SUMMARY PLAN DESCRIPTION OF THE ROOFERS' LOCAL NO. 33 INSURANCE FUND

AS RESTATED AND AMENDED THROUGH NOVEMBER 1, 2015

Dear Members and Dependents:

We are pleased to provide you with this updated Summary Plan Description ("SPD") for the Roofers' Local No. 33 Insurance Fund. This SPD describes the benefits available to you and your eligible Dependents. It is also intended to constitute the written Plan document in accordance with the Employee Retirement Income Security Act of 1974 ("ERISA").

This Summary Plan Description describes all benefits available to Participants in the Insurance Fund. If a benefit, treatment, coverage or other related item is not specifically described in this document, it is not covered by the Insurance Fund.

We all recognize the need for a comprehensive personal medical coverage program that provides hospital, doctor, prescription drug, vision care, and dental benefits. It is also important to have continuation of income during periods of total disability, and Life Insurance.

However, many of us would find the costs of such coverage beyond our financial means if we had to pay for all of it, individually. The Trustees are pleased to be able to provide these benefits to you and your family through the Insurance Fund. We will continue to do everything possible to maintain the Fund on a sound financial basis, so that the level of benefits described in this SPD can continue to be made available to you.

You and your family will be able to take full advantage of the benefits offered through this Fund only if you are aware of all of the provisions of the Fund and the wide scope of services the Fund covers. This SPD furnishes a description of the benefits to which Participants and Eligible Dependents are entitled, the rules governing these benefits, and the procedures that you must follow when making a claim. We have also included, in the back of this booklet, certain information concerning the administration of the Fund as required by the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended.

This booklet replaces all other Summary Plan Descriptions previously published by the Trustees. We suggest you read this booklet carefully in order to fully understand the benefits to which you may be entitled. If you have any questions on claims payment, benefit coverage, or eligibility rules please call the Fund Office at (781) 341-1657.

Sincerely,

Board of Trustees, Roofers' Local No. 33 Insurance Fund

IMPORTANT NOTICES

TRUSTEES' AUTHORITY AND DISCRETION

The Trustees have complete discretionary authority to interpret and apply the provisions of the Plan including, but not limited to, determinations of eligibility for benefits, the right of individuals to participate, the manner by which contributions are credited and the level, extension or discontinuance of benefits. The Trustees have complete discretionary authority to construe and interpret the terms of the Plan and/or any other policy or instrument including ambiguous or disputed terms and meanings. Furthermore, the Trustees have discretionary authority to make all factual findings.

LIMIT ON AUTHORITY OF NON-TRUSTEES

No Local Union, Local Union Officer, Business Agent, Local Union Member, Employer or Employer Representative, Fund Office employee, attorney or consultant is authorized to speak for or to commit the Board of Trustees of this Fund on any matter without express written authority from the Trustees.

TRUSTEES' RIGHT TO AMEND, MODIFY OR DISCONTINUE BENEFITS AT ANY TIME

The Trustees reserve the right to amend, modify, or discontinue all or part of these benefits provided by this Fund, including reducing or eliminating benefits, whenever, in their judgment, conditions so warrant. Benefits, rules governing eligibility and other provisions may change after the date of this SPD booklet. Benefits are not vested. Contact the Fund Office if you have questions regarding current benefits.

YOUR RESPONSIBILITY FOR SELECTION OF PROVIDERS

The selection of medical professionals and service providers is your responsibility. Trustees have contracted with a network to try to find the best selection of providers available. However, the Trustees disclaim any responsibility for the qualification or action of any provider of goods or services.

FOREIGN LANGUAGE ASSISTANCE/SI NO HABLA INGLES

If you do not understand English and have a question about the benefits or the rules of the Fund, contact the Fund Office for assistance.

Si usted no entiende inglés y tiene una pregunta acerca de los beneficios o las reglas del Fondo, llame la oficina de Fondo para asistencia.

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BASIC INFORMATION

Name of Fund

Roofers' Local No. 33 Insurance Fund

Address of Fund

53 Evans Drive
P.O. Box 9106
Stoughton, MA 02072

Employer Identification Number / Fund Number

04-6148460 / 501

Fiscal Year of the Fund (Fund Year)

January 1 through December 31

Plan Sponsor

Roofers Local Union No. 33 and participating employers established and maintain the Fund. Participants of the Fund can receive from the Fund Office, upon written request, information as to whether a particular employer or employee organization is a sponsor of the Fund. If the employer or employee organization is a sponsor of the Fund, the Fund Office will provide the sponsor's address. Pursuant to ERISA, the Board of Trustees is considered to be the Plan Sponsor.

Type of Administration of the Fund

The Fund is administered and maintained by a joint Board of Trustees currently consisting of three Union Trustees and three Employer Trustees. The Board of Trustees is governed by the Trust Agreement established and maintained in accordance with Collective Bargaining Agreements.

The Fund Office currently handles the day to day administration of the benefits under this Plan, including your medical and hospitalization benefits, on behalf of the Trustees. Most benefits under the Fund are self-insured. Some, including life insurance coverage, are purchased from insurance companies (these are referred to in this SPD as "insured benefits").

Board of Trustees

Union Trustees	Employer Trustees
Paul Bickford 53 Evans Drive P.O. Box 9106 Stoughton, MA 02072	Joshua David John F. Shea Co., Inc. 41 Hollingsworth Street / P.O. Box 365 Mattapan, MA 02126
Mark B. Brousseau 53 Evans Drive P.O. Box 9106 Stoughton, MA 02072	David Klein Greenwood Industries, Inc. 640 Lincoln Street /P.O. Box 2800 Worcester, MA 01613
Edward J. Rolfe 53 Evans Drive P.O. Box 9106 Stoughton, MA 02072	John Marcone Gilbert & Becker Company, Inc. 16 Clapp Street / P.O. Box 255066 Boston, MA 02148

Plan Administration / Fund Office

Pursuant to ERISA, the Board of Trustees is considered the "Plan Administrator." The Fund is administered by and for the Trustees through the Fund Office:

Anna D. Brousaides, Administrator
Roofers' Local Union No. 33 Insurance Fund
53 Evans Drive
P.O. Box 9106
Stoughton, MA 02072

Phone (781) 341-1657
Fax (781) 341-1659

Agent for the Service of Legal Process

Anna D. Brousaides, Administrator
Roofers' Local Union No. 33 Insurance Fund
53 Evans Drive
P.O. Box 9106
Stoughton, MA 02072

Service of legal process may also be made on any Trustee.

Legal Counsel

Krakow & Souris, LLC
225 Friend Street
Boston, Massachusetts 02114

The Collective Bargaining Agreement

This Fund is maintained pursuant a Collective Bargaining Agreement. You can obtain copies of this Agreement upon written request to the Plan Administrator or the Union, and it is also available for examination at the Fund Office.

Participants in the Fund can receive from the Fund Office, upon written request, information as to whether a particular employer or employee organization is a contributing employer under the Plan, as well as the contributing employer's address.

Copies of the latest Collective Bargaining Agreement or Agreements are available for examination by visiting the Fund Office or may be obtained for a nominal charge by writing to the Fund Office.

Funding Medium

The Trustees hold the assets and reserves of the Insurance Fund in trust, in a Trust Fund pursuant to the Agreement and Declaration of Trust. Contributing Employers contribute to the Fund at the hourly rates established by and in accordance with the Collective Bargaining Agreements and Participation Agreements.

Plan Change or Termination

The Board of Trustees reserves the right to change or discontinue the types and amounts of benefits available under the Fund and the eligibility rules for extended or accumulated eligibility, even if extended eligibility has already been accumulated. The Board of Trustees also reserves the right to change or increase the cost of coverage charged to all Employees, or to any class or classes of Employees.

Plan benefits and eligibility rules for active, retired, or disabled participants:

- Are not guaranteed;
- Are not vested;
- May be changed or discontinued by the Board of Trustees at any time;
- Are subject to the Trust Agreement which establishes and governs the Fund's operations;
- Are subject to the provisions of any group insurance policies purchased by the Board of Trustees.

The nature and amount of benefits under the Fund are always subject to the actual terms of the Fund as it exists at the time the claim for benefits is made.

If the Plan of benefits is changed or discontinued, it will not affect you or your Eligible Dependent's right to the payment of any benefit if and to the extent that the claim for benefits has already been made.

IMPORTANT: ANY BENEFITS NOT DESCRIBED IN THIS DOCUMENT ARE NOT PART OF THE ROOFERS' LOCAL NO. 33 INSURANCE FUND UNLESS AMENDED BY THE TRUSTEES.

BENEFITS AND ELIGIBILITY RULES DESCRIBED IN THIS DOCUMENT[1] ARE THE ONLY BENEFITS AND ELIGIBILITY RULES THAT APPLY TO PARTICIPANTS AND THEIR ELIGIBLE DEPENDENTS OF THOSE PARTICIPANTS UNLESS AMENDED BY THE TRUSTEES.

[1] From time to time, you may receive one or more "Summary of Material Modifications" or "SMM" whose purpose is to modify this Summary Plan Description. These SMMs are considered to be part of this document. We suggest you keep all SMMs with this SPD.

SECTION 1. ELIGIBILITY RULES

BASIC ELIGIBILITY RULES – COLLECTIVELY BARGAINED EMPLOYEES

Each Employee of an Employer who participates in the Roofers' Local Union No. 33 Insurance Fund is eligible, provided the Employer is making contributions to the Fund on the Employee's behalf in accordance with the terms of a Collective Bargaining Agreement or Participation Agreement between the Local Union and the Employer, and the "hours requirement" is satisfied (see below).

The Insurance Fund has two levels of coverage:

- Plan A, which includes medical, prescription drug, dental, life insurance, vision, and accident & sickness benefit
- Plan B, which includes medical and prescription drug only

Eligibility Rules - Plan A

You may attain eligibility in one of two ways:

1) By working at least **650 hours** during the preceding six-month Eligibility Period, or
2) By working at least **1,300 hours** during the preceding twelve-month Eligibility Period.

Your eligibility for benefits will be determined twice a year: October 1 and April 1.

For the Six-Month Coverage Period Beginning Each October 1:

You must meet one of these rules for coverage on October 1	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
If you work at least 650 hours in these 6 months…													→		You are covered during this 6-month period					
If you work at least 1,300 hours in these 12 months…													→							

For the Six-Month Coverage Period Beginning Each April 1:

You must meet one of these rules for coverage on April 1	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
If you work at least 650 hours in these 6 months…													→		You are covered during this 6-month period					
If you work at least 1,300 hours in these 12 months…													→							

Eligibility Rules – Plan B

You may attain eligibility in one of two ways:

1) By working at least **450 hours** during the preceding six-month Eligibility Period, or
2) By working at least **900 hours** during the preceding twelve-month Eligibility Period.

Your eligibility for benefits will be determined for two coverage periods each year: October 1 and April 1.

For the Six-Month Coverage Period Beginning Each October 1:

You must meet one of these rules for coverage on October 1	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
If you work at least 450 hours in these 6 months…							X	X	X	X	X	X	→		You are covered during this 6-month period					
If you work at least 900 hours in these 12 months…	X	X	X	X	X	X	X	X	X	X	X	X	→							

For the Six-Month Coverage Period Beginning Each April 1:

You must meet one of these rules for coverage on April 1	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
If you work at least 450 hours in these 6 months…							X	X	X	X	X	X	→		You are covered during this 6-month period					
If you work at least 900 hours in these 12 months…	X	X	X	X	X	X	X	X	X	X	X	X	→							

Banking of Hours

Effective Date of the Hour Bank

If a member does not work at least 450 hours in a six-month Eligibility Period or at least 900 hours in a twelve-month Eligibility Period, Banked Hours may be used to maintain eligibility for Plan benefits.

How Does the Hour Bank Work?

You may benefit from Banking of Hours provided that you worked in Covered Employment for a total of at least 3,000 hours during six (6) consecutive six-month Eligibility Periods immediately preceding the six-month Eligibility Period during which you worked 250 but less than 450 hours.

Your Banked Hours

Banked Hours are hours worked in Covered Employment **over** 3,000 hours in six (6) consecutive six-month Eligibility Periods.

Your <u>Maximum</u> Banked Hours

You may bank up to 200 hours, to be applied to the next six-month Eligibility Period in which you do not work the required 450 hours in Covered Employment or to the next twelve-month Eligibility Period in which you do not work the required 900 hours in Covered Employment.

Credit for Non-Work Periods

To maintain eligibility, an insured member who cannot accumulate contribution hours because of a disability for which he is compensated through either Accident and Sickness Benefits or Worker's Compensation shall be credited for such disabilities as though he were actually at work and contributions received on his behalf. The Fund also credits those that are eligible for Plan B benefits who furnish proof of disability from a physician.

In order to receive such credit for non-work periods

1) You must be insured during the period of disability or
2) If you are self-purchasing insurance under the Plan's buy-in provisions during the period of disability, you must also be working for a Contributing Employer when you become disabled.

The following maximums apply to credit for non-work periods:

- A member can receive a maximum of 20 hours of work in any one week
- A member can be credited with a maximum of 13 weeks during any period of disability for which you receive Accident and Sickness Benefits (Plan B participants must furnish proof of disability from a physician)
- A member can be credited with a maximum of 1 year, measured from the date of an accident, during any period of disability for which you receive Worker's Compensation is received
- A member may attain coverage based on credit for non-work periods for a maximum of 2 consecutive Coverage Periods and
- A member may attain coverage based on credit for non-work periods for a maximum of four Coverage Periods during his lifetime.

HIPAA Special Enrollment Rights

If you do not enroll yourself and your dependents in the Insurance Fund after you become eligible or during annual enrollment, you may be able to enroll under the special enrollment rules under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") that apply when an individual initially declines coverage and later wishes to elect it.

Generally, HIPAA special enrollment is available if

- You initially declined coverage because you had other health care coverage that you have now lost through no fault of your own; or
- Since declining coverage initially, you have acquired a new dependent (through marriage or the birth or adoption of a child) and wish to cover that person.

In the first case, you must have given (in writing) the alternative coverage as your reason for waiving coverage under the Insurance Fund when you declined to participate. In either case, as long as you meet the necessary requirements, you can enroll both yourself and all eligible dependents in the Group Medical Plan within 30 days after:

- The date you lose your alternative coverage or
- The date of your marriage or the birth, adoption, or placement for adoption of your child.

See the Plan Administrator for details about the HIPAA special enrollment.

"Buy-Up"/"Buy-In" Provision

Members who are close to required number of hours and:

- Do not have enough hours to be covered by Plan B but would like to "buy in" that coverage;
- Are short by no more than 50 hours to 450 in 6 months;

are allowed to "buy in" additional hours so that they can receive plan coverage under Plan B.

The member must be short by no more than 50 hours to "buy in" to Plan B.

If a Member wants coverage under Plan B, the Member must have at least 400 within the last 6 months to qualify. If payment is not received before the coverage period begins, then the member loses coverage and is Offered COBRA.

BASIC ELIGIBILITY RULES – NON-COLLECTIVELY BARGAINED EMPLOYEES

With the approval of the Board of Trustees, a Contributing Employer currently contributing to the Benefits Fund on behalf of employees covered by a Collective Bargaining Agreement, the Fund, affiliated funds and the Union may provide coverage under this Plan to its employees who do not work in employment covered by a Collective Bargaining Agreement with a Participating Union, and who are not members of another union.

For its non-collectively bargained employees to participate in the Fund, the Contributing Employer must agree to the following:

1. The Employer and the Fund must sign a participation agreement identifying which employees are participating in the Fund; and
2. Contributions on behalf of these non-collectively bargained employees will be made monthly at rates determined by the Board of Trustees. These rates are subject to change at any time at the discretion of the Trustees.
3. Contributions are made consistently and at the same time contributions are made for collectively bargained plan participants.

Initial

Non-collectively bargained employees of Employers who have agreed to contribute to the Fund on their behalf at the required monthly rate will become covered 30 days after hire.

Continuation of Health Coverage

Health coverage will be continued, on a monthly basis, as long as the monthly contributions are remitted timely.

Termination

Eligibility for benefits will terminate on the last day of the following month after the earliest occurs:

- The non-collectively bargained employee stops working for a Contributing Employer;
- The Employer is no longer a Participating Employer;
- The Employer fails to make contributions for the non-collectively bargained employee's coverage;
- The Fund terminates or no longer allows coverage for non-collectively bargained employees.

Reinstatement

Non-collectively bargained employees do not have any reinstatement provisions. They will be offered COBRA privileges when they leave employment pursuant to the COBRA rules.

ELIGIBILITY RULES FOR SPOUSE/DEPENDENTS

1. The term "Eligible Dependent" shall mean lawful spouse of either gender, and does not include common law spouse, spouse lawfully separated by the courts, divorced spouses, or domestic partners. Your spouse will be covered from the date of your marriage, provided that the eligible Participant presents a valid marriage certificate to the Fund Office.

