ROOFERS' LOCAL 195
HEALTH AND ACCIDENT FUND

www.Local195Funds.org

7706 Maltlage Drive **Liverpool, NY 13090**

Tel: (315) 699-1388 **Fax: (315) 699-1390**

Employer Identification Number
16-6148181

Plan Number
501

Summary Plan Description Booklet

Administered by the
BOARD OF TRUSTEES

Union Trustees
Gerald Crouse
Gary Swan
Kevin Milligan

Employer Trustees
Richard Anderson
Joseph Chiarizia
Jo Ann Goodspeed

PLAN MANAGER
Patricia A. Redhead

COUNSEL
Blitman and King, L.L.P.
Charles E. Blitman, Esq.

Effective
January 1, 2014

Type of Administration of Fund: Joint Board of Trustees

Titles and Business Addresses of Trustees:

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Utica, NY 13502 Central Square, NY 13036

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Liverpool, NY 13090

Any service of legal process should be sent to:

Patricia A. Redhead
Plan Manager
Roofers' Local 195 Health and Accident Fund
7706 Maltlage Drive, Liverpool, NY 13090

Fiscal Year:

July 1 - June 30

Employee Organization:

United Union of Roofers, Waterproofers and Allied Workers,
Local Union No.195 ("Roofers Local Union #195")
7706 Maltlage Drive, Liverpool, NY 13090

Employer Association:

Roofing Contractors Association of Central New York, Inc.
c/o WCA
Post Office Box 399, East Syracuse, New York 13057

This Plan is maintained pursuant to Collective Bargaining Agreements. Copies of the agreements and a complete list of contributing employers are available for examination at the Fund Office.

Upon written request, a participant may obtain a copy of the Collective Bargaining Agreement at a reasonable charge or be informed whether a particular employer is part of the Plan.

Roofers' Local 195 Health And Accident Plan

7706 Maltlage Drive, Liverpool, NY 13090
Phone #: (315) 699-1388 * Fax #: (315) 699-1390

TO: PARTICIPANTS IN THE PLAN

FROM: TRUSTEES OF THE PLAN

DATE: January 1, 2014

This booklet is a description of the Plan as in effect on **January 1, 2014** . You will find that the benefits are described, as well as the eligibility requirements that you must satisfy with respect to each of them. These and other matters are discussed in the seven major parts of the booklet, as follows:

A. Plan Benefits, General Eligibility Requirements and Right of Forfeiture
B. Health Insurance Benefit and Health Expense Benefit Provisions
C. Death Benefits
D. Supplemental Weekly Accident and Sickness Benefit
E. Claim Procedures
F. Your Rights as a Participant
G. Technical Details

You should read this booklet thoroughly to make sure that you are completely familiar with the details of the Plan.

To give you an idea of our role with regard to the Plan, you should know that we are responsible for collecting and administering the contributions to the Plan which are required by agreement between your employer and Local 195 or between your employer and the Trustees. In addition, we are required to formulate and administer the provisions of the Plan itself.

The Trustees are assisted in these tasks by professional advisors whom we hire from time to time. These include an actuary, an attorney, an auditor and one or more investment managers. The daily operation of the Plan is maintained by the Plan Manager located at the Fund Office.

It is in your interest and that of your family to familiarize yourself completely with this booklet. If, after having gone through this booklet thoroughly, you have any questions regarding the Plan or its operation, please do not hesitate to contact the Plan Manager.

Sincerely,
The Board of Trustees
Roofers' Local 195 Health and Accident Fund

IMPORTANT ASPECTS OF YOUR PLAN

- FAMILIARIZE YOURSELF WITH THE WHOLE BOOKLET.

- ALL BENEFITS MUST BE APPLIED FOR.

- MAKE SURE THAT THE FUND OFFICE IS AWARE OF ALL YOUR DEPENDENTS AND YOUR CURRENT ADDRESS.

- MAKE SURE YOUR DEATH BENEFIT BENEFICIARY DESIGNATION IS UP TO DATE.

- ALL CLAIM FORMS MUST BE COMPLETELY FILLED IN; INCOMPLETE ONES WILL BE RETURNED.

GRANDFATHERED STATUS

This group health plan is a "grandfathered health plan" under the Patient Protections and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means the plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventative health services without any cost sharing. However, the grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at 508 College Avenue, Elmira, New York 14901, (607) 732-5611. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3273 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

IMPORTANT NOTICE

Nothing in this booklet is meant to interpret, or extend, or change, in any way, the provisions expressed in any of the Plan documents. The Trustees reserve the right to amend, modify, or discontinue all or part of this Plan whenever, in their judgment, conditions so warrant.
In the event there appears to be a conflict between the description of any Plan provision in this booklet and the terms and conditions of any applicable insurance contracts and policies, the language contained in such insurance contracts and policies is the official and governing language.

CAUTION

This booklet and the Trustees are authorized sources of Plan information for you.
The Trustees have not empowered anyone else to speak for them with regard to the Plan. No employer, employee, union representative, supervisor or shop steward is in a position to discuss your rights under this Plan with authority. No oral statements by Plan personnel or any other Plan representative may modify in any respect the written terms of the Plan.

COMMUNICATIONS

If you have a question about any aspect of your participation in the Plan, you should, for your own permanent record, write to the Plan Manager or the Trustees. You will then receive a written reply, which will provide you with a permanent reference.

REQUIRED DOCUMENTATION

You must provide to the Fund Office any requested documents and information it requests to process your claims or to determine your entitlement to benefits or participation in the plan.

FUTURE OF THE PLAN, PLAN CHANGE, AND PLAN TERMINATION

This Summary Plan Description includes information concerning the circumstances, which may result in disqualification, ineligibility, or denial, loss, forfeiture or suspension of benefits that a participant or beneficiary might otherwise reasonably expect the Plan to provide. We refer you to the terms of this booklet, which detail the eligibility rules, qualification rules, benefits, limitations, and exclusions from coverage.

It is anticipated that the Plan will remain in effect indefinitely. However, the right to amend, modify, or terminate the Plan is reserved by the Board of Trustees, in accordance with the Trust Agreement. In addition, the continuance of the Plan is subject to the maintenance of collective bargaining agreements, which provide for employer contributions to the trust fund that provides the Plan benefits.

If it ever becomes necessary to terminate the Plan at some future date, the Trust Agreement provides that assets then held by the Trustees must be used exclusively on behalf of Plan participants and to defray the cost of reasonable administration and termination expenses. In no event will any of the assets revert to any employer or to the union. In the event of termination of the Plan, the Plan's assets are to be used exclusively for the benefit of participants in the ROOFERS' LOCAL 195 HEALTH AND ACCIDENT PLAN.

Upon final liquidation of the Plan, participants and beneficiaries would have no further rights or vested interest in the Plan.

The Trustees reserve the right to change or discontinue the types and amounts of benefits under the Plan and the eligibility rules, for extended or accumulated eligibility, even if extended eligibility has already been accumulated.

Benefits provided by the Plan:

- are not guaranteed;
- are not intended or considered to be deferred income;
- are not vested;
- are contingent upon the right of the Trustees to make modifications or terminate such benefits;
- are subject to the rules and regulations adopted by the Trustees; and
- may be modified or discontinued and such modification or termination right is not contingent on financial necessity.

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PLAN HIGHLIGHTS
PART A

Eligibility requirements that you must satisfy in order to participate in, and be entitled to, a benefit may be different for each of the benefits.

IN GENERAL

A portion of employer welfare contributions are credited to an individual account for you. The portion of the contributions on your work that are credited to your individual account are determined by the Trustees of the Plan, from time to time, and based upon the financial requirements of the whole Plan. Currently, **100%** of the contributions on your work are credited to your individual account.

Once you have an individual account, you will be a participant in the Plan. If you are credited with a "Health Insurance Benefit Allocation", you will also be a participant in this Plan.

Your account will grow with all the employer contributions that are made to it in the future.
You will not be credited with contributions due from an employer, but not received by the Plan.
Your account will be decreased by:

(a) any premium deductions for the Health Insurance Benefit, and
(b) benefit distributions made from it under the Health Expense Benefit, and
(c) when applicable, administration charges as stated below.

An employee/participant does **not** have the option to “opt out” of or decline the Health Insurance Benefit. The Fund Office will automatically deduct your Health Insurance Benefit premium from your individual account on a regular monthly basis, when you satisfy the eligibility requirements and when sufficient funds are available in your account.

No more will be paid out to you (or your beneficiary’s or dependent(s)’ behalf) or deducted from your account for Health Insurance Benefits under this Plan than has come into your individual account by way of contributions made on behalf of your work and special allocations, except, perhaps, under the provisions of the Health Insurance Benefit coverage.

Administration charges may be levied against your (and other participant's) account on an equitable basis.

Once your account is reduced to zero, you will stop being a participant in this Plan and you will not be entitled to any benefits under this Plan, unless your account is credited with a special allocation.

In the following sections you will see what is required to become eligible for the benefits that exist in the Plan for you once you have satisfied the general eligibility requirements. There is also a description of each of the benefits.

GENERAL ELIGIBILITY REQUIREMENTS

Before you are eligible for any of the benefits under this Plan, you must satisfy the general eligibility requirements in your current period of Plan participation.

In order to satisfy the Fund's general eligibility requirements, you must work a sufficient number of hours in covered employment for a contributing employer to remit to the Fund the contributions to your personal account that are sufficient to pay the premiums for at least three (3) months of Health Insurance Benefit coverage at the rate in effect when the Fund receives the contributions from your employer. Your eligibility will be effective on the first day of the month that follows the month after the Fund receives the necessary contributions.

Once you are a participant, you will continue as a participant until your account is reduced to zero, at that time your participation stops. If you are self-paying to the Plan for your Health Insurance Benefit coverage, you are still a participant.

If contributions are made to the Plan for you before you satisfy the general eligibility requirements and such contributions cannot be used to satisfy the general eligibility requirements, such contributions will be forfeited and used for Plan administrative costs.

In addition to having satisfied the general eligibility requirements, you will have to satisfy special eligibility requirements depending upon which of the benefits you use.

If you have once satisfied the general eligibility requirements for this Plan and your participation stops, in order to satisfy them for a future period of Plan participation, you must once again satisfy the general eligibility requirements to be entitled to any benefits.

When needed to maintain eligibility, such as to become re-eligible for health benefits if you opted for self-pay and no lapsation in health coverage occurs, it will not be necessary to accumulate the minimum balance requirement in your individual account.

RIGHT OF FORFEITURE

If you become unavailable for employment covered by this Plan, for a reason other than your total disability or the commencement of a pension under the Local 195 Pension Plan, your participation in the Plan will stop at the end of the month in which you become unavailable. Your entitlement to benefits under the Plan and any balance in your account will be forfeited to the Plan and you will not be eligible again for benefits until you satisfy, again, the general eligibility requirements.

LIMITATION ON BENEFITS

Under no circumstances may any money be drawn from your account once the level of your account has reached zero.

You and your beneficiaries are not permitted to withdraw money for the Health Expense Benefit from your account if the withdrawal would cause your account to contain an insufficient amount to pay the premiums for at least two (2) months of Health Insurance Benefit coverage at the rate in effect when you apply for the withdrawal. This provision is intended to provide a reserve for you to receive Health Insurance Benefits.

Other limitations, if any, will be listed where the individual benefit is described in this booklet.

There shall be no entitlement to a benefit for reimbursement to a participant, beneficiary or others for a claim that arose when the participant or beneficiary was not eligible for benefits from this Fund. For example,

should the participant or beneficiary receive eligibility for benefits from Medicare, Medicaid or Child Health Plus and when such date of service of the aforementioned benefit was at a time when the participant or beneficiary was not eligible for a benefit from this Fund, no reimbursement shall occur to the participant, beneficiary or others for the cost of such services.

TYPES OF BENEFITS

There are different benefits available to you under this Plan if you are eligible. You may, during your Plan participation, draw on one or more of these benefits. For example, even though you may be covered by the Health Insurance Benefit (that is, by having insurance premiums being paid from your account each month), you are still eligible (provided you satisfy the requirements) to draw on the Health Expense Benefit for health care bills not otherwise covered. The following sections describe each of the benefits.

HEALTH INSURANCE BENEFIT

As long as you remain available for employment that calls for contributions to this Plan, each month the charges for certain insurance coverage will be subtracted from your account so long as your account balance is sufficient to cover the total monthly charge. The monthly charge for this coverage is determined by the Board of Trustees to the Plan. If your account is depleted below the required monthly premium amount, you will be permitted to self-pay your Insurance Benefit charge under certain conditions. (See the discussion of the Consolidated Omnibus Budget Reconciliation Act of 1995, usually referred to as "COBRA," and the direct payment option later in this booklet).

The Health Insurance Benefit is available to you, as an eligible participant, to your lawful spouse, and to your eligible dependent children.

The details of your Health Insurance Benefit protection are found in Part B. of this booklet.

HEALTH EXPENSE BENEFIT

If you incur health care expenses (other than insurance premiums for the Health Insurance Benefit) while you are a participant in the Plan, for yourself, your spouse, or your dependent child, which expenses are not covered under the Health Insurance Benefit or any other insurance plan, you may apply for a distribution of a portion of your account to pay for the uncovered bills. To qualify for reimbursement, all expenses must be recognized by the I.R.S. as medical expenses for income tax purposes.

However, you are not allowed to reduce the balance in your account below ***the level necessary to pay the premiums for at least two (2) months of Health Insurance Benefit coverage at the rate in effect when you apply for the withdrawal***.

Claims under this benefit may be submitted only if they total at least **$ 50.00.** You may add several bills together in order to reach the **$ 50.00.** In any event, regardless of the size of your covered bills, in the month of December you may submit such bills to the Plan.

The details of your Health Expense Benefit are found in Part B. of this booklet.

DEATH BENEFIT

In the event you pass away while you are a participant in the Plan and have satisfied the general eligibility requirements, your named beneficiary will be entitled to apply for the Death Benefit.

The amount of the Death Benefit is $5,000.00 for active participant and $1,000.00 for inactive participant. The cost for this death benefit coverage is not charged to your account. There is no death benefit coverage

for dependents. The Trustees may at their discretion contract this benefit with an independent insurance company.

