AMENDED AND RESTATED

ROOFERS AND WATERPROOFERS LOCAL 44

WELFARE PLAN

AND

SUMMARY PLAN DESCRIPTION

May 1, 2023

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THIS AMENDMENT AND RESTATEMENT to the Roofers and Waterproofers Local 44 Welfare Plan, as amended (the "Plan") and related Summary Plan Description are made as of May 1, 2023 by the Board of Trustees (the "Board").

WITNESSETH:

WHEREAS, Local 44 of the United Union of Roofers, Waterproofers and Allied Workers (formerly known as the United Slate, Tile and Composition Roofers Damp and Waterproof Workers Association) and The Greater Cleveland Roofing Contractors' Association, Inc. (formerly known as the Cuyahoga Composition Roofers Association of Cleveland, Ohio) entered into an agreement and declaration of trust on May 30, 1969, which agreement and declaration of trust established the Roofers and Waterproofers Local No. 44 Welfare Trust Fund, such Trust Fund having been established for the purpose of receiving contributions from contributing "Employers" (as hereinafter defined) to provide welfare benefits for certain "Employees" (as hereinafter defined), in accordance with Article VI of such agreement and declaration of trust, and which agreement and declaration of trust was to be administered by a Board of Trustees; and

WHEREAS, the provisions of the Welfare Benefit Plan, known as the Roofers and Waterproofers Local 44 Welfare Plan, were set forth in a Plan document on May 1, 1976; and

WHEREAS, it is the intention of the Board of Trustees that the Plan be amended and restated, and that, with respect to such amendment and restatement, the Plan provide certain life, accidental death and dismemberment, disability, and health care benefits; and

WHEREAS, the Board of Trustees desires to set forth the terms of the Summary Plan Description for the Plan in a single document with the Plan; and

WHEREAS, the Board of Trustees is duly authorized to execute this Amendment and Restatement for the purpose of amending and restating the Plan;

NOW, THEREFORE, the entire Plan and its related Summary Plan Description are amended and restated as follows:

ARTICLE I

DEFINITIONS

The following words, when used in this document, will have the meanings set forth in this Article, unless the context clearly indicates otherwise:

1.1 **"Beneficiary" or "Beneficiaries"** means the person or persons designated by a Participant to receive the life insurance benefit and, if applicable, the accidental death benefit provided for pursuant to the terms of Article II.

1.2 **"Board of Trustees or "Board"** means the group of six (6) persons, as provided pursuant to the provisions of Article III of the Trust Agreement, which six (6) person group shall consist of three (3) Employer Trustees and three (3) Union Trustees, and their alternates or successors while acting as Trustees.

(a) "Employer Trustees" mean the Trustees appointed by the Employers, as provided in Article III of the Trust Agreement.

(b) "Union Trustees" mean the Trustees appointed by the Union, as provided in Article III of the Trust Agreement.

1.3 **"Code"** means the Internal Revenue Code (of 1986) as amended.

1.4 **"Contract" or "Contracts"** means the agreement(s) entered into between the Board of Trustees and any Insurer to provide any of the benefits provided hereunder.

1.5 **"Covered Employment"** means employment for which an Employer is obligated, by or through its collective bargaining agreement with the Union, to contribute to the Trust Fund, either individually or as a member of an Employer Association. Employment as an officer or employee of the Union or as a member of the Board of Trustees shall be deemed to be Covered Employment hereunder; provided, however, that contributions are made to the Trust Fund for such officers or employees at the same contribution rate which is contributed for all other Employees.

1.6 **"Dependent"** means:

(a) a Participant's spouse; and

(b) a Participant's dependent children under the age of twenty-six (26); provided, however, that for purposes of this Section 1.6, a Participant's "children" shall be deemed to include any natural children, legally adopted children (or children placed for adoption), step-children and any other children who are supported solely by the Participant, are permanently living in the Participant's household, and are treated as a dependent for federal income tax purposes.

1.7 **"Disability"** means any disablement resulting from bodily or mental injury or disease which totally prevents an Employee from engaging in any occupation, or performing any work, for wage, profit

or other remuneration during the period or periods for which benefits are payable under the provisions, hereunder, on account of such disablement.

1.8 **"<u>Effective Date</u>"** for purposes of this Amendment and Restatement, shall mean May 1, 2023.

1.9 **"<u>Employee</u>"** means any person who is or has been employed in Covered Employment.

1.10 **"<u>Employer</u>"** means any employer who has entered into a collective bargaining agreement with the Union, which agreement requires that contributions be made to the Trust Fund, either individually or as a member of an Employer Association; provided, however, that the Union and the Board of Trustees shall be considered to be an Employer, hereunder, to the extent that the Union and/or the Board of Trustees enter into a written agreement to make contributions to the Trust Fund, on behalf of its officers, employees, or members at the same contribution rate which is contributed by all other Employers for their Employees.

1.11 **"<u>Fiduciary</u>"** means any person who:

(a) exercises any discretionary authority or discretionary control respecting management of the Plan or exercises any authority or control respecting management or disposition of its assets; or

(b) renders investment advice for a fee or other compensation, direct or indirect, with respect to any monies or other property of the Plan, or has authority or responsibility to do so.

1.12 **"<u>Health Credit</u>"** means a credits equivalent to the Health Contribution amounts paid by the Employee's Employer(s) under the provisions of the collective bargaining agreement between the Employer and the Union and used/deducted for the purpose of determining eligibility for and providing benefits under Article III.

1.13 **"<u>Health Credited Hours of Service</u>"** means all hours performed by an Employee in Covered Employment for which an Employer is required to pay and actually pays Health contributions as established by the provisions of a collective bargaining agreement entered into between the Employer and the Union.

1.14 **"<u>Insurer</u>"** shall mean any person or entity who shall issue Contracts of insurance.

1.15 **"<u>Participant</u>"** means any Employee who is eligible for benefits under this Plan.

(a) **"<u>Active Participant</u>"** means any Participant that meets the eligibility requirements of an Active Participant under Articles II and III of this Plan.

(b) **"<u>Disabled Retired Participant</u>"** means an Employee who is receiving a Permanent and Total Disability benefit under the Roofers and Waterproofers Local 44 Pension Plan, as that term is defined under that Pension Plan.

(c) **"<u>Inactive Participant</u>"** means any Participant who has ceased to be an Active Participant under Article II but continues to be entitled to life insurance benefits as described in Section 2.2 of the Plan.

(d) **"Retired Participant"** means a former Employee who has retired under the provisions of the Roofers and Waterproofers Local 44 Pension Plan on either his "normal retirement date" or his "early retirement date," as those terms are defined under that Pension Plan.

1.16 **"Plan"** means the Amended and Restated Roofers and Waterproofers Local 44 Welfare Plan, as set forth in this document and as may be amended from time to time.

1.17 **"Plan Administrator" or "Administrator"** means the Board of Trustees; provided, however, that the Board may designate a third party administrator, or any other person or persons to assist in the administration of the Plan Administrator.

1.18 **"Plan Sponsor"** shall mean the Board.

1.19 **"Plan Year"** means the Plan's accounting period of twelve (12) months which shall commence May 1 of any year and shall end the following April 30.

1.20 **"Trust Agreement"** means the agreement and declaration of trust establishing the Roofers and Waterproofers Local No. 44 Welfare Trust Fund, as amended from time to time, which agreement and declaration of trust constitutes a part of this Plan.

1.21 **"Trust Fund" "Welfare Fund"** the fund established under the Trust Agreement.

1.22 **"Union"** means Local 44 of the United Union of Roofers, Waterproofers and Allied Workers (formerly known as the United Slate, Tile and Composition Roofers Damp and Waterproof Workers Association).

1.23 **"Welfare Credited Hours of Service"** means all hours performed by an Employee in Covered Employment for which an Employer is required to pay and actually pays Welfare contributions as established by the provisions of a collective bargaining agreement entered into between the Employer and the Union.

