UNION ROOFERS

HEALTH AND WELFARE FUND

SUMMARY PLAN DESCRIPTION

June 1, 2025

PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) - GRANDFATHERED HEALTH PLAN STATUS

The Union Roofers Health and Welfare Fund believes that its medical and prescription drug coverage, provided through the Indemnity Plan, and for participants covered under the insured Kaiser Permanente and Health Net plans is a "grandfathered health plan" under the Patient Protection and Affordable Care Act ("PPACA" or "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 that your 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 preventive health services without any cost sharing. However, 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 Fund Administrator at *9901 Paramount Blvd., Suite 211, Downey, California, telephone: (562) 927-1434*. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at *1 (866) 444-3272* or *www.dol.gov/ebsa/healthreform*. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

UNION ROOFERS HEALTH AND WELFARE FUND

9901 Paramount Boulevard, Suite 211
Downey, California 90240
(562) 927-1434
Fax: (562) 928-9203

BOARD OF TRUSTEES

Union Trustees
Brent Beasley
Clifford Smith
Zack Beasley

Management Trustees
Ernest Glasgow
Greg Banks
Eddie Marquez

FUND MANAGER

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USTED PUEDE OBTENER INFORMACIN EN ESPANOL, SI NO ENTIENDE INGLES, ACERCA DE LOS BENEFICIOS Y REGLAS DE EL PLAN, PONGASE EN CONTACTO CON LA OFICINA A (562) 927-1434, Y PREGUNTE PARA QUE LE AYUDEN.

UNION ROOFERS HEALTH AND WELFARE FUND

9901 Paramount Boulevard, Suite 211
Downey, California 90240
(562) 927-1434

TO ALL ELIGIBLE EMPLOYEES:

We are pleased to provide you with this new booklet which describes the Fund's benefits available to you and your family as of June 1, 2025.

Many changes have been made since the printing of the last benefit booklet. Please take the time to read this booklet and familiarize yourself with the benefits available and your right to those benefits.

The complete text of the Plan is also included in this booklet and should be referred to for a more complete explanation. Please be aware that only the complete rules and regulations of the Trust Fund and the contracts in effect with Health Net, Kaiser Permanente, Standard Insurance Company and Vision Service Plan can determine your eligibility and benefits.

If you have any questions, please contact the Fund Manager's office where the staff will be happy to assist you.

Sincerely,

BOARD OF TRUSTEES

AUTHORIZED SOURCE OF INFORMATION

The only source of authorized information is the benefit booklet and booklet inserts, if any, the Trust Agreement, the Rules and Regulations and the written statements of the Board of Trustees and its authorized agents located in Downey, California. Statements or representations made by individuals other than these designated personnel are not authoritative sources of information. Questions as to eligibility, benefits and other matters should be submitted to the Fund at its office at 9901 Paramount Boulevard, Suite 211, Downey, California 90240.

Plan Amendments and Interpretation

Any modification or amendment to the plan of benefits described in the health and welfare booklet must be in writing and adopted by the Board of Trustees. Only the Board of Trustees is authorized to interpret the Plan of benefits described in the benefit booklet. The Board's interpretation of the Plan of benefits described in the booklet shall be final and binding on all parties. No Employer or local Union, nor any representative of any Employer or Union is authorized to interpret the Plan on behalf of the Board, nor can such person act as an agent of the Board of Trustees.

Nothing in this statement is meant to interpret or extend or change in any way the provisions expressed in the Plan. The Trustees reserve the right to amend, modify or discontinue all or part of this Plan whenever, in their judgment, conditions so warrant.

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CHOICE OF MEDICAL AND DENTAL PLANS AND OPEN ENROLLMENT

MEDICAL PLAN CHOICES
Plan "B" participants (actives and retirees) may select one of the two prepaid medical plans listed below. Plan "A+" and Plan "A" participants can elect coverage under any of the plans.
The three medical benefit plan options available through the Trust are:

1. **A prepaid health plan provided through Health Net**. You and your Dependents must live or work within 30 miles of a Health Net participating medical group in order to enroll in this plan. If you enroll in this option, you and your eligible Dependents will be covered under the Health Net Plan for all Hospital and medical services and supplies.

2. **A prepaid health plan provided through Kaiser Permanente**. In order to enroll in this plan, you must live or work within the Kaiser Permanente enrollment area. If you enroll in this option, you and your eligible Dependents will be covered under the Kaiser Permanente Plan for all Hospital and medical services and supplies.

3. **Roofers Indemnity Medical Benefits (excluding Retired Employees)** where you may use the Doctor of your choice. This plan contains a Preferred Provider Option (PPO) which allows you to save out-of-pocket expense by using Hospitals and professionals which have contracted rates.

Note: Prescription drugs for eligible Active Employees are reimbursed by Sav-Rx regardless of the medical plan you select. However, an HMO sometimes may provide specific prescriptions for its enrollees. Medicare-eligible and Non-Medicare eligible Retirees have prescription drug coverage through the HMO medical plan.

DENTAL PLAN CHOICES (some enrollment restrictions apply to newly eligible employees)
Plan A+ and Plan A Covered Employees are eligible for dental benefits. The dental choices for Plan A+ and Plan A Covered Employees are:

Plan A+ Covered Employees (continuously eligible) can enroll in: (1) the Indemnity Dental Plan self-insured by the Fund; (2) the Dental Preferred Provider option (DPPO) insured by Delta Dental; or (3) the insured DeltaCare Prepaid Dental Plan (DHMO). If you are newly eligible you must be enrolled in the DHMO plan for one year before changing to the DPPO plan. ***Enrollment in the Indemnity Dental Plan is no longer open to employees currently enrolled in the DHMO Plan, the DPPO plan, or to those employees newly eligible.***

Plan A Covered Employees can enroll in: (1) the Dental Preferred Provider option (DPPO) insured by Delta Dental; or (2) the insured DeltaCare prepaid dental plan (DHMO). If you are newly eligible you must be enrolled in the DHMO plan for one year before changing to the DPPO plan.

Plan B Covered Employees are not eligible for dental benefits.

Features of the Dental Plans:

Roofers Indemnity Dental Benefits. If you enroll in this option, you may use the Dentist of your choice. Payments for dental services are based on a percentage of the amounts shown in the Schedule of Dental Allowances. The Indemnity Dental Plan has a deductible, calendar year maximum and orthodontia coverage.

The PPO Dental plan provided through Delta Dental. If you enroll in this option, you may use any dental provider; the type of dentist you use determines payments for dental services. Your out-of-pocket expense is the lowest if you use a Delta Dental PPO dentist, next lowest when using Delta Premier Dentist and your highest out-of-pocket cost is when you use a non-Delta dentist. This plan has a deductible, a calendar year maximum and coverage for orthodontia. ***This plan is not available to new employees until they have been enrolled in the DeltaCare DHMO for one year.***

A prepaid dental plan provided through DeltaCare (DHMO). If you enroll in this option you must select a dentist for you and your family where you will receive all of your dental care – Except: each family member can be enrolled with a separate DeltaCare office where they can receive all of their dental needs. When an Employee first becomes eligible, enrollment in the prepaid dental plan is required. The Employee and any covered Dependents must remain in the Prepaid Dental plan for one year before changing to the PPO Dental plan.

GENERAL INFORMATION
A complete description of the medical and dental benefits provided directly by the Fund is contained in this booklet. Brochures are available from the Fund Manager's office, at no charge, that will provide you with a description of benefits provided by Health Net, Kaiser Permanente, the Delta Dental PPO Dental plan and the DeltaCare DHMO. All Employees (other than Non-Contract Employees), regardless of the medical Plan option, will be covered for Death benefits. Active Roofers (excluding Non-Contract Employees) are also eligible for Weekly Disability benefits that provide income assistance when the employee is disabled due to a non-occupational illness or injury.

Benefits for Active Employees under Plan A+, Plan A and Plan B

Plan A+ active participants are eligible for Hospital/medical, hearing aid, dental and vision benefits.

Plan A active participants are entitled to Hospital/medical, hearing aid and dental coverage, but not vision benefits.

Plan B active participants do not have dental or vision coverage and are eligible only for prepaid medical coverage.

Retiree Benefits
Retirees are only eligible under Plan B for coverage through one of the Prepaid Medical plans. If you are Medicare-eligible or non-Medicare eligible, your prescription Drugs will be provided through the Prepaid Medical plan you have selected.

The Early Retiree Plan (for Retired Employees age 55 to age 59) includes coverage for spouses, domestic partners, and Dependent children. The Regular Retiree Plan (for retirees age 60 or older) does not cover Dependent children.

In addition to medical benefits, when you first become covered under the Regular or Early Retiree Plan, you can elect the dental and/or vision benefits on a full self-pay basis. You will be required to continue the dental or vision coverage until the first Open Enrollment period following your one-year anniversary date for retiree coverage. Thereafter, if you are a continued Early or Regular Retiree and elect dental or vision coverage you must continue with the coverage for one year. The options are offered to you at Open Enrollment. ***Exception: You can no longer purchase dental or vision benefits when you become Medicare eligible***.

Open Enrollment
Each **Active Employee** who qualifies for Plan A or Plan A+ benefits will be given the opportunity to elect the medical coverage provided directly by the Fund (the Indemnity Plan) or the prepaid medical coverage then being offered through any prepaid Hospital/Medical carriers. Active Employees eligible for Plan B benefits may elect coverage under either of the HMO plans. Each **Retired Employee** is eligible for Plan B benefits and may elect coverage under one of the two HMO plans. Non-Contract Employees may elect coverage under either HMO plan or the Indemnity Plan unless the "Exception" has not been satisfied (see below).

The coverage elected by the Active or Retired Employee will remain continuous, except as approved by the Board of Trustees, until the next Open Enrollment period. "Open Enrollment" means that period of time during which an Active or Retired Employee may change from one prepaid plan to the other or the Active Employee can change prepaid coverage or change to or from enrollment in the Indemnity Plan.

If a Retired Employee changes to the status of an Active Employee or when an Active Employee becomes a Retired Employee, a new election will not be made by the Covered Employee until the next Open Enrollment period, unless because of residence a Plan change is required and available under the new plan of benefits.

If no election is made during the Open Enrollment period, the Covered Employee and his eligible Dependents will remain in the plan in which he was enrolled prior to the Open Enrollment period, provided he is eligible for that plan.

Exceptions:

1. Non-Contract Employees and their eligible Dependents will be covered under the Prepaid Dental plan if they first become eligible for coverage on or after October 18, 2011. The new employee must enroll in the prepaid dental plan (DHMO) for one year. After that time, they may select enrollment in the DHMO Dental plan or the DPPO dental plan. Changes may only be made during the open enrollment period.

2. If you are eligible for Plan B benefits and you have not enrolled in a Prepaid Medical Plan during the months of January or July only, you will be covered under the Plan A medical benefits. If you have not enrolled in a prepaid plan by the end of that month, you will have no medical benefits.

3. Non-Medicare Retired employees may elect and self-pay for the DeltaCare prepaid dental plan.

   The prepaid DeltaCare dental plan does not have any calendar year maximums. Copayments apply to certain services but some services have no copayment. You have to select a dentist where you receive all dental care unless you are referred by your dentist. You and your family can select different dentists. Enrollment forms are available at the Fund Manager's Office.

Eligible Dependents will get the same coverage as that of the active or retired employee. The terms of the contract between the Fund and any insured plans prevail in the payment of claims or services rendered to those persons covered by the contract.

Special Open Enrollment – Active Contract Employees Only

Changing From Plan B to Plan A or Plan A+
If you were eligible under Plan B in July and are eligible in January under Plan A or Plan A+, you have a one-time opportunity to change from your HMO to coverage under the Trust Fund's PPO medical plan***. However, if you receive services from your HMO in January or July you will not be permitted to change to the PPO medical Plan***.

It is very important that you notify the Fund Manager's office immediately if you want to change to the PPO medical Plan. If you want to change and you must see a provider before January 16th, you must phone the Fund Manager's office with your request to change. A completed application for the PPO Plan MUST be on file in the Fund Manager's office by January 16th.

Open enrollment is July 1st of each year for medical and dental. However, there is also an Open Enrollment period in January for newly eligible employees.

SCHEDULE OF BENEFITS

For Union Roofer's Indemnity Plan, Medical, Hearing Aid and Dental, Life Insurance, Accidental Death and Dismemberment, Disability and Prescription Drug Benefits.

BENEFITS	
Death Benefits (Excluding Non-Contract Employees- Employee)	
Employee	
Active	$2,000[1]
Retired (Regular and Early Retirees) Dependents	$1,000[1]
Dependents	
Spouse (Active or Retiree)	$1,000
Child 14 days – 6 months – Active only	$100
Child 6 months – 19 years – Active only (23 if full-time student)	$1,000
Accidental Death and Dismemberment Benefit (For Active Contract Employees only)	
	$2,000
Weekly Disability Benefit (For Active Contract Employees only). Provided by Standard Insurance	
Weekly Benefit	An amount not to exceed $75.00
Payment Begins	8th day of disability
Maximum Period of Payments	26 weeks
Indemnity Dental Benefits[2, 3] (For Plan A, Plan A+ Active Employees and non-Contract Employees and their Dependents). This benefit is optional for Early and Regular Retirees not eligible for Medicare[2]	
Dental Maximum	$2,500 per Calendar Year[3,]
Orthodontia Maximum[3]	$3,000 per lifetime
Percentage Payable	
Preventive	100% of Schedule
All Other	80% of Schedule
Dental Annual Deductible [insert footnote: max 3 deductible]	
Plan A+	$50/ person
Plan A	$75/person

1 Reduces by 50% at age 70; in no event will coverage for a dependent exceed 50% of the Retiree's or Employee's amount.

2 Early and Regular Retired Employees must enroll for one-year and pay 100% of cost of coverage.

3 Orthodontia coverage is provided to adults and to dependent children under age 18 enrolled for coverage.

BENEFITS	
Vision Care Benefits (For Plan A+ Active Employees and Dependents, optional for Non-Contract Employees and Early and Regular Retirees not eligible for Medicare.)[2] Provided by Vision Service Plan (VSP)	
Deductible per Exam or Material	$10.00
Examination	Every 12 months
Lenses	Every 24 months
Frames	Every 24 months
Hearing Aids (including tests)	
Deductible	None
Percentage Payable	80%
Maximum	$1,500 each ear every 3 years

HOSPITAL/MEDICAL BENEFITS			
BENEFIT DESCRIPTION	**PLAN B[1]**	**PLAN A**	**PLAN A+**
Required Hours Worked in Qualifying Period	450	600	750
Medical Plan			
Kaiser	Yes	Yes	Yes
Health Net	Yes	Yes	Yes
Affiliated Health Fund (AHF) (PPO Coverage)	No	Yes	Yes
Indemnity Medical (Choice of Providers)	No	PPO only	Yes
Calendar Year Deductible:			
Per Person	-	$200	$100
Per Family	-	$600	$300
Percentage Payable:	-		
AHF Hospital	-	80%	100%
Non-AHF Hospital	-	0%	0%
Other	-		
AHF Provider	-	80%	100%
Non-AHF Provider	-	0%	80%
Where no Contract Exists for Services	-	80%	80%
Lifetime Maximum	-	Yearly Max	Yearly Max
Calendar Year Out-of-Pocket Maximum	-	$5,000[1]	$5,000[1]
Other Maximums:			
Chiropractor/Acupuncturist in any Consecutive 6-Month Period	-	4 visits	4 visits
Psychological			
Inpatient (AHF providers)	-	80%	100%
Outpatient(AHF providers)	-	80%	100%
Non-AHF Provider		0%	80%
Where No Contract Exists for Services		80%	80%
Prescription Drugs [1,2] (For all Active Employees and dependents enrolled in the PPO or HMO medical plan. (Retired Employees and dependents get prescriptions through their HMO)	Yes	Yes	Yes
Calendar Year Deductible	$0	$0	$0
Percentage Payable	90%	90%	90%
Calendar Year Maximum per Person[2]			
Actives	None	None	None
Retirees	None	None	None

[1] Does not apply to chiropractor/acupuncturist.

Note: HMO benefits are described in the Kaiser Permanente and Health Net booklets.

[2] Prescription drugs are reimbursed by Sav-Rx. Prescription drugs for the treatment of sexual dysfunction are only available to Non-Contract and Active employees and their spouses and to Early and regular Retired Employees (not including any dependent children) who are not enrolled in a Senior Plan for Medicare-eligible persons and have a calendar year maximum of $250 per person.

ELIGIBILITY RULES FOR ACTIVE EMPLOYEES

BARGAINING UNIT (CONTRACT) EMPLOYEES

Active Employees Eligibility
If you are employed by one or more contributing Employers under agreement with the Union, you are eligible for the benefits under the Plan, providing you have submitted your enrollment card and have worked sufficient hours to satisfy the requirements below.

Initial Employee Eligibility
If you are a new employee, you must work a minimum of 450 hours for one or more contributing Employers during a Qualifying Period to be covered for benefits in the next Eligibility Period. A **"Qualifying Period"** is a six-month period ending November 30 or May 31 of any year. The hours worked during the Qualifying Period determine the plan of benefits you will be covered under during the "Eligibility Period" that follows the Qualifying Period. **"Eligibility Periods"** are six-month periods that end on June 30 or December 31, of any year.

The Tables below show examples of the Qualifying Periods, Eligibility Periods, Hours Worked and Benefit Plans.

Hours Worked During Qualifying Period	For Coverage During Eligibility Period
June 1 through November 30	January 1 through June 30
December 1 through May 31	July 1 through December 31

Hours Worked During Qualifying Period	For Coverage During Eligibility Period
450 – 599	Plan B
600 – 749	Plan A
750 or more	Plan A+

Hour Bank
All hours actually worked by you in excess of 750 in a Qualifying Period are kept in an "Hour Bank" account (hours earned on Certified Disability cannot be banked). Up to 50 hours per Qualifying Period may be banked for you. Your Hour Bank cannot exceed 400 hours at any time.

You may use up to 100 hours in your Hour Bank to be eligible for Plan B benefits if you do not work enough hours for other coverage. You cannot use bank hours to upgrade to Plan A+ or Plan A coverage. All hours in your Hour Bank will be cancelled if you do not satisfy the requirements for becoming eligible for benefits during two consecutive Qualifying Periods.

Exception: If you are age 54 or older on the date eligibility is run, you may use a maximum of 200 hours from your Hour Bank to obtain Plan B coverage.

NOTE: The hours credited to your Hour Bank are not a vested benefit. If you work for a non-signatory employer or you have reason to know or should know the employer is non-signatory or has under-reported hours to the Fund, any hours in your Hour Bank will be cancelled. The Fund will notify you in writing that any hours in your Hour Bank are cancelled and are reduced to zero.

Coverage During a Certified Disability
If you are unable to work due to a disability that started while you are actively eligible for benefits, you will be given credit for disability hours at the rate of eight (8) hours per day (excluding holidays and weekends) and 40 hours per week, for a period not to exceed the date of your recovery or six (6) months (whichever occurs first). The credited hours will be applied to the hours required during the Qualifying Period for the next Eligibility Period. These hours can only be used to qualify for Plan B benefits. Not more than six (6) months of Certified Disability Credits are available for any disability.

Certified proof of disability must be furnished at the time the disability starts and once each month after that until you return to work for a contributing Employer.

The proof of disability must be submitted by your Doctor (M.D., D.O. or PhD.) in writing on his letterhead (prescription forms or pre-printed forms are not acceptable). The proof must show the beginning date of total disability, the diagnosis, and the date you are expected to be able to return to work.

Continuing or Subsequent Employee Eligibility
After you become eligible, you will remain covered for benefits under the Plan as long as: (1) you work 450 or more hours for one or more contributing Employers during each Qualifying Period and the required contributions are received; and (2) during each month of the Qualifying Period (a) you had worked hours which were contributed upon, or (b) disability hours were credited on your behalf. (Refer to the Hour Bank and Certified Disability sections for other information.)

Working in Non-Covered Employment and Failure to Report Hours Worked
If the Trustees determine that you have worked for wages or profit for a non- contributing Employer in the State of California, your hours reported to date will be cancelled and your coverage and other benefits will end on the last day of the calendar month in which the determination was made by the Trustees. Likewise, if it is determined that your Employer failed to report all hours you worked and you were aware of the failure, your benefits and coverage will cease at the end of the month in which the Trustees made this determination. The Fund will notify you in writing of the termination of your coverage.

When Coverage Begins – Contract Employees
Coverage for you and your eligible dependents (see "Dependents" section) starts on the first day of the Eligibility Period following the Qualifying Period during which sufficient hours were worked to qualify for coverage. Coverage for newly acquired eligible dependents (marriage or birth of a child or adoption) begins based on the date required documents are received. If required documents are received before the 15th of a month, eligibility can start on the 1st day of that month. If required documents are received on the 15th or later, eligibility will be effective the 1st of the following month. If you are enrolled in a prepaid plan, you should review your benefits booklet for requirements on enrollment of newly eligible dependents – **they will not be covered unless you enroll your dependent within 31 days of the date acquired**. Copies of certified birth certificates for your children and a copy of your certified marriage certificate is required before benefit payments are made for a dependent.

Uniformed Services Employment and Re-Employment Rights Act (USERRA)
Under this Federal act, your Employer must offer to continue coverage for you and your Dependents for up to 24 months while you are on military leave. If you make this election, you must submit any self-payment necessary (102% of the cost of coverage continued), which may include administrative costs, to the Fund. If you do not continue your coverage during a military leave, it will be reinstated at the same benefit level you received before your leave if you meet the eligibility criteria established under USERRA. For more information about this act, contact your Employer or the Fund Manager's Office.

If you are an Active Employee and you enter full-time active duty with the Armed Forces of the United States, coverage for you and your dependents will cease at end of the 31st day following the start of your military leave. If you return to work for a contributing Employer within 90 days of the date of discharge (this depends upon the length of time you were away on active duty), your coverage will be reinstated immediately provided you notified the Fund in writing in advance of your entrance into active military service.

Termination of Eligibility – Contract Employees
An Active Employee's eligibility will terminate on whichever of the following dates occurs first:

1. on the date the Plan terminates;

2. on the last day of the calendar month for which the employee qualified under the Active eligibility requirements or the provisions for Certified Disability;

3. on the 32nd day following the date of entrance into full-time active duty with the Armed Forces of the United States;

4. on the last day of the month in which the Trustees determine the Active Employee has worked for a non-signatory employer.

Refer to the COBRA section for your rights to continue coverage.

NON-CONTRACT EMPLOYEE COVERAGE

Eligibility for Non-Contract Employees
Non-Contract Employees (working 30 or more hours per week) of Employers contributing to this Fund may be covered under the Health and Welfare Plan under certain conditions: (1) the roofing contractor must be signatory; (2) the Employer must have elected coverage for its Non-Contract Employees within 30 days of the date it was advised on this option; (3) all Non-Contract Employees must be covered unless the employee provides proof of other coverage and provides a signed affidavit to that effect; (4) one Non-Contract Employee can be covered for each Bargaining Unit Employee contributed for by the Employer; and, (5) contributions must remain timely. In addition, the Employer must have entered into an affirmation on agreement with the Fund in a form that is satisfactory to the Board of Trustees of the Union Roofers Health and Welfare Fund.

Note: All payment of benefits will be based upon the CPT codes for contracted providers. Otherwise claim payments are based upon the current Relative Value Studies for Physicians. If a contracting provider could have been used but was not, Allowable Expenses are based on 80% of the contracting providers' rates.

When Eligibility Begins – Non-Contract Employees
Coverage for a Non-Contract Employee will begin on the first day of the month following receipt from the Employer of two months of contributions for the employee. Coverage will continue for each month for which the Employer has made the required contribution for the Employees unless termination occurs for other reasons. (See Termination of Coverage.)

No benefits will be paid for a dependent until the Fund receives a **copy of the certified birth certificates for dependent children, proof of residency for a step-child, and a copy of your certified marriage certificate** for your spouse. Coverage for newly acquired eligible dependents (marriage, birth of a child or adoption) begins on the date they are acquired if you are enrolled in the Roofers indemnity plan. If you are enrolled in an HMO, enrollment is required within 30 days of the date a new dependent is acquired.

Termination of Coverage – Non-Contract Employees
Coverage for Non-Contract Employees will end on: (1) the last day of the month following the month last contributed upon by the Employer; (2) the last day of the month the Employee no longer satisfies the eligibility rules; or, (3) if the Employer does not employ at least one Bargaining Unit Employee for each Non-Contract Employee for a period of 90 days and does not pay fringe benefits on each bargaining-unit employee for a period of 90 days at the rate of at least 100 hours for the 90 day period.

Coverage for Dependents ceases on the date the employee's coverage ends, the date they no longer meet the definition of a "Dependent", or on the date the dependent enters full- time military duty with the Armed Forces of the United States. Eligibility may be extended under the provisions of COBRA (refer to the COBRA section).

If Coverage ceases, you may not be reinstated unless it is approved by the Board of Trustees

Benefits Available to Non-Contract Employees
The Fund permits Non-Contract Employees to be covered under the Fund, provided certain requirements are met. Non-Contract Employees are eligible for Plan A+ medical and dental benefits. Newly eligible Non-Contract Employees may only enroll in the prepaid medical and dental plan. After having been in the prepaid DHMO Dental plan for one year, Non-Contract Employees may change to the Delta Dental PPO dental plan during the Open Enrollment Period (or remain in the prepaid DHMO Dental Plan), but they may not enroll in the Indemnity Dental Plan. The Indemnity Dental Plan has not and is not available to Non-Contract employees, who are not currently enrolled in that plan. Your Employer may elect to cover all of the Non-Contract Employees for vision benefits.

ELIGIBLE DEPENDENTS OF ACTIVE CONTRACT (BARGAINING UNIT) AND NON-CONTRACT EMPLOYEES

Definition of Dependents
Dependents include your lawful spouse. However, in accordance with state law, if you are enrolled in one of the Prepaid Medical plans, your dependent may include your domestic partner of the same sex or opposite sex, age 18 or older. To qualify for domestic partner coverage, you must have registered as domestic partners and submit required proof of the relationship in accordance with the law. More information on the requirements for domestic partner coverage is available from the Fund Manager.

Your dependents also include your dependent children to their 26th birthday. Legally adopted children and step-children are also considered eligible dependents.

A child over age 25 years of age may continue to be eligible as a dependent if he is incapable of self-support because of physical or mental incapacity that commenced prior to reaching the age of 26, provided a physician's certification of disability is submitted within six months following his 25th birthday or the effective date of eligibility.

A Dependent child who is eligible for group benefits as an employee or as the dependent of any other employee other than one of his parents is still eligible until his or her 26th birthday. Your domestic partner's children are not eligible for coverage.

The Trustees reserve the right to investigate and determine eligibility, dependency and qualification for coverage.

Medicaid and the Children's Health Insurance Program (CHIP)
If you or your dependents are already enrolled in Medicaid or CHIP and you live in California, you can contact your State Medicaid or CHIP office to find out if premium assistance is available. If none of you are currently enrolled in Medicaid or CHIP and you think any of you might be eligible for either of the programs, you can contact your State Medicaid or CHIP office to find out how to apply. If it is determined that any of you are eligible for premium assistance under one of these programs, the Health Fund plan will allow you and/or your dependents to enroll in the Health Fund plan, provided you are eligible and not already enrolled. Under this "special enrollment" option, you must enroll within 60 days of the date you are determined to be eligible for premium assistance or the date of your loss of Medicaid or CHIP assistance

Qualified Medical Child Support Order
Special rules apply to dependents added to the medical or dental plans under a Qualified Medical Child Support Order (QMCSO). A QMCSO is a court order requiring the Plan to provide medical coverage for a child of a participant. Please contact the Fund Manager if you need further information regarding QMCSOs or the Plan's procedures regarding QMCSO determinations. There is no charge to you if you request the Plan's procedures for QMCSOs.

Termination of Coverage - Dependents
A Dependent's eligibility will terminate on whichever of the following dates occurs first:

1. on the date coverage for Dependents is terminated by the Board;

2. on the date the Active Employee's coverage ends;

3. on the date of entrance into full-time active duty in the Armed Forces of the United States, unless prohibited by law;

4. on the date he no longer meets the definition of a Dependent.

An Active Employee and/or eligible Dependent who loses eligibility may be eligible for continued coverage under the provisions of COBRA. (Refer to the COBRA section for details.)

Special Enrollment Rights under HIPAA
If you decline 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.

ELIGIBILITY RULES FOR RETIRED EMPLOYEES

REGULAR RETIREES

If you are a former Contract Active Employee who has retired and/or is receiving a pension from the Pacific Coast Roofers Pension Plan, you may continue coverage under the Plan for yourself and only your eligible spouse or Domestic Partner (coverage is not provided for dependent children) if:

1. you are age 60 or older; and

2. you have been an Active Contract Employee of Local #36 or Local #220 for not less than ten (10) consecutive years prior to reaching age 60 at retirement; and

    a. hours were reported in each of those years, or

    b. during the ten-year period you were eligible as an Early Retiree or had continued coverage through COBRA for the periods when no hours were reported; and

3. you were eligible for benefits under the Plan of this area for at least five (5) of the last ten (10) years and one (1) of the last two and one-half (2½) years prior to retirement; and

4. you make the required self-payments for coverage in a timely manner (self- payments are due on the 1st day of each month of coverage and are delinquent on the 10th day of the month) and coverage remains continuous; and

5. you elect coverage as a Regular Retiree at the time you retire or upon your loss of coverage as an Active Employee; and

6. you reside in the area of one of the Prepaid Medical plans then being offered.

You are eligible for death benefits (for which no self-payment is required), Hospital, medical, hearing aids and prescription drug benefits. All Retired Employees must be enrolled in a prepaid medical plan for coverage. If you or your spouse is eligible for Medicare, the Medicare-eligible person must be enrolled in the HMO Medicare plan and must assign the Medicare Part A and Part B benefits to the HMO. If one of you is not Medicare-eligible, you will have different benefits but you must both be enrolled with the same HMO.

You may also elect dental and vision benefits for you and your spouse or Domestic Partner on a full self-pay basis until you reach age 65, at which time you will no longer be eligible for dental and vision coverage. If dental or vision benefits are elected, you must remain in the plan for a full year. Changes in your election of benefits can only be made during an Open Enrollment period.

When Coverage Begins

Coverage as a Regular Retired Employee will begin on the first day of the month following your loss of coverage as an Active Employee or Early Retired Employee. Except: When your eligibility is ending as an Active Employee, if you elect to continue your active benefits under COBRA coverage as a Regular Retired Employee coverage will begin on the first day of the month following the cessation of COBRA coverage provided you would have qualified as a Regular Retiree on the date your Active Employee coverage ended.

Termination of Coverage – Regular Retirees and their Spouses
Coverage for Regular Retirees will cease on the first of the following dates:

1. on the date the Plan terminates;

2. on the date a self-payment is not received in a timely manner or in the amount required;

3. on the date of your death; or

4. on the date you no longer reside in the area of one of the HMO medical plans.

Coverage for the dependent spouse or Domestic Partner of a Regular Retiree will cease on the earliest of the following dates:

1. on the date of death of the Regular Retiree, except that coverage for your spouse may be continued through self-payment until the spouse remarries, self-payments cease or benefits for widows end;

2. the date the Plan no longer provides coverage for Dependents;

3. the date a self-payment, if required for the Dependent, is not received in a timely manner or in the amount required; or

4. the date of divorce; or

5. the date the dependent no longer qualifies as a Dependent under the Plan; or

6. the date the dependent no longer resides in the area of one of the HMOs; or

7. the date of termination of a Domestic Partner relationship; or

8. the date the Plan terminates.

Continuation of coverage under COBRA may be available to dependents. Refer to the COBRA section.

NOTE: Retired roofers and their dependents have no accrued or vested rights to benefits under this Plan. In the event the Plan is terminated, the Board of Trustees will determine the retiree's rights to benefits under this Plan. The Trustees reserve the right to change or discontinue the types and amounts of benefits under this Plan and the eligibility rules. Plan benefits for retirees are not guaranteed in this form or any form.

EARLY RETIREES

If you are a former Contract Active Employee who has retired and/or is receiving a pension from the Pacific Coast Roofers Pension Plan you may continue coverage under the Plan for yourself and your eligible spouse or Domestic Partner and Dependent children if:

1. you are age 55 to age 60; and

2. you have been an Active Contract Employee of Local #36 or Local #220 for not less than ten (10) consecutive years prior to reaching your age at retirement; and

    a. hours were reported in each of those years; or

    b. during the ten-year period you were on continued coverage through COBRA for the periods when no hours were reported; and

3. you were eligible for benefits under the Plan of this area for at least five (5) of the last ten (10) years and one (1) of the last two and one-half (2½) years prior to retirement; and

4. you make the required self-payments for coverage in a timely manner (self- payments are due on the 1st day of each month of coverage and are delinquent on the 10th day of the month) and coverage remains continuous; and

5. you elect coverage as an Early Retired Employee at the time you retire or upon your loss of coverage as an Active Employee; and

6. you reside in the area of one of the Prepaid Medical plans being offered.

You are eligible for death benefits (for which no self-payment is required), Hospital, medical and prescription drug benefits. However, you may also elect dental and vision benefits for you and your eligible dependents on a full self-pay basis. The Early Retiree and all eligible dependents must be enrolled in the same coverage. If dental or vision benefits are elected, you must remain in the Plan for a full year. New or re-election of benefits can only be made during Open Enrollment periods.

Upon reaching age 60, provided you have been continuously covered as an Early Retiree, you and your spouse only may continue coverage as a Regular Retiree. Dependent children, if any, will be entitled to continue coverage on the basis of COBRA.

When Coverage Begins
Coverage as an Early Retired Employee will begin on the first day of the month following your loss of coverage as an Active Employee. Except: When your eligibility is ending as an Active Employee, if you elect to continue your active benefits under COBRA, coverage as an Early Retired Employee will begin on the first day of the month following the cessation of COBRA coverage provided you would have qualified as an Early Retiree on the date your Active Employee coverage ended.

Termination of Coverage – Early Retirees and their Dependents
Coverage for Early Retirees will cease on the earliest of the following dates:

1. on the date the Plan terminates;

2. on the date a self-payment is not received in a timely manner or in the amount required;

3. on the date of your death;

4. on the date you no longer reside the service area of one of the Prepaid Medical plans;

5. on the date you reach age 60 at which time you may continue coverage as a Regular Retiree; or

6. on the date the Plan terminates.

Coverage for the Dependents of Early Retirees will cease on the earliest of the following dates:

1. on the date of the death of the Early Retiree except that coverage for your spouse and Dependent children may be continued through self-payment until the spouse remarries, self-payments cease or benefits for widows end; or

2. the date the Plan no longer provides coverage for Dependents; or

3. the date a self-payment, if required for the Dependent, is not received in a timely manner or in the amount required; or

4. the date of divorce; or

5. the date the dependent no longer qualifies as a Dependent under the Plan; or

6. the date the Early Retiree is no longer eligible for coverage; or

7. the date of termination of a Domestic Partner relationship; or

8. on the date the Plan terminates.

If coverage is lost, continuation of coverage under COBRA may be available to Dependents. Refer to COBRA section.

NOTE: Retired Roofers and their dependents have no accrued or vested rights to benefits under this Plan. In the event the Plan is terminated, the Board of Trustees will determine the retiree's rights to benefits under this Plan. The Trustees reserve the right to change or discontinue the types and amounts of benefits under this Plan and the eligibility rules. Plan benefits for retirees are not guaranteed in this form or any form.

CONTINUATION OF COVERAGE (COBRA)

For All Active Employees and Dependents of Retired Employees

Continuation of coverage by self-payment of premiums will be offered as required by federal law.

COBRA continuation coverage is a temporary extension of coverage under the Plan. The right to COBRA continuation was created by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. You will be required to pay the full cost of the coverage you continue.

Note: Domestic Partners do not have COBRA rights under federal law; however, if coverage is lost they may be eligible to convert their coverage to an individual plan if offered through their insurance carrier.

The Plan Administrator is the Board of Trustees of the Union Roofers Health and Welfare Fund. The Plan is self-administered which means the day-to-day matters of the Fund, including COBRA, are handled by the Fund Manager and staff who are employed by the Fund. If you have questions about this program, you should contact the Fund Manager:

Sue Perillo
Union Roofers Health and Welfare Fund
9901 Paramount Boulevard, Suite 211
Downey, California 90240
Telephone: (562) 927-1434

COBRA Continuation Coverage and Qualifying Events

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, Active Employees, and spouses of Active and Retired Employees, and dependent children of Active and Retired Employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. In special circumstances (the bankruptcy of the employer) retired employees may also be included.

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

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

If you are the spouse of an Active or Retired Employee, you will become a qualified beneficiary should you lose your coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for reason other than his or her gross misconduct;
4. Your spouse becomes enrolled in Medicare (Part A, Part B or both); or
5. You become divorced from your spouse.

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

1. The parent-Active or Retired Employee dies;
2. The parent-Active Employee's hours of employment are reduced;
3. The parent-Active Employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-Active Employee becomes enrolled in Medicare (Part A, Part B, or both);
5. The parents become divorced; or
6. The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Employer and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

Notification Requirements – Employee's, Your Employer's and the Fund Manager's
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Manager has been notified in writing that a qualifying event has occurred.

Employer's Notification Requirements
When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Fund Manager of the qualifying event within 30 days of any of these events.

Employee's Notification Requirements
For the other qualifying events (divorce of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Fund Manager. The Plan requires you to notify the Fund Manager in writing within 60 days after the qualifying event occurs. You must send this written notice to the Fund Manager at the address previously listed.

Depending upon the type of qualifying event, you will be required to provide: a copy of your divorce decree or legal separation; a certified copy of the death certificate; or, a child losing eligibility because he or she no longer satisfies the rules for dependent eligibility

Fund Manager's Notification Requirements
Once the Fund Manager receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries; notification of your rights will be made to you within 14 days of the date the Fund Manager receives notice of a qualifying event.

Application and Payment of Continuation Coverage
In order to qualify for this continuation coverage, you or your eligible Dependent must apply for coverage by properly completing and submitting to the Fund Manager an election form provided by the Fund within 60 days after the latter of the date coverage for the Eligible Individual would otherwise terminate, or, the date the election form is sent to the potential COBRA participant by the Fund Manager.