The details of your Death Benefit protection are found in Part C. of this booklet.

SUPPLEMENTAL WEEKLY ACCIDENT AND SICKNESS BENEFIT

If, while you are an active employee, you incur an accident or illness causing you to become totally disabled from the occupation of roofer and unable to work, you may be eligible to receive benefits under the Supplemental Weekly Accident and Sickness Benefit. In order to receive benefits under this provision, you will be required to submit proof that you are receiving benefits under the State Disability Benefits Law, the State Workers' Compensation Law, or the Federal Social Security Disability Insurance Program.

The details of your Supplemental Weekly Accident and Sickness Benefit are provided in Part D. of this booklet.

FOREIGN TRAVEL BENEFITS

Medically necessary care provided to participants, spouses, and/or dependents outside of the United States will be covered and paid according to applicable Plan provisions. However, for any Foreign Travel Hospital or Medical Expense Benefits, such coverage is contingent upon the individual purchasing directly from the insurance carrier whatever riders are necessary under insured products applicable to the individual. Covered charges, in excess of the usual, customary and reasonable rate, as determined by the Fund Office, will not be covered. If you need more information about foreign travel benefits, you should contact the Fund Office.

SPECIAL ALLOCATIONS

In addition to employer contributions on your covered work, there are other ways in which your account can grow or in which you might otherwise be eligible to receive benefits. These are called "special allocations".

A. DISABILITY ALLOCATION

In the event you become totally disabled while covered for the Health Insurance Benefit (except through COBRA Continuation Coverage), and your account is not sufficient to pay the monthly Health Insurance Benefit premium, you may qualify for a Disability Allocation which may be used to pay the monthly premium under the Direct Payment Option provision as defined on Page 17 of this Summary Plan Description.

The amount of the monthly Disability Allocation will be the amount necessary to pay the portion of the Health Insurance Benefit monthly premium on a self-pay basis under the Direct Payment Option that is not available in your account. There will be no Disability Allocation for participants whose individual accounts are sufficient to cover their Health Insurance Benefit premium.

Application for allocation and proof of disability must be submitted. You may obtain this application upon request from the Fund Office. You will be considered totally disabled if and only if you file and qualify for New York State Workers' Compensation, New York State Disability Benefits, or Social Security Disability Benefits. Your status as totally disabled continues only as long as you continue to be entitled to New York Workers' Compensation, New York State Disability Benefits, or Social Security Disability Benefits.

No more than three monthly Disability Allocations (total or partial payments) will be made for any one participant during each period of qualified disability; the allocation period used for continued benefits on a self-pay basis under the Direct Payment Option shall run concurrently with any COBRA self-pay entitlement.

B. HEALTH EXPENSE BENEFIT ALLOCATION FOR RETIRED WORKERS

In the event a retired employee receiving benefits under the Roofers' Local 195 Pension Plan ("Pension Plan") and/or the National Roofing Industry Pension Plan is temporarily re-employed, employer contributions received from the employer will be allocated into the Health Expense Benefit Individual Account by the Plan, and the retiree will have the same options for coverage as other active participants, as well as the possibility of "opting out" or waiving coverage to allow accumulations in the personal account, or irrevocably declining all benefits from the Fund, to the extent permitted by the Trustees..

Regarding the availability of benefit reimbursements as described under this special allocation, no minimum account balance requirement greater than zero will apply; however, under no circumstances may any money be drawn from your Individual Account once the level of your account has reached zero. Once a participant's Individual Account reaches zero, participation under the Health Expense Benefit will cease.

HOW TO APPLY FOR BENEFITS

If you are disabled, or if you, your spouse or your dependent child are confined in a hospital or have a surgical operation, or seek medical care, notify the Fund Office immediately for assistance in applying for benefits. All claims should be submitted to the appropriate address as indicated on your insurance cards.

In the event of death, the Fund Office should be notified at once. Your beneficiary will be sent a Claim Form. This form is to be filled in and immediately returned to the Fund Office with a certified copy of the Death Certificate.

Effective January 1, 2013, all medical claims and services provided by a licensed hospital facility are to be processed through the Preferred Provider Network and should be submitted within **one year** of the date of service to:

AETNA Life Insurance Company
P.O. Box 981106
El Paso, Texas 79998-1106

Claims for non-covered medical expenses that are eligible for reimbursement under the Health Expense Benefit must be submitted within the **five-year** period from date of claim payment along with proof of payment to the Fund Office at:

Roofers' Local #195 Fund Office
Personal/Confidential
7706 Maltlage Drive
Liverpool, NY 13090

HEALTH INSURANCE BENEFIT

AND

HEALTH EXPENSE BENEFIT

PROVISIONS

PART B

ELIGIBILITY RULES
For the
Health Insurance Benefit Provisions

All participants with a balance in their Individual Account will be charged the premium for Health Insurance Benefits for this coverage. You and your beneficiaries are not permitted to withdraw money from your Individual Account if the withdrawal would cause your account to contain an insufficient amount to pay the premiums for at least two (2) months of Health Insurance Benefit coverage at the rate in effect when you apply for the withdrawal. Your Health Insurance Benefit coverage will terminate when your Individual Account has insufficient assets to pay the premiums.

Notes*:*

a. Eligibility for the Health Insurance Benefit Provisions will be based on funds available in the Individual Account.

b. All participants with a balance in their Individual Account of at least the determined monthly premium for the Health Insurance Benefits will be charged that premium for Health Insurance Benefits for this coverage.

c. Premiums are subject to change on an Annual Basis as determined by the Trustees.

Eligibility under the Family and Medical Leave

Under Federal Law, you may be eligible for up to twelve (12) weeks of unpaid leave from your employment for any of the following reasons:

1. You need to care for your newborn or adopted child;

2. You need to care for your spouse, child or parent who has a serious health problem; or

3. You have a serious health problem, which prevents you from performing your job.

If you qualify for such a leave, you (and your eligible dependents, if any) will continue to participate in the Plan just as if your work in Covered Employment had not stopped, unless your employer fails to make the required contributions for you. If you do not return to work for your employer at the end of your leave, you may be responsible for repaying the employer contributions made for you during the leave. You should contact your employer or the Fund Office for further information about your eligibility for such a leave. You will, however, be eligible to continue your coverage on a self-pay basis.

Qualified Military Service

If you leave employment for full-time Qualified Military Service, as defined by Federal Law, you and your eligible dependents are permitted to elect to continue health care coverage under the Plan, subject to certain limitations under Federal Law. This coverage, subject to the provisions of the Plan, must last for up to twenty-four (24) months beginning on the date of your absence from employment. However, the coverage will terminate before the end of the twenty-four (24) month period if you enter Qualified Military Service and are discharged earlier and failed to make a timely application for re-employment upon discharge.

If you elect such continuation coverage, you will not be required to pay any premium for the first thirty (30) days of such coverage. However, thereafter, and until the cessation of such coverage, you will be required to make a monthly premium to the Plan, which will be based on the average cost that the Plan incurs annually per participant plus a two percent (2%) administrative charge.

Termination of Coverage:

Termination of the Health Insurance Benefit Provisions will take place on the first of the month in which no premium payments are made or are available from your Individual Account.

Reinstatement:

If your coverage is terminated because you did not meet the minimum eligibility requirement by premium payment, but you do not lose participant status, you will be reinstated to full coverage when you again meet the minimum eligibility requirement, by premium payment from either your Individual Account, Direct Payment Option, or under provisions of COBRA.

No Medical Examination:

No medical examination is required in order to become covered under this Plan and all eligible participants will be covered regardless of age.

Definition of Eligible Dependent:

Eligible Dependent' means the lawful spouse of an Active Participant and each 'child' who has not attained the age of 26. The term "child" includes your naturally born child, legally adopted child, step-child, and/or foster child lawfully placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. In order for a child in your family to obtain continuous coverage through age twenty six (26), the child must complete the necessary enrollment forms and submit them to the Fund Office.

If a dependent child is incapable of self-sustaining employment due to a total and permanent physical or mental disability and that child is dependent upon the Active Participant for support and maintenance, then the Active Participant can apply to the Fund for continued coverage for the disabled child after the child's having attained the age of 26. In order to receive this extended coverage for the disabled dependent, the Active Participant must submit sufficient proof of the dependent child's disability to the Fund Office within 31 days before the beginning of the taxable calendar year in which the child will attain the age of 26. Proof of the continued existence of such disability shall be furnished to the Fund Office from time to time at its request.

In addition, your unmarried children through the age of 29 years can retain coverage if they are living or working in New York and not otherwise insured or eligible for health insurance through their own employers or Medicare. A separate premium will be charged for this coverage between the ages of 26 and 29. Coverage ends when you (the parent) are no longer enrolled in this Plan, your adult child no longer meets the eligibility requirements, or the premium for this extended coverage is not paid in full within the required time period.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Important Notice of Your Rights and Documentation of Health Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before you enroll. Under the law, a pre-existing condition exclusion generally may not be imposed for more than 12 months (18 months for a late enrollee). The 12-month (or 18-months) exclusion period is reduced by your prior health coverage. Effective January 1, 2014, group health plans will no longer be able to exclude employees because of pre-existing conditions, and the Fund will stop providing certificates of creditable coverage effective January 1, 2015.

You have the right to receive a certificate of prior health coverage prior to January 1, 2015. You may need to provide other documentation for earlier periods of health care coverage. Check with your new Fund Administrator to see if your new plan excludes coverage for pre-existing conditions and if you need to provide a certificate or other documentation of your previous coverage.

To get a certificate, please contact the Fund Office. The certificate must be provided to you promptly. You may also request certificates for any of your dependents (including your spouse) who were enrolled under your health coverage.

Certificates of Creditable Coverage

When your (and your covered Dependents') coverage under this Plan ends on or before December 31, 2014, the Plan will issue a Certificate of Creditable Coverage to each individual or family member whose coverage under the Plan ends. The Certificate provides the documentation of prior coverage and/or waiting periods that you and/or your family may need to reduce pre-existing condition limitations when enrolling in a new employer-sponsored health plan.

The Plan must provide you with a Certificate:

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

The Certificate of Creditable Coverage indicates:

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

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

Special Enrollment Rights

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

You and your dependents may also enroll in this plan if you (or your dependents) have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends.

You and your dependents may also enroll in this plan if you (or your dependents) become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after you and/or your dependents are determined to be eligible for such assistance.

Medical Child Support Orders

The Omnibus Budget Reconciliation Act of 1993 requires health plan administrators to recognize qualified medical child support orders ("QMCSOs"). A QMCSO is a court decree under which a court order mandates health coverage for a child. Under a QMCSO, children who might otherwise lose rights to benefits under a group health plan will be entitled to enrollment in a parent's group health plan as "alternate recipients." Both you and your beneficiaries can obtain, without a charge, a copy of the Plan's QMCSO procedures from the Plan administrator.

Upon receipt of a medical child support order, the Plan administrator will promptly notify the participant and each child will be notified within a reasonable period of time whether the order is qualified. A child may designate a representative to receive copies of any notices that are sent to the child. If it has been determined that the order is a Qualified Medical Support Order, the child will then be considered a participant under the Health Fund and will receive copies of summary plan descriptions, summary annual reports, and summaries of any amendments made to the Plan according to current ERISA requirements.

Hospital Stays in Connection with Childbirth

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

Reconstructive Breast Surgery

In accordance with the requirements of a Federal law entitled, The Women's Health and Cancer Rights Act of 1998, if the Plan provides coverage for a mastectomy, it must also cover the following:

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

Mental Health Parity

Group health plans and health issuers generally may not, under Federal Law known as the Mental Health Parity Act, impose an aggregate lifetime or annual limit on mental health benefits if it does not impose such a dollar limit on substantially all of the medical and surgical benefits. However, if the Plan does impose an aggregate lifetime or annual limit on medical and surgical benefits, any limit imposed on mental health benefits must not be less than that applied to medical and surgical benefits.

CONFIDENTIALITY OF PROTECTED INFORMATION

A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), requires that health plans protect the confidentiality of your Protected Health Information ("PHI") effective March 1, 2004. A summary of your rights under HIPAA can be found in the Plan's privacy notice, which *was* distributed to you in accordance with HIPAA and which is available from the Plan's Privacy Official, Patricia Redhead, and the Plan Manager.

This Plan, and the Plan Sponsor (the Plan Sponsor for HIPAA purposes is the Board of Trustees of the Roofers' Local 195 Health and Accident Fund, will not use or disclose your PHI except as necessary for treatment, payment, health care operations and plan administration, or as permitted or required by law.

"Payment" includes activities undertaken by the Plan to determine or fulfill its responsibility for coverage and the provision of plan benefits that relate to an individual to whom health care is provided. The activities include, but are not limited to, the following:

(a) determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and co-payments as determined for a participant's claim);

(b) coordination of benefits;

(c) adjudication of health benefit claims (including appeals and other payment disputes);

(d) subrogation of health benefit claims;

(e) Establishing contributions to the Plan, including, but not limited to, COBRA contributions;

(f) risk adjusting amounts due based on enrollee health status and demographic characteristics;

(g) billing, collection activities and related health care data processing;

(h) claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;

(i) obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

(j) medical necessity reviews or reviews of appropriateness of care or justification of charges;

(k) utilization review, including pre-certification, preauthorization, concurrent review and retrospective review;

(l) disclosure to consumer reporting agencies related to reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and

(m) reimbursement to the plan.

"Health Care Operations" include, but are not limited to, the following activities:

(a) quality assessment;

(b) population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;

(c) rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;

(d) underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess loss insurance);

(e) conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

(f) business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;

(g) business management and general administrative activities of the Plan, including, but not limited to:

(1) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements

(2) customer service, including the provision of data analyses for policy holders, Plan sponsors, or other customers

(h) resolution of internal grievances; and

(i) due diligence regarding a merger with a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the merger, will become a covered entity.