ARTICLE II

LIFE INSURANCE, AD&D, SHORT-TERM DISABILITY, BEREAVEMENT, AND JURY DUTY BENEFITS

2.1 Eligibility for Article II Benefits

A. **Eligibility Terms**: Subject to the other provisions of Section 2.1, an Employee is considered an Active Participant for the purposes of this Article if they:

i. Have 500 Welfare Credited Hours of Service in the immediately preceding 12-month period ("Work Requirement"); and

ii. Are actively working or available for work in Covered Employment ("Availability Requirement").

B. **Exceptions to Work and Availability Requirements**:

i. The Work Requirement's "immediately preceding 12-month period" shall mean the immediately preceding 12 months in which the Employee <u>was not:</u>

a. receiving Short-Term Disability Benefits under Section 2.4 of the Plan;

b. taking leave under the Family and Medical Leave Act of 1993 (FMLA);

c. in active military service; or

d. taking a leave of absence approved by the Trustees under their complete discretion; such leaves of absence may be granted under unique circumstances and only upon an Employee's written request to the Trustees.

ii. The Availability Requirement is not required for any period in which the Employee received Short-Term Disability Benefits or other leave described in Section 2.1(B)(i)(a-d) above.

C. **Availability Requirement**: Employees who are members in good standing with the Union and on its out-of-work list are considered available to work. Retired Participants and Disabled Retired Participants cannot satisfy the Availability Requirement.

D. **Timing of Eligibility**:

i. **Commencement**: An Employee will become an Active Participant on the first day of the calendar month following the date upon which the Administrator has received a report that demonstrates that the Employee has satisfied the Work Requirement, provided the Employee also satisfies the Availability Requirement.

ii. **Termination**: An Employee's status as an Active Participant shall terminate on the first day of the calendar month following the Employee's failure to meet the Work or Availability Requirements under this Section.

iii. **Current Participants**: Any Employee who was an Active Participant for the purposes of this Article as of the effective date of this Plan will continue to be an Active Participant

for the purposes of this Article until such Employee's eligibility terminates pursuant to this Section.

E. Inactive Participants: The following groups may be entitled to certain benefits under this Article despite ceasing to be an Active Participant under this section.

i. Disabled Retired Participants and Retired Participants are eligible for continued life insurance coverage as set forth in Section 2.2(C).

ii. Participants who cease to be an Active Participant as a result of a disability may be eligible for continued life insurance coverage as set forth in Section 2.2(B).

2.2 Life Insurance Benefits

A. Active Participants: In the event of the death of an Active Participant, such Participant's Beneficiary shall be entitled to receive a death benefit in the amount of $20,000.

B. Continuation of Life Insurance in the Event of Disability: If an Employee ceases to be an Active Participant as a result of a Disability (but is not a Disabled Retired Participant), they may continue the life insurance coverage set forth in Section 2.2(A) pursuant to the waiver of premium terms under the group life insurance Contract that provides the life insurance benefit. To remain eligible, the Inactive Participant must timely comply with all the requirements to substantiate and maintain the benefit under the applicable group life insurance contract. If the Inactive Participant does not comply with such requirements, his coverage under this Section 2.2(A) shall terminate.

C. Retired Participants and Disabled Retired Participants: If an Employee ceases to be an Active Participant as a result of becoming a Retired Participant or Disabled Retired Participant, the Employee's Beneficiary shall be entitled to receive a death benefit in the amount of $5,000.

2.3 Accidental Death and Dismemberment Benefits

A. Accidental Death Benefit: In an Active Participant dies as result of an accidental cause, the deceased Active Participant's Beneficiary shall be entitled to receive a death benefit in the amount of $20,000. This benefit is in addition to the life insurance benefit described in Paragraph 2.2(A).

B. Accidental Dismemberment Benefit: In the event an Active Participant sustains a dismemberment as a result of an accidental cause, such Active Participant shall receive a dismemberment benefit, in the amount as follows:

Loss of:	Dismemberment Benefit:
Both hands and both feet	$20,000
Sight of both eyes	$20,000
One hand and one foot	$20,000
One hand and sight of one eye	$20,000
One foot and sight of one eye	$20,000
One hand or one foot	$10,000

Sight of one eye	$10,000

C. Determination of Accidental Cause: Whether an Active Participant's death or dismemberment is the result of an accidental cause shall be determined by the Insurer, and the Insurer shall make such determination with reference to the terms of the Contract between it and the Board to provide such accidental death and dismemberment benefits. In the event that this benefit is not funded by the use of an insurance contract, the issue of whether an Active Participant's death is the result of an accidental cause shall be determined by the Administrator, in its sole discretion.

2.4 Short-Term Disability, Bereavement, and Jury Duty Benefits

A. Short-Term Disability Benefit:

An Active Participant who is unable to work because of a Disability resulting from a sickness lasting 8 or more days or an accident is entitled to the weekly benefits described in Section 2.4(E).

Short-Term Disability Benefits will be paid from the first full day of the Disability. However, in no event shall a Short-Term Disability Benefit be paid for any period prior to the date the Participant first received medical treatment for his Disability by a duly licensed doctor. In order for a Participant to receive the Short-Term Disability Benefit, the Participant must be under professional care during the entire period of his Disability for which he is claiming the Benefit.

If a Participant returns to work after a period of Disability, and subsequently stops working because of a recurrence of the same Disability, such Participant's successive periods of absence from work will be considered to be the result of his initial Disability, unless such Participant had been working for a period of at least 2 full weeks.

Active Participants must present proof of Disability with their written application for Short-Term Disability Benefits pursuant to Section 2.4(E). The determination of whether a Participant has incurred or continues to incur a Disability shall be made by the Administrator, in its sole discretion. In approving or disapproving applications for weekly accident and sickness benefits, the Administrator may rely upon such medical or expert opinions as it deems necessary to render its decision. Any decisions made by the Administrator shall be subject to the claims procedure set forth in Article V.

B. Bereavement Benefit:

An Active Participant whose family member has died is entitled to a per diem benefit, based on the weekly benefits described in Section 2.4(E), for each day (other than Sunday) spent preparing for, traveling to and from, and attending the deceased family member's funeral services. This Bereavement Benefit is limited to relationships and number of days listed below:

4 Days	**3 Days**	**2 Days**
Spouse	Father-in law	Son-in-law
Father	Mother-in-law	Daughter-in-law
Mother	Grandparents	Brother-in-law

Stepfather	Grandchildren	Sister-in-law
Stepmother	Brother	Grandparents-in-law
Children	Sister	
Stepchildren		

Active Participants must take bereavement leave on the day of the funeral to be eligible for the Bereavement Benefit. No Bereavement Benefit will be paid for any day in which a Participant works in Covered Employment.

Active Participants must present proof of death of the family member, such as copy of a published obituary, death notice or a death certificate, with their written application for Bereavement Benefits pursuant to Section 2.4(E).

Time spent on bereavement leave shall not be counted as hours of work in covered employment for benefit eligibility or any other purposes under the Fund.

D. Jury Duty Benefit

An Active Participant who is summoned for and serves jury duty is entitled to a per diem benefit, based on the weekly benefits described in Section 2.4(D), for each day (other than a Sunday) of actual jury service. No Jury Duty Benefit will be paid for any day in which a Participant works in Covered Employment.

Participants must present a jury duty a statement from the court at which he served indicating the dates and hours of actual jury service with their written application for Jury Duty Benefits pursuant to Section 2.4(E).

Time spent on jury duty service shall not be counted as hours of work in covered employment for benefit eligibility or any other purposes under the Fund.

E. Weekly Benefit Application and Amount

i. **Written Application for Benefits Required:** No benefits will be paid under the terms of this Article unless and until the Participant has submitted a written application for benefits with the Administrator. Said written application must be submitted within ninety (90) days after such Participant has encountered the qualifying absence from employment.