If a properly completed election form is not submitted to the Fund Manager as specified above, continuation coverage will not be available. In the event that a person has requested COBRA coverage but is not qualified, the Fund Manager will notify the participant of the denial of coverage and the reason for the decision.

COBRA participants must pay premiums for continuation coverage. The amount of the monthly premium will be furnished to potential COBRA participants at the same time as the election form. The cost for COBRA coverage during an 18 or 36 month period will be equal to the cost of the benefits elected plus 2% as allowed by federal legislation. Payment of the required premium must be made on the following basis:

- All premium payments must be made by personal check, money order or cashier's check.

- The initial premium payment must be submitted to the Fund within 45 days of the date continuation coverage is elected and must be in an amount sufficient to cover the premiums due retroactive to the date coverage would otherwise terminate through the beginning of the month when the initial payment is made.

- Subsequent premium payments must be made on no less than a monthly basis and are due on the first day of each coverage month. If payment is not received within 30 days of the due date, coverage will terminate and cannot be reinstated.

- If the initial premium payment is not submitted to the Fund as specified above, continuation coverage will not be available.

Remember that the rules of notice and payment for COBRA coverage are strict and failure to comply completely will result in your loss of coverage. You have 60 days to elect COBRA after the loss of coverage after a qualifying event and an additional 45 days to pay after the election, which means that as much as three months of contributions may be due at once. These are federally mandated time limitations. The Fund will not change these due dates or time limitations.

When COBRA Continuation Coverage Begins and Duration of Coverage
For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date Plan coverage would otherwise have been lost.

COBRA continuation coverage is temporary continuation coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. In accordance with federal law, you will be required to pay 102% of the cost of the coverage you have extended under COBRA.

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

1. Disability extension of 18-month period of continuation coverage

   If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Fund Manager in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. During this extension, you will be required to pay 150% of the cost for coverage you continue in accordance with federal law.

   You must make sure that the Fund Manager is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the Fund Manager at the address listed above.

   You must include the following information with your notification: a copy of the Social Security Disability Award along with sufficient information for the Fund Manager to identify you.

Note: Before applying for the disability extension, be sure to read the provisions of California COBRA Extension for Qualified Beneficiaries enrolled in insured medical plans in California below.

2. Second Qualifying Event Extension of 18-month period of continuation coverage

   If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former Active or Retired employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. You will continue to pay 102% of the cost of the coverage you elect during this extension period.

   In all of these cases, you must make sure that the Fund Manager is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Fund Manager at the address listed above.

   Depending upon the type of qualifying event, you will be required to provide: a copy of your divorce decree or legal separation; a certified copy of the death certificate; or a child no longer satisfying the eligibility rules for dependents.

California COBRA Extension – Medical Benefits Only

California law requires insured plans to provide up to 36 months (combined federal and state COBRA extensions) of continued medical coverage. California COBRA legislation does not apply to vision or dental coverage. The California COBRA extension will affect you if you have an 18-month or 29-month COBRA Qualifying Event. Any extension under this provision will be provided through your insurance carrier and will no longer be handled by the Trust Fund. If you are enrolled in the indemnity medical plan and will want to have the additional month of state coverage, you should enroll in one of the Prepaid Medical plans during the Open Enrollment period just before your COBRA coverage through the Trust will end.

In order to be eligible for the California COBRA extension, you must have exhausted your federal COBRA coverage. You will be charged premiums that are consistent with the California law (generally 110% of the cost of coverage).

Termination of COBRA

COBRA continuation coverage will terminate before the end of the 18 months, 29 months or 36 months in any of the following circumstances:

1. You or your dependents fail to pay the required contribution on time.

2. The individual who has previously elected continuation coverage, first becomes covered under any other group plan (as an employee or otherwise).

3. The Plan terminates all group health plans for all participants.

4. The individual, who has previously elected continuation coverage, first becomes entitled to Medicare (under Part A, Part B, or both).

5. The Social Security Administration (SSA) makes a final determination that a qualified beneficiary is no longer disabled beyond the initial 18-month period. In such a case, coverage will end for all qualified beneficiaries with the first month beginning more than 30 days after the SSA makes such a final determination.

6. The Fund may terminate continuation coverage early of any individual for any reason (such as fraud) for which the Fund would terminate coverage of an individual otherwise receiving coverage under the Fund.

Conversion Option
When your coverage ends, you have the option of converting your group coverage to an individual plan if conversion is available. You have 60 days to convert your coverage. You should contact your insurance carrier for information on conversion plans and their costs prior to the date of your loss of coverage. Conversion plans do not provide the same level of coverage as the plan for Active or Retired Employees and dependents, and they generally cost more. The coverage will be provided directly by the insurance carrier; the Fund will not be involved.

Special Enrollment Rights

Your special enrollment rights may be affected if you do not elect COBRA. For instance, 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.

If you have any questions about these provisions or any other aspect of your COBRA continuation coverage, please contact the Fund Manager. Also, if you or a family member has any change in disability status, marital status, dependents, additions of a newborn or adopted child, health plan eligibility, Medicare eligibility or change of address, please notify the Fund Manager promptly in writing.

You may also have health insurance options available through a Health Insurance Marketplace. If you have questions regarding those options, visit www.healthcare.gov.

If You Have Questions
If you have questions about your COBRA continuation coverage, you should contact the Fund Manager or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at https://www.dol.gov/agencies/ebsa.

Keep Your Plan Informed of Address Changes
In order to protect your family's rights, you should keep the Fund Manager informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund Manager.

FAMILY MEDICAL LEAVE (FMLA) AND CALIFORNIA FAMILY RIGHTS ACT (CFRA)

Under the Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA), your Employer must continue to pay for your health coverage during any approved leave. In general, you may qualify for up to 12 weeks of unpaid FMLA/CFRA leave each year if*:*

1. Your employer has at least 50 employees under the FMLA or at least 5 employees under the CFRA;

2. You worked for the employer for at least 12 months and for a total of at least 1,250 hours during the most recent 12 months; and

3. You require leave for one of the following reasons:

    a. Birth or placement of a child for adoption or foster care,

    b. To care for your child, spouse or parent with a serious medical condition[1], or

    c. Your own serious health conditions.

The FMLA also permits an employee to take up to 26 weeks of leave to care for a spouse, son, daughter, parent, or next of kin, who is a: (1) member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, therapy, is otherwise in outpatient status, or is otherwise on a temporary disability retired list, for a serious injury or illness; or (2) veteran within the meaning of the FMLA. An employee is permitted to take up to 12 weeks of FMLA leave for "any qualifying exigency" (as defined by the Secretary of Labor) for his spouse, son, daughter, or parent, who is deployed with the Armed Forces to a foreign country.

Your Employer is required to maintain your coverage during the 12-week or 26-week period as the case may be.

Details concerning FMLA and CFRA leave are available from your Employer.

In addition to the Fund rules for payment to the Fund because of disability, if your Employer is covered under the FMLA and/or CFRA and you are eligible for FMLA and/or CFRA leave, your Employer may have the responsibility to continue making payments into the Fund for your coverage for up to 12 weeks or 26 weeks, depending on the type of FMLA and/or CFRA leave for which you are eligible. Where employer contributions are otherwise required by the Family Medical Leave Act or the California Family Rights Act for a serious health condition of an employee and such employee is entitled to the Certified Disability Leave extension described above, such employer contributions shall be required and the Fund shall enforce the collection of such employer contributions on behalf of such employee irrespective of whether the Certified Disability leave available under the Fund is used (or not). Where employer contributions are not otherwise required by the Family Medical Leave Act or the California Family Rights Act for a serious health condition of an employee but such employee is entitled to the Certified Disability leave extension described above, such disability leave will be exhausted.

Notify your Employer if you believe you are entitled to leave under the FMLA or CFRA.

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[1] In addition to allowing leave for the care of a serious health condition of a minor child or dependent adult, parent or spouse, the CFRA also allows leave for the care of serious health condition of child of any age, grandparent, grandchild, sibling, or domestic partner.

It is not the role of the Trustees or Fund to determine whether or not an individual employee is entitled to leave with continuing medical care under the federal statute, any state statute or the provisions of the collective bargaining agreement. Disputes as to the entitlement to leave with continuing medical benefits must be resolved by the employer, employee, and where applicable, the Union.

To the extent the participants are entitled to leave with continuing medical coverage pursuant to the federal act, state legislation or provisions contained within a collective bargaining agreement, the Fund will provide continuing medical coverage so long as required monthly contributions are received from the participating employer. Rights under this section in no way affect your rights under COBRA.

Remember that the entire area of disability and illness is complex. Therefore, should you be disabled or ill for any period of time, please notify the Fund Manager.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

This federal law applies to the Trust. It generally forbids health plans and health insurance issuers from limiting a Hospital stay benefit to any less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section for both the mother or newborn child in connection with childbirth. Plans and insurers may not require that a provider obtain authorization from the plan or the insurer for prescribing a length of stay that does not exceed those described. However, the attending provider may discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable), after consulting with the mother, without violating this the law.

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

The Genetic Information Nondiscrimination Act (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

This federal law applies to the Trust. It generally requires that group health plans, insurers, and HMOs that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. In the case of a participant or beneficiary who is receiving benefits under the plan in connection with a mastectomy and who elects breast reconstruction, federal law requires coverage in a manner determined in consultation with the attending physician and the patient, for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

This coverage is subject to a plan's annual deductibles and coinsurance provisions.

OTHER PROVISIONS AND FACTS

The Fund will reimburse the employee or the providers of professional services for charges covered by the Plan at the Affiliated Health Fund (AHF) rate based upon CPT codes, or updated schedule in accordance with the opinion of the responsible Medical Association's Review Committee. Otherwise, claim payments are based upon the Relative Values for Physicians. If a contracting provider could have been used but was not, Allowable Expenses are based on 80% of the contracting provider rates.

Notes
All benefits described herein are for non-occupational accidents and diseases only (except Death, Accidental Death & Dismemberment and Certified Disability Credit).

Third Party Liability (Subrogation)
If an employee or dependent is injured through the fault of another person (third party), benefits of this Plan are not applicable unless the employee or dependent agrees to reimburse the Fund for benefits provided for treatment of the injury, from any payment for bodily injury which may be collected. If reimbursement is not made, the amount paid by the Plan will be withheld from future benefit payments for you OR your dependents.

The Fund has a right to be reimbursed for the amount of any benefits it pays out to you if you receive, directly or indirectly, any money from a third party (such as a person responsible for an injury or an insurance company) on account of the same injury, illness or condition for which the Plan has paid benefits (any such money is referred to here as a "Recovery"). Therefore, as a condition of receiving benefits from the plan for medical and other expenses, you agree that if you receive any recovery from a third party on account of an injury, illness, or condition for which the Plan has paid benefits, you will pay to the plan the amount of that Recovery, up to the total amount of benefits paid to you by the plan.

In case of an injury or illness which may have been caused to you by the act or omission of a third person, you must complete the Fund's Injury or Illness Questionnaire ("Questionnaire") and the Fund's Acknowledgment of Equitable Lien and Subrogation Agreement ("Agreement"). The Agreement provides that you recognize the Fund's equitable lien on any money you recover from a third party (whether by settlement or judgment or otherwise) on account of that injury or illness. The dollar amount of this equitable lien is the dollar amount of benefits that are owed or paid to you by the Fund on account of that injury or illness. (See below for further details).

If you decide not to pursue a claim relating to any injury, illness or condition for which the Fund has paid benefits, the Fund shall be subrogated to your right to pursue such claim. The Fund may assert a claim, in its discretion, to collect a recovery directly from any third party against whom you have any rights in any court of competent jurisdiction, or in any tribunal or other proceeding. You agree not to object to the jurisdiction of any such court or venue and otherwise cooperate in pursuing the recovery. The Agreement provides that you separately recognize the Fund's right of subrogation with respect to any legal right you have against such third party, again in the amount of the benefits owned or paid to you by the Fund. If any Dependents were so injured or became ill, each of them must also sign the Agreement. A parent or guardian may sign for a minor Dependent. Completion of the Questionnaire and the Agreement is a condition of eligibility for Fund benefits for you and your affected Dependents, so failure to do so will result in nonpayment of any benefits. Breach of the Agreement will also be grounds for denying benefits and be grounds for recovery by the Fund. You and your affected Dependents will also be required to furnish the Fund with periodic reports of the status of any and all claims against any such third party.

In connection with the Fund's rights of subrogation and reimbursement, you are required to:

- notify the Fund within thirty (30) days of the date when any notice is given to any party, including an attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to any injury, illness, or condition for which the Fund has paid benefits;

- promptly notify the Fund of any recovery paid as a result of any injury, illness or condition for which the Plan has paid you benefits that you become aware of, by any person from any source;

- fully cooperate with the Fund's efforts to enforce its rights of subrogation and reimbursement;

- complete all forms and provide all information requested by the Fund, including completing and submitting any applications or other forms or statements the Fund may reasonably request;

- cooperate in all efforts to pursue the recovery, including in the preparation and execution of any case or otherwise, and by attendance or giving testimony at depositions and in court, or as otherwise may be necessary; and

- do nothing to prejudice or impede the Fund's rights of subrogation and reimbursement, including by making any settlement or recovery that attempts to reduce or exclude the full cost of the benefits provided by the Fund, except as reasonably agreed to by the Fund.

Please note the following regarding the Fund's right of reimbursement:

- The source and timing of the recovery do not matter. The Fund has the right to be reimbursed whether that recovery is made to or on behalf of the covered person; made in a single payment or over a period of time; or collected by action at law, judgment, settlement, or otherwise.

- The Fund will automatically have a lien against the recovery in the amount of any benefits the Fund provided as a result of the injury, illness, or condition for which the recovery is collected.

- The Fund may enforce the lien with any court or agency with jurisdiction over the matter against the covered person, an insurance company acting on behalf the covered person, or the third party or its agent, or with anyone who is in possession of the recovery.

- The lien may be enforced by any claims administrator or other person acting as the Fund's delegate or as a provider of administrative services to this Fund.

- The Fund, or other person acting as the Fund's delegate or provider of administrative services to this Fund, has the sole authority and discretion to decide whether to pursue any right of recovery in favor of the Fund.

- The Fund's recovery rights are a first priority claim against all responsible parties and are to be paid to the Fund before any other claim against the recovery.

- The Fund's lien on the recovery is not dependent upon whether or not:

    - the recovery is insufficient to make the covered person whole or otherwise compensate the covered person for the injury, illness, or condition;

    - the Fund participates in or assists in claims made to obtain the recovery;

    - the Fund bears any court costs or attorney fees in furtherance of claims seeking the recovery;

    - any liability for payment is admitted by anyone;

- the recovery identifies the benefits provided by the Fund; or
- the recovery identifies payment, in whole or in part, as for pain and suffering or for non-economic damages.

The reason for this is that under the above circumstances the Fund has an equitable lien on any Recovery by you or your affected dependents in the amount of benefits that all or any of you are owned or received from the Fund, and, also, the Fund is subrogated to your (or your dependents') right to recover money damages from such third party, up to the amount of benefits owed or paid to you and them by the Fund. The dollar amount of the equitable lien and the dollar amount of the subrogation rights of the Fund shall not be reduced (1) even if you and your dependents have not been "made whole" or have not received the full damages claimed, and (2) by any attorney's fees you and your dependents had to pay to pursue your claims against such third party. The Fund retains the right, however, for good cause shown, to agree to credit you and your dependents for all or part of their attorney's fees; any agreement to do so much be in writing to be valid. Notwithstanding any other provision in this Plan Document/Summary Plan Description, the Fund's lien and subrogation rights shall arise when the Fund becomes obligated to pay your claim or the claim of any dependent, not when the claim is paid.

This provision shall not be interpreted as conferring any benefit not specifically conferred elsewhere in the Plan.

Right of Recovery and Release of Necessary Information
Whenever payments have been made by the Fund for services or supplies, the Fund shall have the right to recover such payments with respect to a participant or dependent that was not eligible at the time services or supplies were rendered or when benefits were paid incorrectly for services or supplies.

The Fund has the right to recover any such payments to the extent of the excess from among one or more of the following: the persons to or for or with respect to whom such payments were made; the person who benefited from such payments or his legal guardian; or insurance companies, service plans or any other organization.

Any person claiming benefits under the Plan must furnish to the Fund such information as may be necessary to make a proper claim determination. With the consent of the participant, the Fund may obtain from, or provide to, any other organization or person any information about the participant that is necessary for this purpose.

FUND REIMBURSEMENT

In addition to the specific circumstances set forth elsewhere in this document in which the Trustees may suspend the payment of benefits to a participant or a beneficiary, the Trustees shall also have the general power to withhold and offset such benefits for claims incurred on behalf of any participant or beneficiary who: (1) owes money to the Trust because of any obligations imposed upon them by this Plan booklet or the rules and regulations of the Fund, or (2) owes money to the Fund because the Fund overpaid a participant or beneficiary, (3) or in any other circumstance in which a participant or beneficiary legally owes money to the Trust. The Trustees also reserve the right to refuse payment for services rendered or facilities or supplies furnished by particular health care providers. These powers may be used as the Trustees deem necessary.

The Trustees must ensure that all who benefit from the Plan do so appropriately, and only as they are entitled. For example, if the Trustees determine that a Participant, his Dependents, or health care provider has committed any fraud or made any intentional misrepresentation in connection with claims for benefits or has committed any act or omission resulting in abuse or misuse of the Plan, the Board of Trustees reserves the right and authority to impose upon Participants and their Dependents restrictions with respect to their future rights to receive benefits from the Trust.

The Trustees reserve the right to seek reimbursement and other damages, together with attorney's fees (to the extent provided by law) and other costs incurred in connection with recovering any benefits incorrectly paid, or not reimbursed when reimbursement is required under the Plan.

To be reimbursed for benefits improperly paid, the Trustees may also exercise a right of offset against future benefits payable on behalf of the Participant and his Dependents.

All these powers (stated above) may be used as the Trustees deem necessary.

Medicare Provision
With respect to each Active Employee or dependent who is eligible for coverage under Medicare, the Fund will pay its benefits before Medicare, unless the Medicare eligible person elects Medicare as their primary coverage. The Fund may not pay any benefits where a portion of the charges were covered by Medicare, if Medicare is elected as primary payor. Important: You should be certain to enroll in Medicare on a timely basis to avoid any late penalties. Contact your local Social Security Office within three months of reaching age 65 for information.

In order to receive benefits through the Trust as a Medicare-eligible Retiree, you must assign your Part A and Part B Medicare benefits to the insurance carrier.

NON-ASSIGNABILITY OF CLAIMS AND BENEFITS UNDER THE PLAN

Please be advised that no rights under the Plan, including but not limited to the right to receive any benefit or any right to pursue a claim or cause of action, are assignable, either in whole or in part, to any person, medical provider or other entity. Any payment by the Plan directly to a provider pursuant to a written election or purported assignments submitted by a Participant or a Dependent is provided at the discretion of the Board of Trustees as a convenience to the Participant, Dependent or beneficiary and such payment to a provider does not serve as a waiver of this non-assignability clause nor does it imply an enforceable assignment of any benefits or the right to pursue a claim or cause of action.
The Trustees also reserve the right to refuse payment for services rendered or facilities or supplies furnished by particular health care providers. The Trustees are afforded the discretion to recognize purported assignments and require that such providers provide to the Trust supporting documentation that: (1) the Participant and Dependents authorized and purportedly assigned benefits payable on their behalf to the provider; and (2) medical and diagnostic notes, records, tests, exams, and x-rays show that the services rendered were medically necessary. To the extent the Trustees recognize such purported assignments of benefits, the assignments must be complete and signed by the Participant and/or Dependent on or before the date that services were rendered.

Coordination of Benefits
This Plan has been designed to help you meet the cost of medical expenses. Since it is not intended for you to receive greater benefits than the expenses actually incurred, all benefits (with the exception of the Death Benefit, Accidental Death and Dismemberment, Vision and Weekly Disability Benefits) will be subject to coordination with any benefits that you may be entitled to receive under any other insurance plan as described below. The Prepaid Medical plans have their own coordination of benefits rules as outlined in the benefit booklets issued by them.

“Coordination” means that this Plan will work together with any other plan under which you may have coverage, enabling you to receive the full amount of benefits to which you are entitled under both plans. In other words, by “coordinating” the benefits of this Plan with the benefits of another plan, you may receive full payment of your medical and dental expenses (but not more than 100% of Allowable Expense) rather than partial payment. “Allowable Expense” means any expense for services or supplies (based on Reasonable Charges) which are covered at least in part by one or more of the plans under which you or your dependent is covered.

The following information explains how benefits are determined when the "coordination of benefits" provision is applied:

One of the two or more plans involved is the primary plan and the other plans are secondary plans. If this is the primary plan, it pays benefits first and without consideration of the other plans. If this Plan is the secondary plan, it will then pay as if it were the primary plan, not to exceed 100% of the Allowable Expense incurred when the amount paid by this Plan is added to the amount paid by the other plan. No plan will pay more than it would have paid without this special provision. (If one plan has no coordination of benefits provision, it automatically is Primary.)

In order to determine which plan is the primary plan and which plan is the secondary plan, the following rules have been established:

1. The benefits of the plan which covers the person as an active employee will be determined before the benefits of a plan which covers such person as a dependent, except that this Plan will be primary payor for a Medicare eligible dependent of an active employee.

2. When both plans cover the person as a dependent child of an active employee, the benefits of the plan which covers the parent whose birthday (month and day only) occurs first during a Calendar Year will be determined before the benefits of the plan which covers the parent whose birthday (month and day only) occurs later in the year. If both parents have the same birth date, the plan covering the parent the longer period of time shall pay benefits first. However, in the event a father and mother are legally separated or divorced and no Qualified Medical Child Support Order (QMCSO) exists, the following rules will apply:

    a. The benefits of a plan which covers the person as a dependent of the parent with financial responsibility for the child's medical expenses by virtue of a court decree will be determined first.

    b. If there is no court decree, the benefits of a plan which covers the person as a dependent child of the parent with legal custody will be determined first.

    c. If there is no court decree and the parent with legal custody has remarried, the order of benefit determination will be as follows:

        (1) The plan which covers the parent with legal custody.

        (2) The plan which covers the step-parent with legal custody.

        (3) The plan which covers the parent without legal custody. If a QMCSO exists, the terms of it shall be recognized.

3. When this Plan and another plan cover the person as a dependent child and such other plan does not contain the birthday rule as described above, but uses the benefit determination provision which provides that the plan which covers such person as a dependent child of the father shall determine benefits before the plan which covers such person as a dependent child of the mother, then this Plan will also use this benefit determination provision when applicable.

4. The benefits of a plan covering the person as an active employee shall determine benefits before the plan which covers the person as a laid-off or retired employee. However, if this Plan coordinates benefits against a plan without this provision, then this rule is ignored.

5. When these rules do not establish an order of benefit determination, the benefits of a plan which has covered the person for the longer period of time will be determined before the benefits of a plan which has covered such person the shorter period of time.

6. When this coordination of benefits provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan, each benefit that would be payable in the absence of this provision will be reduced proportionately, and such reduced amount will be charged against any applicable benefit limit of this Plan.

7. Medicare is the primary plan of all retired eligible members and their dependent spouses, providing they are also eligible for Medicare, unless they are the dependent of an active employee. In this case, the active employee's plan is primary, Medicare is secondary and the retiree's plan pays last.

8. If an individual has End-Stage Renal Disease (ESRD) the order of benefit payments is:

    a. The Plan is the primary payer for the ESRD coordination period of 30 months regardless of employment status or eligibility for COBRA or a retirement plan.

    b. Medicare is the secondary payer.

    c. After the 30-month eligibility period or entitlement to Medicare, Medicare becomes primary.

Coordination with Prepaid Plans
If your spouse or a dependent child has benefits provided on a primary basis by a prepaid Plan and is covered as a dependent under the Union Roofer's Indemnity plan, no benefits will be payable under this Plan if your dependent does not receive treatment from the prepaid plan. If your dependent does seek or receive treatment from the prepaid plan, the secondary coverage under the Union Roofer's Indemnity plan will coordinate benefits in accordance with the above indicated provisions.

If you are covered as an employee under the Union Roofer's Indemnity plan and as a dependent under a prepaid plan, you may receive treatment from either your own physician or privately selected Hospital or from the prepaid physicians or Hospitals. If you receive treatment through the prepaid plan, your primary coverage under the Union Roofer's Indemnity plan will pay its normal benefits for any expenses that you are legally obligated to pay.

Physical Examination
The Fund at its own expense shall have the right and opportunity to require the examination of any individual, by an appropriately licensed Doctor, whose sickness or injury is the basis of a claim when and as often as it may reasonably require during the pendency of a claim hereunder

ENROLLMENT CARDS

It is necessary that you complete an enrollment card for the Fund records. Any change in your status or your dependents' status must be reported to the Fund Office immediately.

Written Proof
Any inquiry as to benefit status must be confirmed in writing by the Trust.

Permanent and Total Disability
Permanent and total disability means any disability resulting from bodily injury or disease occurring after this coverage becomes effective, which wholly and continuously prevents you from engaging in any occupation or employment for wage or profit.

Notice of Claim
Written notice of claim must be given to the Fund Manager's Office at Downey, California, within 90 days after the occurrence or commencement of any loss covered by the Plan. No claim will be honored if it is not submitted within one year of the date services were rendered.

Claim Forms
The Fund will furnish claim forms to the employee as soon as possible after receipt of notice of claim. However, written proof covering the occurrence, character and extent of loss will be sufficient and submitted within the time limit allowed for furnishing proof of loss.

Payment of Claim
Benefits for loss of life will be paid to the named beneficiary, if living, otherwise to the legal heirs. All other amounts due will be paid to you as they accrue. The Fund will pay the employee the amount of Coverage shown in the Schedule of Benefits on the life of any covered dependent at the time of the death of such dependent. A Certified copy of the Death Certificate must be submitted.

Legal Actions
No action at law or in equity shall be brought to recover on any coverage under the Plan prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of the Plan and the appeals procedure has been exhausted. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Disclaimer
The death, accidental death and dismemberment, Roofers Indemnity medical and dental benefits described in this booklet are not insured by any contract of insurance. There is no liability on the Board of Trustees or any individual or entity to provide payment over and beyond the amounts in the Fund collected and available for such purposes.

Amendment and Termination
In order that the Fund may carry out its obligation to maintain, within the limits of its resources, a program dedicated to providing the maximum possible benefits for all Covered Employees and retirees, the Board of Trustees expressly reserves the right, in its sole discretion, at any time and from time to time, but upon a non-discriminatory basis:

1. to terminate or amend either the amount or condition with respect to any benefits even though such termination or amendment affects claims which have already accrued; and

2. to alter or postpone the method of payment of any benefits; and

3. to amend or rescind any other provisions of the Plan.

Any Plan modification or amendment to benefits described in this booklet shall be in writing and adopted by the Board of Trustees.

Provider Disclosure Information
The Fund shall advise you of the services provided by a carrier having a contract with the health Fund and tell you how to obtain assistance under ERISA. A list of the providers of service, the services rendered, and the address of the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, is provided in the ERISA section of this booklet. Provider directories are available from the Fund Manager's Office.

HOW TO FILE A CLAIM

DOES NOT APPLY TO HEALTH NET OR KAISER PERMANENTE WHEN YOU HAVE A CLAIM, THIS IS WHAT SHOULD BE DONE:

Medical, Prescription Drugs and Indemnity Dental Claims

1. Obtain a claim form from your Fund Manager's Office at:

   Union Roofers Health and Welfare Fund
   9901 Paramount Boulevard, Suite 211
   Downey, California 90240
   Telephone: (562) 927-1434

2. Carefully fill in the employee section of the claim form and give it to your Doctor or Dentist for completion of his section.

3. The Doctor or Dentist should send the completed form to the Fund Manager's Office.

4. Remember that your claim cannot be paid until complete information is provided.

   The promptness with which you and the Doctor or Dentist completes your sections of the claim form determines how quickly you are reimbursed on your claim.

5. All claims must be filed within 90 days of completion of treatment, or date of operation, or confinement. If not filed within one year of the date the charges were incurred, regardless of the reason, the claims will not be honored.

6. You have the right to appeal a claim that is denied in whole or in part. (Refer to page 131).

Death and Dismemberment Benefits
Contact the Fund Manager at the address above to request a claim form for death or dismemberment benefits. Upon submission of the requested supporting documentation a payment will be made to you or to your designated beneficiary on file with the Fund Manager's office.

Weekly Disability Benefits
Contact the Fund Manager at the address above to request a claim form for weekly disability benefits. You and your doctor will be required to furnish the information requested so that a determination can be made of your right to benefits. The form must be returned to the Fund Manager. If you qualify for benefits Standard Insurance will begin issuing checks to you.

Vision Care
Refer to page 744 on how to use the Vision Service Plan.

Claims under the Kaiser or Health Net plans
If you are enrolled in the Kaiser or Health Net medical plans and you have a claim for benefits, you must follow their claims procedures. If you have any questions about those benefits, you should refer to the separate Evidence of Coverage (EOC) you receive from the carrier.

Refer to page 131 for detailed information on how to file a claims appeal if your claim is denied in whole or in part.

Delta Dental PPO Dental Plan
If you are enrolled in the Delta Dental PPO dental plan and you have a claim for benefits, you must follow their claims procedures. If you have questions about those benefits, you should refer to the separate Evidence of Coverage (EOC) you receive from the carrier.

DeltaCare DHMO Dental Plan
There generally are not claims if you are enrolled in this plan. However, if you have questions about the plan or emergency claims, you must contact the carrier for assistance. Refer to the separate brochure about the DHMO dental plan.

DEATH BENEFITS

For Active Contract Employees and their Dependents and Retired Employees

The Benefit is payable in the event of death subject to the limitations below.

SCHEDULE OF BENEFITS

Death Benefit

Employee	$2,000[1]
Early and Regular Retired Employees	$1,000[1]
Spouse:	
Active Employee	$1,000[1]
Retired Employee	$ 500[1]
Dependent Children of Active Employees only:	
Dependent child age 14 days, but less than 6 months	$ 100
Dependent child age 6 months, but less than 19 years	

In the event of death of a Covered Employee, $100 of the Death Coverage may be paid immediately; the balance to be paid upon receipt by the Fund of satisfactory proof of death.

Beneficiary
Death Benefits for your dependents will be paid to you.

The following rules apply to benefit payments in the event of your death:

- You may designate a beneficiary or beneficiaries to receive the Death Benefit by completing a beneficiary form and forwarding it to the Fund Manager's office. You have the right to change your designation of beneficiary without consent of the beneficiary, but no such change will be effective or binding on the Fund unless it is received by the Fund Manager's office prior to the time any payments are made to the beneficiary whose designation is on file with the Fund. If more than one beneficiary is designated, and their respective interests are not specified, they will share alike.

No Death Benefits are payable to a beneficiary who commits an unlawful act against the Employee resulting in the death of the Employee. Such a beneficiary shall not be deemed an eligible beneficiary in the section below.

Lack of Designated Beneficiary
If no beneficiary has been designated, or if the designated beneficiary dies before your Death Benefit is paid, the Death Benefit will be paid to your lawful spouse or Domestic Partner if then living, or if there is no lawful spouse or Domestic Partner alive at the time of payment, payment will be made to the first surviving class of the following classes of successive preference beneficiaries: your (1) surviving children; (2) surviving parents; (3) surviving brothers and sisters; (4) executors or administrators.

Assignment
No benefits provided under the plan are assignable.

Notice of Claim
Written notice of claim must be given to the Fund Manager's Office at Downey, California, within ninety (90) days but will be accepted up to twelve (12) months after the date of death. A certified copy of the Death Certificate must be submitted.

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[1] When an Active or Retired Employee or spouse attains the age of 70 years, this maximum amount automatically reduces by 50%. In no event will the amount of coverage on any dependent of an Active or Retired Employee exceed 50% of the amount of coverage of such Active or Retired Employee.

ACCIDENTAL DEATH AND DISMEMBERMENT

For Active Contract Employees

Upon receipt by the Fund of due proof that the employee has suffered any of the losses listed below as a result of bodily injuries caused directly and independently of all other causes and that such injuries resulted in the loss within ninety days from the date the injuries were sustained, and that the loss did not result directly or indirectly from a risk here excluded, the Fund will pay the benefit designated for the loss, subject to the provisions and limitations hereinafter set forth.

Amount of the Principal Sum.....$2,000[1]

The Principal Sum will be paid for Loss of Life, Loss of Both Hands, Loss of Both Feet, Loss of the Sight of Both Eyes, Loss of One Hand and One Foot, Loss of One Hand and the Sight of One Eye, or Loss of One Foot and the Sight of One Eye.

One-half the Principal Sum will be paid for: Loss of One Hand, Loss of One Foot, or Loss of the Sight of One Eye.

Loss means, with regard to hands and feet, dismemberment by severance through or above the wrist or ankle joints; with regard to eyes, the entire and irrecoverable loss of sight beyond remedy by surgical or other means.

Risks Excluded

No benefit will be paid for any loss resulting directly or indirectly, wholly or partially from: suicide or intentionally self-inflicted injury unless it is the result of a mental illness or condition,; ptomaines, bacterial infections (except pyogenic infection which occurs with an accidental cut or wound); any disease; war or any act of war; or any sickness.

Beneficiary

Benefits will be paid to you for dismemberment. If an accidental death benefit is payable, it will be paid to the beneficiary you have named for your life insurance benefits.

No Benefits are payable to a beneficiary who commits an unlawful act against the Employee resulting in the death or serious injury of the Employee. Such a beneficiary shall not be deemed an eligible beneficiary for purposes of this Benefit.

[1] Reduces by 50% at age 70.

WEEKLY DISABILITY BENEFIT

For Active Bargaining Unit Employees Only
(Provided by Standard Insurance Company)

When you are Totally Disabled (unable to perform your regular occupation) because of pregnancy, non-occupational sickness or non-occupational accidental injury, a benefit of $75.00 per week will be paid.

Benefits begin with the 8th day of disability. No more than 26 weekly payments will be paid for any one continuous period of disability during any calendar year.

Successive periods of disability resulting from the same or related causes, separated by less than two weeks of active full time employment, shall be considered as one period of disability.

NOTE: You must be eligible for benefits at the time of the onset of the illness or injury.

EXCLUSIONS AND LIMITATIONS

- You must be under the care of a physician to qualify for benefits.
- Benefits are not paid for any disability arising out of or in the course of any employment or for disability in connection with war or intentionally self-inflicted injury unless it is the result of a mental illness or condition.
- Benefits are not payable for any period during which you are engaged in any occupation, confined in jail or entitled to any benefits under Worker's Compensation Act (whether permanent or temporary benefits) or Occupational Disease Law.

SUPPLEMENTAL ACCIDENT PROTECTION

For All Employees Enrolled in the Union Roofer's Indemnity Medical Plan and their Dependents

For each accident occurring after the effective date of this coverage, your Plan provides up to a total of $500 for the following expenses:

- Medical or surgical treatment by licensed physicians and surgeons. These services are paid in accordance with the physician charges;
- Hospital services including room and board, Drugs, medicines and serums;
- Laboratory and X-ray examinations;
- Services of Registered Nurses (not members of the family);
- Ambulance transportation to the first Hospital of confinement;
- Services of legally qualified physical therapists;
- Prescription Drugs; and
- Dental care in accident cases: In case of accidental injury, payment will be made for services customarily performed by Dentists and Oral Surgeons incident to the treatment of injuries to the natural teeth, jaws and their dependent tissues. The benefit does not include expenses or services for restoration of function or appearance, i.e., dentures, braces, etc.

Expenses must be incurred within three months of the date of the accident in order to qualify for this Supplemental Accident Protection.

LIMITATIONS AND EXCLUSIONS

Benefits will not be provided for:

- any injury covered by Worker's Compensation;
- ptomaine poisoning, disease or infection (except pyogenic infection occurring through an accidental cut or wound);
- eye refractions or fitting of eyeglasses;
- an intentionally self-inflicted injury unless it is the result of a mental illness or condition;
- routine treatment of the teeth or gums, except that in the case of dental care for accidental injuries, the Plan will provide payment for services rendered by a Dentist or oral surgeon for treatment to natural teeth, jaws and their dependent tissues; and
- expenses or services for restoration of function or appearance, such as dentures or braces.

COMPREHENSIVE MAJOR MEDICAL BENEFITS

For All Employees Enrolled in the Union Roofer's Indemnity Plan and their Dependents

GENERAL INFORMATION

This section describes the benefits available to you and your eligible dependents who are enrolled in the Roofer's Indemnity Hospital/medical plan. **The deductibles, Calendar Year maximums and percentages payable by the Plan depend upon the hours you work in a Qualifying Period** - You will be covered for Plan A+, Plan A or Plan B benefits. Early and Regular Retirees are covered for Plan B benefits only and are required to make a payment for coverage. All indemnity plans are subject to the following: pre- certification of a Hospital stay; and, in Plan A, the use of Preferred Provider Organization (PPO) when services can be obtained through them.

PRE-CERTIFICATION OF A HOSPITAL STAY

If your Doctor recommends a Hospital stay, you must receive pre-certification for the inpatient care by calling (562) 927-1434 prior to admission. They will determine if the treatment can be received as an outpatient which will save both you and the Fund money. Failure to obtain the authorization will result in a reduction in your benefit payments. If admission is an Emergency, you must notify Medical Case Review within 72 hours of the admission.

SECOND SURGICAL OPINION

If your Doctor recommends surgery that will be Hospital-based, you may obtain a second surgical opinion prior to the surgery. If the need for surgery is not confirmed, you may get another opinion or you may proceed with the surgery. This program allows you to examine the options available. You should contact Medical Case Review when elective surgery is recommended. (Elective surgery is surgery that is not a matter of life and death and can be obtained at any time.)