Only the employees of the Roofers' Local 195 Health and Accident Fund who assist in the Plan's administration and the Board of Trustees of the Roofers' Local 195 Health and Accident Fund will have access to your PHI. These individuals may only have access to use and disclose your PHI for plan administration functions. This Plan provides a complaint mechanism for resolving noncompliance matters. If these individuals do not comply with the above rules, they will be subject to disciplinary sanctions.

By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules.

The Plan will not, without your authorization, use or disclose your PHI for employment related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

HIPAA provides that this Plan may disclose your PHI to the Plan Sponsor only upon receipt of a Certification by the Plan Sponsor that it agrees to the following: (a) not use or further disclose the information other than as permitted or required by the plan documents or as required by law; (b) ensure that any agents, including a subcontractor, to whom it provides PHI received from this Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information; (c) not use or disclose the information for employment related actions and decisions unless authorized by you; (d) not use or disclosure the information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by you; (e) report to this Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware; (f) make PHI available to you in accordance with HIPAA's access requirements; (g) make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA; (h) make available the information required to provide an accounting of disclosures; (i) make its

internal practices, books, and records relating to the use and disclosure of PHI received from this Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by this Plan with HIPAA; (j) if feasible, return or destroy all PHI received from this Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and (k) maintain adequate separation between the Plan and the Plan Sponsor. The Plan Sponsor has made such Certification to the Plan.

Under HIPAA, you have certain rights with respect to your PHI, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with this Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan's privacy notice provides a summary of your rights under HIPAA's privacy rules. Please contact Patricia Redhead, the Plan's Privacy Official and Plan Manager, at (315) 699-1388 if: (a) you wish to obtain a copy of the notice; (b) you have questions about the privacy of your health information; or (c) you wish to file a complaint under HIPAA.

The Plan Sponsor will:

(a) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains or transmits on behalf of the Plan;

(b) ensure that the adequate separation between the Plan and the Plan Sponsor, as required by HIPAA, with respect to electronic protected health information, is supported by reasonable and appropriate security measures;

(c) ensure that any agent, including a subcontractor, to whom it provides electronic protected health information agrees to implement reasonable and appropriate security measures to protect the information; and

(d) report to Plan any security incident of which it becomes aware concerning electronic protected health information.

The Plan Manager has been appointed as the HIPAA Security Official. You can contact the Plan Manager at the Fund Office (315) 699-1388.

Examination:

The Plan shall have the right and opportunity through its medical representative to examine any claimant (while living) making claim, when and as often as it may reasonably require during the pending of a claim hereunder, unless otherwise forbidden by law.

Benefits Cover Specific Claims Only:

Notwithstanding any other provision of this Plan, benefits available under this Plan provide only for the payment of certain specific expenses. Benefits do **NOT** cover illnesses, conditions, diseases, injuries, etc. Thus, while the Plan will make payments for certain expenses you incur with respect to certain illnesses, conditions, diseases, injuries, etc., the Plan does not provide for the payment of **all** of the expenses you incur with respect to a **particular** illness, condition, disease, injury, etc.

For example, if you sustain an injury, which requires surgery, the surgeon's fee may be covered by your Surgical Expense Benefits. However, if the Plan were later amended to eliminate Surgical Expense Benefits and subsequently required a second surgery with respect to the **same injury**, then the surgeon's fee for the second surgery would **NOT** be covered. Even though Surgical Expense Benefits were available when you sustained the injury, the expenses of the second surgery are not covered because Surgical Expense Benefits were **NOT** available when you incurred the specific claim for the second surgery.

RIGHT OF RECOVERY

In the event that a participant, spouse, and/or dependent or a third party on a participant's, spouse's, and/or dependent's behalf, is paid benefits from the Plan in an improper amount or otherwise receives Plan assets not in compliance with the Plan (hereinafter "overpayments" or "mistaken payments"), the Plan has the right to start paying the correct benefit amount. In addition, the Trustees have the right to recover any overpayment or mistaken payment made to you or to a third party on your behalf. The claimant receiving the overpayment or mistaken payment must pay back the overpayment or mistaken payment to the Plan with interest at 12% per annum. Such a recovery may be made by reducing other benefit payments made to or on behalf of you, your spouse or dependents, by commencing a legal action or by such other methods as the Trustees, in their discretion, determine to be appropriate. The claimant shall reimburse the Plan for attorney's fees and paralegal fees, court costs, disbursements, and any expenses incurred by the Plan in attempting to collect and in collecting the overpayment or mistaken payment of benefits. The determination as to these matters is solely made by the Trustees.

Third Party Liabilities

Note: This provision applies to all participants, spouses, eligible dependents, retirees, their spouses and their qualified dependents and beneficiaries with respect to all of the benefits provided under this Plan. For the purpose of this provision, the terms "you" and "your" refer to all participants, spouses, eligible dependents, retirees, their spouses and their qualified dependents and beneficiaries.

A. GENERAL

Occasionally, a third party may be liable for your medical expenses. This may occur when a third party is responsible for causing your illness or injury, or otherwise responsible for your medical bills. The Trustees, in their discretion, may determine to not provide benefits under the Plan for you if a third party may be responsible for the payment of benefits, until a determination is made by the proper and final decision-maker regarding the third party's responsibility to you. The rules in this Section govern how the Plan pays benefits, if at all, in such situations.

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

Second, the rules protect the Plan from bearing the full expense in situations where a third party is liable. Under these rules, once it is determined that a third party is liable in any way for the injuries giving rise to these expenses, this Plan must be reimbursed for the benefits it has advanced to you. That reimbursement must come out of any recovery whatsoever that you receive that is in any way related to the event, which caused you to incur the medical expenses.

B. RIGHTS TO SUBROGATION AND REIMBURSEMENT

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

The Trustees may, in their sole discretion, require the execution of this Plan's Subrogation Agreement by you (or your authorized representative, if you are a minor or you cannot sign) before this Plan pays you any benefits related to such expenses. If the Trustees have required execution of the Plan's Subrogation Agreement, no benefits will be provided unless you, your spouse (if any) and your attorney (if any) sign the form. You must also notify the Plan before you retain another attorney or an additional attorney, since that attorney must also execute the Subrogation Agreement. The Plan's Subrogation Agreement must be signed by you and your attorneys and received at the Fund Office on the earlier of either (1) one year from the date of your accident; or (2) thirty (30) days after the date of the letter from the Fund Office forwarding the Subrogation Agreement to be signed. No Benefits will be paid by the Plan for the expenses related to that accident if the Agreement is not signed.

IN NO EVENT SHALL THE FAILURE OF THE TRUSTEES TO REQUIRE EXECUTION OF THE SUBROGATION AGREEMENT DIMINISH OR BE CONSIDERED A WAIVER OF THE PLAN'S RIGHT OF SUBROGATION AND REIMBURSEMENT.

At the Plan's request, you must complete a form(s) which includes, but is not limited to, the following information:

1. The details of your accident or injury;

2. The name and the address of the person you claim caused the accident or injury as well as the name and address of that person's insurance company and attorney; and

3. The name and address of your attorney.

You must also:

1. Sign the Plan's Subrogation Agreement;

2. Have your attorney sign the Subrogation Agreement and return it to the Fund Office before any benefits are paid;

3. Provide the Fund Office with quarterly reports regarding the status of your third party claim or action including, but not limited to, motions, depositions, pretrial conferences, trial dates, settlement conferences, etc.; and

4. Promptly respond to any inquiries from the Plan regarding the status of the third party claim or action including, but not limited to, motions, depositions, pretrial conferences, trial dates, settlement conferences, etc.

Your duty to provide this information to the Plan is a continuing one.

In addition to its subrogation rights, the Plan has the right to be reimbursed for payment made on your behalf under these circumstances. The plan must be reimbursed from any settlement, judgment, or other payment that you obtain from the liable third party before any other expenses, including attorneys' fees and costs, are taken out of the payment regardless of how you or the Court characterize the nature of the recovery. In enforcing the Plan's rights to subrogation and reimbursement, the Trustees are not limited by any determination of the trier of fact as to the causal relationship between the injuries giving rise to these expenses and the liability of the third party if evidence exist which, in the opinion of the Trustees, supports causation.

The Plan must be paid in full without regard to whether you have received compensation for all of your damages and without regard to whether you have been "made whole". The Plan's rights to subrogation and reimbursement will not be affected, reduced or eliminated by the make-whole doctrine, comparative fault or the common fund doctrine. The Plan has no responsibility to contribute to the payment of your attorneys'

fees and costs with respect to any aspect of your representation including the third party action itself, the reimbursement action or any other matter.

C. RIGHT OF FUTURE SUBROGATION AND REIMBURSEMENT

In addition to satisfaction of the existing lien from any recovery by you, the Plan is also entitled to a future credit for future related expenses equal to the net proceeds received by you.

"Net proceeds" shall be defined as the amount of your total recovery and/or judgment less payment in full of the amount of the Plan's lien, less payment of your attorneys' fees and costs related to the third party action. You must spend the net proceeds on medical or related expenses arising out of or related to the injuries which were the subject of the third party action and which would have otherwise been covered by the Plan until the amount of said proceeds is exhausted.

It is only at that point that your future related Plan benefits will again be the responsibility of the Plan pursuant to the terms of the Plan. The Plan will not resume payment of medical and related benefits until such time as you have provided the Plan with proof that you have utilized the net proceeds of the recovery and/or judgment to pay for medical and related expenses arising out of or related to the injuries which were the subject of the third party settlement or action. The Administrator will determine the net proceeds available for a future credit.

D. ASSIGNMENT OF CLAIM

You may not assign any rights or causes of action that you may have against any third-party tortfeasor without the express written consent of the Plan.

The Trustees, in their sole discretion, may require you to assign your entire claim against the third party to the Plan. If this Plan recovers from the third party any amount in excess of the benefits paid to you, plus the attorneys' fees, costs and expenses incurred in making the recovery, then the excess will be paid to you.

E. FAILURE TO COOPERATE WITH PLAN

You will be personally liable to the Plan for reimbursement owed to the Plan and the Plan will discontinue your benefits if any of the following occurs:

1. You fail to tell the Plan that you have a claim against a third party;
2. You fail to assign your claim against the third party to this Plan when required to do so;
3. You fail to cooperate with the Plan's efforts to recover the full amount of benefits paid by the Plan;
4. You fail to require any attorney you subsequently retain to sign the Plan's Subrogation Agreement;
5. You and/or your attorney fail to reimburse the Plan;
6. You fail to provide the Plan with medical or other authorization to obtain necessary information; or
7. You or your attorneys fail to file written quarterly reports regarding your case with the Fund Office.

This Plan may offset the amount you owe from any future claims submitted by you as well as by your dependents and beneficiaries and/or will discontinue benefits to you, your dependents and beneficiaries, or, if necessary, take legal action against you and you will be personally liable to this Plan for the Plan's attorney's fees and costs incurred in recovering that amount. The Board of Trustees has the sole discretion to determine whether you and your attorney have cooperated with the Plan's efforts to recover the entire amount of its lien**.** The reimbursement owed to the Plan may also, in the Trustees' discretion, be considered an overpayment or mistaken payment and must be repaid as provided in the section of this Plan dealing with overpayments and mistaken payments.

DIRECT PAYMENT OPTION

Anyone who becomes eligible for COBRA continuation coverage and who is an inactive participant may be eligible for extended coverage under the "Direct Payment Option." Election of the Direct Payment Option is a substitute for COBRA continuation coverage, and the periods of time that a participant or beneficiary takes advantage of the Direct Payment Option will not extend the length of time for COBRA continuation coverage.

For purposes of this Option, an inactive participant is an employee who (i) is not eligible for Health Insurance Benefits because of insufficient moneys in his/her Individual Account; (ii) is available for work and keeps his/her name on the out-of-work list of Roofers Local Union #195; and (iii) does not refuse referrals for covered employment, except for good cause determined solely by the Business Manager of Roofers Local Union #195. You may qualify for the Direct Payment Option for a maximum of 6 months. To qualify for the Direct Payment Option, the inactive participant must have previously been eligible as a result of covered employment immediately preceding such coverage.

Under the Direct Payment Option, to continue coverage, the employee self-pays an amount equal to the applicable premium charge for single or family coverage. An employee will receive notice of his or her opportunity to select the Direct Payment Option at the same time and in the same manner that the employee is provided with notice of his or her COBRA rights.

To select the Direct Payment Option, the employee must elect such coverage, and must make the required monthly payment, within ten (10) days of receipt of the notice of the Option.

After payment of the first premium for coverage under the Option, payments of monthly premiums thereafter must be made directly to the Fund Office by the tenth of each month. The responsibility to timely make such payments rests solely with the employee. All payments must be made by check or money order. The Fund Office cannot accept late payment of premiums.

By payment of the premium, the inactive participant and eligible dependents will be entitled to the same benefits provided under the Health Insurance Benefit Provisions as active participants.

Failure to make timely premium payments will result in termination of coverage under the Direct Payment Option. In addition, the employee will lose eligibility for coverage under the Direct Payment Option if the Plan:

(a) ceases to provide group health coverage;
(b) the employee becomes covered under another group health plan except for any period the other group health plan limits coverage of the employee's pre-existing conditions;
(c) the employee enrolls in Medicare; or
(d) circumstances are such that the individual's participation could be cancelled if the individual were covered by the Plan on other than a Direct Payment Option or COBRA basis.

Upon loss of coverage under the Direct Payment Option, the employee will receive notice of his or her right to COBRA continuation coverage for the remainder of the applicable time period of continuation coverage.

COBRA CONTINUATION COVERAGE

A. WHAT IS COBRA CONTINUATION COVERAGE?

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") provides that you, your spouse, and your other dependents are entitled to elect to continue coverage on a self-pay basis under the Plan, under certain circumstances, if coverage would otherwise stop. The Plan's COBRA Continuation Coverage is administered by the Fund Office. Unlike the Direct Payment Option for continued coverage, your spouse and your dependent children may elect COBRA Continuation Coverage even if you do not.

B. WHO MAY CONTINUE COVERAGE?

1. *Employees:*

   For individuals covered by the Plan as employees, COBRA continuation coverage may be elected upon loss of health insurance coverage under the Plan due to voluntary or involuntary termination of employment (except for gross misconduct) or because the employee no longer meets the eligibility requirements of the Plan due to a reduction in hours worked, including a strike, walkout or layoff, or a loss of eligibility due to reduction of individual account. You may elect COBRA continuation coverage for the Health Insurance Benefit only or for both the Health Insurance Benefit and the Health Expense Benefit.