For Active Participants receiving Short-Term Disability Benefits, supplementary medical reports required for the continuation of the Short-Term Disability Benefit must be completed by the Participant and his physician and returned to the Administrator within twenty (20) days of the date such supplementary medical report request was mailed to the Participant by the Administrator.

ii. **Benefit Schedule:** As set forth in the schedule below, a Journeyman's Participant's weekly benefit under Section 2.4 shall be determined by the number of Welfare Credited Hours

of Service in the preceding 12-months, the week in which the benefit is received, and whether the Participant's Disability entitles him to receive a benefit under any Worker's Compensation (WC) law.

If a Journeyman's Disability entitles him to receive a benefit under any Worker's Compensation law, he will receive an adjusted benefit during the first 13 weeks of his Short-Term Disability Benefit. If a Journeyman's Short Term Disability Benefit continues beyond 26 weeks, his Benefit will be reduced by 50% for weeks 27 through 52 of his Benefit. In no instance will a Benefit under Section 2.4 be paid beyond 52 weeks.

SECTION 2.4 JOURNEYMAN BENEFIT SCHEDULE

Welfare Credited Hours in Preceding 12 months	Benefit Week			
	Weeks 1-13		Weeks 14-26	Weeks 27-52
	WC	Regular		
500-599	$99.00	$137.00	$137.00	$68.50
600-699	$117.00	$162.00	$162.00	$81.00
700-799	$135.00	$187.00	$187.00	$93.50
800-899	$153.00	$212.00	$212.00	$106.00
900-999	$171.00	$237.00	$237.00	$118.50
1000-1099	$189.00	$262.00	$262.00	$131.00
1100-1199	$207.00	$287.00	$287.00	$143.50
1200-1299	$225.00	$312.00	$312.00	$156.00
1300-1399	$243.00	$337.00	$337.00	$168.50
1400-1499	$243.00	$362.00	$362.00	$181.00
1500-1599	$243.00	$387.00	$387.00	$193.50
1600-1699	$243.00	$412.00	$412.00	$206.00
1700-1799	$243.00	$437.00	$437.00	$218.50
1800-1899	$243.00	$462.00	$462.00	$231.00
1900-1999	$243.00	$487.00	$487.00	$243.50
2000-2099	$243.00	$512.00	$512.00	$256.00
2100-2199	$243.00	$537.00	$537.00	$268.50
2200-2299	$243.00	$562.00	$562.00	$281.00
2300-2399	$243.00	$587.00	$587.00	$293.50
2400-2499	$243.00	$612.00	$612.00	$306.00
2500 or more	$243.00	$637.00	$637.00	$318.50

A non-Journeyman's benefit under Section 2.4 shall be a percentage of the benefit that he would otherwise receive as a Journeyman under the above schedule. The amount of the percentage will be the same as the percentage of Journeyman's wages that the non-Journeyman is receiving under the terms of the collective bargaining agreement covering him at the time of his qualifying event.

ARTICLE III

HEALTH CARE AND OPTIONAL HEALTH BENEFITS

3.1 Eligibility for Article III Benefits

A. Commencement of Eligibility: An Employee (including Employees who were previously but no longer Active Participants) will become an Active Participant for the purposes of Article III on the first day of the calendar month following the date upon which the Administrator has received a report that the Employee has 300 Health Credited Hours of Service in the immediately preceding 12-month period.

B. Termination of Eligibility: An Employee's status as an Active Participant shall terminate when the Employee's Health Credit balance, as defined in Section 3.2, is zero. However, an Employee whose status as an Active Participant is terminated may continue to maintain health coverage through Self-Pay and/or COBRA continuation coverage rights as set forth in Sections 3.3(B) and 3.6, respectively.

C. Current Participants: Any Employee who was an Active Participant for the purposes of Article III as of the effective date of this Amended and Restated Plan will continue to be an Active Participant for purposes of Article III until such Employee's status as an Active Participant terminates as set forth in Section 3.1(A).

D. Surviving Spouses: The surviving spouse of an Active Participant may become an Active Participant for purposes of Article III if the deceased Active Participant is enrolled in the Health Insurance Coverage, as defined in Section 3.3(A), and has a Health Credit balance, as defined in section 3.2, at the time of death. The deceased spouse's Health Credit balance shall be transferred to the surviving spouse, and the surviving spouse may only use those Health Credits to maintain Health Insurance Coverage under Section 3.3 and, if maintaining such Insurance Coverage, to receive Medical Reimbursements under Section 3.4(B)(iv). The surviving spouse's status as an Active Participant shall terminate pursuant to Section 3.1(B).

3.2 Health Credits

A. Health Credit Additions: Each Employee will receive Health Credits equivalent to the Health Contribution amounts paid by the Employee's Employer(s) as required under the provisions of the collective bargaining agreement between the Employer and the Union. Health Credits will be accumulated on a monthly basis, when the Employer's Health Contribution payment is received by the Fund.

The rate of Health Contributions required is determined by the collective bargaining agreement between the Union and the Employer that is in effect on the date for which contributions are made.

B. Health Credit Deductions: Health Credits will be deducted from an Active Participant's Health Credit balance based on each Article III benefit that the Active Participant elects or otherwise

participates in under this Plan. The Health Credits deducted will generally be the dollar amount charged to the Fund for providing the benefit. However, in order to account for the administrative cost or burden to the Fund, the Trustees retain the sole discretion to establish the number of Health Credits deducted for each benefit provided under Article III.

C. Health Credit Forfeiture: Under the certain circumstances of Health Credit inactivity, the entirety of an Active Participant's Health Credit balance may be forfeited in order to defray the reasonable costs of Plan administration and to provide benefits under the Plan.

An Active Participant that is not a surviving spouse, Retired Participant, or Disabled Retired Participant shall have their Health Credit balance forfeited if there have been no Health Credit additions to their balance in the immediately preceding 9-month period. For the purposes of this Section 3.2(C) the "immediately preceding 9-month period" shall mean the immediately preceding 9 months in which the Participant <u>was not:</u>

i. receiving Short-Term Disability Benefits under Section 2.4 of the Plan;

ii. taking leave under the Family and Medical Leave Act of 1993 (FMLA);

iii. in active military service; or

iv. taking a leave of absence approved by the Trustees under their complete discretion; such leaves of absence may be granted under unique circumstances and only upon an Employee's written request to the Trustees.

An Active Participant that is a surviving spouse, Retired Participant, or Disabled Retired Participant, shall have their Health Credit balance forfeited if there have been no Health Credit deductions to their balance in the immediately preceding 24-month period.

3.3. Health Care Benefits

A. Enrollment in the Health Care Plan

i. **Health Insurance**: Upon satisfying the eligibility requirements of Section 3.1, and having a sufficient Health Credit balance, an Active Participant will be automatically enrolled in the Health Insurance (including Prescription Coverage and Telehealth) at the coverage level (i.e. Single, Family) the Participant provides to the Administrator. If the Participant fails to inform the Administrator of his desired coverage level, the Participant will be enrolled in the single coverage plan with the lowest premium cost. Active Participants may elect to change Health Insurance coverage levels during each annual open enrollment period.

ii. **Dental and Vision Insurance**: Upon satisfying the eligibility requirements of Section 3.1, and having a sufficient Health Credit balance, an Active Participant, who has not opted out of Health Coverage under Section 3.3(B), may elect to enroll in Dental and/or Vision

Insurance coverage. Active Participants may elect to change or opt-out of their Dental and/or Vision Insurance enrollment during each annual open enrollment period.

B. **Opting Out**. An Active Participant may opt out of the Health Insurance portion of the Plan if the Participant he is covered under a group health insurance policy provided by his spouse's employer, under another group health insurance policy provided by Participant's employer or by a governmental agency based upon the Participant's prior service with that governmental agency or which is provided as part of the Participant's retirement benefits.

To opt out of the Health Insurance portion of the Plan a Participant must attest and provide the Administrator with proof that he is covered by one of the foregoing alternative health insurance plan and that the alternative policy is compliant with the coverage mandates of the Patient Protection and Affordable Care Act. At least annually, and upon any request by the administrator of the Plan, the Participant must verify and attest that such alternative coverage remains in effect.