PREFERRED PROVIDER ORGANIZATION (PPO)

The Trust Fund has contracted with **Affiliated Health Funds (AHF)**, a PPO organization, to obtain discount arrangements from various Hospitals and other providers. If you become covered under the Roofer's Indemnity hospital/medical plan, you are encouraged to use contracting providers. Use of these providers saves you and the Fund money. A listing of the current AHF contracting providers (updated from time-to-time) is available at:

www.ahfonline.org

You should always check with the provider to make certain they are still under contract before you receive services. If your Doctor refers you for additional treatment at a Hospital, other facility, or to another professional, tell him you want to use a PPO provider. **You must always use a PPO provider Hospital for Hospital-based services for any benefits to be paid under the Plan.** If you are covered for Plan A benefits, no benefits will be payable unless you use a PPO provider. If you are covered for Plan A+ benefits, your out-of-pocket expenses will be at least 20% higher if you do not use a PPO provider.

A PPO provider will accept the contracted rates as payment in full. The Fund will pay its percentage of the contracted amount and you will only be responsible for your percentage of the allowable expenses after your deductible, if any, has been satisfied. A non-contract provider may charge more than the allowable amount, and you will have to pay your percentage plus anything above the allowable amount.

NOTE: All payment of benefits will be based upon the CPT codes for contracted providers. Otherwise, claim payments are based upon the current Relative Values Studies for Physicians. If a contracting provider could have been used, but was not, Allowable Expenses are based on 80% of the contracting provider rates.

HOURS REQUIREMENT FOR PLAN A+, PLAN A AND PLAN B

If you have 750 or more hours reported and contributed upon in the Qualifying Period preceding the Eligibility Period, you are eligible for **Plan A+ Benefits**. If you have at least 600 but not more than 749 hours reported and contributed upon in the Qualifying Period preceding the Eligibility Period, you are eligible for **Plan A Benefits**. If you have **hours reported for at least 450 but not more than 599** in a Qualifying Period or you are a retiree, you are eligible for **Plan B benefits** and you must enroll in one of the prepaid Hospital/medical plans. You will, however, continue to be covered for prescription Drugs which are reimbursed by Sav-Rx. All Retirees (regardless of age) and their spouses or domestic partners have prescription drug coverage through their HMOs. For Early Retirees (ages 55 to 59) their dependent children are reimbursed for prescription drug coverage through Sav-Rx.

PLAN DEDUCTIBLES, PAYMENT MAXIMUMS – PLAN A+ AND PLAN A

The Table below summarizes the deductibles, Plan payments and maximums. Refer to the section "Covered Expenses" for details of the benefits.

SUMMARY OF BENEFITS		
	PLAN A+	**PLAN A**
Calendar Year Deductible	$100/person; $300/family	$200/person; $600/family
Percentage Payable		
AHF Hospital	100%[1]	80%[1]
Non-AHF Hospital	0%[2]	0%
Other -		
Where AHF contract exists for services and an AHF provider is used	100%	80%
Where AHF contract exists for services but was not used	80%[3]	0%
Where no AHF contract exists for services	80%[2]	80%[2]
Calendar Year Out-of-Pocket Maximum	$5,000[4]	$5,000[3]
Other Maximums -		
Chiropractor/Acupuncturist per 6 months	4 visits	4 visits
Prescription Drugs[5] -		
Calendar year Deductible	$0	$0
Percentage Payable	90%	90%
Calendar Year Maximum	None	None

NOTE: For services relating to anesthesia administration or to the reading of test results by a pathologist or radiologist, the following rules will apply:

If a Plan A+ participant uses a contracted Hospital and their primary physician is also contracted, benefits will be paid at 100% of the billed charges. If either the Hospital or the primary care physician is not contracted, then charges will be paid at 80% of the contracted rate. If a participant has minor surgery in the Doctor's office as an outpatient, the physician must be contracted in order for charges to be paid at 100% of the billed charges. If the physician is not, charges will be paid at 80% of the contracted rate. Plan

1 Charges for an anesthesiologist and physician and diagnostic services in the Emergency room of a contracting facility are payable at the same percent of allowable billed charges.

2 Benefits are paid at the AHF rates for emergencies.

3 Payments for services will be calculated as if an AHF provider was used.

4 Does not apply to chiropractic.

5 Prescription drugs are reimbursed by Sav-Rx.

A participant billed charges will be paid at 80% if both a contracted Hospital and physician are used; if not, no benefit is payable for these services.

SUMMARY OF BENEFITS		
	PLAN A+	**PLAN A**
Supplemental Accident		
Deductible	None	None
Maximum Amount Payable Per Accident	$500	$500
Hearing Aids		
Deductible	None	None
Percentage Payable	80%	80%
Maximum – testing of hearing ability	Yearly max	Yearly max
Devices	$1,500 each ear every 3 years	$1,500 each ear every 3 years
Mental Health Services		
Inpatient Care		
AHF Contracting Hospital	100%	80%
Non-Contracting Hospital	0%	0%
Outpatient Care		
AHF Contracting Provider	100%	80%
Non-Contracting Provider	80%[1]	0%
Where no AHF contract exists for services	80%[1]	80%[1]
Service Limits	None	None
Providers Covered		
M.D., PhD, M.F.T. only		
Substance Use Disorder Benefits (AHF providers only)		
Inpatient care	100%	80%
Outpatient care	100%	80%

Note: HMO benefits are described in the Kaiser and Health Net booklets.

[1] Payments for services will be calculated as if an AHF provider was used.

Plan B Benefits
Plan B participants must use the prepaid Hospital/medical providers. They will continue to be covered for prescription Drugs through the Indemnity medical plan. The reimbursement of covered prescription expenses does not require a Calendar Year deductible. Reimbursement will be made for 90% of Allowable Expense. Sexual dysfunction Drugs are not available to dependent children of Active Employees.

COVERED EXPENSES
NOTE: Plan A+ and Plan A must always use AHF contracting Hospitals for all Hospital-based services (inpatient and outpatient) for benefits to be paid. Plan A+ has a choice of providers for all other services, however if you use AHF contracting providers, you save out-of-pocket expense. Plan A must always use AHF contracting providers for all other services in order for benefits to be payable, unless no contract exists.

Charges for the following are covered when necessary for treatment of a non-occupational injury or illness, to the extent that charges do not exceed Reasonable Charges.

1. Hospital Care: Hospital room, board, general nursing care, anesthetic supplies, surgical supplies, use of operating cystoscopic Drugs, oxygen, blood and blood plasma, physical therapy including hydrotherapy and x-ray and laboratory (excluding that part of the Hospital's charge for a private room in excess of an amount equal to the Hospital's most common semiprivate room rate).

2. Charges for confinement in an intensive or coronary care unit in excess of the Hospital's most common charge for a semiprivate room.

3. Emergency room and supplies when needed for treatment of an illness if a medical Emergency (i.e., heart attack, poisoning, loss of consciousness or convulsions). Except: if the condition is determined to not be an Emergency or you are not admitted as a bed patient, a $25 deductible will apply to each visit.

4. Doctor's fees for medical and surgical service.

5. Services of a Registered Nurse, provided that the services rendered require the skill or training of a Registered Nurse and services of a licensed vocational nurse when medically necessary.

6. Prescription Drugs which required a prescription received from a Licensed Pharmacist when prescribed by a Doctor or Dentist including insulin and insulin injection kits, compounding drugs, dermatological preparations (see Limitations and Exclusions).

7. Doctor's or Dentist's charges for any Drugs or insulin or insulin injection kits (i) which are supplied to the patient in the Doctor's or Dentist's office, and (ii) for which a charge is made separately from the charge for any other item of expense, provided the Doctor or Dentist is licensed by law to administer Drugs.

8. Services of a Doctor or psychologist for inpatient or outpatient treatment of mental illness or a functional nervous disorder as follows:

    a. Counseling service must be provided by a Doctor (M.D. or D.O.), a psychologist (PhD) or a Masters Prepared Behavioral Health Counselor (e.g. F.M.C., M.F.T).

9. Services of a Chiropractor or Acupuncturist not to exceed 80% of Reasonable Charges in any consecutive six-month period. Benefit payments shall commence:

    a. on the first day of treatment with respect to any one accident;

    b. on the first day of treatment for illness if admitted to the Hospital; or

    c. on the second day of treatment for illness if not admitted to the Hospital.

10. Any of the items listed below:

    a. Artificial limbs, eyes or larynx (excluding their replacements), casts, splints, trusses, braces or crutches.

    b. Electronic heart pacemaker.

    c. Rental of a wheelchair, Hospital-type bed, iron lung or other durable equipment used exclusively for treatment of injury or illness not to exceed the reasonable purchase price.

    d. Blood, blood plasma and blood processing fees.

    e. Diagnostic X-ray, and laboratory services.

    f. Use of X-ray, radium and other radioactive substances.

    g. Oxygen and rental of equipment for administration of oxygen.

    h. Professional ambulance service to the nearest Hospital where care and treatment of the injury or illness can be given.

    i. Services of a paramedic.

    j. A physiotherapist, either inpatient or outpatient care, for short-term therapy.

    k. Services must be ordered by a Doctor under an individual treatment plan and must be certified by the Doctor as medically necessary for the improvement of the patient's condition through short-term care.

    l. Cosmetic surgery and repair of damage to natural teeth required as a result of an accident are covered within 90 days of the accident.

    m. Treatment of teeth and gums in connection with tumors.

    n. Anesthesia and its administration.

    o. Reconstructive surgery as a result of a mastectomy including:

        (1) Reconstruction of the breast on which the mastectomy was performed;

        (2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

    p. Hearing aids, including hearing tests, not to exceed one Hearing Aid per ear every 36 months subject to a maximum payment of $1,500 per ear every 36 months.

11. Wellness Program

    a. The wellness program includes immunizations and testing, mammograms, and routine physical exams. AHF contracting providers must be used for mammograms and routine physical exams.

    b. Immunizations and Testing

        Immunizations and testing will be covered in accordance with the guidelines published by the American Academy of Pediatrics and the Patient Protection and Affordable Care Act.

c. Mammograms

Mammograms, only when obtained from a AHF contracting provider, will be covered once every two years for women ages 35 to age 40 and one every year thereafter, or as required by the patient's history.

d. Routine Physical Exams

Routine physical exams (excluding exams for insurance, licensing, employment, school, camp, immigration or other non-preventative purposes)

e. Physical exams including complete blood counts, urinalyses, chest x-rays and chemical panels will be covered once every two years; pap smears and prostate exams will be covered once every year. The physical exam benefit is limited to once every two years, except pap smears and prostate exams are limited to one per year.

f. The Plan will cover the cost for Flu shots up to a maximum of $150 per person per calendar year and may be obtained from any appropriately licensed Doctor, clinic or facility for participants enrolled in the fee-for-service medical plan.

MAXIMUM BENEFITS

Out-of-Pocket Maximum
If the amount you are required to pay for covered expenses during a Calendar Year reaches $5,000, the percentage payable by the Plan for the balance of the Calendar Year will increase to 100% of covered charges. The out-of-pocket maximum applies separately to each Eligible participant. **Except:** Charges for acupuncture or chiropractor benefits will never be payable at more than 80%.

Lifetime and Calendar Year Maximums
There is no Calendar or Lifetime maximum on the amount payable by the Plan.

DISABILITY EXTENSION OF MAJOR MEDICAL BENEFITS FOR EMPLOYEE ONLY

If a Covered Employee is Totally Disabled on the date coverage terminates and submits a completed application to the Fund office, Comprehensive Major Medical Benefits will be extended to apply to Covered Expenses incurred after termination of coverage for treatment of that uninterrupted injury or illness until the earliest of:

1. the end of one year from the date the illness or injury causing the disability occurred,

2. the date the Plan ends,

3. the date the disability ceases,

4. the date the illness or injury begins to be covered under another group plan.

MEDICAL SERVICES NOT COVERED AND BENEFIT LIMITATIONS

The Comprehensive Major Medical Benefits under the Union Roofers' Indemnity plan are subject to the following exclusions. Benefits shall not be provided with respect to:

1. At the sole and absolute discretion of the Board of Trustees, the Plan shall not be liable to provide benefits for medical services or supplies that are not reasonably necessary for the care or treatment of bodily injury or sickness.

2. Services resulting from disease for which the Member is entitled to benefits under any Worker's Compensation Law or Act, or from accidental bodily injury arising out of or in the course of the Member's employment;

3. Services customarily provided by, or incident thereto, a Dentist or Oral Surgeon including any operation or treatment in connection with the fitting or wearing of dentures or for treatment of any condition involving teeth, surrounding tissue or structure except for accidental injuries to natural teeth;

4. Hospitalization primarily for rest, convalescence or rehabilitation care;

5. Services incident to Hospitalization primarily for medical observation or diagnostic examinations;

6. Services provided by a Hospital incident to Hospitalization for tuberculosis, after diagnosis, except that Hospital services with respect to tuberculosis surgery are a benefit of this Plan;

7. Cosmetic surgery except operations necessary to repair disfigurement due to an accident occurring while covered and except for treatment of a congenital anomaly in a Dependent child;

8. Services performed in an institution owned or operated by a State or political subdivision thereof, unless there is an unconditional requirement to pay charges without regard to rights against others, contractual or otherwise;

9. Any services incurred before the effective date of coverage;

10. Weight reduction and related medical or surgical treatment;

11. Charges incurred as a result of war, or any act of war whether declared or not; atomic explosion or release of nuclear energy;

12. Organ transplants other than kidney transplants;

13. Eyeglasses (covered under Vision Care only), refractions, fitting of glasses, radial keratotomy, corrective appliances and artificial aids; vision therapy (orthoptics) unless it is in lieu of a surgical procedure;

14. Vocal cord treatment or training by a non-medical Doctor (M.D.); practice beyond scope of professional license; occupational therapy; vision orthoptic training; tonography; speech therapy;

15. Any bodily injury that is self-inflicted unless this injury results from a medical condition (including any physical or mental health condition) whether or not such medical condition had been diagnosed before the accident, or that results from the covered person's commission of a crime (including but not limited to driving under the influence). (However, benefits are payable for bodily injuries incurred during the commission of crimes where the covered person was a victim of domestic violence or where the crimes were committed as a result of a physical or mental condition.);

16. Any bodily injury that occurs during employment or occupation for compensation, unless coverage states otherwise;

17. Treatment of infertility;

18. Treatment for tobacco use;

19. Suicide or self-inflicted injury except as a result of a mental illness or condition;

20. Chiropractic and acupuncture services (except as provided for in the Plan);

21. Treatment due to pregnancy of dependent child;

22. Experimental procedures and procedures not customarily accepted as general practice in the area where the service is performed;

23. B-12 injections; non-prescription drug items, vitamins, minerals, food supplements, digestive enzymes and substances, natural animal or vegetable substance, bacterial, viral substances or homeopathic preparations;

24. Expenses in connection with marriage counseling;

25. Donor expenses;

26. Charges for medical records or discharge planning;

27. Charges in connection with the pregnancy of a surrogate employee or dependent spouse and delivery and care of child(ren) resulting thereof;

28. Charges in connection with the pregnancy of an employee or dependent spouse when the resulting child(ren) are placed for adoption and such charges are paid for by a third party;

29. Following delivery of a child, routine well baby care obtained in the Hospital at the time of delivery unless included as part of an in-Hospital per diem charge;

30. The cost for flu shots that exceed $150 and flu shot received by an individual not enrolled in the medical indemnity plan (HMO enrollees can get their flu shots through the HMO);

31. Any services or supplies that are not considered medically necessary as determined in the sole discretion of the Trustees;

32. Expenses for a reversal of a voluntary sterilization;

33. Charges for services or supplies paid for under any other benefits provided this Plan;

34. Temporomandibular joint dysfunction (TMJ);

35. Holistic medicine and compounding medicines are not covered;

36. Expenses in excess of $250 per Eligibility Period for the treatment of sexual dysfunction for Active Employees and Early or Regular Retirees. This benefit is only available to Active Employees and their spouses;

37. The administration of local infiltration anesthetics, or for the administration of anesthetics by a Doctor performing or assisting in performing a surgical operation procedure;

38. Diagnostics is not a covered expense if performed or referred by a chiropractor's office;

39. Nurse Practitioner or Physician Assistant;

40. Mobile Devices, Smartphones, IPad, Tablet's, Computers and Software Applications for usage of Durable Medical Equipment are not covered;

41. Apps or cellular phone updates.

Benefit Limitations

1. Treatment of a fractured jaw and related x-rays will be payable for services rendered within ninety (90) days of the accident, provided the accident occurred while the participant was covered and eligible for benefits.

2. Charges for surgical operations or procedures for sterilization if contracting providers are not utilized.

3. Charges for an assistant surgeon if required for a covered surgical procedure are limited to 20% of the listed value for the primary surgeon for the operation.

4. If multiple surgical procedures are performed through the same incision, the maximum payable will be the largest of the maximums for the individual operations.

   Multiple Procedures: Unless otherwise identified in the listings, when multiple procedures add significant time and/or complexity, and when each procedure is clearly identified and defined, the following values shall prevail:

   a. 100% (full value) for the first or major procedure

   b. 50% for the second procedure

   c. 25% for the third procedure

   d. 10% for the fourth procedure 5% for the fifth procedure

   e. Over five procedures – by report

   The second and each subsequent procedure should be identified by adding this modifier (51) and valued at the appropriate percent of its listed value. A report outlining each procedure and the clinical indications may be required.

5. Payments for treatments of a Chiropractor or Acupuncturist are limited to 4 visits per consecutive six-month period, payable at 80% of Reasonable Charges.

   a. The payment of chiropractic and acupuncture benefits is in lieu of all other benefits payable under this Plan.

   b. The Plan will consider for payment only those visits wherein the Eligible Individual is personally seen by the chiropractor or acupuncturist.

   c. X-rays performed by a chiropractor's office are not a covered expense.

6. Hearing aids are limited to one per ear, once every three years and a maximum payment of $1,500 per device once every three years. Coverage for medically necessary hearing tests is unlimited up to the yearly maximum shown in the Summary of Benefits.

7. Charges for flu shots that exceed $150.

Women's Health and Cancer Rights Act of 1998
Under Federal law, group health plans, insurers, and HMOs that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery, effective for the first plan year beginning on or after October 21, 1998. In the case of a participant or beneficiary who is receiving benefits under the plan in connection with a mastectomy and who elects breast reconstruction, federal law requires coverage in a manner determined in consultation with the attending physician and the patient for:

1. reconstruction of the breast on which the mastectomy was performed;

2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. prostheses and treatment of physical complications at all stages of the mastectomy including lymphedemas.

This coverage is subject to the plan's annual deductibles and coinsurance provisions.

DENTAL BENEFITS

For Active Plan A and A+ Employees and Non-Contract Employees and their Dependents
(Optional Benefits for Retirees not eligible for Medicare)

Enrollment in a dental plan is required if you want coverage for yourself and your dependents.

This section describes the Indemnity Dental benefits that are self-insured by the Fund. The dental benefits that are offered through the Delta Dental PPO plan and the DeltaCare prepaid DHMO plan are described in a later section.

Percentage Paid by Fund.....80% of Schedule of Dental Allowances

Calendar Year Deductible –

Plan A+.....$50/person
Plan A.....$75/person

Maximum Benefit per Person per Calendar Year $2,500.00

Orthodontic Maximum per Adult or Dependent
Child's Lifetime.....$3,000.00

NOTE: Orthodontia for cosmetic reasons for adults is not covered.

DEFINITIONS

Covered Dental Expense
The term "Covered Dental Expense" means only expenses incurred for necessary treatment which is received by you from a Dentist or a dental hygienist under the supervision of a Dentist and which, in the geographical area where treatment is rendered, is the usual and customary procedure for the condition being treated. However, the amount allowable as Covered Dental Expense will not exceed the total of the amounts specified in the Schedule of Dental Allowances for the procedures reported on any one attending Dentist's statement. A Covered Dental Expense is deemed to be incurred on the date on which the service or supply which gives rise to the expense is rendered.

Covered Expense for Orthodontic Procedures
The term "Covered Expense for Orthodontic Procedures" means only the expense incurred for any necessary treatment which is received by an Active Employee, a Non-Contract Employee or their dependents or a Retiree or his/her dependent if they paid for such coverage in the geographical area where the treatment is rendered, and is customary, as determined by the standards of generally accepted dental practice for the condition being treated. Expense incurred for diagnosis, consultation and necessary records (study models, x-rays, cephalometrics, photographs, etc.) required for orthodontic treatment, whether or not performed by a Dentist who limits his practice to the specialty of orthodontics, shall be considered Covered Expense for Orthodontic Procedures.

BENEFITS
If you incur Covered Dental Expense after satisfaction of the Calendar Year deductible, the Plan will pay the lesser of the applicable amount for the treatment, examination or procedure listed in the Schedule of Dental Allowances, or the Dentist's usual, customary and reasonable fees. The maximum amount payable for Covered Dental Expense incurred by each person in any Calendar Year is $2,500. Except that dentally necessary treatment for dependent children to age 18 is unlimited ; the unlimited coverage does not apply to orthodontic treatment or procedures.

Covered Expense for Orthodontic Procedures for an adult or a dependent child under age 18 is payable at the lesser of the amounts listed in Schedule of Dental Allowances, or the Dentist's usual, customary and reasonable fees. In no event, however, will the maximum amount paid in a person's lifetime exceed $3,000 for Covered Expense for Orthodontic Procedures whether or not coverage is unbroken. **A person must be covered each month in which Covered Expense for Orthodontic Procedures is incurred. Orthodontia for adults that is for cosmetic reasons is not a covered expense.**

DEDUCTIBLE
The Calendar Year deductible is the amount of covered expenses you must pay each year before benefits are payable by the Plan.

SCHEDULE OF SERVICES
Subject to the exclusions and limitations sections, the following is the Schedule of Services covered hereunder when rendered by a Dentist or a dental hygienist under the supervision of a Dentist, and when necessary and customary, as determined by the standards of generally accepted dental practice.

Basic Benefits

Diagnostic:
Procedures to assist the Dentist in evaluating the existing conditions to determine the required dental treatment.

Preventive:
Prophylaxis once every six months or more frequently if determined to be medically necessary; topical application of fluoride solutions; space maintainers.

Oral Surgery:
Procedures for extractions and other oral surgery including pre and post-operative care.

General Anesthesia:
When administered for a covered oral surgery procedure performed by a Dentist.

Restorative:
Provides amalgam, synthetic porcelain and plastic restorations for treatment of carious lesions. Gold restorations, crowns and jackets will be provided when teeth cannot be restored with the above materials.

Endodontics:
Procedures for pulpal therapy and root canal filling (treatment of non-vital teeth).

Periodontic:
Procedures for treatment of the tissues supporting the teeth.

Prosthetic Benefits:
Procedures for construction of bridges, implants, partial and complete dentures.

Orthodontic Benefits:
Procedures for straightening teeth, including diagnosis, consultation and necessary records.

LIMITATIONS
The benefits as outlined are subject to the following limitations:

All services that are anticipated to exceed $200 must be submitted to the Fund Manager's office for pre-determination. Should a major change in treatment occur, additional pre-determination is required.

In all cases in which the patient selects a more expensive plan of treatment than is customarily provided, the Plan will pay the lesser fee. You will be responsible for the remainder of the Dentist's fee.

1. Examinations are limited to once every 6 months.

2. Full mouth x-rays and/or Panorex are limited to once every 24 months, unless they are necessary for orthodontic diagnosis or a special need is shown.

3. All x-rays are limited to once every 12 months, unless special need is shown.

4. Prophylaxis and Periodontal maintenance share the same benefit and are limited to once every 6 months or more frequently if medically necessary.

5. Fluoride treatment is limited to dependent children only up to their 18th birthday.

6. Subgingival curettage and/or periodontal scaling, root planning and full mouth debridement are not allowed on the same day as a prophylaxis or periodontal maintenance and is limited to 4 quadrants in a 6 month period. Pocket depths must be at least 5 mm or greater in order for Subgingival curettage and/or periodontal scaling and/or root planning to be covered. Localized placement of chemotherapeutic agents is not covered at the same time any of these procedures are done.

7. Periodontal pocket depth charting is included in oral examination fee.

8. Sealants are limited to non-carious and unrestored posterior teeth for dependent children only under 16 years of age once every three years.

9. Porcelain, labial veneer, acrylic and resin crowns are limited to anterior teeth.

10. Replacement of crowns, bridges, partial dentures, implants and complete dentures are limited to once every 5 years.

11. Dependent children under the age of 12 are limited to stainless steel crowns on posterior teeth and acrylic crowns on anterior teeth and replacement is limited to once every 5 years.

12. Root canals require pre-treatment and final treatment x-rays.

13. All adjustments on complete and partial dentures within the first six months of installation are included in the allowance.

14. Tissue conditioning is limited to 2 per year after 6 months from installation date of complete denture.

15. Deep sedation, general anesthesia and intravenous conscious sedation, analgesia are limited to surgical procedures.

16. Emergency palliative treatment is covered only when no other treatment is provided for that tooth or area on the same date.

17. Replacement of an existing prosthetic appliance will be made only if it is un-satisfactory and cannot be made satisfactory. Prosthetic appliances (including partial and complete dentures, crowns, implants and bridges) will be replaced only after five years have elapsed following the date expense was incurred, unless:

    a. the prosthetic appliance was made necessary by the initial placement of an opposing full denture or the extraction of natural teeth; or

    b. the prosthetic appliance is a stayplate, or a similar partial denture; or

    c. the prosthetic appliance, while in the oral cavity, has been damaged as a result of an injury occurring while the person is covered under the Plan.

18. **Gold Crowns or Restorations:**
The Plan will provide the amount for an amalgam restoration, unless there is no other reasonable means to restore the proper contour of a tooth.

19. **Partial Dentures:**
The Plan will provide standard cast chrome or acrylic partial dentures or will allow the cost of such procedure toward a more complicated or precision appliance that you and the Dentist may choose to use. Any denture for which a charge is made which exceeds the customary fee, shall be considered an optional service.

20. **Complete Dentures:**
If in the construction of a denture, you and the Dentist decide on personalized restorations or employ specialized techniques as opposed to standard procedures, the Plan will allow an appropriate amount for the standard denture toward such treatment and the person shall bear the difference in cost. Any denture for which a charge is made which exceeds the customary fee shall be considered an optional service.

21. **Occlusion:**
The Plan will allow the cost of restorations required to replace missing teeth. Procedures, appliances, or restorations necessary to increase vertical dimension and/or restore or maintain the occlusion are considered optional, and the cost is the responsibility of the person. Such procedures include, but are not limited to: equilibration, periodontal splinting, restoration of tooth structure lost from attrition, and restoration for malalignment of the teeth.

22. Stayplates are not covered unless anterior teeth have been extracted.

23. Payment for Covered Dental Expense incurred as a result of tumors and accidental injury occurring while covered under the Plan shall be made only for such expenses actually incurred in excess of all other benefits provided under the Plan.

24. Acid etch – included with composite/resin fillings.

25. Bonding is included in the filling fee.

26. Analgesia, anxiolysis, nitrous oxide is covered for dependent children up to age 14.

27. Occlusal guards are limited to once every 5 years.

28. Benefits for the replacement of an existing amalgam or composite restoration will only be considered if at least 12 months have passed since the existing filling was placed.

EXCLUSIONS

No benefit shall be provided for:

1. services for injuries or conditions which are compensable under Worker's Compensation or Employer's Liability laws; services which are provided to the person by any Federal or State Government Agency or are provided without cost to the person by any municipality, county or other political subdivision, unless mandated by law;

2. services with respect to congenital or developmental malformations or cosmetic surgery or dentistry for purely cosmetic reasons, including but not limited to: cleft palate, maxillary and mandibular malformations, enamel hypoplasia, fluorosis and anodontia, attrition, erosion or abrasion;

3. prosthodontic and orthodontic services or devices (including crowns and bridges) or any single procedure started prior to the date the patient became eligible under the Plan;

4. general anesthesia and IV sedation for restorative procedures;

5. services and supplies not furnished by a Dentist or not necessary for dental care;

6. any orthodontic expenses incurred when the dependent child's coverage was not in effect;

7. fluoride treatments for a dependent child after the child reaches his/her eighteenth birthday;

8. Hospitalization in connection with any dental service or procedure;

9. orthodontic treatment or services for anyone not covered for the Dental Benefits;

10. fixed bridges or removable partials for dependent child under the age of sixteen;

11. porcelain or gold crowns for a dependent child under the age of twelve, however, acrylic or stainless steel crowns will be provided;

12. lost or stolen appliances;

13. adjustments to complete and partial dentures within the first six months from installation;

14. temporomandibular joint dysfunctions;

15. oral hygiene instruction and supplies;

16. bleaching of teeth;

17. broken or cancelled appointments;

18. insurance filing form fees;

19. base fillings;

20. periodontal irrigation; and

21. local anesthesia for dental.

EXTENDED BENEFITS

If you are receiving treatment for services required for the completion of a procedure which is considered a Covered Dental Expense or a Covered Expense for Orthodontic Procedures at the time your coverage terminates, Dental Benefits will be payable for such expense, but not beyond one month after termination of coverage. X-rays and prophylactic treatment is not considered to be the commencement of a procedure. If the person is Totally Disabled as a result of an accident on the date coverage terminates, Dental Benefits will be payable for repair or alleviation of damage to natural teeth as a result of such accident, but not beyond three months after termination of coverage.

APPENDIX A. SCHEDULE OF DENTAL ALLOWANCES

CODE	PROCEDURE	ALLOWANCE
DIAGNOSTIC (D0100-D0999)		
	EVALUATIONS (D0120 and D0150) Comprehensive Oral Evaluation (D0150) - Union Roofers considers this evaluation to include the elements contained in the ADA descriptor. It will be allowed for the initial evaluation of a patient by either a general dentist or an appropriate specialist. Union Roofers will regard subsequent evaluations as either procedure (0120) or problem focused (0140). Periodic Oral Evaluation (D0120) Union Roofers considers a nonemergency evaluation performed on a patient of record as a Periodic Oral Evaluation. INTRAORAL COMPLETE SERIES OF X-RAYS (D0210) Union Roofers considers a Complete Series of x-rays as: nine or more periapicals with or without bitewing x-rays (D0270 - D0274); or, Vertical bitewings (D0277) with four or more additional periapical x-rays. X-rays, bitewings (D0270—D0274), or periapicals, or a combination of a panoramic film and bitewing x-ray(s) (D0270 - D0277). Submission of any of the above combinations may result in a benefit determination for a D0210. Whenever we determine that a complete series of x-rays has occurred, no additional allowance will be made for any periapicals taken during that visit. BACTERIOLOGIC STUDIES FOR (D0415) Procedure D0415 should not be billed as a separate charge when performed in conjunction with an oral evaluation or endodontic therapy. This does not include the fee for the independent laboratory. PULP VITALITY TESTS (D0460) Procedure D0460 submitted on the same date of service as an evaluation or performed in conjunction with root canal therapy should not be billed as a separate charge.	
Submit pretreatment estimates for codes not shown above. Maximum benefit is $2,500 per person per calendar year. Dependent child covered from birth to age 18 has no maximum amount Deductible: Plan A+ - $50 per person per calendar year Plan A - $75 per person per calendar year Amount Payable by the Plan: 80% of the fee schedule for all treatment, except preventive is paid at 100% of the scheduled amount **Pre-Authorization is Required for All Treatment Plans that exceed $500.00**		

CODE	PROCEDURE	ALLOWANCE
CLINICAL ORAL EVALUATIONS (DO100-DO999 – Diagnostic)		
D0120	Periodic Oral Evaluation (Once Per Patient Per 6 month period)	$33
D0140	Limited Oral Evaluation - Problem Focused	$47
D0145	Oral Evaluation – patient under three counselling with primary caregiver	$42
D0150	Comprehensive Oral Evaluation: New or Established Patient	$48
D0160	Detailed and Extensive Oral Evaluation - Problem Focused, By Report	$78
D0170	Re-evaluation - Problem Focused (Established patient; not post-operative visit)	$40
D0180	Comprehensive Periodontal Evaluation	$52
DIAGNOSTIC IMAGING		
D0210	Intraoral Complete Series of radiographic images	$92
D0220	Intraoral Periapical - First Film	$20
D0230	Intraoral Periapical - Each Additional Film	$10
D0240	Intraoral - Occlusal Film	$27
D0250	Extra-oral – 2D projecting radiographic image	$58
D0251	Extra-oral posterior dental radiographic image	$58
D0270	Bitewing - Single Film	$20
D0272	Bitewings - Two Films	$30
D0273	Bite wings – three radiographic images	$31
D0274	Bitewings - Four Films	$39
D0277	Vertical Bitewings - 7 or 8 films	$39
D0290	Posterior – Anterior or Lateral Skull and Facial Bone Survey Film	$65
D0310	Sialography	$262
D0320	TMJ Arthrogram, Incl. Injection	Not covered
D0321	Other TMJ films by Report	Not covered
D0322	Tomographic Survey	Not covered
D0330	Panoramic Film	$76
D0340	Cephalometric Film	$81
D0350	Oral/Facial Images (Includes Intra- and Extra-oral Images)	$47
D0351	3D photographic image	$54
D0364	Cone beam CT capture and interpret w/limited FOV - <one whole jaw	$407
D0365	Cone beam CT capture and interpret w/FOV of 1 full dental arch - mandible	$407
D0366	Cone beam CT capture and interpret w/FOV of 1 full dental arch – maxilla	$407
D0367	Cone beam CT capture and interpret w/FOV of both jaws	$407
D0368	Cone beam CT capture and interpret for TMJ series incl. two + exposures	Not covered
D0369	Maxillofacial MRI capture and interpretation	$1,004
D0370	Maxillofacial ultrasound capture and interpretation	$363
D0380	Cone beam CT image capture with limited field of view - <one whole jaw	$251
D0381	Cone beam CT image capture with FOV of 1 full dental arch – mandible	$251
D0382	Cone beam CT image capture with FOV of 1 full dental arch – maxilla	$251
D0383	Cone beam CT image capture with FOV of both jaws, with/without cranium	$251
D0384	Cone beam CT image capture for TMJ series incl. two + exposures	Not covered
D0385	Maxillofacial MRI image capture	$690
D0386	Maxillofacial ultrasound image capture	$376
D0391	Interpretation of diagnostic image, including report	$251
D0393	Treatment simulation using 3D image volume	$339
D0394	Digital subtraction of two + images or image volumes of the same modality	$339
D0395	Fusion of two or more 3D image volumes of one or more modalities	$339

CODE	PROCEDURE	ALLOWANCE
TESTS AND EXAMINATIONS		
D0414	Laboratory processing of microbial specimen	$131
D0415	Bacteriologic Studies for Determination of Pathologic Agents	$47
D0416	Viral culture	$72
D0460	Pulp Vitality Tests	$29
D0470	Diagnostic Casts	$81
ORAL PATHOLOGY LABORATORY – BY REPORT		
D0472	Accession of tissue, gross examination, pre and report	B/R
D0473	Accession of tissue, gross and micro exam, prep and report	B/R
D0474	Accession of tissue, gross and micro exam, assess margins, prep and report	B/R
D0475	Decalcification procedure	B/R
D0476	Special stains for microorganisms	B/R
D0477	Special stains, not for microorganisms	B/R
D0478	Immunohistochemical stains	B/R
D0479	Tissue in situs hybridization, including interpretation	B/R
D0480	Accession of exfoliative cytologic smears, micro exam, prep and trans report	B/R
D0481	Electron microscopy	B/R
D0482	Direct immunofluoresence	B/R
D0483	Indirect immunofluoresence	B/R
D0484	Consultation on slides prepared elsewhere	B/R
D0485	Consultation, including preparation of slides from biopsy material supplied	B/R
D0486	Lab accession transepithelial cytologic sample, micro exam prep trans report	B/R
D0520	Other oral pathology procedures by report	B/R
PREVENTIVE (D1000-D1999)		
DENTAL PROPHYLAXIS		
D1110	Prophylaxis - Adult	$64
D1120	Prophylaxis - Child (through age 13)	$49
TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)		
D1203	Topical application of fluoride Excl. Prophy. – child (up to age 18)	$28
D1204	Topical Application of Fluoride, Excl. Prophy - Adult	
D1206	Topical application of fluoride vanish	$28
D1208	Topical application of fluoride – excluding varnish	$28
OTHER PREVENTIVE SERVICES		
D1310	Nutritional counseling for control of dental disease	Not covered
D1320	Tobacco counselling for the control and prevention of oral disease	Not covered
D1330	Oral hygiene instructions	Not covered
D1351	Sealant - Per Tooth	$38
SPACE MAINTENANCE (PASSIVE APPLIANCES)		
D1510	Space Maintainer - Fixed - Unilateral	$229
D1515	Space Maintainer - Fixed - Bilateral	$327
D1520	Space Maintainer- Removable - Unilateral	$229
D1525	Space Maintainer - Removable - Bilateral	$327
D1550	Re-cement or re-bond spaced maintainer	$47
D1555	Removal of fixed space maintainer	$51
SPACE MAINTAINERS		
D1575	distal shoe space maintainer – fixed – unilateral	$229

CODE	PROCEDURE	ALLOWANCE
RESTORATIVE (D2000-D2999)		
AMALGAM RESTORATIONS (INCLUDING POLISHING)		
DIAGNOSTIC DOCUMENTATION REQUIREMENTS **Most recent pre-operative x-rays are required for crowns, onlays and veneers and should be included with initial claim submission and pre-treatment estimates.**		
D2140	Amalgam - One Surface, Primary or Permanent	$94
D2150	Amalgam - Two Surfaces, Primary or Permanent	$114
D2160	Amalgam - Three Surfaces, Primary or Permanent	$136
D2161	Amalgam - Four or More Surfaces, Primary or Permanent	$159
RESIN-BASED COMPOSITE RESTORATIONS - DIRECT		
D2330	Resin-Based - One Surface, Anterior	$102
D2331	Resin-Based - Two Surfaces, Anterior	$128
D2332	Resin-Based - Three Surfaces, Anterior	$152
D2335	Resin-Based - Four or More Surfaces or Involving Incisal Angle (Anterior)	$174
D2390	Resin-Based Composite Crown - Anterior	$177
D2391	Resin-Based Composite - One Surface, Posterior	$108
D2392	Resin-Based Composite - Two Surfaces, Posterior	$147
D2393	Resin-Based Composite - Three Surfaces, Posterior	$176
D2394	Resin-Based Composite - Four or More Surfaces, Posterior	$192
GOLD FOIL RESTORATIONS		
D2410	Gold Foil - One Surface	$374
D2420	Gold Foil - Two Surfaces	$444
D2430	Gold Foil - Three Surfaces	$552
INLAY/ONLAY RESTORATIONS		
D2510	Inlay, Metallic - One Surface	$533
D2520	Inlay, Metallic - Two Surfaces	$584
D2530	Inlay, Metallic - Three or More Surfaces	$614
D2542	Onlay, Metallic - Two Surfaces	$684
D2543	Onlay, Metallic - Three Surfaces	$688
D2544	Onlay, Metallic - Four or More Surfaces	$795
D2610	Inlay, Porcelain/Ceramic-One Surface	$474
D2620	Inlay, Porcelain/Ceramic - Two Surfaces	$552
D2630	Inlay, Porcelain/Ceramic - Three or More Surfaces	$581
D2642	Onlay, Porcelain/Ceramic - Two Surfaces	$644
D2643	Onlay, Porcelain/Ceramic - Three Surfaces	$689
D2644	Onlay, Porcelain/Ceramic - Four or More Surfaces	$790
D2650	Inlay, Composite/Resin - One Surface (Lab Proc)	$462
D2651	Inlay, Composite/Resin - Two Surfaces (Lab Proc)	$548
D2652	Inlay, Composite/Resin - Three or More Surfaces (Lab Proc)	$605
D2662	Onlay, Composite/Resin - Two Surfaces (Lab Proc)	$554
D2663	Onlay, Composite/Resin - Three Surfaces (Lab Proc)	$659
D2664	Onlay, Composite/Resin - Four or More Surfaces (Lab Proc)	$714