   You are NOT required to elect COBRA continuation coverage or pay COBRA premiums to continue to receive reimbursements from your Health Expense Benefit as long as your Health Expense Benefit account has not been forfeited as described in the "Right of Forfeiture" section on page 2 of this Summary Plan Description. You will continue to have access to your Health Expense Benefit account and to receive reimbursements under such coverage so long as the account balance is sufficient to cover your claims and exceeds the minimum required account balance. In fact your Health Expense Benefit account can be used to pay the required COBRA premiums for Health Insurance Benefits.

2. *Spouses:*

   Your spouse may elect COBRA continuation coverage upon the occurrence of any of the following events:

   (a) Your death.
   (b) Your spouse's loss of health insurance coverage under the Plan due to voluntary or involuntary termination of your employment (except for gross misconduct) or because you no longer meet the eligibility requirements of the Plan due to a reduction in hours worked including a strike, walkout or layoff, or a loss of eligibility due to reduction of individual account.
   (c) Divorce or judicial order of legal separation.
   (d) Your enrollment in Part A or Part B of Medicare.

   If your spouse has a COBRA Qualifying Event as a result of your death, because you have terminated covered employment or because of a reduction of your hours of Covered Employment, your spouse may elect COBRA continuation coverage for the Health Insurance Benefit only or for both the Health Insurance Benefit and the Health Expense Benefit. In this case, your spouse is NOT required to elect COBRA continuation coverage or pay COBRA premiums to continue to receive reimbursements from your Health Expense Benefit as long as your Health Expense Benefit account has not been forfeited as described in the "Right of

Forfeiture” section on page 2 of this Summary Plan Description. Your spouse will continue to have access to your Health Expense Benefit and to receive reimbursements under such coverage so long as the account balance is sufficient to cover the claims and exceeds the minimum account balance.

In the event your spouse has a COBRA Qualifying Event as a result of divorce or judicial order of legal separation, to continue to have access to your Health Expense Benefit and to receive reimbursements from your Health Expense Benefit account, your spouse MUST elect COBRA continuation coverage for both Health Insurance Benefits and Health Expense Benefits and pay COBRA premiums.

3. *Dependent children:*

Your dependent children can elect COBRA continuation coverage upon the occurrence of any of the following events:

a. Your death.
b. Your dependent child's loss of health insurance coverage under the Plan due to termination of your employment (for reasons other than gross misconduct) or because you no longer meet the eligibility requirements of the Plan due to a reduction in hours worked including a strike, walkout or layoff, or loss of eligibility due to reduction of individual account.
c. Divorce or judicial order of legal separation of the child's parents.
d. Your enrollment in Part A or Part B of Medicare.
e. The child ceases to qualify as an "eligible dependent" as described in the Section of the Plan entitled “Definition of Eligible Dependent”.

If your dependent child has a COBRA Qualifying Event as a result of your death, because you have terminated covered employment or because of a reduction of your hours of Covered Employment, your dependent child may elect COBRA continuation coverage for the Health Insurance Benefit only or for both the Health Insurance Benefit and the Health Expense Benefit. In this case, your dependent child is NOT required to elect COBRA continuation coverage or pay COBRA premiums to continue to receive reimbursements from your Health Expense Benefit as long as your Health Expense Benefit account has not been forfeited as described in the “Right of Forfeiture” section on page 2 of this Summary Plan Description. Your dependent child will continue to have access to your Health Expense Benefit and to receive reimbursements under such coverage so long as the account balance is sufficient to cover the claims and exceeds the minimum account balance.

In the event your dependent child has a COBRA Qualifying Event as a result of your divorce or judicial order of legal separation or because your child ceases to qualify as an “eligible” dependent, to continue to have access to your Health Expense Benefit and to receive reimbursements from your Health Expense Benefit account, your dependent child MUST elect COBRA continuation coverage for both Health Insurance Benefits and Health Expense Benefits and pay COBRA premiums.

If, while you are receiving COBRA continuation coverage, you have a newborn child or a child is placed with you for adoption, the child may be added to your coverage. You must, however, notify the Fund Office immediately of such a change.

4. *Retirees:*

A retired participant, or the covered spouse, dependent child or surviving spouse of a retired participant whose coverage under this Plan ends or is substantially eliminated within one year of the commencement of a bankruptcy proceeding, may continue coverage.

A retired participant between the ages of 62 and 65 and their covered spouse and dependent child or their surviving spouse may continue coverage. This coverage will end for the participant (or spouse) on the date the participant (or spouse) becomes enrolled in Medicare (Part A or Part B).

A retired participant, or the covered spouse, dependent child or surviving spouse of a retired participant covered under the "Health Expense Benefit as a Retired Worker" provisions under the Special Allocations section of this Plan, may elect COBRA continuation coverage upon loss of the Health Expense Benefit coverage due to voluntary or involuntary termination of employment (except for gross misconduct) or because the retiree no longer meets the eligibility requirements of the Health Expense Benefit due to a reduction in hours worked, including a strike, walkout or layoff, or a loss of eligibility due to reduction of the retiree's Health Expense Benefit individual account. A retiree and their covered spouse and dependents may elect COBRA continuation coverage for the Health Expense Benefit only.

C. *HOW IS A PERSON ELIGIBLE FOR COBRA CONTINUATION COVERAGE NOTIFIED OF HIS OR HER ELIGIBILITY?*

Your employer has the obligation to notify the Fund Office of your death or your enrollment in Part A or Part B of Medicare. The Trustees have determined that because employees frequently work for more than one employer making contributions to the Plan and because of the difficulty which this causes employers in providing this notice, employment will be deemed to have terminated and/or the number of hours worked will be deemed to have been reduced when your regular group health care coverage terminates.

You have the responsibility to inform the Fund Office of a divorce, judicial order of legal separation, a child's loss of status as an eligible dependent, the birth or adoption of a dependent or of a determination by the Social Security Administration that a qualified beneficiary is disabled. This notice must be given within 60 days after the occurrence of the qualifying event or the date coverage would be lost because of the event, whichever is later. Failure to give notice to the Fund Office within the time limits may result in your ineligibility for COBRA continuation coverage.

In addition to giving notice of certain qualifying events, you have the responsibility to inform the Plan in the event that the Social Security Administration has determined you or one of your qualified beneficiaries to no longer be disabled. This notification must be made within 30 days of the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled.

After the Fund Office receives notice of the occurrence of one of the above qualifying events, it will notify each eligible individual whether he or she has the right to elect COBRA continuation coverage and will send the materials necessary to make the proper election. In general, the Fund Office will notify eligible individuals of their COBRA rights within 14 days after receiving notice of the occurrence of one of the qualifying events described above or after it has determined that your regular group health care coverage has terminated.

D. *WHEN MUST THE ELECTION BE MADE?*

The employee, spouse and dependent children each have independent election rights. Covered employees may elect COBRA continuation coverage on behalf of their spouses and parents may elect COBRA continuation coverage on behalf of their children. Each individual will have 60 days from the date he or she would lose coverage because of one of the qualifying events described above or the date on which he or she is advised of the right to elect continuation coverage, whichever date is later, to inform the Fund Office that he or she wants COBRA continuation coverage. If no election of COBRA continuation coverage is made, the individual's group health coverage will terminate, except for any other extended coverage for which the individual may be eligible under the Plan. You will not have another opportunity to elect continuation coverage. However, you may change your election within the 60 day period described above as long as the completed COBRA Election Form is received by the Fund Office on or before the due date. If you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date the completed Election Form is received by the Fund Office.

You may elect COBRA continuation coverage for the health insurance benefits only or for both the health insurance benefits and the health reimbursement account benefits. You are NOT required to elect COBRA continuation coverage or pay COBRA premiums to continue to receive reimbursements from your Individual Account as long as your Individual Account has not been forfeited as described in the "Right of Forfeiture" section on page 2 of this Summary Plan Description. You will continue to have access to your Individual Account and to receive reimbursements from your Individual Account so long as the account balance is sufficient to cover your claims and exceeds the minimum required account balance. In fact, your Individual Account can be used to pay the required COBRA premiums for health insurance benefits.

E. *WHAT TYPE OF BENEFITS ARE AVAILABLE UNDER COBRA CONTINUATION COVERAGE?*

The benefits an eligible individual is allowed to elect to receive will include all benefits the individual was entitled to before the occurrence of the event making the individual eligible for COBRA continuation coverage. However, no life insurance (death benefits) or disability benefits or accidental death and dismemberment benefits or other non-health benefits will be included.

F. *WHAT ARE THE CONSEQUENCES OF FAILING TO ELECT OR WAIVING COBRA CONTINUATION COVERAGE?*

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you prior to January 1, 2015 by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions prior to January 1, 2015 if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

G. *HOW LONG DOES COBRA CONTINUATION COVERAGE LAST?*

If the election is due to termination of your employment or a reduction in hours worked or a loss of eligibility due to reduction in individual account, COBRA continuation coverage will end 18 months after your other coverage ended. However, if you, your spouse or one of your dependent children is determined by the Social Security Administration to be disabled on the day regular coverage terminates or within 60 days thereafter, each of you can receive a total of 29 months of COBRA continuation coverage. For all other situations, such coverage is available for 36 months. COBRA continuation coverage will end at an earlier time for any of the following reasons:

1. The employer no longer provides group health coverage.
2. Failure to pay the monthly premium on time.
3. The individual becomes covered under another group health plan (other than one sponsored by the employer) except for any period the other group health plan limits coverage of your pre-existing conditions.
4. The individual enrolls in Part A or Part B of Medicare.
5. Circumstances are such that the individual's participation could be canceled if the individual were an active employee.

If any of these events occur, the Fund Office will send you a Notice of Termination of Coverage, explaining the reason the COBRA coverage terminated early, the date coverage terminated, and any rights the employee, spouse or dependent child may have under the Plan to elect alternate coverage.

H. *HOW DOES COBRA CONTINUATION COVERAGE AFFECT ELIGIBILITY FOR OTHER EXTENDED BENEFITS UNDER THE PLAN?*

Anyone who becomes eligible for COBRA continuation coverage may also become eligible for continuation coverage under the "Direct Payment Option," which is discussed on page 17 of this Summary Plan Description. If the employee chooses the Direct Payment Option, he will be covered by the Option and not through COBRA**.** However, upon the loss of such Direct Payment Option coverage, or failure to elect the Option, the Plan will provide all proper notices of COBRA rights and will afford the affected individuals the opportunity to elect COBRA continuation coverage at that time.

There may also be alternative health insurance coverage options for you and your family other than purchasing COBRA coverage from this Plan. When key parts of the health care law take effect in 2014, you'll be able to buy coverage through the Health Insurance Marketplace. The Marketplace is designed to help people without employer sponsored coverage find health insurance that meets their needs and fits their budget. More information about the Health Insurance Marketplace generally is available at: HealthCare.gov. In considering whether coverage through the Marketplace is better for you than COBRA coverage, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away. Information about the Marketplace can help you see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. In addition to the options available from the Marketplace, you may qualify for a special enrollment opportunity to obtain coverage from another group health plan for which you are eligible (such as a spouse's plan). Even if the other plan generally does not accept late enrollees, you may still qualify if you request enrollment within 30 days. If you would like more information regarding the Marketplace, you should contact the Health Benefit Exchange Marketplace in your state of residence. For example, in New York State, the website for the Marketplace is: healthbenefitexchange.ny.gov.

I. *WHAT IS THE COST OF COBRA CONTINUATION COVERAGE AND HOW IS THE COST COMPUTED?*

Each month, any individual electing COBRA continuation coverage will be required to make a payment to the Fund Office to continue COBRA continuation coverage. The monthly premium will be based on the average

cost which the Plan incurs annually per participant plus a two percent administrative charge. The extra 11 months of COBRA continuation coverage available to disabled participants are at a monthly charge based on one and one-half times the average annual per participant cost incurred by the Plan. The monthly COBRA premium will usually be more than the monthly premium charged to participants for extended coverage provided under the "Direct Payment Option" as described on page 17 of this Summary Plan Description.

J. *WHEN MUST YOU PAY FOR YOUR COVERAGE?*

Your first payment must be made within 45 days from the date you elect to continue coverage. You may make monthly payments for your coverage. If you do not pay for your coverage within 30 days from the date any payment after the first payment is due, then the coverage will be terminated as of the date payment was due.

K. WHAT IS THE HEALTH INSURANCE MARKETPLACE?

There may be other coverage options for you and your family. When key parts of the health care law take effect, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

L*. IS THERE ANYTHING ELSE I SHOULD KNOW ABOUT COBRA CONTINUATION COVERAGE?*

COBRA continuation coverage is described in greater detail in a letter sent out by the Fund Office to each participant when the participant becomes eligible to participate in the Plan or when COBRA first became applicable to the Plan, if later. If you have any questions concerning COBRA continuation coverage, you should contact the Plan Manager.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website @ www.dol.gov/ebsa. (Addresses and telephone number of Regional and District EBSA Offices are available through EBSA's website).

In order to protect your family's rights, you should keep the Plan Manager informed of any changes in the address of family members. You should also keep a copy, for your records, of any notices you send to the Plan Manager.

COORDINATION OF BENEFITS

Frequently, working parents are covered under more than one "Health Care Plan". Thus, in some instances, the combined benefits received under both plans could exceed the medical bill. Therefore, if both parents are covered under this Plan as well as another plan providing medical benefits, then these Coordination of Benefits rules apply. In the event the spouse or dependent chooses not to submit claims to the other health plan, then this Plan's Coordination of Benefits rules will apply as if such other coverage was in effect. The purpose of this Plan is to provide a benefit program to cover medical expenses. These rules determine how the benefits payable under all plans will be reduced so that the total benefits payable will not exceed the "allowable expenses" incurred during any calendar year.

Under the Coordination of Benefits rules, one plan is determined to be the "Primary Plan". That plan pays its benefits first, as if there are no Coordination of Benefit rules. The other plan, the "Secondary Plan", determines its benefits only after the Primary Plan has made its determination as to what it will pay.

