ROOFERS' LOCAL UNION NO. 22 WELFARE PLAN
Summary Plan Description

Reflecting the Provisions of the Plan
in Effect on January 1, 2024

Roofers' Local Union No. 22 Welfare Plan
Summary Plan Description

To All Participants:

The Roofers' Local Union No. 22 Welfare Plan is maintained pursuant to collective bargaining agreements between employers and Local Union No. 22 Rochester, New York of the United Union of Roofers, Waterproofers and Allied Workers. The Plan has been in effect since 1973 and is administered by the Roofers' Local Union No. 22 Welfare Fund Board of Trustees. The Trustees are pleased to present you with this booklet explaining and summarizing the Plan benefits in effect as of January 1, 2024. You should share this booklet with your family, since they have an interest in these benefits as well and keep it for future reference.

Este folleto contiene un resumen en el inglés de sus derechos y beneficios bajo la Unión Local de Techadores No. 22 Plan de la Salud y el Bienestar. Si usted tiene la comprensión de dificultad cualquier parte de este folleto, avise la Unión Local de Techador No. 22 Oficina de Fondos de Beneficios, 280 Parque de Metro, Rochester, Nueva York 14623, durante horas de negocio (8:00 esta a 4:30 p.m. lunes por viernes). Usted puede llarnar también la Oficina de Fondos en (585) 235-0829.

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GENERAL DEFINITIONS

Throughout this booklet, masculine terms include the feminine, feminine terms include the masculine and, unless the context indicates otherwise, the following terms have the meaning indicated below.

Child. A Participant's natural or legally adopted child, a stepchild chiefly dependent upon a Participant for support, a child for whom a Participant is the legal guardian and is chiefly dependent upon the Participant for support, or a child for whom a Participant is the proposed adoptive parent and is dependent upon the Participant during the waiting period prior to the adoption becoming final.

COBRA Continuation Coverage. A temporary extension of Health Coverage only (see page 12).

Co-insurance. Your share of the cost of a covered medical service, calculated as a percent of the allowed amount for the service. (For example, if the Insurer's allowed amount for an overnight hospital stay is $1,000, a Co-insurance payment of 20% would be $200. This may change if you have not met the Deductible Amount.)

Collective Bargaining Agreement. An agreement between the Union and an Employer requiring the Employer to make contributions to the Fund on behalf of persons working in Covered Employment.

Contributions. Employer contributions to the Plan at the hourly rate specified in the Collective Bargaining Agreement.

Co-payment. The fixed dollar amount (for example, $40) you pay for covered medical care, usually when you receive the service. Co-payment does not refer to the Deductible Amount or any part of an expense in excess of the Reasonable and Customary Charge or other benefit limits.

Covered Employment. Employment that falls within the scope of a Collective Bargaining Agreement.

Credited Hours. Hours of employment for which an Employer is required to contribute to the Fund on behalf of an Employee under the terms of a Collective Bargaining Agreement, or other agreement between the Employer and the Fund, which are reported to the Funds Office.

Deductible Amount. The amount of certain covered medical expenses that you are required to pay before the Insurer starts paying for those covered expenses. Only medical expenses that would be paid by the Insurer but for the Deductible Amount count toward

satisfying the Deductible Amount requirement. Deductible Coverage may pay Deductible Amounts for inpatient and outpatient services.

Deductible Coverage. The deductible coverage described on page 19.

Dental Coverage. The dental coverage described beginning on page 20.

Dental Hygienist. A person licensed to practice dental hygiene by the governmental authority having jurisdiction over the licensing and practice of dental hygiene, and who works under the direct supervision and direction of a Dentist.

Dentist. A currently duly licensed dentist practicing within the scope of his license, and any other physician furnishing dental services that he is licensed to perform.

Dependent Child. A Child under age 26, or an unmarried Child (regardless of age) who is incapable of self-sustaining employment because of mental retardation, mental illness, or developmental disability as defined under the New York Mental Hygiene Law, or because of physical handicap, provided the condition occurred before the Child reached the age at which the Child's Plan Coverage would have otherwise terminated, the Child's disability is certified by a physician, and the Participant files an application for approval of Plan Coverage for the Child. The Plan reserves the right to require proof that a Child qualifies as a Dependent Child as defined above.

Eligible Employee. An Employee who satisfies the requirements for Plan Coverage.

Employee. A person who works: (i) for an Employer in Covered Employment; (ii) for an Employer and for whom the Employer is obligated to contribute to the Fund under some other agreement between the Fund and the Employer; or (iii) as a full-time employee of the Funds Office or the Union.

Employer. The Funds Office, the Union, or an Employer obligated to make contributions to the Fund on behalf of Employees pursuant to a Collective Bargaining Agreement.

Family Health Coverage. Health Coverage for an Eligible Employee or Retiree under age 65, his Spouse and/or his Dependent Children.

Fund. The Roofers' Local No. 22 Welfare Fund, maintained in accordance with an Agreement and Declaration of Trust, dated March 25, 1998, as amended.

Funds Office. The Roofers' Local No. 22 Benefit Funds Office.

Health Coverage. Health coverage available under the Plan (see page 17).

Injury. An accidental bodily injury. All injuries sustained as a result of any one accident shall be deemed to be one Injury.

Insured Coverage. Health Coverage (other than Deductible, Dental and Vision Coverage), and Life and Accidental Death and Dismemberment Coverage.

Insurer. The company that provides Insured Coverage.

Life and Accidental Death and Dismemberment Coverage. The life and accidental death and dismemberment coverage described beginning on page 31.

Medically Necessary. A service, treatment, drug, supply or equipment provided or prescribed by a licensed health care provider (unless stated otherwise in the Plan) that is: (i) appropriate to diagnose or treat the patient's Injury or Sickness; (ii) consistent with standards of good medical practice in the United States; and (iii) not primarily for the personal comfort or convenience of the patient, the family or health services provider. When treating an inpatient, Medically Necessary also means that the patient's condition requires that the services cannot be provided on an outpatient basis. The Plan pays only for expenses that are Medically Necessary. The Trustees reserve the right to require documents and other proof satisfactory to them that a service, treatment, drug, supply or equipment is Medically Necessary.

New York Continuation Coverage. A temporary extension of Health Coverage only (see page 17).

New York Extended Child Coverage. A temporary extension of Health Coverage only for a Child (see page 17).

Participant. An Eligible Employee or Retiree participating in the Plan.

Plan. The plan under which the Fund provides benefits to Participants.

Plan Administrator. The person or legal entity with responsibility for the overall administration of the Plan, and who serves as the Plan Administrator pursuant to the Employee Retirement Income Security Act of 1974 (ERISA).

Plan Coverage. Health Coverage (including Deductible Coverage, Dental Coverage, and Vision Coverage), Life and Accidental Death and Dismemberment Coverage, and Weekly Indemnity Coverage.

Reasonable and Customary Charge. A charge by a health care provider that is within the range of charges made by other health care providers of the same professional standing in the same geographic area for similar services or supplies provided to a person of the same

sex and similar age for a similar Injury or Sickness. The Plan's payment for an expense is based only on the Reasonable and Customary Charge for the care, treatment, service or supply provided by a health care provider.

Retiree. A former Employee receiving a pension from the Roofers' Local Union No. 22 Pension Fund.

Retiree Coverage. Health Coverage available to a Retiree, his Spouse and/or Dependent Children, and the Life and Accidental Death and Dismemberment Coverage available to a Retiree.

Self-Payment. The amount an Eligible Employee may have to pay for Family Health Coverage (see page 8).

Sickness. A disease, mental, emotional, or nervous disorder, or pregnancy. A recurrent Sickness, and all related Sicknesses, are considered to be one Sickness. Concurrent Sicknesses are also considered to be one Sickness unless totally unrelated.

Single Health Coverage. Health Coverage for an Eligible Employee only.

Spouse. A Participant's legal spouse.

Trustees. The Trustees of the Fund.

Union. Local Union No. 22 Rochester, New York of the United Union of Roofers, Waterproofers and Allied Workers.

Vision Coverage. The vison coverage described beginning on page 25.

Weekly Indemnity Coverage. The weekly indemnity coverage described (see page 30).

ELIGIBILITY FOR PLAN COVERAGE

General Eligibility Requirements

For an Employee to be eligible for Plan Coverage, he must satisfy the eligibility rules described in this Section. However, the Plan does not guarantee that every Employee, his Spouse and Dependent Child will qualify for Insured Coverage and, in the case of an Employee, also Life and Accidental Death and Dismemberment Coverage. ***To obtain and continue any Insured Coverage, an Employee, his Spouse and Dependent Children must also meet any additional Insurer requirements. Please refer to the benefit booklets and summaries provided by the Insurers for these requirements***.

In addition, for an Eligible Employee, his Spouse and Dependent Children to actually be enrolled in Insured Coverage, the Eligible Employee must complete and return enrollment forms to the Funds Office before the end of the enrollment period for the applicable Coverage Period. (Coverage Periods are described below.) The Funds Office will inform Eligible Employees when the enrollment period begins and ends. These forms must identify the Eligible Employee and, if applicable, his Spouse, Dependent Children, and the level of Health Coverage in which the Eligible Employee wishes to enroll. The Plan reserves the right to require proof that a person qualifies as a Spouse or Dependent Child.

Finally, if an Employer does not timely pay Plan contributions to the Funds Office, the Trustees may terminate the Employer's participation in the Plan and employment with that Employer thereafter will not be counted for Plan Coverage eligibility purposes.

Hours Requirement for Employees Covered by Collective Bargaining Agreement

There are two Coverage Periods and two Qualifying Periods. The Spring Coverage Period is March 1 through August 31, and the Fall Coverage Period is September 1 through February 28 (or February 29). The Spring Qualifying Coverage Period is January 1 through June 30, and the Fall Qualifying Period is July 1 through December 31. For an Employee covered by a Collective Bargaining Agreement, except as explained in the "Special Enrollment" Section beginning on page 9, coverage begins only on the first day of a Coverage Period.