CODE	PROCEDURE	ALLOWANCE
CROWNS – SINGLE RESTORATIONS ONLY		
D2710	Crown - Resin (Indirect)	$289
D2720	Crown - Resin with High Noble Metal	$712
D2721	Crown - Resin with Predominantly Base Metal	$627
D2722	Crown - Resin with Noble Metal	$665
D2740	Crown - Porcelain/Ceramic Substrate	$835
D2750	Crown - Porcelain Fused to High Noble Metal	$852
D2751	Crown - Porcelain Fused to Predominantly Base Metal	$807
D2752	Crown - Porcelain Fused to Noble Metal	$831
D2780	Crown - 3/4 Cast High Noble Metal	$818
D2781	Crown - 3/4 Cast Predominately Base Metal	$750
D2782	Crown - 3/4 Cast Noble Metal	$818
D2783	Crown - 3/4 Cast Porcelain/Ceramic	$762
D2790	Crown - Full Cast High Noble Metal	$843
D2791	Crown - Full Cast Predominantly Base Metal	$750
D2792	Crown - Full Cast Noble Metal	$818
D2794	Crown – Titanium	$750
D2799	Provisional Crown	$240
OTHER RESTORATIVE SERVICES		
D2910	Recementment or re-bond inlay, onlay, veneer or partial coverage restoration	$54
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$71
D2920	Recement or re-bond Crown	$54
D2921	Reattachment of both tooth fragment, incisal edge or cusp	$71
D2929	Prefabricated porcelain/ceramic crown – primary tooth	$268
D2930	Prefabricated Stainless Steel Crown, Primary Tooth	$179
D2931	Prefabricated Stainless Steel Crown, Permanent Tooth	$219
D2932	Prefabricated Resin Crown	$203
D2933	Prefabricated Stainless Steel Crown with Resin Window	$211
D2940	Sedative protective restoration	$70
D2941	Interim therapeutic restoration – primary dentition	$71
D2949	Restorative foundation for an indirect restoration	$25
D2950	Core Buildup, Including any Pins	$136
D2951	Pin Retention - Per Tooth, in Addition to Restoration	$38
D2952	Cast Post and Core in Addition to Crown	$280
D2953	Cast Post and Core, each additional - same tooth	$26
D2954	Prefabricated Post and Core in Addition to Crown	$220
D2955	Post Removal (Not in Conjunction with Endodontic Therapy)	$110
D2957	Prefabricated Post and Core, each additional - same tooth	$16
D2960	Labial Veneer (Laminate) - Chairside	$352
D2961	Labial Veneer (Resin Laminate) - Lab	$531
D2962	Labial Veneer (Porcelain Laminate) - Lab	$726
D2970	Temporary Crown (Fractured Tooth)	$40
D2971	Add' l procedures to construct new crown under existing partial denture	$35
D2975	Coping	$213
D2980	Crown Repair, By Report	$139
D2981	Inlay repair necessitated by restorative material failure	$98
D2982	Onlay repair necessitated by restorative material failure	$98
D2983	Veneer repair necessitated by restorative material failure	$98

CODE	PROCEDURE	ALLOWANCE
	ENDODONTICS (D3000-D3999)	
	ROOT CANAL THERAPY INCLUDES The following procedure(s) should not be billed as a separate charge when performed in conjunction with root canal therapy on the same tooth: Intraoperative treatment x-rays (D0220/D0230); Pulp Testing (D0460); Pulpotomy (D3220); Canal Preparation (D3950); Palliative Treatment (D9110) **APEXIFICATION/RECALCIFICATION (D3351-D3353)** This procedure is performed in three stages consisting of an initial visit, interim visit(s) and a final visit, which includes completed root canal therapy. It is important to submit all visits along with your fee for each stage to ensure accurate claim processing. **CANAL PREPARATION AND FITTING OF PREFORMED DOWEL OR POST (D3950)** Procedure D3950 should not be billed as a separate charge when performed in conjunction with a post and core (D2952/D2954) or root canal therapy on the same tooth.	
PULP CAPPING		
D3110	Pulp Cap - Direct (Excl. Final Restoration)	$37
D3120	Pulp Cap - Indirect (Excl. Final Restoration)	$33
PULPOTOMY		
D3220	Therapeutic Pulpotomy (Excl. Final Restoration)	$122
D3221	Pulpal Debridement, Primary and Permanent Teeth	$121
D3222	Partial pulpotomy for apexogeneis – perm tooth with incomplete root dev	$123
ENDODONTIC THERAPY ON PRIMARY TEETH		
D3230	Pulpal Therapy (Resorbable Filling) - Anterior, Primary Tooth (Excl. Final Restoration)	$188
D3240	Pulpal Therapy (Resorbable Filling) - Posterior, Primary Tooth (Excl. Final Restoration)	$229
ENDONTIC THERAPY		
D3310	Anterior (Excl. Final Restoration)	$516
D3320	Bicuspid (Excl. Final Restoration)	$601
D3330	Molar (Excl. Final Restoration)	$811
D3331	Treatment of Root Canal Obstruction; Non-Surgical Process	$40
D3332	Incomplete Root Canal Therapy Inoperable or Fractured Tooth	$262
D3333	Internal Root Repair of Perforation Defects	$97
ENDODONTIC RETREATMENT		
D3346	Retreatment of Previous Root Canal Therapy - Anterior	$557
D3347	Retreatment of Previous Root Canal Therapy - Bicuspid	$639
D3348	Retreatment of Previous Root Canal Therapy - Molar	$912
APEXIFICATION/RECALCIFICATION		
D3351	Apexification/Recalcification - Initial Visit (Apical Closure/Calcific Repair of Perforations, Root Resorption, etc.)	$232
D3352	Apexification/Recalcification - Interim Medication Replacement (Apical Closure/Calcific Repair of Perforations, Root Resorption, Etc.)	$123
D3353	Apexification/Recalcification - Final Visit (Incl. Completed Root Canal Therapy - Apical Closure/Calcific Repair of Perforations, Root Resorption, etc.)	$374
PULPAL REGENERATION		
D3355	Pupal regeneration – initial visit	$232
D3356	Pupal regeneration – interim medication replacement	$123
D3357	Pupal regeneration – completion of treatment	$123

CODE	PROCEDURE	ALLOWANCE
APICOECTOMY/PERIRADICULAR SERVICES		
D3410	Apicoectomy/Periradicular Surgery - Anterior	$468
D3421	Apicoectomy/Periradicular Surgery - Bicuspid (1st Root)	$543
D3425	Apicoectomy/Periradicular Surgery - Molar (1st Root)	$622
D3426	Apicoectomy/Periradicular Surgery (Each Additional Root)	$224
D3427	Periradicular surgery without aplocetomy	$268
D3428	Bone graft in conjunction with periradicular surgery – per tooth, single site	$262
C3429	Bone graft in conjunction with periradicular surgery – each addl. same site	$229
D3430	Retrograde Filling - Per Root	$140
D3431	Biologic materials to aid in soft and osseous tissue regeneration	$229
D3432	Guided tissue regeneration, restorable barrier, per site	$229
D3450	Root Amputation - Per Root	$234
D3460	Endodontic endosseous implant	$1,474
D3470	Intentional Re-implantation (Incl. Necessary Splinting)	$468
OTHER ENDODONTIC PROCEDURES		
D3910	Surgical Procedure for Isolation of Tooth with Rubber Dam	$152
D3920	Hemisection (Incl. Any Root Removal), Not Incl. Root Canal Therapy	$284
D3950	Canal Preparation and Fitting of Pre-Formed Dowel or Post	$140
PERIODONTICS (D4000-D4999)		
	PER QUADRANT SURGICAL PROCEDURES Union Roofers defines a full quadrant as four or more teeth. Procedures involving one to three teeth per quadrant will have their own codes and fees. Quadrant indicators (UR, UL LL, LR) are required on claim submissions. Union Roofers will determine the benefit on a quadrant-related procedure for the number of teeth, which require that procedure, based on our dental consultant's review of submitted documentation. **PERIODONTAL CHARTING** Union Roofers considers periodontal charting part of the evaluation process and should not be billed a separate charge for periodontal charting. **DIAGNOSTIC DOCUMENTATION REQUIREMENTS** Most recent periodontal charting (dated) and full mouth x-rays, or as complete a series as is available, should be included in the initial claim submission and pre-determination of periodontal procedures. For procedures D4270, D4271 and D4273, include a narrative report indicating the location, nature and extent of the mucogingival problem. For procedure D4249, include a recent pre-operative x-ray.	
	SPECIAL NOTES REGARDING "PER SITE" PERIODONTAL CODES Union Roofers has traditionally considered allowances for procedures D4263, D4264, D4266, D4267, D4381 on the basis of one site = one tooth. Our documented fee data has been based on this. Therefore, future allowances will continue to be considered as such. Procedures for soft tissue grafting have traditionally been considered on a "per site" basis. This, according to the Current Procedural Terminology of the American Academy of Periodontology, included one or two contiguous teeth. Our fee data has been based upon this established precedent.	

CODE	PROCEDURE	ALLOWANCE
SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE CARE)		
D4210	Gingivectomy or Gingivoplasty - Four or More Contiguous Teeth or Bounded Teeth Spaces Per Quadrant	$420
D4211	Gingivectomy or Gingivoplasty - One to Three Teeth, Per Quadrant	$189
D4212	Gingivectomy or Gingivoplasty allow access for restorative proc., per tooth	$262
D4230	Anatomical crown exposure – 4 + contiguous teeth/spaces, per quadrant	$684
D4231	Anatomical crown exposure – 1-3 teeth/spaces per quadrant	$410
D4240	Gingival Flap Procedure, Incl. Root Planning - Four or More Teeth Per Quadrant	$446
D4241	Gingival Flap Procedure, lncl. Root Planning - One to Three Teeth, Per Quadrant	$253
D4245	Apically Positioned Flap	$178
D4249	Clinical Crown Lengthening - Hard Tissue - (Up to Three Contiguous Teeth)	$570
D4260	Osseous Surgery (Incl. Flap Entry and Closure) - Four or More Contiguous Teeth or Bounded Teeth Spaces Per Quadrant	$810
D4261	Osseous Surgery (Incl. Flap Entry and Closure) - One to Three Teeth, Per Quadrant	$355
D4263	Bone Replacement Graft - First Tooth in Quadrant – natural teeth	$262
D4264	Bone Replacement Graft - Each Additional Tooth in Quadrant – natural teeth	$229
D4265	Biologic Materials to Aid in Soft and Osseous Tissue Regeneration	$229
D4266	Guided Tissue Regeneration - Resorbable Barrier, Per Tooth	$262
D4267	Guided Tissue Regeneration – Non-Resorbable Barrier, Per Tooth (Includes Membrane Removal)	$446
D4268	Surgical Revision Procedure, Per Tooth	$262
D4270	Pedicle Soft Tissue Graft Procedure - Per Tooth	$468
D4271	Free Soft Tissue Graft Procedure (Including Donor Site Surgery) - (Up to Two Contiguous Teeth)	$515
D4273	Autogenous connective tissue graft procedure, first tooth or position in graft	$467
D4274	Distal or Proximal Wedge Procedure (When Not Performed in Conjunction with Surgical Procedures in the Same Anatomical Area) - Submit Quadrant Involved	$202
D4275	Non-autogenous connective tissue graft, first tooth or position in graft	$471
D4276	Combined Connective Tissue and Double Pedicle Graft (For up to Two Teeth)	$749
D4277	Free soft tissue graft procedure first tooth, implant or position in graft	$301
D4278	Free soft tissue graft procedure each add ’l continuous tooth or position	$100
D4283	Autogenous connective tissue graft proc – each add ‘l graft site	$155
D4285	Non-autogenous connective tissue graft proc – each add ‘l same graft site	$157
NON-SURGICAL PERIODONTAL SERVICES		
D4320	Provisional Splinting - Intracoronal - Per Tooth (Maximum of Six Teeth)	$318
D4321	Provisional Splinting - Extracoronal - Per Tooth (Maximum of Six Teeth)	$223
D4341	Periodontal Scaling and Root Planning - Four or More Teeth Per Quadrant	$161
D4342	Periodontal Scaling and Root Planning - One to Three Teeth, Per Quadrant	$71
D4346	Scaling in presence of generalized mod. or severe inflammation – full mouth	$82
D4355	Full Mouth Debridement to Enable Comprehensive Evaluation and Diagnosis	$82
D4381	Localized Delivery of antimicrobial agents via controlled release vehicle	$79
OTHER PERIODONTAL SERVICES		
D4910	Periodontal Maintenance	$93
D4920	Unscheduled Dressing Change (Other Than Treating Dentist or their staff)	$46

CODE	PROCEDURE	ALLOWANCE
PROSTHODONTICS, REMOVABLE (D5000-D5899)		
	INITIAL AND REPLACEMENT DENTURES For initial dentures, please indicate extraction dates on the submitted claim. For replacement dentures, please indicate date of original dentures on submitted claim. **COMPLETE DENTURE ADJUSTMENTS (D5410-D5411)** Union Roofers considers all adjustments performed on complete dentures within the first six months part of the total treatment of inserting the denture. **PARTIAL DENTURES (D5211-D5281)** Partial dentures includes an allowance for all teeth and all clasps.	
COMPLETE DENTURES		
D5110	**MATERIALS AND LABORATORY COSTS** There should not be a separate charge for materials and laboratory cost since they are included in the services provided. Complete Denture, Upper (Includes All Adjustments for the First Six Months)	$1,011
D5120	Complete Denture Mandibular, Lower (Includes All Adjustments for the First Six Months)	$1,049
D5130	Immediate Denture, Maxillary Upper (Includes All Adjustments for the First Six Months)	$1,097
D5140	Immediate Denture, Mandibular Lower (Includes All Adjustments for the First Six Months)	$1,100
PARTIAL DENTURES		
D5211	Upper Partial Denture - Resin Base (Incl. Any Conventional Clasps, Rests and Teeth)	$849
D5212	Lower Partial Denture - Resin Base (Incl. Any Conventional Clasps, Rests and Teeth)	$849
D5213	Upper Partial Denture - Cast Metal Framework with Resin Denture Bases (Incl. Any Conventional Clasps, Rests and Teeth)	$1,116
D5214	Lower Partial Denture - Cast Metal Framework with Resin Denture Bases (Incl. Any Conventional Clasps, Rests and Teeth)	$1,117
D5221	Immediate maxillary partial denture – resin base	$900
D5222	Immediate mandibular partial denture – resin base	$900
D5223	Immediate maxillary partial denture – case metal with resin bases	$1,183
D5224	Immediate mandibular partial denture – cast metal with resin bases	$1,183
D5225	Maxillary partial denture – flexible base	$999
D5226	Mandibular partial denture – flexible base	$999
D5281	Removable Unilateral Partial Denture - One Piece Cast Metal (Incl. Clasps and Teeth)	$367
ADJUSTMENTS TO DENTURES		
D5410	Adjust Complete Denture - Upper (Only After Six Months Following Insertion)	$47
D5411	Adjust Complete Denture - Lower (Only After Six Months Following Insertion)	$47
D5421	Adjust Partial Denture – Upper	$47
D5422	Adjust Partial Denture – Lower	$47
REPAIRS TO COMPLETE DENTURES		
D5510	Repair Broken Complete Denture Base	$129
D5511	Repair broken complete denture base, mandibular	$129
D5512	Repair broken complete denture base, maxillary	$129
D5520	Replace Missing or Broken Teeth, Complete Denture (Each Tooth)	$112

CODE	PROCEDURE	ALLOWANCE
REPAIRS TO PARTIAL DENTURES		
D5611	Repair resin partial denture base, mandibular	$118
D5612	Repair resin partial denture base maxillary	$118
D5621	Repair cast partial framework mandibular	$136
D5622	Repair cast partial framework, maxillary	$136
D5630	Repair or Replace Broken Clasp	$120
D5640	Replace Broken Teeth - Per Tooth	$112
D5650	Add Tooth to Existing Partial Denture	$112
D5660	Add Clasp to Existing Partial Denture	$152
D5670	Replace All Teeth and Acrylic an Cast Metal Framework (Maxillary)	$591
D5671	Replace All Teeth and Acrylic on Cast Metal Framework (Mandibular)	$591
DENTURE REBASE PROCEDURES		
D5710	Rebase Complete Upper Denture	$346
D5711	Rebase Complete Lower Denture	$346
D5720	Rebase Upper Partial Denture	$333
D5721	Rebase Lower Partial Denture	$333
DENTURE RELINE PROCEDURES		
D5730	Reline Complete Upper Denture (Chairside)	$215
D5731	Reline Complete Lower Denture (Chairside)	$215
D5740	Reline Upper Partial Denture (Chairside)	$188
D5741	Reline Lower Partial Denture (Chairside)	$188
D5750	Reline Upper Complete Denture (Lab)	$303
D5751	Reline Lower Complete Denture (Lab)	$303
D5760	Reline Upper Partial Denture (Lab)	$307
D5761	Reline Lower Partial Denture (Lab)	$307
INTERIM PROSTHESIS		
D5810	Temporary Complete Denture (Upper)	$562
D5811	Temporary Complete Denture (Lower)	$562
D5820	Temporary Partial Denture (Upper)	$467
D5821	Temporary Partial Denture (Lower)	$467
OTHER REMOVABLE PROSTHETIC SERVICES		
D5850	Tissue Conditioning, Upper	$122
D5851	Tissue Conditioning, Lower	$122
D5862	Precision Attachment, By Report	$416
D5863	Overdenture – complete maxillary	$1,132
D5864	Overdenture – partial maxillary	$1,119
D5865	Overdenture – complete mandibular	$1,131
D5866	Overdenture – partial mandibular	$1,119
D5867	Replacement of Replaceable Part of Semi-Precision/Precision Attachment (male or female component)	$178
D5875	Modification of Removable Prosthesis Following Implant Surgery	$491

CODE	PROCEDURE	ALLOWANCE
	IMPLANT SERVICES (D6000-D6199)	
	PLACEMENT OF A SINGLE CROWN OVER AN IMPLANT Union Roofers recommends that pre-treatment estimates be submitted for these procedures to assist the patient and the dentist in treatment decisions and determining the patient's financial responsibility. **PLACEMENT OF ABUTMENT CONNECTOR (D6020, D6056, D6057)** When an implant requires an Abutment Connector in order to support a prosthetic device such as a single crown, you should submit code D6020 (Abutment Placement or Substitution) or D6056 or D6057 in addition to the prosthetic device and implant charge. **DIAGNOSTIC DOCUMENTATION REQUIREMENTS** Most recent pre-operative x-rays of the remaining teeth in the respective upper or lower arch are required for implants and should be included on initial claim submission and pre-treatment estimates.	
SURGICAL SERVICES		
D6010	Surgical Placement of Implant Body: Endosteal Implant	$1,769
D6011	Second stage implant surgery	$131
D6013	Surgical placement of mini implant	$655
D6040	Surgical Placement: Eposteal Implant	$2,872
D6050	Surgical Placement: Transosteal Implant (Incl. Hardware)	$3,275
IMPLANT SUPPORTED PROSTHETICS		
D6051	Interim abutment	$409
D6052	Semi-precision attachment abutment	$298
D6053	Implant/Abutment Supported Removable Denture for Completely Edentulous Arch	$1,144
D6054	Implant/Abutment Supported Removable Denture for Partially Edentulous Arch	$1,062
D6055	Dental Implant Supported Connecting Bar	$731
D6056	Prefabricated Abutment	$472
D6057	Custom Abutment	$591
D6058	Abutment Supported Porcelain/Ceramic Crown	$853
D6059	Abutment Supported Porcelain Fused to Metal Crown (High Noble Metal)	$853
D6060	Abutment Supported Porcelain Fused to Metal Crown (Predominantly Base Metal)	$831
D6061	Abutment Supported Porcelain Fused to Metal Crown (Noble Metal)	$831
D6062	Abutment Supported Cast Metal Crown (High Noble Metal)	$818
D6063	Abutment Supported Cast Metal Crown (Predominantly Base Metal)	$750
D6064	Abutment Supported Cast Metal Crown (Noble Metal)	$818
D6065	Implant Supported Porcelain/Ceramic Crown	$762
D6066	Implant Supported Porcelain Fused to Metal Crown TI,TI alloy PFM (High Noble Metal)	$831
D6067	Implant Supported Metal Crown TI,TI alloy PFM (High Noble Metal)	$831
D6068	Abutment Supported Retainer for Porcelain/Ceramic FPD	$831
D6069	Abutment Supported Retainer for Porcelain Fused to Metal FPD (High Noble Metal)	$831
D6070	Abutment Supported Retainer for Porcelain Fused to Metal FPD (Predominantly Base Metal)	$831
D6071	Abutment Supported Retainer for Porcelain Fused to Metal FPD (Noble Metal)	$831
D6072	Abutment Supported Retainer for Cast Metal FPD (High Noble Metal).	$818
D6073	Abutment Supported Retainer for Cast Metal FPD (Predominantly Base Metal)	$818
D6074	Abutment Supported Retainer for Cast Metal FPD (Noble Metal)	$818
D6075	Implant Supported Retainer for Ceramic FPD	$818
D6076	Implant Supported Retainer for Metal FPD TI,TI alloy PFM (High Noble Metal)	$832
D6077	Implant Supported Retainer for Cast Metal FPD TI,TI alloy PFM (High Noble Metal)	$831
D6078	Implant/Abutment Supported Fixed Denture for Completely Edentulous Arch	$1,144
D6090	Repair Implant Supported Prosthesis, By Report	$198
D6095	Repair Implant Abutment, By Report	$212
D6096	Remove broken implant retaining screw	$134

CODE	PROCEDURE	ALLOWANCE
D6100	Implant Removal, By Report	$604
D6101	Debridement of peril implant defect, surface clean, exposed implant surfaces	$263
D6102	Debridement and osseous contouring of a peril implant defect	$355
D6103	Bone graft to repair of peril-implant defect	$262
D6104	Bone graft at time of implant placement	$262
D6110	Implant/abutment sup removable denture edentulous arch – maxillary	$1,661
D6111	Implant /abutment sup removable denture edentulous arch – mandibular	$1,661
D6112	Implant /abutment sup removable den partially edentulous arch – maxillary	$1661
D6113	Implant /abutment sup removable den partially edentulous arch – mandibular	$1,661
D6114	Implant/abutment sup fixed denture edentulous arch – maxillary	$1,637
D6115	Implant/abutment sup fixed denture edentulous arch – mandibular	$1,637
D6116	Implant/abutment sup fixed denture partially edentulous arch – maxillary	$1,451
D6117	Implant/abutment sup fixed denture partially edentulous arch – mandibular	$1,451
D6118	Implant/abutment sup interim fixed denture for edentulous arch - mandibular	$655
D6119	Implant/abutment sup interim fixed denture for edentulous arch – maxillary	$655
D6194	Abutment supported retainer crown for FPD (TI)	$750
	PROSTHODONTICS, FIXED (D6200-D6999)	
FIXED PARTIAL DENTURE PONTICS		
	DIAGNOSTIC DOCUMENTATION REQUIREMENTS Most recent pre-operative x-rays of the remaining teeth in the respective upper or lower arch are required for fixed bridgework and should be included on initial claim submission and pre-treatment estimates.	
D6210	Pontic - Cast High Noble Metal	$724
D6211	Pontic - Cast Predominantly Base Metal	$724
D6212	Pontic - Cast Noble Metal	$724
D6214	Pontic – titanium	$725
D6240	Pontic- Porcelain Fused to High Noble Metal	$733
D6241	Pontic - Porcelain Fused to Predominantly Base Metal	$733
D6242	Pontic - Porcelain Fused to Noble Metal	$733
D6245	Pontic- Porcelain/Ceramic	$687
D6250	Pontic - Resin with High Noble Metal	$621
D6251	Pontic - Resin with Predominantly Base Metal	$521
D6252	Pontic - Resin with Noble Metal	$576
D6253	Provisional Pontic	$242
FIXED PARTIAL DENTURE RETAINERS – INLAYS/ONLAYS		
D6545	Retainer - Cast Metal for Resin Bonded Fixed Prosthesis	$336
D6548	Retainer - Porcelain/ Ceramic for Resin Bonded Fixed Prosthesis	$336
D6549	Resin retainer – for resin bonded fixed prosthesis	$304
D6600	Inlay - Porcelain/Ceramic Two Surfaces	$537
D6601	Inlay - Porcelain/Ceramic, Three or More Surfaces	$581
D6602	Inlay - Cast High Noble Metal, Two Surfaces	$569
D6603	Inlay - Cast High Noble Metal Three or More Surfaces	$614
D6604	Inlay- Cast Predominantly Base Metal, Two Surfaces	$569
D6605	Inlay - Cast Predominantly Base Metal, Three or More Surfaces	$614
D6606	Inlay - Cast Noble Metal, Two Surfaces	$569
D6607	Inlay - Cast Noble Metal Three or More Surfaces	$612
D6608	Onlay - Porcelain/Ceramic, Two Surfaces	$684
D6609	Onlay - Porcelain/Ceramic, Three or More Surfaces	$688
D6610	Onlay - Cast High Noble Metal, Two Surfaces	$676
D6611	Onlay - Cast High Noble Metal Three or More Surfaces	$689
D6612	Onlay- Cast Predominantly Base Metal, Two Surfaces	$660

CODE	PROCEDURE	ALLOWANCE
D6613	Onlay - Cast Predominantly Base Metal, Three or More Surfaces	$688
D6614	Onlay - Cast Noble Metal, Two Surfaces	$651
D6615	Onlay - Cast Noble Metal, Three or More Surfaces	$689
D6624	Retainer inlay – titanium	$532
D6634	Retainer onlay - titanium	$688
D6720	Crown - Resin with High Noble Metal	$621
D6721	Crown - Resin with Predominantly Base Metal	$521
D6722	Crown - Resin with Noble Metal	$576
FIXED PARTIAL DENTURE RETAINERS - CROWNS		
D6740	Crown - Porcelain/Ceramic	$835
D6750	Crown - Porcelain Fused to High Noble Metal	$825
D6751	Crown - Porcelain Fused to Predominantly Base Metal	$762
D6752	Crown - Porcelain Fused to Noble Metal	$831
D6780	Crown - 3/4 Cast High Noble Metal	$818
D6781	Crown - 3/4 Cast Predominantly Base Metal	$713
D6782	Crown - 3/4 Cast Noble Metal	$720
D6783	Crown - 3/4 Cast - Porcelain/Ceramic	$701
D6790	Crown - Full Cast High Noble Metal	$818
D6791	Crown - Full Cast Predominantly Base Metal	$751
D6792	Crown - Full Cast Noble Metal	$818
D6793	Provisional Retainer Crown	$242
D6794	Retainer crown – titanium	$750
OTHER FIXED PARTIAL DENTURE SERVICES		
D6920	Connector Bar	$425
D6930	Recement Bridge or rebond	$96
D6940	Stress Breaker	$262
D6950	Precision Attachment	$368
D6970	Cast Post and Core in Addition to Bridge Retainer	$255
D6971	Cast Post as Part of Bridge Retainer	$248
D6972	Prefabricated Post and Core, in Addition to Bridge Retainer	$165
D6973	Core Build Up for Retainer, Incl. Any Pins	$107
D6975	Coping - Metal	$284
D6976	Each Additional Cast Post - Same Tooth	$26
D6977	Each Additional Prefabricated Post - Same Tooth	$16
D6980	Bridge Repair	$174

CODE	PROCEDURE	ALLOWANCE
ORAL AND MAXILLOFACIAL SURGERY (D7000-D7999)		
	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS When fewer than three contiguous teeth are extracted in a given quadrant, the provider should not bill a separate charge for the Alveoloplasty unless the Alveoloplasty extends into adjacent edentulous areas.	
EXTRACTIONS		
D7111	Coronal Remnants - Deciduous Tooth	$41
D7140	Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)	$96
D7210	Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth	$183
D7220	Removal of Impacted Tooth - Soft Tissue	$183
D7230	Removal of Impacted Tooth - Partially Bony	$341
D7240	Removal of Impacted Tooth - Completely Bony	$341
D7241	Removal of Impacted Tooth - Completely Bony, with Unusual Surgical Complications	$313
D7250	Surgical Removal of Residual Tooth Roots (Cutting Procedure)	$186
D7251	Coronectomy – intentional partial tooth removal	$295
OTHER SURGICAL PROCEDURES		
D7260	Oroantral Fistula Closure	$819
D7261	Primary Closure of Sinus Perforation	$485
D7270	Tooth Re-implantation and/or Stabilization of Accidentally Avulsed or Displaced	$332
D7272	Tooth Transplantation (Including Re-implantation from One Site to Another and Splinting and/or Stabilization)	$543
D7280	Surgical Access of an Un-erupted Tooth	$350
D7281	Surgical Exposure of Impacted or Un-erupted Tooth to Aid Eruption	$276
D7282	Mobilization of Erupted or Mal-positioned Tooth to Aid Eruption	$40
D7283	Placement of device to facilitate eruption of impacted tooth	$96
D7285	Incisional biopsy of oral tissue – hard (bone, tooth)	$243
D7286	Incisional biopsy of oral issue – soft	$327
D7290	Surgical Repositioning of Teeth	$304
D7291	Transseptal Fiberotomy/Supra Crestal Fiberotomy, By Report (orthodontic)	$87
D7296	Corticotomy – one to three teeth or tooth spaces, per quadrant (orthodontic)	$188
D7297	Corticotomy – four or more teeth or tooth spaces, per quadrant (orthodontic)	$245
ALVEOLOPLASTY - PREPARATION OF RIDGE		
D7310	Alveoloplasty in Conjunction with Extractions - Per Quadrant	$176
D7320	Alveoloplasty Not in Conjunction with Extractions - Per Quadrant	$215
D7321	Alveoloplasty not in conjunction with extractions – 1-3 teeth per quadrant	$154
D7340	Vestibuloplasty - Ridge Extension (Secondary Epithelializabon)	$705
EXCISION OF SOFT TISSUE LESIONS		
D7410	Excision of benign lesion up to 1.25 cm	$235
D7411	Excision of benign lesion greater than 1.25 cm	$458
D7412	Excision of benign lesion, complicated	$510
D7413	Excision of malignant lesion up to 1.25 cm	$467
D7414	Excision of malignant lesion greater than 1.25 cm	$660
D7415	Excision of malignant lesion, complicated	$664

CODE	PROCEDURE	ALLOWANCE
EXCISION OF INTRA-OSSEOUS LESIONS		
D7440	Excision of malignant tumor – up to 1.25 cm	$370
D7441	Excision of malignant tumor – greater than 1.25 cm	$748
D7450	Removal of Benign Odontogenic Cyst or Tumor - Lesion Diameter Up to 1.25 cm Include pathology report with submission[1].	$239
D7451	Removal of Benign Odontogenic Cyst or Tumor - Lesion Diameter Greater Than 1.25 cm - Include pathology report with submission.	$624
D7460	Removal of benign nonodonogenic cyst or tumor – up to 1.25 cm	$313
D7461	Removal of benign nonodonogenic cyst or tumor – greater than 1.25 cm	$388
D7465	Destruction of lesion(s) by physical of chemical method, by report	$360
EXCISION OF BONE TISSUE		
D7471	Removal of Lateral Exostosis - (Maxilla or Mandible)	$407
D7472	Removal of Torus Palatinus	$410
D7473	Removal of Torus Mandibularis	$367
D7485	Surgical Reduction of Osseous Tuberosity	$370
D7490	Radical resection of maxilla or mandible	$5,801
SURGICAL INCISION		
D7510	Incision and Drainage of Abscess - Intraoral Soft Tissue	$102
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated	$206
D7530	Removal of foreign body from mucosa skin, subcutaneous alveolar tissue	$347
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	$675
D7560	Maxillary simusotomy for removal of tooth fragment or foreign body	$2,194
TREATMENT OF CLOSED FRACTURES		
D7610	Maxilla – open reduction (teeth immobilized, if present)	$3,602
D7620	Maxilla – closed reduction (teeth immobilized, if present)	$2685
D7630	Mandible open reduction (teeth immobilized if present)	$4,650
D7640	Mandible – closed reduction (teeth immobilized, if present)	$2,947
D7650	Malar and/or zygomatic arch – open reduction	$2,947
D7660	Malar and/or zygomatic arch – closed reduction	$1,778
D7680	Facial bones – complicated reduction	$6,681
TREATMENT OF OPEN FRACTURES		
D7710	Maxilla – open reduction	$4,192
D7720	Maxilla – closed reduction	$2,058
D7730	Mandible - open reduction	$6,058
D7740	Mandible – closed reduction	$3,013
D7750	Malar and/or zygomatic arch – open reduction	$3,799
D7760	Malar and/or zygomatic arch – closed reduction	$2,807
D7780	Facial bones – complicated reduction with fixation and multiple approaches	$8,940
REPAIR OF TRAUMATIC WOUNDS		
D7910	Suture of recent small wounds up to 5 cm	$262
COMPLICATED SUTURING		
D7911	Complicated suture – up to 5 cm	$540
D7912	Complicated suture – greater than 5 cm	$655

[1] Maximum allowable calendar year benefit is $1,500.

CODE	PROCEDURE	ALLOWANCE
OTHER REPAIR PROCEDURES		
D7960	Frenulectomy (Frenectomy or Frenotomy) – Separate Procedure	$228
D7963	Frenuloplasty	$228
D7970	Excision of Hyperplastic Tissue, Per Arch	$436
D7971	Excision of Pericoronal Gingiva	$120
D7972	Surgical Reduction of Fibrous Tuberosity	$289
D7979	Non-surgical sialolithotomy	$123
D7980	Surgical sialolithotomy	$523
D7982	Sialodochoplasty	$1,478
D7983	Closure of salivary fistula	$1,539
D7990	Emergency tracheotomy	$1,342
ORTHODONTICS (D8000-D8999)		
	FULL COURSE OF ORTHODONTIC TREATMENT B/R Orthodontic Maximum per Adult or Child's Lifetime is $3,000.00 PRE-AUTHORIZATION IS MANDATORY. Orthodontia for adult eligible individuals age 19 years and older must be MEDICALLY NECESSARY. Treatment for cosmetic purposes is not a covered benefit. Supporting documentation along with the Medical Doctor's referral and his diagnosis must be submitted for review at the time of submission for pre-authorization.	
LIMITED ORTHODONTIC TREATMENT		
D8010	Limited Orthodontic Treatment of the Primary Dentition	B/R
D8020	Limited Orthodontic Treatment of the Transitional Dentition	B/R
D8030	Limited Orthodontic Treatment of the Adolescent Dentition	B/R
D8040	Limited Orthodontic Treatment of the Adult Dentition	B/R
D8050	Interceptive Orthodontic Treatment of the Primary Dentition	B/R
D8060	Interceptive Orthodontic Treatment of the Transitional Dentition	B/R
D8070	Comprehensive Orthodontic Treatment of the Transitional Dentition	B/R
D8080	Comprehensive Orthodontic Treatment of the Adolescent Dentition	B/R
D8090	Comprehensive Orthodontic Treatment of the Adult Dentition	B/R
	INITIAL WORK-UP The total allowable charge for the combination of these services will be set equal to the lesser of: 1) $250 or 2) The total of the submitted charges for the work-up services.	
	MINOR TREATMENT TO CONTROL HARMFUL HABITS – B/R	
D8210	Removable Appliance Therapy	B//R
D8220	Fixed Appliance Therapy	B/R
OTHER ORTHODONTIC SERVICES – B/R		
D8660	Pre-Orthodontic Treatment Visit	$42
D8670	Periodic Orthodontic Treatment Visit (By Report)*	B/R
D8680	Orthodontic Retention (Removal of Appliances, Construction & Placement of Retainer)*	$332
	* Procedure D8670 and D8680 should not be billed as a separate charge when the dentist has provided Limited, Interceptive or Comprehensive Treatment to the same Patient.	
D8691	Repair of Orthodontic Appliance	B/R
D8692	Replacement of Lost or Broken Retainer	Not covered

CODE	PROCEDURE	ALLOWANCE
ADJUNCTIVE GENERAL SERVICES (D9000-D9999)		
	PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN Palliative Treatment (D9110) should not be billed as a separate charge when performed during the same visit with definitive treatment. LOCAL ANESTHESIA (D9215) Local Anesthesia (D9215) done in conjunction with definitive treatment should not be billed. OTHER DRUGS AND/OR MEDICAMENTS, BY REPORT (D9630) The allowance for code D9630 applies for the administration of the drug and/or medicaments. Irrigation is not included in the description for Code D9630 and should not be submitted under this code. Irrigation is normally included within other services rendered to the patient and should not be billed as a separate charge. OCCLUSAL ADJUSTMENT- LIMITED/COMPLETE (D9951-D9952) Procedures D9951 and D9952 should not be billed when in conjunction with the placement of restorations or prostheses. Union Roofers considers an occlusal adjustment as part of the restorative process when performed during the same patient visit.	
UNCLASSIFIED TREATMENT		
D9110	Palliative (Emergency) Treatment Of Dental Pain – Minor Procedure [1]	$57
ANESTHESIA		
D9210	Local Anesthesia not in Conjunction with Operative or Surgical Procedures [1]	$19
D9211	Regional Block Anesthesia [1]	$19
D9212	Trigeminal Division Block Anesthesia [2]	$18
D9220	Deep Sedation/General Anesthesia - First 30 Minutes [2]	$235
D9221	Deep Sedation/General Anesthesia - Each Additional 15 Minutes	$76
D9222	Deep sedation/general anesthesia – first 15 minutes	$197
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment	$179
D9230	Inhalation of nitrous oxide/Anxiolysis, analgesia	$50
D9239	Intravenous moderate (conscious) sedation – first 15 minutes	$164
D9243	Intravenous moderate (conscious) sedation – each subsequent 15 min increment	$149
D9248	**Non-intravenous conscious sedation**	$178
PROFESSIONAL CONSULTATION		
D9310	Consultation (other than requesting dentist or physician)	$57
PROFESSIONAL VISITS		
D9410	House/Extended Care Facility Call	$127
D9420	Hospital Call [3]	$227
D9430	Office Visit for Observation (No Other Services Performed)	$37
D9440	Office Visit - After Regularly Scheduled Office Hours	$95
DRUGS		
D9610	Therapeutic Drug Injection, single administration	$47
D9612	Therapeutic parenteral drugs, two or more administrations, different meds	$117
D9630	Other Drugs and/or Medicaments, By Report	$34

1 Supporting documentation is required with claim.

2 Deep sedation/general anesthesia and intravenous conscious sedation/analgesia is only covered when used in conjunction with oral surgery.