"Allowable expenses" means any necessary, reasonable, and customary item of expenses for medical care or treatment covered under at least one of the plans. A "Health Care Plan" is any plan or program providing health care coverage on an insured or uninsured basis. This includes another Welfare Plan; Labor Management Trusteed Plan; Employer Plan; any Prepayment Arrangement; Group or Blanket Insurance; and any coverage under Government Programs (except Medicaid), and No-Fault Auto Insurance.

If the other plan which may be liable for benefits does not contain a Coordination of Benefits provision, this Plan will be the Secondary Plan. If the other plan does contain such provisions, this Plan will be the Primary Plan if the person incurring the expense is covered by this Plan as an employee. If the person incurring the expense is covered by this Plan as a dependent, this Plan will be the Secondary Plan if the other plan covers such person as a covered employee regardless of contrary statements in the dependent's Plan.

If your children are eligible for coverage under both this Plan and the plan provided by the other parent's employer, then this Plan will be the Primary Plan if your birthday falls earlier in the year than the other parent's birthday. If you happen to have the same birthday, this Plan will be the Primary Plan if it has covered you longer than the other parent's plan.

If the expenses are for a child whose parents are divorced or separated, the plan covering the parent with the custody is primary. If the parent with custody remarries, the order of payment is as follows:

a) Natural parent with whom the child resides;

b) Step-parent with whom the child resides; and

c) Natural parent not having custody of the child.

If the divorce decree makes one parent liable for the expenses of the child's medical care, then the plan covering that parent will be the Primary Plan regardless of these rules.

If the other Health Care Plan is a No-Fault Auto Insurance Policy, this Plan will be the secondary plan.

If, for some reason, the proper coordination of benefits cannot be determined under the rules described above, then the plan that covered the patient for the longest time is primary. The other plan is secondary.

It is your obligation to notify this Plan if you, your spouse, or any of your eligible dependents are covered by another health care plan. If you fail to do so, any amount by which this Plan overpays benefits will be recovered from you, either directly or through a reduction in future benefits.

COORDINATION OF BENEFITS WITH MEDICARE

The Fund will play Plan benefits in accordance with the Medicare Secondary Payor ("MSP") regulations for your and your eligible dependent's healthcare expenses. Medicare primary plan status is determined pursuant to these regulations, and revisions or amendments to these regulations will automatically apply to the Fund.

For individuals who are eligible for Medicare due to age (65 and over) or due to disability, Medicare is secondary to the Plan that covers this person as an active employee or the dependent of an active employee. For retirees, Medicare is secondary only to the extent permitted by the MSP regulations. For individuals eligible for Medicare due to End-Stage Renal Disease ("ESRD"), Medicare is secondary for the first thirty months following the month of the first eligible ESRD treatment for this person. Once Medicare eligibility is established due to ESRD, the eligible person is entitled to full Medicare coverage. Medicare benefits are not limited to ESRD expenses.

If Medicare is found to be the primary payer for you or your dependent, the usual Plan benefit for a covered service will be reduced by the Medicare payment for that service. The Plan will pay the balance of the usual Plan benefit, if any, which results from this reduction. The combination of the Plan payment and the Medicare payment shall not exceed the usual Plan benefit for a covered expense. This integration will apply to persons eligible for Medicare whether or not actually enrolled in Medicare. If a Medicare eligible person is not enrolled in Medicare Part A or Part B and Medicare is found primary, the Medicare benefit will be estimated and used to reduce allowable fees. **This could result in significant reduction or denial of the Plan benefits.**

If the provider accepts Medicare assignment of benefits, the allowable fee will be the same fee allowed by Medicare. However, if the provider does not accept Medicare assignment, the allowable fee will be based on the usual, customary, and reasonable charge or the charge as determined by Medicare limiting charge regulations whichever is the lower charge. According to Medicare regulations, a beneficiary cannot be billed the difference between the Medicare allowed amount and the provider's charge when that provider accepts Medicare assignment. If a provider does not accept assignment, a beneficiary cannot be billed for charges more than the limiting charge established by Medicare for that service by that provider.

Please note: If you or your dependent is eligible for Medicare primary benefits, claims should be submitted to Medicare first. Medicare explanation of benefits should be attached to your health claims forms.

SPOUSES' EMPLOYER INSURANCE -- ENROLLMENT RULE

In the interest of fairness and to prevent the Fund (your Plan) from being responsible for claims for other employers' employees, the Trustees have instituted a protective measure for your Plan's assets.

When a participant's spouse has health insurance or expense benefits available to him/her under his/her employer's plan, there will be no coverage under this benefit Plan, unless such spouse enrolls in his/her employer's plan. We will then coordinate benefits with the spouse's employer plan as a secondary payer.

An exception will be considered if the cost for his/her enrollment is substantial (more than 10% of her/his gross pay). Note that if he/she is enrolled in his/her employer's plan, coordination with that plan will take place, in the event of a claim with his/her plan paying first.

If the spouse fails to enroll in his/her plan, when there is no exception granted based on cost, the Plan will coordinate benefits as if the Spouse were enrolled in their employers plan. The Fund Office has the right to require submission of the spouse's employer plan documents to coordinate these benefits. Failure to submit required documentation will result in denial of claims.

GENERAL EXCLUSIONS

No benefits are payable under the Health Insurance Benefit Provision part of the Plan for the following expenses:

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

2. Charges for services or supplies, which are paid for or otherwise provided for in accordance with laws or regulations of any government or political subdivision, including Workers' Compensation.

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

4. Hospital confinement primarily for cosmetic surgery unless required as a result of an accident sustained while covered or for reconstruction of a breast on which a covered mastectomy has been performed, including reconstruction of the other breast to produce a symmetrical appearance; prosthesis; and treatment of physical complications at all stages of the mastectomy, including lymph edemas.

5. Confinement for sanitarium-type, custodial or convalescent care.

6. Any hospital room and board charges in excess of the lesser of the daily semiprivate room and board rate on an expense incurred basis.

7. Charges that are not reasonable or customary.

8. Charges for services or supplies that are not medically necessary. "**Medically Necessary**" or "**Medical Necessity**" means health care services, supplies or treatment that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

   a. in accordance with generally accepted standards of medical practice;
   b. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease;
   c. not primarily for the convenience of the patient, physician or other health care provider; and
   d. not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's illness, injury or disease.

   "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer review medical literature generally recognized by the relevant medical community when available, Physician Specialty Society recommendations, the view of prudent physicians practicing in relevant-clinical areas, and any other clinically relevant factors.

   The fact that a physician or health care practitioner may order, recommend, or approve a service, supply or treatment does not itself make it medically necessary. The Board of Trustees or its designee has the discretion and authority to determine if a service, supply or treatment is medically necessary.

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

10. Services or supplies that are experimental or investigational. Services or supplies will be considered "experimental or investigational" as follows:

    if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; if "Reliable Evidence" shows that the drug, device, or medical treatment or procedure is the subject of on-going Phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with the standard means of treatment or diagnosis; or if "Reliable Evidence" shows that the consensus of opinion among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with the standard means of treatment or diagnosis." "Reliable Evidence" means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure. The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as experimental or investigational.

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

12. Bariatric and related weight-loss surgery, unless otherwise to be determined to be medically necessary through a pre-certification process.

13. Services related to the treatment of infertility, including but not limited to in vitro fertilization; artificial insemination; and surrogacy (except where otherwise provided for by law).

14. For reversal of elective sterilization procedures, as referred to on page 33 of this Plan booklet.

15. Elective Abortion; except when a pregnancy is considered life threatening to that of the mother and then only when an opinion is rendered by two physicians, one of which may be at the choice of the Fund Office. For non-emergency cases the surgery must be pre-certified by the Plan prior to surgery.

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

17. Services for treatment of obesity, except for surgical treatment of morbid obesity in life threatening circumstances.

18. Diet and weight loss programs, except for counseling services directly related to the treatment of diabetes.

19. Charges for services or supplies related to an injury, condition or disease resulting from, or incurred while committing an unlawful act, or resulting from being engaged in an Illegal Act.

    For the purpose of this exclusion, the term "Illegal Act" means any action or omission that is contrary to, or in violation of, any statute, rule, regulation, ordinance, court order, or other established custom having the force and effect of law. The Plan's Trustees reserve the

exclusive right to determine, in their sole discretion, whether an action or omission is an illegal Act based upon the facts and circumstances involved in the case and regardless of whether a criminal prosecution or conviction resulted. In accordance with the source of injury rules established pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the term "Illegal Act" shall not be interpreted to exclude coverage related to injuries incurred as a result of domestic violence and/or self-inflicted injuries that are the result of depression or mental illness.

20. Injuries and expenses incurred as a result of an accident, if at the time of the accident, you were driving while intoxicated, or driving with impaired ability due to the use of legal or illegal substances, including but not limited to alcohol.

21. Any expenses incurred as a result of self-inflicted injury or disease, unless due to a health-related factor as defined in the Health Insurance Portability and Accountability Act of 1996.

22. Any expenses related to the treatment of alcohol or substance abuse, unless due to a health-related factor as defined in the Health Insurance Portability and Accountability Act of 1996 or unless the Fund is required to pay the expense by the Mental Health Parity Addiction Equity Act of 2008, including the related regulations.

23. Services rendered by a podiatrist, except for those services which are considered medically necessary as defined by the Plan.

24. Services rendered by a chiropractor and chiropractic treatment or chiropractic services performed by any other licensed medical professional such as a M.D. or D.O.

25. Services or supplies not prescribed as necessary by a physician legally licensed to practice medicine.

26. Charges that the covered person is not required to pay.

27. Acupuncture services, regardless of whether such services are rendered by a certified acupuncturist or any other licensed medical professional such as a M.D. or D.O.

28. Services for Biofeedback, Hypnosis, or Hypnotherapy.

29. Claims incurred when someone or some entity is responsible for the medical or non-medical services that an individual receives, subject to the Plan's subrogation rights provided herein.

ANNUAL DEDUCTIBLE INFORMATION

The Cash Deductible:

The Cash Deductible, out of pocket expense, is the amount of **Covered Charges, which you pay before you are entitled to any Benefits under the Health Plan.

The deductible shall be:

$100.00 per person, with a maximum of

$300.00 per family, in any calendar year.

A deductible paid late in one year, **will not** apply to the deductible in the following year.

The Cash Deductible applies only once in any calendar year (January through December) even though you may have several different disabilities.

The deductible is only required for those benefits covered under the Health Insurance Benefit Provisions of the Plan.

**** Covered Charges are those charges that would be normally reimbursable by the Fund under the benefit Plan, not necessarily the amount of the bill.**

PREFERRED PROVIDER NETWORK

How the Program Works

If you use a physician or hospital that participates in the Preferred Provider Network ("Network"), the Plan will pay 100% of the Network's contracted allowance minus the applicable co-payment to the physician, after the applicable annual deductible is met. Contact the Fund Office for more information about the physicians and hospitals that participate in the Fund's Network. In addition, the Network is subject to change periodically as determined by the Fund's Trustees.

The Plan's payment, plus the co-payment which is your responsibility, will be accepted as payment in full. You should make the co-payment at the time of the office visit.

Well child co-payments, when rendered under the Network, are per the Well Child Care benefit on page 35 of this SPD.

Surgical procedure and x-ray/laboratory procedures are also included in the program and will be reimbursed at 100% of the Network's allowance, and are not subject to a co-payment.

Any benefits other than physician and x-ray/laboratory benefits will be paid under the Major Medical portion of your Plan. These charges will be subject to a 20% co-payment of Network's contractual amount.

Any physician or hospital that does not participate with the Preferred Provider Network is an "Out-of-Network" provider. Benefits may defer depending upon whether the provider is "in-network" or "out-of-network".

HOSPITAL EXPENSE BENEFIT
For Active Participants and Eligible Dependents

In-Patient Benefits

The Plan pays benefits if you are:

a. A registered bed patient.

b. Required to stay in a hospital for care or treatment which we determine is medically necessary.

In a "Network Hospital"

If you are an inpatient in a network hospital, the plan will cover the following services at 100% after the applicable annual deductible is met:

a. Hospital diagnostic and treatment services necessary for your medical or surgical care. These services must be:
   - available in the hospital in which you are a patient;
   - performed by an employee of the hospital;
   - billed by, and payable to the hospital.

b. Bed, board and general nursing service in a semi-private room. A semi-private room is a room which the hospital considers to be semi-private.

   If you occupy a private room in a network hospital, regardless of the reason, we will only cover that hospital's most common semi-private room charge. You will be responsible to the hospital for the difference between the semi-private room charge and the private room charge.

In a "Non-Network Hospital"

If you are an in-patient in a non-member hospital, the plan will cover 80% of the following services after the applicable annual deductible is met:

a. The regular charges of the hospital for the same diagnostic and treatment services covered in a member hospital.

b. The regular charge for bed, board, and general nursing service for their most common semi-private rooms.

Number of days of Hospital Care

The Plan will cover the first 70 days of each hospital stay, starting with the date of your admission. Each hospital stay means an admission or series of admissions to member or non-member hospitals which are not separated by 90 days. If for 90 days, you are not a bed patient receiving medical care in a hospital or other institution, and then you are admitted to a hospital, you start a new hospital stay. In that event, another 70 days of hospital care are available to you.

Hospital admissions for accidental injuries are counted separately. Such admissions are not combined with hospital stays for illnesses. In other words, you can receive 70 days for an illness, and 70 days for stays related to the same accidental injury. The day you are admitted to a hospital, and each day after that, will be counted. However, the day you are discharged will not be counted. If you are admitted and discharged on the same day, one day will be counted. You cannot choose which days of hospital care will be counted. We will not cover any days of hospital care which we decide were not necessary for the treatment of your illness or injury.