An Employee's eligibility for Plan Coverage during the Spring Coverage Period, and whether he is eligible for Single (Employee only) or Family (Employee, Spouse and/or Dependent Children) Health Coverage without any Self-Payment, depends on the number of his Credited Hours for the preceding Fall Qualifying Period or for the preceding calendar year. Similarly, his eligibility for Plan Coverage during the Fall Coverage Period, and whether he is eligible for Single (Employee only) or Family (Employee, Spouse and/or Children) Health Coverage without any Self-Payment, depends on the number of his Credited Hours for the preceding Spring Qualifying Period.

Credited Hours required for the Spring Coverage Period are shown in the tables below.

This number of Credited Hours reported for the Fall Qualifying Period (July 1 – December 31)	Makes you eligible for Plan Coverage, and for this level of Health Coverage without any Self-Payment, during the next Spring Coverage Period (March 1 – August 31)
600	Single Health Coverage
850	Family Health Coverage

OR

This number of Credited Hours reported for a Calendar Year (January 1 – December 31)	Makes you eligible for Plan Coverage. and for this level of Health Coverage without any Self-Payment, during the next Spring Coverage Period (March 1 – August 31)
900	Single Health Coverage
1,300	Family Health Coverage

The Credited Hours required for the Fall Coverage Period are shown in the table below.

This number of Credited Hours reported for a Spring Qualifying Period (January 1 – June 30)	Makes you eligible for Plan Coverage, and for this level of Health Coverage without any Self-Payment, during the next Fall Coverage Period (September 1 - February 28 or 29)
300	Single Health Coverage
450	Family Health Coverage

Special Eligibility Rule For New Hires Covered by Collective Bargaining Agreement

Under a special rule, an Employee who has 450 or more Credited Hours reported for his first full three calendar months of work under the Collective Bargaining Agreement, is eligible for Plan coverage (with Family Health Coverage) from the first day of the next month through the end of the Coverage Period in which that month occurs and, if there are less than three months left in that Coverage Period, through the end of the next Coverage Period.

If an Employee has at least 300 but less than 450 Credited Hours reported for his first full three calendar months of work under the Collective Bargaining Agreement he is eligible for Plan Coverage (with Single Health Coverage) from the first day of the next month through the end of the Coverage Period in which that month occurs and, if there are less than three months left in that Coverage Period, through the end of the next Coverage Period. He will also qualify to self-pay for Family Health Coverage for the time period he is eligible for Plan coverage under this special rule. The amount of the self-payment required for Family Health Coverage for that period will equal the hourly Contribution rate specified for the Employee in the Collective Bargaining Agreement multiplied by the

difference between: (i) 450; and (ii) the number of Credited Hours reported for his first full three calendar months of work under the Collective Bargaining Agreement.

When an Employee's Plan coverage under this special rule ends, he must satisfy the normal eligibility rules above in order to continue to be eligible for Plan Coverage during the following Coverage Periods. Credited Hours reported for the Qualifying Period preceding the next Coverage Period will be counted when determining if he is eligible for Plan coverage during the next Coverage Period even if they are also taken into account under this special rule.

Note that this special rule does not apply when an employee is re-hired. In other words, it can make an employee eligible for Plan Coverage only once. Also, the earliest date Plan Coverage under this special rule could begin was January 1, 2023.

Credited Hours While Disabled

Subject to the limitations and exclusions below, an Employee may automatically receive Credited Hours for purposes of eligibility for Plan Coverage while he is disabled and unable to work due to an Injury suffered as a result of an accident while working in Covered Employment. To qualify for Credited Hours under this provision, within thirty (30) days after the accident the Employer for whom the Employee was working at the time of the accident must provide an incident report to the Funds Office stating the accident occurred and describing the accident. In addition, the Employee must: (i) provide the Funds Office with documentation from the New York State Workers' Compensation Board stating that he qualifies for New York State Workers' Compensation Benefits due to the Injury; and (ii) from time to time upon request, provide the Funds Office with evidence that he continues to qualify for New York State Workers' Compensation Benefits due to the Injury.

If an Employee qualifies for Credited Hours under this provision, he will receive eight (8) Credit Hours for each workday (but not more than forty (40) hours per week), minus the number of whole hours he worked on the day of the accident).

However, an Employee will not receive Credited Hours under this provision for:

- a disability due to repetitive (motion related) Injury;
- any Qualifying Period beginning before January 1, 2023;
- more than one Qualifying Period in his lifetime;
- any time period for which he fails to provide the Funds Office with

documentation from the New York State Workers' Compensation Board that he continues to be disabled and unable to work due to the Injury;

- any time period during which the Participant engages in any type of work for remuneration or profit; or

- any time period in which the Participant does not continue to qualify for New York State Workers' Compensation Benefits due to the Injury.

Self-Payments

If an Employee is eligible for Single Health Coverage during a Coverage Period without any Self-Payment, but not Family Health Coverage, he may still qualify for Family Health Coverage during that Coverage Period through Self-Payment. He must pay an amount equal to: (i) the hourly Contribution rate specified for the Employee in the Collective Bargaining Agreement; multiplied by (ii) the number of additional Credited Hours he needed to be eligible for Family Coverage during the Coverage Period without any Self-Payment.

The Funds Office must receive the full Self-Payment by the last day of the first month of the Coverage Period (i.e., by September 30th for the Fall Coverage Period and by March 31st for the Spring Coverage Period).

If an Employee does not have enough Credited Hours to qualify for Employee (Single) Coverage during a Coverage Period without any Self-Payment, he is not eligible for any Plan Coverage during that Coverage Period. However, he may be eligible for COBRA Continuation Coverage (see page 12).

Full-Time Funds Office and Union Employees

A full-time Employee of the Funds Office or the Union becomes eligible for Plan Coverage on the first day of the month coinciding with or immediately following the date two months after his/her date of hire, and remains eligible for Plan Coverage through the end of the Coverage Period in which he is first eligible for Plan Coverage. His/her eligibility for Plan Coverage after that Coverage Period shall be determined based on the same eligibility rules that apply to Employees who are not Funds Office or Union employees.

Military Leaves

Under the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), an Employee absent from employment because of military service has certain reemployment rights if the length of the military service is not more than five

years and the Employee reports back to work within a certain time period after the military leave ends. An Employee who reports back to work within that required time period will automatically be credited with 650 Credited Hours as of the date his military health coverage ends; provided he notifies the Funds Office of the date his military health coverage will end at least ten (10) days before it does end. The Credited Hours may be used to qualify for Plan Coverage after the military health coverage ends, through the end of the Coverage Period in which it ends. However, if he does not need all of the Credited Hours to qualify for Plan Coverage in that Coverage Period, the excess Credited Hours may be applied to qualify (or help qualify) for Plan Coverage in the next Coverage Period.

Reciprocal Agreements

From time to time, the Plan may enter into agreements that provide for the exchange of contributions made on behalf of participants in one employee welfare plan who work in the jurisdiction of another employee welfare plan (a "reciprocal agreement"). A participant in another plan with which the Plan has a reciprocal agreement will not become a participant in this Plan during a period in which the reciprocal agreement is in effect, unless the reciprocal agreement so provides. Hours of employment by a participant in this Plan for which an employer contributes to another plan while a reciprocal agreement between the other plan and this Plan is in effect will be treated as hours of employment under this Plan; provided, however, the hours of employment credited will equal the number of hours of employment for which contributions are remitted to this Plan, multiplied by a fraction, the numerator of which is the employer's hourly contribution rate under the other plan when the hours of employment were completed and the denominator of which is the hourly employer contribution rate under this Plan when the contributions are received by this Plan.

SPECIAL ENROLLMENT RULES

When You Acquire a Spouse or Dependent Child

If you were eligible, but declined, Single or Family Health Coverage, for a Coverage Period and later during that Coverage Period you acquire a Spouse or Dependent Child by marriage, birth, adoption or placement for adoption, you may enroll yourself, your Spouse and newly acquired Dependent Child in Health Coverage within thirty (30) days after the date of the marriage, birth, adoption or placement for adoption.

When You, Your Spouse or Dependent Child Lose Other Coverage

If you were eligible for, but declined, Health Coverage for a Coverage Period because you had other health care coverage (including COBRA Continuation Coverage from another employer) and later during that Coverage Period you lose that other coverage

through no fault of your own, you can enroll yourself, your Spouse and Dependent Children in Health Coverage within thirty (30) days after losing the other health care coverage. Note, for this special enrollment rule to apply, you may be required to provide in writing the reason you declined Health Coverage at the time you decline it and provide evidence of the other health care coverage.

If you were eligible for, but declined, Health Coverage for a Coverage Period because you had other health care coverage from an employer and later during that Coverage Period that employer stops contributing toward the cost of that other coverage, you can enroll yourself, your Spouse and Dependent Children in Health Coverage within thirty (30) days after that employer stopped contributing toward the cost of the other coverage. Note, for this special enrollment rule to apply, you may be required to provide in writing the reason you declined Health Coverage at the time you decline it and provide evidence of the other health care coverage.

When You, Your Spouse or Dependent Child Lose Eligibility or Become Eligible for Medicaid or State Children's Health Insurance Program Coverage

If you are otherwise eligible for Health Coverage for a Coverage Period and you, your Spouse or Dependent Child later during that Coverage Period lose eligibility for Medicaid coverage or coverage under a State Children's Health Insurance Program, you can enroll yourself, your Spouse and Dependent Child in Health Coverage within sixty (60) days after the loss of that coverage.

If you are otherwise eligible for Health Coverage for a Coverage Period and you, your Spouse or Dependent Child later during that Coverage Period become eligible to participate in a premium assistance program under Medicaid or a State Children's Health Insurance Program, you can enroll yourself, your Spouse and Dependent Child in Health Coverage within sixty (60) days after that eligibility determination.