2. The term "Eligible Dependent" shall also mean all natural, or legally adopted children of a Participant, under 26 years of age), and who are not members of the armed services on active duty. Newborn children are covered as part of the mother's coverage for the first thirty (30) days of the newborn's life. To continue coverage for a newborn after the first thirty days, the eligible Participant must present a valid birth certificate to the Fund Office listing the Participant as the child's parent.

3. The term "child" also includes any child under 26 years of age for whom you have legal guardianship. The effective date of such child's enrollment will be the first day of the first calendar month after the date you provide a certified or attested copy of the court order appointing you Guardian of the child to the Fund Office. The court that issues the appointment must be a court of competent jurisdiction. The Participant must immediately notify the Fund Office in the event your appointment is no longer effective, is revoked or modified, or if you are no longer the legal Guardian of such child. Copies of pertinent papers or other sufficient proof must be sent to the Fund Office.

4. The term "child" also includes any stepchild under 26 years of age. A stepchild is the child a Participant's spouse and the Participant's spouse must be listed as the parent of the child on the child's birth certificate. The effective date of such child's enrollment will be the first day of the first calendar month after the date you provide such birth certificate.

5. An "Eligible Dependent" shall also mean a child 26 years of age or older who is unable to earn a living due to a physical or mental incapacity and who is dependent upon a Participant for support. Proof of the continued existence of such incapacity and of the Participant's support shall be furnished to the Fund Office upon request. Notification of the child's incapacity should be submitted to the Fund Office within 31 days after the child turns 26.

6. The term "Eligible Dependent" shall also mean a child under the age of 26 years of age who is placed with a Participant for adoption by a legally licensed adoption agency before being formally adopted by the Participant. Such child must not have attained age 26 as of the date of placement for adoption. In addition, the Participant with respect to such placement for adoption must have assumed and retained a legal obligation for the total or partial support of such child in anticipation of the adoption of such child and for the period before being formally adopted by the Participant. The Plan considers the child's placement with the Participant to terminate upon the termination of such legal obligation.

7. The term "Eligible Dependent" shall also mean a child under the age of 26 years of age for whom you are required to provide coverage pursuant to a Qualified Medical Child Support Order

8. The term "Eligible Dependent" shall also mean your child under the age of 26 years, born out of wedlock, for whom you acknowledge paternity, if appropriate, in writing, and who otherwise meets the conditions for "Eligible Dependent" described in Paragraph 2 (above).

Documents required by the Fund Office to establish coverage as an "Eligible Dependent" follow:

- Marriage Certificate
- Birth Certificate showing both parents' names
- Court documents from a court of law showing legal guardianship/adoption
- Affidavit stating that a Dependent child, between the ages of 19 and 26, does not have employer-sponsored health benefits available (other than through a parent).
- Student Status information for Dependent children between the ages of 19 and 23 if the child has employer-sponsored health benefits available.
- Documentation and medical records showing proof of a Dependent child's mental or physical incapacity, because of which he or she cannot maintain self-supporting employment, where applicable.
- Documentation that a child is being placed for adoption.

When enrolling an individual as an Eligible Dependent or in determining or making any payments for benefits for an individual as an Eligible Dependent, the Fund will not take into account the fact that the individual is eligible for or is provided medical assistance under a State plan for medical assistance approved under Title XIX of the Social Security Act (Medicaid). In addition, when enrolling a Dependent the Fund Office must receive a copy of a birth certificate or a marriage certificate. In no event will such Dependent be eligible for benefits without this documentation. In no event will such Dependent be eligible for benefits more than 12 months before the Fund Office receives such documentation.

Dependent children of bargaining unit employees of a signatory Local Union who are Actively Working or Available for Work in Covered Employment, who lose coverage due to the dependent child's no longer meeting the Eligibility Rules for Dependent Children, will be offered COBRA.

When Coverage Begins

You will be covered on the first day of the October or April upon qualifying for coverage. Each of your Eligible Dependents will be covered on the date you become covered, or the date this person becomes your Eligible Dependent (if later).

SPOUSE AND DEPENDENTS' COVERAGE AFTER A PARTICIPANT'S DEATH

If you die while you are an active Participant, your spouse and your Dependents will be provided with full coverage under the Insurance Fund, at no cost, until the end of the period for which the employee would have been insured had the employee lived. Thereafter, the participant's surviving spouse and dependent children will be eligible for benefits through the Insurance Fund at COBRA monthly premium rates for 36 months.

PRE-EXISTING CONDITIONS

The Fund has no pre-existing condition exclusions.

However, if you leave the Fund and go to work elsewhere, the health plan provided by your new employer may have a pre-existing condition exclusion. "Pre-existing condition exclusion" means that for a certain

period of time, usually one year, any condition for which you or an eligible Dependent received medical attention within the last six months will not be covered by your new health plan.

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), such an exclusion must be reduced by any period of time you carried "creditable coverage" for such a condition. If you leave the Fund and go to work elsewhere, your new employer may ask you to provide information regarding your "creditable coverage" under HIPAA. You can obtain the Certificate of Creditable Coverage from this Fund. More information about HIPAA begins on Page 60 of this SPD.

Because some people have had creditable coverage through multiple sources, you should always check with all sources of prior health coverage to be sure you get the credit you deserve. If you lose your certificate, you can go back and request another one, free of charge. In most cases, even if you do not receive a certificate, you can use other evidence to prove creditable coverage. These include:

- Pay stubs that reflect a premium deduction;
- Explanation of benefit forms;
- A benefit termination notice from Medicare or Medicaid and;
- Verification by a doctor or your former health care benefits provider that you had prior health coverage.

You also can request a certificate describing your coverage under a particular group health plan, policy, or contract (free of charge) at any time while you are still covered or up to 24 months after the coverage has ended. Each certificate that you request should describe the creditable coverage you have received for the prior 24 months.

Additional information about HIPAA is available at the Heath Care Financing Administration web site: www.hcfa.gov/medicaid/hipaa.

TERMINATION/CHANGES OF COVERAGE

Termination of Coverage

Your insurance will terminate on the last day of a Coverage Period

1. Following a six month Eligibility Period during which you fail to accumulate at least 450 hours of work with Participating Employers or
2. Following a twelve-month eligibility period during which you fail to accumulate at least 900 hours of work with Participating Employers.

At termination, you can purchase temporary coverage under the plan under which you were covered before your termination.

In addition, coverage will terminate on the earliest of the following dates:

- The date the Fund terminates
- The date you die (See "Spouse and Dependents' Coverage After a Participants' Death" above for additional information about continuing coverage.

The Trustees may, in their sole discretion, from time to time, change or discontinue all or any part of the benefits for Participants and Eligible Dependents. Such change or discontinuance may be retroactive as

determined in the sole discretion of the Trustees. This right to change, modify, or discontinue benefits includes, but is not limited to, the right to change eligibility requirements or benefits for Participants and Eligible Dependents. The Trustees also may, in their sole discretion, adopt and amend from time to time any rules, policies or regulations they may deem appropriate. The Trustees may, in their sole discretion, change from time to time the premiums that shall be paid to maintain coverage under the Fund.

Termination of Dependent Coverage

Coverage for Eligible Dependents will terminate on the earliest of the following dates:

- The date on which the Participant's coverage terminates, except that upon the death of an eligible employee, the employee's eligible dependents remain insured until the end of the period for which the employee would have been insured had the employee lived
- The date an Eligible Dependent no longer satisfies the eligibility rules for Dependent coverage
- Coverage of each Eligible Dependent terminates when he or she no longer qualifies as an Eligible Dependent. However, an Eligible Dependent whose coverage is terminating may be eligible to elect COBRA continuation coverage.
- The date the Dependent does not make the appropriate monthly self-payment.

Divorce/Legal Separation

Upon divorce or legal separation from the employee, the participant's ex-spouse is no longer covered by the plan, and will be offered COBRA coverage, as described in SECTION 10 unless the participant is required by a court order to pay for the health insurance for the participant's ex-spouse who is not covered by the participant's insurance.

If the participant's ex-spouse is covered under this provision, coverage for the participant's ex-spouse will end under this Fund at the earliest of the following:

1) The participant remarries;
2) The participant's ex-spouse remarries;
3) The termination date set forth in the court order.

SECTION 2. MEDICAL BENEFITS

Under the Roofers' Union No. 33 Fund, employers make payments to the Fund on your behalf of eligible members under Collective Bargaining Agreements negotiated between the Unions and various employers and employer associations. Members and their families pay a "Copayment" for most covered medical services received within the Network (as described later in this document).

PREFERRED PROVIDER NETWORK ("PPO")

To reduce and control health care costs, the Fund has contracted with Blue Cross Blue Shield's "Preferred Provider Organization Network" also known as a "PPO". This network allows Participants of the Fund to pick doctors and hospitals from a select group. When you choose providers from this group, you will have to pay only a copayment, and for some coverage, the copayment is zero (that is, you pay nothing). This Fund does not require doctor referrals. Please call Blue Cross Blue Shield at (800) 241-0803 to locate an In-Network provider, or use the Internet.

Quick Internet Reference – Please note that Blue Cross Blue Shield may periodically change the procedures to locate an In-Network Medical or Dental provider, on line. If the following procedures do not work, please call the Fund Office for assistance.

To locate a Medical Provider that participates with Blue Cross Blue Shield:

- Go to https://findadoctor.bluecrossma.com/
- From there, you can either enter the name of a specific health care professional or medical facility by filling in the blanks on the screen
- The network you should use is "Blue Care Elect (PPO/EPO)"
- Click the "Search" Button.

If the professional or facility is in the network, you'll be brought to a page that contains detailed information about the professional or facility. Any such professional/facility is "In Network".

If the professional or facility is not found, they are "Out of Network"

IN-NETWORK COMPARED TO OUT-OF-NETWORK

A health care professional or a facility that is in the Blue Care Elect network is considered to be an "In-Network" provider. When you visit an "In-Network" provider, you will usually pay a "copayment" (see the next section).

If you visit a health care professional or a facility that is not in the Blue Care Elect network, it is considered to be an "Out-of-Network" provider. The Fund does not restrict your ability to use an "Out-of-Network" provider, but the amount that you pay will usually be considerably higher than the amount that you'd pay an "In Network" provider.

If you visit an Out-of-Network provider, you will pay the first $500 (if you are single) or $1,000 (if you are married). After that, you will be responsible for 20% of the remaining charges.

Copayment

A "copayment" is the flat dollar portion of a medical bill that a participant is responsible for. For example, for In-Network services, the copayment is a dollar amount, currently such as $15 for certain Physician visits. Note that "copayment" is not the same as "coinsurance".

Coinsurance

"Coinsurance" is the percentage of charges for which a Participant or Eligible Dependent is responsible for, excluding any "Copayment." For example, a Participant who visits an Out-of-Network Physician will be responsible for the 20% Coinsurance payment that the Plan will impose (the Plan pays the other 80%). The percentage of Coinsurance for which a Participant or Eligible Dependent is responsible is described in other Sections of this SPD.

Out of Pocket Maximum

There is a limit on how much you must pay "out of pocket" for services you receive during a calendar year from all In-Network providers. If you are single, you will not pay more than $1,000 in a year; if you have family coverage, the limit you will pay is $2,000.

PREVENTIVE CARE SERVICES UNDER PPACA

Under the "Patient Protection and Affordable Care Act of 2010" or the "ACA" (many people refer to as the "New Health Care Law"), health services, including certain office visits, that are considered to be "preventive" in nature require ***no copayment or coinsurance*** for In-Network providers.

- In-Network providers will be paid at 100% of the Allowed Charge. **You have no copayment for these services.**
- The Plan will pay Out-of-Network providers 80% of the Allowed Charge

At the time this Summary Plan Description was drafted, the U.S. Department of Health & Human Services published the list that can be found in SECTION 22, starting on Page 72. Please note that this list is subject to change. You should discuss with your Physician whether your services are considered to be "preventive" in nature, and therefore require no copayment from you:

Please make sure to inform your Physician that this Plan is complying with all "preventive care" provisions of the ACA, and that you should not be charged a copayment for any of the services listed. Contact the Fund Office if you have questions about this list.

SCHEDULE OF BENEFITS

The following is a summary of covered benefits provided through the Fund. Use this chart for quick reference when you need these services. In the table below, you will be responsible for any In-Network copayments. For Out-of-Network services, you will be responsible for paying any difference between the portion of the "Reasonable & Customary" amount that the Fund pays. In addition, you may be responsible for any Out-of-Network charges in excess of the "Reasonable & Customary" allowance, up to the actual billed charges.

	Covered Service	In-Network You Pay…	Out-of-Network You Pay…[1]
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copayment	20% coinsurance
	Specialist visit	$15 copayment	20% coinsurance
	Other practitioner office visit	$15 copayment	20% coinsurance
	Preventive care/screening/immunization	No charge	20% coinsurance
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance
If you need a prescription	Generic drugs	Retail or Mail Order: $10	Not covered
	Preferred brand drugs	Retail or Mail Order: $20	Not covered
	Non-preferred brand drugs	Retail or Mail Order: $35	Not covered
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance
	Physician/surgeon fees	No charge	20% coinsurance
If you need immediate medical attention	Emergency room services	$50 copayment/ visit No copayment if admitted	$50 copayment/visit No copayment if admitted
	Emergency medical transportation	No charge	No charge
	Urgent care	$15 copayment/ visit	20% coinsurance
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance
	Physician/surgeon fee	No charge	20% coinsurance
If you are pregnant	Prenatal and postnatal care	No charge	20% coinsurance
	Delivery and all inpatient services	No charge	20% coinsurance
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance
	Rehabilitation services	$15 copayment/ visit	20% coinsurance
	Habilitation services	$15 copayment/ visit	20% coinsurance
	Skilled nursing care	No charge	20% coinsurance
	Durable medical equipment	No charge	20% coinsurance
	Hospice service	No charge	20% coinsurance
If your child needs dental or eye care	Eye exam	No charge	20% coinsurance
	Glasses	Not covered	Not covered
	Dental check-up	Not covered	Not covered

[1] Out-of-Network percentage applies after deductible ($500 single; $1,000 family) is met

MENTAL HEALTH/SUBSTANCE ABUSE SERVICES

Mental Health and Substance Abuse services have the same copayments (In-Network), coinsurance (Out-of-Network) and limitations as any other medical service under this plan.

Schedule of Benefits

	Covered Service	In-Network You Pay…	Out-of-Network You Pay…[1]
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 copayment/ visit	20% coinsurance
	Mental/Behavioral health inpatient services	No charge	20% coinsurance
	Substance use disorder outpatient services	$15 copayment/ visit	20% coinsurance
	Substance use disorder inpatient services	No charge	20% coinsurance

Provider of Substance Abuse Services

Substance Abuse services are also provided through an arrangement with Modern Assistance Programs in Quincy. Their phone number is (617) 774-0331.

MEDICAL OPT-OUT PROVISION

A medical "opt–out" choice is available to active members.

Who Is Eligible?

If you have satisfied the Insurance Fund's eligibility requirements for coverage (see page 4), you will have the option of waiving medical coverage in favor of a cash payment. This "opt-out" provision will only be available to a member who demonstrates coverage by a medical plan from another source, such as under the plan of a spouse's employer. Your decision regarding the "opt–out" will remain in effect for the entire plan year (October 1 to the following September 30) unless special circumstances arise which would entitle you to change your decision.

Family Status Changes

Under the following special circumstances, called family status changes, a member may revoke his election regarding the waiver of medical coverage, and may rejoin the medical plan:

- Marriage
- Divorce
- Birth of a child
- Adoption of a child
- Death of a spouse or dependent child
- Unpaid leave of absence of the participant's spouse
- Significant change in coverage due to spouse's employment (example: change from full-time to part-time status or vice versa)

[1] Out-of-Network percentage applies after deductible ($500 single; $1,000 family) is met

"Opt–out" elections may only be changed if they are necessary or appropriate because of family status changes. If the member experiences one of these family status changes and wishes to change his election, he must file a *Change in Family Status Election Form* at the Fund Office within 30 days of the event. Your change of election will become effective on the first day of the month following the date of the family status change. *Change in Family Status Election Forms* are available at the Fund Office.

Cash Payment

If you elect to waive coverage in favor of a cash payment, at the end of the Coverage Period you will receive a cash payment for the six-month period beginning October 1 and ending March 31. If you remain eligible for insurance coverage in the next six-month period, from April 1 to September 30, then at the end of the coverage period you will receive a cash payment of the same amount for this period. The amount of the cash payment is determined by the Trustees, and is subject to change from time to time. The amount will be pro-rated if you rejoin the Plan during a Coverage Period, because of a family status change.

Payment of Taxes

Under Federal and State tax laws, certain taxes will be payable on the amount you receive in cash. The Trustees, however, will consider this before determining the "opt–out" amount to assist you with the tax liability. .