Out-patient Benefits

If you are an out-patient and qualify for benefits under this section if you are not admitted as a registered bed patient. Only those services we determine are medically necessary will be covered. The plan will cover the 100% of following benefits in a network hospital and 80% of the following benefits in a non-network hospital after the applicable deductible is met:

a. **For surgery.** Hospital services in connection with surgery. This will also include the setting of a fracture or dislocation.

b. **For an accidental injury.** Emergency care given to you after an accidental injury requiring this type of care. This care must be given within 72 hours or a reasonable period of time after the injury.

c. **For sudden and serious illness.** Emergency care for a sudden, unexpected beginning of a medical condition. The condition must be serious enough that if you did not receive immediate care, your life would be in danger or your body functions seriously damaged. This care must be given within 12 hours or a reasonable period of time after the beginning of the condition.

d. **For pre-surgical testing.** Tests ordered by your surgeon leading up to surgery in the same hospital, it:
    a. proper diagnosis and treatment require the tests;
    b. an operating room has been reserved before the tests are given;
    c. you are present at the hospital for the tests; and
    d. the surgery actually takes place within 7 days after the tests were given.

e. **For kidney dialysis.** Treatment for chronic kidney disease if the damage is permanent and cannot be controlled by medicine and you require dialysis to maintain life. You are covered until you are eligible for dialysis benefits under Medicare. Even if you fail to apply for, or receive Medicare dialysis benefits, we will not cover dialysis for more than 12 months.

f. **For Chemo therapy and Radiation therapy**, the therapy must be ordered by your physician and performed in the hospital.

g. **Diagnostic service and therapy**. We will cover the following benefits:
    a. Diagnostic X-Rays and laboratory tests
    b. Radiological therapy and inhalation therapy; and physical therapy following hospitalization.
    c. The diagnostic services or therapy must be ordered by your physician and performed in the hospital.

Skilled Nursing Facility Benefits

You qualify for benefits under this section if:

You are a registered bed patient and

a. You have to stay in a skilled nursing facility for care or treatment, which we determine is medically necessary; and
b. You would otherwise have to stay in a hospital if you did not stay in a skilled nursing facility.

What is a skilled nursing facility?

A skilled nursing facility (SNF) is an institution, or a distinct part of an institution, which is:

a. Accredited as a SNF by the Joint Commission on Accreditation of Hospitals; or
b. Certified as a network SNF with Medicare.

What benefits are covered?

If you are a patient in a SNF, the plan will cover the following services:

a. Nursing care given or supervised by a registered nurse.
b. Bed and board in a semi-private room. A semi-private room is a room which the SNF considers to be semi-private.
c. Physical or speech therapy given by the SNF, or by others under an agreement with the SNF.
d. Drugs, supplies and equipment used in and furnished by the SNF.
e. Other services generally provided by the SNF which would be covered if you were an in-patient in a hospital.

Number of days of skilled nursing facility care.

We will cover the first 120 days of each hospital and SNF stay, starting with the date of your admission. In counting the number of days under this contract, 2 days in a SNF equal 1 day in a hospital. The total number of hospital and SNF days combined cannot exceed 120 days.

Here is an example:

You are in a hospital for 10 days. You are immediately transferred to a SNF. You stay in the SNF for 120 days You have used the entire 120 days under this contract C 10 days in a hospital = 10 days; 120 days in SNF = 60 days (2 days in a SNF count as 1 day in a hospital).

If you are out of a SNF, hospital, and other institution for 90 consecutive days, you are eligible for another 120 days of hospital and/or SNF care.

Which days are counted? The day you are admitted to a SNF, and each day after that, will be counted. However, the day you are discharged will not be counted. If you are admitted and discharged on the same day, 1 day will be counted. You cannot choose which days of SNF care will be counted. We will not cover any days of SNF care which we decide were not necessary for treatment or care of your illness or injury.

The Roofers' Local 195 Health and Accident Fund will also cover the following services:

1. Elective Sterilization:

The Plan shall pay hospital or ambulatory service charges for elective sterilization to a maximum of $ 2,000.00. Benefits will be paid on an outpatient only basis, for the participant or eligible dependent **spouse** only. Benefits for reversals of elective sterilization will not be covered. Physician charges are covered under the surgical benefit portion of this Plan.

2. Emergency Treatment Benefits:

The Plan will pay benefits for charges made by a doctor or other medical provider for emergency treatment provided as a result of illness, surgery or bodily injury. Benefits will be paid in accordance with the applicable Medical Benefit on page 35, even though the covered person is not admitted as an inpatient. This Emergency Room Benefit will be paid in the event a **life threatening condition exists, or for medically necessary treatment received during other than normal business hours.**

HOSPICE CARE BENEFITS
For Active Participant and Eligible Dependents

If you are eligible, you will be reimbursed per the appropriate Expense Benefit, up to a maximum of:

$ 200.00 per day for a maximum number of 90 days

This includes actual fees charged for patient care in a designated hospice facility or a hospice unit within a regular hospital; for hospice care provided by a hospital; or for home day care services. The hospital, facility, or unit must be a certified organization, which meets the standards of the State (in which the participant or eligible dependent resides) licensing agency. Effective July 1, 2011, the lifetime limit described above shall be replaced with an annual limit of $200.00 per day for a maximum of 90 days per year.

The terms "patient care", "hospice care", and "home day care services" include, but are not limited to the following:

1. Periodic nursing care by a RN, LPN, or Home Health Aide.
2. Physical Therapy.
3. Speech Therapy.
4. Respiratory Therapy.
5. Social Services.
6. Nutritional Services.
7. Laboratory exams, x-rays, chemotherapy and radiation therapy as needed to control symptoms.
8. Medical supplies.
9. Drugs and medications as prescribed by a licensed physician and approved under the U.S. Pharmacopoeia and/or National Formulary, as needed to control symptoms. **Note:** The Plan will not cover drugs or medications that are of an experimental nature, as per General Exclusions on pages 26 through 28.
10. Durable medical equipment.
11. Medical Care provided by the hospice physician.

Eligibility for Hospice Care:

In order to be eligible for the Hospice Care Benefit, the attending physician must estimate the prognosis of the patient's life expectancy to be 3 months or less. The attending physician must also consider palliative care (relief of symptoms and pain control) to be the most appropriate treatment for the illness and consider such treatment to be medically necessary.

Exclusions to the Hospice Care Benefit:

The Plan will not pay the following under the Hospice Care Benefit:

1. Volunteer or other services which would normally be provided free of charge under the hospice care program.

2. Legal and/or financial advice services (such as preparation and execution of a will, estate planning and liquidation, financial investment planning, etc.).

3. Counseling by clergy or volunteer groups.

4. Services provided by an individual who is either a participant of the patient's or spouse's family or who normally lives in the patient's home.

5. Services not provided and billed through a recognized hospice program and not authorized by the patient's attending physician and the Plan.

MEDICAL EXPENSE BENEFIT
For Active Participant and Eligible Dependents

You will be reimbursed for the actual charges made by a legally qualified physician or licensed nurse practitioner for medical services rendered to you as a result of non-occupational injury or non-occupational sickness. Such payment shall not exceed the following after the applicable annual deductible is met:

Office Visits, Home or Emergency Hospital Visits:
$ 15.00 co-payment applies to all visits
PPO physicians – 100% of contractual rate after co-payment
Non PPO physicians – 80% after co-payment

Non-Emergency Hospital Visits maximum of: **$30.00** per visit

OUT OF HOSPITAL NERVOUS OR MENTAL DISORDERS

Nervous or Mental disorders refer to conditions and diseases as defined in the Mental Disorders section of the International Classification Diseases Clinical Modification (ICD) manual current edition. Covered Charges for psychological or psychiatric treatment while not confined to a hospital will be paid according to the above medical benefit. Provider must be a legally licensed Clinical Psychologists or Psychiatric Physician. Provider must submit a treatment plan to the Fund Office upon request. Effective July 1, 2011, the Fund's limitations and exclusions for nervous and mental disorders are revised to cover only those benefits required by the Mental Health Parity Addiction Equity Act of 2008, including the related regulations.

WELL CHILD BENEFIT

This benefit was established to be paid pursuant to criteria developed by the New York State Department of Health. Those criteria recommend that a child receive a range of physician office visits, immunizations, and examinations, depending on the child's age. If you need more information about the services covered for your child, you should contact the Fund Office. ***The Fund pays for the reasonable and customary office visit, co-pays and administrative costs for the benefits provided under the Well Child Benefit.***

PPO physicians - 100% of contractual rate after co-payment
Non PPO physicians - 80% after co-payment

Medical Expense Benefit Limitations:

One Visit in any **one** day per participant or per eligible dependent, per physician.

No payment shall be made if visits are due to intentional self-inflicted injuries, unless due to a health-related factor as defined in the Health Insurance Portability and Accountability Act of 1996.

No payment shall be made for visits or services rendered by a chiropractor or for chiropractic services.

No payment shall be made for fees for dental work or treatment, nursing care, eye examinations or the fitting of glasses, nor for laboratory or x-ray charges, or drugs, dressings or medicines, unless otherwise specified under a separate benefit to the Plan.

SUBSTANCE USE DISORDER
For Active Participant and Eligible Dependents

All substance use disorder treatment inpatient and outpatient requires **Pre-Certification** and must be determined to be medically necessary. You may contact the Pre-Certification number listed on your insurance card or contact fund office for further information.

Inpatient services are covered after the applicable deductible is met at:
In-Network Provider - 100%
Out-of-Network Provider – 80%

The Plan will cover the hospital stay in accordance with the limitations for the Hospital Expense benefit, starting with the date of your admission. Each hospital stay means an admission or series of admissions to member or non-member hospitals which are not separated by 90 days. If for 90 days, you are not a bed patient receiving medical care in a hospital or other institution, and then you are admitted to a hospital, you start a new hospital stay. In that event, another 70 days of hospital care are available to you. Limit of 70 days per disability as stated for the Hospital Expense benefit.

Outpatient services are covered after the applicable deductible is met at:
In-Network Provider - $ 15.00 copay
Out-of-Network Provider – 20% copay

Although treatment for a substance use disorder is covered by the Fund, the Fund does not cover expenses related to the treatment of alcohol or substance abuse generally. In other words, coverage will depend on whether the expense is due to a health-related factor concerning the substance abuse. For further information on substance use disorder and treatment, see page 28, exclusion #22.

SURGICAL EXPENSE BENEFIT
For Active Participant and Eligible Dependents

You will be reimbursed for the actual fee charged by licensed physicians for the surgical procedure performed, after the applicable deductible is met, as follows:

PPO Provider: 100% of contractual PPO rate – less any applicable co-payment
Non-PPO Provider: 80% of actual charges – less any applicable co-payment

but not to exceed the maximum amount specified for such operation as reasonable and customary. Hospital confinement is not required.

If more than one operation is performed during any one continuous period of disability, a benefit is payable for each operation except that:

(1) If more than one operation is performed through the same surgical approach or incision, the total payment for all such operations shall not exceed the maximum payment specified in the Schedule for that of such operations for which the largest amount is payable;

(2) the total payment for all operations performed during one continuous period of disability shall not exceed the maximum Surgical Expense Benefit.

Successive operations shall be considered one operation unless the subsequent operation is performed after complete recovery from the injury or sickness causing the previous operation, or unless the subsequent operation is due to causes entirely unrelated to the causes of the previous operation. A successive operation performed on a Working Participant for the same or related cause or causes as a previous operation shall be considered as a new operation if the Working Participant had returned to work for at least **one** full working day after the previous operation.

A successive operation performed on an Eligible Dependent or a Retired Participant due to the same or related cause or causes as the previous operation shall be considered as a new operation if such operations are separated by at least **90 days**.

Surgical Expense Benefits for vasectomy, tubal ligation or other sterilization operations or procedures, will be paid for participant or eligible dependent spouses **only**. Dependent children are not eligible for this benefit.

No Surgical Expense Benefits will be paid for operations or procedures performed in a hospital operated by Federal or State agencies, nor for operations or procedures covered by Workers' Compensation legislation, unless otherwise provided for under federal law.

No Surgical Expense Benefits will be paid for Bariatric Surgery or related weight loss surgery, unless determined to be medically necessary. Pre-Certification is required to determine medical necessity for all related bariatric and weight loss surgeries. You may contact the Fund Office for further information.

No Surgical Expense Benefits will be paid for procedures or operations performed for cosmetic services, (except for benefits related to the reconstruction of a breast on which a covered mastectomy has been performed or for surgery and reconstruction of the other breast to produce a symmetrical appearance), or for services rendered in conjunction with breast reduction unless otherwise to be determined to be medically necessary through precertification.

MATERNITY AND OBSTETRICAL BENEFIT
For Active Participant and Eligible Dependents

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

Maternity Benefit (Hospital):

If you, your spouse or any eligible dependent child is confined in a hospital for pregnancy, you will be reimbursed for room and board and other hospital charges in accordance with the Hospital Expense Benefit. Hospitalization benefits will be paid in accordance with Preferred Provider Network.

Obstetrical Benefit (Surgical):

If you, your spouse or any eligible dependent child undergoes an obstetrical procedure, you will be reimbursed for the physician's fees under this benefit for such procedure, after the applicable deductible is met, as outlined below:

PPO physicians - 100% of contractual rate after co-payment
Non PPO physicians - 80% after co-payment

There is no waiting period for these Maternity and Obstetrical Benefits. You, your dependent spouse and your eligible dependent children are covered on the date they become an Eligible Participant/Dependent.

Elective Abortion is generally not covered. See General Exclusions, Page 27, exclusion # 15 for further information.

LABORATORY AND X-RAY EXAMINATIONS EXPENSE BENEFIT
For Active Participant and Eligible Dependents

If you undergo Laboratory or X-Ray examinations, including basal metabolism determination and electrocardiograms, provided that such examination is not due to

(a) occupational accidental bodily injury or

(b) a sickness due to an occupational disease,

you will be reimbursed for the fees charged for such examination, after the applicable deductible is met, as follows:

PPO Provider – 100% of the approved charges
Non-PPO Provider – 80% of charges

No benefits are paid for any:

(a) X-Ray examination made without film or computers, or

(b) medical technical procedure or examination in connection with dental work or treatment, or

(c) for examination made on account of any injury or sickness for which you are entitled to benefits as a result of being covered under the Hospital Expense Benefit of the Plan.