When Health Coverage Begins and Ends under these Special Rules

If you complete and file the required enrollment forms within the required period described above, the Health Coverage becomes effective on the first day of the month after the date the Funds Office receives the forms or, in the case of birth or adoption, as of the date of birth, adoption or placement for adoption. You must satisfy the eligibility rules described in the preceding Section (ELIGIBILITY FOR PLAN COVERAGE) for Health Coverage to continue after the Coverage Period in which the special enrollment rule applied.

TERMINATION OF COVERAGE

When Plan Coverage Ends

Unless an Employee is eligible for and elects COBRA Continuation Coverage (as described beginning on page 12), his Plan Coverage (including Health Coverage) ends on the earliest date listed below:

- The August 31st or last day of February following the Qualifying Period for which the Employee fails to have the required Credited Hours for Single Health Coverage, as set forth in the Section entitled ELIGIBILITY FOR PLAN COVERAGE beginning on page 4.

- The last day of the Coverage Period during which he begins employment (including self-employment) with an employer that is not the Funds Office, the Union or an employer obligated to make contributions to the Fund on behalf of Employees pursuant to a Collective Bargaining Agreement.

- The last day of the Coverage Period during which his Employer no longer has an obligation to make Contributions to the Plan on his behalf.

- The date Plan Coverage is discontinued with respect to a class of Employees to which he belongs.

- The date coverage is discontinued with respect to all Employees.

Unless an Employee's Spouse is eligible for and elects COBRA Continuation Coverage (as described beginning on page 12), her Health Coverage ends on the earliest date listed below.

- The August 31st or last day of February following the Qualifying Period for which the Employee fails to have the Credited Hours required for Family Health Coverage, as set forth under the Section entitled ELIGIBILITY FOR PLAN COVERAGE beginning on page 4, unless the Employee is eligible for Single Health Coverage and timely makes the Self-Payment for Family Health Coverage described in that Section.

- The date the Employee's Plan Coverage ends.

- The last day of the month in which she is no longer the Employee's legal spouse.

Unless an Employee's Child is eligible for and elects COBRA Continuation Coverage (as described beginning on page 12), his Health Coverage ends on the earliest date listed below.

- The August 31st or last day of February following the Qualifying Period for which the Employee fails to have the Credited Hours required for Family Health Coverage, as set forth under the Section entitled ELIGIBILITY FOR PLAN COVERAGE beginning on page 4, unless the Employee is eligible for Single Health Coverage and timely makes the Self-Payment for Family Health Coverage described in that Section.

- The date the Employee's Plan Coverage ends.

- The last day of the month in which he is no longer the Employee's Dependent Child.

COBRA Continuation Coverage

COBRA Continuation Coverage, which is a temporary extension of Health Coverage ***only*** under the Plan. The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA Continuation Coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should contact the Funds Office.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a thirty (30) day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA Continuation Coverage is a continuation of group health plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA Continuation Coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if Health Coverage 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're an employee, you'll become a qualified beneficiary if you lose your Health Coverage because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your Health Coverage because of the following qualifying events:

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

Your dependent children will become qualified beneficiaries if they lose Health Coverage because of the following qualifying events:

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

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 the respect to an employer whose employees are covered by the Plan and that bankruptcy results in the loss of any retired employee Health Coverage, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their Health Coverage.

When is COBRA Continuation Coverage Available?

The Plan will offer COBRA Continuation Coverage to qualified beneficiaries only after the Funds Office has been notified that a qualifying event has occurred. An employer must notify the Funds Office of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for Health Coverage as a dependent child), you must notify the Funds Office within sixty (60) days after the qualifying event occurs. <u>If you do not notify the Funds Office within sixty (60) days after the qualifying event occurs, you may lose your right to elect COBRA Continuation Coverage</u>. You must provide this notice in writing to the Roofers' Local Union No. 22 Benefit Funds Office, 280 Metro Park, Rochester, New York 14623.

How is COBRA Continuation Coverage Provided?

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

COBRA Continuation Coverage is a temporary continuation of Health Coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which an 18-month period of COBRA Continuation Coverage can be extended:

Disability Extension of 18-Month Period of COBRA 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 Funds Office within sixty (60) days of the determination, you and your entire family may be entitled to get up to an

additional 11 months of COBRA Continuation Coverage, for a maximum of 29 months. The disability would have to have started at some time before the sixtieth (60^{th}) day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. You must provide the notice to the Roofers' Local Union No. 22 Benefit Funds Office, 280 Metro Park, Rochester, New York 14623. The notice must be in writing, and must contain your name and address, the name and address of the disabled person, and the date the disability was determined to have begun. You must also attach a copy of the Social Security Administration determination. You may be asked for additional documentation or information after you have submitted the notice.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event during the 18 months of COBRA Continuation Coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA Continuation Coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose Health Coverage had the first qualifying event not occurred. Within sixty (60) days of the second qualifying event, you must provide notice of the event to the Roofers' Local Union No. 22 Benefit Funds Office, 280 Metro Park, Rochester, New York 14623. The notice must be in writing, and must contain your name and address, a description of the second qualifying event, and the date of the second qualifying event. You may be asked for additional documentation or information after you have submitted the notice.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA Continuation Coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, 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.

Can I enroll in Medicare instead of COBRA Continuation Coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed and have Health Coverage, 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 Health 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 Continuation 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 Continuation 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 https://www.medicare.gov/medicare-and-you.

If You Have Questions

Questions concerning your Plan or your COBRA Continuation Coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, 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 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.

* https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

Keep Your Plan Informed of Address Changes

To protect your family's rights, let the Funds Office know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Funds Office.

New York Continuation Coverage

Under New York law, if a person is entitled to COBRA Continuation Coverage (described above) for less than 36 months and he has COBRA Continuation Coverage through that period, he may be entitled to additional Health Coverage (New York Continuation Coverage). The maximum period of combined COBRA Continuation Coverage and New York Continuation Coverage is 36 months. For example, if your maximum federal COBRA Continuation Coverage period is 18 months, the longest New York Continuation Coverage would be available is another 18 months. The cost for this New York Continuation Coverage is 102% of the full premium for the health coverage and must be paid by the person receiving the New York Continuation Coverage. ***Note, New York Continuation Coverage does not include Deductible, Dental or Vision Coverage described in this booklet***.

New York Extended Child Coverage

Under New York law, if a child has reached the maximum age for Health Coverage as a Dependent Child, the Child may be entitled to extended Health Coverage until he reaches age 29 (New York Extended Child Coverage). To be eligible for New York Extended Child Coverage, the child must be unmarried and satisfy certain other requirements. New York Extended Child Coverage is provided directly by the Insurer providing health coverage for the child's parent. The child must pay the full cost for his New York Extended Child Coverage. If you have reached, or are about to reach, the maximum age for Dependent Child coverage under the Plan and are interested in New York Extended Child Coverage, you should contact the Insurer providing your parent's Health Coverage for more information. ***Note, New York Extended Child Coverage does not include the Deductible, Dental or Vision Coverage described in this booklet***.

HEALTH COVERAGE

Note: To obtain and continue Health Coverage, you must meet any requirements imposed by the Insurer providing the Health Coverage. All Insured Coverage benefits are paid or provided only by the Insurer and are subject to the terms of the Insurer's applicable policy, which may contain definitions and provisions different from those in this booklet.

Health Coverage for Eligible Employees, their Spouses and Dependent Children

The Health Coverage available to Eligible Employees, their Spouses and Dependent Children is Excellus BluePPO Signature Hybrid 1 coverage, which is described in booklets and summaries issued by Excellus BlueCross BlueShield. Information about Co-insurance, Co-Payments, Deductible Amounts, etc. is in the booklets and summaries. Excellus BlueCross BlueShield guarantees BluePPO Signature Hybrid 1 benefits, and is responsible for processing BluePPO Signature Hybrid 1 claims. If anything in this booklet is inconsistent with the insurance policy for Excellus BluePPO Signature Hybrid 1 coverage, the policy controls and determines your right to any benefits. The address and telephone number for Excellus BlueCross BlueShield is:

Excellus BlueCross BlueShield
165 Court Street
Rochester, NY 14647
(585) 325-3630 or (800) 499-1275

Health Coverage for Retirees, their Spouses and Dependent Children

The Health Coverage available to Retirees, their Spouses and Dependent Children under age 65 is Excellus Blue Choice 25 coverage. The Health Coverage available to Retirees and their Spouses age 65 or over is Excellus Medicare Blue Choice (High or Low Option) coverage, which supplements Medicare Parts A and B coverage.

Excellus Blue Choice 25 coverage and Excellus Medicare Blue Choice (High or Low Option) coverage is described in booklets and summaries issued by Excellus BlueCross BlueShield. Information about Co-insurance, Co-Payments, Deductible Amounts, etc. is in the booklets and summaries. Excellus BlueCross BlueShield guarantees Excellus Blue Choice 25 and Excellus Medicare Blue Choice (High or Low Option) benefits, and is responsible for processing Excellus Blue Choice 25 and Excellus Medicare Blue Choice (High or Low Option) claims. If anything in this booklet is inconsistent with the insurance policy issued for Excellus Blue Choice 25 or Excellus Medicare Blue Choice (High or Low Option) coverage, the policy controls and determines your right to any benefits.

Approximately two months before reaching age 65, Retirees who want Excellus Medicare Blue Choice (High or Low Option) coverage must contact the Social Security Administration to enroll for Medicare Parts A and B. The Social Security Administration can advise Retirees of the cost of Medicare Part B.

Retiree Coverage is offered upon retirement and during each Open Enrollment Period for the following calendar year. The Open Enrollment Period for a calendar year (with coverage beginning January 1st of that year) is usually the period beginning early

November and ending early to mid-December of the prior calendar year. The Funds Office will notify Retirees with coverage of annual rate increases as they become available (usually in early to mid-December).