C. **Self-Payment.** If a Participant lacks sufficient Health Credits needed to continue participation in the Health, Dental, and Vision Insurance coverage described in Section 3.3(D), the participant may elect to maintain such coverage on a self-pay basis pursuant to this Section.

i. **Eligibility**: A Participant is eligible to make self-payments if he has completed at least 500 Health Credited Hours of Service within the immediately preceding 12-month period.

Participants whose coverage is terminated for ineligibility or failure to self-pay are not permitted to self-pay for subsequent months without regaining eligibility under Section 3.1 and reenrolling in Health Insurance coverage under Section 3.3(A).

ii. **Self-Payment Process**: If a Participant lacks sufficient Health Credits needed to continue participation in the Health, Dental, and Vision Insurance coverage described in Section 3.3(D), the Administrator shall end an invoice for the premium payment to the Participant. To maintain coverage through self-payment, the Participant's premium payment must be received by the Administrator prior to the premium due date (i.e., the first day of the month). Participants may authorize payment of self-pay invoices from their Savings Vacation Plan accounts.

Payments received by the Administrator after the premium due date will be returned to the Participant. If a Participant's self-pay check is returned for insufficient funds, a $30 fee will be charged to the Participant. If a Participant has two self-pay checks insufficient funds, he will no longer be permitted to make self-pay payments with personal checks.

D. **Termination and COBRA Coordination.** If a Participant lacks sufficient Health Credits needed to continue participation in the Health, Dental, and Vision Insurance coverage described in Section 3.3(D) and is not eligible to self-pay or fails to make a self-pay payment, their Health, Dental, and Vision Insurance coverage will be terminated as of the end of the month for which the last premium was self-paid or provided via Health Credits, as the case may be.

An individual whose coverage is so terminated retains any rights that he may have to COBRA Continuation Coverage under the rules and procedures provided in Section 3.6.

E. Special Enrollment

i. Newly Acquired Spouse and/or Dependent Child(ren):

If a Participant acquires a Spouse by marriage, or if a Participant acquires any Dependent children by birth, adoption, or placement for adoption, the Participant may enroll his newly acquired Spouse and/or Dependent children no later than 31 days after the date of marriage, birth, adoption or placement of adoption.

If a Participant did not enroll his Spouse for coverage within 31 days after the date on which the Spouse became eligible for coverage, and if the Participant subsequently acquire a Dependent child by birth, adoption, or placement for adoption, the Participant may enroll hi Spouse together with his newly acquired Dependent child no later than 31 days after the date of the Participant's newly acquired Dependent child's birth, adoption, or placement for adoption.

If the Participant submits a completed written enrollment form within the times required above, special enrollment coverage will be effective on the date of the qualifying event (i.e. marriage, birth, adoption, or placement for adoption). If the Participant fails to timely enroll, special enrollment coverage will be effective on the date of enrollment.

ii. Enrollment After Opt-Out:

A Participant who has opted-out of Coverage under Section 3.3(B) may enroll in health coverage if he provides proof that that his alternative health coverage has been terminated. Timing on enrollment in the Health Care Plan will depend on when the Participant provides the Administrator with proof that that his alternative health coverage has been terminated:

a. If the Participant provides such proof (with a written enrollment form) within 31 days of loss of coverage, the Participant's coverage will be effective upon the date of the loss of coverage.

b. If the Participant provides such proof (with a written enrollment form) after 31 days of the loss of coverage, the Participant's coverage will be effective on the first open enrollment date following the date upon which the proof of loss of coverage and enrollment materials were provided.

iii. Special Rules for Adopted Dependent Children

A Participant's Dependent child will be covered from the date that child is adopted or "Placed for Adoption" with the Participant, whichever is earlier. A child is "Placed for Adoption" on the date the Participant first becomes legally obligated to provide full or partial support for the child the Participant plans to adopt. A child who is Placed for Adoption within 31 days after the child was born will be covered from birth, provided the Participant complies with the Plan's Special Enrollment rules above. If a child is Placed for Adoption with a Participant, and the adoption does not become final, coverage of that

child will terminated as of the date the Participant no longer has a legal obligation to support that child.

F. **Health Care Benefits Provided.** The health care benefits provided under this Section are those benefits set forth in the health, dental, and insurance benefits Contract(s) entered into between the Board of Trustees and the applicable Insurer(s). Since the actual benefits provided under those Contract(s) may vary because of the specific provisions of the Contract(s), and because those benefits are subject to change, said health care benefits are not specifically detailed in this Section 3.3; but the terms of such Contract(s) are incorporated herein by reference as if they had been set forth in full.

Detailed descriptions of all covered benefits, limitations, and exclusions under the applicable Insurer(s)' contract is provided in separate Certificates/Benefits Booklet prepared by the Insurer(s). These documents are sent directly to you and should be kept as they are part of the overall Plan. If you need an additional copy, please contact the Fund Office and you will be provided a copy at no charge.

The benefits under this Section are provided subject to the coordination and subrogation provisions of Section 3.5.

i. Special Notices:

If a mastectomy is performed, federal law requires that the plan provide reconstructive surgery, including surgery to produce a symmetrical appearance, a prostheses and treatment for lymphedema.

Since this plan may offer maternity and newborn coverage, Participants are advised that under federal law, this plan may not restrict benefits (or fail to provide reimbursement) for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require authorization from this plan or its Administrator or the insurance issuer for prescribing a length of stay not in excess of the above periods. However, federal law does not permit a mother's or newborn's provider after consulting with the mother from discharging the mother or newborn earlier than 48 hours (or 96 hours as applicable).

If there has been a "break in coverage," no creditable coverage will be provided for any periods prior to the break in coverage. A "break in coverage" means a period of at least 63 days after coverage lapsed under any other health care plan or insurance policy. A leave of absence under the provisions of the Family and Medical Leave Act or the Uniformed Service Employment and Reemployment Act will not be counted as a break in coverage. The previous employer, insurer or plan is required by law to provide a certification to the Employee or Dependent on request.

3.4 Optional Health Benefits

A. **Eligibility**. An Active Participant is eligible for Optional Health Benefits under this Section if:

i. The Participant has opted-out of the Health Insurance portion of the Plan pursuant to Section 3.3(B); or

ii. The Participant has Health Credits necessary to provide 6 months of coverage under the Health Insurance coverage that the Participant is currently enrolled in under Section 3.3(A) of the Plan.

Enrollment in or claims for Optional Health Benefits must be made on an application or forms made available at the Fund Office.

B. Optional Health Benefits Provided. The following Optional Health Benefits are provided under Article III of the Plan:

i. Supplemental Life and Accidental Death and Dismemberment Policy: A Participant may secure $30,000 of life and accidental death and dismemberment insurance coverage in addition and pursuant to the same terms as the benefits provided under Sections 2.2 and 2.3 of the Plan.

ii. Inpatient Allowance: A Participant may secure an inpatient allowance of $150 per day for each day of inpatient hospital confinement, up to 45 days per hospital stay and 90 total days per calendar year.

iii. Supplemental Vacation Benefit Plan: A Participant may enroll in the supplemental vacation benefit payment plan. The annual maximum amount of this benefit shall be $3,500 per calendar year, less the amount of Medical Reimbursements received in the calendar year under Section 3.4(B)(iv). The supplemental vacation benefit payments will be automatically paid in November or December of each year.

Enrollment in the supplemental vacation benefit payment plan shall be made on such form or forms and at such times as may be required by the Board of Trustees, with such forms submitted to the Fund office for processing and benefit payment. Payment may be made only from such portion of a member's Optional Plan credit balance as is comprised of employer contributions; no payment may be made from any portion comprises of a member's self-payments. Payments are subject to withholding of all applicable federal, state and local income, payroll, employment and other taxes and the Board of Trustees may require such additional information and documentation as it deems necessary or appropriate with respect to any withholding and reporting obligations to governmental agencies as to such taxes.

iv. Medical Reimbursements: A Participant may be reimbursed for 100% of covered medical expenses up to $3,500 per calendar year, less the amount of any Supplemental Vacation Benefit Plan benefits received in the calendar year under Section 3.4(B)(iii). For the purpose of this Section, "covered medical expenses" are defined as co-payments, co-insurance, and deductibles, as well as medical care (as defined under Internal Revenue Code § 213(d)) that does not constitute essential health benefits.

