") or others in the administration of your claims, and certain rights that you have. For a complete, detailed description of all privacy practices, as well as your legal rights, please refer to the Notice of Privacy Practices below.

Our Pledge Regarding Medical Information

We are committed to protecting your personal health information. We are required by law to: (1) make sure that any medical information that identifies you is kept private, (2) provide you with certain rights with respect to your medical information,

(3) give you a notice of our legal duties and privacy practices, and (4) follow all privacy practices and procedures currently in effect.

How We May Use and Disclose Medical Information About You

We may use and disclose your personal health information without your permission to facilitate your medical treatment, for payment for any medical treatments, and for any other health care operation. We will disclose your medical information to Fund Trustees and certain Fund employees for Fund administration purposes. We may also use and disclose your personal health information without your permission as allowed or required by law. We must obtain your written authorization for any other use and disclosure of your medical information. We cannot retaliate against you if you refuse to sign an authorization or revoke an authorization given previously. Use or disclosure of your medical information, or that communications about your medical information be made in different ways or at different locations.

How to File Complaints

If you believe your privacy rights have been violated, you have the right to file a complaint with us or with the Office for Civil Rights. We will not retaliate against you for making a complaint.

Notice of Privacy Practices

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

This notice describes the legal obligations of the **United Union of Roofers, Waterproofers and Allied Workers Local Union 154 Welfare Fund of Nassau & Suffolk Counties** ("Fund") and your legal rights regarding your protected health information obtained by the Fund. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. We are required to provide this Notice of Privacy Practices ("Notice") to you pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, that relates to: (1) your past, present or future physical or mental health or condition, (2) the provision of health care to you, or (3) the past, present or future payment for the provision of health care to you.

This Notice is effective September 23, 2013. If you have questions about this Notice or about our privacy practices, please contact **Pat Moss, Marshall & Moss Administrative Services** the Fund's Administrator, at (516) 209-4016.

Our Responsibilities

We are required by law to maintain the privacy of your protected health information, provide you with certain rights with respect to your protected health information, provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information, and follow the terms of this Notice that is currently in effect. Furthermore, we are required to notify you if your protected health information has been breached.

We reserve the right to change the terms of this Notice as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice, mailed to your last known address on file.

How We May Use and Disclose Your Protected Health Information

The law permits us to use or disclose your protected health information without your permission in the following cases:

For Treatment. We may use or disclose your protected health information to facilitate medical treatment or services by providers, including doctors, nurses or other hospital personnel who are involved in taking care of you. Such disclosures will usually be made by the insurance company paying or administering the benefits, or TPA, not the Fund Office. For example, the TPA may disclose the name of your treating physician to a treating orthopedist so that the orthopedist can obtain your x-rays from your physician.

For Payment. We may use or disclose your protected health information to determine your eligibility for Fund benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility, or to coordinate Fund coverage. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments. Such disclosures will usually be made by the insurance company paying or administering the benefits, or our TPA, not the Fund Office.

For example, our TPA may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by our TPA.

For Health Care Operations. We may use or disclose your protected health information for other Fund operations. For example, we may use medical information in connection with conducting quality assessment and improvement activities, reviewing competence or qualifications of health care professionals, creating or renewing insurance contracts, underwriting, premium rating and other activities related to Fund coverage. This may include submitting claims for stop-loss coverage, disease management, case management, conducting or arranging for medical review, audit services including fraud and abuse detection programs, business management and general administrative activities. We will not use or disclose your personal health information that is genetic information for underwriting purposes.

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or provide these services, Business Associates may receive, create, maintain, use or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to provide support services, such as utilization management or subrogation.

As Required by Law. We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use or disclose your protected health information 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 your protected health information in a proceeding regarding the licensure of a physician.

To Fund Trustees. For Fund administration purposes, we may disclose protected health information to the Fund Trustees or certain Fund employees. However, those individuals will only use or disclose that information as necessary to perform Fund administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. For example, we may disclose information to the Fund Trustees to allow them to decide a claim appeal.

Treatment Alternatives. We may contact you to provide you information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Organ and Tissue Donation. If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or transplantation, as necessary to facilitate donation or transplantation.

Workers' Compensation. We may release your protected health information for workers' compensation or similar programs providing benefits for work-related injuries or illness.

Public Health Risks. We may disclose your protected health information for public health actions, including prevention or control of disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting reactions to medications or problems with products; notification to affected individuals of recalls of products; notification to affected individuals of exposure to a disease or increased risk for contracting or spreading a disease or condition; notification to appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this last disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law, including, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order; for example, in response to a subpoena, discovery request, or other lawful process by someone involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may disclose your protected health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness or missing person; about the victim of a crime, if under certain limited circumstances, we are unable to obtain the victim's agreement; about a death that we believe may be the result of criminal conduct; and about criminal conduct.

Coroners, Medical Examiners, Funeral Directors. We may release protected health information to a coroner or medical examiner; for example, to identify a deceased person or determine cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

Inmates. If you are an inmate of a correctional institution or are in the custody of law enforcement officials, we may disclose your protected health information if necessary for the institution to provide you with health care or to protect your health and safety or the health and safety of others.

Research. We may disclose your protected health information to researchers when the individual identifiers have been removed or when an institutional review board or privacy board has reviewed the research proposal and established privacy protocols and has approved the research.

Required Disclosures

We are required to make the following disclosures:

Government Audit. We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.