Retirees must pay 100% of the monthly Excellus Blue Choice 25 or Excellus *Medicare Blue Choice (High or Low Option) premium for themselves, their Spouses and Dependent Children. Payment for each month's coverage is due in the Funds Office on the first day of that month. For example, the payment due March 1st is for coverage beginning that March 1st and ending the following March 31st. Payments must be in the form of checks or money orders made payable to the Roofers' Local 22 Benefit Funds Office. If full payment is not received by the Funds Office within thirty (30) days after payment is due, Health Coverage for the Retiree, his Spouse and Dependent Children will be terminated as of the due date.*

Telemedicine Services

Health Coverage includes a telemedicine service offered through Excellus BlueCross BlueShield. The telemedicine service employs a network of U.S. board-certified doctors and pediatricians who use electronic health records, telephone consultations and online video consultations to diagnose common health conditions, recommend treatment, and prescribe medication when medically appropriate. Keep in mind that:

- Telemedicine service is not intended to replace the services of your regular physician(s).

- Telemedicine service is available only to eligible persons enrolled in Health Coverage ***and*** are registered for the telemedicine service.

More information about telemedicine service, including how to register for it, is available from Excellus BlueCross BlueShield or the Funds Office.

DEDUCTIBLE COVERAGE

For Eligible Employees, their Spouses and Dependent Children, Health Coverage includes Deductible Coverage, which supplements their Health Coverage. ***Deductible Coverage is not available to Retirees, their Spouses or their Dependent Children***. Deductible Coverage is self-funded, i.e., Deductible Coverage benefits are paid directly by the Plan. Specifically, the Plan pays $1,000 per calendar year of the Deductible Amount applicable to inpatient or outpatient services incurred for each Eligible Employee, his Spouse and each of his Dependent Children). Deductible Coverage is subject to the **Coordination of Benefits** and **Right of Recovery** and **Subrogation** rules explained beginning on page 26. To receive Deductible Coverage benefits, you must

provide the Funds Office with a copy of the Insurer's Explanation of Benefits (EOB) detailing the inpatient and outpatient services subject to the Insurer's Deductible Amount.

DENTAL COVERAGE

General

For Eligible Employees, their Spouses and Dependent Children, Health Coverage includes Dental Coverage. (Dental Coverage is not available to Retirees, their Spouses or their Dependent Children, but they may be entitled to dental benefits under their Health Coverage.) Dental Coverage is self-funded, i.e., dental benefits are paid directly by the Plan.

Dental care can be expensive and it is to your advantage to know what benefits are payable under the Plan before you agree to have the work done. Therefore, you should submit a predetermination request to the Funds Office for any dental expense estimated to exceed $100. A predetermination helps avoid any misunderstanding as to what is covered by the Plan and helps you to estimate what you will owe.

A predetermination is not mandatory, except for orthodontic services. As explained below, any orthodontic services covered by the Plan must be a part of a treatment plan submitted to the Funds Office, and returned to the dentist showing estimated benefits, before treatment begins.

Forms for making a predetermination request are available from the Funds Office.

All Dental benefits are subject to the rules and limits described in the Sections below. (See **Annual Benefit Limit, Lifetime Orthodontic Benefit Limit,** and **Exclusions**.) These benefits are also subject to the **Coordination of Benefits,** and **Right of Recovery and Subrogation** rules explained beginning on page 26. Subject to these rules and limits, the Plan covers the services described below based on the Reasonable and Customary Charge.

Preventive Dental Care Services

Up to two dentist visits each calendar year for standard cleaning, oral examinations, x-rays, space maintainers, or fluoride applications, except when additional visits are deemed Medically Necessary (e.g., pregnancy).

Basic Dental Services

Extractions, impacted teeth, drugs, anesthesia, recementation, scaling and extensive cleaning. After a $25 per Participant, Spouse and Dependent Child per calendar year

Deductible Amount, the Plan pays 80% of the Reasonable and Customary Charge for basic dental services.

Major Dental Services

Restorative inlays, crowns, pontics, bridges, and dentures. After a $25 per Participant, Spouse and Dependent Child per calendar year Deductible Amount, the Plan pays 50% of the Reasonable and Customary Charge for major dental services.

Orthodontic Services

The Plan pays for orthodontic services only for a Dependent Child if the treatment begins (i.e., an orthodontic appliance is installed) before the Dependent Child reaches age 26 and after the Dependent Child is covered under the Plan. After a $50 per Dependent Child per lifetime Deductible Amount, the Plan pays 50% of the Reasonable and Customary Charge for orthodontic services. Orthodontic services are covered under the Plan only if they are listed below and only if the service is provided to treat one or more of the following conditions:

- Overbite or over jut of at least four millimeters.
- Maxillary (upper) and mandibular (lower) arches in either protrusive or retrusive relation or at least one cusp.
- Cross-bite.
- An arch length discrepancy of more than four millimeters in either the upper or lower arch.

The following is a complete list of orthodontic services covered by the Plan.

Preventive Treatment Procedures

- Radiographs
- Cephalometric film

Minor Treatment for Tooth Guidance

- Removable appliance therapy
- Fixed or cemented appliance therapy
- Interceptive orthodontic treatment

Treatment of the Transitional Dentition

- Class I malocclusion
- Class II malocclusion
- Class III malocclusion

Treatment of the Permanent Dentition

- Class I malocclusion
- Class II malocclusion
- Class III malocclusion

Any service not listed above is excluded, unless it is for a condition for which a listed service is appropriate according to customary dental practice. In that case, the maximum benefit for the non-listed service will be the benefit that would have been paid for the listed service.

Any orthodontic services covered by the Plan must be a part of a treatment plan submitted to the Funds Office, and returned to the dentist showing estimated benefits, before treatment begins. The treatment plan must: (i) itemize the dental services recommended by him for the necessary and customary dental care of an insured; (ii) show the charge for each dental service; (iii) provide a classification of the malocclusion; (iv) recommend and describe necessary treatment by orthodontic procedures; (v) estimate the duration over which treatment will be completed; (vi) estimate the total charge for such treatment; and (vii) be accompanied by cephalometric x-rays, study models and such other supporting information and documentation that the Trustees may require.

The total Plan benefit for all services rendered under the treatment plan will be paid in equal monthly installments over a period of time equal to the estimated duration of the treatment provided, however, that the number of monthly installments will not exceed 36. The first installment will be payable on the date on which the orthodontic appliance(s) are first installed, and subsequent installments are payable at the end of each month thereafter.

Annual Benefit Limit

An Annual Benefit Limit applies to preventive dental care services, basic dental services, and major dental services (as described in this booklet) covered under the Plan. This is a combined limit that applies to all covered dental services, except orthodontic services. The Annual Benefit Limit is $2,000 per person per calendar year. However, Plan payments for preventive dental care, basic dental, or major dental services provided for a Dependent Child are not subject to the Annual

Benefit Limit until the Dependent Child attains age 19. When the Dependent Child does attain age 19, any Plan payments for these services incurred during the part of the calendar year before his nineteenth (19th) birthday count against his Annual Benefit Limit for the remainder of that calendar year. For example, if the Plan's payments for these services incurred during the part of the calendar before his nineteenth (19th) birthday already equal or exceed $2,000, the Dependent Child will not be eligible for any additional preventive care, basic or major dental benefits for the rest of that calendar year.

Lifetime Orthodontic Benefit Limit

The Plan pays for orthodontic services (described in this booklet) for a Dependent Child only up to the Lifetime Orthodontic Benefit Limit. The Lifetime Orthodontic Benefit Limit is separate from the Annual Benefit Limit for other dental services and is $1,000 per Dependent Child.

However, Plan payments for ***Medically Necessary*** orthodontic services provided for a Dependent Child before he attains age 19 do not count against his Lifetime Orthodontic Benefit Limit until he attains age 19. For example, a Dependent Child who has attained age 19, will not be eligible for additional orthodontic benefits if total Plan payments for his orthodontic services before he attained age 19 (including Medically Necessary orthodontic services) already equal or exceeded $1,000.

Exclusions

In no event will the Plan pay for expenses paid for any dental service, treatment or supply that is or is related to:

- Consultations.
- A cosmetic purpose, unless necessitated as a result of an accident sustained while the patient qualified for Dental Coverage and the service is furnished within one year of the date of the accident and while the patient remains qualified for Dental Coverage. For purposes of this limitation, facings, or crowns, or pontics, posterior to the second bicuspid and the personalization and characterization of dentures are always considered cosmetic.
- Care of a congenital or developmental malformation (unless specifically included above).
- Replacement of lost, missing or stolen prosthetic device, or any other device or appliance.
- Appliances, restorations, or procedures for the purpose of altering vertical dimension, restoring or maintaining occlusion, splinting, or replacing tooth

structure lost as a result of abrasion or attrition, or treatment of disturbances of the temporomandibular joint.

- A service not reasonably necessary, or not customarily performed, for the dental care of the individual.
- A service not furnished by a dentist, unless the service is performed by a licensed dental hygienist under the supervision of a dentist or is an x-ray ordered by a dentist.
- Sealants, plaque control programs or dietary instruction.
- Implantology.
- A service furnished by or on behalf of any government, unless as to such government, payment of a charge for such service is legally required, or charges for any dental services to the extent that benefits are payable therefore under any law or governmental program under which an individual is or could be covered. The term "any government" includes the federal, state, provincial or local government or any political subdivision thereof of the United States or any other country.
- Replacement of any prosthetic appliance, crown, inlay or onlay restoration or fixed bridge within five years of the date of the last placement of such appliance, crown inlay or onlay restoration or fixed bridge unless such replacement is required as a result of accidental bodily Injury sustained while the covered individual is insured under this benefit.
- Services, treatment or supplies covered under other provisions of the Plan (e.g., Health Coverage).
- Care, treatment, services, or supplies furnished by a person who: (i) ordinarily resides in the covered person's home; or (ii) is the Spouse or any other relative of the covered person or of the covered person's Spouse.
- An initial placement of a partial or full removable denture or fixed bridge work involving replacement of one or more natural teeth extracted prior to the covered individual becoming insured under this benefit, unless the denture or fixed bridgework also included replacement of a natural tooth that is extracted while the covered individual is insured under this benefit.
- Any loss caused or contributed to by: (i) war or act of war, whether war is declared or not; or (ii) Sickness contracted or injuries sustained while in any of the armed forces, whether land, water, or air, of any country or international authority at war, whether war is declared or not or engaged in any armed conflict.
- Any Sickness or Injury for which an individual is entitled to benefits under any workers' compensation or similar law.