"Opt–Out" Election Forms

"Opt–out" election forms are available at the Fund Office and are sent to all participants every enrollment period. Forms and proof of other insurance must be returned to the Fund Office within 30 days of start of each "eligibility period".

SECTION 3. PRESCRIPTION DRUG PLAN

The Fund uses Blue Cross/Blue Shield for its prescriptions. You can obtain either a 30-day or 90-day supply, although it is typically more economical and efficient to receive a 90-day supply (if your doctor prescribes this amount)

COPAYMENTS

The drug program has three "tiers":

1. Generic Drugs,
2. Preferred Brand Name Drugs, and
3. Non-Preferred Brand Name Drugs with a Generic Substitute.

The benefits in this third category apply when a Participant chooses to receive the brand name drug even though a generic formulation is available.

The Copayments for each of these tiers for both retail pharmacy and mail order pharmacy appear in the following table. Note that all amounts shown are for **In-Network** only. The Fund does not cover Out-of-Network prescriptions.

	Retail Pharmacy[1]	Mail Order Pharmacy[2]
Generic Drug	**$10**	**$10**
Preferred Brand Drug	**$20**	**$20**
Non-Preferred Brand Drug	**$35**	**$35**

Specialty Drugs

For a drug that is considered to be "specialty" (talk to your health care professional for information about the meaning of this term for a prescription), you will pay the applicable cost-share (generic, preferred, non-preferred) amount. In addition, please note that pre-authorization is required for certain specialty drugs. Please contact Blue Cross/Blue Shield if you have questions about whether a prescription will require pre-authorization.

Mail Order/90-day

Through the Mail Order Service, you can purchase a 90-day supply of prescription drugs for one Copayment. Please contact the Fund Office or Blue Cross for Mail Order envelopes.

[1] Maximum 30 day supply
[2] Maximum 90 day supply

SECTION 4. DENTAL PLAN

Dental disease exists in nearly everyone and is cumulative in its destructive effect. Delayed oral examinations or poor dental health habits may progress from tooth decay to severe oral complications. More extensive and expensive dental treatment may be the consequence.

The Fund's dental plan described in the following pages has been designed to:

- Encourage diagnostic treatment
- Eradicate existing dental disease
- Provide preventative dental care
- Supply reasonable assistance toward major restoration and replacement services

The dental plan's emphasis is on preventative services such as routine examination, cleaning and scaling of teeth, application of topical fluoride solutions, and prevention of severe tooth destruction or loss of teeth. These preventative measures lessen the need for extensive tooth restoration, or replacement services; treatments that are costly to both the Participant and the Insurance Fund.

Any benefits payable under the medical plan will be excluded under the dental plan.

TYPES OF SERVICES PROVIDED

Our dental benefits cover four categories of dental services:

- ***Diagnostic and Preventive Services*** to diagnose or prevent tooth decay and other oral diseases. These are the types of dental services most members receive during a routine dental checkup or visit.
- ***Restorative and Other Basic Services*** to restore or remove diseased or damaged natural teeth; treat oral disease; and repair dentures, bridges, crowns, inlays, and onlays.
- ***Prosthodontic and Major Restorative Services*** to replace missing natural teeth with artificial ones and to restore severely diseased or damaged teeth. Services requiring the use of gold are always classified as major restorative services, and may be subject to an alternative benefit. Dentures, complete and partial, are limited to once per 60-month period.
- ***Orthodontic Services*** to correct the position of teeth using braces and other appliances.

DENTAL NETWORK

The Fund uses Delta Dental for our dental coverage. Dentists in the dental network will, generally, charge lower fees than those charged by dentists outside the network.

Summary of Covered Services

You will receive benefits for only those dental services that are "necessary and appropriate" to diagnose and treat your dental condition, as determined by Delta Dental Plan. To be necessary and appropriate, Delta Dental Plan must determine that the service its:

- Consistent with the prevention of oral disease or with the diagnosis and treatment of the dental condition.

- In accordance with standards of good dental practice.
- Not solely for the convenience of you or your dentist.
- Not more costly than the services that are customarily provided (benefits will be based on the least costly method of treatment).
- Generally accepted as appropriate for treating your condition.

Delta Dental Plan determines what is necessary and appropriate based on its review of dental records describing your condition and treatment. Delta Dental may decide a service is not necessary and appropriate under the terms of your group's plan even if your dentist has furnished, prescribed, ordered, recommended, or approved the service. Please note that you have a right to appeal decisions regarding your claim (see "Claims Review and Appeals").

DENTAL BENEFIT

Calendar Year Maximum per patient per year: **$2,500**

All dental benefits are paid by Delta Dental based on a table of allowance. In most cases you will still owe a portion for all services (even if you have not met the $2,500 max).

It's a good idea to have your provider obtain a pre-estimate for all procedures before they are performed so you will know the amount you will owe. The maximum for Periodontic Services per year is **$360** in addition to the overall maximum of $2,500 per patient per year.

The maximums for Orthodontic Services per lifetime are:

Diagnostic and initial orthodontic appliances Orthodontic treatment ..... $ 800

Orthodontic treatment -- 24 months of treatment, per month ..... $ 80

Lifetime orthodontic maximum ..... $ 2,500

Orthodontic benefits are available to all covered members, eligible spouses, and eligible dependent children.

ELIGIBLE EXPENSES

Eligible expenses are the usual, customary, and reasonable charge for the services for dental care. The usual, customary, and reasonable charge for a service will be the fee charged by the dentist, but only to the extent that the fee is reasonable taking into consideration the prevailing range of fees charged in the locality for similar services by dentists of similar training and experience; and/or up to the Delta Dental allowance.

DENTAL SERVICES RECEIVED ON AN OUTPATIENT HOSPITAL BASIS

In certain instances, under strict guidelines, the Fund will consider the facility and anesthesia charges for a participant or a dependent child, based upon their age and circumstances as well as the services involved, the medical necessity of the situation, and confirmation by Delta Dental. In addition, the Fund will consider the facility and anesthesia charges for Participants who have suffered a major accidental injury to sound natural teeth.

INELIGIBLE DENTAL EXPENSES

The Fund will not pay for any of the following:

- Dental care not included in the list of eligible expenses, or that does not meet the standards of dental practice accepted by the American Dental Association
- Dental care that is furnished while a Participant is confined in a hospital operated by the United States government or any agency thereof, or dental care for which the Participant would not be required to pay if there were no insurance
- Dental care that is provided by employer-related facilities
- Dental care that is provided by a HMO or similar organization
- Dental care that is provided solely for the purpose of improving appearance, when form and function of the teeth are satisfactory and no pathological condition exists
- Any charges in excess of Delta Dental's negotiated rate or the usual, customary, and reasonable charge of a less-expensive alternative service or material consistent with adequate dental care, when such alternate services or materials are customarily provided
- Charges for appointments not kept, for completion of claims forms, or for treatment by other than a dental practitioner
- Expenses related to services or supplies normally intended for sport or home use
- Charges, in respect of any dental care directly or indirectly due to or resulting from:
  - War, insurrection, or the hostile action of the armed forces of any country
  - Any cause for which indemnity or compensation is provided under any Workers' Compensation Law or similar legislation
- Charges for
  - Drugs administered by the attending dental practitioner
  - Periodontal splinting
  - Education or training in and supplies used for dietary or nutritional counseling, personal oral hygiene, or dental plaque control
- Charges for the treatment of Temporomandibular Joint (this is covered by the medical portion of this Insurance Fund).
- Service received or supplies purchased outside the United States except for Canada.
- Charges for:
  - Replacement of an appliance or prosthetic device, crown, cast restoration or a fixed bridge within five years of the date it was last placed. This exclusion will not apply if replacement is necessary due to an accidental injury received while insured.
  - Duplicate bridges or dentures or any other duplicate dental appliances
  - Replacement of bridges or dentures lost, misplaced, or stolen
  - Appliances or restorations to increase the vertical dimensions or restore occlusion or splinting
  - Dental care to correct congenital or development malformation
  - Charges for bony impacted wisdom teeth are covered under the Medical Benefit.
  - Accidental injuries to sound natural teeth are covered by the Medical benefits of the Plan.

SECTION 5. VISION AND HEARING CARE BENEFITS

VISION CARE BENEFIT

Who Is Eligible? What Are the Benefits?

For purposes of vision care benefits, eligible members are:

- Active members
- Members eligible for retiree coverage under the Roofers' Local Union No. 33 Insurance Fund.

A member and the member's eligible dependents are each entitled to an examination and a pair of eyeglasses, if required, once every two years. Dependent children under age 19 are entitled to an examination once each year and new lens each two years, if required.

As with any benefit in the Insurance Fund, please call the Fund Office at (781) 341-1657 if you have questions about your eligibility or the eligibility of your Eligible Dependents for vision benefit coverage.

What Benefits are Not Included?

Medical or surgical treatment of the eye is not included. However, in the event the examination indicates the need for medical or surgical treatment, such care may be covered under the benefits of the Insurance Fund.

Is there a Vision "Network" for the Plan? Who is it?

Yes. The plan uses Davis Vision for In-Network coverage. Please do not show your BCBS ID card or you will not receive the maximum benefit possible.

Who are the network providers?

Network providers are licensed providers who are extensively reviewed and credentialed to ensure that stringent standards for quality service are maintained. Please call (800) 999-5431 to access the Interactive Voice Response ("IVR") Unit, which will supply you with the names and addresses of the network providers nearest you, or you may access Davis Vision's website at http://www.davisvision.com/.

What lenses/coatings are included?

- Plastic or glass single vision, bifocal or trifocal lenses, in any prescription range.
- Glass gray #3 prescription lenses.
- Oversize lenses.
- Post-cataract lenses.
- Fashion, sun, or gradient tinted plastic lenses.
- Photogrey Extra® (sun-sensitive) glass lenses.
- Blended invisible bifocals.
- Transitions® (sun-sensitive) plastic lenses.

- Progressive addition multifocals[1].
- Are there any optional frames, lens types or coatings available?

Yes, you can pay the low, discounted fixed fees indicated and receive the following optional items:

$25.00 for Premier frame from the "Tower Collection".
$30.00 for Intermediate Lenses
$20.00 for Super-Shield® (scratch-protective) coating.
$12.00 for ultraviolet (UV) coating.
$35.00 for glare resistant treatment.
$75.00 for polarized lenses.
$55.00 for high-index (thinner and lighter) lenses.

What are the plan benefits, frequencies, and costs?

Type of Benefit	Frequency Allowed	Copayment	In-Network
Eye Examinations	Every 24 months, including dilation as professionally indicated	None	Covered
Lenses (for glasses)	Every 24 months	None	Covered
Frames	Every 24 months	None	Designer Selection from the exclusive "Tower Collection" in network provider offices or a $300 wholesale credit toward a network provider's own frame.

Information about Laser Vision Correction Services

Davis Vision offers Laser Vision Correction Services at significant discounts through a network of experienced, credentialed surgeons (please note that some providers have flat fees equivalent to these discounts). For more information, please visit Davis Vision's website at www.davisvision.com or call 1 (800) 584-2866, and enter client code #7585.

Can I use the benefit at different times?

All available services must be obtained at one time from one network or one out-of-network provider.

When will I receive my eyewear?

Your eyeglasses will be sent to your provider from the laboratory generally within two to five business days. More delivery time may be needed when out-of-stock frames, glare resistant treatment, specialized prescriptions or non-"Tower Collection" frames are selected.

[1] Most people can wear progressive addition multifocals. Conventional bifocals will be supplied for anyone who is unable to adapt to progressive addition lenses.

Are there any exclusions under the vision care provisions?

Yes. The following services and products are excluded:

- Medical treatment of eye disease or injury
- Vision therapy
- Special lens designs or coatings, other than those previously described
- Replacement of lost eyewear
- Non-prescription (Plano) lenses
- Services not performed by licensed personnel
- Contact lenses

HEARING CARE BENEFIT

Active Members are eligible to receive coverage for hearing aids once every five years. The maximum amount that the Fund will pay for a hearing aid is $ 1,000. Members should pay for any hearing aid, then submit a claim form (available at the Fund Office) for reimbursement up to the $ 1,000 level.

VISION CARE: CHILDREN UNDER AGE 19

This plan provides a special set of vision benefits for Eligible Dependents who are under age 19:

	Covered Service	In-Network You Pay…	Out-of-Network
If your child needs eye care	Eye exam	No charge	Not covered
	Glasses	No charge	Not covered

SECTION 6. WEEKLY ACCIDENT AND SICKNESS BENEFITS (LOSS OF TIME)

ELIGIBILITY

If a Participant is unable to work because of a non-work related illness or injury, they may be eligible to receive a Weekly Accident and Sickness benefit. In order to be eligible for this benefit a Participant must be receiving regular care or treatment from a licensed certified medical doctor. Call the Fund Office to determine eligibility for this benefit. A statement of claim form must be completed by your attending physician and returned to the Fund Office in a timely fashion. You will be asked to have your licensed certified medical doctor complete an Attending Physician Statement, periodically throughout your period of disability.

AMOUNT OF BENEFIT

Weekly Accident and Sickness Benefit..... $ 200

Length of Benefit (maximum).....13 weeks

"Injury" means a bodily injury resulting from an accident and independently of all other causes.

"Sickness" means a disease or illness; mental, emotional or nervous disorder; or pregnancy.

"Total Disability" means you cannot perform all of the material duties of your regular occupation because of your disability. It must be caused by Injury or Sickness.

Accident Benefit

The amount of accident benefit ($200) will be paid to you weekly. Benefits begin on the first day of disability, and are payable for not more than 13 weeks during anyone continuous period of disability.

Sickness Benefit

The amount of sickness benefit ($200) will be paid to you weekly. Benefits begin on the eighth day of disability, and are payable for not more than 13 weeks during anyone continuous period of disability.

Note: Payments received under this benefit are considered as taxable income and must be reported on your Federal Income Tax Return. Taxes will be automatically withheld from your disability payments. FICA payments are automatically withheld as well.

A claim for benefits must be filed with the Fund Office within 90 days of your disability.

TERMINATION OF WEEKLY BENEFIT

1. You have received 13 Weekly Accident and Sickness benefit payments;
2. Your death;
3. The date you no longer satisfy the eligibility rules for benefits;
4. The date you are determined not to be disabled by your licensed certified medical doctor;
5. The date you are reemployed regardless of part-time or full-time status;
6. The date the Trustees, in their sole discretion, determine that you are able to return to work.

The Trustees have the right to change, limit, or discontinue Plan benefits at any time. The Trustees also have the right to require a Second Opinion from a licensed certified medical doctor selected by the Benefit Fund, which would be paid for by the Benefit Fund. If the Trustees eliminate the Weekly Accident and Sickness benefit, in whole or in part, the effective date of such amendment is the date in which a Participant's accident and sickness benefits terminate.

SECOND OPINION

The Trustees, in their sole discretion, have the right to request a second opinion regarding a Participant's ability or inability to return to work. The Insurance Fund will pay for any such second opinion.

SECTION 7. LIFE INSURANCE BENEFIT

Life Insurance protection for you and your family is a significant part of your family's long-term financial welfare. The Fund has contracted with an insurance company to provide Participants with life insurance coverage. The following description summarizes this coverage under the Plan. Additional information is available in the Certificate(s) of Insurance from the contracted insurance company, and from the Fund Office.

BASIS OF INSURANCE

This insurance is provided on a non-contributory basis. Life insurance for Participants is payable through an insurance contract between the Insurance Fund and the insurance carrier.

AMOUNTS OF INSURANCE – ACTIVE PARTICIPANT

Life Insurance..... $40,000

Filing a Claim

A claim for benefits must be filed with the Fund Office.

Beneficiary

You may name anyone you wish as your beneficiary, and you may change your beneficiary at any time by completing the proper form available at the Fund Office.

Total and Permanent Disability

If you become totally and permanently disabled while insured and before age sixty, your life insurance will remain in force at no cost to you, as long as you remain so disabled, provided proofs of disability are furnished as required. Proof must be furnished to the Insurance Company no later than twelve months following the date of the last premium payment for you and not later than 24 months following the date you become totally disabled. Approval cannot be granted until you have been disabled for nine (9) months. Subsequent proofs of disability must be furnished each year thereafter.

An employee whose eligibility terminates while he is totally disabled should immediately convert to an individual Life Insurance Policy and continue the Policy, until he receives notice from the insurance carrier that his application for total and permanent disability has been approved.

The words "totally disabled" mean that you are disabled because of disease or accidental bodily injury; and, the disability has resulted in your complete inability to engage, for wage or profit, in any employment or occupation for which you are reasonably suited by education, training or experience.

Extended Benefits

If you die during the 31-day period during which your insurance may be converted, the full amount of life insurance will be payable to your named beneficiary.