Claims for Medical Reimbursements must be accompanied by: 1) receipts for the services provided and 2) an attestation that the reimbursement request is for a co-payment, co-insurance, or deductible under non-HRA group coverage, or is for medical care (as defined under Internal Revenue Code § 213(d)) that does not constitute an essential health benefits.

Reimbursements will be made only for those services for which a Participant has already made payment (payments will not be made directly to doctors, hospitals, or other service providers).

3.5 Coordination of Benefits

A. In General

The benefits payable under Sections 3.3 and 3.4 are subject to the coordination and non-duplication of benefits provision set forth in this Plan and under the terms of any insurance Contract(s) entered into between the Board of Trustees and the Insurer(s) to provide benefits under this Plan. The coordination and nonduplication of benefits of such Contract shall be applicable and are incorporated by reference into this Plan.

In the event that any benefit provided under this Plan is not funded fully through the use of an insurance Contract or is funded by the use of an insurance Contract but such Contract does not contain provisions relating to coordination of benefits and nonduplication of benefits, then the coordination and nonduplication of benefits-provisions of this Section 3.5 shall be applicable.

B. Definitions - For the purposes of this Section 6.5 only, the following terms shall be defined as provided below:

i. **Plan** means any of the following coverages, including coverage under this Plan, which provide benefit payments or services to a Participant and his covered dependents for hospital, medical, surgical, prescription drug, dental, or vision expenses, disability, or death:

   a. Group, blanket, or franchise coverage;

   b. Group health insurance benefits and other prepayment coverage on a group basis, including HMO's (Health Maintenance Organizations);

   c. Coverage under a labor-management trusteed plan, a union welfare plan, an employer organization plan, or an employee benefits plan;

   d. Coverage under government programs and any other coverage required or provided by law;

   e. Coverage under any individual policy, including an automobile liability insurance policy; or

   f. Any other arrangements by Participants or their dependents.

ii. **This Plan** means the Amended and Restated Roofers and Waterproofers Local 44 Welfare Plan, under which covered individuals are provided with life insurance, accidental death and dismemberment benefits, weekly accident and sickness, bereavement, jury duty and health care benefits.

iii. **Claim Period** means part of all of a calendar year during which a Participant or his dependents are covered under This Plan.

iv. **Covered Expense** means any expense which is covered by at least one Plan during a Claim Period. Any expense which is not payable by the primary plan because of the Participant's or dependent's failure to comply with cost containment requirements (such as second surgical opinions, preadmission testing, preadmission review of hospital confinement, mandatory outpatient surgery, etc.) will not be considered a Covered Expense by the secondary plan. Where a Plan provides benefits in the form of a service rather than cash payments, the reasonable cash value of the service during a Claim Period will also be considered a Covered Expense.

C. Coordination of Benefits

If a Participant or dependent is covered by another Plan or Plans, the benefits under This Plan and the other Plan(s) will be coordinated. This means one Plan pays its full benefits first, then the other Plan(s) pay(s) secondarily, but total benefits from all Plans will not be more than 100% of Covered Expenses incurred. The Order of Benefit Determination paragraph below explains the order in which Plans must pay. No payment will be paid for expenses incurred by a Participant or dependent to the extent a benefit is paid or is payable for those expenses under the mandatory part of any auto insurance policy written to comply with a no-fault insurance law, or an uninsured or underinsured motorist insurance law.

D. Order of Benefit Determination Rules

i. **In General.** When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

a. the other Plan has rules coordinating its benefits with those of This Plan; and

b. both that Plan's rules and This Plan's rules (stated in Subparagraph (b) below) require that This Plan's benefits be determined before those of the other Plan.

ii. **Rules**. This Plan determines its order of benefits using the first of the following rules which applies:

a. **Non-Dependent/Dependent.** The benefits of the Plan which covers the person as an insured person (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent.

b. **Dependent Child/Parents Not Separated or Divorced.** Except as stated in Subparagraph (b)(3) below, when this Plan and another Plan cover the same child as a dependent of different persons, called "parents":

1. The benefits of the Plan of the parent whose birthday falls earlier in a calendar year are determined before those of the Plan of the parent whose birthday falls later in that calendar year; but

2. If both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in (a) above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

c. If the patient is a dependent child whose parents are separated or divorced, the following order of benefit determination shall apply:

   1. When the parents are separated or divorced and the parent with custody of the child was not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody; or

   2. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers the child as a dependent of the step-parent, and the benefits of a plan which covers the child as a dependent of the step-parent will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

   However, if there is a court decree which otherwise establishes financial responsibility for the health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other plan which covers the child as a dependent child.

d. **Active/Inactive Employee.** The benefits of a Plan which covers a person as an employee who neither is laid-off nor retired (or as that Employee's dependent) are determined before those of a Plan which covers that person as a laid-off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Rule 4 is ignored.

e. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the Plan which covered an insured person longer are determined before those of the other Plan.

If COB reduces the benefits payable under more than one Plan provision, each benefit will be reduced proportionately. Only the reduced amount will be charged against any benefit limit in those Plan provisions.

In order to receive benefits, a Participant or his dependent must give the Administrator any information about himself or his dependent which is needed to coordinate benefits. The Administrator may release to or collect from any person or organization any needed information about the Participant or his dependent. Each Participant or dependent shall be obligated to execute all documents and take all other actions necessary for the Plan to coordinate benefits.

If benefits which this Plan should have paid are instead paid by another plan, the Administrator may reimburse the other Plan. Amounts reimbursed are Plan benefits and are treated like other Plan benefits in satisfying this Plan's liability.

If this Plan pays more for a Covered Expense than is required by this provision, the Administrator may recover the excess payment from:

a. A Participant or his dependent;

b. Any person to or from whom the payment was made; or

c. Any coverage company, service plan or any other organization which should have made payment.

E. **Coordination with Medicare**

The Plan will pay its benefits before Medicare only for: an active employee who is age 65 or older; an active employee's dependent spouse who is age 65 or older; the first 30 months of treatment for end-stage renal disease received by any covered pension; and any person who may be covered under the Plan as an active employee, who is less than 65 years of age and who is receiving Medicare benefits because of disability.

When the above rules do not apply, the Plan will pay its benefits only after Medicare has paid its benefits. Medicare benefits will be taken into account for any individual while he is eligible for Medicare whether or not he is enrolled for Medicare. If a participant receives treatment at a Hospital operated by the Veterans Administration for an illness or injury which is not related to military service, the medical benefits paid by the Plan will be the amount that would have been paid had the service been provided in a non-governmental facility, with Medicare as the primary payor. The Plan will pay the percent payable under the schedule of coverage for covered expenses which are not or would not be paid by Medicare (subject to the limiting charge amount established by Medicare guidelines), after the Plan's deductible has been met.

F. Coordination With Medicare Private Contracts.

The Plan will not coordinate benefits with, nor will coverage be provided if you elect to participate in, a "Medicare Private Contract." A Medicare Private Contract is an arrangement whereby Medicare eligible individuals contract with a physician or certain other practitioners allowing that provider to treat the individual on whatever terms are agreed to, outside of Medicare, its regulations and its price controls. Currently, any provider who enters into a Medicare Private Contract will have to agree not to bill Medicare for a two-year period for any services that physician provides which would normally be covered by Medicare Part B. This applies to all services provided by that doctor to any Medicare eligible individual.

G. Right to Receive and Release Necessary Information.

For purposes of determining the applicability and implementing the terms of the coordination-of-benefits and related provisions of this Plan or any other plan, the Plan may, without the consent of or notice to any persons, release to, or obtain from any insurance company or other organization or person, any such information with respect to any person which it deems to be necessary for such purposes, subject to applicable law regarding the privacy of such information.

Any person claiming benefits under this Plan may be required to furnish to the Plan information as may be necessary to implement this provision.