VISION COVERAGE

For Eligible Employees, their Spouses and Dependent Children, Health Coverage includes Vision Coverage. (Vision Coverage is not available to Retirees, their Spouses or their Dependent Children, but they may be entitled to vision benefits under their Health Coverage.) Vision Coverage is self-funded, i.e., vision benefits are paid directly by the Plan.

For each covered individual other than a Dependent Child under age 19, the Plan pays:

- $40 for a basic eye examination every two calendar years performed by an ophthalmologist (a licensed physician specializing in eye care and eye surgery) or optometrist (a professional licensed to perform eye examinations and recommend corrective action); and
- up to $300 every two calendar years for any combination of prescribed lenses, frames, or prescribed contact lenses provided by an ophthalmologist, optometrist or optician.
- up to $200 every two calendar years for "Z-87" prescription safety glasses.

For each Dependent Child under age 19, the Plan pays:

- 50% of the cost of a basic eye examination every two calendar years performed by an ophthalmologist (a licensed physician specializing in eye care and eye surgery) or optometrist (a professional licensed to perform eye examinations and recommend corrective action), but not less than $40 of the cost; and
- up to $300 every two calendar years for any combination of prescribed lenses, frames, or prescribed contact lenses provided by an ophthalmologist, optometrist or optician.

Exclusion

In no event will the Plan pay for vision services, treatment or supplies covered under other provisions of the Plan (e.g., Health Coverage).

Also, keep in mind that Vision Coverage is subject to the **Coordination of Benefits** and **Right of Recovery** and **Subrogation** rules described below.

COORDINATION OF BENEFITS (COB)

If a person has Health Coverage under this Plan and also has other health coverage, this Plan follows a procedure called coordination of benefits ("COB") to determine how much this Plan should be paid when there is a claim. These COB rules are complicated and cover a wide variety of circumstances. This discussion below is not a complete description of all of the COB rules, and does not change or replace the COB provisions of the Plan which determine actual Plan benefits. **It also does not change the COB rules under any Insurer's policy, so if those rules are different from the rules discussed below, the policy will control a person's right to benefits**.

A Participant, his Spouse or Dependent Child may be asked to identify and provide information regarding all of his Health Plan Coverage so that the Plan can determine whether it is the "Primary Plan" (the Plan that pays the claim first) or "Secondary Plan." For purposes of the COB rules, "Health Plan" means any: individual, group, fraternal, blanket or franchise insurance policy; health maintenance organization (HMO) contract; other form of group or non group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; coverage under a group or individual automobile contract; Medicare; and any other governmental plan, program or coverage provided by federal or state statute. However, it does not include any coverage for which federal law prohibits coordination of benefits with this Plan.

When a person is covered under more than one Health Plan, the "Primary Plan" and the "Secondary Plan" are determined using the following rules applied in the order below (i.e., the first rule to apply will control).

- If a Health Plan covers the person as other than a spouse or dependent (e.g., a Health Plan that covers the person as an employee, member, policy holder, subscriber or Retiree) and another Health Plan covers the person as a spouse or dependent, the Health Plan covering the person as other than a spouse or dependent is the Primary Plan and the Health Plan covering the person as a spouse or dependent is the Secondary Plan. However, if the person is a retiree and a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Health Plan covering the person as a dependent and primary to the Health Plan not covering the person as a dependent, then the Health Plan not covering the person as a dependent is the Secondary Plan and the other Health Plan is the Primary Plan. If the person is an active employee and a Medicare beneficiary and, as a result of federal law, Medicare is secondary to both Health Plans, then the Health Plan covering the person as a dependent is the Secondary Plan and the other Health Plan is the Primary Plan.

- Unless a court decree states otherwise, if a dependent is covered by the Health Plans of his parents and:

(1) the child's parents are married or are living together, (whether or not they have ever been married), the Health Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan or, if both parents have the same birthday, the Health Plan that has covered a parent the longest is the Primary Plan.

(2) the child's parents are divorced, separated or not living together (whether or not they have ever been married) and:

(i) a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage, the Health Plan of that parent is the Primary Plan for the child. This rule applies to Plan Years commencing after the Health Plan is given notice of such court decree;

(ii) a court decree states that both parents are responsible for the dependent's health care expenses or health care coverage, the Health Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan for the child or, if both parents have the same birthday, the Health Plan that has covered a parent the longest is the Primary Plan for the child;

(iii) a court decree states that the parents have joint custody without specifying which parent has responsibility for the health care expenses or health care coverage of the child, the Health Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan for the child or, if both parents have the same birthday, the Health Plan that has covered a parent the longest is the Primary Plan for the child; or

(iv) there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the Primary Plan for the child shall be:

- the Health Plan covering the custodial parent or, if no Health Plan covers the custodial parent,

- the Health Plan covering the spouse of the custodial parent or, if no Health Plan covers the spouse of the custodial parent,

- the Health Plan covering the non-custodial parent or, if no Health Plan covers the non-custodial parent,

- the Health Plan covering the spouse of the non-custodial parent.

The custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

(v) If the child is covered under more than one Health Plan of individuals who are not both parents of the child, the rules above apply as if those individuals were the parents of the child.

- If a person is covered by a Health Plan as an active employee, e.g., an employee who is neither laid off nor retired (or as a spouse or dependent of an active employee) and is covered by another Health Plan as an inactive employee (or as a spouse or dependent of an inactive employee), the Health Plan covering the person as an active employee (or as a spouse or dependent of an active employee) is the Primary Plan, and the Health Plan covering the person as an inactive employee (or as a spouse or dependent of an inactive employee) is the Secondary Plan.

- If a person is covered by a Health Plan pursuant to COBRA or similar state law and is covered by another Health Plan as a member, policy holder, subscriber, active employee or Retiree, the Health Plan covering the person as a member, policy holder, subscriber, active employee or Retiree is the Primary Plan and the other Health Plan is the Secondary Plan.

- If a person is covered by the Health Plans as a member, policy holder, subscriber, active employee or Retiree, the Health Plan covering the person as a member, policy holder, subscriber, active employee or Retiree for the longer period of time is the Primary Plan and the Health Plan covering the person as a member, policy holder, subscriber, active employee or Retiree for the shorter period of time is the Secondary Plan.

- If the rules above do not determine the order of benefits, the Allowable Expenses (as defined in below) are shared equally between the Health Plans; provided, however that this Health Plan will not pay more than it would have paid had it been the Primary Plan.

The Primary Plan pays benefits before, and without regard to, those of any Secondary Plan. A Secondary Plan determines its benefits after those of the Primary Plan, and may reduce the benefits it pays so that all Health Plan benefits do not exceed 100% of total Allowable Expenses. Generally, an Allowable Expense is a health care expense,

including Deductible Amounts, Co-insurance and Co-Payments, covered at least in part by a Health Plan. If a Health Plan provides benefits in the form of services, the reasonable cash value of each service is considered an Allowable Expense. Any expense that a provider by law or in accordance with a contract is prohibited from charging a covered person is not an Allowable Expense.

A Secondary Plan may reduce its benefits so that the total benefits paid or provided by all Health Plans during a Plan Year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other Health Plans and apply that calculated amount to any Allowable Expense that is unpaid by the Primary Plan. However, the Secondary Plan may reduce this amount so that its payment, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Health Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit against its Deductible Amounts any amounts it would have credited against its Deductible Amount in the absence of other Health Plan Coverage.

Payment made under another Health Plan may include an amount that should be paid under this Health Plan. In that event, this Health Plan shall pay that amount directly to the Health Plan that made the payment. That amount will then be treated as though it were a benefit paid under this Health Plan, and this Health Plan will not have to pay that amount again. If benefits are provided in the form of services, "payment made" means the reasonable cash value of the benefits provided in the form of services.

If the amount of the payments made by this Plan (including the reasonable cash value of any benefits provided in the form of services) is more than it should have paid, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person.

Contact the Funds Office if you have any questions about the COB rules or you would like a complete copy of the Plan's COB rules.

Apart from the COB rules, keep in mind that the Plan does not pay for:

- Medical care or services furnished by the Veteran's Administration to a veteran of the United States Armed forces in connection with the treatment of a service-connected disability which was incurred or aggravated in the line of duty in the active military, naval, or air service.
- Medical care or services furnished at an armed forces facility to an armed forces retiree or his dependents under the Civilian Health and Medical Program for the Uniformed Services, but only to the extent such person

would not have to pay for such medical care or services if he did not have Plan Coverage.

- Medical care or services for injuries or diseases covered under any workers' compensation program.

RIGHT OF RECOVERY AND SUBROGATION

If Health Coverage benefits (including Deductible, Dental or Vision Coverage benefits) are paid by the Plan in excess of the Plan's benefit limits or other rules, the Plan has the right to recover the excess from the person who received the payments, the person for whom the payments were made, or from any insurance company or other party that owes payment for the expense for which the excess payment was made. The Plan also has the right to decrease future benefits otherwise payable under the Plan to the Participant who benefited from the excess payment.