Conversion Privileges

If your group life insurance ends due to the end of employment, the end of membership in an eligible class, or a reduction of benefits, or because the Policy ended (and you have been insured by it for five years), you may apply to the Insurance Company, within 31 days, for an individual policy of life insurance (other than term insurance). Subject to the maximum amounts, exceptions, limitations and exclusions set forth in the Group Life Insurance contract, the individual policy will be issued without evidence of insurability. Please contact the Insurance Company to obtain the necessary forms and monthly premium information.

SECTION 8. ACCIDENTAL DEATH AND DISMEMBERMENT ("AD&D")

The Fund provides you with additional insurance in the case of accidental death, dismemberment, and loss of sight. The Fund has contracted with an insurance company to provide Active Participants with this coverage. The following description summarizes this coverage under this plan. Additional information is available from the Certificate(s) of Insurance and from the Fund Office.

AMOUNT OF INSURANCE

Accidental Death & Dismemberment Benefit $40,000

In the event any of the following losses are sustained due to bodily injuries resulting directly from any accident and independent of all causes, on or off the job, the following benefits will be paid in addition to any other benefits payable:

Specific Payments

Life Insurance

In the event of your death from any cause - on the job or off - while you are insured, $40,000 (the full amount shown in the Schedule of Benefits) will be paid to your named beneficiary.

Permanent loss of one hand by severance at or above the wrist joint

$20,000 (one-half the full amount shown in the Schedule of Benefits) will be paid to you.

Permanent loss of one foot by severance at or above the ankle joint

$20,000 (one-half the full amount shown in the Schedule of Benefits) will be paid to you.

For the loss of sight of one eye entirely, irrecoverably and uncorrectably

$20,000 (one-half the full amount shown in the Schedule of Benefits) will be paid to you.

For two of the above losses in any one accident

$40,000 (the full amount shown in the Schedule of Benefits) will be paid to you.

Permanent loss of the thumb and index finger of either hand by severance of entire digit at or above joints

$10,000 (one-quarter the full amount shown in the Schedule of Benefits) will be paid to you.

Loss must be suffered within 90 days from the date of the accident. The total amount payable for all losses sustained in any one accident may not exceed the full amount shown in the Schedule of Benefits.

No payment will be made for any loss that results from any of the following:

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

- Participation in, or the result of participation in, the commission of an assault, or a felony, or a riot, or a civil commotion
- War or act of war, declared or undeclared, or any act related to war, or insurrection
- Medical or surgical treatment of an illness or disease
- Service in the armed forces of any country while such country is engaged in war; or
- Intake of any drug, medication or sedative unless prescribed by a doctor, or the intake of any alcohol in combination with any drug, medication or sedative

Filing a Claim

A claim for benefits must be filed with the Fund Office within 20 days of your loss.

SECTION 9. RETIREE COVERAGE

ELIGIBILITY FOR RETIREE COVERAGE

Retirees are required to pay a portion of the premium for their coverage as a retiree:

- Early Retirees pay 30% of the total cost of coverage.
- Normal retirees pay 20% of the total cost of coverage.

Fund contributions toward retiree medical coverage are subject to modification by the Trustees.

Eligibility for Retiree Coverage in General

In general, employees and spouses may be eligible for retiree coverage if:

1) The employee is eligible for a pension under the Roofers' Local Union No. 33 Pension Fund or National Roofers Industry Pension Plan , and
2) The employee was eligible for benefits under the Roofers' Local Union No. 33 Insurance Fund during five out of the last ten Eligibility Periods before retirement, and has at least 3,000 hours in Covered Employment during the five-year period immediately preceding his retirement.

What Does "Covered Employment" mean for Retiree Coverage?

"Covered Employment" means employment with respect to which contributions are required to be made to the Insurance Fund by the various Employers under the Collective Bargaining Agreements or other written agreement. Covered Employment also includes employment by the Fund.

SPOUSE COVERAGE

Spouses of participants who retire are covered according to the following table:

Age of Participant at Retirement	Eligibility
Age 60 and older	5 years or until participant becomes Medicare eligible, whichever comes first.
Age 55-60	10 years or until participant becomes Medicare eligible, whichever comes first

After the five or ten years has expired, if the participant is not Medicare eligible, the spouse can purchase coverage at full cost until he/she becomes Medicare eligible.

TERMINATION OF SPOUSE'S COVERAGE

The spouse's retiree coverage or the spouse's coverage for Medicare-eligible retirees will terminate at the death of the retiree. However, the spouse may continue her coverage for 12 months following the retiree's death, by paying the full premium.

SECTION 10. CONTINUATION OF COVERAGE ("COBRA" COVERAGE)

IN GENERAL

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA") is a law that entitles Participants and their Eligible Dependents to continue certain coverage provided by the Plan on a self-pay basis if their coverage would otherwise terminate due to the occurrence of certain "Qualifying Events" (defined below).

When a Participant or an Eligible Dependent notifies the Fund Office that a Qualifying Event has happened, the Fund Office will notify him of his right to choose continuation of coverage. Satisfactory evidence of good health will not be required to purchase continued coverage.

General Eligibility for COBRA Continuation Coverage

Employees, spouses and/or dependent children may self-purchase group health and welfare benefits if Plan coverage is lost due to any of the following reasons, called "qualifying events":

- The employee loses eligibility due to a reduction in hours of employment;
- The employee retires;
- The employee dies;
- The employee or ex-spouse remarries or the member's Plan coverage terminates within 36 months of divorce or legal separation; or
- The dependent child ceases to be a dependent child as defined under the Plan.
- Spouses and dependent children may purchase benefits if the employee becomes entitled to Medicare and the employee's coverage under the Plan terminates.

Eligibility Rules

The rules concerning eligibility to elect COBRA continuation coverage follow:

1. If a covered Participant loses coverage under the Fund due to the termination of employment or a reduction in work hours, the covered Participant may purchase continued coverage under the Fund for up to eighteen (18) months. If the spouse or dependent child would also lose coverage under the Fund, each of them may separately elect to purchase coverage for the 18 months. If, during the 18-month period, another Qualifying Event occurs, an Eligible Dependent may elect another continuation. However, the length of the combined continuation periods may not exceed 36 months from the date of the original Qualifying Event.
2. If the Participant entitled to the COBRA continuation coverage is disabled (as determined under the Social Security Act) the Fund provides COBRA continuation coverage for 29 months, rather than 18 months. The disability extension applies if the Participant is disabled at the time of the termination of employment or if the Participant becomes disabled at any time during the first 60 days of COBRA continuation coverage. If the Participant entitled to the disability extension has nondisabled family members who are entitled to COBRA continuation coverage, those nondisabled family members are also entitled to the 29-month disability extension. Note that the monthly COBRA premium reverts to 150% of the current monthly premium throughout this eleven (11) month extension.

3. To be eligible for COBRA, the person must have been eligible for coverage under the Fund at the time of the Qualifying Event, i.e., the termination of employment or reduction in hours. However, a child who is born to or placed for adoption with the Participant during a period of COBRA continuation coverage may make an election to continue COBRA continuation coverage, if the Participant elects COBRA coverage during the election period and enrolls the new child upon birth or adoption.
4. If the spouse or dependent child of any covered Participant is covered by the Fund and loses coverage due to one of the following Qualifying Events, they may purchase continuing coverage under the Fund for up to thirty-six (36) months:
    a. Death of the covered Participant
    b. Divorce of the covered Participant and spouse
    c. A dependent child is no longer considered a dependent child as defined by the Fund; or
    d. A dependent child or spouse loses coverage because the covered Participant becomes entitled to Medicare.
5. A covered Participant's spouse or dependent child's right to elect COBRA continued coverage is subject to limitations and may be terminated before the period stated above. In no event will the maximum period of continued coverage for any Qualifying Event, or any combination of Qualifying Events, exceed thirty-six (36) months from the first Qualifying Event.

COBRA Premium Payment

Employees and/or their dependents may be required to pay the entire cost of continued group coverage at group rates. Specific cost information will be provided to you when you become eligible for continuation coverage.

COBRA is paid in monthly installments. The amount of the monthly COBRA premium will be provided when eligibility for COBRA continuation coverage has been determined. Monthly premiums must be paid on time. If payments are not made on time (including any grace period), coverage will terminate. The first payment must be received by the Fund Office forty-five (45) days from the date of COBRA election or coverage will end. Under no circumstances will the option to make self-payment to the Fund be permitted on a retroactive basis, except as described in this Section of the booklet. The rates charged for individual and family COBRA continuation coverage will be established by the Trustees from time to time, and may be modified by the Trustees.

NOTE: It is recommended that COBRA payments be received in the Fund Office the month prior to the coverage month, i.e., January's COBRA payment received by the Fund Office on December 20th. This will avoid any interruption of claim and/or prescription coverage.

Note: You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage at www.HealthCare.gov or call 1-800-318-2596.

How long does continuation coverage last?

The length of time that the employee, spouse and/or dependent children may purchase group health benefits is set forth in the following schedule:

Qualifying Event	Maximum Length of Continuation
Reduction in Hours	18 Months[1]
Employee Retires	18 Months
Employee Dies	36 Months
Employee or spouse's remarriage	36 Months
Dependent becomes ineligible	36 Months

For an employee's spouse and dependent children, COBRA continuation coverage may be extended if a second qualifying event occurs within the first continuation period. However, in no event will COBRA continuation coverage extend beyond 36 months from the first qualifying event.

Regardless of which continuation period applies, your continuation of coverage with COBRA may end earlier than the 18, 29, or 36 months (whichever is applicable) if any of the following situations occur:

1. You do not pay the required premium on time (including any grace period required under COBRA); or
2. You or your Eligible Dependent who is continuing coverage first become covered under any other group health plan (in a plan without pre-existing condition limitations as defined in the federal law known as HIPAA) after the date of the election to continue coverage; or
3. You or your Eligible Dependent who is continuing coverage first becomes eligible for Medicare after the date of the election to continue coverage; or
4. The Fund no longer provides coverage under any group health plan to any employee; or
5. You obtained COBRA continuation coverage because of disability under Title II or XVI of the Social Security Act and have been given a final determination by Social Security that you are no longer disabled. You must notify the Fund Office of such determination no later than thirty (30) days after the date Social Security has deemed the Participant as no longer disabled; or
6. The Plan terminates.

How does the election occur?

You or your family member must inform the Fund Office of the employee's death, divorce, or legal separation, a child's losing dependent status, or a Social Security disability determination. You must notify the Fund Office within 60 days of the event.

The Fund Office will send you an election form and information about the continuation coverage. Within 60 days of the event that would cause the end of your health coverage, you must inform the Fund Office that you want this continuation coverage. Your first payment must be received by the Fund Office within 45 days of your COBRA election. If you do not choose continuation coverage, your group health coverage under this Plan will end.

[1] If an employee, spouse, or dependent child is determined by the Social Security Administration to have been disabled at the time of the qualifying event or during the first 60 days of COBRA continuation coverage and notice is provided to the Fund Administrator within 60 days after the date the determination is issued, the required continuation period is 29 months.

Certification of coverage when coverage ends

When your medical, dental, and vision coverage ends, the Fund Office will provide you and any of your covered dependents with a certificate of coverage that indicates the period of time that you (and they) were covered under the Plan. The Certificate may be necessary to reduce any pre-existing condition exclusion from future insurance coverage. If, within 62 days after your coverage under this Plan ends, you and/or your covered dependents become eligible for coverage under another group health plan, or if you buy for yourself and/or your covered dependents you may need this Certificate. The Certificate will indicate the period of time that coverage was provided under the Plan, and certain information required by law.

The Fund Office will send the Certificate to you (or to any of your covered dependents) shortly after your coverage under this Plan ends. If you (or any of your covered dependents) elect COBRA continuation coverage, another certificate will be sent to you (or if COBRA continuation coverage is provided only to your covered dependent(s), to the dependent(s) by first class mail shortly after the COBRA continuation ends for any reason.

In addition, a Certificate will be provided to you and/or any covered dependent upon receipt of a request for such a certificate if that request is received by the Fund Office within two years after the later of the date your coverage under this Plan ended or the date COBRA continuation coverage ended, if the request is addressed to:

Roofers Local Union No. 33 Insurance Fund
53 Evans Drive
PO BOX 9106
Stoughton, MA 02072
Phone (781) 341-1657

A covered Participant, spouse, or dependent child must notify the Fund Office within sixty (60) days after a divorce or a dependent child's loss of Fund eligibility. Failure to notify the Fund Office regarding your divorce or a dependent child's loss of eligibility will make you financially responsible for all claims which may have been paid on behalf of your ineligible family member. If the Participant has been determined by the Social Security Administration to be disabled and wishes to purchase up to 29 months of continued coverage, they must provide a copy of the Social Security Administration's determination to the Fund Office within sixty (60) days after the date such a determination is made and in no event later than the expiration of the 18 month period.

The Fund assumes no responsibility or liability if you or your Eligible Dependent allows coverage to terminate. It is the Participant's or Eligible Dependent's responsibility to contact the Fund Office to verify eligibility status.

SECTION 11. COORDINATION OF BENEFITS

In many families today both the husband and wife work and are covered under more than one group health plan. In many instances, this results in duplication of coverage: two plans pay benefits for the same hospital and medical expenses. Duplicative payments could result in a loss of health care dollars to the Fund. For that reason, the Fund has adopted a Coordination of Benefits ("COB") provision. Under the Coordination of Benefits provision, if you or your Dependents are also covered under another group health plan, the total payment received from all such programs combined for a claim may not amount to more than 100% of the allowable expenses. For example, if your spouse who is covered by another plan incurs a $1,000 charge, your spouses' plan allows $800 and pays at an 80% coinsurance rate (or pays $640.00). When the claim is received by the Insurance Fund it is determined that the Blue Cross/Blue Shield Allowance would have been $850, therefore, the Benefit Fund will pay the difference between the Primary Insurance Allowance of $800, making a payment of $160.00. Allowable expenses are any necessary and reasonable expenses for medical services or supplies covered by one of the Funds under which the individual is insured. This Coordination of Benefits is designed to conserve health care costs and insure that providers are not overpaid. **If used correctly, the Coordination of Benefits can reduce your out-of-pocket costs for health care**.

Participants must report any duplicate group health coverage for themselves or Dependents to the Fund Office.

WHO PAYS FIRST

1. The Fund with no Coordination of Benefits provision pays first. The Fund with a Coordination of Benefits provision is secondary.
2. The Fund that covers the Participant based on his or her employment pays first. If your spouse has a group health plan through your spouse's employer, that plan would pay first for your spouse, even if your spouse is covered as a retiree and even if that plan is a "reimbursement plan."
3. If both your plan and your spouse's plan cover your children, the plan of the parent whose birth date (month) falls first during the year will pay first. This is the "Birthday Rule."
4. If a child's parents are divorced or separated, the parent's plan will pay in the following order:
    a. First, the plan of the parent who has financial responsibility for the child's health care expense pursuant to a Qualified Medical Child Support Order ("QMCSO"), court decree or administrative order;
    b. Second, the Fund of the parent with custody of the child;
    c. Third, the Fund of the step-parent married to the parent with custody of the child; or
    d. Fourth, the Fund of the parent not having custody of the child;
5. The Fund that insures the Participant against a particular injury (e.g. sports insurance) will pay first when treatment is sought for such an injury covered under that plan.
6. This plan will not provide coverage if the plan that covers the Participant or Dependent first has denied coverage because the Participant or Dependent has not complied with that plan's rules.

MEDICARE: COORDINATION

If you are Working in Covered Employment

If you or any of your Dependents are eligible for Medicare;

- **And** you remain eligible for benefits from the Fund because you are working in Covered Employment and contributions are being made to the Fund on your behalf by your employer pursuant to a Collective Bargaining Agreement or other document;
- **Then** the Fund will continue to pay for your benefits and your Dependents' benefits as the primary payer (pursuant to the other Coordination of Benefit rules and other provisions of the Plan) until you retire. After you retire or after 104 weeks of disability, Medicare will be the primary payor.
- **However**, if you (or your Eligible Dependent) are eligible for Medicare solely because of "end stage renal disease" ("ESRD") and your employer employs 20 or more individuals for each day of 20 or more calendar weeks in the current and previous calendar years, the Plan will pay as primary for the first 30 months of such eligibility. After 30 months, Medicare will be the primary payor.

If you are Retired

Unlike the Coordination of Benefits provisions for Participants covered by the Plan based on active employment, Medicare is considered "Primary" (pays first) for covered medical and hospital expenses for Retirees. Your retiree benefits through the Insurance Fund are "Secondary" (pays second). The benefits provided under the Retiree Medicare Supplemental Benefit Program will be coordinated with the benefits payable under Medicare for the same expenses. If a retiree or spouse of a retiree is 65 or over, or otherwise eligible for Medicare, reimbursement will first be made under Medicare. If there are any unpaid covered expenses remaining, the Fund will pay these expenses at 100%, including Medicare deductibles, subject to the limitations and exclusions of this Fund.