H. Facility of Payment.

Whenever payments, which should have been made by the Plan in accordance with the coordination-of-benefits and related provisions of the Plan, have been made by any other plan, the Plan will have the right, exercisable alone and at its sole discretion, to pay any organizations making such other payments, any amounts it determines to be warranted in order to satisfy the intent of this provision, and amounts so paid will be deemed to be benefits paid under this Plan and to the extent of such payment for covered services, the Plan will be fully discharged from liability.

3.6 COBRA Continuation Coverage

A. In General

In order to comply with the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1986 (i.e., COBRA), each "qualified beneficiary" (as hereinafter defined) shall have the opportunity to elect the continuation of health care coverage under this Article VI in the event a "qualifying event" (as hereinafter defined) occurs. If the coverage provided by the Plan is changed in any respect for active Plan participants, those changes will apply at the same time and in the same manner for everyone whose coverage is continued, as required by COBRA. If any of those changes result in either an increase or decrease in the cost of coverage, that increase or decrease will apply to all individuals whose coverage is continued, as required by COBRA, as of the effective date of those changes.

For purposes of this Section 3.6, a "qualified beneficiary" is any individual who, on the day before a "qualifying event" occurs, is covered under the Plan, and who would otherwise lose coverage as the result of the occurrence of a "qualifying event."

For purposes of this Section 3.6, a "qualifying event" is any one of following events which, but for continuation coverage, would result in the loss of coverage under the Plan:

i. the death of the Participant;

ii. the voluntary or involuntary termination of a Participant's employment (other than by reason of the Participant's gross misconduct);

iii. a reduction in the Participant's hours of employment;

iv. the divorce or legal separation of the Participant from the Participant's spouse;

v. the Participant's becoming entitled to Medicare coverage;

vi. the cessation of dependent child coverage under the terms of the Plan; and

vii. bankruptcy proceedings of the Employer under Title 11 of the U.S. Code.

B. Election of Continuation Coverage

In order to elect health care continuation coverage under Article III, a qualified beneficiary must elect such coverage during the election period, which election period:

i. must begin not later than the date coverage would otherwise terminate due to the occurrence of the qualifying event;

ii. must last at least sixty (60) days; and

iii. does not end earlier than sixty (60) days after the coverage ends due to the occurrence of the qualifying event, or after the qualified beneficiary receives notice of his health care continuation rights under the provisions of this Article III of the Plan.

C. Determination of Qualifying Event

It is the responsibility of the Plan Administrator to determine when a qualifying event has occurred; provided, however, that each qualified beneficiary is responsible for notifying the Plan Administrator of the occurrence of the following two qualifying events:

i. A dependent child no longer meets the definition of a dependent child of the Participant; or

ii. The divorce or legal separation of the participant.

This notice must be provided to the Plan Administrator within sixty (60) days after the later of the date of the occurrence of the qualifying event or the date that the qualified beneficiary will lose coverage on account of the qualifying event. If notices is not timely provided, the Plan does not have to offer the qualified beneficiary an opportunity to elect COBRA health care continuation coverage.

If more than one qualified beneficiary would lose coverage on account of a divorce or legal separation of a Participant, a timely notice of the divorce or legal separation which is sent by the Participant, or by any of the qualified beneficiaries, will be sufficient to preserve the election rights of all qualified beneficiaries.

D. Revocation of Waiver of COBRA Continuation Coverage

A qualified beneficiary who, during the election period, waives COBRA health care continuation coverage may revoke the waiver at any time before the end of the election period; provided, however, that if a qualified beneficiary who waives COBRA continuation coverage later revokes the waiver, coverage need not be provided retroactively. Waivers and revocations of waivers are considered to be made on the date they are sent to the Plan Administrator.

E. Duration of Continuation Coverage

i. The following qualified beneficiaries are eligible to continue COBRA coverage for up to thirty-six (36) months:

a. widows who lost coverage due to the death of the Participant

b. divorced spouses and children who lose coverage due to the divorce from the Particiapnt; and

c. spouses of Medicare-eligible Employees.

Provided, however, that if the qualifying event is the Participant becoming entitled to Medicare coverage, the duration of health care continuation coverage shall be measured from the date the Participant became entitled to Medicare coverage.

ii. The following qualified beneficiaries are eligible to continue COBRA coverage for up to eighteen (18) months:

a. terminated Participants; and

b. Participants with reduced hours that results in a loss of coverage.

Provided, however, that in the event a Participant is determined to have been disabled under Title II or Title XVI of the Social Security Act, at the time of such Participant's termination of employment or reduction in hours, such disabled Participant shall be entitled to extend his continuation coverage for an additional eleven (11) months.

Such disabled Participant must notify the Plan Administrator of the Social Security Administration's determination of his disability within sixty (60) days after the date of such determination; provided, however, that said notification must occur before the end of the initial eighteen (18)-month continuation coverage period. In addition, a Participant who is no longer deemed to be disabled under Title II or Title XVI of the Social Security Act must notify the Plan Administrator within thirty (30) days of the date of any final determination that such Participant is no longer considered to be disabled under the applicable Title(s) of the Social Security Act.

iii. A qualified beneficiary may have more than one qualifying event which entitles such qualified beneficiary to COBRA health care continuation coverage; provided, however, that in no event may the period of COBRA continuation coverage exceed thirty-six (36) months; and, provided further, that, in order for the qualified beneficiary to be eligible for a total of thirty-six (36) months of health care continuation coverage, the second qualifying event must take place during the period of coverage of the first qualifying event.

iv. Continuation coverage begins on the date the qualifying event occurs.

F. Termination of COBRA Continuation Coverage

COBRA health care continuation coverage will end if one of the following events occurs before the expiration of the eighteenth (18th) or thirty-sixth (36th) month:

i. termination of all Plan Sponsor-provided group health plans;

ii. failure to make timely premium payments under the Plan;

iii. the qualified beneficiary becoming covered under another health care plan as a result of employment, re-employment or remarriage; or

iv. the qualified beneficiary becoming entitled to Medicare benefits.

Anything contained in this Section 6.6(f) to the contrary notwithstanding, a qualified beneficiary's COBRA health care continuation coverage will not be terminated upon such qualified beneficiary's becoming covered under another health care plan if such other health care plan contains any exclusion or limitation with respect to any preexisting condition of the qualified beneficiary. Under the foregoing circumstances, such qualified beneficiary's health care continuation coverage shall continue until the expiration of the applicable period of time set forth in Section 6.6(e).

G. Cost of COBRA Continuation Coverage

With respect to the payment of premiums for health care coverage, hereunder, the Plan may charge a qualified beneficiary with payment of a premium for any period of health care continuation coverage; provided, however, that the cost of such coverage may not exceed one hundred two percent (102%) of the "applicable premium" (as hereinafter defined); provided, however, that the Plan may charge a qualified beneficiary one hundred fifty percent (150%) of the "applicable premium" for the additional eleven (11) months of health care continuation coverage referred to in clause (ii) of Section 6.6(e). The qualified beneficiary may elect to pay the premium in monthly installments.

For purposes of this Section 6.6, the "applicable premium" is the Plan's cost for the period of health care coverage for a similarly situated Participant with respect to whom a qualifying event has not occurred (without regard to whether the cost is paid by a contributing Employer or by the Participant).

H. Payment of Premium and Grace Period

The first monthly applicable premium must be received by the Plan Administrator within 45 days of the election of continuation coverage. With respect to subsequent monthly applicable premiums, the Participant must pay the applicable premium for coverage for a month on or before the first day of the month of coverage; provided, however, that such payments will be timely if they are received within the applicable "grace period." That grace period is the longest of:

i. thirty (30) days after the date upon which the applicable premium is due;

ii. any other grace period established by the Plan Administrator; or

iii. any other grace period established by the Insurer, if appropriate.