Whenever the Plan pays a Health Coverage benefit (including Deductible, Dental or Vision Coverage benefits), the Plan is subrogated to the right of recovery of the Participant, his Spouse or Dependent Child against any third party that caused the Injury or Sickness for which the expense was incurred. The Participant, his Spouse or Dependent Child may not act to prejudice this right of subrogation, and must execute and deliver documents and do whatever else is necessary to secure the Plan's right of subrogation (including the right to sue the third party in the name of the Participant, Spouse or Dependent Child). The Trustees may require a Participant, Spouse or Dependent Child to sign an agreement acknowledging these Plan rights as a condition to receiving payment from the Plan. However, even if the Plan does not require such an agreement, this will not affect the Plan's subrogation rights.

WEEKLY INDEMNITY COVERAGE

Weekly Benefit

Subject to the Exclusions and Limitations below, if a Participant becomes totally disabled due to accidental bodily Injury or Sickness while covered under the Plan, and is prevented by the disability from performing any and every duty pertaining to his occupation, the Plan pays a weekly benefit to the Participant of $50.00 for the period of the total disability, but not more than 26 weeks. Successive periods of disability separated by less than two weeks of Covered Employment are considered one period of disability unless the subsequent disability is due to an Injury or Sickness entirely unrelated to the cause of the previous disability and commences after return to Covered Employment. Successive periods of disability due to Injuries received in one accident are considered one period of disability.

Exclusions and Limitations

No Weekly Indemnity benefits are paid for:

- Any Injury or Sickness sustained on or off the job while engaged in any occupation or job for profit or remuneration other than Covered Employment.
- The first seven (7) days of disability resulting from Sickness.
- Any period during which the Participant engages in any work for remuneration or profit.
- Any period for which the Participant does not provide the Plan with a physician's statement of continuing disability.

LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE

General

The Life and Accidental Death and Dismemberment Coverage described below is provided through a group life insurance policy with Union Labor Life Insurance Company (ULLICO). More information about this coverage is in the ULLICO Certificate of Insurance, which is available from the Funds Office. If anything in this booklet or the Certificate of Insurance is inconsistent with the terms of the ULLICO insurance policy, the ULLICO insurance policy controls and determines your right (or your beneficiary's right) to any benefits.

Death Benefit

Subject to the Exclusions below, if a Participant dies while covered under the Plan and under the age of 65, a death benefit is payable to his designated beneficiary through a group life insurance policy with ULLICO. If death is the result of natural causes, the death benefit is $5,000 for an Eligible Employee and $2,500 for a Retiree under age 65. If death is the result of accidental causes, the death benefit is $10,000 for an Eligible Employee and $5,000 for a Retiree under age 65.

Beneficiary Designations

The death benefit will be paid to the Participant's beneficiary or beneficiaries, as designated by the Participant on a form provided by the Funds Office, signed by the Participant, and filed with the Funds Office. A properly completed death beneficiary designation form becomes effective when it is filed with the Funds Office, and remains in effect until a new form is filed. If a designated beneficiary predeceases the Participant, that beneficiary's share will be paid equally to the remaining surviving designated beneficiaries. If all designated beneficiaries predecease the Participant, or there is no

properly completed beneficiary designation form in effect, the death benefit will be paid to his surviving Spouse or, if he has no surviving Spouse, to his children in equal shares. If he has no surviving Spouse or children, the benefit will be paid to his other relatives or to his estate, as specified in the ULLICO policy.

If a designated beneficiary is a minor or is otherwise incapable of giving a valid release for any payment due, payment may be made to the beneficiary's legal guardian or, if there is no legal guardian, to the person or institution appearing to have assumed the custody and principal support of the beneficiary.

Accidental Dismemberment Benefits

Subject to the **Exclusions** below, if a Participant sustains bodily Injury solely through accidental means while covered under the Plan that results in one of the losses listed below within ninety (90) days of the date of the accident, a benefit is payable in accordance with the following schedule through the ULLICO policy.

For loss of	Benefit Payment
Two Hands or Two Feet	The Principal Sum
Sight of Two Eyes	The Principal Sum
One Hand and One Foot	The Principal Sum
One Hand and Sight of One Eye	The Principal Sum
One Foot and Sight of One Eye	The Principal Sum
One Hand or One Foot	One-half of the Principal Sum
Sight of One Eye	One-half of the Principal Sum

The Principal Sum is the benefit that would be payable in the event of death while covered under the Plan. With regard to hands and feet, "loss" means dismemberment by severance at or above wrist or ankle joints. With regard to eyes, "loss" means entire and irrecoverable loss of sight.

Exclusions

No death or accidental dismemberment benefit is paid for any death or loss resulting directly or indirectly from, or contributed to by:

- Bodily or mental illness or disease of any kind.
- Ptomaines or bacterial infections (except infections caused by pyogenic organisms which occur with and through an accidental cut or wound).
- Suicide or attempted suicide.
- Intentional self-inflicted injury.

- Participation in, or the result of participation in, a felony or a riot.
- War or any act of war, declared or undeclared, or any act related to war or insurrection.
- Service in the armed forces of any country while the country is at war.
- Police duty performed in the Armed Forces or unit auxiliary thereto.

Disability Premium Waiver

If a Participant who becomes totally disabled before reaching age 60 while covered under the Plan files a disability premium waiver application with ULLICO and, within 12 months from the date premium payments to ULLICO cease, furnishes proof satisfactory to ULLICO that the disability has existed uninterrupted for nine months, his Life and Accidental Death and Dismemberment Coverage will continue during the period of the disability, subject to: (i) annual submission by the Participant of proof satisfactory to ULLICO of the uninterrupted existence of such disability within the three months preceding each anniversary of receipt of initial proof; and (ii) submission by the Participant to examination by a physician, as provided below. Forms necessary to apply for this waiver can be obtained from the Funds Office. For this purpose, total disability means complete inability, due to injury or illness, to engage in any business, occupation or employment, even on a part-time basis, for which the Participant is qualified or becomes qualified.

The waiver and coverage will terminate upon the earliest of: (i) the date the total disability ends; (ii) the Participant's failure to submit annual proof of the uninterrupted existence of total disability, as specified above and whether or not ULLICO requests such proof; or (iii) the Participant's failure to submit to examination by a physician, as provided below. If the Participant dies during the period the waiver is in effect, payment of a death benefit is conditioned on submission of proof satisfactory to ULLICO within one year after death that the disability existed uninterruptedly since the time the Participant last provided proof of uninterrupted existence of total disability.

ULLICO has the right to designate a physician to examine a Participant during his disability, but not more often than once a year after the Participant's insurance has been continued for two full years.

Conversion

If a Participant who is under age 65 is no longer eligible for coverage under the Plan, he may have the right to convert his Life and Accidental Death and Dismemberment Coverage under the ULLICO group policy to an individual policy with ULLICO. He will then be responsible for the payment of all necessary premiums directly to ULLICO.

Information about, and the forms necessary for, this conversion can be obtained from the Funds Office or directly from ULLICO.

ULLICO is responsible for processing all death and dismemberment coverage claims. Its address and telephone number is:

Union Labor Life Insurance Company
8403 Colesville Road
Silver Springs, MD 20910
(202) 682-6768

CLAIM PROCEDURES

General

If you have questions about specific Health Coverage, you should contact Excellus BlueCross BlueShield, 165 Court Street. Rochester, NY 14647. If you believe you are entitled to specific Health Coverage benefits you should submit a claim directly to the health insurance company. Each health insurance company is responsible for processing claims and paying benefits under the coverage it provides. Forms for making claims for Health Coverage benefits are available from the insurance company or Funds Office.

You should contact the Funds Office if you have questions about eligibility under the Plan, the cost of coverage, for Dental, Vision, Deductible, Life and Accidental Death and Dismemberment, or Weekly Indemnity benefits. Claims for these benefits should also be filed with the Funds Office. Forms for making claims for these benefits are available from the Funds Office.

The Insurers have discretionary authority to make claim, eligibility and other administrative determinations regarding their policies, and to interpret the meaning of their policies' terms and language. However, this authority is limited to their policies and does not extend to other aspects of the Plan.

Each Insurer is responsible for processing claims and paying the specific benefits under its policies and has discretion and authority to: (i) carry out all actions involving claims procedures for benefits under its policies; (ii) grant or deny any and all claims for benefits; and (iii) construe any and all policy issues relating to eligibility for benefits. The procedures and time limits for claims are subject to required ERISA claims procedures. To the extent there is any inconsistency between an Insurer's procedures and rules and the following ERISA procedures, the ERISA procedures apply.

Specific Claim Procedures

For Health, Deductible, Dental, Vision Coverage Benefits

The claim procedures are different for "concurrent claims," "pre-service claims," "post-service claims," and "urgent claims." A concurrent claim is a request for an extension of health treatment (i.e., treatment provided over a period of time or a number of treatments). A pre-service claim is a claim requiring advance approval to receive all or part of the benefit. A post-service claim is any claim that is not a concurrent claim or pre-service claim. An urgent claim is any claim for medical care or treatment that, if non-urgent claim procedures were followed, could seriously jeopardize the life or health of the patient or his ability to regain maximum function, or in the opinion of a physician with knowledge of the patient's medical condition would subject the patient to severe pain that cannot be adequately managed without the care or treatment requested.

You may appoint someone to file a claim and act on your behalf; provided you give the Plan signed written notification of the appointment. In the case of an urgent claim, a health care professional with knowledge of your medical condition will be permitted to act as your representative.

Post-service claims for Health Coverage benefits (including Deductible, Dental, or Vision Coverage benefits) must be filed within 12 months after the service or expense claimed was incurred. Post-service claims for Health Coverage benefits must be filed within 24 months after the service or expense claimed was incurred. All claims must be submitted by mail, except urgent claims may be made orally and information may be transmitted by telephone or facsimile, provided that any necessary written forms are later completed and filed. The phone numbers are:

<u>Telephone</u>

(800) 499-1275 for BluePPO Signature Hybrid 1 coverage
(585) 325-3630 or (800) 499-1275 for Excellus Blue Choice 25 coverage
(877) 883-9577 for Excellus Medicare Blue Choice Low Option or High Option coverage
(585) 235-0829 for Deductible, Dental or Vision Coverage

<u>Facsimile</u>

(585) 238-3692 for BluePPO Signature Hybrid 1 coverage
(585) 238-3692 for Excellus Blue Choice 25 coverage
(716) 843-7860 for Excellus Medicare Blue Choice Low Option or High Option coverage
(585) 235-7123 for Deductible, Dental or Vision Coverage

If you make a request for benefits that does not comply with the Plan's procedure for pre-service claims, you will be notified of the proper procedure within 24 hours if it involves an urgent pre-service claim, or within five (5) days if it involves a non-urgent pre-service claim. (This notification may be oral, unless you request written notification.)