It is important to note that the benefit levels, limitations, and exclusions for Medicare Part A and B coverage are subject to change by the Federal Government. The Insurance Fund shall only reimburse under Medicare rules in effect at the time you or your spouse incurs the claim.

The Fund requires Retired or Inactive members to purchase BOTH Medicare Part A and Part B when they become eligible. If a member is eligible to purchase Medicare and does not, the Fund will not provide Medical Coverage for either Medicare Part A or Medicare Part B services until the retiree shows proof of Medicare coverage.

SECTION 12. ASSIGNMENT AND SUBROGATION

The Fund is a self-funded "employee welfare benefit plan" as that term is defined in ERISA and, as such, it is governed by rules of ERISA. ERISA pre-empts any state law purporting to restrict the Fund's rights to reimbursement as outlined below.

The Fund does not cover any expenses related to an injury, illness, or loss due to an accident or other occurrence that is the result of an act or omission by another person. This exclusion applies if the injury, illness or other loss occurred during or prior to coverage under the Fund. However, the Trustees, in their sole discretion, may advance payment for such expenses if certain preconditions are met, as outlined below.

If the Fund incurs expenses related to such an illness, injury, or loss, the Fund has the right to be fully reimbursed from, and holds a lien on the proceeds of any recoveries, settlements, or judgments obtained by the Participant or Eligible Dependent against any another person or insurance carrier, however described or allocated. The plan shall be reimbursed from recoveries, settlements, or judgments to the full extent of its expenses (ahead of the Participant, his or her attorneys, and any other person and without reduction for attorney's fees or other costs or expenses and without regard to the "common fund" doctrine). Such recoveries, settlements, or judgments shall constitute plan assets to the extent of the benefits paid or to be paid by the Fund, and any person in possession of such assets shall hold them in trust for the Fund. The requirement to repay the Fund and the Fund's lien apply whether or not:

- Proceeds are received by you or by someone acting on your behalf, such as your attorney;
- Proceeds make you whole for all of your damages and medical expenses; and
- Proceeds are received by way of settlement, judgment, payment from an insurance company or individual, arbitration award or administrative decision.

The requirement to reimburse the Fund and to honor the Fund's lien also applies if you receive or are entitled to receive payment under any no-fault, underinsured, or uninsured motorist insurance policy or from a homeowner's insurance policy.

When automobile insurance, including no-fault, is mandated by state law and you do not have it, the Fund will consider your claim as if you did have it and determine your eligibility for benefits accordingly.

Any Participant acknowledges that these reimbursement, assignment and subrogation rules are binding upon the Participant, his or her attorneys, or the agents, assigns or heirs and executors of the Participant. The Participant is required to pay his or her legal expenses and the Participant is required to notify his or her attorney of these provisions and assignment.

IF YOU INCUR CLAIMS BECAUSE OF A THIRD PARTY

In order for the Trustees to consider advancing benefits to you and/or your Eligible Dependent related to such an injury, illness, or loss, you are required to notify the Fund Office within seven (7) days (or a reasonable time frame) of the accident or other occurrence. You and/or your Eligible Dependent must complete such forms, including a "Reimbursement Agreement and Consent to Lien" form, and supply such information as may be requested by the Fund Office. If you or your Dependent retains an attorney, he (and any successor) must also sign the "Reimbursement Agreement." If you do not initially hire an attorney, but change your mind and subsequently retain one, you must inform the Fund immediately and he must sign a

"Reimbursement Agreement." A "Reimbursement Agreement" executed by you and/or your Dependent and attorney, if you have retained one, is binding upon you, your Dependent and attorney. The Fund will not pay claims arising from the accident or other occurrence if you, your Eligible Dependent, and your attorney do not complete such forms or provide such information as is required by the Fund.

However, the failure of any Participant or attorney to sign any form shall in no way affect the Fund's right to enforce these provisions and to be reimbursed from the proceeds of any recoveries, settlements, or judgments, as described above. By accepting benefits from the Fund, you agree to reimburse the Fund and to the terms of this and all other provisions of the Fund. The Participant or Eligible Dependent is required to notify the Fund Office of any claim made by the Participant or Eligible Dependent for damages or other recovery against another person or insurance carrier. The Participant is required to notify the Fund Office immediately of any recoveries, settlements, or judgments recovered against any source (for example, the person at fault, any insurance company, etc.). The Fund shall be reimbursed from such recoveries as stated herein.

If you or your dependents do not comply with the obligations in this section, the Fund may take whatever action it deems appropriate, including the withholding of future health coverage from you as well as all of your dependents.

SUBROGATION RULES / SUBROGATION AGREEMENT

If the Fund incurs expenses on behalf of a Participant or Eligible Dependent who suffers an injury, illness, or loss due to an accident or other occurrence that is the result of an act or omission by another person, the Fund shall subrogate to any rights of the Participant or Eligible Dependent to the extent of such expenses. The Trustees may intervene in or be subrogated to any related claim or cause of the Participant may have against another person or insurance carrier in order to secure reimbursement of the Fund's expenses.

ASSIGNMENT RULES

By accepting payment of work-related claims or claims related to an injury, illness, or loss due to an accident or other occurrence that is the result of an act or omission by another person, you and/or your Eligible Dependent agree to assign your rights to receive payment of any recoveries and/or the proceeds from any settlement, judgment or administrative decision to the Fund.

ENFORCEMENT PROCEDURES AND REMEDIES

In addition to any legal or equitable remedy that may be available under applicable law, the Trustees may exercise the following remedies if a Participant fails to comply with the rules herein:

- Refuse to pay any benefits related to the Participant's or Eligible Dependent's injuries or illness;
- Disqualify the Participant or Eligible Dependent from participating in the Fund;
- Recover from the Participant benefits already paid through deducting any overpayments from claims otherwise payable. The Trustees may also offset claims payable to any Eligible Dependent of the Participant. In regard to an Eligible Dependent, the Trustees may also offset claims payable to any other Eligible Dependent or the Participant;

- Assess interest on the outstanding benefits or the amount of claims paid at a rate of 12 percent per annum, compounded annually, until paid, or
- In the event the Trustees institute litigation to enforce these provisions, the Participant, and any other responsible person, shall be required to pay the Fund's costs and attorneys' fees, liquidated damages, any investigation fees, in addition to the costs of the claims and interest.

Any recoveries, settlements, or judgments against another person or insurance carrier resulting in reimbursement to the Fund shall be considered the final resolution of all claims related to that injury, illness, or loss. The Fund will not be responsible for any subsequent expenses related to the accident or other occurrence.

WORKERS' COMPENSATION

The Fund does not cover expenses directly or indirectly related to a work-related injury, illness, or loss, unless the Workers' Compensation Commission denies the Participant's claim. Any such expenses you or your Dependent may incur must be submitted through your employer for Workers' Compensation coverage.

The Board of Trustees, in their sole discretion, may advance payment for such expenses if you provide the Fund Office with a copy of the notice that your employer is contesting liability for these expenses in addition to complying with all other provisions of this Section.

NO-FAULT

The following applies to Participants and Eligible Dependents in states that have a no-fault insurance law. If you or your Dependent are involved in an automobile accident in a state where there is a no-fault insurance law, your automobile insurance carrier will be liable for lost wages, medical, surgical, hospital and related charges and expenses up to the greater of:

1. The maximum amount of basic reparation benefit required by applicable law; or
2. The maximum amount of applicable no-fault insurance coverage in effect.

The Trustees may, in their sole discretion, consider payment of any excess charges and expenses under the provisions of the Plan, if you comply with all applicable provisions of this Section.

The Trustees may promulgate rules and regulations to govern procedures hereunder.

SECTION 13. GENERAL INFORMATION

RIGHT OF RECOVERY

If the amount of payments made by the Fund is more than it should have paid under this Summary Plan Description, the Fund may recover the excess. The Trustees may recover from you, your spouse, or Eligible Dependent any overpayments or payments made in error because of any misrepresentation or failure by you, your spouse, or Eligible Dependent to notify the Fund Office as requested in the Fund. The Trustees may, in their discretion, set off any amounts you, your spouse or your Eligible Dependent owe to the Fund or to which the Fund has a right of recovery against payment of medical or other benefits to which you, your spouse or Dependents may be otherwise eligible, until all amounts owed the Fund have been recovered.

CHANGE OF STATUS

Please notify the Fund Office of any change in your family status: when you get married, have a new baby, adopt a child, there is a death, you get a divorce or a legal separation. The Fund requires a copy of all documents to support this change: your marriage certificate, a baby's birth certificate, etc. When you divorce, the Fund requires a copy of the certificate of divorce. Your former spouse may then elect to continue coverage under the Plan's COBRA rules. If you wish to change your beneficiary, please notify the Fund Office in writing so that we can supply you with the proper cards.

When you change your address, you must notify the Fund Office in writing with a copy of a Photo ID.

SECTION 14. HOW TO FILE A CLAIM

Remember, as a Participant, you have agreed to be bound by the Fund's rules and regulations described in this booklet and implemented by the Board of Trustees.

A claim for benefits is a request made in accordance with these claims procedures for the Fund to pay benefits as outlined in this Summary Plan Description. General inquiries about the Fund's provisions or eligibility questions that are unrelated to any specific benefit claim or requests to add or improve the Plan's benefits are not be treated as claims for benefits. In addition, a request for proof of coverage of a benefit is not a claim for benefits.

The following procedure applies to medical **Pre-Service Claims**, **Post-Service Claims**, **Concurrent Claims**, and **Urgent Care Claims**, as well as claims for Disability Benefits, Life Insurance, Accidental Death & Dismemberment, Death Benefits and disability determinations:

CLAIMS FROM PARTICIPANTS

In rare instances, you will file a claim for benefits from the Fund, for instance, if you paid a provider directly and are seeking payment of the benefit from the Fund. In most circumstances, providers will bill the Fund, directly. Generally, if you receive bills or statements from a provider for more than the appropriate Copayment, please call the Fund office.

All of the following information must be completed on the claim form you submit in order for your request for benefits to be a claim, and for the Fund to be able to process your claim:

- Participant's name and Alternate Identification Number
- Participant's address
- Participant's date of birth
- Participant's marital status
- Spouse's name and social security number (if applicable)
- Spouse's date of birth and employment status (if applicable)
- Name, address and telephone number for Spouse's employer
- Patient name and address (if different from Participant)
- Patient's relationship to Participant
- Patient's date of birth
- Patient's sex
- Patient's student status
- Was condition related to patient's employment, or accident?
- Date of service
- Date patient able to return to work
- Date of total/partial disability
- Hospitalization dates, if applicable
- CPT-4 (the code for physician services and other health care services found in the *Current Procedural Terminology*, Fourth Edition or later, as maintained and distributed by the American Medical Association)(your provider will give you this information)

- ICD-9 (the diagnosis code found in the *International Classification of Diseases*, 9th Edition or later, Clinical Modification as maintained and distributed by the U.S. Department of Health and Human Services)(Your provider will give you this information)
- Billed charge, amount paid and balance due
- Federal taxpayer identification number (TIN) of the provider
- Provider billing name and address
- Coordination of benefits information

The Fund Office will not accept photocopies, unless the copies are being submitted to document payment from a primary insurer when the Fund is secondary.

Your spouse or an authorized representative may complete the claim form for you, if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. If you need one, a form can be obtained from the Fund Office to designate an authorized representative. The Fund may request additional information to verify that this person is authorized to act on your behalf. A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an Urgent Care claim without your having to complete the special authorization form.

You are responsible for reviewing the Explanation of Benefits statement (EOB) you receive every time a benefit is paid to you or to your provider. In the event the EOB reflects expenses for services you do not believe you received, you must contact the Fund.

CLAIMS FROM NETWORK PROVIDERS

Claims from providers participating in the medical and mental health/substance abuse provider networks are submitted to the Fund through the network. It is not necessary for you to submit a claim to the Fund.

Network claims are paid directly to the provider. However, the provider may require you to pay Copayments, at the time the services are provided.

CLAIMS FROM NON-NETWORK PROVIDERS

Claims from providers who are not participating in the Fund's provider networks should be submitted by that provider according to the instructions on the back of your identification card. Please tell your Non Network Provider to clearly mark the claim as OUT OF NETWORK before sending it to the Fund Office.

WHEN CLAIMS MUST BE FILED

Claims must be filed within twelve (12) months from the date the charges were incurred. However, all claims for benefits should be submitted as soon as possible. No claim will be paid if first submitted more than twelve (12) months after you received treatment or, in the case of Disability benefits, more than six (6) months after you lost income because you could not work.

In the event that a claim is denied for lack of information, you will be informed of the additional information necessary to complete the claim. You must submit the requested information no later than twelve (12) months after the date that it was requested. No claim will be paid if the Fund receives this information more than twelve (12) months after it is requested.

Claims for a Death Benefit are not subject to the twelve (12) month claim filing period. The beneficiary of a Death Benefit available under the Fund, or his representative, should send a certified copy of the death certificate to the Fund Office. In addition, if the beneficiary is the spouse of the deceased, a copy of a

marriage certificate must be submitted to the Fund, as well. If the beneficiary is the parent of the deceased, a birth certificate must be submitted.

WHEN A CLAIM IS CONSIDERED RECEIVED BY THE FUND

A *Post-Service Medical, Disability, Accidental Death & Dismemberment or Death Benefit Claim* is considered received on the first business day when the claim is received by U.S. mail or hand-delivered to the Fund Office, or, on the first business day when the claim is received electronically by the Fund Office.

Concurrent, Pre-Service and Urgent Care Claims are generally requests for pre-certification of a treatment or hospital stay. (The Plan does not require pre-certification of any services.) A Concurrent, Pre-Service or Urgent Care claim is considered received when a telephone call is made to the Fund Office at the telephone number in this SPD, or your provider electronically contacts the Fund Office at its electronic address requesting pre-certification.

DEFINITIONS OF CLAIM TYPES

Concurrent Claim A claim for additional treatment or hospital days that is being considered concurrently with the provision of treatment and results in a reduction, termination, or extension of a benefit. It also means a claim that is reconsidered after an initial approval was made. (An example of this type of claim would be an inpatient hospital stay originally approved for five days that is reviewed at three days to determine if the full five days is appropriate.)

Post-Service Claim A claim that is not a Pre-Service, Urgent Care, or Concurrent Claim (for example, a claim submitted for payment after the services or treatment have been obtained).

Pre-Service Claim A claim for a benefit for which pre-approval of the benefit (in whole or in part) is required before medical care is obtained. The Fund does not require pre-certification for any services.

Urgent Care Claim A claim for pre-certification of benefits for treatment that, if not received, (1) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (2) in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

SECTION 15. APPEAL AND GRIEVANCE PROCESS – MEDICAL CLAIMS

You have the right to a full and fair review when you disagree with a decision that is made by Blue Cross and Blue Shield to deny a request for coverage or payment for services; or you disagree with how your claim was paid; or you are denied coverage in this health plan; or your coverage is canceled or discontinued by Blue Cross and Blue Shield for reasons other than nonpayment of your cost for coverage in this group health plan. You also have the right to a full and fair review when you have a complaint about the care or service you received from Blue Cross and Blue Shield or from a provider who participates in your health care network. Part 10 explains the process for handling these types of problems and concerns.

INQUIRIES AND/OR CLAIM PROBLEMS OR CONCERNS

Most problems or concerns can be handled with just one phone call. For help to resolve a problem or concern, you should first call the Blue Cross and Blue Shield customer service office. The toll free phone number to call is shown on your ID card. A customer service representative will work with you to help you understand your coverage or to resolve your problem or concern as quickly as possible.

Blue Cross and Blue Shield will consider all aspects of the particular case when resolving a problem or concern. This includes looking at: all of the provisions of this health plan; the policies and procedures that support this health plan; the health care provider's input; and your understanding of coverage by this health plan. Blue Cross and Blue Shield may use an individual consideration approach when Blue Cross and Blue Shield judges it to be appropriate. Blue Cross and Blue Shield will follow its standard guidelines when it resolves your problem or concern.

If after speaking with a Blue Cross and Blue Shield customer service representative, you still disagree with a decision that is given to you, you may request a formal review through the Blue Cross and Blue Shield Member Appeal and Grievance Program.

APPEAL AND GRIEVANCE REVIEW PROCESS

Internal Formal Review

How to Request an Internal Formal Appeal or Grievance Review

To request an internal formal appeal or grievance review, you (or your authorized representative) have three options.