I. COBRA Continuation Coverage to Run Concurrently With Self Payment

The period of time during which an individual is eligible to elect COBRA continuation coverage under this Section 3.6 shall run concurrently with the Participant's rights to make self-payments under Sections 3.3(C). Upon the occurrence of a qualifying event (under Section 3.6(C)) that also entitles a Participant to make self-payment under Sections 3.3(C), such Participant may elect either, but not both, COBRA continuation coverage or self-payment.

3.7 Family Medical Leave Act

The Family and Medical Leave Act of 1993 (FMLA) provides a right for an employee to take up to 12 weeks (during any 12-month period) of unpaid leave for any serious health condition, birth or adoption of a child, or to care for a seriously ill spouse, parent or child, if the employee is otherwise eligible for such unpaid leave. FMLA requires the employer to continue making contributions for the employee's health care coverage for the length of the qualified FMLA leave, as if the employee were still working.

An employer will be eligible for FMLA benefits if he:

- works for the same contributing employer for at least 12 months;
- has worked at least 1,250 hours during the previous 12 months; and
- works at a location where at least 50 employees are employed by the employer each working day during each of 20 or more work weeks during the current or preceding calendar year.

When taking an FMLA leave, the employee and employer need to inform the Plan Office in writing so that his rights to health care coverage are protected during the leave.

If the employee returns to work within 12 weeks, he will not lose health care coverage. If he does not return to work within 12 weeks, he may then qualify to continue his coverage under COBRA. He may self-pay for COBRA coverage for up to 18 additional months.

3.8 Uninformed Services Employment and Reemployment Rights Act.

The Uninformed Services Employment and Reemployment Rights Act of 1994 (USERRA) requires that an employer continue to contribute for medical coverage if the employee goes into active military service for no more than 30 days. If the employee goes into military service for more than 30 days, he may be able to continue his medical coverage at his own expense for up to 18 months under the COBRA continuation coverage provisions of the Plan.

ARTICLE IV

SAVINGS PLAN

Employers shall deduct Vacation Savings sums from Employees' taxable hourly wage pursuant to the rates and provisions of the collective bargaining agreement between the Employer and the Union and remit the

same to the Welfare Plan. Each Employee's Vacation Savings monies will be distributed by the Fund to the Employee twice yearly during the months of May and November.

ARTICLE V

FUNDING
AND
PLAN AMENDMENT AND TERMINATION

5.1 Level or Amount of Benefits

The benefits provided under the Plan, and the cost of administering the Plan and Trust, are paid entirely out of the assets of the Trust Fund; provided, however, that certain benefits are made available to Participants on a self-pay basis, as set forth in Sections 3.3(C). In the event the Board of Trustees makes a determination, at any time, that the Trust Fund cannot continue to provide the level of benefits currently provided under the Plan, the Board shall take all necessary steps to adjust the level of benefits provided under the Plan.

5.2 Funding of Benefits

The Board of Trustees shall determine, from time to time, whether benefits shall be paid directly from assets of the Trust Fund, or whether they will be funded through the purchase of Contracts issued by an Insurer. The Board of Trustees shall have complete discretion to make this decision and also shall have complete discretion to select the Insurers from which Contracts are purchased.

5.3 Insured Benefits

With respect to those benefits which are insured or administered through a Contract entered into with an Insurer, a Participant's right to such benefits will be limited to the amounts payable under insurance Contract(s), and the receipt of those benefits will be subject to the satisfaction of all of the terms, covenants, conditions, rules and regulations of such insurance Contract(s). Furthermore, the Board of Trustees shall not have any separate obligation or duty to provide benefits to Participants, and/or their Dependents or Beneficiaries, to the extent such benefits are to be provided under an insurance Contract.

To the extent the Board of Trustees enters into a Contract with an Insurer to provide any of the benefits, hereunder, the Board shall have the right, from time to time, to change the coverages under such Contract of the Insurer; and the Board shall provide written notice to Participants regarding such changes in a timely manner.

5.4 Board of Trustees' Protective Clause

The Board of Trustees, or its successors, shall not be responsible for the validity of any Contract of insurance issued with respect to any benefit, or for the failure, on the part of the Insurer, to make payments provided by any such Contract, or for the action of any person which may delay payment or render a Contract null and void or unenforceable, in whole or in part.

5.5 Benefits Funded Through the Trust Fund

To the extent certain Plan benefits are funded through the Trust Fund, the Board shall have no additional responsibility for the payment of any benefits funded by contributions to such Trust Fund. Instead, any benefits so accruing shall be payable solely out of the assets of the Trust Fund.

5.6 Amendment and Termination

The Board of Trustees reserves the right, at any time and from time to time, to amend or terminate the Plan, in whole or in part. If the Board decides to terminate the Plan, it shall do so by delivering a written notice of termination to the Administrator. In the event of the termination of the Plan, assets of the Trust Fund first shall be used to pay the reasonable expenses of administering and terminating the Plans and then shall be applied to provide benefits to Active Participants as of the effective date of termination of the Plan. The Board of Trustees shall have complete discretion to determine the type and amount of benefits provide subsequent to termination of the Plan.

5.7 Recovery of Overpayment

Any misrepresentation or error by a Participant, dependent or beneficiary, Plan Administrator or Employee or any Trustee which results in any benefit or other payments (including, without limitation, any taxes paid or payable with respect to any benefit) by the Fund to, for, or on behalf of a Participant, dependent or beneficiary to which such person was not entitled (in whole or in part), or which should have been paid by such person and not the Fund, or any failure on the part of a Participant, dependent or beneficiary to repay to the Fund any or all amounts due under any reimbursement, or similar provisions of the Fund or any agreement relating thereto, shall constitute grounds for the recovery of all amounts paid by the Fund as a result thereof. The Trustees may recover such amounts by retention or withholding or future benefit payments or portions thereof which may be payable to, for, or on behalf of the Participant or his dependents or beneficiaries.

ARTICLE VI

CLAIMS PROCEDURE

6.1. Submission of Claim*.* Any claim for specific benefits under any plan described in Article III shall be made in accordance with the applicable insurance policy directly to the insurer providing coverage or services pursuant to the plan or in accordance with any claims procedures set forth in such document. Otherwise claims for benefits under this Plan are to be submitted using the following guidelines:

A. A Participant or Beneficiary may file a claim with the Administrator for benefits or for a greater amount of benefits. The claim must be in writing and must contain the following information:

i. a description of the claim;

ii. the facts supporting the claim;

iii. the amount claimed; and

iv. the name and address of the person filing the claim.

B. A Claimant who fails to follow the preapproval procedures for pre-service claims, will be notified of the failure and of the proper procedures for filing these claims not later than 5 days (24 hours in the case of a failure to file a claim for urgent care (as defined by regulation)) following the failure if his/her communication is received by the organizational unit that normally handles these claims and if the communication names a specific Claimant, a specific medical condition, and a specific product or treatment for which approval is requested. The Claimant may request written notification.

6.2. Timing of Benefit Determinations for Urgent Care Claims. The timing of benefit determinations for urgent care claims and decisions (as defined by regulation) is as follows:

A. "Urgent care claim" means any claim for medical care (as defined in ERISA section 733(a)) or treatment with respect to which the application of the time periods for making non-urgent care determinations--(i) Could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or, (ii) 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.

B. The Administrator will designate a representative to answer urgent care claims as soon as possible (taking into account medical exigencies) but no later than 72 hours after receipt of the claim if sufficient information is provided so that a determination may be made as to the extent benefits are covered under the Plan. A Claimant who fails to provide sufficient information shall (i) be notified as soon as possible (and not later than 24 hours after the receipt of the claim by the Plan) of the specific information needed to complete the claim and (ii) given a reasonable amount of time (and not less than 48 hours) to provide such information.

C. The Administrator shall notify the Claimant of the plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of--

i. the Plan's receipt of the specified information, or

ii. the end of the period afforded the Claimant to provide the specified additional information.

D. Concurrent care decisions shall be made in accordance with Article VI, pre-service claims in accordance with Article VI, and post-service claims in accordance with Article VI.

6.3 Denial of Claim*.* Except as otherwise provided in Sections 6.3(C)(D), and (E), if an Employee's claim for benefits under this Plan is denied, the Administrator shall provide notice to the Employee in writing of the denial within 90 days after its submission.