If a claimant fails to submit sufficient information for a determination on an urgent claim, he will be notified of the specific information necessary to complete the claim within 24 hours after the Plan receives the claim. He may then submit the additional information within 48 hours and will be notified of the determination on his claim within 48 hours after the earlier of the receipt of the additional information or the end of the period the additional information could have been submitted.

A claimant will be notified of the determination on his claim within: 24 hours in the case of a concurrent claim involving urgent health care if the request is received at least 24 hours before the scheduled expiration of the treatments; 72 hours in the case of any other urgent claim (or earlier if possible); fifteen (15) days in the case of a non-urgent pre-service claim; or thirty (30) days in the case of a post-service claim. However, if an extension to make a determination on a non-urgent claim is necessary due to reasons beyond the Plan's control, the time to make the determination may be extended for up to another fifteen (15) days. In that case, the claimant will receive written notice of the reasons for the extension, any additional information required from him to make the determination, and the date the determination is expected. Also, if the extension is necessary because additional information is needed from the claimant, the claimant will be given forty-five (45) days after he receives the notice to provide the information.

If an adverse determination is made, the claimant will be sent a notice containing: (i) the specific reasons for the adverse determination; (ii) references to the specific Plan provisions on which it is based; (iii) the names of any medical or vocational experts whose advice was obtained by the Plan in connection with the determination; (iv) a description of any additional material or information necessary to complete the claim and an explanation of why it is necessary; (v) a description of the Plan's review procedures and time limits; (vi) a statement that the claimant has a right to sue following an adverse determination upon review; (vii) if the Plan relied upon an internal rule, guideline, protocol or similar criterion in making the determination, either the criterion relied upon or a statement that the Plan relied upon such criterion and that a copy of the criterion is available free of charge upon request; (viii) if the determination was based upon a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to the claimant's medical circumstances), or a statement that such explanation will be provided free of charge upon request; and (ix) for urgent claims, a description of the expedited review procedure for such claims. This notice may be provided orally for an urgent claim, but will then be sent to the claimant in writing within three (3) days after oral notification.

If a claim is denied and the claimant wants a review of the denial, he must file a written request for a review within one hundred and eighty (180) days after he receives the written notice of denial of health claim. He may submit written comments, documents and other information relating to the claim, and may have reasonable access to, and copies of, all documents, records, and other information relevant to the claim. For an urgent claim, the claimant may request, in writing or orally, an expedited review of the initial determination, and information may be transmitted by telephone by telephone or by facsimile, provided that any necessary written forms are later completed and filed. The phone numbers are:

Telephone

(877) 253-4797 for BluePPO Signature Hybrid 1 coverage
(585) 454-4810 for Excellus Blue Choice 25 coverage
(877) 883-9577 for Excellus Medicare Blue Choice Low Option or High Option coverage
(585) 235-0829 for Deductible, Dental or Vision Coverage

Facsimile

(585) 238-3692 for BluePPO Signature Hybrid 1 coverage
(585) 238-3692 for Excellus Blue Choice 25 coverage
(716) 847-1257 for Excellus Medicare Blue Choice Low Option or High Option coverage
(585) 235-7123 for Deductible, Dental or Vision Coverage

A reduction or termination of health treatment (other than by Plan amendment or termination) will be treated as an adverse determination, and the Participant or beneficiary will be notified sufficiently in advance to allow him to appeal before the reduction or termination occurs.

The review on appeal will take into account all documents, records and information submitted by the claimant, and will be conducted by an appropriate named fiduciary who did not make the initial determination and who is not a subordinate of the person who did. For a claim based on medical judgment (e.g., whether a treatment or drug is experimental, investigational, or medically necessary or appropriate), the person conducting the review will consult with a state licensed or certified independent health care professional with appropriate training and experience in the field who was not consulted in connection with the initial determination and is not a subordinate of any health care professional who was consulted.

The claimant will be notified of the determination on review within seventy-two (72) hours after the Plan receives the request for review of an urgent claim (or earlier if possible), thirty (30) days after the Plan receives a request for review of a non-urgent pre-

service claim, or sixty (60) days after the Plan receives a request for review of a post-service claim.

The notice of an adverse determination on review will contain: (i) the specific reasons for the adverse determination; (ii) reference to the specific Plan provisions on which the determination is based; (iii) a statement that, upon request, the claimant is entitled free of charge to reasonable access to, and copies of, all documents and records relevant to the claim; (iv) if the Plan relied upon some internal rule, guideline, protocol, or similar criterion in making the determination, either the criterion relied upon or a statement that the Plan relied upon such criterion and a copy of the criterion is available free of charge upon request; (v) if the determination is based upon a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and (vi) the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

An external claim review procedure applies final internal adverse benefit determinations. Contact Excellus BlueCross BlueShield for information on how to make a request for an external claim review and other external claim review procedures.

For Weekly Indemnity Claims

You may appoint someone to file a claim and act on your behalf; provided you give the Plan signed written notification of the appointment.

All claims must include either: (i) a copy the Worker's Compensation form submitted to your Employer for the disability; (ii) a copy New York State Disability Claim Form submitted to your Employer for the disability; or (iii) a letter from your physician describing your Sickness or Injury, the date you were no longer able to perform your occupational duties, and an estimated date on which you could return to work (which must be periodically updated for continued weekly indemnity claims.)

A claimant will be notified of the determination on his claim within forty-five (45) days. However, if an extension to make a determination is necessary due to reasons beyond the Plan's control, the time to make the determination may be extended for up to two thirty (30) day extension periods. In that case, the claimant will receive written notice of the reasons for the extension, any additional information required from him to make the determination, and the date the determination is expected. Also, if the extension is necessary because additional information is needed from the claimant, the claimant will be given forty-five (45) days after he receives the notice to provide the information.

If an adverse determination is made, the claimant will be sent a notice containing: (i) the specific reasons for the adverse determination; (ii) references to the specific Plan provisions on which it is based; (iii) the names of any medical or vocational experts whose advice was obtained by the Plan in connection with the determination; (iv) a description of any additional material or information necessary to complete the claim and an explanation of why it is necessary; (v) a description of the Plan's review procedures and time limits; and (vi) a statement that the claimant has a right to sue following an adverse determination upon review.

If a claim is denied and the claimant wants a review of the denial, he must file a written request for a review within one hundred and eighty (180) days after he receives the written notice of denial of health claim. He may submit written comments, documents and other information relating to the claim, and may have reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The review on appeal will take into account all documents, records and information submitted by the claimant, and will be conducted by an appropriate named fiduciary who did not make the initial determination and who is not a subordinate of the person who did. For a claim based on medical judgment, the person conducting the review will consult with a state licensed or certified independent health care professional with appropriate training and experience in the field who was not consulted in connection with the initial determination and is not a subordinate of any health care professional who was consulted.

The claimant will be notified of the determination on review within forty-five (45) days after the Plan receives a request for review. However, if an extension to make a determination is necessary due to reasons beyond the Plan's control, the time to make the determination may be extended for up to another forty-five (45) days. In that case, the claimant will receive written notice of the reasons for the extension, any additional information required from him to make the determination, and the date the determination is expected.

The notice of an adverse determination on review will contain: (i) the specific reasons for the adverse determination; (ii) reference to the specific Plan provisions on which the determination is based; (iii) a statement that, upon request, the claimant is entitled free of charge to reasonable access to, and copies of, all documents and records relevant to the claim; and (iv) the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

For Life and Accidental Death and Dismemberment Claims

All claims must be filed on forms provided by the Funds Office and submitted by mail or personally delivered.

A claimant will be notified of the determination on his claim within ninety (90) days. However, if an extension to make a determination is necessary due to reasons beyond the Plan's control, the time to make the determination may be extended for up to another ninety (90) days. In that case, the claimant will receive written notice of the reasons for the extension, any additional information required from him to make the determination, and the date the determination is expected.

If an adverse determination is made, the claimant will be sent a notice containing: (i) the specific reasons for the adverse determination; (ii) references to the specific Plan provisions on which it is based; (iii) a description of any additional material or information necessary to complete the claim and an explanation of why it is necessary; (iv) a description of the Plan's review procedures and time limits; and (v) a statement that the claimant has a right to sue following an adverse determination upon review.

If an adverse determination is made, the claimant may file a written appeal to the Funds Office for a full and fair review of the claim and determination. The appeal must be filed within sixty (60) days after he receives the written notice of denied of health claim. He may submit written comments, documents and other information relating to the claim, and may have reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The review on appeal will take into account all documents, records and information submitted by the claimant.

The claimant will be notified of the determination on review within sixty (60) days after the Plan receives a request for review. However, if an extension to make a determination on review is necessary due to reasons beyond the Plan's control, the time to make the determination may be extended for up to another sixty (60) days. In that case, the claimant will receive written notice of the reasons for the extension, any additional information required from him to make the determination, and the date the determination is expected.

The notice of an adverse determination on review will contain: (i) the specific reasons for the adverse determination; (ii) reference to the specific Plan provisions on which the determination is based; and (iii) a statement that, upon request, the claimant is entitled free of charge to reasonable access to, and copies of, all documents and records relevant to the claim.

Legal Action

Any legal action brought against the Plan, Fund, Fund Employee, or any Trustee by Participant, Spouse, Dependent Child or other person, to recover any benefit from the Plan, must be commenced no later than one year after the claimant received written notice of the determination on review of his claim.