3 For dependent children only up to age 14.

CODE	PROCEDURE	ALLOWANCE
MISCELLANEOUS SERVICES		
D9910	Application of Desensitizing Medicament	$39
D9911	Application of Desensitizing Resin for Cervical and/or Root Surface, Per Tooth	$39
D9920	Behavior Management, By Report	$78
D9930	Treatment of Complications (Post-Surgical) – Unusual Circumstances, By Report	$80
D9940	Occlusal Guard, By Report	$465
D9941	Fabrication of Athletic Mouth guard	Not covered
D9943	Occlusal guard adjustment	$48
D9950	Occlusion Analysis - Mounted Case	$211
D9951	Occlusal Adjustment - Limited	$131
D9952	Occlusal Adjustment - Complete	$374
D9971	Odontoplasty 1 - 2 Teeth; Includes Removal of Enamel Projections	Not covered
D9972	External Bleaching - Per Arch	Not covered
D9973	External Bleaching - Per Tooth	Not covered
D9974	Internal Bleaching - Per Tooth	Not covered
D9975	External bleaching for one application per arch	Not covered

Submit Pre-Treatment Estimates for Codes Not Shown Above.

DELTA DENTAL BENEFITS
THE DELTA DENTAL PPO PLAN AND THE DELTA CARE DHMO PLAN

Enrollment in a dental plan is required if you want coverage for yourself and your dependents.

GENERAL INFORMATION
If you are a Plan A+ or Plan A Covered Employee you can enroll in the DeltaCare DHMO plan. Once enrolled, you can only change to the Delta Dental PPO Plan during Open Enrollment.

If you have not been eligible for enrollment in the DHMO plan for at least one year, you cannot enroll in the Delta Dental PPO plan. Once you have completed the one year waiting period, you can change to the PPO Dental plan.

DELTA DENTAL PPO DENTAL PLAN
The following summarizes the features of the **Delta Dental PPO Plan:**

- You must enroll in this plan but you do not have to select a dentist.
- You can go to any licensed dentist for care but your lowest cost will be when using Delta Dental PPO dentists, next lowest out-of-pocket cost when using a Delta Premier dentist and highest out-of-pocket expense when you use a non-Delta dentist.
- You can only make changes into or out of any dental plan during the Open Enrollment period.
- A Schedule of benefits, detailing the benefits, exclusions and limitations will be provided to you by Delta Dental of California, and is available from the Fund Manager's office
- Delta Dental PPO Customer Service number: 800.765.6003

A summary of the benefits and maximums under the Delta Dental Plan follows:

Delta Dental PPO Dental Plan		
Deductibles Deductible waived for Orthodontics?	$50 per person / $150 per family each calendar year Yes	
Maximums	$1,500 per person each calendar year	
Benefits and Covered Services[1]	**Delta Dental PPO & Premier Dentists[2]**	**Non-Delta Dental PPO Dentists****
Diagnostic & Preventive Services (D & P) Exams, cleanings and x-rays	90%	80%
Basic Services Fillings and sealants	80%	70%
Endodontics (root canals) Covered Under Basic Services	80%	70%
Periodontics (gum treatment) Covered Under Basic Services	80%	70%
Oral Surgery Covered Under Basic Services	80%	70%
Major Services Crowns, inlays, onlays and cast restorations	50%	40%
Prosthodontics Bridges, dentures and implants	50%	40%
Orthodontic Benefits Adults and dependent children	50%	50%
Orthodontic Maximums	$5,000 Lifetime	$5,000 Lifetime

DELTA CARE PREPAID (DHMO) DENTAL PLAN
The following summarizes the features of the **Delta Dental DHMO Plan:**

- You must enroll in this plan and you must select a dentist where you will receive all dental care.
- Each of your family members may select a different dental office for their dental care.
- If you do not use the dental office you select, you will be responsible for all dental costs.
- You may change dental offices each month by contacting DeltaCare.
- You can only change to the Indemnity or PPO Dental plan after you have been covered under (or eligible for) this plan for at least one year.
- This plan does not have any deductibles and it does not have any calendar year maximums.
- Under the DHMO dental plan, you only pay the copayments for the specific services you receive.
- A Schedule of copayments for benefits is available from Delta Dental or from the Fund Manager's office.

[1] Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

[2] Reimbursement is based on PPO contracted fees for PPO dentists, PPO contracted fees for Premier dentists and PPO contracted fees for non-Delta Dental dentists.

A sample summary of the benefits and copayments under the Delta Dental Prepaid DHMO Dental Plan follows:

Sample of DHMO Dental Copayments		
Category	**Procedure Code**	**Copayment**
Preventive Care (Preventive care does not apply to annual maximum on the PPO plan)		
Periodic oral examination	D0120	No Charge
Full mouth X-ray (see frequency limitations)	D0120	No Charge
Prophylaxis (cleanings) 1 per six months	D1110 (Adult) D1120 (Child)	No Charge
Restorative Dentistry		
Amalgam ("silver" fillings) on primary or permanent teeth: 1, 2, 3 or 4 surfaces	D2160 (3)	No Charge
Resin composite (white filings), posterior (molars): 1, 2, 3 or 4 surfaces	D2392 (2)	$55.00
Porcelain/ceramic inlay - Up to 3+ surfaces	D2620 (2)	$150.00
Periodontics		
Gingival flap, per quadrant	D4240 (4+) (# of teeth)	$80.00
Gingivectomy/gingivoplasty (gum surgery), per quadrant	D4211 (1-3) (# of teeth)	$50.00
Endodontics		
Root canal – anterior (front) teeth	D3310	$45.00
Root canal - Molar	D3330	$205.00
Oral Surgery		
Extraction – impacted partially bony, per tooth	D7230	$50.00
Extraction – impacted completely bony, per tooth	D7240	$70.00
Crowns and Bridges[1]		
Crown – full cast high noble metal (gold)	D2790	$170.00
Crown – porcelain/ceramic substrate	D6740	$195.00
Prosthetics[1]		
Complete upper or lower denture	D5110 (Upper) D5120 (Lower)	$100.00 $100.00
Implants	D6010 - D6050	Not Covered
Orthodontics		
Comprehensive orthodontic treatment	D8090	$1,900.00 24-month treatment
Limited orthodontic treatment of the adult teeth	D8040	$1,150.00 24-month treatment

[1] This procedure may be subject to additional costs based on materials used and/or location of the tooth/teeth within the mouth. If there are any discrepancies between the amounts on the description of benefits and copayments and the amounts on your treatment plan, please contact Delta Dental Customer service at (855) 244-7323 to confirm your out-of-pocket cost.

VISION CARE BENEFITS

For All Active Plan A+ Employees and their Dependents

(Optional Benefit for Retirees and Non-Contract Employees)

Provided By Vision Service Plan

What are the benefits?

Vision Examination

A complete analysis of the eyes and related structures to determine the presence of vision problems, or other abnormalities. Supplemental testing for contact lenses, low vision, and vision training are not covered. Medical testing of the eyes should be done by an ophthalmologist and is not covered under the Vision Service Plan.

Lenses

The VSP Panel Doctor will order the proper lenses (only if needed). The program provides the finest quality lenses fabricated to exacting standards. The Doctor also verifies the accuracy of the finished lenses.

Frames

The Plan offers a wide selection of frames, however, if you select a frame which costs more than the amount allowed by your Plan, there will be an additional charge. The annual allowance for glass frames is $185, with an additional $20 provided for featured frame brands.

Contact lenses

Contact lenses are furnished under the VSP Plan when the VSP Panel Doctor secures prior approval for the following conditions: Following cataract surgery; to correct extreme visual acuity problems that cannot be corrected with spectacle lenses; Anisometropia; or Keratoconus. When VSP Panel Doctors receive approval for such cases, they are fully covered by VSP.

When patients choose contact lenses for other reasons, VSP will make a combined allowance of $150 toward their cost for contacts and the contact lens exam in lieu of all other benefits for that year.

How much do I pay?

When you select a Doctor from the VSP list, this plan covers the visual care described herein (examination, professional services, lenses and frame) at no expense to you except for small deductibles. Any additional care, service and/or materials not covered by this Plan may be arranged between you and the Doctor.

How to Use This Plan

1. Select the Doctor of your choice, ask if they participate in the VSP Plan and make an appointment for an examination. Your eligibility will be checked when you tell the provider you are covered under the Union Roofers Plan.

2. When the examination has been completed, the Doctor will have you sign your name in the space provided. Pay only $10.00 to the Doctor for the examination and $10.00 for the material services described herein. VSP will pay the panel Doctor directly according to their agreement with the Doctor.

3. Selecting a Doctor from VSP assures direct payment to the Doctor and a guarantee of quality and cost control. However, if you seek the services of a Doctor who is not a VSP Panel Member, you should pay the Doctor his full fee. You will be reimbursed in accordance with a reimbursement schedule. THERE IS NO ASSURANCE THAT THE SCHEDULE WILL BE SUFFICIENT TO PAY FOR THE EXAMINATION OR THE GLASSES. REIMBURSEMENT BENEFITS ARE NOT ASSIGNABLE.

Note: When you obtain service from a Doctor who is not a VSP Panel Member, and/or obtain glasses from a dispensing optician, be sure to send your itemized statement of charges to VSP along with your benefit form.

How often are these services available?

1. VISION EXAMINATION: Every 12 months.

2. LENSES: Every 24 months unless a significant (a change of at least .5 diopter) prescription change requires lenses more frequently.

3. FRAMES: Every 24 months only if needed.

LIMITATIONS

Extra Cost
This Plan is designed to cover your visual needs rather than cosmetic materials. If you select any of the following and your VSP Doctor does not receive prior authorization, there will be an extra charge: a) blended lenses; b) contact lenses (except as noted elsewhere herein); c) double segment bifocals; d) multifocal plastic lenses; e) oversize lenses; f) progressive multifocal lenses; or g) photochromic lenses or tinted lenses other than Pink #1 or #2.

Not Covered
There is no benefit for professional services or materials connected with:

1. The additional costs associated with: a) coated lenses; b) laminated lenses; or c) a frame that costs more than the Plan allowance.

2. Orthoptics or vision training, subnormal vision aids, plain (non-prescription) lenses; glasses secured when there is no prescription change; or two pairs of glasses in lieu of bifocals.

3. Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available.

4. Medical or surgical treatment of the eyes.

5. Services or materials provided as a result of any Workers Compensation law, or similar legislation, or obtained through or required by any government agency or program, whether federal, state or any subdivision thereof.

6. Any eye examination required by an employer as a condition of employment.

7. If the covered person does not obtain the VSP benefit form in advance, but visits the panel Doctor as a private patient, the panel Doctor is not obligated to accept VSP fees as full payment for these services, but may elect to charge his usual and customary fees.

UNION ROOFERS HEALTH AND WELFARE FUND
RULES AND REGULATIONS
PROVIDING HEALTH AND WELFARE BENEFITS FOR EMPLOYEES
RESTATED July 1, 2005

ARTICLE I. DEFINITIONS

Section 1. The term "Active Employee" means any person who, by reason of his active employment, meets the eligibility requirements hereunder as established by the Fund and as amended from time to time, and such other persons as the Employer and the Union may agree to designate as employees within the meaning and purpose of an applicable bargaining agreement. The term also includes those Non-Contract Employees who meet the eligibility rules under Section 2 of Article II.

Section 2. The term **"**Allowable Expense" means the expense or charge for medical services and supplies or any dental and/or orthodontic services and supplies, which are determined by the Trustees or their designee to be:

a. with respect to a covered PPO Provider, the fee required pursuant to the agreement between the Plan's preferred provider organization (PPO) network and the Plan; or

b. with respect to a Non-PPO Provider, the lesser of:

(1) The schedule that lists the dollar amounts the Trustees have determined the Plan will allow for Covered Medical or Dental Expenses

(2) The Plan will not always pay benefits equal to or based on the Provider's actual charge for health care services or supplies, even after you have paid the applicable Deductible, Copay and/or Coinsurance. This is because the Plan covers only the "Allowed Expense" amount for health care services or supplies.

(3) Participants are responsible for amounts that exceed "Allowed Expense" amounts by this Plan.

(4) The provider's actual billed charge.

No expense or charge will be an Allowable Expense unless it is Medically Necessary. As used herein, the term "Medically Necessary" means it is:

a. for the care and treatment of a non-occupational accidental bodily Injury or Illness of a person who is an Eligible Individual at the time the expense is incurred. No expense or charge will be considered Medically Necessary unless it is recommended and approved by a Physician and is for a valid course of medical treatment, which is not Experimental or Investigational (except as authorized as a clinical trial and which is recognized as valid by an established medical society in the United States). No expense or charge will be an Allowable Expense and Medically Necessary if it is otherwise excluded or limited by Plan provisions.

The Trustees may obtain and rely upon independent medical advice to determine whether services or supplies are Medically Necessary, are consistent with professionally recognized standards of care with regard to quality, frequency and duration and are provided in the most economical and medically appropriate site for treatment.

b. "Medically Necessary" treatment of a mental health or substance use disorder means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

(i) In accordance with the generally accepted standards of mental health and substance use disorder care.

(ii) Clinically appropriate in terms of type, frequency, extent, site, and duration.

(iii) Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.

Section 3. The term "Calendar Year" means January 1 through December 31 of each year.

Section 4. The term "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985.

Section 5. The term "Contract Employee" or "Bargaining Unit Employee" means an employee working for an Employer that is required to make contributions to the Fund in accordance with the terms of the Collective Bargaining Agreement between the Union and the Employer.

Section 6. The term "Covered Employee" means each Active Employee and Retired Employee.

Section 7. The term "Dentist" means a person licensed to practice Dentistry in the state in which he renders treatment.

Section 8. The term "Dependent(s)" means:

a. With respect to a Regular Retired Employee, the Regular Retired Employee's lawful spouse or, if enrolled in a Prepaid Medical plan, the same or opposite sex Domestic Partner, age 18 or older in accordance with state law,;

b. With respect to all other Covered Employees,

1. the Covered Employee's lawful spouse; or

2. if enrolled in a Prepaid Medical plan, the same or opposite sex Domestic Partner, age 18 or over in accordance with state law,;

3. the Covered Employee's (but not the Domestic Partner's) children from birth to age 26;

4. the Covered Employee's (but not the Domestic Partner's) dependent child over age 25 if the child is incapable of self-sustaining employment by reason of a mental or physical handicap which commenced prior to the limiting age and while such child was eligible hereunder, provided a physician certificate is furnished to the Plan within six months following the dependent child's 25th birthday or eligibility date.

The term "child(ren)" as used herein means a Covered Employee's (but not the Domestic Partner's) natural child, step child or legally adopted.

A child shall in no event be an eligible Dependent of more than one Covered Employee, nor shall a lawful spouse or child be eligible under the Plan both as an eligible Dependent and as a Covered Employee.

Section 9. The term “Doctor” means a physician or surgeon, M.D., D.O. or psychologist practicing within the scope of his license. In no event will such term include the Eligible Individual or any person who is the spouse, parent, child, brother or sister of the Eligible Individual.

Section 10. The term “Drugs” means any article which may be lawfully dispensed, as provided under the Federal Food, and Drug and Cosmetic Act, including any amendments thereto, only upon a written or oral prescription of a Doctor or Dentist licensed by law to administer it.

Section 11. The term “Early Retiree” or “Early Retired Employee” means a person who meets the eligibility requirements hereunder, as specified in **Section 4, Article II.**

Section 12. The term “Eligibility Period” means a six-month period ending on any June 30 or December 31 during which the Eligible Employee receives benefits based upon hours worked in the prior Qualifying Period.

Section 13. The term “Eligible Individual” means each Covered Employee and each of his Dependents, if any.

Section 14. The term “Emergency” means a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1) placing the health in serious jeopardy 2) serious impairment to bodily functions or 3) serious dysfunction of any bodily part or organ. Emergency services include services to screen, treat, and stabilize the patient in any dept of the facility. The term Emergency shall include post-stabilization services if the patient cannot be transported using non-medical transportation..

Section 15. The term “Employer” means any association, individual, partnership, joint venture or corporation which has agreed to be bound by the terms and provisions of the Trust Agreement and is obligated to make Employer contributions to the Fund in accordance with a Collective Bargaining Agreement. “Employer” may also mean any Local Union, signatory hereto, and the Fund which makes contributions hereto on behalf of its employees, provided the inclusion of said Local Union or Fund as an Employer is not a violation of any applicable law or statute. An employer shall not be deemed an Employer simply because he is part of a controlled group of corporations or a trade or business under common control, some part of which is a contributing Employer.

Section 16. The term “Extended Care Facility” means an institution which is primarily engaged in providing inpatients with (1) skilled nursing care and related services for patients who require medical or nursing care, or (2) rehabilitation services for the rehabilitation of injured, disabled or sick persons and which meets all of the following requirements:

a. it is regularly engaged in providing skilled nursing care for sick and injured persons under 24 hours a day supervision of a physician and surgeon (MD) or a graduate Registered Nurse (RN);

b. it has available at all times the services of a physician and surgeon (MD) who is a staff member of a general Hospital;

c. it has on duty 24 hours a day a graduate Registered Nurse (RN), Licensed Vocational Nurse (LVN), or skilled practical nurse, and it has a graduate Registered Nurse (RN) on duty at least eight hours per day;

d. it maintains a clinical record for each patient;

e. it is not, other than incidentally, a place for rest, a place for custodial care, a place for the aged, a place for drug addicts, a place for alcoholics, a hotel, or a similar institution;

f. it complies with all licensing and other legal requirements, and is recognized as an “extended care facility” by the Secretary of Health and Human Services of the United States pursuant to Title XVIII of the Social Security Amendments of 1965, as amended.

Section 17. The term “Fund” means the Union Roofers Health and Welfare Fund; the term “Fund” also means the Board of Trustees established by the Trust Agreement where applicable.

Section 18. The term “Fund Manager” means the office that is charged by the Trustees with the responsibility to administer the day-to-day operations of the Fund.

Section 19. The terms “he”, “his” and “himself” shall apply to both genders whenever used.

Section 20. The term “HIPAA” means the Health Insurance Portability and Accountability Act of 1996.

Section 21. The term “Hospital” means an institution which:

a. has permanent full-time facilities for bed care of five or more resident patients,

b. has a Doctor in regular attendance,

c. provides 24-hour a day service by Registered Nurses,

d. primarily provides diagnostic and therapeutic facilities for the medical and surgical care of patients, and

e. is not a rest home, nursing home, convalescent home, or place for the aged or for alcoholics or drug addicts.

Section 22. The term “Licensed Pharmacist” means a person who is licensed to practice pharmacy by the governmental authority having jurisdiction over the licensing and practice of pharmacy.

Section 23. The term “Medicare” as used herein, means the program established under Title XVIII of the Social Security Act (Federal Health Insurance for the Aged) as it is presently constituted or may hereafter be amended.

Section 24. The term “Non-Contract Employee” or “Non-Bargaining Unit Employee” means an employee who is not covered under the terms of a Collective Bargaining Agreement who is working for an Employer that makes contributions to the Fund on the employee’s behalf.

Section 25. The term “Open Enrollment” means the period of time each year during which the Covered Employee may change enrollment in a plan of benefits or elect to add or delete benefits as a Retired Employee.

Section 26. The term “Plan” means these Rules and Regulations as adopted and thereafter amended by the Board of Trustees.

Section 27. The term “Plan A Benefits” means those benefits described in Articles V, VI, VII, IX and X, payable in accordance with the provisions of Articles III, IV, VIII and XI available to Eligible Individuals qualifying by hours worked.

Section 28. The term “Plan A+ Benefits” means those benefits described in Articles V, VI, VII, IX and X, payable in accordance with the provisions of Articles III, IV, VIII and XI available to Eligible Individuals qualifying by hours worked, or to Non-Contract Employees for whom contributions are made.

Section 29. The term “Plan B Benefits” means those benefits described in Articles V, VI, VII, IX and X, payable in accordance with the provisions of Articles III, IV, VIII and XI available to Eligible Individuals qualifying by hours worked.

Section 30. The term “Preferred Provider” or “PPO Provider” means a Hospital, Doctor, Dentist or other service provider bound to a written agreement with the Fund concerning the provisions of the health care services to Eligible Individuals of the Fund. The term “Non-PPO Provider” means a provider that does not have a written agreement with the Fund concerning the provisions of the health care services to the Individuals of the Fund.

Section 31. The term “Prepaid Medical” means any Health Maintenance Organization (HMO) contracted by the Board of Trustees to provide coverage for Eligible Individuals.

Section 32. The term “Qualifying Period” means a six-month period ending on any November 30 or May 31 during which the employee works sufficient hours for one or more Employers to qualify for benefits in the next Eligibility Period.

Section 33. The term “Reasonable Charges” means the customary charges in the area in which they are incurred, but not exceeding such charges as would have been made in the absence of the benefits provided under these Rules and Regulations. A “customary charge” as used herein means the usual charge made by a Hospital, Physician, Dentist, Licensed Pharmacist or other professional person, or other person or firm having rendered or furnished the services, treatments or supplies which do not exceed the general level of charges made by others rendering or furnishing such services, treatments or supplies within the area in which the charge is incurred, for bodily injuries or illnesses comparable in severity and nature to the bodily injuries treated or being treated. The term “area,” as it would apply to any particular item for which a covered charge may be incurred, means a county or such greater area as is necessary to obtain a representative cross-section of entities furnishing such items. A charge is considered to have been incurred as of the date on which the service or supply for which the charge is made is rendered or obtained.

Section 34. The term “Registered Nurse” means a registered graduate nurse who does not ordinarily reside in the Covered Employee’s home and is not the spouse, child, brother, sister or parent of the Covered Employee or of the Covered Employee’s spouse.

Section 35. The term “Regular Retiree” or “Regular Retired Employee” means a person who meets the eligibility requirements hereunder, as specified in Section 4 of Article II.

Section 36. The term “Retired Employee” means each Early Retiree and Regular Retiree who meets the eligibility requirements hereunder, as specified in Section 3 or Section 4 of Article II.

Section 37. The term “Schedule of Dental Allowances” means the description of dental procedures and the amounts payable for each as approved by the Board of Trustees and as amended from time to time.

Section 38. The term “Totally Disabled” means, with respect to an Active Employee, that as a result of bodily injury or sickness, the Active Employee is completely unable to engage in any gainful occupation for which he is reasonably qualified by reason of education, training or experience and that he is not engaged in any gainful occupation for wages or profit. For this purpose, acceptable proof as to whether an Active Employee or Eligible Individual is Totally Disabled shall be a physician written statement on the physician’s stationary.

The term “Totally Disabled” means, with respect to any other Eligible Individual, that as a result of bodily injury or sickness, the Eligible Individual is unable to engage in his regular and customary activities and is not, in fact, engaged in any employment or occupation for wage or profit.

Section 39. The term “Trust Agreement” means the Agreement and Declaration of Trust establishing the Union Roofers Health and Welfare Fund dated January 1, 1977, and any modification, amendment, extension or renewal thereof.

Section 40. The term “Trustees” means any person designated as Trustees pursuant to the terms of the Trust Agreement, and the successor of such persons from time to time in office. The Term “Board of Trustees” and “Board” means the Board of Trustees established by the Trust Agreement.

Section 41. The term “Union” means Locals No. 36 and 220 of the United Union of Roofers, Waterproofers and Allied Workers of Los Angeles, Ventura, Orange, Santa Barbara and San Luis Obispo Counties, and any other Local Unions which have a Collective Bargaining Agreement in effect with an Employer and agree to be bound by the terms and provisions of the Trust Agreement.

Section 42. The term “Prepaid Dental” means any Dental Health Maintenance Organization (DHMO) contracted by the Board of Trustees to provide coverage for Eligible individuals.

ARTICLE II. ELIGIBILITY

Section 1. Active Employees - Bargaining Unit

a. **Establishment of Eligibility.**

1. An employee shall be eligible as an Active Employee entitled to Plan B benefits in the next Eligibility Period if the hours worked for one or more contributing Employers during a Qualifying Period total at least 450 but not more than 599.

2. An employee shall be eligible as an Active Employee entitled to Plan A benefits in the next Eligibility Period if the hours worked for one or more contributing Employers during a Qualifying Period total at least 600 but not more than 749.

3. An employee shall be eligible as an Active Employee entitled to Plan A+ benefits in the next Eligibility Period if the hours worked for one or more contributing Employers during a Qualifying Period total at least 750 or more.

b. **Maintenance of Eligibility.**

Except as provided in the provisions of Hour Bank or Certified Disability sections below, an Employee shall continue to be eligible as an Active Employee during subsequent Eligibility Periods provided at least 450 or more hours are worked for Employers during the preceding Qualifying Periods and provided during each month of the Qualifying Period the Employee had worked hours which were contributed upon or disability hours were credited on his behalf.

c. **Hour Bank.**

1. Active Employees who work more than 750 hours during a Qualifying Period for one or more Employers may bank up to 50 of the additional hours in an Hour Bank account during each Qualifying Period. No hours earned on a Certified Disability may be banked. An Hour Bank account may not contain more than 400 hours at any time.

2. If required for coverage during an Eligibility Period, up to 100 hours may be used from the Hour Bank to obtain Plan B benefits.

3. If an Employee is age 54 or older on the date eligibility is run, he may use a maximum of 200 Hours from his Hour Bank to obtain Plan B coverage.

4. Hours credited to the Hour Bank account are not a vested benefit.

5. Residual hours in the Hour Bank shall be cancelled if the Active Employee performs work for a non-signatory employer or, if the Active Employee knew or should have known his Employer is non-signatory or has under-reported hours to the Fund.

d. **Certified Disability.**

1. If an Active Employee incurs an injury or illness which began while actively eligible for benefits, credit shall be given for the period of the disability at the rate of 8 hours per day (excluding holidays and weekends) and 40 hours per week. The period of disability credit may not exceed 6 months during any calendar year or the date of recovery from the disability, whichever occurs first.

2. The hours credited for a Certified Disability shall be added to the hours required during the Qualifying Period for coverage during the next Eligibility Period.

3. Certified Disability credited hours shall be used to qualify for Plan B benefits only.

4. Certified proof of disability shall be required at the start of the disability and monthly thereafter until the Active Employee returns to work for a contributing Employer. The proof of disability must be submitted in writing by a Doctor (MD., D.O. or PhD) on the Doctor's letterhead, showing the beginning date of disability, diagnosis, and expected date of return to work.

e. **Working in Non-Covered Employment and Failure to Report Hours Worked.**

1. If it is determined by the Board that an Active Employee worked for wages or profit for a non-signatory employer in the State of California, all hours reported to that date shall be cancelled and coverage and benefits shall terminate on the last day of the Calendar Month in which the determination was made.

2. If it is determined by the Board that an Active Employee knew of or should have known that his Employer failed to report all hours worked by him to the Plan, all benefits and coverage shall cease on the last day of the calendar month in which the determination was made.

f. **When Coverage Begins.**

Coverage for an Active Employee and his Eligible Dependents begins on the first day of the Eligibility Period following the Qualifying Period during which sufficient hours were worked to qualify for coverage. Coverage for newly acquired Dependents begins on the date they are acquired if the employee is then eligible as an Active Employee.

g. **Benefits.**

Contract Employees are eligible for death benefits, accidental death and dismemberment benefits, weekly disability, a choice of medical plans, a choice of dental plans, and vision benefits. The hours worked will determine the medical plan and choices. Dependents of the Contract Employee shall be enrolled in the same medical plans as the Contract Employee.

When a Contract Employee first becomes eligible under Plan A or A+, the family must be enrolled in a prepaid medical plan and prepaid dental plan for the first year. After the first year, the employee may elect coverage under the Delta Dental PPO plan.

h. **Reinstatement of Eligibility.**

If an Active Employee enters full-time active duty with the Armed Forces of the United States and subsequently returns to work for a contributing Employer within 13 to 90 days (depending upon the length of time the Employee was on active duty) from his discharge, he will be eligible for Plan benefits immediately, provided that written notice was given to the Fund upon entrance into military service.

i. **Termination of Eligibility.**

An Active Employee's eligibility will terminate on whichever of the following dates occurs first:

1. on the date the Plan terminates;

2. on the last day of the calendar month the employee qualified as an Active Employee;

3. on the 32nd day following the date of entrance into full-time active duty with the Armed Forces of the United States unless mandated by law;

4. on the last day of the month in which the Trustees determine the Active Employee has worked for a non-signatory employer, or knew or should have known that his Employer under-reported hours to the Plan.

   Eligibility for Dependents of Active Employees shall cease on the earliest of the following dates:

   (a) the date of loss of eligibility of the Active Employee;

   (b) the date of entrance into full-time active military duty with the Armed Forces of the United States;

   (c) the date the dependent no longer meets the definition of a Dependent;

   (d) the date the Plan terminates or no longer provides coverage for Dependents of Active Employees;

   (e) If coverage for an Active Employee or Dependent is lost, benefits may be continued on the basis of COBRA or under the terms of USERRA.

Section 2. Non-Contract Employees.

a. **Establishment of Eligibility.**

1. Employees of Employers who are not covered under the terms of the Collective Bargaining Agreement may be eligible for Plan A+ benefits under the Plan provided:

   (a) the Employer elected coverage for its Non-Contract Employees within 30 days of the date it is advised of this option; and

   (b) all of the Employer's Non-Contract Employees who work a minimum of 30 hours per week are covered, unless the employee provides proof of other coverage and provides a signed affidavit to that effect; and

   (c) only one Non-Contract Employee may be covered for each Employee covered under the terms of the Collective Bargaining Agreement; and

   (d) contributions must remain continuous and be made in a timely manner; and

   (e) the employee must be on the payroll of the Employer.

2. Coverage for a Non-Contract Employee shall begin on the first day of the second month for which the Employer paid two consecutive months of contributions to the Trust on the person's behalf.

b. **Maintenance of Eligibility.**

Except as provided under Termination of Coverage, eligibility for Non-Contract Employees and their eligible Dependents shall continue during each month for which an Employer contribution has been received for coverage.

c. **Benefits**

Non-Contract Employees shall be eligible for Plan A+ medical benefits. Dental and Vision benefits shall be an optional benefit if the Employer elects such coverage for all of its Non-Contract Employees. New employees must also be covered under the prepaid Dental DHMO plan for the first year. Thereafter, the employee may change to the Delta Dental PPO Plan or can remain in the prepaid dental plan.

The Fund permits Non-Contract Employees to be covered under the Fund, provided certain requirements are met. After having been in the prepaid DHMO Dental plan for one year, Non-Contract Employees may change to the DPPO Dental plan during the Open Enrollment Period (or remain in the prepaid DHMO Dental Plan), but they may not enroll in the Indemnity Dental Plan. The Indemnity Dental Plan is not available to Non-Contract employees.

d. **Termination of Eligibility.**

Eligibility for a Non-Contract Employee shall cease on the earliest of the following dates:

1. the last day of the month following the month last contributed upon by the Employer;

2. the last day of the month the Non-Contract Employee no longer satisfies the rules for eligibility;

3. if the Employer does not employ at least one Bargaining Unit Employee for each Non-Contract Employee for a period of 90 days and does not pay fringe benefits on each Bargaining Unit Employee for a period of 90 days at the rate of at least 100 hours for the 90-day period, eligibility for the Non-Contract Employees of the Employer will cease on the last day of the month following the 90-day period;

4. the date coverage for Non-Contract Employees is no longer provided by the Plan;

5. the 32nd day following the date of entrance into full-time active military duty with the Armed Forces of the United States, unless mandated by law.

Eligibility for Dependents of Non-Contract Employees will cease on the earliest of the following dates:

1. the date eligibility for the Non-Contract Employee ceases;

2. the date the dependent no longer meets the definition of a Dependent;

3. the date of entrance into full-time active military duty with the Armed Forces of the United States;

4. the date the Plan terminates or no longer provides coverage for Dependents of Non-Contract Employees.

If coverage for a Non-Contract Employee or Dependent is lost, benefits may be continued on the basis of COBRA or USERRA. A Non-Contract Employee may not be reinstated unless approved by the Board of Trustees.

Section 3. Family or Medical Leave.

Under the Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA), your Employer must continue to pay for your health coverage during any approved leave. In general, you may qualify for up to 12 weeks of unpaid FMLA/CFRA leave each year if*:*

1. Your employer has at least 50 employees under the FMLA or at least 5 employees under the CFRA;

2. You worked for the employer for at least 12 months and for a total of at least 1,250 hours during the most recent 12 months; and

3. You require leave for one of the following reasons:

    a. Birth or placement of a child for adoption or foster care,

    b. To care for your child, spouse or parent with a serious medical condition[1], or

    c. Your own serious health conditions.

The FMLA also permits an employee to take up to 26 weeks of leave to care for a spouse, son, daughter, parent, or next of kin, who is a: (1) member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, therapy, is otherwise in outpatient status, or is otherwise on a temporary disability retired list, for a serious injury or illness; or (2) veteran within the meaning of the FMLA. An employee is permitted to take up to 12 weeks of FMLA leave for "any qualifying exigency" (as defined by the Secretary of Labor) for his spouse, son, daughter, or parent, who is deployed with the Armed Forces to a foreign country.

Your Employer is required to maintain your coverage during the 12-week or 26-week period as the case may be.

Details concerning FMLA and CFRA leave are available from your Employer.

In addition to the Fund rules for payment to the Fund because of disability, if your Employer is covered under the FMLA and/or CFRA and you are eligible for FMLA and/or CFRA leave, your Employer may have the responsibility to continue making payments into the Fund for your coverage for up to 12 weeks or 26 weeks, depending on the type of FMLA and/or CFRA leave for which you are eligible. Where employer contributions are otherwise required by the Family Medical Leave Act or the California Family Rights Act for a serious health condition of an employee and such employee is entitled to the Certified Disability Leave extension described above, such employer contributions shall be required and the Fund shall enforce the collection of such employer contributions on behalf of such employee irrespective of whether the Certified Disability leave available under the Fund is used (or not). Where employer contributions are not otherwise required by the Family Medical Leave Act or the California Family Rights Act for a serious health condition of an employee but such employee is entitled to the Certified Disability leave extension described above, such disability leave will be exhausted.

Notify your Employer if you believe you are entitled to leave under the FMLA or CFRA.

It is not the role of the Trustees or Fund to determine whether or not an individual employee is entitled to leave with continuing medical care under the federal statute, any state statute or the provisions of the collective bargaining agreement. Disputes as to the entitlement to leave with continuing medical benefits must be resolved by the employer, employee, and where applicable, the Union.

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[1] In addition to allowing leave for the care of a serious health condition of a minor child or dependent adult, parent or spouse, the CFRA also allows leave for the care of serious health condition of child of any age, grandparent, grandchild, sibling, or domestic partner.

To the extent the participants are entitled to leave with continuing medical coverage pursuant to the federal act, state legislation or provisions contained within a collective bargaining agreement, the Fund will provide continuing medical coverage so long as required monthly contributions are received from the participating employer. Rights under this section in no way affect your rights under COBRA.

Remember that the entire area of disability and illness is complex. Therefore, should you be disabled or ill for any period of time, please notify the Fund Manager.