- **Write or Fax**. The preferred option is for you to send your request for an appeal or a grievance review in writing to: Member Appeal and Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126. Or, you may fax your request to (617) 246-3616. Blue Cross and Blue Shield will let you know that your request was received by sending you a written confirmation within 15 calendar days. When you send your request, you should be sure to include any documentation that will help the review.
- **E-mail**. Or, you may send your request for an appeal or a grievance review to the Blue Cross and Blue Shield Member Appeal and Grievance Program e-mail address **grievances@bcbsma.com**. Blue Cross and Blue Shield will let you know that your request was received by sending you a confirmation

immediately by e-mail. When you send your request, you should be sure to include any documentation that will help the review.

- **Telephone Call**. Or, you may call the Blue Cross and Blue Shield Member Appeal and Grievance Program at 1-800-472-2689.

Important Note: Before you make an appeal or file a grievance, you should read "What to Include in an Appeal or Grievance Review Request" that shows later in this section.

Once your appeal or grievance request is received, Blue Cross and Blue Shield will research the case in detail. Blue Cross and Blue Shield will ask for more information if it is needed and let you know in writing of the review decision or the outcome of the review. If your request for a review is about termination of your coverage for concurrent services that were previously approved by Blue Cross and Blue Shield, the disputed coverage will continue until this review process is completed. This continuation of your coverage does not apply to services: that are limited by a day, dollar, or visit benefit limit and that exceed the benefit limit; that are non-covered services; or that were received prior to the time you requested the formal review. It also does not apply if your request for a review was not received on a timely basis, based on the course of the treatment.

All requests for an appeal or a grievance review must be received by Blue Cross and Blue Shield within one year of the date of treatment, event, or circumstance which is the cause of your dispute or complaint, such as the date you were told of the service denial or claim denial.

Time Limit to Request Appeal or Grievance Review:

Effective on and after January 1, 2016, all requests for an appeal or a grievance review must be received by Blue Cross and Blue Shield within 180 calendar days of the date of treatment, event, or circumstance which is the cause of your dispute or complaint, such as the date you were told of the service denial or claim denial.

What to Include in an Appeal or Grievance Review Request

Your request for an internal formal appeal or grievance review should include: the name, ID number, and daytime phone number of the member asking for the review; a description of the problem; all relevant dates; names of health care providers or administrative staff involved; and details of the attempt that has been made to resolve the problem.

- **Appealing a Coverage Decision**. A "coverage decision" is a decision that Blue Cross and Blue Shield makes about your coverage or about the amount your group health plan will pay for your health care services or drugs. For example, your doctor may have to contact Blue Cross and Blue Shield and ask for a coverage decision before you receive proposed services. Or, a coverage decision is made when Blue Cross and Blue Shield decides what is covered and how much you will pay for services you have already received. In some cases, Blue Cross and Blue Shield might decide a service or drug is not covered or is no longer covered for you. You can make an appeal if you disagree with a coverage decision made by Blue Cross and Blue Shield.

  When you make an appeal about a medical necessity coverage decision, Blue Cross and Blue Shield will review your health plan contract and the policies and procedures that are in effect for your appeal along with medical treatment information that will help in the review. Some examples of the medical information that will help Blue Cross and Blue Shield review your appeal may include: medical records related to your appeal, provider consultation and office notes, and related lab or

other test results. If Blue Cross and Blue Shield needs to review your medical records and you have not provided your consent, Blue Cross and Blue Shield will promptly send you an authorization form to sign. You must return this signed form to Blue Cross and Blue Shield. It will allow for the release of your medical records. You have the right to look at and get copies (free of charge) of records and criteria that Blue Cross and Blue Shield has and that are relevant to your appeal, including the identity of any experts who were consulted.

If you disagree with how your claim was paid or you are denied coverage for a specific health care service or drug, you can make an appeal about the coverage decision. Blue Cross and Blue Shield will review the health plan contract that is in effect for your appeal to see if all of the rules were properly followed and to see if the service or drug is specifically excluded or limited by your health plan. The appeal decision will be based on the terms of your health plan contract. For example, if a service is excluded or limited by your health plan contract, no benefits can be provided even if the services are medically necessary for you. For this reason, you should be sure to review all parts of your health plan contract for any coverage limits and exclusions. These parts include this benefit booklet, your Schedule of Benefits, and riders (if there are any) that apply for your health plan contract.

- **Filing a Grievance**. You can file a grievance when you have a complaint about the care or service you received from Blue Cross and Blue Shield or from a health care provider who participates in your health care network. Some examples of these types of problems are: you are unhappy with the quality of the care you have received; you are having trouble getting an appointment or waiting too long to get care; or you are unhappy with how the customer service representative has treated you. If you submit a formal grievance about the quality of care you received from a Blue Cross and Blue Shield provider, Blue Cross and Blue Shield will contact you to obtain your permission to contact the provider (if your permission is not included in your formal grievance). For this type of grievance, Blue Cross and Blue Shield will investigate the grievance with your permission, but the results of any provider peer review are confidential. For this reason, you will not receive the results of this type of investigation.

Choosing an Authorized Representative

You may choose to have another person act on your behalf during the appeal or grievance review process. You must designate this person in writing to Blue Cross and Blue Shield. Or, if you are not able to do this, a person such as a conservator, a person with power of attorney, or a family member may be your authorized representative. Or, he or she may appoint another party to be the authorized representative. (When you are an inpatient, a health care provider may act as your authorized representative to ask for an expedited review. In this case, you do not have to designate the health care provider in writing.)

Who Handles the Appeal or Grievance Review

All appeals and grievances are reviewed by professionals who are knowledgeable about Blue Cross and Blue Shield and the issues involved in the appeal or grievance. The professionals who will review your appeal or grievance will be different from those who participated in Blue Cross and Blue Shield's prior decisions regarding the subject of your review, nor will they work for anyone who did. When a review is related to a medical necessity denial, at least one reviewer will be an individual who is an actively practicing health care professional in the same or similar specialty who usually treats the medical condition or performs the procedure or provides treatment that is the subject of your review.

Response Time for an Appeal or Grievance Review

The review and response for an internal formal appeal or grievance review will be completed within 30 calendar days. Every reasonable effort will be made to speed up the review for requests that involve health care services that are soon to be obtained by the member.

Blue Cross and Blue Shield may extend the 30-calendar-day time frame to complete a review when both Blue Cross and Blue Shield and the member agree that additional time is required to fully investigate and respond to the request. Blue Cross and Blue Shield may also extend the 30-calendar-day time frame when the review requires your medical records and Blue Cross and Blue Shield needs your authorization to get these records. The 30-day response time will not include the days from when Blue Cross and Blue Shield sends you the authorization form to sign until it receives your signed authorization form. If Blue Cross and Blue Shield does not receive your authorization within 30 working days after your request for a review is received, Blue Cross and Blue Shield may make a final decision about your request without that medical information. In any case, for a review involving services that have not yet been obtained by you, Blue Cross and Blue Shield will ask for your permission to extend the 30-day time frame if it cannot complete the review within 30 calendar days of receipt of your request for a review.

Important Note:

If your appeal or grievance review began after an inquiry, the 30-day response time will begin on the day you tell Blue Cross and Blue Shield that you disagree with Blue Cross and Blue Shield's answer and would like an internal formal review.

Written Response for an Appeal or Grievance Review

Once the review is completed, Blue Cross and Blue Shield will let you know in writing of the decision or the outcome of the review. If Blue Cross and Blue Shield continues to deny coverage for all or part of a health care service or supply, Blue Cross and Blue Shield will send an explanation to you. This notice will include: information related to the details of your appeal or grievance; the reasons that Blue Cross and Blue Shield has denied the request and the applicable terms of your coverage in this health plan; the specific medical and scientific reasons for which Blue Cross and Blue Shield has denied the request; any alternative treatment or health care services and supplies that would be covered; Blue Cross and Blue Shield clinical guidelines that apply and were used and any review criteria; and how to request an external review.

Appeal and Grievance Review Records

You have the right to look at and get copies of records and criteria that Blue Cross and Blue Shield has and that are relevant to your appeal or grievance. These copies will be free of charge. Blue Cross and Blue Shield will maintain a record of all formal appeals and grievances, including the response for each review, for up to seven years.

Expedited Review for Immediate or Urgently-Needed Services

In place of the internal formal review as described above in this section, you have the right to request an "expedited" review right away when your situation is for immediate or urgently-needed services and waiting for a response under the review time frames described above would seriously jeopardize your life or health or your ability to regain maximum function as determined by Blue Cross and Blue Shield or your physician, or if your physician says that you will have severe pain that cannot be adequately managed without the care or treatment that is the subject of the review. If you request an expedited review, Blue Cross and Blue Shield

will review your request and notify you of the decision within 72 hours after your request is received, or such shorter time period as required by federal law.

External Review

You must first go through the Blue Cross and Blue Shield internal formal appeal and grievance review process as described above. The Blue Cross and Blue Shield review decision may be to continue to deny all or part of your coverage in this health plan. In this case, you may be entitled to a voluntary external review. You are not required to pursue an external review. Your decision whether to pursue an external review will not affect your other coverage. If you receive a denial letter from Blue Cross and Blue Shield in response to your internal appeal or grievance review, the letter will tell you what steps you can take to file a request for an external review. If you decide to request an external review, you must file your request within the four months after you receive the denial letter from Blue Cross and Blue Shield. Blue Cross and Blue Shield will work closely with you to guide you through the external review process.

You (or your authorized representative) have the right to file an "expedited" external review at the same time that you file a request for an internal expedited review. This right applies to a member who is in an urgent care situation or to a member receiving an ongoing course of treatment. See below for more information about requesting an expedited external review.

How to Request an External Review

To request an external review, you must complete the external review request form that is provided with the denial letter you receive from Blue Cross and Blue Shield. Once your external review request form is completed, you must send it to Blue Cross and Blue Shield as shown on the form.

You (or your authorized representative) have the right to request an expedited review when your situation is for immediate or urgently-needed services as follows:

- When your request concerns medical care or treatment for which waiting for a response under the standard (non-expedited) external review time frames would seriously jeopardize your life or health or your ability to regain maximum function; or
- When your request concerns an internal formal review final adverse benefit determination for an admission, availability of care, continued stay, or health care services for which you received emergency services, while you are an inpatient.

External Review Process

When Blue Cross and Blue Shield receives your request for an external review, your case will be referred to an external review agency to complete your external review. You (or your authorized representative) will be notified by the external review agency of your eligibility and acceptance for an external review. In some cases, the review agency may need more information about your situation. If this is the case, they will request it from Blue Cross and Blue Shield, you, or your authorized representative.

The review agency will consider all aspects of the case and send a written response of the outcome. They will send the response to you (or your authorized representative) and to Blue Cross and Blue Shield within 45 days of receiving the request. If the agency determines additional time is needed to fully and fairly evaluate the request, the agency will notify you and Blue Cross and Blue Shield of the extended review period. In the case of an expedited review, you will be notified of their decision within 72 hours. This 72-hour period starts when the external review agency receives your case.

If the review agency overturns Blue Cross and Blue Shield's decision in whole or in part, Blue Cross and Blue Shield will send you (or your authorized representative) a notice of the review decision made by the agency. This notice will confirm the decision of the review agency. It will also tell you (a) what steps or procedures you must take (if any) to obtain the requested coverage or services; (b) the date by which Blue Cross and Blue Shield will pay for or authorize the requested services; and (c) the name and phone number of the person at Blue Cross and Blue Shield who will make sure your appeal or grievance is resolved.

The decision made by way of the external review process will be accepted as final.

You have the right to look at and get copies of records and criteria that Blue Cross and Blue Shield has and that are relevant to your appeal or grievance. These copies will be free of charge.

Appeals Process for Rhode Island Residents or Services

You may also have the right to appeal as described in this section when your claim is denied as being not medically necessary for you. If so, these rights are in addition to the other rights to appeal that you have as described in other parts of this benefit booklet. The following provisions apply only to:

- A member who lives in Rhode Island and that member is planning to obtain services that Blue Cross and Blue Shield has determined are not medically necessary.
- A member who lives outside of Rhode Island and that member is planning to obtain services in Rhode Island that Blue Cross and Blue Shield has determined are not medically necessary.

Blue Cross and Blue Shield decides which covered services are medically necessary for you by using its medical necessity guidelines. Some of the services that are described in this benefit booklet may not be medically necessary for you. If Blue Cross and Blue Shield has determined that a service is not medically necessary for you, you have the right to the following appeals process:

Reconsideration

A reconsideration is the first step in this process. If you receive a letter from Blue Cross and Blue Shield that denies payment for your health care services, you may ask that Blue Cross and Blue Shield reconsider its decision. You must do this by writing to: Member Appeal and Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126. You must send your request within 180 days of Blue Cross and Blue Shield's adverse decision. Along with your letter, you should include any information that will support your request. Blue Cross and Blue Shield will review your request. Blue Cross and Blue Shield will let you know the outcome of your request within 15 calendar days after it has received all information needed for the review.

Appeal

An appeal is the second step in this process. If Blue Cross and Blue Shield continues to deny coverage for all or part of the original service, you may request an appeal. You must do this within 60 days of the date that you receive the reconsideration denial letter from Blue Cross and Blue Shield. Your appeal request should include any information that supports your appeal. You may also inspect and add information to your Blue Cross and Blue Shield case file to prepare your appeal. In accordance with Rhode Island state law, if you wish to review the information in your Blue Cross and Blue Shield case file, you must make your request in writing and you must include the name of a physician who may review your case file on your behalf. Your physician

may review, interpret, and disclose any or all of that information to you. Once received by Blue Cross and Blue Shield, your appeal will be reviewed by a health care provider in the same specialty as your attending provider. Blue Cross and Blue Shield will notify you of the outcome of your appeal within 15 calendar days after it has received all information needed for the appeal.

External Appeal

If your appeal is denied, you have the right to present your case to an appeals agency that is designated by Rhode Island and not affiliated with Blue Cross and Blue Shield. If you request this voluntary external appeal, Rhode Island requires that you pay for half of the cost of the appeal. Blue Cross and Blue Shield will pay for the remaining half. The notice you receive from Blue Cross and Blue Shield about your appeal will advise you of: the name of the appeals agency that is designated by Rhode Island; and your share of the cost for an external appeal. To file an external appeal, you must make your request in writing to: Member Appeal and Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126. Along with your request, you must: state your reason(s) for your disagreement with Blue Cross and Blue Shield's decision; and enclose a check made payable to the designated appeals agency for your share of the cost for the external appeal.

Within five working days after Blue Cross and Blue Shield receives your written request and payment for the appeal, Blue Cross and Blue Shield will forward your request to the external appeals agency. Blue Cross and Blue Shield will also send its portion of the fee and your entire Blue Cross and Blue Shield case file. The external appeals agency will notify you in writing of the decision within ten working days of receiving all necessary information.

Expedited Appeal

If your situation is an emergency, you have the right to an "expedited" appeal at all three levels of appeal as stated above. An emergency is defined as the sudden onset of a medical or mental condition that in the absence of immediate medical attention could reasonably be expected to result in placing your health or your ability to regain maximum function in serious jeopardy or, in your physician's opinion, would result in severe pain. You may request an expedited reconsideration or appeal by calling Blue Cross and Blue Shield at the phone number shown in your letter. Blue Cross and Blue Shield will notify you of the result of your expedited appeal within two working days or 72 hours of its receipt, whichever is sooner, or such shorter time period as required by federal law. If your appeal is denied, you have the right to request an expedited external appeal. The notice you receive from Blue Cross and Blue Shield about your appeal will advise you of: the name of the appeals agency that is designated by Rhode Island; and the amount that Rhode Island requires you pay for your share of the cost for an expedited external appeal. To request an expedited external appeal, you must send your request in writing to: Member Appeal and Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171-2126. Your request should state your reason(s) for your disagreement with the decision and include signed documentation from your provider that describes the emergency nature of your treatment. In addition, you must also enclose a check made payable to the designated appeals agency for your share of the cost for the expedited external appeal.

Within two working days after the receipt of your written request and payment for the appeal, Blue Cross and Blue Shield will forward your request to the external appeals agency along with Blue Cross and Blue Shield portion of the fee and your entire Blue Cross and Blue Shield case file. The external appeals agency will notify you in writing of the decision within two working days or 72 hours, whichever is sooner, of receiving your request for a review.

External Appeal Final Decision

If the external appeals agency upholds the original decision of Blue Cross and Blue Shield, this completes the appeals process for your case. But, if the external appeals agency reverses Blue Cross and Blue Shield's decision, the claim in dispute will be reprocessed by Blue Cross and Blue Shield upon receipt of the notice of the final appeal decision. In addition, Blue Cross and Blue Shield will repay you for your share of the cost for the external appeal within 60 days of the receipt of the notice of the final appeal decision.

SECTION 16. ADVERSE BENEFIT DETERMINATIONS – OTHER THAN MEDICAL

If you believe benefits (other than medical benefits) provided for under the Fund have been improperly denied or if your eligibility was improperly rescinded, you are entitled to a full and fair review of your claim.