MAJOR MEDICAL EXPENSE BENEFIT
For Active Participant and Eligible Dependents

If Covered Charges are incurred within a calendar year you will be reimbursed for **80%** of such charges which are in excess of the Deductible Amount.

Covered Charges:

"Covered Charges" means the reasonable charges outlined below for necessary medical care and services which are ordered by a physician legally licensed to practice medicine:

1. When applicable, charges made by a duly constituted hospital, except that the daily room and board charge may not exceed the hospital's regular rate for semi-private accommodations, or if the hospital does not have such accommodations, an amount not to exceed 80% of the hospital's minimum daily rate for private room and board, and only when denied or not otherwise provided for under the Hospital Expense Benefit portion of the Plan.

2. Charges for diagnosis, treatment, or surgery by a physician or nurse practitioner legally licensed to practice medicine, not covered under the basic benefits of the Plan.

3. Charges made by a registered graduate nurse for private duty nursing service, or a licensed nursing agency, when medically prescribed and preauthorized by the Fund Office as an alternative to long term inpatient care.

4. Charges for the following not otherwise covered under the prescription benefit portion of this Plan;
    a. anti-viral and chemotherapy medications when prescribed by a legally licensed physician or nurse practitioner.

    b. diabetic implements, medications and supplies.

5. Charges for the following: Local ambulance service, anesthesia and the administration thereof, the use of radium and radioactive isotopes, iron lung, physiotherapy, oxygen and rental of durable medical equipment required for temporary therapeutic use or purchase if adjudged more economical by the Plan*; casts, splints, trusses, and braces*, and similar services, supplies and treatment.

*However, coverage of Rental or Purchase of Equipment is subject to the following conditions:

(a) With respect to equipment, which may be rented, you must contact the Plan immediately when you find out that you require the use of such equipment. The Plan will then determine whether the equipment should be rented or purchased for your use, on the basis of the cost of the equipment and the period of time during which you will be required to use it.

(b) Repair and maintenance costs are NOT covered.

(c) The equipment must be primarily and customarily used for medical purposes.

(d) The equipment must be generally not useful to a person in the absence of injury or illness. For example, equipment that may be enjoyed by the entire family, such as air conditioners, exercise bicycles, etc. are **not** covered.

(e) The equipment must be safe and effective for home use.

6. Charges for prosthesis and treatment of physical complications at all stages of a covered mastectomy, including lymph edemas.

Limitations to Major Medical Coverage:

In addition to the exclusions listed on pages 26 through 28 we do not pay for the following:

1. Services, supplies, and treatment not prescribed as necessary by a physician or nurse practitioner legally licensed to practice medicine.

2. Services rendered by a chiropractor.

3. Charges that the covered person is not required to pay.

4. Charges incurred on:

(a) account of dental work or treatment or dental x-rays, except as required because of accidental injury to sound natural teeth;

(b) cosmetic surgery, except as required because of accidental injury or for the reconstruction of the breast on which a mastectomy has been performed or for surgery and reconstruction of the other breast to produce a symmetrical appearance;

(c) eye refractions, eye glasses or the fitting thereof;

(d) transportation, except local ambulance service;

(e) war, declared or undeclared, including armed aggression;

(f) accidental bodily injuries (or occupational disease) arising out of and in the course of the covered person's employment.

PRESCRIPTION DRUG BENEFITS
For Active Participant and Eligible Dependents

Each active participant and his/her Dependents will be entitled to reimbursement for prescribed drugs dispensed by a pharmacist. When using a network pharmacy, you are not required to make full payment at the time your prescription is filled. However, if you use a non-network pharmacy, you are required to pay the full cost, out-of-pocket, and then submit the receipt to **ProAct RX** for processing claim expenses.

ProAct will coordinate benefits as a secondary payer when applicable. Participants and/or dependents must submit their primary Explanation of Benefits and receipts to ProAct for applicable reimbursements.

Drugs covered by this Plan must be prescribed by a licensed Medical Doctor, Nurse Practitioner, Dentist or Osteopathic Physician. The Drugs must fall into one or more of the following categories:

1. They must require compounding, or
2. They must be legend type drugs which need not necessarily require compounding.

Your pharmacy benefits are limited to an annual benefit (January – December) of:

a.) 100% for the first $ 5000.00 per family after applicable co-payment, after such limit then
b.) 80% with an applicable 20% co-pay

You are enrolled in a Prescription Card Program through Pro-Act. The Plan requires the Active Participant or Dependent to pay a co-payment of:

Generic Drugs	$ 10.00 copay per prescription
Preferred Brand Drugs	$ 15.00 copay per prescription
Specialty Drugs	20% copay per prescription

Retail is limited to a one month supply. Mail order is limited to a three month supply, with only one copay applying.

However, all Specialty Pharmacy Medications including but not limited to Anti-Viral and Chemo Therapy medications will be processed at 80% of the negotiated rate, with an applicable 20% copayment under the Major Medical Benefit at 80%. However, you must first utilize the ProAct Benefit prior to submission under Major Medical.

As an added feature, the Plan will pay for Insulin and Diabetic Medications on prescription will be processed as a Major Medical Benefit at 80%, under the major medical schedule, as well as any companion implements, on prescription, such as hypodermic syringes, needles, meters, etc. However, you must first utilize the ProAct Benefit prior to submission for reimbursement under the Major Medical portion of your Plan for any of these benefits.

Pre-Authorization and proof of medical necessity may be required for some medications.

The Plan will not cover certain drugs, including any diet supplements, etc., which, even though prescribed by a physician and written as a prescription, cannot be legally purchased over the counter without a prescription. Vitamins are covered only in the event they are proven to be medically necessary for the treatment of a documented chronic illness or condition**.**

For dependent children: Birth control pills at the pharmacy level will be covered. However, in office birth control procedures and/or permanent sterilization is not a covered service of the plan.

You should contact the Fund Office if you have any questions regarding the prescription benefits.

HEALTH EXPENSE BENEFIT

Individual Account Limitations

Under no circumstances may any money be drawn from your Individual Account once the level of your account has reached zero.

You and your beneficiaries are not permitted to withdraw money for the Health Expense Benefit ***if the withdrawal would cause*** your account ***to contain an insufficient amount to pay the premiums for at least two (2) months of Health Insurance Benefit coverage at the rate in effect when you apply for the withdrawal***. This provision is ***intended*** to provide a reserve for you to ***receive Health Insurance Benefits***. ***After you retire from active employment through the Roofers Local #195 Pension Fund and/or the National Roofing Industry Pension Plan, you may claim reimbursement until your account equals zero.***

If you incur health care expenses (other than insurance premiums for the Health Insurance Benefit) while you are a participant in the Plan; for yourself, your spouse, or your dependent child, which expenses are not covered under the Health Insurance Benefit or any other insurance plan, you may apply for a distribution of a portion of your account to pay for the uncovered bills. Such bills may include charges for dental and optical care as well as all other expenses recognized by the I.R.S. as medical expenses for income tax purposes.

Claims under this benefit may be submitted to the Fund Office only if they total at least **$50.00**. You may add several bills together in order to reach the **$50.00**. In any event, regardless of the size of your covered bills, in the month of December you may submit all such bills to the Plan for reimbursement.

Under this provision of the Plan, no benefits or payments may be assigned to a provider. This is a reimbursable benefit only.

Qualified Reimbursement Expenses

Benefits that can be submitted for reimbursement include but are not limited to:

a. Dental Expenses

b. Orthodontic Expenses

c. Vision Care Expenses

d. Prescription Expenses – not covered under the insurance portion of the plan, including co-pays

e. Insurance Premium Expenses, as allowed for under federal law (i.e. Spousal or Dependent Premiums, Supplemental Medicare Premiums, COBRA Premiums)

f. Deductibles or balances on all medical expenses covered under the insurance portion of the Plan, including co-payments.

The participant must submit receipts and an application for reimbursable benefits to receive this benefit. Co-payments are not automatically refunded by the Fund Office while processing an insurance claim. You must submit the physicians or pharmaceutical receipt, along with a copy of any applicable billing, to receive your reimbursement. The Plan will not reimburse any claims ***submitted beyond the five-year period from the date of claim or claim payment***. Application for reimbursement may be obtained from the Fund Office or on our website at: **www.local195funds.org**

DEATH BENEFITS
PART C

Benefit:

In the event of death to a participant, from any cause, a death benefit will be paid to the named beneficiary or beneficiaries as follows:

Active Participant: **$ 5,000.00**

Inactive Participant **$ 1,000.00**

An active participant is an employee eligible for Health Insurance Benefits through payment of premium from their Individual Account.

An inactive participant is an employee who is ineligible for insurance through the Individual Account Premium payment, but who is available for work and keeps his/her name on the out-of-work list of the Roofers Local Union #195 and does not refuse referrals for work, except for good cause as determined solely by the Business Manager of Roofers Local Union #195. An inactive participant is eligible for Death Benefits for maximum of 6 months.

Be sure to fill out a Designation of Beneficiary Card now, if you have not already done so. These cards are always available at the Fund Office. You may change your beneficiary at any time you desire.

If you do not name a beneficiary, or if the person you name dies before you, your Death Benefit will be paid as follows:

First: to your spouse; or if your spouse is not living

Second: to your children in equal shares; or if there are no children

Third: to your parents in equal shares; or if neither parent is living

Fourth: to your estate

The Board of Trustees may at their discretion contract this benefit with an independent insurance company. When this benefit is contracted with an independent insurance company, the determination of benefit eligibility and benefit amount lies solely with the contracted insurance company.

SUPPLEMENTAL WEEKLY ACCIDENT AND SICKNESS BENEFIT
PART D

For Active Members

Non-Occupational:

$216.56 a week will be paid to you if you become totally disabled from the occupation of roofer and unable to work, and are under the care of a physician legally licensed to practice medicine, because of:

(a) Any injury not arising out of or in the course of your employment.
(b) Any sickness not entitling you to benefits under any workers' compensation or occupational disease law.

However, because of the required Social Security tax deduction from weekly disability benefits enacted by the U.S. Congress, you will receive **$ 200.00** a week.

This Benefit will be payable to you as of the **first** day of disability, if it is due to an accident, or as of the eighth day of disability, if it is due to sickness, and will continue for a maximum of **10 weeks** for any one continuous period of disability, whether from one or more causes, or for successive periods of disability due to the same or related cause or causes.

Occupational:

$ 216.56 a week will be paid to you if you become totally disabled from the occupation of roofer and unable to work, and are under the care of a physician legally licensed to practice medicine.

However, because of the required Social Security tax deduction from weekly disability benefits enacted by the U.S. Congress, you will receive **$ 200.00 a week**.

This Benefit will be payable to you as of the **eighth day** of disability, and will continue for a maximum of **10 weeks** for any one continuous period of disability, whether from one or more causes, or for successive periods of disability due to the same or related cause or causes.

Additional Information:

Successive periods of disability separated by less than two weeks of continuous active employment shall be considered as one continuous period of disability unless they arise from different and unrelated causes.

It is not necessary to be confined to your home to collect benefits, but you must be under the care of a legally qualified physician.

You are also required to submit periodic proof that you are in receipt of benefits under the State Disability Benefits Law, the State Workers' Compensation Law, or the Social Security Disability Benefits Law.

In the event a third party may be liable or responsible for your disability due to an accident or illness for which you make claim for benefits under this Part D, the Plan's subrogation provisions under the Section entitled "Right of Recovery" as explained in Part B of this booklet will apply.

Determination for benefits payable under the Supplemental Weekly Accident and Sickness Benefits under this Part D are at the sole discretion of the Board of Trustees.

CLAIM PROCEDURES
PART E

Timely Submission

A claim, to be honored, must be submitted to the Fund Office in the format described by the Trustees. You are encouraged to submit your claims to the Office as soon as possible to avoid failing to meet the deadline for submitting claims.

"This includes claims under both the Health Insurance Benefit (which must be submitted within the one (1) year period from the date of service) and the Health Expense Benefit (which must be submitted within the ***five (5)*** year period from the date of ***claim payment***)."

PLAN INTERPRETATIONS AND DETERMINATIONS

Notwithstanding any other provisions of this Plan, the Trustees are responsible for interpreting the Plan and for making determinations under the Plan. In order to carry out this responsibility, the Trustees shall have exclusive authority and discretion:

- to determine whether an employee is eligible for any benefits under the Plan;
- to determine the amount of benefits, if any, an individual is entitled to from the Plan;
- to determine or find facts that are relevant to any claim for benefits from the Plan;
- to interpret all of the Plan provisions;
- to interpret all of the provisions of the Summary Plan Description;
- to interpret the provision of any collective bargaining agreement or written participation agreement involving or impacting the Plan;
- to interpret the provisions of the Trust Agreement governing the operation of the Plan;
- to interpret all of the provisions of any other document or instrument involving or impacting the Plan; and
- to interpret all of the terms used in this Plan and all of the other previously mentioned agreements, document, and instruments.

All such determinations and interpretations made by the Trustees, or their designee:

- shall be final and binding upon any individual claiming benefits under the Plan and upon all employees, all employers, the Union, and any party who has executed any agreement with the Trustees or the Union;
- shall be given deference in all courts of law to the greatest extent allowed by applicable law; and,
- shall not be overturned or set aside by any court of law unless the court finds that the Trustees, or their designee, abused their discretion in making such determination or rendering such interpretation.

Benefits under this Plan will be paid only if the Trustees decide, in their discretion, that you are entitled to them.

MAILING ADDRESS OF CLAIMANT

If a claimant fails to inform the Trustees of a change of address and the Trustees are unable to communicate with the claimant at the address last recorded by the Trustees and a letter sent by first class mail to such claimant is returned, payments due the claimant will be held without interest until payment is successfully made.

COOPERATION

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

CLAIM REVIEW AND APPEAL PROCEDURES

For medical claims, the rules that apply depend on the type of claim. There are four types of claims: Pre-Service, Urgent, Concurrent, and Post-Service.

A Pre-Service Claim is any claim with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

An Urgent Care Claim is a Pre-Service Claim for medical care or treatment in which application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or the treatment that is the subject of the claim.

A Concurrent Care Claim is a claim involving a pre-approved, ongoing course of treatment, including a request for extension of a course of treatment.