Section 4. Early Retired Employees

a. **Establishment of Eligibility**

Former Bargaining Unit Active Employees who have retired and are receiving a pension from the Pacific Coast Roofers Pension Plan may continue coverage under the Plan for himself and his eligible Dependents on the basis of self-payment, provided:

1. the Early Retired Employee is age 55 to age 60; and

2. as an Active Employee, he was a member of Local #36 or Local #220 for not less than ten (10) consecutive years prior to reaching retirement age; and

   (a) hours were reported in each of those years; or

   (b) during the ten-year period the Active Employee was receiving certified disability credit or had continued coverage through COBRA for the periods when no hours were reported; and

   (c) self-payments for coverage were made in a timely and continuous manner; and

   (d) early Retired Employee coverage is elected upon loss of coverage as an Active Employee or following cessation of COBRA coverage elected upon loss of Active Employee coverage; and

   (e) the Early Retired Employee resides within the service area of one of the Prepaid Medical plans being offered; and

   (f) you were eligible for benefits under the Plan of this area for at least five of the last ten (10) years and one (1) of the last two and one-half (2½) years prior to retirement.

b. **Coverage Available.**

Early Retired Employees are eligible for Plan B benefits. They may also elect and pay for coverage under the one of the dental plans and/or vision program; however, these benefits shall not be available without medical coverage. Once an election has been made for vision or dental coverage, self-payments must be made for a 12-month consecutive period before the coverage is discontinued. If dental or vision is not elected at the time the former Active Employee elects coverage as an Early Retired Employee, it may be elected during any subsequent Open Enrollment period and 12 months of self-payment will be required before coverage can be dropped. All Early Retired Employees shall continue to be covered by the Fund for death benefits, for which no self-payment shall be required.

c. **Self-Payment for Coverage.**

Self-payments for coverage are required on a monthly basis, in an amount determined to be sufficient to cover the entire cost of the coverage elected. Payments are due on the 1st day of the month of coverage. If payment is not received by the 10th, coverage is cancelled.

d. **When Coverage Begins.**

Coverage as an Early Retired Employee shall begin on the first day of the month following loss of coverage as an Active Employee. Except: If the former Active Employee elects to continue coverage under COBRA on the date the Active Employee coverage ends, coverage as an Early Retired Employee shall begin on the first day of the month following the cessation of COBRA coverage provided he would have qualified as an Early Retiree on the date his Active Employee coverage ended.

e. **Maintenance of Eligibility.**

An Early Retired Employee and his eligible Dependents shall remain covered for benefits in each month for which the required self-payment is received by the Plan in a timely manner.

f. **Termination of Eligibility.**

1. Eligibility for an Early Retired Employee shall cease on the earliest of the following dates:

   (a) the date the Plan terminates;

   (b) the date a self-payment is not received in a timely manner or in the amount required;

   (c) the date of death of the Early Retired Employee;

   (d) the date the Early Retired Employee no longer resides within the service area of any of the Prepaid Medical plans providing coverage;

   (e) the date the Early Retired Employee reaches age 60 at which time he may continue coverage as a Regular Retired Employee;

   (f) the date of entrance into full-time military duty unless precluded by law.

g. **Dependents of Early Retired Employees**

Eligible Dependents of Early Retired Employees include the Dependent spouse or Domestic Partner and Dependent children, other than those of the Domestic Partner.

h. **Termination of Eligibility for Dependents.**

Eligibility for the Dependent spouse and children of an Early Retired Employee shall cease on the earliest of the following dates:

1. the date of loss of eligibility of the Early Retired Employee except for death;

2. on the date of death of the Early Retired Employee, except that coverage for a Dependent spouse and children may be continued through self-payment until;

3. the date the spouse remarries, self-payments cease or benefits for widows end; or

   (a) the date the spouse turns age 60 at which time the coverage may be continued under the plan for Regular Retirees;

   (b) the date the Plan no longer provides coverage for Dependents;

4. the date a self-payment, if required for the Dependent, is not received in a timely manner or in the amount required;

5. the date of legal separation or divorce;

6. the date the dependent no longer qualifies as a Dependent under the Plan;

7. for a Dependent Child, on the date the Early Retired Employee qualifies as a Regular Retiree;

8. on the date of entrance into full-time military duty;

9. Dependent Children, if any, who lose coverage when the Early Retired Employee becomes eligible as a Regular Retiree, may continue coverage under COBRA;

10. The date of termination of a Domestic Partner relationship;

11. Divorce or legal separation from the Early Retired Employee.

i. **Non-Vested Benefits.**

Early Retired Employees and their Dependents have no accrued or vested rights to benefits under the Plan. Benefits for Early Retired Employees are not guaranteed in this form or in any form.

If coverage for a Dependent of an Early Retired Employee is lost, benefit may be continued on the basis of COBRA.

Section 5. Regular Retired Employees.

a. **Establishment of Eligibility.**

1. Former Early Retired Employees and their Dependent Spouse or, in the case of death of the Early Retired Employee, the surviving spouse will be eligible for benefits in the Regular Retired Employees' Plan on the date the Retired Employee or surviving spouse reaches age 60, provided that on the day before reaching age 60, the person was then covered under the Early Retired Employee's Plan.

2. Former Bargaining Unit Active Employees who have retired and/or are receiving a pension from the Pacific Coast Roofers Pension Plan may continue coverage under the Plan as a Regular Retired Employee entitled to Plan B benefits, for himself and his eligible Dependent spouse, provided:

(a) the Regular Retired Employee is age 60 or older; and

(b) as an Active Employee, he was a member of Local #36 or Local #220 for not less than ten (10) consecutive years prior to reaching retirement age; and

(c) hours were reported in each of those years; and

(d) during the ten-year period the Active Employee had continued coverage through COBRA for the periods when no hours were reported; and

(e) self-payments for coverage were made in a timely and continuous manner; and

(f) Regular Retired Employee coverage is elected upon loss of coverage as an Active Employee, Early Retired Employee or discontinuance of COBRA coverage if elected after Active Employee Coverage ceased; and

(g) the Regular Retired Employee resides within the service area of one of the Prepaid Medical plans being offered; and

(h) you were eligible for benefits under the Plan of this area for at least five (5) of the last ten (10) years and one (1) of the last two and one-half (2½) years prior to retirement.

b. **Coverage Available.**

Regular Retired Employees are eligible for Plan B benefits. They may also elect and pay for coverage under one of the dental plans and/or vision program; however, these benefits are not available without medical coverage nor will the benefits be available when the Retired Employee or surviving spouse becomes Medicare-eligible. Once an election has been made for vision or dental coverage, self-payments must be made for a 12-month consecutive period before the coverage is discontinued. If dental or vision is not elected at the time the coverage as an Regular Retired Employee begins, it may be elected during any subsequent Open Enrollment period and 12 months of self-payment shall be required before coverage can be dropped. All Regular Retired Employees shall continue to be covered by the Fund for death benefits, for which no self-payment shall be required.

A Medicare-eligible Retired Employee or surviving spouse must enroll in a Medicare Advantage plan and assign Medicare Part A and Part B benefits to the carrier.

c. **Self-Payment for Coverage.**

Self-payments for coverage are required on a monthly basis, in an amount determined to be sufficient to cover the cost of the coverage elected. Payments are due on the 1st day of the month of coverage. If payment is not received by the 10th, coverage is cancelled.

d. **When Coverage Begins.**

Coverage as a Regular Retired Employee shall begin on the first day of the month following loss of coverage as an Active Employee or Early Retired Employee. Except: If the former Active Employee elects to continue coverage under COBRA on the date the Active Employee coverage ends, coverage as a Regular Retired Employee shall begin on the first day of the month following the cessation of COBRA coverage provided he would have qualified as a Regular Retired Employee on the date his Active Employee coverage ended.

e. **Maintenance of Eligibility.**

A Regular Retired Employee and his eligible Dependent spouse shall remain covered for benefits in each month for which the required self-payment is received by the Plan in a timely manner.

f. **Termination of Eligibility.**

1. Eligibility for a Regular Retired Employee shall cease on the earliest of the following dates:

(a) the date the Plan terminates;

(b) the date a self-payment is not received in a timely manner or in the amount required;

(c) the date of death of the Regular Retired Employee;

(d) the date the Regular Retired Employee no longer resides within the service area of any of the Prepaid Medical plans providing coverage;

(e) the date of entrance into full-time military service.

2. Eligibility for the Dependent spouse of a Regular Retired Employee shall cease on the earliest of the following dates:

(a) on the date of loss of eligibility for the Regular Retired Employee for a reason other than death;

(b) on the date of death of the Regular Retired Employee, except that coverage for a Dependent spouse may be continued for herself through continuous self-payments she remarries, self-payments cease or benefits for widows end;

(c) the date a self-payment, if required for the Dependent, is not received in a timely manner or in the amount required;

(d) the date the Plan no longer provides coverage for Dependents;

(e) the date of legal separation or divorce;

(f) the date the Dependent spouse no longer resides within the service area of one of the Prepaid Medical plans providing coverage to Regular Retired Employees and their spouses;

(g) the date of entrance into full-time military service as required by USERRA;

(h) the date of termination of a Domestic Partner relationship;

(i) the date of divorce or legal separation from the Regular Retired Employee.

g. **Non-Vested Benefits.**

Regular Retired Employees and their Dependent spouses have no accrued or vested rights to benefits under the Plan. Benefits for Regular Retired Employees are not guaranteed in this form or in any form.

If coverage is lost for the Dependent of a Regular Retiree, benefits may be continued on the basis of COBRA.

Section 6. Continuation Coverage During Military Service.

a. **Right to Continuation Coverage.**

A Covered Employee may continue coverage for himself and his eligible Dependents without interruption if such coverage would otherwise terminate as a result of entrance into the Armed Forces of the United States, provided the Covered Employee satisfies the application and premium payment requirements.

b. **Type of Coverage.**

Coverage provided to a Covered Employee under this extension will include all benefits provided to similarly situated individuals for whom Fund coverage has not terminated except death benefits, accidental death and dismemberment benefits and weekly disability benefits. The Eligible Individual may choose to elect either “Core Benefits” (Medical) only or both “Core Benefits” and “Non-Core Benefits” (Medical, Dental and Vision). Nothing herein shall be interpreted to give an Eligible Individual the right, at the time continuation coverage is elected, to change coverage options.

c. **Application and Payment of Continuation Coverage.**

In order to qualify for this continuation coverage, the Covered Employee must apply for coverage by properly completing an election form available from the Fund and returning it to the Fund within 60 days of entering the Armed Forces full-time. Such Active Employee that elects continuation coverage must pay premiums in the same amount, form and manner as provided for COBRA participants.

d. **Maximum Period of Continuation Coverage.**

The maximum period of continuation coverage is the lesser of:

1. the 24-month period beginning on the date of loss of coverage under the Plan due to the Covered Employee's leave of absence for full-time active duty with the Armed Forces of the United States;

2. the period ending on the day after the date on which the Covered Employee fails to apply for or return to a position of employment with an Employer, as determined under Section 4312(e) of the Uniformed Services Employment and Reemployment Rights Act of 1994.

Section 7. COBRA Continuation Coverage.

a. **Right to Continuation Coverage.** An Eligible Individual other than a Retired Employee or a Domestic Partner may continue coverage without interruption if such coverage would otherwise terminate because of any of the following qualifying events:

1. an Active Employee's termination of employment for reasons other than gross misconduct, or a reduction in employment hours;

2. the Active or Retired Employee's death;

3. divorce or legal separation of the Active or Retired Employee and spouse;

4. loss of eligible Dependent status.

There may be other health coverage alternatives available through the Health Insurance Marketplace. Individuals could be eligible for a new kind of tax credit that lowers their monthly premiums. At the market place the individual can see what the premiums, deductibles and out-of-pocket costs will be before making a decision to enroll in COBRA. Being eligible for COBRA does not limit the individual's eligibility for coverage for a tax credit through the marketplace. The individual may qualify for a special enrollment opportunity for another group health plan for which the individual may be eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, the individual may request enrolment within 30 days.

It is very important that the individual considers taking advantage of COBRA coverage since a lapse of insurance coverage that lasts 63 days or more may result in a loss of coverage rights.

b. **Notice Obligations.**

An Active Employee, Retired Employee or former eligible Dependent must inform the Fund in writing of a divorce, legal separation or a child losing eligible Dependent status under the Fund within 60 days after the later of the date the event occurred, or, the date coverage for the Eligible Individual would otherwise terminate as a result of the event.

If written notification of the event is not submitted as specified above, continuation coverage will not be available.

Within 30 days of the event, an Employer is required to notify the Fund Manager of an Active Employee's death, termination of employment, or reduction in work hours. Within 14 days of receiving notice of an event specified in item (a) of this Section 7, the Fund Manager will notify each potential COBRA participant of the right to continuation coverage. Notification delivered to an Active or Retired Employee's spouse shall be treated as notification to all other potential COBRA participants residing with such spouse at the time notification is made. If a Dependent resides at a different address than the Active or Retired Employee, a separate notice shall be provided to that individual provided the Fund Manager has knowledge of the address.

c. **Type of Coverage.**

Coverage provided to an Eligible Individual under this extension will include all benefits provided to similarly situated individuals for whom Fund coverage has not terminated except death benefits, accidental death and dismemberment benefits, and weekly disability benefits. The Eligible Individual may choose to elect either "Core Benefits" (Medical) only or both "Core Benefits" and "Non-Core Benefits" (Medical, Dental and Vision). Nothing herein shall be interpreted to give an Eligible Individual the right, at the time continuation coverage is elected, to change coverage options.

For Dependents of Retired Employees, dental and vision benefits are not subject to COBRA because they are optional benefits that are paid for by the Retiree at the time of the Qualifying Event.

d. **Application and Payment of Continuation Coverage.**

In order to qualify for this continuation coverage, the Eligible Individual must apply for coverage by properly completing and submitting to the Fund an election form provided by the Fund within 60 days after the latter of the date coverage for the Eligible Individual would otherwise terminate, or, the date the election form is sent to the potential COBRA participant.

If a properly completed election form is not submitted to the Fund as specified above, continuation coverage will not be available. In the event that a person has requested COBRA coverage but is not qualified, the Fund Manager shall notify the participant of the denial of coverage and the reason for the decision.

COBRA participants must pay premiums for continuation coverage. The amount of the monthly premium will be furnished to potential COBRA participants at the same time as the election form. The cost for COBRA coverage during an 18 or 36 month period shall be equal to the cost of the benefits elected plus 2% as allowed by federal legislation. Payment of the required premium must be made on the following basis:

1. all premium payments must be made by personal check, money order or cashier's check;

2. the initial premium payment must be submitted to the Fund within 45 days of the date continuation coverage is elected and must be in an amount sufficient to cover the premiums due retroactive to the date coverage would otherwise terminate through the beginning of the month when the initial payment is made;

3. Subsequent premium payments must be made on no less than a monthly basis and are due on the first day of each coverage month. If payment is not received within 31 days of the due date, coverage will terminate and cannot be reinstated.

If the initial premium payment is not submitted to the Fund as specified above, continuation coverage will not be available.

A COBRA participant enrolled in continuation coverage may enroll newly acquired eligible Dependents under his coverage option upon the proper application and payment of any additional premium within 31 days from the date eligible Dependent status was met. If a Dependent spouse or child of a Covered Employee is not enrolled in continuation coverage but has other coverage under another group health plan, if such coverage terminates, any such Dependent may be enrolled for coverage for the balance of the period of continuation coverage even though they were not newly acquired. The Dependent spouse or child must have been eligible but not enrolled for coverage under the terms of the Plan and, when enrollment was previously offered under the Plan and declined, the Dependent spouse or child must have been covered under another group health plan or had other health insurance coverage. The loss of coverage must be due to exhaustion of COBRA continuation coverage under another plan, termination as a result of loss of eligibility for coverage, or termination as a result of Employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause.

e. **Maximum Period of Continuation Coverage.**

The maximum period of continuation coverage is, as follows:

1. 18 months from date coverage would otherwise end if coverage would have been lost due to the termination or reduction in hours, except as follows:

   (a) If a COBRA participant is totally and permanently disabled as of the date coverage would otherwise end due to the termination of employment or reduction in hours, or within a 60 day period commencing on that date, the maximum period of continuation coverage for such COBRA participant and his immediate family members who are also COBRA participants is extended 11 months, to a total of 29 months from the date coverage would have been lost due to the event, provided the Social Security Administration determines that he was totally and permanently disabled as of the date coverage would have been lost as a result of the event or within the 60 days commencing on that date, and provided the COBRA participant notifies the Fund in writing of his Social Security disability determination within 60 days after it is made and before the first 18 months of continuation coverage have expired.

   (b) If the Active Employee is enrolled in Medicare (Part A or Part B) as of the date coverage would otherwise end for his eligible Dependents due to the termination of employment, or reduction in hours, the maximum period of continuation coverage for such Dependents is the longer of 36 months from the date the eligible employee first enrolled in Medicare or 18 months from the date the employee's eligible Dependent's coverage would have been lost due to the event.

   (c) If a second event occurs during the 18 month coverage period, the maximum period of continuation is extended to 36 months from the date of the initial event but only for those Dependents who were COBRA participants as of the first event and were also COBRA participants at the time of the second event. However, this extended period of coverage is available to any child(ren) born to, adopted by or placed for adoption with the Covered Employee during the 18-month coverage period.

   It is the COBRA participant's responsibility to report and submit proof in writing of a second qualifying event within 60 days of the date of the event.

2. For any other qualifying event specified in Section 7 (a)., 36 months from the date of the initial event even if multiple events occur during the period of continuation coverage.

3. Any periods of Hour Bank eligibility (as defined in Article II or disability extension will be applied against the maximum COBRA period.

f. **Termination of Continuation Coverage.** A COBRA participant's continuation coverage shall terminate on the earliest of the following dates:

1. the first day of the month following the failure to pay the required applicable premium within 30 days of its due date;

2. the date the COBRA participant first becomes, after the date of the COBRA election, covered under another group health plan as an employee

3. the date, after the date of the COBRA election, on which the COBRA participant first becomes entitled to Medicare;

4. the date the Fund terminates all group health plans;

5. the date the employee's employer ceases to be an Employer if (a) the Employer subsequently establishes one or more group health plans covering any of the Employer's employees formerly covered under this Plan, or (b) the Employer starts contributing to another multiemployer plan that is a group health plan;

6. the last day of the maximum period of continuation coverage;

7. with respect to a totally and permanently disabled COBRA participant and his immediate family members who are extending continuation coverage an additional 11 months, 30 days after the month in which Social Security determines that the COBRA participant is no longer disabled. A COBRA participant must notify the Fund's Fund Manager immediately upon receipt of such a Social Security determination;

8. If a COBRA participant's coverage ceases due to non-payment of premiums or expiration of the maximum period of coverage, the Fund Manager shall advise the participant of the consequences of discontinuance of coverage or if the maximum period has been reached or the right to conversion if available under the plan.

g. **California COBRA**

In the event a participant has a qualifying event that results in less than 36 months of coverage, provided he has exhausted the federal COBRA coverage period, he may apply for coverage under California COBRA. Only medical benefits may be continued under California COBRA and will be available through the Prepaid Medical plan at a cost of 110% of the premium rate for the benefits. California COBRA shall be administered by the insurance carrier and shall not be the responsibility of the Fund.

For more information about an individual's right under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA), EBSA at www.dol.gov/ebsa or call their toll-free number at 866-444-3272. For more information about health insurance options available through a Health Insurance marketplace, visit www.healthcare.gov.

Section 8. Qualified Medical Child Support Orders.

a. **Determination of a Qualified Medical Child Support Order.**

In the event that a Medical Child Support Order is received by the Fund, the Fund will promptly notify the affected individuals of the receipt of such order and the Fund's procedures for determining the qualified status of such order under Section 609 of ERISA. The Fund shall then, within a reasonable period after receipt of such order, determine whether such order is a Qualified Medical Child Support Order in accordance with written procedures adopted for such purpose, and the Fund will notify the affected individuals of its determination.

b. **Payment of Benefits.**

Any payment of benefits under coverage provided through the Fund pursuant to a Qualified Medical Child Support Order in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian will be made to the Alternate Recipient or Alternate Recipient's custodial parent or legal guardian.

c. **Definitions.**

1. Alternate Recipient as used herein means any child of any Covered Employee other than a child of a Regular Retiree who is recognized under a Medical Child Support Order as having a right to enrollment under the Fund.

2. Medical Child Support Order as used herein means any judgment, decree, or order (including a court approved settlement agreement) issued by a court of competent jurisdiction which either provides for child support with respect to a child of a Covered Employee other than a child of a Regular Retiree is not an eligible Dependent or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and which relates to benefits under the Fund, or, enforces a law relating to medical child support, described in 42 U.S.C. Section 1936, with respect to the Fund.

3. Qualified Medical Child Support Order as used herein means a Medical Child Support Order which creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which an eligible employee is eligible under the Fund, and satisfies the following requirements:

   (a) A Qualified Medical Child Support Order must clearly specify the name and last known mailing address of the Covered Employee and each Alternate Recipient, a reasonable description of the type of coverage to be provided through the Fund to each Alternate Recipient or the manner in which such type of coverage is to be determined, the period to which such order applies and, each plan to which the order applies;

   (b) A Qualified Medical Child Support Order may not require the Fund to provide any type or form of benefit or any option not otherwise provided under the Fund, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act.

Section 9. "Medicaid and the Children's Health Insurance Program (CHIP)

If an Eligible Employee or Eligible Dependent is enrolled in Medicaid or CHIP and lives in California, the individual may contact the State Medicaid or CHIP to determine if premium assistance is available. If it is determined that any one of you are eligible for premium assistance under one of the programs, you will be allowed to enroll in the Health Fund, if not enrolled already. Under this special enrollment option, enrollment must occur within 60 days of the date the individual was determined to be eligible for premium assistance from one of the programs.

If neither the Employee nor Dependent is enrolled in one of the plans, they should contact the State Medicaid or CHIP office for assistance to determine eligibility for premium assistance.

Section 10. Special Enrollment under HIPAA Upon Loss of Other Coverage.

If a Covered Employee declines enrollment for himself and/or any eligible Dependents on the date they first became eligible because they had other health coverage and they later lose that other coverage, the Covered Employee and/or the Dependents may specially enroll in this Fund within 30 days after the other health coverage ends if that other coverage terminated because:

a. the loss of eligibility for that other coverage as a result of termination of employment or reduction in the number of hours of employment, or death, divorce or legal separation; or

b. the termination of Employer contributions toward that other coverage; or

c. if that other coverage was COBRA continuation coverage, the coverage was exhausted. For this purpose, COBRA coverage is not exhausted if it ceases because the COBRA participant or beneficiary fails to pay premiums in a timely manner or because coverage was terminated for cause.

Coverage for such individual(s) shall commence on the first day of the month following the date the Fund Manager's office receives a properly completed enrollment form for the individual(s).

Section 11. Genetic Information Nondiscrimination Act (Gina)

The Genetic Information Nondiscrimination Act (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

ARTICLE III. PERCENTAGE PAYABLE AND CALENDAR YEAR DEDUCTIBLE FOR COMPREHENSIVE MAJOR MEDICAL

Section 1. Eligible Individuals Who Qualify for Plan A+ Benefits.

a. The term "Applicable Percentage" as used in Article V means the percentage payable for Covered Expenses outlined below:

AHF Hospital	100%[1]
Non-AHF Hospital	0%
Other AHF contracting Providers	100%
Other Providers where a contract exists for the service but an AHF provider was not used	80%
Other Providers where no contract exists for a service rendered	80%
Prescription Drugs[2]	90%
Supplemental Accident	100%
Hearing Aids and Tests	80%

b. The term "Calendar Year Deductible" as used in Article V means with respect to Covered Charges, the first $100 per person, but not more than $300 per family, incurred by the Eligible Individual each Calendar Year. Except: no deductible shall apply to benefits payable for prescription Drugs or for benefits payable under the Supplemental Accident benefit.

Section 2. Eligible Individuals Who Qualify for Plan A Benefits.

a. The term "Applicable Percentage" as used in Article V means the percentages payable for Covered Expenses outlined below:

AHF Hospital	80%[1]
Non-AHF Hospital	0%
Other AHF contracting providers	80%
Other Providers where a contract exists for the service but an AHF provider was not used	0%
Other Providers where no contract exists for a service rendered	80%
Prescription Drugs[2]	90%
Supplemental Accident	100%

b. The term "Calendar Year Deductible" as used in Article V means with respect to Covered Charges, the first $200 per person, but not more than $600 per family, incurred by the Eligible Individual each Calendar Year. Except: no deductible shall apply to benefits payable for prescription Drugs or for benefits payable under the Supplemental Accident benefit.

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[1] Charges for an anesthesiologist and physician and diagnostic services in the Emergency room of a contracting facility are payable at the same percent of allowable billed charges.

[2] Prescription drugs are reimbursed by Sav-Rx.

Section 3. Plan B Prescription Drug Benefits.
Benefits payable under the Plan for Plan B Eligible Individuals shall be limited to 90% of Allowable Expense for covered Prescription Drugs.

Section 4. Special Provisions.
Benefits shall be payable as if a contracting AHF provider were used under the following conditions:

a. there is no AHF provider within 30 miles of the Eligible Individual's home;

b. the Eligible Individual is obtaining Covered Services that are not available from a contracting AHF provider;

c. use of a non-contracting provider is beyond the Eligible Individual's control; or

d. services rendered are of an Emergency nature where the use of a contracting provider would result in death, serious disability or significant jeopardy to the Eligible Individual.

e. Emergency services are covered only as long as the condition continues to be an Emergency. Once the condition is under control and the Eligible Individual can be safely transferred or discharged, additional charges incurred through the Emergency facility will not be covered at the maximum level, subject to the continuity of care requirements set out in the Consolidated Appropriations Act of 2021 (CAA).

Section 5.
All payment of benefits will be based upon the CPT codes for contracted providers. Otherwise claim payments are based upon the current Relative Values Studies for Physicians. If a contracting provider could have been used, but was not, Allowable Expenses are based on 80% of the contracting provider rates.

ARTICLE IV. UTILIZATION REVIEW PROGRAMS

For Eligible Individuals
Enrolled in the Union Roofers Indemnity Plan

Section 1. Preadmission Certification.
If non-Emergency Hospitalization, as defined in Subsection (a) below, has been recommended by a Physician for an Eligible Individual, the Plan will, subject to the terms and conditions hereafter stated, pay all benefits according to Plan A+ or Plan A allowable at the Affiliated contract rate.

a. **Non-Emergency Hospitalization.** Non-Emergency Hospitalization is Hospitalization that is not:

1. a matter of life or death; or

2. hospitalization that requires immediate admission in order to protect health or life.

b. **Preadmission Certification** must be obtained through the services of Medical Case Review.

The provisions of this Section shall not apply to an Eligible Individual for whom this Plan would be the secondary payor of benefits.

Section 2. Concurrent Review.
If an Eligible Individual is admitted to a Hospital for any reason, the Plan will, subject to the terms and conditions hereafter stated, pay all charges incurred in connection with obtaining a concurrent review of the Hospitalization.

a. Concurrent review must be obtained through the services of Medical Case Review.

b. The provisions of this Section shall not apply to an Eligible Individual for whom this Plan would be the secondary payor of benefits.

Section 3. Second Surgical Opinion.
If an Elective Surgery is recommended for an Eligible Individual, the Plan will, subject to the terms and conditions hereafter stated pay all charges incurred in connection with obtaining a Second Surgical Opinion provided:

a. the Second Surgical Opinion must be obtained through Medical Case Review.

b. a Second Surgical Opinion is not required for benefits to be payable, nor must a Second Surgical Opinion confirm the need for the elective surgery.

Section 4. Full Plan Benefits.
The term “Full Plan Benefits” as used herein means those benefits described in Article V subject to the provisions of Article III of these Rules and Regulations.

Section 5. Calculation of Benefits.

a. **Eligible Individuals Who Obtain Utilization Review.** Subject to the terms and conditions hereafter stated, the Plan will provide Full Plan Benefits to All Eligible Individuals who obtain:

1. preadmission certification for non-Emergency Hospitalization; and

2. concurrent review for all Hospitalizations.

b. **Eligible Individuals Who Do Not Obtain Utilization Review.** Subject to the terms and conditions hereafter stated, the Plan will provide 50% of Full Plan Benefits for Eligible Individuals who do not obtain:

1. preadmission certification for non-Emergency Hospitalization; or

2. concurrent review for all Hospitalizations.

c. **Eligible Individuals Who Do Not Comply With Utilization Review Recommendations**

Subject to the terms and conditions hereafter stated, no benefits will be payable for any inpatient Hospital charges incurred on days which the utilization review determines are unnecessary.

Section 6. Exclusions and Limitations.

a. Payment of benefits shall be reduced by the amounts payable in accordance with Article VII.

b. The provisions of Article VII shall apply to all benefit payments.

ARTICLE V. COMPREHENSIVE MAJOR MEDICAL BENEFITS

Provided for Eligible Individuals Enrolled in the Union Roofer's Indemnity Plan A+ or Plan A and Plan B Prescription Drug Benefits

Section 1. Comprehensive Major Medical Benefits.

a. **Definitions.**

1. **Basic Benefits** — "Basic Benefits" means any one of the following items:

(a) any benefits, other than Comprehensive Major Medical Benefits provided by the Plan, to which the Eligible Individual is entitled under the provisions of the Plan for expenses incurred for treatment of injury or illness during a Calendar Year; and

(b) any plan sponsored, underwritten, subsidized, or otherwise provided for, by or through a government or instrumentality of a nation, state, province, county, municipality, or other subdivision of government, except benefits provided under "Medicare", or when excluded by law.

2. **Covered Expenses** — The term "Covered Expenses" refers to the items of medical expenses for which Comprehensive Major Medical Benefits may be payable.

b. **Benefits.** If an Eligible Individual receives therapeutic treatment of an injury or illness, the Plan will pay the Applicable Percentage of the Covered Charges as follows:

1. the percentage payable will be in accordance with the provisions of Articles III and IV;

2. the percentage payable under Article III shall increase to 100% if during a Calendar Year, the Eligible Individual's out-of-pocket expenses exceed $5,000 for Covered Expenses, except that the percentage payable for acupuncture, chiropractor shall not increase to 100% and shall remain at 80%;

3. the maximum amount payable by the Plan for any Eligible Individual is not limited during a Calendar Year;

4. For services relating to anesthesia administration or to the reading of test results by a pathologist or radiologist, the following rules will apply:

If a Plan A+ participant uses a contracted Hospital and their primary physician is also contracted, benefits will be paid at 100% of the billed charges. If either the Hospital or the primary care physician is not contracted, then charges will be paid at 80% of the contracted rate. If a participant has minor surgery in the Doctor's office as an outpatient, the physician must be contracted in order for charges to be paid at 100% of the contracted rate. If the physician is not contracted, charges will be paid at 80% of the contracted rate. A Plan A participant's billed charges will be paid at 80% if both a contracted Hospital and physician are used.

c. **Covered Expenses.** Covered Lifetime Expenses include charges for the following services and supplies, which are certified by the attending Doctor, and determined by the Fund, to be necessary for treatment to the extent that the charges do not exceed Reasonable Charges:

1. Hospital Care: Hospital room, board, general nursing care, anesthetic supplies, surgical supplies, use of operating cystoscopic and cartrum Drugs, oxygen, blood and blood plasma, physical therapy including hydrotherapy and x-ray and laboratory (excluding that part of the Hospital's charge for a private room in excess of an amount equal to the Hospital's most common semiprivate room rate).

2. A Hospital length of stay in connection with childbirth for the Eligible Individual who is the mother or newborn child shall not be restricted to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. An attending Doctor, after consulting with the mother, may, however, discharge the mother or her newborn child earlier. A Doctor's prior authorization from the Plan shall not be required for a length of stay that is not in excess of these periods.

3. Charges for confinement in an intensive or coronary care unit in excess of the Hospital's most common charge for a semiprivate room.

4. Emergency room and supplies when needed for treatment of an illness if a medical Emergency (i.e., heart attack, poisoning, loss of consciousness or convulsions).

5. Doctor's fees for medical and surgical service.

6. Services of a Registered Nurse, provided that the services rendered require the skill or training of a Registered Nurse and services of a licensed vocational nurse when medically necessary.

7. Prescription Drugs which require a prescription received from a Licensed Pharmacist when prescribed by a Doctor or Dentist including insulin and insulin injection kits and compounding drugs, dermatological preparations.

8. Doctor's or Dentist's charges for any Drugs or insulin or insulin injection kits which are supplied to the patient in the Doctor's or Dentist's office, and (b) for which a charge is made separately from the charge for any other item of expense, provided the Doctor or Dentist is licensed by law to administer Drugs.

9. Services of a Doctor or psychologist for inpatient or outpatient treatment of mental illness or a functional nervous disorder is payable the same as any other illness.

   Counseling service must be provided by a Doctor (M.D. or D.O.), a psychologist (PhD) or a Masters Prepared Behavioral Health Counselor (e.g. F.M.C., M.F.T).

10. Payments for treatments of a Chiropractor or Acupuncturist are limited to the number of treatments shown in the Schedule of Benefits in any consecutive six-month period, subject to the following:

    (a) The payment of chiropractic and acupuncture benefits is in lieu of all other benefits payable under this Plan.

    (b) The Plan will consider for payment only those visits wherein the Eligible Individual is personally seen by the chiropractor or acupuncturist.

(c) Benefit payments shall commence:

(1) on the first day of treatment with respect to any one accident;

(2) on the first day of treatment for illness if admitted to the Hospital; or

(3) on the second day of treatment for illness it not admitted to the Hospital.

11. Any of the items listed below:

(a) Artificial limbs, eyes or larynx (excluding their replacements), casts, splints, trusses, braces or crutches.

(b) Electronic heart pacemaker.

(c) Rental of a wheelchair, Hospital-type bed, iron lung or other durable equipment used exclusively for treatment of injury or illness not to exceed the reasonable purchase price.

(d) Blood, blood plasma and blood processing fees.

(e) Diagnostic X-ray, and laboratory services.

(f) Use of X-ray, radium and other radioactive substances.

(g) Oxygen and rental of equipment for administration of oxygen.

(h) Professional ambulance service to the nearest Hospital where care and treatment of the injury or illness can be given.

(i) Services of a paramedic.

(j) A physiotherapist, either inpatient or outpatient care, for short-term therapy. Services must be ordered by a Doctor under an individual treatment plan and must be certified by the Doctor as medically necessary for the improvement of the patient's condition through short-term care.

(k) Cosmetic surgery and repair of damage to natural teeth required as a result of an accident are covered within 90 days of the accident.

(l) Treatment of teeth and gums in connection with tumors.

(m) Anesthesia and its administration.

(n) Reconstructive surgery as a result of a mastectomy including:

(1) Reconstruction of the breast on which the mastectomy was performed;

(2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

12. Wellness Benefits for any of the following:

(a) Immunizations and testing in accordance with the guidelines published by the American Academy of Pediatrics and the schedule recommended by the Patient Protection and Affordable Care Act.

(b) Mammograms for women obtained from a Preferred Provider:

(1) once every two years from age 35 to age 40; and

(2) once every year for women age 40 and older or as required by patient's history.

(c) Routine physical exams (excluding exams for insurance, licensing, employment, school, camp, immigration or other non-preventative purposes) obtained from a Preferred Provider for Eligible Individuals including:

(1) complete blood counts, urinalyses, chest x-rays and chemical panels once every two years; and pap smears and prostate exams once every year; and

(2) testing for hearing health is covered under the American Medical Association guidelines.

(d) The plan will cover the cost for Flu shots up to a maximum of $150 per person per calendar year and may be obtained from any, clinic or facility for participants enrolled in the fee-for-service medical plan.

13. Hearing aids, including hearing tests, not to exceed one Hearing Aid per ear every 36 months subject to a maximum payment of $1,500 per ear every 36 months.

d. **Limitations.**

1. Payment of prescription Drugs relating to the treatment of sexual dysfunction are limited to $250 per Eligibility Period and shall not be considered a Covered Expense for anyone other than a Covered Employee or the spouse of a Covered Employee.

2. Treatment of a fractured jaw and related x-rays will be payable for services rendered within ninety (90) days of the accident, provided the accident occurred while the participant was covered and eligible for benefits.

3. Charges for surgical operations or procedures for sterilization will be paid only if all services are received from Preferred Providers.

4. Charges for an assistant surgeon if required for a covered surgical procedure are limited to 20% of the amount payable to the primary surgeon for the operation.

5. Multiple Procedures: Unless otherwise identified in the listings, when multiple procedures add significant time and/or complexity, and when each procedure is clearly identified and defined, the following values shall prevail:

(a) 100% (full value) for the first or major procedure
(b) 50% for the second procedure
(c) 25% for the third procedure
(d) 10% for the fourth procedure
(e) 5% for the fifth procedure
(f) Over five procedures – by report

The second and each subsequent procedure should be identified by adding this modifier (-51) and valued at the appropriate percent of its listed value. A report outlining each procedure and the clinical indications may be required.

e. **Exclusions.** Benefits are not payable for:

1. Services resulting from disease for which the Member is entitled to benefits under any Worker's Compensation Law or Act, or from accidental bodily injury arising out of or in the course of the Member's employment;

2. Services customarily provided by, or incident thereto, a Dentist or Oral Surgeon including any operation or treatment in connection with the fitting or wearing of dentures or for treatment of any condition involving teeth, surrounding tissue or structure except for accidental injuries to natural teeth;

3. Hospitalization primarily for rest, convalescence or rehabilitation care;

4. Services incident to Hospitalization primarily for medical observation or diagnostic examinations;

5. Services provided by a Hospital incident to Hospitalization for tuberculosis, after diagnosis, except that Hospital services with respect to tuberculosis surgery are a benefit of this Plan;

6. Cosmetic surgery except operations necessary to repair disfigurement due to an accident occurring while covered and except for treatment of a congenital anomaly in a Dependent child;

7. Services performed in an institution owned or operated by a State or political subdivision thereof, unless there is an unconditional requirement to pay charges without regard to rights against others, contractual or otherwise;

8. Any services incurred before the effective date of coverage;

9. Weight reduction and related medical or surgical treatment;

10. Charges incurred as a result of war, or any act of war whether declared or not; atomic explosion or release of nuclear energy;

11. Organ transplants other than kidney transplants;

12. Eyeglasses (covered under Vision Care only), refractions, fitting of glasses, radial keratotomy, corrective appliances and artificial aids; vision therapy (orthoptics) unless it is in lieu of a surgical procedure;

13. Vocal cord treatment or training by a non-medical Doctor (M.D.); practice beyond scope of professional license; occupational therapy; vision orthoptic training; tonography; speech therapy;

14. Any bodily injury that is self-inflicted unless this injury results from a medical condition (including any physical or mental health condition) whether or not such medical condition had been diagnosed before the accident, or that results from the covered person's commission of a crime (including but not limited to driving under the influence). (However, benefits are payable for bodily injuries incurred during the commission of crimes where the covered person was a victim of domestic violence or where the crimes were committed as a result of a physical or mental condition.);

15. Any bodily injury that occurs during employment or occupation for compensation, unless coverage states otherwise;

16. Treatment of infertility;

17. Treatment for tobacco use;

18. Suicide or self-inflicted injury except as a result of a mental illness or condition;

19. Chiropractic and acupuncture services (except as provided for in the Plan);

20. Treatment due to pregnancy of dependent child;

21. Experimental procedures and procedures not customarily accepted as general practice in the area where the service is performed;

22. B-12 injections; non-prescription drug items, vitamins, minerals, food supplements, digestive enzymes and substances, natural animal or vegetable substance, bacterial, viral substances or homeopathic preparations;

23. Expenses in connection with marriage counseling;

24. Donor expenses;

25. Charges for medical records or discharge planning;

26. Charges in connection with the pregnancy of a surrogate employee or dependent spouse and delivery and care of child(ren) resulting thereof;

27. Charges in connection with the pregnancy of an employee or dependent spouse when the resulting child(ren) are placed for adoption and such charges are paid for by a third party;

28. Following delivery of a child, routine well baby care obtained in the Hospital at the time of delivery unless included as part of an in-Hospital per diem charge;

29. The cost for flu shots that exceed $150 and flu shot received by an individual not enrolled in the medical indemnity plan (HMO enrollees can get their flu shots through the HMO);

30. Any services or supplies that are not considered medically necessary as determined in the sole discretion of the Trustees;

31. Expenses for a reversal of a voluntary sterilization;

32. Charges for services or supplies paid for under any other benefits provided this Plan;

33. Temporomandibular joint dysfunction (TMJ);

34. Holistic medicine and compounding medicines are not covered;

35. Expenses in excess of $250 per Eligibility Period for the treatment of sexual dysfunction for Active Employees and Early or Regular Retirees. This benefit is only available to Active Employees and their spouses;

36. The administration of local infiltration anesthetics, or for the administration of anesthetics by a Doctor performing or assisting in performing a surgical operation procedure;

37. Diagnostics is not a covered expense if performed or referred by a chiropractor's office;

38. Nurse Practitioner or Physician Assistant;

39. Mobile Devices, Smartphones, IPad, Tablet's, Computers and Software Applications for usage of Durable Medical Equipment are not covered;

40. Apps or cellular phone updates.

f. **Disability Extension of Major Medical Benefits (for Employee Only).**

If a Covered Employee is Totally Disabled on the date coverage terminates and submits a completed application to the Fund office, Comprehensive Major Medical Benefits will be extended to apply to Covered Expenses incurred after termination of coverage for treatment of that uninterrupted injury or illness until the end of one year from the date the illness or injury causing the disability occurred, the date the Plan ends, the date the disability ceases, or the date the illness or injury begins to be covered under another group plan.