Notice of Claim Denial

If a claim for Fund benefits is denied, in whole or in part, or if your eligibility is rescinded, the Fund, with the authority granted by the Board of Trustees, will give written notice to the claimant of such denial or rescission. Such notice will include the following:

1. A clear explanation of the reason for the denial or rescission;
2. Reference to the specific provisions of the Summary Plan Document (this booklet) or amendment, where appropriate, on which the denial or rescission is based;
3. A description of any additional material or information, if necessary for you to pursue your claim and, where appropriate, explanation of why the material or information is necessary; and
4. An explanation of the Fund's claim review procedure, including applicable time limits, a statement of your right to sue under Federal law following an adverse determination or review, and a statement that you may make an appeal if your claim is denied, if your eligibility has been rescinded or if you have not been notified of action taken on your claim within the applicable time period.

Request for an Appeal

In the event that an eligible Participant is denied a benefit or claim, in whole or in part, or if eligibility is rescinded, the Fund will follow this notice and appeal procedure:

1. The Fund will notify the Participant of the denial or rescission in writing by First Class United States mail, addressed to the Participant's last address on record with the Fund, within the period of time after the denial of the benefit or rescission of eligibility shown on the table on Page 52 of this SPD. Such notice will include the specific reason or reasons for the denial and will be written in a manner anticipated to be understood by the Participant.
2. The Participant (claimant) will have 180 days following receipt of notification of the denial or eligibility rescission to file an appeal. Such appeal shall be made by letter addressed to the Fund Office.
3. The claimant's letter of appeal must state, in general terms, the grounds on which the appeal is being made and what is considered to be erroneous in the original decision. The claimant also may submit written comments, documents, records, and other information relating to the claim. Claimants shall be provided, upon request and free of charge, reasonable access to copies of all documents, records, and other information relevant to the claim. The claimant will be advised within 10 days of the receipt of the letter of appeal when the Board of Trustees is scheduled to review the appeal.

The Fund will provide, free of charge, any new or additional evidence considered, relied upon, or generated by the Fund (or at the direction of the Fund) in connection with the appeal, as soon as possible and sufficiently in advance of the date on which the Trustees will review the appeal to give the claimant a

reasonable opportunity to respond prior to that date. Additionally, before the Trustees can act on an appeal based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale as soon as possible and sufficiently in advance of the date on which the Trustees must act on the appeal to give the claimant a reasonable opportunity to respond prior to that date.

The Board of Trustees will make a final decision within the period of time after the receipt of the appeal shown on the table that follows. If the appeal is denied, the denial will contain the same information as described above for an initial adverse benefit decision.

The Fund is required to maintain your coverage until a decision is made on your appeal of a rescission. If you are not notified within the appropriate time period of the action taken of review of your appeal, you may treat the appeal as "denied" and may initiate a lawsuit as described under "Your Rights under ERISA," beginning on Page 58.

Time Limits for Claims			
	Health Claims (including Eligibility issues, Medical Services, Dental Services, and Vision Services	**Disability Claims**	**All Other Claims**
Notice of Failure to Follow Claims Procedure for Filing a Pre-Services Claim	N/A	N/A	N/A
Notice of Incomplete Claim	N/A, but may extend deadline for initial claim decision by 15 days	N/A, but may extend deadline for initial claim decision twice, for periods of up to 30-days each	N/A, but may extend deadline for initial claim decision by 90-days
Claimant Furnishes Missing Information	At least 45 days	At least 45 days	N/A

Time Limits for Claims			
	Health Claims (including Eligibility issues, Medical Services, Dental Services, and Vision Services	**Disability Claims**	**All Other Claims**
Fund Notice of Initial Claim Denial Decision	**30-days** after receiving the initial claim **45 days** after receiving the claim if Fund needs more claimant information and if Fund provides an extension notice during initial 30-day period.	**45 days** after receiving the initial claim **75 days** after receiving the claim if Fund needs more claimant information and if Fund provides an extension notice during initial 45-day period. **105 days** if Fund needs another extension	**90-days** after receiving the initial claim **180 days** after receiving the claim if Fund needs more claimant information and if Fund provides an extension notice during initial 90-day period.
Claimant Deadline to Complete Non-Urgent Claim	**45 days** after receiving extension notice	**45 days** after receiving extension notice	**N/A**
Claimant Deadline to Appeal Decision	**180 days** after receiving claim denial	**180 days** after receiving claim denial	**60 days** after receiving claim denial

Time Limits for Claims			
	Health Claims (including Eligibility issues, Medical Services, Dental Services, and Vision Services	**Disability Claims**	**All Other Claims**
Trustees Action on Appeal on Post Service Claims	**No later than date of meeting of Board of Trustees next following Fund Office's receipt of appeal request.** If appeal request is received within 30-days of the next meeting, determination will be made by date of second meeting next following receipt of appeal request. If extension of time is needed, then decision will be made by date of the third meeting following receipt of appeal request.	**No later than date of meeting of Board of Trustees next following Fund Office's receipt of appeal request.** If appeal request is received within 30-days of the next meeting, determination will be made by date of second meeting next following receipt of appeal request. If extension of time is needed, then decision will be made by date of the third meeting following receipt of appeal request.	**No later than date of meeting of Board of Trustees next following Fund Office's receipt of appeal request.** If appeal request is received within 30-days of the next meeting, determination will be made by date of second meeting next following receipt of appeal request. If extension of time is needed, then decision will be made by date of the third meeting following receipt of appeal request.
Trustees Action on Appeal on Concurrent Claims	**Within 30 days**	**N/A**	**N/A**
Trustees Action on Appeal on Pre Service Claims	**Within 30 days**	**N/A**	**N/A**
Trustees Action on Appeal on Urgent Claims	**Within 24 hours**	**N/A**	**N/A**
Fund Notice of Appeal Decision on Post Service Claims	**As soon as possible, but no later than five (5) days from the date the appeal is acted upon**	**As soon as possible, but no later than five (5) days from the date the appeal is acted upon**	**As soon as possible, but no later than five (5) days from the date the appeal is acted upon**

Time Limits for Claims			
	Health Claims (including Eligibility issues, Medical Services, Dental Services, and Vision Services	Disability Claims	All Other Claims
Fund Notice of Appeal Decision on Concurrent Service Claims	As soon as possible, but no later than 30 days from the receipt of the appeal	N/A	N/A
Fund Notice of Appeal Decision on Pre-Service Claims	As soon as possible, but no later than 30 days from the receipt of the appeal	N/A	N/A
Fund Notice of Appeal Decision on Urgent Care Claims	As soon as possible, but no later than 24 hours from the receipt of the appeal	N/A	N/A

SECTION 17. PLAN INFORMATION REQUIRED BY ERISA

The following information together with the information contained in this Summary Plan Description is being provided to you in accordance with government regulations

Reference to Collective Bargaining Agreements

This Fund is maintained pursuant to Collective Bargaining Agreements between Roofers Local Union No. 33, and contributing employers. A copy of these Collective Bargaining Agreements may be obtained by Participants and beneficiaries upon written request to the Trustees and are available for examination by Participants and beneficiaries at the Fund Office. Participants and beneficiaries may receive from the Trustees, upon written request, information as to whether a particular employer or employee organization is a Contributing Employer and/or a sponsor of the Fund.

Type of Fund

The Fund provides medical benefits, prescription drug benefits, dental benefits, vision benefits, hearing benefits, life, Weekly Accident, and Sickness insurance.

Funding Medium/Source of Contribution of the Insurance Fund

The assets and reserves of the Fund are held in trust by the Trustees in a trust fund pursuant to an Agreement and Declaration of Trust.

The Fund is funded through contributions to the Fund by Contributing Employers at the hourly rates established by the Collective Bargaining Agreements between the Union and participating employers and in accordance with the provisions of such Agreements, and by investment income earned on a portion of the Fund's assets. Contributions are held in a trust fund for the purpose of providing benefits to covered Participants and defraying reasonable administrative expenses. Under certain circumstances, Participants and beneficiaries losing eligibility under the Fund may maintain eligibility for a limited period of time on a self-pay basis.

Eligibility

The Fund's requirements with respect to eligibility for Participants and for beneficiaries, as well as circumstances that may result in disqualification, ineligibility, or denial, loss, forfeiture, or suspension of any benefits are described in this Summary Plan Description. Also, please note any restrictions or requirements in relation to particular benefits are set forth in the Sections of this Summary Plan Description that describe those benefits.

Description of Benefits

The benefits provided by this Fund are set forth in this Summary Plan Description. The complete terms of any insured benefits provided through an insurance company engaged by the Fund are provided in a certificate of coverage. This certificate, if applicable, is available to Participants and beneficiaries from the Fund Office upon request.

Termination Provisions

The Roofers' Local No. 33 Insurance Fund shall continue during the term of the Collective Bargaining Agreements referred to herein and during the term of any renewal or extension of the Agreements as long as there are available assets. In the event that the obligations of all the participating employers to make

contributions and negotiations therefore terminate, the Trustees, by unanimous agreement will determine how any assets, which may remain after expenses have been paid, will be disposed of. The distribution made by the Trustees shall be made only for the benefit of former eligible Participants and for legitimate Fund purposes; for example, the purchase of insurance benefits, the provision of benefits in any other form, or the transfer to another trust fund.

Claims Procedure

The procedure for filing a claim for benefits is set forth in this Summary Plan Description. If all or any part of your claim is denied you may appeal that decision. A Participant or Eligible Dependent must submit the claim within one (1) year of the date on which the services were rendered.

SECTION 18. YOUR RIGHTS UNDER ERISA

As a Participant in the Roofers' Local No. 33 Insurance Fund, you are entitled to certain rights and protections under ERISA[1]. ERISA provides that all Fund Participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine (without charge) at the Fund Office and at other specified locations - such as work sites and union halls - all documents governing the Fund. These may include insurance contracts, Collective Bargaining Agreements and a copy of the latest annual report (Form 5500 series) filed by the Fund with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain copies of documents governing the operation of the Fund, including insurance contracts, Collective Bargaining Agreements, and copies of the latest Form 5500 annual report and updated Summary Plan Description by writing to the Fund Office. The administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

Continue health care coverage for you, your spouse, or your Dependents if there is a loss of coverage under the Fund due to a qualifying event. You, your spouse, or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Fund for the rules regarding your COBRA continuation rights.

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

Prudent Action by Plan Fiduciaries

In addition to creating rights for Fund Participants, ERISA imposes duties upon the people who are responsible for the operation of the Fund. The people who operate the Fund, called "fiduciaries," have a duty to do so prudently for the purpose of providing benefits and in the interest of you and other Fund 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 ERISA rights.

[1] The Employee Retirement Income Security Act of 1974

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce your above rights. For instance:

If you request a copy of the Fund documents or the latest annual report from the Fund Office 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 Fund's administrator to provide the materials and pay you up to $110 a day until you receive the materials-unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits that is denied or ignored - in whole or in part - you may file suit in federal court.

If you disagree with the Fund's decision or lack of response to your request concerning the qualified status of a medical child support order, you may file suit in federal court.

If it should happen that Fund fiduciaries misuse the Fund's money, or if you are discriminated against for asserting your ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

If you file suit against the Fund, 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 if, for example, it finds your claim to be frivolous.

Help with Your Questions

If you have any questions about the Fund, you should contact the Fund Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Fund's administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210.

You may also obtain certain publications regarding your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration's Employee and Employer Hotline at (866)444-EBSA(3272), by logging on to the Internet at http://www.dol.gov/ebsa/publications/main.html, or by contacting the EBSA field office nearest you.

SECTION 19. HIPAA PRIVACY AND SECURITY RULES

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

The Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 (as amended) provides privacy protection of your verbal, written, and electronic records under a company-sponsored health care benefits plan. On April 14, 2003, in compliance with HIPAA requirements, this Fund introduced new privacy policies and procedures to protect you and your family's health information under the various health plans maintained at the Fund Office. Please read the privacy notice carefully and share the information with family members as appropriate. If you have any questions, please call the Fund Office at (781) 341-1657.

Introduction

Title II of HIPAA imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information, known as "Protected Health Information," or "PHI," includes virtually all individually identifiable health information held by the Fund, whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of the Roofers' Local No. 33 Insurance Fund.

THE FUND'S DUTIES WITH RESPECT TO HEALTH INFORMATION ABOUT YOU

The Fund is required by law to maintain the privacy of your health information and to provide you with this notice of the Fund's legal duties and privacy practices with respect to your health information. It is important to note that under Title II of HIPAA, these rules apply to the Fund, not to any participating union or any contributing sponsor to this Fund. Different policies may apply to other Fund programs or to data unrelated to this Insurance Fund.

HOW THE FUND MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an "authorization") for purposes of health care treatment, payment activities, and health care operations. Here are some examples of these purposes:

Treatment includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers**. For example, the Fund may share health information about you with Physicians who are treating you.**

Payment activities include activities by this Fund, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing; as well as "behind the scenes" plan functions such as risk adjustment, collection, or reinsurance. **For example, the Fund may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate payment of benefits.**

Health care operations include activities by this Fund (and in limited circumstances other plans or providers) such as wellness and risk assessment programs, quality assessment and improvement activities, customer

service, and internal grievance resolution. Health care operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development**. For example, the Fund may use information about your claims to review the effectiveness of wellness programs.**

The amount of health information used or disclosed will be limited to the "Minimum Necessary" for these purposes, as defined under the HIPAA rules. The Fund may also contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

HOW THE FUND MAY SHARE YOUR HEALTH INFORMATION WITH THE FUND OFFICE

The Fund may disclose your health information without your written authorization to the Fund Office for plan administration purposes. The Fund Office may need your health information to administer benefits under the Fund. The Fund Office agrees not to use or disclose your health information other than as permitted or required by the Fund documents and by law. Only the Fund Administrator will have access to your health information for plan administration functions.

Here is how additional information may be shared between the Fund and the Fund Office, as allowed under the HIPAA rules:

The Fund may disclose "summary health information" to the Fund Office if requested, for purposes of obtaining premium bids to provide coverage under the Fund, or for modifying, amending, or terminating the Fund. Summary health information is information that summarizes participants' claims information, but from which names and other identifying information have been removed.

The Fund may disclose to the Fund Office information on whether an individual is participating in the Fund.

In addition, you should know that the Fund Office cannot and will not use health information obtained from the Fund for any employment-related actions. However, health information collected by the Fund Office from other sources, for example under the Family and Medical Leave Act, Americans with Disabilities Act, disability income programs, or Workers' Compensation is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

OTHER ALLOWABLE USES OR DISCLOSURES OF YOUR HEALTH INFORMATION

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care.

Information describing your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You will generally be given the opportunity to agree or object to these disclosures (although exceptions may be made, for example if you are not present or if you are incapacitated). In addition, your health information may be disclosed to your legal representative without authorization.

The Fund is also allowed to use or disclose your health information without your written authorization for the following activities:

Activity	Reason
Workers' Compensation	Disclosures to Workers' Compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with such laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (including disclosures to the target of the threat); includes disclosures to assist law enforcement officials in identifying or apprehending an individual because the individual has made a statement admitting participation in a violent crime that the Fund reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Fund believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Fund's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Fund may be required to notify you of the request, or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or pursuant to legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosure about a death that may have resulted from criminal conduct; and disclosure to provide evidence of criminal conduct on the Fund's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death

Activity	Reason
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, and subject to certain assurances and representations by researchers regarding necessity of using your health information and treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services (HHS) to investigate or determine the Fund's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. You may revoke your authorization as allowed under the HIPAA rules. However, you cannot revoke your authorization if the Fund has taken action relying on it. In other words, you cannot revoke your authorization with respect to disclosures the Fund has already made.

It is the Fund's procedure, upon request for assistance, to disclose your health information to your spouse or your domestic partner (if applicable), and your spouse's or your domestic partner's (if applicable) health information to you, and to disclose the health information of your over-age enrolled Dependent (for example, your Child who is over the age of 21) to you or your spouse or your domestic partner (if applicable), unless the person whose health information would otherwise be disclosed chooses to opt out of this default procedure. For example, if you and your spouse are enrolled for Fund benefits and believe that the Fund has paid only a portion of the service fee it should have for a service provided to your spouse, the Fund will work with you to obtain the correct payment for the service rendered, even if doing so requires sharing with you some health information about your spouse. (And the reverse would be true: your health information would be shared with your spouse in such a situation.) You may request the Fund not share your health information with your spouse or your domestic partner (if applicable) by opting out of this default procedure. To opt out, you must contact the Fund Office at (781) 341-1657. Your spouse, domestic partner (if applicable), and/or your over-age enrolled Dependent may also opt out of this procedure by contacting the Fund Office at (781) 341-1657. Once an individual has opted out of this default, the Fund generally will not disclose any of the individual's health information to family members, unless some other part of the HIPAA regulations permits or requires it (for example, that individual becomes incapacitated). Any individual may change the opt-out election at any time by contacting the Fund Office at (781) 341-1657.