Disclosures to You. When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

When the Disclosure of Your PHI Requires Your Written Authorization
Although the Fund does not routinely obtain psychotherapy notes, it must generally obtain your written authorization before the Fund will use or disclose psychotherapy notes about you. However, the Fund may use and disclose such notes when needed by the Fund to defend itself against litigation filed by you. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment.

Although the Fund does not routinely sell PHI or use it for marketing purposes, it must obtain your written authorization before it may sell your PHI or use it for marketing purposes.

All Other Disclosures

Personal Representatives. As permitted by law, we will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, so long as you provide us with a written authorization and any supporting documents (i.e., power of attorney).

Restrictions. With only limited exceptions, we will send all mail to your last known address on file. This includes mail with information on the use of Fund benefits by you, your spouse and other family covered members. If a person has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses and disclosures or your protected health information not elsewhere described in this Notice will only be made with your written authorization. You may revoke written authorization at any time, so long as the revocation is in writing. Your written revocation, once received by us, will only be effective for future uses and disclosures.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy. You have a right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy such information, you must submit your request in writing to:

Marshall & Moss Administrative Services, Administrator
United Union of Roofers, Waterproofers and Allied Workers Local Union 154 Welfare Fund of Nassau & Suffolk Counties
1400 Old Country Road, Suite 406
Westbury, NY 11590
Tel: (516) 209-4016

If you request a copy of the information, we may charge a reasonable fee for providing the information. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to the Fund's Privacy Official.

Right to Amend. If you feel that the protected health 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 Fund. To request an amendment, your request must be made in writing and submitted to the Fund's Privacy Official, whose contact information appears in the preceding paragraph. 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 information that is not part of the medical information kept by or for the Fund; was not created by us, unless the person or entity that created the information is no longer available to make the amendment; is not part of the

information that you would be permitted to inspect or copy; or is already accurate and complete. If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include: (1) disclosures for purposes of treatment, payment, or health care operations, (2) disclosures made to you, (3) disclosures made pursuant to your authorization, (4) disclosures made to friends or family in your presence or because of an emergency, (5) disclosures for national security purposes, or (6) disclosures incidental to otherwise permissible disclosures. To request an account of disclosures, you must submit your request in writing to the Fund's Privacy Official, whose contact information appears in the first paragraph of this section entitled "Your Rights." Your request must state a time period of no longer than six years. Your request should indicate in what form you want the information (i.e., paper or electronic). The first request you make for an accounting within a twelve-month period will be provided free of charge. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the costs involved and you may choose to withdraw or' modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations, or that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could request that we not use or disclose information about a surgery that you had. We are not required to agree to your request. However, if we do agree, we will honor the restriction until you revoke it, or we notify you. To request a restriction, you must make your request in writing to the Fund's Privacy Official, whose contact information appears in the first paragraph of this section entitled "Your Rights." In your request, you must tell us: (1) what information you want to limit, (2) whether you want-to limit our use, disclosure, or both, and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

The Fund, however, is not required to agree to your request except if the use or disclosure is for purposes of carrying out payment or health care operations, is not otherwise required by law, and the PHI pertains solely to a health care item or service that has been paid for in full by you or somebody other than the Fund.

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. To request confidential communications, you must make your request in writing to the Fund's Privacy Official, whose contact information appears in the first paragraph of this section entitled "Your Rights." We will not ask you the reason for your request.

Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to a Paper Copy of this Notice. You have the right to obtain a paper copy of this Notice from us at any time, even if you have agreed to receive the Notice electronically. You may request a copy by contacting the Fund's Privacy Official, whose contact information appears in the first paragraph of this section entitled "Your Rights."

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Fund or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Fund, contact: **Pat Moss, Administrator, United Union of Roofers, Waterproofers and Allied Workers Local Union 154 Welfare Fund of Nassau & Suffolk Counties** located at **1400 Old Country Road, Suite 406, Westbury, NY 11590**. All complaints must be submitted in writing. You will not be penalized, or in any way retaliated against, for filing a complaint with the Office of Civil Rights or with us.

Security of Protected Health Information

The Security Rule of HIPAA provides procedures to safeguard your “Electronic Protected Health Information”. “Electronic Protected Health Information” is defined in government regulations and generally is any Protected Health Information that is created, received, maintained, or transmitted in electronic form. The security requirements of this Section are effective April 21, 2005. If any other provision(s) of this booklet conflicts with the requirements of this Section, this Section will control.

The Plan will safeguard Electronic Protected Health Information by:

- Administrative, Physical, and Technical Safeguards. Implementing administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic Protected Health Information the Plan creates, receives, maintains, or transmits on behalf of the Plan.

- Security of Adequate Separation. Ensuring that the “adequate separation” between the Plan and other offices or plans of the Union or employers described in the “Privacy of Protected Health Information” section is supported by reasonable and appropriate security measures.

- Subcontractors and Agents. Ensuring that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such information.

- Reporting. Reporting to the security official of the Plan or the security official's designee any Security Incident of which it becomes aware.

- These requirements do not apply to Electronic Protected Health Information that the Plan; (1) receives pursuant to an appropriate authorization that complies with HIPAA regulations or that qualifies as "Summary Health Information" and that it receives for the purpose of either (a) obtaining premium bids for providing health insurance coverage under the Plan, or (b) modifying, amending, or terminating the Plan as authorized by the HIPAA Privacy Rules. Summary Health Information is defined in HIPAA regulations and generally is claims data for the Plan from which most information that could be used to identify you individually is removed.

25. APPENDIX – CIGNA BENEFITS BOOKLET