Section 2. Supplemental Accident Benefits.

a. **Benefits.**

If an Eligible Individual sustains an accidental injury while covered hereunder, the Plan will pay expenses of professional medical treatment incurred within three (3) months from the date of the accident subject to the limitations hereinafter set forth. Payment shall be made only for Reasonable Charges actually incurred in excess of all other benefits provided hereunder and shall not exceed $500 for any one accident. Professional medical treatment as used herein shall mean only:

1. medical or surgical treatment by a Doctor;

2. necessary services furnished and billed by a legally operated Hospital, excluding personal services such as charges for radio, telephone and the like;

3. services of a Registered Nurse;

4. laboratory and X-ray examinations;

5. local professional ambulance service to the first Hospital of confinement;

6. out-patient services of a licensed physical therapist;

7. prescription Drugs;

8. dental care required as a result of the accident performed by a licensed Dentist or oral surgeon for injuries to the natural teeth, jaw and their dependent tissues, but shall not include services for restoration of function or appearance (i.e., dentures, braces, etc.).

b. **Limitations and Exclusions.** The foregoing benefits will not be provided for:

1. any injury covered by Worker's Compensation;

2. ptomaine poisoning, disease or infection (except pyogenic infection occurring through an accidental cut or wound);

3. eye refractions or fitting of eyeglasses;

4. an intentionally self-inflicted injury unless it is the result of a mental illness or condition;

5. routine treatment of the teeth or gums, except that in the case of dental care for accidental injuries, the Plan will provide payment for services rendered by a Dentist or oral surgeon for treatment to natural teeth, jaws and their dependent tissues; or

6. expenses or services for restoration of function or appearance, such as dentures or braces.

ARTICLE VI. DENTAL BENEFITS

Provided for Active Employees, Plan A+ and Plan A and their Dependents

Fully insured PPO and DHMO dental benefits are an option for Plan A+ and Plan A Active Employees. The PPO and DHMO dental benefits are described in separate brochures.

Section 1. Definitions

a. **Covered Dental Expense**

The term "Covered Dental Expense" means only expenses incurred for necessary treatment which is received by an Eligible Individual from a Dentist or a dental hygienist under the supervision of a Dentist and which, in the geographical area where treatment is rendered, is the usual and customary procedure for the condition being treated. However, the amount allowable as Covered Dental Expense will not exceed the total of the amounts specified in the Schedule of Dental Allowances for the procedures reported on any one attending Dentist's statement. A Covered Dental Expense is deemed to be incurred on the date on which the service or supply which gives rise to the expense is rendered or obtained.

b. **Covered Expense for Orthodontic Procedures**

The term "Covered Expense for Orthodontic Procedures": means only the expense incurred for any necessary orthodontic treatment which is received by an Eligible Individual from a participating Dentist and which, in the geographical area where the treatment is rendered, is the usual and customary procedure for the condition being treated. Covered Expenses shall include charges incurred for diagnosis, consultation and necessary records (study models, x-rays, cephalometrics, photographs, etc.) required for treatment.

c. **Optional Dental Benefits for Retirees Ages 55 to 64**

Retired Employees not eligible for Medicare have the option of self-paying for the DPPO or DHMO dental plans underwritten by Delta Dental.

Section 2. Deductible.

The Calendar Year Deductible is the amount of Covered Dental Expense the Eligible Individual is required to pay before dental benefits become payable by the Plan. The Calendar Year Deductible applicable to Plan A participants is $75 per person, for Plan A+ participants the deductible is $50 per person.

Section 3. Benefits.

If an Eligible Individual incurs Covered Dental Expense, the Plan will pay the applicable amount for the treatment, examination or procedure listed in the Schedule of Dental Allowances, but not more than the Dentist's usual, customary and reasonable fees. The maximum amount payable hereunder for Covered Dental Expense incurred by each Eligible Individual in any Calendar Year shall be $2,500.

Covered Expense for Orthodontic Procedures is payable at the amounts listed in the Schedule of Dental Allowances, or the Dentist's usual, customary and reasonable fees. In no event, however, will the maximum amount paid in an Eligible Individual's lifetime exceed $3,000 for Covered Expense for Orthodontic Procedures.

An Eligible Individual must be covered each month in which Covered Expense for Orthodontic Procedures is incurred.

Section 4. Schedule of Services.
Subject to the Exclusions and Limitations hereinafter contained in Sections 4 and 5 of this Article, the following is the Schedule of Services covered hereunder when rendered by a Dentist or a dental hygienist under the supervision of a Dentist, and when necessary and customary, as determined by the standards of generally accepted dental practice.

a. **Basic Benefits:**

1. Diagnostic:

   Procedures to assist the Dentist in evaluating the existing conditions to determine the required dental treatment.

2. Preventive:

   Prophylaxis once every six months, or more frequently if determined to be medically necessary; topical application of fluoride solutions; space maintainers.

3. Oral Surgery:

   Procedures for extractions and other oral surgery including pre and post-operative care.

4. General Anesthesia:

   When administered for a covered oral surgery procedure performed by a Dentist.

5. Restorative:

   Provides amalgam (including acid etching and bonding), synthetic porcelain and plastic restorations for treatment of carious lesions. Gold restorations, crowns and jackets will be provided when teeth cannot be restored with the above materials.

6. Endodontics:

   Procedures for pulpal therapy and root canal filling (treatment of non-vital teeth).

7. Periodontic:

   Procedures for the treatment of the tissues supporting the teeth.

b. **Prosthetic Benefits:**

Procedures for construction of bridges, Implants, partial and complete dentures.

c. **Orthodontic Benefits:**

Procedures for straightening the teeth, including diagnosis, consultation and necessary records. Treatment for orthodontia of adult Eligible Individuals age 19 years and older must be medically necessary. Treatment for cosmetic purposes is not a covered benefit.

Section 5. Limitations.

The benefits as outlined are subject to the following limitations:

a. All services which are anticipated to exceed $200 must be submitted to the Fund Manager's office for preauthorization. Should a major change in treatment occur, additional preauthorization is required.

b. Prophylaxis and or Periodontal maintenance is covered once every six months unless prophylaxis or Periodontal maintenance is required more often due to medical necessity. Fluoride treatment is a covered expense for covered Dependent children to age 18.

c. Complete mouth X-rays or panorex are provided only once in a twenty-four (24) month period, unless they are necessary for orthodontic diagnosis or special need is shown. Supplementary bite-wing X-rays are provided only once in a twelve-month period, unless special need is shown.

d. Replacement of an existing prosthetic appliance will be made only if it is unsatisfactory and cannot be made satisfactory. Prosthetic appliances (including partial or complete dentures, crowns, implants and bridges) will be replaced only after five years have elapsed following the date expense was incurred, unless:

    1. the prosthetic appliance was made necessary by the initial placement of an opposing full denture or the extraction of natural teeth; or

    2. the prosthetic appliance is a stayplate, or a similar partial denture; or

    3. the prosthetic appliance, while in the oral cavity, has been damaged as a result of an injury occurring while the Eligible Individual is covered under the Plan.

    4. In all cases in which the patient selects a more expensive plan of treatment than is customarily provided, the Plan will pay the lesser fee. The Eligible Individual shall be responsible for the remainder of the Dentist's fee.

    5. Gold Crowns or Restorations. The Plan will provide the amount for an amalgam restoration, unless there is no other reasonable means to restore the proper contour of a tooth.

    6. Partial Dentures. The Plan will provide standard cast chrome or acrylic partial dentures or will allow the cost of such procedure toward a more complicated or precision appliance that the Eligible Individual and Dentist may choose to use. Any denture for which a charge is made which exceeds the customary fee shall be considered an optional service and the provisions of d. 4., above, shall apply.

    7. Complete Dentures. If in the construction of a denture the Eligible Individual and Dentist decide on personalized restorations or employ specialized techniques as opposed to standard procedures, the Plan will allow an appropriate amount for the standard denture toward such treatment and the Eligible Individual shall bear the difference in cost. Any denture for which a charge is made which exceeds the customary fee shall be considered an optional service and the provisions of d. 4. above, shall apply.

    8. Occlusion. The Plan will allow the cost of restorations required to replace missing teeth. Procedures, appliances, or restorations necessary to increase vertical dimension and/or restore or maintain the occlusion are considered optional, and the cost is the responsibility of the Eligible Individual. Such procedures include, but are not limited to: equilibration, periodontal splinting, restoration of tooth structure lost from attrition, and restoration for malalignment of the teeth.

9. Stayplates are not covered unless anterior teeth have been extracted.

10. Periodontal pocket depth charting is included in oral examination fee.

11. Analgesia anxiolysis, nitrous oxide is covered for Dependent children up to age 14.

12. Sealants are limited to non-carious and unrestored posterior teeth for Dependent children only under 16 years of age once every three years.

13. Porcelain, labial veneer, acrylic and resin crowns are limited to anterior teeth.

14. Replacement of crowns, inlays, onlays, bridges, partial dentures, implants and complete dentures are limited to once every 5 years.

15. Dependent children under the age of 12 are limited to stainless steel crowns on posterior teeth and acrylic crowns on anterior teeth and replacement is limited to once every 5 years.

16. Root canals require pre-treatment and final treatment x-rays.

17. All adjustments on complete and partial dentures within the first six months of installation are included in allowance.

18. Tissue conditioning is limited to 2 per year after 6 months from installation date of complete denture.

19. Deep sedation, general anesthesia and intravenous conscious sedation analgesia are limited to surgical procedures.

20. Emergency palliative treatment is covered only when no other treatment is provided for that tooth or area on the same date.

21. An Eligible Individual must be covered each month in which Covered Expense for Orthodontic Procedures is incurred.

22. Payment for Covered Dental Expense incurred as a result of tumors and accidental injury occurring while covered under the Plan shall be made only for such expenses actually incurred in excess of all other benefits provided under the provisions of these Rules and Regulations.

23. Emergency palliative treatment to a tooth when other treatment is performed on the same tooth on the same day.

24. Occlusal guard is limited to once every 5 years.

25. Periodontal maintenance is covered only when the patient has a history of periodontal root planning and is not covered until 4 months after periodontal root planning to be considered.

26. Mandatory preauthorization is required for localized delivery of chemotherapeutic agents and is not covered when placed at the same time of periodontal root planning or a prophylaxis.

27. Periodontal-oral irrigation is not covered as a separate charge.

28. Pocket depths must be 5 mm or greater in order for subgingival curettage and/or periodontal scaling and root planning to be covered.

Section 6. Exclusions.
No benefits shall be provided for:

a. services for injuries or conditions which are compensable under Worker's Compensation or Employer's Liability laws; services which are provided to the Eligible Individual by any Federal or State Government Agency or are provided without cost to the Eligible Individual by any municipality, county or other political subdivision, unless mandated by law;

b. services with respect to congenital or developmental malformations or cosmetic surgery or Dentistry for purely cosmetic reasons, including but not limited to: cleft palate, maxillary and mandibular malformations, enamel hypoplasia, fluorosis and anodontia, attrition, erosion or abrasion;

c. prosthetic and orthodontic services or devices (including crowns and bridges) or any single procedure started prior to the date the patient became an Eligible Individual;

d. general anesthesia and IV sedation for restorative procedures;

e. services and supplies not furnished by a Dentist or not necessary for dental care;

f. any orthodontic expenses incurred when the Eligible Individual's coverage was not in effect;

g. fluoride treatments for a Dependent child after the child reaches his/her eighteenth birthday;

h. hospitalization in connection with any dental service or procedure;

i. treatment for orthodontia of an Eligible Individual over age 19 that is not considered medically necessary or that is considered cosmetic in nature;

j. fixed bridges or removable partials for a Dependent child under the age of sixteen;

k. lost or stolen appliances;

l. adjustments to complete and partial dentures within the first six months from installation;

m. emergency palliative treatment when other treatment is done on the same day on the same tooth;

n. broken or cancelled appointments, bleaching of teeth, temporomandibular joint dysfunctions; oral hygiene instruction and supplies; insurance filing form fees and base fillings;

o. acid etch – included with composite/resin fillings; bonding is included in filling fee.

Section 7. Extended Benefits.

If an Eligible Individual is receiving treatment for services required for the completion of a procedure which was considered a Covered Dental Expense or a Covered Expense for Orthodontic Procedures at the time his coverage hereunder terminates, Dental benefits will be payable for such expense, but not beyond one month after termination of coverage. X-rays and prophylactic treatment will not be considered to be the commencement of a procedure. If an Eligible Individual is Totally Disabled as a result of an accident on the date his coverage hereunder terminates, Dental Benefits will be payable for repair or alleviation of damage to natural teeth as a result of such accident, but not beyond three months after termination of coverage.

ARTICLE VII. GENERAL EXCLUSIONS AND LIMITATIONS

Section 1.

The Plan shall not provide benefits for:

a. any bodily injury or sickness for which the Eligible Individual is not under the care of a Doctor or Dentist;

b. any condition for which benefits of any nature are recovered or found to be recoverable, whether by adjudication or settlement, under any worker's compensation or Occupational Disease Law, even though the Eligible Individual fails to claim his or her rights to such benefits;

c. conditions caused by or arising out of an act of war, armed invasion or aggression;

d. any supplies or services (1) for which no charge is made; or (2) for which the Eligible Individual is not required to pay, or (3) furnished by a Hospital or facility operated by the United States Government or any authorized agency thereof or furnished at the expense of such Government or Agency; or (4) which are provided without cost by any municipal, county, or other political subdivision;

e. charges for expenses incurred outside of the United States, unless such expenses are for Emergency care received while traveling on business or vacation;

f. charges for services received by a Covered Employee or Dependent which are performed by the spouse, child, brother, sister or parent of the Covered Employee or of the Covered Employee's spouse;

g. expenses for services required as a result of injury or illness sustained in the commission of a felony or engagement in an illegal activity;

h. non-prescribed Drugs;

i. charges for care and treatment in any penal institution; and

j. charges resulting from intentionally self-inflicted actions, unless it is the result of a mental illness or condition.

Section 2.

The Plan shall not be liable to provide benefits for medical services or supplies not reasonably necessary for the care and treatment of bodily injuries or sicknesses or for dental services or supplies not reasonably necessary for dental health unless specifically provided for. Furthermore, the Plan will not provide benefits for services, treatments or supplies for the care and treatment of bodily injuries or sicknesses which are in excess of the Reasonable Charge therefore.

Section 3.

If any payments are made to or on behalf of any Eligible Individual for illness or injury caused by the negligence of a third party, and the Eligible Individual receives Worker's Compensation or insurance benefits, the Plan shall be subrogated to such Eligible Individual's claim to the extent of the payments made or to be made by reason of the foregoing. Upon settlement of the Eligible Individual's claim, the Eligible Individual shall reimburse the Plan to the extent of the benefits provided by the Plan. The Eligible Individual shall agree in writing to provide the Plan with a lien, to the extent of benefits by the Plan, which lien may be filed with the person whose act caused the injury or illness, that person's agent, the Court, or otherwise as necessary to protect the interests of the Plan.

ARTICLE VIII. ELECTION OF COVERAGE

Each Covered Employee who qualifies for Plan A or Plan A+ benefits shall be given the opportunity to elect the medical coverage provided directly by the Fund (the Indemnity medical Plan) as described in these Rules and Regulations or the coverage then being offered through any prepaid Hospital/medical plan. The newly eligible employee (if enrolled) will also become covered under the prepaid DHMO dental plan. The coverage shall remain continuous, except as approved by the Board of Trustees, until the next "Open Enrollment" period or, in the case of the dental coverage, at least one year has elapsed. At the end of the one-year period required for DHMO dental coverage, the Covered Employee will be given the opportunity to enroll in the DPPO dental plan. The Indemnity Dental plan is no longer available to employees not currently enrolled in that plan.

Plan B employees must be enrolled in a prepaid medical plan and they are not eligible for dental coverage. Plan B employees may change their medical plan for another prepaid medical plan during Open Enrollment.

The term "Open Enrollment" shall mean that period of time as determined by the Board of Trustees, during which an Active Employee may change from the prepaid dental coverage to the PPO dental plan, change from DPPO dental coverage to DHMO coverage, or from the Indemnity medical plan to the HMO medical plan or from the HMO medical plan to the indemnity medical plan.

Coverage selected by the Active Employee shall apply to any Dependents of such person. The eligibility rules established by the Board of Trustees shall prevail, regardless of the coverage selected. The terms of the contract between the Fund and any prepaid plan shall prevail in the payment of claims or services rendered to those persons covered by the contract.

If a Retired Employee changes to the status of an Active Employee or when an Active Employee becomes a Retired Employee, a new election will not be made by the employee until the next "Open Enrollment" period, unless because of residence a plan change is required and available under the Plan of benefits.

If no election is made during the "Open Enrollment" period, the Covered Employee and his eligible Dependents shall remain in the plan in which he was enrolled at this "Open Enrollment" period, if he is eligible for that plan.

Note:

1. If an Active Employee is eligible for Plan B benefits and has not enrolled in a Prepaid Medical plan during the months of January or July only, he will be covered under the Plan A medical benefits. If he has not enrolled in a prepaid plan by the end of that month, he will have no medical benefits.

2. If an Active Employee was eligible for Plan B benefits in July and is then eligible for Plan A+ benefits, he will have a one-time opportunity to change coverage from a Prepaid Medical plan to the Indemnity Plan.

Exception:

The Active Employee may not change coverage if services were received from a Prepaid Medical plan in January, and must wait until the next Annual Open Enrollment."

Special Open Enrollment - Active Contract Employees Only

Changing From Plan B to Plan A or Plan A+

Changing From Plan B to Plan A or Plan A+
If you were eligible under Plan B in July and are eligible in January under Plan A or Plan A+, you have a one-time opportunity to change from your HMO to coverage under the Trust Fund's PPO medical plan***. However, if you receive services from your HMO in January or July you will not be permitted to change to the PPO medical Plan***.

It is very important that you notify the Fund Manager's office immediately if you want to change to the PPO medical Plan. If you want to change and you must see a provider before January 16th, you must phone the Fund Manager's office with your request to change. A completed application for the PPO Plan MUST be on file in the Fund Manager's office by January 16th.

Open enrollment is July 1st of each year for medical and dental. However, there is also an Open Enrollment period in January for newly eligible employees.

ARTICLE IX. DEATH AND DISMEMBERMENT BENEFITS

For Active Bargaining Unit Employees and Retired Employees

Section 1. Death Benefits

a. **Benefit.**

If a Covered Employee other than a Non-Contract Employee dies while eligible or within 31 days following the termination of his eligibility, the Fund will, subject to the provisions hereafter stated, pay a Death Benefit of $2,000 to the beneficiary of an Active Employee and $1,000 to the beneficiary of a Retired Employee as provided in Section 3 of this Article IX. Upon attainment of age 70, the amount of the death benefit reduces by 50%.

b. **Facility of Payment.**

The Fund may, at its option, pay an amount not to exceed $100 of the Death Benefit to any person who has incurred expenses in connection with the last disability and death of the Covered Employee. Any payment made under this Subsection (b) shall discharge the obligation of the Fund hereunder to the extent of such payment.

Section 2. Accidental Death and Dismemberment Benefits

a. **Accidental Death Benefit.**

If a Covered Employee, other than a Non-Contract or Retired Employee, sustains bodily injuries solely through external, violent and accidental means, and dies as a result of such injuries within 90 days following the accident in which injuries were sustained and while eligible hereunder, the Fund will, subject to the provisions hereafter state, pay an Accidental Death Benefit of $2,000 to the beneficiary as provided in Section 3 of this Article IX. Upon attainment of age 70, the amount of the death benefit reduces by 50%.

b. **Accidental Dismemberment Benefits.**

If a Covered Employee, other than a Retired Employee, sustains bodily injuries solely through external, violent and accidental means, and within 90 days following the accident in which the injuries were sustained and while eligible hereunder, suffers as the result of such injuries one of the losses enumerated below, the Fund will, subject to the provisions hereafter stated, pay to the Covered Employee a Dismemberment Benefit in the following amount:

1. $1,000 (50% less at age 70) for: (a) the loss of a hand by severance at or above the wrist, (b) the loss of a foot by severance at or above the ankle, or (c) the irrecoverable loss of sight of an eye;

2. $2,000 (50% less at age 70) for the loss of more than one of the members enumerated in the foregoing Subsection (b)(1).

c. **Limitations and Exclusions.**

1. Not more than $2,000 (50% less at age 70) is payable under the foregoing Subsections (a) and (b) as a result of any one accident.

2. No benefits are payable for any loss resulting from bodily injuries sustained, directly or indirectly, as a result of:

   (a) suicide or intentionally self-inflicted injury unless it is the result of a mental illness or condition;

   (b) war or any act of war, or service in the armed forces of any country engaged in war or police duty;

   (c) participation in, or as the consequence of having participated in, the commission of an assault or a felony by the Covered Employee;

   (d) travel in any aircraft as a pilot or crewman, or in any aircraft privately owned, operated or leased; or

   (e) disease or bodily or mental infirmity, or medical or surgical treatment thereof, ptomaine or bacterial infections (except infections occurring through an accidental cut or wound).

3. These benefits are not assignable.

4. A claim for benefits must be filed within one year of the date of death to be payable.

Section 3. Beneficiaries.

a. **Designation of Beneficiary.**

A Covered Employee may designate a beneficiary or beneficiaries to receive the Death Benefit or Accidental Death Benefit payable under this Article by forwarding such designation on a form acceptable to the Trustees to the Fund Manager's office. A Covered Employee shall have the right to change his designation of beneficiary without consent of the beneficiary, but no such change shall be effective or binding on the Fund unless it is received by the Fund Manager's office prior to the time any payments are made to the beneficiary whose designation is on file with the Fund. If more than one beneficiary is designated, and their respective interests are not specified, they will share alike.

(1) No Death Benefits are payable to a beneficiary who commits an unlawful act against the Employee resulting in the death of the Employee. Such a beneficiary shall not be deemed an eligible beneficiary in the section below.

b. **Lack of Designated Beneficiary.**

If no beneficiary has been designated, or if the designated beneficiary dies before the Death Benefit or Accidental Death Benefit is paid, the Death Benefit or Accidental Death Benefit shall be paid to the lawful spouse of the Covered Employee if then living, or if there is no lawful spouse alive at the time of death, payment will be made to the first surviving class of the following classes of successive preference beneficiaries: he Covered Employee's (1) surviving children; (2) surviving parents; (3) surviving brothers and sisters; and (4) executors or administrators.

ARTICLE X. DEATH BENEFITS

Provided for Dependents of Active Bargaining Unit Employees and Retired Employees

The Benefit is payable in the event of death subject to the limitations below.

SCHEDULE OF BENEFITS

Death Benefit

Employee	$2,000[1]
Early and Regular Retired Employees	$1,000[1]
Spouse:	
Active Employee	$1,000[1]
Retired Employee	$ 500[1]
Dependent Children of Active Employees only:	
Dependent child age 14 days, but less than 6 months	$ 100
Dependent child age 6 months, but less than 19 years	

In the event of death of a Covered Employee, $100 of the Death Coverage may be paid immediately; the balance to be paid upon receipt by the Fund of satisfactory proof of death.

Beneficiary
Death Benefits for your dependents will be paid to you.

The following rules apply to benefit payments in the event of your death:

- You may designate a beneficiary or beneficiaries to receive the Death Benefit by completing a beneficiary form and forwarding it to the Fund Manager's office. You have the right to change your designation of beneficiary without consent of the beneficiary, but no such change will be effective or binding on the Fund unless it is received by the Fund Manager's office prior to the time any payments are made to the beneficiary whose designation is on file with the Fund. If more than one beneficiary is designated, and their respective interests are not specified, they will share alike.

No Death Benefits are payable to a beneficiary who commits an unlawful act against the Employee resulting in the death of the Employee. Such a beneficiary shall not be deemed an eligible beneficiary in the section below.

Lack of Designated Beneficiary
If no beneficiary has been designated, or if the designated beneficiary dies before your Death Benefit is paid, the Death Benefit will be paid to your lawful spouse or Domestic Partner if then living, or if there is no lawful spouse or Domestic Partner alive at the time of payment, payment will be made to the first surviving class of the following classes of successive preference beneficiaries: your (1) surviving children; (2) surviving parents; (3) surviving brothers and sisters; (4) executors or administrators.

Assignment
No benefits provided under the plan are assignable.

Notice of Claim
Written notice of claim must be given to the Fund Manager's Office at Downey, California, within ninety (90) days but will be accepted up to twelve (12) months after the date of death. A certified copy of the Death Certificate must be submitted.

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[1] When an Active or Retired Employee or spouse attains the age of 70 years, this maximum amount automatically reduces by 50%. In no event will the amount of coverage on any dependent of an Active or Retired Employee exceed 50% of the amount of coverage of such Active or Retired Employee.

ARTICLE XI. COORDINATION OF BENEFITS

Section 1. Benefits Subject to This Provision.

All benefits provided under these Rules and Regulations, except benefits provided under Articles V and VI, are subject to the following additional provisions and limitations.

Section 2. Definitions.

a. **Plan.** For purposes of this Article only, the term "Plan" means (1) group, blanket or franchise insurance, (2) service plan contracts, group practice, individual practice and other prepayment coverage, (3) labor-management trusteed plans, Union welfare plans, employer organization plans, or employee benefit organization plans, and (4) any coverage under governmental programs, and any coverage required or provided by any statute, which provides benefits or services for medical or dental care or treatment.

The term "Plan" shall be construed separately with respect to each benefit or service.

b. **This Plan**. For purposes of this Article only, the term "This Plan" means that portion of the Rules and Regulations which provides Medical, Hospital or Dental Benefits.

c. **Allowable Expense**. For purposes of this Article only, the term "Allowable Expense" means any necessary, reasonable and customary item of medical or dental care expense incurred, a portion of which is covered under one of the Plans covering the Eligible Individual for whom claim is made.

When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

The Fund shall not be required to determine the existence of any other Plan, or the amount of benefits payable under any Plan other than This Plan. The payment of benefits under This Plan shall be affected by the benefits payable under other Plans only if the Fund is furnished with information concerning the existence of such other Plans by the Eligible Individual or insurance company, organization, agency of government or person.

d. **Claim Determination Period.** The term "Claim Determination Period" means a period commencing with any January 1 and ending at 12 o'clock midnight on the next succeeding December 31st or that portion of such period during which the Eligible Individual with respect to whose expense claim is based has been covered under This Plan.

Section 3. Effect on Benefits.

a. This provision shall apply in determining the benefits due an Eligible Individual under This Plan for any Claim Determination Period if, for the Allowable Expenses incurred as to such Eligible Individual during such period, the sum of the benefits that would be payable under This Plan in the absence of this provision, and the benefits that would be payable under all other Plans in the absence in them of provisions of similar purpose to this provision would exceed such Allowable Expenses.

b. As to any Claim Determination Period to which this provision is applicable, the benefits that would be payable under This Plan in the absence of this provision for the Allowable Expenses incurred as to such Eligible Individual during such Claim Determination Period shall be reduced to the extent necessary so that the sum of such reduced benefits and (2) all the benefits payable for such Allowable Expenses under all other Plans, except as provided in item (c) of this Section 3, shall not exceed the total of such Allowable Expenses. Benefits payable under another Plan include the benefits that would have been payable had claim been duly made for them.

c. When, in accordance with items (d) and (e) of this Section 3, This Plan will determine its benefits before the benefits of another Plan, then the benefits of This Plan shall not be reduced as provided in the preceding paragraph.

d. For the purpose of item (c) of this Section 3, the rules establishing the order of benefit determination are:

1. The benefits of the Plan which covers the person as an active employee will be determined before the benefits of a Plan which covers such person as a dependent.

2. When both Plans cover the person as a dependent child of an active employee, the benefits of the Plan which covers the parent whose birthday (month and day only) occurs first during a Calendar Year will be determined before the benefits of the Plan which covers the parent whose birthday (month and day only) occurs later in the year. If both parents have the same birth date, the Plan covering the parent the longer period of time shall pay benefits first. However, in the event a father and mother are legally separated or divorced and no Qualified Medical Child Support Order (QMCSO) exists, the following rules will apply:

(a) The benefits of a Plan which covers the person as a dependent of the parent with the financial responsibility for the child's medical expenses by virtue of a court decree will be determined first.

(b) If there is no court decree, the benefits of a Plan which covers the person as a dependent child of the parent with legal custody will be determined first.

(c) If there is no court decree and the parent with legal custody has remarried, the order of benefit determination will be as follows:

(1) The Plan which covers the parent with legal custody.

(2) The Plan which covers the step-parent with legal custody.

(3) The Plan which covers the parent without legal custody. If a QMCSO exists, the terms of it shall be recognized.

e. When This Plan and another Plan cover the person as a dependent child and such other Plan does not contain the birthday rule as described above, but uses the benefit determination provision which provides that the Plan which covers such person as a dependent child of the father shall determine benefits before the Plan which covers such person as a dependent child of the mother, then This Plan will also use this benefit determination provision when applicable.

f. The benefits of a Plan covering the person as an active employee shall determine the benefits before the Plan which covers the person as a laid-off or retired employee. However, if This Plan coordinates benefits against a Plan without this provision, then this rule is ignored.

g. When these rules do not establish an order of benefit determination, the benefits of a Plan which has covered the person for the longer period of time will be determined before the benefits of a Plan which has covered such person the shorter period of time.

h. When this coordination of benefits provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan, each benefit that would be payable in the absence of this provision will be reduced proportionately, and such reduced amount will be charged against any applicable benefit limit of This Plan.

i. Medicare shall determine benefits first for all eligible retired employees and their dependent spouses, provided they are also eligible for Medicare.

j. If an individual has End-Stage Renal Disease (ESRD) the order of benefit payments is:

1. The Plan is the primary payer for the ESRD coordination period of 30 months regardless of employment status or eligibility for COBRA or a retirement plan.

2. Medicare is the secondary payer.

3. After the 30-month eligibility period or entitlement to Medicare, Medicare becomes primary.

k. If a Dependent has benefits provided on a primary basis by a prepaid plan and is covered under the Union Roofer's Indemnity plan, no benefits will be payable under this Plan if the Dependent does not receive treatment from the prepaid plan. If the Dependent does seek or receive treatment from the prepaid plan, the secondary coverage under the Union Roofer's Indemnity Plan will coordinate benefits in accordance with the provisions of this Article.

l. If the Eligible Employee is covered under the Union Roofer's Indemnity Plan, and as a dependent under a prepaid plan, the Eligible Employee may receive treatment from either a personal physician or a privately selected Hospital or from the prepaid physicians or Hospitals. If the Eligible Employee receives treatment through the prepaid plan, the primary coverage under the Union Roofer's Indemnity Plan will pay its normal benefits for any expenses that the Eligible Employee is legally obligated to pay.

Section 4. Right to Receive and Release Necessary Information.

For the purpose of determining the applicability of and implementing the terms of this provision of This Plan or any provision of similar purpose of any other Plan, the Fund may, with the consent of the Eligible Individual, release to or obtain from an insurance company or other organization or person any information, with respect to any person, which the Fund deems to be necessary for such purposes. Any Eligible Individual claiming benefits under This Plan shall furnish to the Fund such information as may be necessary to implement this provision.

Section 5. Facility of Payment.

Whenever payments which should have been made under This Plan in accordance with this provision have been made under any other Plan, the Fund shall have the right in its sole discretion to pay to any organization making such payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under This Plan and to the extent of such payments, the Fund shall be fully discharged from liability under This Plan.

Section 6. Right of Recovery.

Whenever payments have been made by the Fund for services or supplies, the Fund shall have the right to recover such payments with regards to:

a. a member or Dependent that was not eligible at the time services or supplies were rendered;

b. when benefits were paid incorrectly for services or supplies.

c. The Fund shall have the right to recover such payments, to the extent of such excess from among one or more of the following, as the Fund shall determine;

d. the persons to or for or with respect to whom such payments were made;

e. the person who benefited from such payments, or his legal guardian; or

f. insurance companies, service plans or any other organizations.

ARTICLE XII. CLAIMS AND APPEALS PROCEDURES

These procedures for filing claims for benefits from the Indemnity Plan of the Union Roofers Health and Welfare Fund (the Plan) cover all Indemnity Plan benefits from the Fund including Hospital, Doctor, prescription drug, dental, vision, hearing aid, death, accidental death and dismemberment, and supplemental accident protection benefits. This section also describes the procedure to follow if a claim is denied in whole or in part and the claimant wishes to appeal the decision. These appeals procedures also apply to a denial of a vision claim by Vision Service Plan, weekly disability benefits by Standard Insurance Company, and when a Hospital stay pre-admission certification has been denied.

HMO Enrollees: If a participant is covered under an HMO plan such as Kaiser, Health Net, DeltaCare or the insured Delta Dental PPO, the participant should refer to the latest **Evidence of Coverage** certificate and any supplement for the current version of their claims and appeals procedures. A copy of the Evidence of Coverage may be obtained from the HMO or from the Fund Office.

A. CLAIMS PROCEDURES

Section 1. Claims for Vision Benefits

If you are in a plan with vision coverage and use a vision provider in the Vision Service Plan member panel, you need not file a claim. VSP contracted vision providers will file vision claims directly to VSP. If you use a vision provider that is not in the VSP member panel, you must file your claim for reimbursement directly with VSP.

Section 2. Filing a Claim for Benefits Under the Indemnity Plan

a. **Post-Service Claims**

Post-Service Claims are claims for payment of treatment, services or supplies that have already been provided to you. You may obtain a claim form by calling the Fund Office at (562) 927-1434. Be sure to specify whether your claim is for medical or dental benefits, as there are separate claim forms for medical and dental expenses.

Note: Pre-Certification is required for Hospital Stays and Dental Expenses estimated to exceed $500. Refer to the section below on Pre-Service Claims and Claims Involving Urgent Care.

Carefully fill in the employee section of the claim form and give it to your Doctor or Dentist to complete the provider portion of the claim form. Your provider should then send the written claim to the Fund Office at the following address:

Union Roofers Health and Welfare Fund
9901 Paramount Boulevard, Suite 211
Downey, California 90240

If a provider submits a claim electronically, it must comply with the federal standards for electronic transmission of health claims and should include the following information:

- Patient's name
- Patient's date of birth

- Patient's address
- Patient's relationship to the employee
- Current ICD (the code for physician services and other health care services found in the *Current Procedural Coding Expert*, as maintained and distributed by the American Medical Association) ICD (the diagnosis code found in the *International Classification of Diseases, current Edition, Clinical Modification* as maintained and distributed by the U.S. Department of Health and Human Services)
- Services rendered (including dates)
- Name of the eligible employee, his or her Social Security number, his or her Local number and the designation Plan B, A, or A+
- Billed charges (bills must be itemized on Form 150 with all dates of Physician visits shown)
- Number of Units (for anesthesia and certain other claims)
- Federal taxpayer identification number (TIN) of the provider
- Provider's billing name, address, phone number and professional degree or license Provider's signature
- If treatment is due to accident, accident details (you may be required to sign a Third Party Liability Agreement to reimburse the Plan if you recover damages)
- Information on other insurance, if any
- In the event of death, written notice of claim and a certified copy of the death certificate must be submitted to the Fund Office

b. **Pre-Service Claims**

Pre-Service Claims are claims that require pre-certification before treatment is rendered. You must obtain pre-certification in the following situations:

1. Elective procedures must be pre-certified by calling the Trust Fund Office at (562) 927-1434.

2. Dental expenses that are estimated to exceed $500.00 must be submitted for prior approval. The Dentist or orthodontist must submit the proposed treatment plan and x-rays to the Fund Office.

c. **Urgent Care Claims**

A request for pre-certification involving a Hospital stay or dental expenses that are estimated to exceed $500 is a claim involving Urgent Care if the standard 15-day deadline to notify you of a decision regarding pre-certification could either:

1. seriously jeopardize the participant's life or health or ability to regain maximum function, or

2. in the opinion of a physician with knowledge of the medical condition, would subject the person to severe pain that cannot be adequately managed without the medical care or treatment for which the person is seeking pre-certification.