Non-Assignment

The rights of Participants, Spouses and Dependent Children under the Plan are not subject to assignment, attachment, garnishment, or alienation, except to the extent required under a "qualified medical child support order."

OTHER IMPORTANT INFORMATION ABOUT THE PLAN

Official Name of Plan

Roofers' Local Union No. 22 Welfare Plan

Employer Identification Number

23-7381527

Plan Number

501

Plan Year End Date

June 30

Type of Coverage and Plan Administration

Plan Coverage is insured except for Deductible, Dental, and Vision Coverage. Deductible, Dental, and Vision Coverage is also self-administered.

Plan Administrator

Board of Trustees
Roofers' Local Union No. 22 Welfare Fund
280 Metro Park
Rochester, NY 14623

Telephone: (585) 235-0829

Agent for Service of Legal Process

Service of legal process may be made on the Plan Administrator.

Funding

All contributions to the Plan are made by the Employers pursuant to the terms of Collective Bargaining Agreements between Employers and the Union, except for contributions required by an Eligible Employee who elects the Self-Payment option (see page 8), or a person who elects COBRA Continuation Coverage (see page 12), New York Continuation Coverage or New York Extended Child Coverage (see page 17). These Collective Bargaining Agreements set forth the conditions under which Employers are required to contribute to the Plan and the rate(s) of contribution. Employees may examine the Collective Bargaining Agreements at the Funds Office, and may request a copy of the Collective Bargaining Agreements and a list of contributing Employers from the Funds Office.

Authority of Trustees

In addition to all of the other powers conferred upon it by law, the Trustees have the power and discretion at any time to:

- Establish, amend, modify and revoke the rules, terms and provisions of the Plan, including eligibility for coverage, termination of coverage, and any and all other matters which it deems necessary or proper to carry out the purpose and intent of the Plan. This includes any amendment that reduces or eliminates Coverage or benefits for any Employees, former Employees (including Retirees), Spouses or Dependents. ***No Employee, former Employee (including a Retiree), Spouse or Dependent Child ever has a vested right to Coverage or benefits from the Plan, except as may be required by law***.
- Establish and, from time to time, change the rate of Contributions to the Plan, as they deem necessary or appropriate to preserve the financial integrity of the Plan or to carry out the purpose and intent of the Plan.
- Establish and, from time to time, increase, decrease or otherwise modify or eliminate specific Plan benefits, as they deem necessary or appropriate to preserve the financial integrity of the Plan or to carry out the purpose and intent of the Plan.
- Administer the Plan in all of its details, including the authority to: (i) decide any issues of fact relevant to the eligibility of any person to receive benefits under the Plan, or the amount or time of payment of benefits under the Plan; (ii) interpret the terms of the Plan; (iii) supply any omission, interpret any ambiguous or

uncertain provisions of the Plan, and reconcile any inconsistency that may appear in the Plan; and (iv) make and enforce such rules and regulations as it deems necessary or proper for the administration of the Plan.

- Enter into reciprocal agreements with other plans of similar nature, and industry-wide agreements involving such plans, which provide for the exchange of contributions with respect to employees covered under one plan who work in the jurisdiction of another plan.

No Liability for Practice of Medicine

The Plan, Trustees, Funds Office Employees and their designees are **not** engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any health care provider. Neither the Plan, Trustees, Funds Office Employees nor any of their designees will have any liability whatsoever for any loss or Sickness or Injury caused to any person by any health care provider by reason of negligence, by failure to provide care or treatment, or otherwise.

HIPAA and USERRA Participation Rights

You may be entitled to commence, continue, suspend and recommence participation in this Plan in accordance with your rights under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

The Uniformed Services Employment and Reemployment Rights Act ("USERRA") also gives an Employee who is absent from work due to service in the uniformed services (including active or reserve duty, whether voluntary or involuntary, and time off for training or instruction) the right to continuation coverage under the Plan if the Employee is covered under the Plan when the period of military service begins, and certain other requirements are satisfied. For example, the period of military service generally cannot exceed five years, and the Employee (or an appropriate officer) must give advance oral or written notice of the absence to the Employee's Employer as early as is reasonable under the circumstances, unless notice is prevented by military necessity or is otherwise impossible or unreasonable under the circumstances.

An Employee entitled to USERRA continuation coverage may elect continuation coverage (for him/herself and his/her covered dependents) for a period of up to 24 months. However, USERRA continuation coverage will terminate if the Employee's military service ends because of: (i) separation from service with a dishonorable or bad-conduct discharge; (ii) separation from service under certain less-than-honorable conditions; or (iii) for a commissioned officer, dismissal in connection with a court-martial or, in time of war, by the President, or dropping of the commissioned officer from the rolls as a result of an unauthorized absence for at least three months or as a result of a

sentence imposed after a court-martial or a conviction in another court. USERRA continuation coverage will also terminate if the Employee fails to report back to work or apply for reemployment within the time period required under USERRA after completion of military leave.

All election and premium payment procedures, rules and deadlines for USERRA continuation coverage under the Plan are the same as the COBRA Continuation Coverage election and premium payment procedures, rules and deadlines described in the SPD, except to the extent any of those procedures, rules or deadlines conflict with USERRA regulations (e.g., if compliance with any particular procedure, rule or deadline is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances).

An Employee also has the right to reinstatement in the Plan, without any exclusions or waiting periods due to the military leave, when he timely returns to work after a military leave, assuming he is otherwise eligible for Plan Coverage. If the Employee timely returns to work after a military leave before the maximum USERRA continuation coverage period but the Employee is not reinstated in the Plan because he is not eligible for coverage at that time (for reasons unrelated to the military leave), then the Employee has a right to continuation coverage for the entire 24 month USERRA continuation coverage period (or, if sooner, the date he is reinstated).

Information concerning your HIPAA and USERRA rights is available from the Roofers' Local Union No. 22 Benefit Funds Manager, 280 Metro Park, Rochester, NY 14623 (Telephone No. (585) 235-0829).

HIPAA Privacy Rights

The Plan has responsibilities under the Health Insurance Portability and Accountability Act ("HIPAA") regarding the use and disclosure of your protected health information ("PHI"). Your PHI is any information that: (i) identifies you or may reasonably be used to identify you; (ii) is created or received by a health care provider, health plan, employer or health care clearinghouse; and (iii) relates to your past, present or future physical or mental health or condition, or the provision of or payment for health care.

The Plan is required to maintain the privacy of your PHI. It is also required to provide you with a notice of its legal duties and privacy practices, and to follow the terms of the privacy notice. However, the Plan is also permitted by law to use and disclose your PHI in certain ways, which are described in the privacy notice.

If you believe your PHI has been impermissibly used or disclosed, or that your privacy rights have been violated in any way, you may file a complaint with the Plan or with the Secretary of United States Department of Health and Human Services. If you want a copy

of the Plan's privacy notice or more information about the Plan's privacy practices, or you want to file a privacy violation complaint, please contact the Roofers' Local Union No. 22 Benefit Funds Manager, 280 Metro Park, Rochester, NY 14623 (Telephone No. (585) 235-0829).

Family and Medical Leave Act

If you are an Employee covered under the Plan and are eligible for and take a leave of absence under the Family and Medical Leave Act ("FMLA Leave"), you may continue Plan Coverage during the FMLA Leave, provided you would have been continuously employed during the entire FMLA Leave. Plan Coverage will continue as if you were actively employed by the Employer until the earlier of the date: (i) the FMLA Leave ends; or (ii) you notify the Employer that you will not return to work. If you choose not to continue Plan Coverage during an FMLA Leave, you may resume Plan Coverage when you return to work (provided you return when the FMLA Leave expires), and any pre-existing condition exclusion rules under the Plan will be waived.

You are also eligible to elect COBRA Continuation Coverage after the FMLA Leave if you:

- were covered under the Plan on the day before the FMLA Leave,
- do not return to work at the end of the FMLA Leave, and
- would otherwise lose coverage under the Plan.

You also may be able to elect COBRA Continuation Coverage even if you choose not to continue regular Plan Coverage during the FMLA Leave.

Women's Health and Cancer Rights Act

The Plan provides coverage in connection with a mastectomy (in the manner determined by the attending physician and the patient) for:

- reconstruction of the breast on which the mastectomy is performed,
- surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- prostheses and physical complications at all stages of the mastectomy, including lymphedema.

The Plan may not deny eligibility to enroll, renew or continue group health plan coverage to avoid providing coverage for breast reconstruction or mastectomy complications. Deductible and Co-payment amounts for covered care will be consistent with those

established for other Plan benefits. In addition, the law prohibits penalizing or otherwise reducing or limiting the reimbursement of an attending provider for the required care, or providing any incentive (monetary or otherwise) to induce the attending provider to provide care that would be inconsistent with the law.

If you have any questions about this coverage, please contact the Funds Office.

Newborn Mothers and Minimum Maternity Stay

The Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarian section, or require that a health care provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order (QMCSO) is an order by a court or a state agency for one parent to provide a Dependent Child with Health Coverage. If the Plan receives a QMCSO for your Dependent Child, you will be contacted about the procedure for the QMCSO. Copies of the Plan's QMCSO procedures are available, without charge, from the Funds Office.

Your Rights Under ERISA

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

Receive Information About Your Plan and Benefits

This includes the ability to:

- Examine, without charge, at the Funds office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the Funds Office, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated

summary plan description. The Funds Office may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

You may have a right to continue health care coverage for yourself, Spouse or Dependent Children if there is a loss of coverage under the Plan as a result of a qualifying event. You, your Spouse or Dependent Children may have to pay for such coverage. Review this booklet and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within thirty (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 $184 a day until you receive the materials (but not more than $1,846 per request), unless the materials were not sent because of reasons beyond the Plan Administrator's control. (These dollar amounts are periodically adjusted for cost-of-living increases.). 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. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who

should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

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