A Post-Service Claim means any claim that is not a Pre-Service claim, i.e., prior Plan approval is not a prerequisite to obtaining medical care and payment is being requested for medical care already rendered to the claimant.

INITIAL DECISIONS

Time Frames

a. Post-Service Claims

For Post-Service Claims, you will be notified of any adverse benefit determination within a reasonable period, but not later than 30 days after receipt of the claim. The 30-day period may be extended for up to 15 days for matters beyond the Plan's control if, before the end of the initial 30-day period, the Plan notifies you of the reasons for the extension and of the date by which the Plan expects to render a decision. If the extension is needed because you did not submit the information necessary to decide the claim, the notice of extension will describe the required information and give you at least 45 days from receipt of the notice to provide it.

A determination will then be made within 15 days after the earlier of the date you supply the requested information or the date you must provide the additional information.

b. Pre-Service Claims

The Pre-Service Claims rules apply to the following benefits, which benefits are described earlier in this Summary Plan Description:

(1) certain hospital expense benefits;
(2) abortion; and
(3) in-patient mental health treatment and/or substance abuse.

For Pre-Service Claims, you will be notified of the Plan's benefit determination (whether adverse or not) either by the insurance company, for any insured benefits (otherwise by the Plan) within a reasonable period, but not later than 15 days after receipt of the claim. The 15-day period may be extended for up to 15 days for matters beyond the Plan's (or the insurance company', if applicable) control if, before the end of the initial 15-day period, you are notified of the reasons for the extension and of the date by which the Plan (or the insurance company's, if applicable) expects to render a decision. If the extension is needed because you did not submit the information necessary to decide the claim, the notice of extension will describe the required information and the claimant will have 45 days from receipt of the notice to provide the specified information. A decision will then be made within 15 days after the earlier of the date you supply the requested information or the date by which you must provide the additional information. In addition, if the claim is improperly filed, the Plan (or the insurance company, if applicable) will provide notice of the failure within 5 days.

c. Urgent Care Claims

The rules are slightly different for Pre-Service Claims involving urgent care. Such claims are called Urgent Care Claims. An urgent care claim is a Pre-Service Claim for treatment in which application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. For Urgent Care Claims, you will be notified either by the insurance company, for any insured benefits (otherwise by the Plan) regarding the benefit determination (whether adverse or not) as soon as possible, as and not later than 72 hours after receipt, unless you fail to provide sufficient information to decide the claim. In the case of a failure to provide sufficient information or to follow filing procedures, you will be notified of the failure as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information needed to complete the claim. Notification of the decision on that

claim will then be provided within 48 hours after the earlier of the receipt of the specified information or the end of the additional period afforded you to provide such information. Notification can be made orally, provided a written or electronic communication is provided within 3 days of the oral notification.

d. Concurrent Care Claims

Certain Pre-Service Claims involve pre-approved, ongoing courses of treatment, including requests to extend such courses of treatment. These Pre-Service Claims are called Concurrent Care Claims. With regard to Concurrent Care Claims, if the insurance company has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the insurance company of such course of treatment is an adverse benefit determination. The claimant will receive notice of such an adverse determination sufficiently in advance of the reduction or termination to allow for an appeal and determination on review before the reduction or termination occurs. Also, for any request to extend an urgent care ongoing course of treatment beyond the initially prescribed period of time, you will be notified of the determination (whether adverse or not) within 24 hours after receipt of the claim, if the claim is made at least 24 hours before the end of the initially-prescribed period of time or number of treatments.

e. Death Benefits

If your claim for death benefits is denied in whole or in part for any reason, then within 90 days after the Plan receives your claim, the Plan will send you written notice of its decision, unless special circumstances require an extension, in which case the Plan will send you written notice of the decision no later than 180 days after it receives your claim. If an extension is necessary, you will be given written notice of the extension before the expiration of the initial 90-day period, which shall indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the benefit determination. Any claim concerning the disability allocation will be treated under the same procedures as claims for death benefits.

f. Supplemental Weekly Accident and Sickness Benefit

If your claim for Supplemental Weekly Accident and Sickness benefits is denied in whole or in part for any reason, then within 45 days after the Plan receives your claim, the Plan will send you written notice of its decision. This period may be extended for up to two 30-day periods due to matters beyond the control of the Plan. For any extensions, the Plan will provide advance written notice indicating the circumstances requiring the extension and the date by which the Plan expects to render a decision. Any notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues (if any), and you shall be afforded at least 45 days within which to provide specified information (if applicable).

Content of Notification of Initial Adverse Benefit Determination

In an initial notification of adverse benefit determination, the notification shall set forth:

1. The specific reasons for the adverse determination;

2. Reference to the specific Plan provisions (including any internal rules, guidelines, protocols, criteria, etc.) on which the determination is based;

3. A description of any additional material or information necessary for you to complete the claim and an explanation of why such material or information is necessary;

4. A description of the Plan's review procedures and the time limits, applicable to such procedures, including a statement of your right to bring a civil action under § 502(a) of ERISA following an adverse benefit determination on review;

5. In the case of an adverse determination involving the claim for urgent care, a description of the expedited review process applicable to such claims;

6. If an internal rule, guideline, or protocol was relied upon in making the adverse determination, the rule, etc., or a statement that the rule was relied upon and that a copy of it will be provided free of charge upon request; and

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

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

An adverse benefit determination is defined as: (1) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, or failure to provide or make payment that is based on a determination of a participant's eligibility to participate in this Plan; and (2) a denial, reduction, or termination of, or a failure to make payment (in whole or in part) for a benefit resulting from the application of any utilization review or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

For claims other than insured claims, if you are not satisfied with the reason or reasons why your claim was denied, then you may appeal to the Board of Trustees. To appeal, you must write to the Trustees within 180 days after you receive the Plan's initial adverse benefit determination, except that with regard to death benefit claims, the time frame is 60 days, not 180 days. All documentation must be sent in writing to the:

Board of Trustees
Roofers Local #195 Health & Accident Fund
7706 Maltlage Drive
Liverpool, New York 13090

For appeals to the Board of Trustees, your correspondence (or your representative's correspondence) must include the following statement: "I AM WRITING IN ORDER TO APPEAL YOUR DECISION TO DENY ME BENEFITS. YOUR ADVERSE BENEFIT DETERMINATION WAS DATED _____, 20____." If this statement is not included, then the Trustees may not understand that you are making an appeal, as opposed to a general inquiry. If you have chosen someone to represent you in making your appeal, then your letter (or your representative's letter) must state that you have authorized him or her to represent you with respect to your appeal, and you must sign such statement. Otherwise, the Trustees may not be sure that you have actually authorized someone to represent you, and the Trustees do not want to communicate about your situation to someone unless they are sure he or she is your chosen representative. In an appeal of an Urgent Care Claim, a health care professional with knowledge of your medical condition shall be permitted to act as your authorized representative.

You shall have the opportunity to submit written comments, documents, records, and other information related to the claim for benefits. You shall also be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In addition, in regard to all appeals other than those involving Death Benefits: (1) the review will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination nor the subordinate of such individual; (2) insofar as the adverse benefit determination is based on medical judgment, the Board will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment; (3) such health care professional shall not be the individual, if any, who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; and (4) medical or vocational experts whose advice was obtained on behalf of the Plan, without regard to whether the advice was relied upon in making the adverse benefit determination, will be identified.

Special Rule Regarding Urgent Care Claims: For urgent care claims, you may request an expedited appeal, either orally or in writing, and all necessary information, including the Plan's benefit determination on review, shall be transmitted between you and the Plan (or insurance company, as applicable) by telephone, facsimile, or other similarly expeditious method.

Determinations on Appeal

Time Frames

a. **Insured Post-Service Claims**: The insurance company will decide the appeal in accordance with ERISA regulations within 60 days if one (1) level of appeal is provided, or if two (2) levels of appeal are provided, within 30 days at each level.

b. **Pre-Service Claims*:*** You will be notified of the decision within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the request for review. The insurance company will decide appeals of insured claims in accordance with the ERISA regulations within the same time frame (except that if the insurer provides two (2) levels of appeal, the decision has to be made within 15 days at each level).

c. **Urgent Care Claims*:*** You will be notified of the decision as soon as possible, taking into account medical exigencies, but not later than 72 hours after receipt of the request for review. The insurance company will decide appeals of insured claims within the same time frame in accordance with ERISA regulations.

d. **All Other Claims:** The Trustees at their next regularly scheduled meeting will make a determination of the appeal. However, if the appeal is received less than 30 days before the meeting, the decision may be made at the second meeting following receipt of the request. If special circumstances require an extension of time for processing, then a decision may be made at the third meeting following the date the appeal is made. Before an extension of time commences, you will receive written notice of the extension, describing the special circumstances requiring the extension and the date by which the determination will be made. The Plan will notify you of the benefit determination not later than 5 days after the determination is made.

Content of Adverse Benefit Determination on Review

The Plan's written notice of the Board's decision will include the following:

1. The specific reasons for the adverse benefit determination;

2. Reference to specific Plan provisions on which the determination is based;

3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;

4. A statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act;

5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, the notice will provide either the specific rule, guideline, protocol, or other similar criterion, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and

6. If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, the written notice shall contain 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 upon request.

The Trustees' Decision is Final and Binding

The Trustees' final decision with respect to their review of any appeal will be final and binding upon you because the Trustees have exclusive authority and discretion to determine all questions of eligibility and entitlement under the Plan. Any legal action against this Plan must be started within 180 days from the date the adverse benefit determination denying your appeal is deposited in the mail to your last known address.

No Liability for Practice of Medicine

The Plan, the Trustees, or any of 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, the Trustees, nor any of their designees will have any liability whatsoever for any loss or injury caused to you by any health care provider by reason of negligence, by failure to provide care or treatment, or otherwise.

YOUR RIGHTS AS A PARTICIPANT
PART F

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

a. Receive Information About Your Plan and Benefits

Examine, without charge, at the Fund Office, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

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

b. Continue Group Health Plan Coverage

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

c. Reduction or elimination of exclusionary periods of coverage

Prior to January 1, 2015, you may be entitled to a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. After December 31, 2014, no group health plan will be permitted to impose a preexisting condition limitation regardless of whether you have creditable coverage. Consequently, effective May 1, 2014, this Plan will no longer apply any preexisting condition exclusions, but the Plan will provide the certificate of creditable coverage through December 31, 2014 to reduce any preexisting condition limitation that may be imposed by another group health plan.

d. Prudent Actions by Plan Fiduciaries

In addition to creating rights for the 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 benefit or exercising your rights under ERISA.

e. Enforce Your Rights

If your claim for a 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, 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 the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations 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 that your claim is frivolous.

f. Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, JFK Federal Building, Room 575, Boston, Massachusetts 02203, (617) 565-9600, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

The Department of Labor requires that this booklet contain this description of your ERISA-rights set forth above. Its inclusion in this SPD is not offered, and should not be considered, as legal advice of any kind. For legal advice, you should consult with a licensed attorney.

TECHNICAL DETAILS
PART G

As required by the Employee Retirement Income Security Act of 1974

1. PLAN NAME: Roofers' Local 195 Health and Accident Plan.

2. EDITION DATE: This Summary Plan Description is produced as of January 1, 2014

3. PLAN SPONSOR: Board of Trustees of Roofers' Local 195 Health And Accident Plan.

4. PLAN SPONSOR'S EMPLOYER IDENTIFICATION NUMBER: 16-6148181

5. PLAN NUMBER: 501 (assigned by federal government)

6. TYPE OF PLAN: Welfare Plan

7. PLAN YEAR END: June 30th.

8. PLAN MANAGER: Patricia Redhead
7706 Maltlage Drive, Liverpool, NY 13090
Phone #: (315) 699-1388

9. AGENT FOR SERVICE OF LEGAL PROCESS:
Patricia A. Redhead, Plan Manager,
Roofers' Local 195 Health and Accident Plan
7706 Maltlage Drive, Liverpool, NY 13090
Phone #: (315) 699-1388.

In addition to the person designated as agent for legal process, service of legal process may also be made upon any Plan Trustee.

10. TYPE OF PLAN ADMINISTRATION: Direct employees of the Board of Trustees.

11. TYPE OF PLAN FUNDING: Partly Self-insured and Partly Insured Benefits.

12. SOURCES OF CONTRIBUTIONS TO PLAN: Employers required to contribute to the Roofers' Local 195 Health and Accident Plan and certain welfare plans with which this Plan has reciprocal agreements from time to time.

13. COLLECTIVE BARGAINING AGREEMENTS: This Plan is maintained in accordance with collective bargaining agreements. A copy of an agreement may be obtained by you upon written request to the Plan Manager and is available for examination by you at the Fund Office.

14. NETWORK EMPLOYERS: You may receive from the Plan Manager, upon written request, information as to whether a particular employer participates in the sponsorship of the Plan. If so, you may also request the employer's address.

TECHNICAL DETAILS (CONT'D)

15. PLAN BENEFITS PROVIDED BY: The Roofers' Local 195 Health and Accident Plan.

16. ELIGIBILITY REQUIREMENTS, BENEFITS and TERMINATION PROVISIONS OF THE PLAN: See Part A. of this booklet.

17. HOW TO FILE A CLAIM: Application for all benefits must be made in accordance with the provisions of the Plan set forth in Part A, page 5 of this booklet. You may obtain any necessary forms by writing, telephoning, or visiting the Fund Office (during the hours of 8:30 A.M. to 4:30 P.M., on regular business days). The address is:

7706 Maltlage Drive
Liverpool, NY 13090
Phone # (315) 699-1388

18. REVIEW OF CLAIM DENIAL: If you submit a benefit application to the Fund Office and it is denied, in whole or in part, you will be so notified. If a denial takes place, you are entitled to appeal the decision as described in Part E. of this booklet.

19. RIGHTS AND PROTECTIONS: As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). A “Statement of ERISA Rights” is contained on pages 53 and 54 of this SPD.

20. NO INSURANCE UNDER PBGC: Because this Plan is not a defined benefit pension plan, it does not enjoy coverage under the Pension Benefit Guaranty Corporation.