Whether a claim is an **Urgent Care Claim** is determined by the Plan applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine. Alternatively, any claim that a physician with knowledge of your medical condition determines is an **Urgent Care Claim** within the meaning described above, shall be treated as an **Urgent Care Claim**.

To initiate an Urgent Care Claim involving pre-certification of a Hospital stay you must call (562) 927-1434. To initiate an Urgent Care Claim involving pre-certification of dental expenses that are estimated to exceed $500 your Dentist or orthodontist must submit the proposed treatment plan and x- rays to the Fund Office.

Note: the Urgent Care Claims procedures described in this notice do not apply to Emergency care. If a person experiences a medical Emergency he or she should go to the nearest Hospital Emergency room. The term "Emergency" means the sudden onset of a condition requiring immediate treatment, including but not limited to heart attack, poisoning, loss of consciousness or convulsions. The charges for these services will be submitted as post-service claims and will be subject to the Plan's limits and exclusions.

d. **Disability Claims**

A Disability Claim is any claim that requires a finding of disability as a condition of eligibility. For example, claims for Weekly Disability Benefits will be treated as Disability Claims. In the event that a participant becomes disabled, he or she should notify the Fund Office in writing of this fact at once to obtain the necessary forms and specific instructions.

e. **Concurrent Care Claims**

A Concurrent Claim is a claim involving an ongoing course of treatment that is reconsidered after it was initially pre-certified and results in a reduction, termination or extension of a benefit. An example of this type of claim would be an inpatient Hospital stay originally certified for five days that is reviewed at three days to determine if the full five days is appropriate. In this situation a decision to reduce, terminate or extend treatment is made concurrently with the provision of treatment.

To request an extension or other modification of a Hospital stay that has been pre- certified the participant must call (562) 927-1434.

To request an extension or other modification of dental treatment that has been pre-certified the participant must call the Fund Office at 562-927-1434.

f. **Other Claims**

If the participant has coverage for Death Benefits, Accidental Death and Dismemberment Benefits, and Supplemental Accident Protection benefits and wishes to initiate a claim, he or she should contact the Fund Office to obtain the necessary forms and specific instructions on how to submit proof of loss. For example, claims for Death Benefits should be filed with the Fund Office along with a certified copy of the death certificate.

g. **Eligibility Disputes**

If a claim is denied because a person is not shown as eligible on the records of the Fund Office, the eligibility status will be resolved by the Trust Fund Office in accordance with the time lines described below, depending on the classification of your claim as Urgent, Pre-Service, Post-Service, etc.

h. **What is NOT a "Claim" Under These Procedures**

Simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim will not be treated as a claim for benefits. For example, calling the Fund Office and asking whether the Fund covers speech therapy is not a claim for benefits.

1. A request for pre-authorization regarding the Plan's coverage of a medical treatment, service or supply that a participant's physician has recommended is not a "claim" under these procedures unless the Plan requires the participant to obtain pre-authorization. For example, a request for pre-authorization of an outpatient procedure is not a mandatory condition for receiving benefits and will not be treated as a claim for benefits.

2. According to federal regulations, a "claim" does not include an attempt to fill a prescription at a retail pharmacy. On the other hand, a "claim" does include attempts to have a prescription filled through a mail order program. However, in either case, if a participant's request for a prescription is denied, in whole or in part, he or she may file an appeal by using the procedures described below.

3. Requests for determination of whether a person is eligible for benefits will not be considered a claim under these procedures unless a specific claim for benefits is denied for lack of eligibility.

i. **When Claims Must Be Filed**

Claims for services that have been received, or death or disability claims, should be filed with the Fund Office within 90 days after the date the expense or loss is incurred. a claim will not be denied or reduced due to untimely filing if a person is unable to file the claim within 90 days, provided the person sends the claim as soon as reasonably possible but in no event later than one year from the date the expense or loss was incurred.

j. **Authorized Representatives**

An authorized representative, such as spouse, may complete the claim form for the person if he or she is unable to complete the form and has previously designated the individual to act on his or her behalf. A form can be obtained from the Fund Office to designate an authorized representative. The Plan may request additional information to verify that this person is authorized to act on the person's behalf. Even if the participant has designated an authorized representative to act on his or her behalf, the participant must personally sign a claim form and file it with the Fund Office at least annually.

A health care professional with knowledge of the medical condition may act as an authorized representative in connection with an **Urgent Care Claim** without having to complete the special authorization form.

Section 3. Timing of Notification of Decision on Claims for Benefits

The time by which a claimant will be notified of a decision on his or her claim for benefits will vary depending on the classification of your claim. The following sections determine which procedure is applicable to a request for benefits:

a. **Post-Service Claims**

Ordinarily, a claimant will be notified of a decision on a **Post-Service Claim** within 30 days from the Plan's receipt of the claim. This period may be extended one time by the Plan for up to 15 days if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, the claimant will be notified before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If an extension is needed because the Plan needs additional information from the claimant, the extension notice will specify the information needed. In that case the claimant will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, the claim will be denied. During the period in which the claimant is allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The period for making the determination is suspended from the date of the extension notice until either 45 days or until the date the claimant responded to the request (whichever is earlier). The Plan then has 15 days to make a decision on a **Post-Service Claim** and notify the claimant of the determination.

b. **Pre-Service Claims**

For properly filed **Pre-Service Claims**, the claimant will be notified of a decision within *15 days* from receipt of the claim unless additional time is needed. The time for response may be extended up to *15 days* if necessary due to matters beyond the control of the Plan. The claimant will be notified of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If an extension is needed because the Plan needs additional information from the claimant, the extension notice will specify the information needed. In that case the claimant and/or his or her Doctor will have *45 days* from receipt of the notification to supply the additional information. If the information is not provided within that time, the claim will be denied. During the period in which the claimant is allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The period for making the determination is suspended from the date of the extension notice until either 45 days or the date the claimant responded to the request (whichever is earlier). The Plan then has *15 days* to make a decision on a **Pre-Service Claim** and notify the claimant of the determination.

If the claimant's provider improperly files a Pre-Service Claim, the claimant and/or his or her provider will be notified as soon as possible but not later than *5 days* after receipt of the claim, of the proper procedures to be followed in filing a claim. Notice of an improperly filed Pre-Service claim will only be sent if the claim includes: (a) the claimant's name; (b) the specific medical condition or symptom; and (c) a specific treatment, service or product for which approval is requested. Unless the claim is re-filed properly, it will not constitute a claim.

c. **Urgent Care Claims**

If a claimant is requesting pre-certification of an **Urgent Care Claim**, the Fund Office will respond to the request with a determination by telephone as soon as possible taking into account the medical circumstances, but not later than *72 hours* after receipt of the claim by Medical Case Review (in the case of a request for pre-certification of a Hospital stay) or by the Fund Office (in the case of a request for pre-certification of dental expenses that are estimated to exceed $200). The determination will also be confirmed in writing.

If an Urgent Care Claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, the Doctor or Dentist will be notified as soon as possible, but not later than *24 hours* after receipt of the claim, of the specific information necessary to complete the claim. The claimant and/or his or her Doctor must provide the specified information within two working days. If the information is not provided within that time, the claim will be denied.

Notice of the decision will be provided no later than *48 hours* after receipt of the specific information but only if the information is received within the required time frame. The notification will specify the proper procedures to be followed in filing a claim. Unless the claim is re-filed properly, it will not constitute a claim.

d. **Concurrent Claims**

In the event the Plan has pre-certified an ongoing course of treatment to be provided over a period of time or a number of treatments, and a determination is made to terminate or reduce such course of treatment (other than by Plan amendment or termination), the claimant will be notified by either Medical Case Review (for inpatient Hospitalization) or the Fund Office (for dental services) as soon as possible, but in any event early enough to allow the claimant to have an appeal decided before the benefit is reduced or terminated.

Any request by a claimant to *extend* approved Urgent Care treatment will be acted upon within 24 hours of receipt of the claim, provided the claim is received at least 24 hours prior to the expiration of the approved treatment. A request to extend approved treatment that does not involve Urgent Care will be decided according to Pre-Service or Post-Service timeframes, whichever applies.

e. **Disability Claims**

For Disability Claims, the Fund Office (or Standard Insurance Company for weekly Disability Benefits) will make a decision on the claim and notify the claimant of the decision within *45 days*. If the Fund Office requires an extension of time due to matters beyond the control of the Fund Office, the Fund Office will notify the claimant of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 45-day period. The notice of extension will 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.

A decision will be made within *30 days* of the time the Plan notifies the claimant of the delay. The period for making a decision may be delayed an additional *30 days*, provided the Fund Office notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision.

If an extension is needed because the Plan needs additional information from the claimant, the extension notice will specify the information needed. In that case the claimant will have *45 days* from receipt of the notification to supply the additional information. If the information is not provided within that time, the claim will be denied. During the period in which the claimant is allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until specified information, but only if the information is received within the required time frame.

If the claimant's Doctor or Dentist improperly files an Urgent Care Claim, they will either *45 days* or until the date the claimant responded to the request (whichever is earlier). Once the claimant responds to the Plan's request for the information, the claimant will be notified of the Plan's decision on the claim within *30 days*.

For **Disability Claims**, the Plan reserves the right to have a Physician examine the claimant (at the Plan's expense) as often as is reasonable while a claim for benefits is pending.

f. **Other Claims**

The Fund Office will notify the claimant of its decision on claims for Death Benefits, Accidental Death and Dismemberment Benefits, and Supplemental Accident Protection benefits within 90 days of receipt of the claim. This period may be extended for up to 90 additional days for special circumstances. If an extension applies, the claimant will be notified of the extension and the circumstances prior to the expiration of the first 90-day period.

Section 4. Content of Notice of Decision

The claimant will be provided with written notice of a denial of a claim, whether denied in whole or in part. The notice will state:

a. The specific reason(s) for the determination.

b. Reference to the specific Plan provision(s) on which the determination is based.

c. A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary.

d. A description of the appeal procedures and applicable time limits.

e. A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

f. If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge.

g. If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

h. For Urgent Care Claims, the notice will describe the expedited review process applicable to Urgent Care Claims. For Urgent Care Claims, the required determination may be provided orally and followed with written notification.

B. APPEALS PROCEDURES

Section 1.

If a claim is denied in whole or in part, or if the claimant disagrees with the decision made on a claim, the claimant may ask for a review. The request for review must:

a. be made in writing by you or your authorized representative;

b. state the reason(s) for disputing the denial;

c. be accompanied by any pertinent material not already furnished to the Plan;

d. be submitted to the Fund office within *180 days* after you receive notice of denial.

Failure to file an appeal that meets all of these criteria will constitute a waiver of your right to a review of the denial of your Claim.

Appeals involving an adverse determination of an **Urgent Care Claim** may be made by calling the Fund Manager's Office at **(562) 927-1434**.

Section 2. Review Process

A claimant has the right to submit comments, documents, records and other information in support of a claim for benefits. Upon request and free of charge, the Plan will provide the claimant with reasonable access to and copies of all documents, records, or other information relevant to the claim. A document, record or other information is relevant if it was relied upon by the Plan in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon) in connection with the claim, it demonstrates compliance with the Plan's administrative processes for ensuring consistent decision-making; or it constitutes a statement of Plan policy regarding the denied treatment or service.

Upon request, a claimant will be provided with the identification of medical or vocational experts, if any, that gave advice to the Plan on the claim, without regard to whether their advice was relied upon in deciding your claim.

A different person will review the claim and such person will not be a subordinate of the person who originally denied the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted relating to the claim.

If a claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted. Such professional will not be an individual who was consulted in connection with the initial determination that is the subject of the appeal, or any subordinate of such individual.

Section 3. Timing of Notice of Decision on Appeal

a. **Pre-Service Claims:** The claimant will be sent a notice of decision on review within *30 days* of receipt of the appeal by the Fund Office.

b. **Urgent Care Claims:** A claimant will be sent a notice of a decision on review within *72 hours* of receipt of the appeal by the Fund Office.

c. **Post-Service Claims**

Ordinarily, decisions on appeals involving Post-Service Claims will be made at the *next regularly* scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received in the Fund Office within 30 days of the next regularly scheduled meeting, your request for review may be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified by the Fund Office of the decision as soon as possible, but no later than 5 days after the decision has been reached.

d. **Disability Claims**: The decision will be made in the same manner as for Post- Service Claims.

e. **Other Claims:** The decision regarding an appeal involving Death, AD&D, or Supplemental Accident Protection benefits will be made in the same manner as for Post-Service or Disability Claims.

Section 4. Notice of Decision on Review

The decision on any review of your claim will be given to you in writing. The notice of a denial of a claim on review will state:

a. The specific reason(s) for the determination.

b. Reference to the specific Plan provision(s) on which the determination is based.

c. A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge.

d. A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

e. If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge.

f. If the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

The denial of a claim to which the right to review has been waived, or the decision of the Board or its designated Appeals Committee with respect to a petition for review, is final and binding upon all parties including the claimant or the petitioner, subject only to any civil action you may bring under ERISA. Following issuance of the written decision of the Board on an appeal, there is no further right of appeal to the Board or right to arbitration.

Section 5. Limitation on When a Lawsuit May be Started

A claimant may not start a lawsuit to obtain benefits until after he or she has requested a review and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review and the claimant has not received a final decision or notice that an extension will be necessary to reach a final decision. Any lawsuit to obtain benefits must be filed within one year of the final decision.

Section 6. Restriction on Venue.

Any action in connection with the Fund or Plan by an Employee, Participant or beneficiary may only be brought in Federal District Court in either Los Angeles or Orange County, California.

ARTICLE XIII. GENERAL PROVISIONS

Section 1.

All Hospital Benefits will be paid by the Fund to the Hospital, or to the Covered Employee upon receipt of proof that the Hospital has been paid, and all other benefits will be paid by the Fund to the Covered Employee as they accrue upon receipt of written proof, satisfactory to the Fund, covering the occurrence, character, and extent of the event for which claim is made.

Section 2.

Benefits payable hereunder shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person; however, any Covered Employee may direct that benefits due him be paid to an institution in which he or his eligible Dependent is Hospitalized or to any other provider of medical or dental services or supplies in consideration for medical, Hospital or dental services rendered or to be rendered.

A direction to pay a health care provider is not an assignment of any right under this Plan or under ERISA, is not authority to act on a Participant's behalf in pursuing and appealing a benefit determination under the Plan, is not an assignment of rights respecting anyone's fiduciary duty, and is not an assignment of any legal or equitable right to institute any court proceeding. Any attempted assignment is void and not recognized by the Plan, if performed without the Plan's express written permission.

Section 3.

Benefits will be paid by the Fund only if notice of claim is made within 90 days from the date on which expenses with respect to which claim is made were first incurred unless it shall be shown by the Covered Employee not to have been reasonably possible to give notice within such time limit, but in no event shall benefits be allowed if notice of claim is made beyond one year from the date on which expenses were incurred.

Section 4.

In the event the Fund determines that the Covered Employee is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Covered Employee has not provided the Fund with address at which he can be located for payment, the Fund may, during the lifetime of the Covered Employee, pay any amount otherwise payable to the Covered Employee, to the spouse or to a relative by blood of the Covered Employee, or to any person or institution determined by the Fund to be equitably entitled thereto. In the event of the death of the Covered Employee before all amounts payable under Articles V, VI, IX, and X have been paid, the Fund may pay any such amount to any person or institution determined by the Fund to be equitably entitled thereto. The remainder of such amount shall be paid to one or more of the following surviving relatives of the Covered Employee: lawful spouse, child or children, mother, father, brothers or sisters, or to the Covered Employee's estate, as the Board of Trustees in its sole discretion may designate. Any payment in accordance with this provision shall discharge the obligation of the Fund hereunder to the extent of such payment.

Section 5.

a. No Covered Employee, Dependent, beneficiary or other person shall have any right or claim to benefits under the Plan, other than as specified in the Plan. The Trustees shall act upon any application for benefits within 90 days after receipt of the application by the Trustees. If special circumstances require an extension of time for processing the application, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period, setting forth the special circumstances requiring an extension of time and indicating the date by which the Trustees expect to render the final decision on the application. Such extension shall not exceed 90 days from the date of this initial period.

b. If any person shall have a dispute with the Board of Trustees as to eligibility, type, amount or duration of such benefits, the dispute shall be resolved by the Board of Trustees, in its sole and absolute discretion pursuant to the Plan, and its decision of the dispute shall be final and binding upon all parties thereto.

Section 6.

The Fund at its own expense, shall have the right and opportunity to examine the person of any Eligible Individual when and so often as it may reasonably require during the pendency of any claim, and also the right and opportunity to make an autopsy in case of death where it is not forbidden by law. Proof of claim forms, as well as other forms, and methods of administration and procedure, will be solely determined by the Fund.

Section 7.

The benefits provided by this Fund are not in lieu of and do not affect any requirement for coverage by Worker's Compensation Insurance laws or similar legislation.

Section 8.

The provisions of these Rules and Regulations are subject to and controlled by the provisions of the Trust Agreement, and in the event of any conflict between the provisions of these Rules and Regulations and the provisions of the Trust Agreement, the provisions of the Trust Agreement shall prevail.

ARTICLE XIV. AMENDMENT AND TERMINATION

Section 1.

In order that the Fund may carry out its obligation and maintain, within the limits of it resources, a program dedicated to providing the maximum possible benefits for all Covered Employees, the Board of Trustees expressly reserves the right, in its sole discretion at any time and from time to time, but upon a non-discriminatory basis:

a. to terminate or amend either the amount or condition with respect to any benefits even though such termination or amendment affects claims which have already accrued; and

b. to alter or postpone the method of payment of any benefit; and

c. to amend or rescind any other provisions of these Rules and Regulations.

ARTICLE XV. PRIVACY PRACTICES

The Union Roofers Health and Welfare Plan (the "Plan") is required by law to take reasonable steps to ensure the privacy of personally identifiable health information and to inform a participant about:

a. the Plan's uses and disclosures of Protected Health Information (PHI);

b. a participant's privacy rights with respect to your PHI;

c. the Plan's duties with respect to a participant's PHI;

d. a participant's right to file a complaint with the Plan and with the Secretary of the U.S. Department of Health and Human Services; and

e. the person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

Section 1. Required PHI Uses and Disclosures

Upon request, the Plan is required to give a participant access to his or her PHI in order to inspect and copy it.

Use and disclosure of a participant's PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

a. Uses and disclosures to carry out treatment, payment and health care operations.

The Plan and its business associates will use PHI without your authorization or opportunity to agree or object to carry out treatment, payment and health care operations. The Plan and its business associates (and any health insurers providing benefits to Plan participants) may also disclose the following to the Plan's Board of Trustees: (1) PHI for purposes related to Plan administration (payment and health care operations); (2) summary health information for purposes of health or stop loss insurance underwriting or for purposes of modifying the Plan; and (3) enrollment information (whether an individual is eligible for benefits under the Plan). The Trustees have amended the Plan to protect your PHI as required by federal law.

b. "Treatment" is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of a participant's providers.

For example, the Plan may disclose to a treating physician the name of a treating radiologist so that the physician may ask for a participant's X-rays from the treating radiologist.

c. "Payment" includes but is not limited to actions to make coverage determinations and payment (including billing, claims processing, subrogation, reviews for medical necessity and appropriateness of care, utilization review and pre-authorizations).

For example, the Plan may tell a Doctor whether a participant is eligible for coverage or what percentage of the bill will be paid by the Plan.

d. "Health care operations" include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

For example, the Plan may use information to project future benefit costs or audit the accuracy of its claims processing functions.

Section 2. Uses and Disclosures that Require your Written Authorization

The Plan will obtain a participant's authorization before releasing his or her PHI in those circumstances where the law or the Plan's privacy practices do not otherwise permit disclosure. For example, your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you prepared by your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about a participant's mental health treatment.

Uses and disclosures that require that the participant be given an opportunity to agree or disagree prior to the use or release.

Disclosure of a participant's PHI to family members, other relatives and your close personal friends is allowed if:

a. the information is directly relevant to the family member or friend's involvement with the participant's care or payment for that care; and

b. the participant has either agreed to the disclosure or has been given an opportunity to object and has not objected.

Additional rules and exceptions apply with family members. A participant may request additional information from the Plan. Uses and disclosures for which a participant has given consent, authorization or opportunity to object is not required.

The Plan is allowed to use and disclose a participant's PHI without authorization under the following circumstances:

a. For treatment, payment and health care operations.

b. Enrollment information can be provided to the Trustees.

c. Summary health information can be provided to the Trustees for the purposes designated above.

d. When required by law.

e. When permitted for purposes of public health activities, including when necessary to report product defects and to permit product recalls. PHI may also be disclosed if a participant has been exposed to a communicable disease or are at risk of spreading a disease or condition, if required by law.

f. When required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that a participant may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform the participant that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

g. The Plan may disclose your PHI to a public health oversight agency for oversight activities required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

h. The Plan may disclose PHI when required for judicial or administrative proceedings. For example, PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to the participant, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

i. When required for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the Plan is unable to obtain the individual's agreement because of Emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

j. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

k. When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

l. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with the participant's written authorization subject to the right to revoke such authorization.

Section 2. Rights of Individuals

a. **Right to Request Restrictions on Uses and Disclosures of PHI**

A participant may request the Plan to restrict the uses and disclosures of PHI. However, the Plan is not required to agree to the request.

A participant or his or her personal representative will be required to submit a written request to exercise this right.

Such requests should be made to the Plan's Privacy Official at the Union Roofers Health & Welfare Fund, 9901 Paramount Boulevard, Suite 211, Downey, California 90240. Telephone: (562) 927-1434, Fax (562) 928-9203.

b. **Right to Request Confidential Communications**

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations if necessary to prevent a disclosure that could endanger the participant.

The participant or his or her personal representative will be required to submit a written request to exercise this right.

Such requests should be made to the Plan's Privacy Official at the Union Roofers Health & Welfare Fund, 9901 Paramount Boulevard, Suite 211, Downey, California 90240. Telephone: (562) 927-1434, Fax (562) 928-9203.

c. **Right to Inspect and Copy PHI**

A participant has a right to inspect and obtain a copy of his or her PHI contained in a "designated record set," for as long as the Plan maintains the PHI.

"Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

"Designated Record Set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained off site. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

A participant or his or her personal representative will be required to submit a written request to request access to the PHI in your designated record set. Such requests should be made to the Plan's Privacy Official at the Union Roofers Health
& Welfare Fund, 9901 Paramount Boulevard, Suite 211, Downey, California 90240. Telephone: (562) 927-1434, Fax (562) 928-9203.

If access is denied, the participant or personal representative will be provided with a written denial, setting forth the basis for the denial, a description of how to appeal the Plan's decision and a description of how to complain to the Secretary of the U.S. Department of Health and Human Services.

The Plan may charge a reasonable, cost-based fee for copying records as requested.

d. **Right to Amend PHI**

A participant has the right to request the Plan to amend his or her PHI or a record about his or her designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide a written denial that explains the basis for the denial. The participant or personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Such requests should be made to the Plan's Privacy Official at the Union Roofers Health & Welfare Fund, 9901 Paramount Boulevard, Suite 211, Downey, California 90240. Telephone: (562) 927-1434, Fax (562) 928-9203.

The participant or personal representative will be required to submit a written request to request amendment of the PHI in the participant's designated record set.

e. **Right to Receive an Accounting of PHI Disclosures**

At the participant's request, the Plan will also provide an accounting of disclosures by the Plan of PHI during the six years prior to the date of the participant's request. However, such accounting will not include PHI disclosures made: (1) to carry out treatment, payment or health care operations (including to business associates pursuant to a business associate agreement and to the Trustees as authorized by the Plan or the HIPAA privacy regulations); (2) to individuals about their own PHI; (3) pursuant to the participant's authorization; (4) prior to April 14, 2004; and (5) where otherwise permissible under the law and the Plan's privacy practices. In addition, the Plan need not account for certain incidental disclosures.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If a participant requests more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Such requests should be made to the Plan's Privacy Official at the Union Roofers Health & Welfare Fund, 9901 Paramount Boulevard, Suite 211, Downey, California 90240. Telephone: (562) 927-1434, Fax (562) 928-9203.

f. **Right to Receive a Paper Copy of This Notice upon Request**

A participant has the right to obtain a paper copy of this Notice.

Such requests should be made to the Plan's Privacy Official at the Union Roofers Health & Welfare Fund, 9901 Paramount Boulevard, Suite 211, Downey, California 90240. Telephone: (562) 927-1434, Fax (562) 928-9203.

g. **A Note about Personal Representatives**

A participant may exercise his or her rights through a personal representative. The personal representative will be required to produce evidence of his/her authority to act on the participant's behalf before that person will be given access to your PHI or allowed to take any action for the participant. Proof of such authority may take one of the following forms:

1. power of attorney for health care purposes, notarized by a notary public;

2. a court order of appointment of the person as the conservator or guardian of the individual; or

3. an individual who is the parent of an un-emancipated minor child may generally act as the child's personal representative (subject to state law).

The Plan retains discretion to deny access to your PHI by a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

Section 3. The Plan's Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of the Plan's legal duties and privacy practices.

The Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to all participants for whom the Plan still maintains PHI. The revised Notice will be distributed in the same manner as the initial Notice was provided or in any other permissible manner.

Any revised version of this Notice will be distributed within 60 days of the effective date of any material change to the Plan's policies regarding the uses or disclosures of PHI, the individual's privacy rights, the duties of the Plan or other privacy practices stated in this Notice.

The Plan will also inform the participant promptly if a breach of unsecured PHI occurs that may have compromised the privacy or security of the participant's health information.

Section 4. Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

a. disclosures to or requests by a health care provider for treatment;

b. uses or disclosures made to the individual;

c. disclosures made to the Secretary of the U.S. Department of Health and Human Services;

d. uses or disclosures that are required by law; and

e. uses or disclosures that are required for the Plan's compliance with legal regulations.

Section 5. De-Identified Information

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

Section 6. Summary Health Information

The Plan may disclose "summary health information" to the Trustees for obtaining insurance premium bids or modifying, amending or terminating the Plan. "Summary health information" summarizes the claims history, claims expenses or type of claims experienced by participants and excludes identifying information in accordance with HIPAA.

Section 7. A Participant's Right to File a Complaint with the Plan or the HHS Secretary

If a participant believes that his or her privacy rights have been violated, the participant may complain to the Plan. Such complaints should be made to the Plan's Privacy Official at the Union Roofers Health & Welfare Fund, 9901 Paramount Boulevard, Suite 211, Downey, California 90240. Telephone: (562) 927-1434, Fax (562) 928-9203.

A participant may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, D.C. 20201.

You may also email the completed complaint and consent forms to OCRComplaint@hhs.gov.

The Plan will not retaliate against a participant for filing a complaint.

Section 8. Whom to Contact at the Plan for More Information

If a participant has any questions regarding this notice or the subjects addressed in it, the participant may contact the Plan's Privacy official. Such questions should be directed to the Plan's Privacy Official at the Union Roofers Health & Welfare Fund, 9901 Paramount Boulevard, Suite 211, Downey, California 90240. Telephone: (562) 927-1434, Fax (562) 928-9203.

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). Participants may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. The Plan intends to comply with these regulations. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

ARTICLE XVI. DISCLAIMER

Section 1.

None of the benefits provided in these Rules and Regulations, except benefits provided under Article XIV, XV, XVI, XVII and XVIII is insured by any contract of insurance, and there is no liability on the Board of Trustees or any other individual or entity to provide payments over and beyond the amounts in the Fund collected and available for such purpose.

ARTICLE XVII. WEEKLY DISABILITY BENEFITS
For Active Employees
Provided By Standard Insurance Company – Group Policy No. 409901

Section 1.

If an Active Employee has a Certified Disability which is not job-related, the Standard Insurance Company will pay, subject to the terms and conditions of Group Policy No. 409901, and as amended from time to time, an amount equal to the amount set forth in the aforementioned policy.

ARTICLE XVIII. VISION CARE BENEFITS PROVIDED BY VISION SERVICE PLAN
For Active Employees and their Dependents

Section 1.

If an Eligible Individual obtains optometric services, Vision Service Plan will provide, subject to the terms and conditions of its agreement with the Fund, benefits and services as set forth in the aforementioned agreement.

ARTICLE XIX. HEALTH NET PREPAID MEDICAL BENEFITS
Provided for Eligible Individuals Enrolled in the Health Net Prepaid Medical Plan

Section 1.

If an Eligible Individual is enrolled in the Health Net plan, such Eligible Individual will be entitled to benefits under that Plan in accordance with the terms and conditions of Group Policy Nos. 76855A, 76855C, 76855D, 76855J, and 57417S and as amended from time to time.

ARTICLE XX. KAISER PERMANENTE PREPAID MEDICAL BENEFITS

Provided for Eligible Individuals enrolled in the Kaiser Permanente Prepaid Medical Plan

Section 1.

If an Eligible Individual is enrolled in the Kaiser plan, such Eligible Individual will be entitled to benefits under that plan in accordance with the terms and conditions of Group Policy Nos. 107370-00 and 107370-01 and as amended from time to time.

ARTICLE XXI. DELTA CARE PREPAID DENTAL BENEFITS

Provided for Eligible Individuals enrolled in the DeltaCare Prepaid Dental Plan

Section 1.

If an Eligible Individual is enrolled in the Delta Care Prepaid Dental Plan, such Eligible Individual will be entitled to benefits under that plan in accordance with the terms and conditions of Group Policy No. 76243 and as amended from time to time.

ARTICLE XXI. DELTA DENTAL PPO DENTAL BENEFITS

Provided for Eligible Individuals enrolled in the Delta Dental PPO Dental Plan

Section 1.

If an Eligible Individual is enrolled in the Delta Dental PPO Dental Plan, such Eligible Individual will be entitled to benefits under that plan in accordance with the terms and conditions of Group Policy No. 19964 and as amended from time to time.

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

1. **Name of Plan**. This Plan is known as the Union Roofers Health and Welfare Fund.

2. **Plan Administrator and Sponsor.** The Board of Trustees is the Plan Administrator. This means that the Board of Trustees is responsible for seeing that information regarding the Plan is reported to government agencies and disclosed to Plan participants and beneficiaries in accordance with the requirements of the Employee Retirement Income Security Act of 1974.

   The 'Fund Manager's office will provide you, upon written request, information as to whether a particular employer is a sponsor of the Plan and the address of the employer or Union.

3. **Name and Address of the Board of Trustees.** The Board of Trustees consists of an equal number of Employer and Union representatives, selected by the Employers and Unions, in accordance with the Trust Agreement which relates to this Plan.

   If you wish to contact the Board of Trustees, you may use the address and phone number below:

   Union Roofers Health and Welfare Fund
   9901 Paramount Boulevard, Suite 211
   Downey, California 90240
   (562) 927-1434

   The Trustees have designated the Fund Manager named below to perform the routine functions of the Fund:

   Sue Perillo
   Union Roofers Health and Welfare Fund
   9901 Paramount Boulevard, Suite 211
   Downey, California 90240

4. **Names, Titles and Addresses of Any Trustees.** The Trustees of this Plan are:

UNION	**MANAGEMENT**
Mr. Brent Beasley Roofers Union Local 220 283 N Rampart Street, Suite F Orange, CA 92868	Mr. Ernest Glasgow 766 N Cambridge St Orange, CA 92867
Mr. Cliff Smith Roofers Union Local 36 5380 Poplar Blvd. Los Angeles, CA 90032	Mr. Greg Banks San Marino Roof Co 2187 N Batavia St Orange, CA 92665
Mr. Zack Beasley Roofers Union Local 220 283 N Rampart Street, Suite F Orange, CA 92868	Mr. Eddie Marquez Union Roofing Contractors Association 2914 E. Katella Avenue, Suite 202 Orange, CA 92867

5. **IRS Identification Numbers.** The number assigned to the Plan by the Internal Revenue Service is 95-1856197. This Plan Number is 502.

6. **Agent for Service of Legal Process.** The name and address of the agent designated for the service of legal process is Sue Perillo at the above address. Legal process may also be served on any Plan Trustee.

7. **Collective Bargaining Agreement.** Contributions to this Plan are made on behalf of each employee in accordance with a Collective Bargaining Agreement between Locals No. 36 and 220 of the United Union of Roofers, Waterproofers and Allied Workers of Los Angeles, Orange, San Luis Obispo, Santa Barbara, and Ventura Counties and employers in the industry.

   The Fund Manager's office will provide you, upon written request, a copy of the Collective Bargaining Agreement. The Collective Bargaining Agreement is also available for examination at the office of the Fund Manager.

8. **Source of Contributions.** The benefits described in this section are provided primarily through Employer contributions to the Plan on a fixed rate per hour worked basis. Contributions for certain employees are made on a per person per month basis. The Fund Manager's office will provide you, upon written request, information as to whether a particular Employer is contributing to this Plan.

9. **Type of Plan.** This Plan is maintained for the purpose of providing Death, Accidental Death and Dismemberment, Weekly Disability, Hospital, Medical, Dental and Vision Care benefits in the event of sickness or accident.

10. **Trust Fund.** The Trust's assets and reserves are held in trust by the Board of Trustees (item 4, above) of the Union Roofers Health and Welfare Fund.

11. **Identity of Provider Benefits.**
    The following benefits are provided directly from the assets of the Plan itself: death benefits, accidental death & dismemberment benefit, and the hospital, medical and dental indemnity plan benefits. Indemnity medical and dental benefits, as well as death and dismemberment benefits

    The following benefits are fully insured by the providers:

    DeltaCare USA
    Prepaid Dental Benefits
    1130 Sanctuary Parkway
    Alpharetta, GA 30009
    Telephone: (800) 422-4234

    Delta Dental of California
    Indemnity Delta PPO Plan
    P.O. Box 997330
    Sacramento, CA 95899-7330
    (888) 335-8227 Customer Service

    Prepaid Medical Plans

    Health Net
    P.O. Box 9103
    Van Nuys, CA 91409-9103

    Kaiser Permanente
    393 E. Walnut Street
    Pasadena, CA 91188
    (800) 464-4000

Weekly Disability Benefits

Standard Insurance
900 S.W. Fifth Avenue
Portland, OR 97204

The Plan is self-funded (claims paid directly from the assets of the Fund) for the benefits listed below. The carriers administer at least a portion of the benefits for the Plan, but do not insure or otherwise guarantee any of the benefits of the Plan.

Vision Benefits – Administrative Services Only

Vision Service Plan
5000 Airport Plaza Drive, Suite 250
Long Beach, CA 90815

PPO Contracting Provider Network for Medical Providers

Affiliated Health Fund (AHF)
9901 Paramount Blvd., Suite 211
Downey, CA 90240

All types of benefits provided through the Plan are set forth in the Schedule of Benefits on pages 4 through 6. The complete terms of the insured benefits are set forth in the group insurance policy with Standard Insurance Company and the agreements with Health Net, Kaiser and Vision Service Plan. The complete terms of the self-funded benefits are set forth in the Rules and Regulations beginning on page 76.

12. **Fiscal Plan Year.** The fiscal records of the Plan are kept separately for each Fiscal Plan Year. The Fiscal Plan Year begins September 1 and ends on the following August 31.

13. **The Plan's Requirements with Respect to Eligibility for Participation and Benefits.** The eligibility requirements are specified on pages 7 to 16.

14. **Circumstances Resulting in Disqualification, Ineligibility or Denial or Loss of Benefits.** Loss of eligibility is described on pages 7 to 16.

15. **Procedures to Follow for Filing a Claim.** The procedure to be followed in filing a claim for benefits is described on page 32.

    All claims must be submitted on claim forms made available by the Fund Manager's office or the insurance carrier. Claims submitted must be accompanied by any information or proof requested and reasonably required to process such claims.

16. **Review Procedure.** Remedies available under the Plans for the redress of claims which are denied in whole or in part.

    a. If your claim is denied in whole or in part, you will receive a letter setting out the reason(s) for the denial; reference to provisions on which the denial is based; a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary.

    b. If you are not satisfied, or do not agree with the reasons for the denial of your claim, you may appeal the decision to the Board of Trustees, Union Roofers Health and Welfare Fund.

c. The appeal must be in writing and can be made by you or your duly authorized representative. It must set out your reasons for your appeal and your dissatisfaction or disagreement.

Any evidence or documentation to support your position should be submitted with your written appeal. Upon written request, you may review pertinent documents that pertain to your claim and its denial.

d. Your appeal must be made within 60 days of the date you receive the letter denying your claim.

e. The Board of Trustees will review your claim and appeal. They will advise you of their decision in writing, setting out references to pertinent Plan provisions on which the decision is based. This written decision will be sent to you not later than 60 days after its receipt of your written appeal, unless special circumstances require an extension of time for processing the appeal, or obtaining more information, or conducting an investigation of the facts. In no event will the written decision be sent later than 120 days after receipt by the Board of Trustees of your written appeal.

17. **Availability of Documents and Other Important Information.** As a participant in the Union Roofers Health and Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all Plan participants shall be entitled to:

a. Receive Information about Your Plan and Benefits

Examine, without charge, at the Fund Manager's office and at other specified locations such as worksites and Union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Fund Manager, 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 Plan Fund Manager 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

You may continue health care coverage for yourself, your spouse or Dependent(s) if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependent(s) may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on rules governing your COBRA continuation coverage rights.

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.

c. Prudent Actions by Plan Fiduciaries

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

d. 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, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in Federal court, but only after first exhausting the claims and appeals procedures herein. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court, but only after first exhausting the claims and appeals procedures herein. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

e. 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 (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at *1 (866) 444-3272* or *www.dol.gov/ebsa/*. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

18. **Translation Assistance Notice.** You may obtain assistance in Spanish if you do not understand English and have questions about the benefits or the rules of the Plan. Contact the Fund Manager's office at (562) 927-1434 to find out how to obtain such help.

19. USTED PUEDE OBTENER INFORMACIN EN ESPANOL, SI NO ENTIENDE INGLES, ACERCA DE LOS BENEFICIOS Y REGLAS DE EL PLAN, PONGASE EN CONTACTO CON LA OFICINA A (562) 927-1434, Y PREGUNTE PARA QUE LE AYUDEN.

Nothing in this statement is meant to interpret or extend or change in any way the provisions expressed in the Plan. The Trustees reserve the right to amend, modify or discontinue all or part of this Plan whenever, in their judgment, conditions so warrant.