YOUR INDIVIDUAL RIGHTS

You have the following rights with respect to your health information the Fund maintains. These rights are subject to certain limitations, as discussed below. This Section of the Summary Plan Description describes how you may exercise each individual right.

Right to request restrictions on certain uses and disclosures of your health information and the Fund's right to refuse

You have the right to ask the Fund to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Fund to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Fund to restrict use and disclosure of health information to notify those persons of your location, general condition, or death, or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Fund must be in writing.

The Fund is not required to agree to a requested restriction. And if the Fund does agree, a restriction may later be terminated by your written request, by agreement between you and the Fund (including an oral agreement), or unilaterally by the Fund for health information created or received after you are notified that the Fund has removed the restrictions. The Fund may also disclose health information about you if you need emergency treatment, even if the Fund has agreed to a restriction.

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Fund will accommodate reasonable requests to receive communications of health information from the Fund by alternative means or at alternative locations.

If you want to exercise this right, your request to the Fund must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "Designated Record Set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Fund uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. In addition, the Plan may deny your right to access, although in certain circumstances you may request a review of the denial.

If you want to exercise this right, your request to the Fund must be in writing. Within 30-days of receipt of your request (60 days if the health information is not accessible onsite), the Fund will provide you with:

The access or copies you requested;

A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint; or

A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Fund expects to address your request.

The Fund may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Fund may also charge reasonable fees for copies or postage.

If the Fund does not maintain the health information but knows where it is maintained, you will be informed of where to direct your request.

Right to amend your health information that is inaccurate or incomplete

You have a right to request that the Fund amend your health information in a Designated Record Set; however there are certain exceptions. The Fund may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Fund (unless the person or entity that created the information is no longer available), is not part of the Designated Record Set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Fund must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Fund will:

Make the amendment as requested;

Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint; or

Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Fund expects to address your request.

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures the Fund has made of your health information. This is often referred to as an "accounting of disclosures." You generally may receive an accounting of disclosures if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information going back for 6 years from the date of your request, but not earlier than April 14, 2003 (the general date that the HIPAA privacy rules are effective). You do not have a right to receive an accounting of any disclosures made:

For Treatment, Payment, or Health Care Operations;

To you about your own health information;

Incidental to other permitted or required disclosures;

Where authorization was provided;

To family members or friends involved in your care (where disclosure is permitted without authorization);

For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; or

As part of a "limited data set" (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Fund must be in writing. Within 60 days of the request, the Fund will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Fund expects to address your request. You may make one request in any 12-month period at no cost to you, but the Fund may charge a fee for subsequent requests. You will be notified of the fee in advance and have the opportunity to change or revoke your request.

Changes to the Information in this Notice

The Fund must comply with these new privacy requirements as of April 14, 2003. However, the Fund reserves the right to change the terms of its privacy policies as described in this notice at any time, and to make new provisions effective for all health information that the Fund maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Fund's privacy policies described in this notice, you will be provided with a revised privacy notice that will be sent to you in the same manner as this notice was provided.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Secretary of Health and Human Services and or with the Fund. You will not be retaliated against if you file a complaint. To file a complaint with respect to a violation of your privacy rights, please contact the Privacy Official or its designee.

CONTACT

For more information on the Fund's privacy policies or your rights under HIPAA, please call the Fund Office at (781) 341-1657.

The Fund supports your right to the privacy of your protected health information. The Fund will not retaliate against you in any way for filing a complaint with it or the U.S. Department of Health and Human Services.

SECTION 20. OTHER LEGAL REQUIREMENTS

WORKERS' COMPENSATION COVERAGE

Medical expenses covered by the Insurance Fund are generally for services and supplies received for the treatment of non-occupational bodily injuries and illnesses. If you incur a work related injury or illness (one which arises out of or in connection with your employment), your claim for any charges related to that injury or illness must be submitted through your employer for Workers' Compensation coverage. No benefits are payable by the Fund for such charges, unless the claim is denied by the Workers' Compensation Commissioner and is otherwise eligible for payment.

However, if you have been notified that your employer is contesting liability of your Workers' Compensation claim, the Fund will pay related Hospital and medical expenses provided a copy of the "Notice to Contest Liability" is submitted to the Fund Office. Weekly Disability Income Benefits will be paid as long as a signed, written Agreement, which gives the Fund the right to recover from the claimant the full amount of benefit paid, has been executed. The Fund must be promptly reimbursed in full or the claimant will have additional liability for interest and all costs of collection, including reasonable attorneys' fees incurred by the Fund. Before related claims will be paid through the Fund, you will be required to sign a Subrogation Agreement as discussed on Page 37.

Although charges relating to an occupational injury or illness must be submitted to Workers' Compensation, the Life Insurance and other medical benefits will continue for yourself and your Eligible Dependents for charges incurred due to non-occupational accidental bodily injuries or illnesses, as long as you are receiving Workers' Compensation payments and contributions are paid for the injured.

Where a claim for Workers' Compensation is settled by stipulation or Agreement, you cannot claim benefits for the same disability from the Fund. If benefits are paid in error, the Insurance Fund must be reimbursed for any payments to you or your Dependents or providers, and all costs of collection, including attorney's fees and court costs.

FAMILY AND MEDICAL LEAVE ACT ("FMLA")

Under this federal law, you may have the right to take up to 12 weeks of unpaid leave in a 12-month period for the birth or adoption of a child; to care for a spouse, child, or parent with a serious health condition; and when you are unable to work because of a serious health condition. If you are out of work because of a qualified Family and Medical Leave Act leave of absence, you may choose to continue coverage during your leave of absence, or you may choose to suspend coverage during your leave. If you continue coverage during your leave of absence you and your Eligible Dependents will be covered under your plan while you are absent from work. The coverage will continue as if you were actively working until the earlier of the expiration of your FMLA leave or the date you give notice to your employer that you will not return from your leave. You are required to pay the employee's portion of the cost of medical coverage, where applicable.

However, if you choose to suspend coverage during your absence, you and your Eligible Dependents will become covered immediately upon your return to work without being required to give evidence of insurability. If you decide to take a FMLA leave of absence, contact the Fund Office for further information and election forms.

CONTINUATION OF HEALTH COVERAGE UPON MILITARY LEAVE ("USERRA")

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") continues the protection of civilian job rights and benefits for veterans and members of Reserve components. If you are absent from employment due to service in the United States Armed Forces, you may be eligible to continue medical coverage under this Fund for you or your eligible dependents on a self-pay basis for the period of your military service (to a maximum of 24 months) and may be eligible for medical coverage when you return to employment at the conclusion of your military service. Please contact the Fund Office for additional information.

THE NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT ("NMHPA")

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT ("WHCRA")

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan as described in the Schedule of Benefits.

Contact the Fund Office for further information.

QUALIFIED MEDICAL CHILD SUPPORT ORDER ("QMCSO")

The Fund Office shall enroll for immediate coverage under the Fund any Alternate Recipient who is the subject of a Medical Child Support Order that is a "Qualified Medical Child Support Order" ("QMCSO") or a National Medical Support Notice ("NMSN") if such an individual is not already covered by the Fund as an Eligible Dependent once the Fund Office has determined that such order meets the standards for qualification set out in the paragraph below.

The following definitions shall apply for these purposes:

- **"Alternate Recipient"** means any child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under the Fund as the Employee's Eligible Dependent. For purposes of the benefits provided under The Fund, an Alternate Recipient shall

be treated as an Eligible Dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient shall have the same status as an employee.

- **"Medical Child Support Order"** means any judgment, decree, or order (including approval of a domestic relations settlement Agreement) issued by a court of competent jurisdiction that (1) provides for child support with respect to an employee's child or directs the employee to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law), or (2) enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.
- **"Qualified Medical Child Support Order"** is a Medical Child Support Order that 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 employee or Eligible Dependent is entitled under the Fund. In order for such an order to be a QMCSO, it must clearly specify (1) the name and last known mailing address (if any) of the employee and the name and mailing address of each such Alternate Recipient covered by the order; (2) a reasonable description of the type of coverage to be provided by the Fund to each Alternate Recipient, or the manner in which such type of coverage is to be determined; (3) the period of coverage to which the order pertains; and (4) the name of this Fund and the Fund. However, such an order need not be recognized as "qualified" if it requires the Fund to provide any type or form of benefit, or any option, not otherwise provided to employees and Eligible Beneficiaries without regard to this Section, except to the extent necessary to meet the requirements of a state law relating to medical child support orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).
- **"National Medical Support Notice"** is a notice issued by an appropriate agency of a state or local government similar in form, content, and legal effect to a Qualified Medical Child Support Order that directs the Fund Office to effectuate coverage for an Alternate Recipient as the dependent child of the noncustodial parent who is (or will become) an employee covered by the Fund pursuant to a domestic relations order that includes a provision for health care coverage.

Upon receiving a Medical Child Support Order or National Medical Support Notice, the Fund Office shall-as soon as administratively possible- (1) notify the employee and each Alternate Recipient covered by the order (at the address included in the order) in writing of the receipt of such order and the Fund's procedures for determining whether the order qualifies as a QMCSO, and (2) make an administrative determination if the order is a QMCSO and notify the employee and each affected Alternate Recipient of such determination. To give effect to this requirement, the Fund Office shall (1) establish reasonable, written procedures for determining the qualified status of a Medical Child Support order; and (2) permit any Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to the order.

Within twenty (20) business days after the date of the NMSN, the Company shall provide the Fund Office with the notice. Within forty (40) business days of the date of the notice, the Fund Office shall: (1) notify the state or local agency issuing the NMSN whether coverage is available to the child who is the subject of the notice and, if so, whether the child is covered under the Fund, and either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent (or by an official of the issuing agency) to

effectuate coverage, and (2) provide to the custodial parent (or official of the governmental agency involved in the notice) a description of the coverage available and any forms or documents necessary to effectuate the coverage.

Contact the Fund Office to obtain, without charge, a copy of the Fund's QMCSO procedures and further information.

SECTION 21. FREQUENTLY ASKED QUESTIONS

1. What is a "Copayment"?

A copayment is an amount you pay to an In-Network doctor, hospital, or pharmacy for services you receive. After you have paid your copayment, the Fund pays 100% of all remaining charges for the doctor, hospital, or pharmacy; you pay nothing more. When you have either In-Patient or Out-Patient hospital stays, the copayment is larger than the standard amount because you are paying for a broad range of services and many doctors. So, instead of paying a copayment for each service or to each doctor, you pay a one-time (per stay) copayment. See the Schedule of Benefits beginning on Page 15 for more information.

2. Do I need a referral to see a specialist or another doctor?

No. The Fund contracts with Blue Cross/Blue Shield, which is a Preferred Provider Network, not HMO. You may use any doctor within the network or outside the network. However, if you choose to use a provider outside the network you will incur out-of-pocket expenses.

3. What if I have a balance due from the health care provider after the Fund has paid my bill?

Please call the Fund Office should you receive a balance due bill from a provider.

4. My wife just had a baby. How do I enroll the new baby for health coverage?

First, notify the Fund Office and inform them of the baby's name and date of birth. You must submit a copy of the baby's full birth certificate as soon as it becomes available.

5. Which card is my Insurance Fund card?

You should have one card, which will enable providers to identify the type of health plan you have for medical and dental services, and prescriptions:

This card is printed with the participant's name and Alternate Identification Number, and identifies the Plan's medical network. All covered family members may use this card. Give this card to your doctor, hospital, pharmacist, dentist, etc., at the time of service.

If you do not have a card or find incorrect information printed on it, please contact the Fund Office.

6. If I get injured on the job, who pays my medical bills?

Any injury that has occurred on the job should be reported immediately to your employer. An accident report should be filled out promptly. Please notify the Fund Office about work-related injuries as soon as possible. We will be alerted to any medical bills that were incurred because of a work-related injury and contact the providers as to where to submit them for proper payment. All work-related charges should be covered with your employer's workers' compensation carrier. The Fund does not cover work-related charges.

7. If I travel out of state or out of the country, will I have coverage for any medical care?

Yes, if it is a covered medical service under the Fund. You may have to pay for services up front, if the provider refuses to submit billing to the Fund Office. Please be sure to ask for an itemized bill in English.

8. How long will my Dependent Children be covered under the Fund?

A dependent child who does not have coverage offered from employment is covered until the end of the month in which they turn age 26.

SECTION 22. PREVENTIVE CARE SERVICES UNDER THE AFFORDABLE CARE ACT OF 2010 ("ACA")

The following preventive services are covered without your having to pay a copayment or co-insurance or meet your deductible. This applies only when these services are delivered by an In-Network provider.

COVERED PREVENTIVE SERVICES FOR ADULTS

1. Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
2. Alcohol Misuse screening and counseling
3. Aspirin use for men and women of certain ages
4. Blood Pressure screening for all adults
5. Cholesterol screening for adults of certain ages or at higher risk
6. Colorectal Cancer screening for adults over 50
7. Depression screening for adults
8. Type 2 Diabetes screening for adults with high blood pressure
9. Diet counseling for adults at higher risk for chronic disease
10. HIV screening for all adults at higher risk
11. Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
    - Hepatitis A
    - Hepatitis B
    - Herpes Zoster
    - Human Papillomavirus
    - Influenza (Flu Shot)
    - Measles, Mumps, Rubella
    - Meningococcal
    - Pneumococcal
    - Tetanus, Diphtheria, Pertussis
    - Varicella
12. Obesity screening and counseling for all adults
13. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
14. Tobacco Use screening for all adults and cessation interventions for tobacco users
15. Syphilis screening for all adults at higher risk

COVERED PREVENTIVE SERVICES FOR WOMEN, INCLUDING PREGNANT WOMEN

1. Anemia screening on a routine basis for pregnant women
2. Bacteriuria urinary tract or other infection screening for pregnant women
3. BRCA counseling about genetic testing for women at higher risk
4. Breast Cancer Mammography screenings every 1 to 2 years for women over 40

5. Breast Cancer Chemoprevention counseling for women at higher risk
6. Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women*
7. Cervical Cancer screening for sexually active women
8. Chlamydia Infection screening for younger women and other women at higher risk
9. Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs*
10. Domestic and interpersonal violence screening and counseling for all women*
11. Folic Acid supplements for women who may become pregnant
12. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes*
13. Gonorrhea screening for all women at higher risk
14. Hepatitis B screening for pregnant women at their first prenatal visit
15. Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women*
16. Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older*
17. Osteoporosis screening for women over age 60 depending on risk factors
18. Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
19. Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users
20. Sexually Transmitted Infections (STI) counseling for sexually active women*
21. Syphilis screening for all pregnant women or other women at increased risk
22. Well-woman visits to obtain recommended preventive services

COVERED PREVENTIVE SERVICES FOR CHILDREN

1. Alcohol and Drug Use assessments for adolescents
2. Autism screening for children at 18 and 24 months
3. Behavioral assessments for children of all ages
4. Blood Pressure screening for children
5. Cervical Dysplasia screening for sexually active females
6. Congenital Hypothyroidism screening for newborns
7. Depression screening for adolescents
8. Developmental screening for children under age 3, and surveillance throughout childhood
9. Dyslipidemia screening for children at higher risk of lipid disorders
10. Fluoride Chemoprevention supplements for children without fluoride in their water source
11. Gonorrhea preventive medication for the eyes of all newborns
12. Hearing screening for all newborns
13. Height, Weight and Body Mass Index measurements for children
14. Hematocrit or Hemoglobin screening for children

15. Hemoglobinopathies or sickle cell screening for newborns
16. HIV screening for adolescents at higher risk
17. Immunization vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
    - Diphtheria, Tetanus, Pertussis
    - Haemophilus influenzae type b
    - Hepatitis A
    - Hepatitis B
    - Human Papillomavirus
    - Inactivated Poliovirus
    - Influenza (Flu Shot)
    - Measles, Mumps, Rubella
    - Meningococcal
    - Pneumococcal
    - Rotavirus
    - Varicella
18. Iron supplements for children ages 6 to 12 months at risk for anemia
19. Lead screening for children at risk of exposure
20. Medical History for all children throughout development
21. Obesity screening and counseling
22. Oral Health risk assessment for young children
23. Phenylketonuria (PKU) screening for this genetic disorder in newborns
24. Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk
25. Tuberculin testing for children at higher risk of tuberculosis
26. Vision screening for all children

SECTION 23. IMPORTANT PHONE NUMBERS

Blue Cross/Blue Shield of Massachusetts
(800) 241-0803

Behavioral Health
1-800-524-4010

Pre-Admission Review of Non-Emergency, Non-Maternity Care
(800) 327-6716

Emergency Admissions or Maternity Admissions
1-800-327-6716

Modern Assistance Program

Substance Abuse
(617) 774-0331

Delta Dental (Dental Coverage)
(800) 872-0500

Davis Vision (Vision Coverage)
(800) 999-5431

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