A. The notice shall be written in a manner calculated to be understood by the Claimant and shall include:

i. the specific reason or reasons for the denial;

ii. specific references to the pertinent Plan provisions on which the denial is based;

iii. a description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary; and

iv. an explanation of the Plan's claims review procedures.

B. If special circumstances require an extension of time for processing the initial claim, a written notice of the extension and the reason therefore shall be furnished to the Claimant before the end of the initial 90 day period. In no event shall such extension exceed 90 days.

C. Concurrent care decisions--If the Plan has approved an ongoing course of treatment over a specified time or for a specified number of treatments any reduction or termination by the Plan of such course of treatment before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The Administrator will notify the Claimant of the adverse benefit determination sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. For claims involving urgent care, any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments will be decided as soon as possible, taking into account the medical exigencies, and the Administrator shall notify the Claimant of the benefit determination within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

D. Pre-service claims--The Administrator will notify the Claimant of the Plan's benefit determination within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days, provided that the Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information, and the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

E. Post-service claims--The Administrator will notify the Claimant of the plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information, and the period for making the benefit

determination will be tolled from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

F. If the claim results in an adverse benefits decision, the Claimant will be provided with a written or electronic notice containing:

i. the specific reasons for the denial;

ii. references to the specific provisions in the Plan document on which the denial is based;

iii. a description of any additional information needed to perfect the claim and an explanation of why the additional information is needed; and

iv. a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA section 502(a).

v. if applicable a copy of any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request;

vi. if the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

vii. in the case of an adverse benefit determination concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

For urgent care claims, the above information may be provided to the Claimant orally, provided that a written or electronic notification containing this information is furnished to the Claimant not later than 3 days after the oral notification.

6.4 Appeal of Denial of Benefit Claim*.*

If a claim for benefits is denied or if the Claimant has had no response to such claim within 90 days of its submission or such shorter time as is specified in Subparagraph (B), (C), (D), or (E) (in which case the claim for benefits shall be deemed to have been denied), the Claimant, at the Claimant's sole expense, may appeal the denial to the Administrator within 180 days of the receipt of written notice of the denial or 180 days from the date such claim is deemed to be denied. In pursuing such appeal the Claimant or his duly authorized representative:

- may request in writing that the Administrator review the denial;

- may review pertinent documents; and
- may submit issues and comments in writing.

A. **Appeal the adverse benefit determination***.* A Claimant must file a written request of appeal with the Administrator within 180 days after receiving notice of denial:

   i. a statement of the grounds on which the appeal is based;

   ii. reference to the specific provisions in the Plan document on which the appeal is based;

   iii. the reason or argument why the Claimant feels the claim should be granted and the evidence supporting each reason; and

   iv. any other documents, comments or information the Claimant wishes to submit to support the appeal.

B. A Claimant seeking review shall (i) have the opportunity to submit written comments, documents, records, and other information relating to the claim and (ii) be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to that claim for benefits. Such review shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

C. Except as otherwise provided in Article VI, the decision on review shall be made within 60 days of receipt of the request for review, unless special circumstances require an extension of time for processing, in which case a decision shall be rendered as soon as possible, but not later than 120 days after receipt of the request for review. If such an extension of time is required, written notice of the extension shall be furnished to the Claimant before the end of the original 60 day period. The decision on review shall be made in writing, shall be written in a manner calculated to be understood by the Claimant, and shall include specific references to the provisions of the Plan on which the denial is based. If the decision on review is not furnished within the time specified above, the claim shall be deemed denied on review.

D. The Administrator shall notify a Claimant of the plan's benefit determination on review in accordance with the following:

   i. Urgent care claims. The Administrator shall notify the Claimant of the plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 2 hours after receipt of the Claimant's request for review.

   ii. Pre-service claims. The Administrator shall notify the Claimant of the plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Such notification shall be provided not later than 30 days after receipt by the plan of the Claimant's request for review of an adverse benefit determination.

   iii. Post-service claims. The Administrator shall notify the Claimant of the plan's benefit determination on review within a reasonable period of time. Such notification shall be

provided not later than 60 days after receipt by the plan of the Claimant's request for review of an adverse benefit determination.

E. The review of adverse benefit determinations will be conducted by a plan fiduciary other than the individual who made the adverse benefit determination and who is not a subordinate of that individual. No deference shall be given to that benefit determination. In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, the fiduciary conducting the review shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional shall not be an individual who was consulted in connection with the adverse benefit determination that is on appeal nor the subordinate of any such individual. Any medical or vocational experts whose advice was obtained on behalf of the plan in connection with a Claimant's adverse disability benefit determination shall be identified.

F. The Administrator will provide the Claimant with electronic or written notification of the determination on review. If the determination on review is adverse the Administrator's notification will give:

   i. specific reasons for the adverse determination;

   ii. references to the Plan provisions supporting the adverse determination;

   iii. a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits;

   iv. a statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to obtain the information about these procedures and a statement of the Claimant's right to bring an action under section 502(a) of ERISA;

   v. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either (1) the specific rule, guideline, protocol, or other similar criterion; or (2) a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request;

   vi. if the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

   vii. the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

In the case of an adverse benefit determination on review, the Administrator shall provide such access to, and copies of, documents, records, and other information described in items (iii), (iv),(v), (vi), and (vii) above as is appropriate.

G. For claims involving urgent care, a Claimant may submit a request for an expedited review of an adverse benefit determination. If the Administrator concurs with the request, the appeal may be submitted orally or in writing by the Claimant and all necessary information, including the plan's benefit determination on review, shall be transmitted between the Plan and the Claimant by telephone, facsimile, or other available similarly expeditious method.

H. The Administrator has the discretion to determine eligibility for benefits and the amount of benefits payable, both initially and on review, make factual determinations and construe the terms of the Plan. Such determinations and constructions shall be conclusive and binding on all persons and entities.

I. Any Claimant who initiates litigation over the Plan's denial of a claim, must do so within three (3) years from the date of the denial of the claim.

ARTICLE VII

ADMINISTRATION

7.1 Plan Administration

The Plan Administrator shall be responsible for the general administration of the Plan and for carrying out the Plan's provisions.

The Board of Trustees shall be the Administrator of the Plan, unless the Board has named a third party administrator, or designated some other person or persons, to serve as the Administrator in its stead.

7.2 Powers and Responsibilities of the Board of Trustees

Where the Board of Trustees has designated someone other than itself to serve as Plan Administrator, the Board of Trustees shall be empowered to appoint and remove the Administrator, from time to time, as it deems necessary for the proper administration of the Plan to ensure that the Plan is being operated for the exclusive benefit of the Participants and their Dependents or Beneficiaries, in accordance with the terms of the Plan and the Code.

In addition, the Board shall periodically review the performance of any Fiduciary, or other person, to whom duties have been delegated, or allocated, by it, in accordance with the provisions of the Plan or pursuant to procedures established, hereunder. This responsibility may be satisfied by formal periodic review by the Board, or by daily monitoring the Fiduciary's conduct via a qualified person (specifically designated by the Board) or through other appropriate ways.

7.3 Duties of the Administrator

The Administrator shall be charged with the duties of the general administration of the Plan, including, but not limited to, the following:

- to determine all questions relating to the eligibility of an Employee to become a Participant or remain a Participant, hereunder;
- to maintain all necessary records for the administration of the Plan;
- to interpret any provisions of the Plan and to make and publish such rules for regulation of the Plan as are consistent with the terms of the Plan;
- to advise, counsel and assist Employees or Participants regarding their rights, benefits or elections available under the Plan; and
- to take such action as the Administrator may deem advisable in the administration of the Plan.

7.4 Records and Reports

The Administrator and the Insurer shall keep a record of all actions taken and shall keep all other books of account, records and other data that may be necessary for the proper administration of the Plan. In addition, the Administrator and the Insurer(s) shall be responsible for supplying all information and reports to the Board so that the Board may file such reports as are required to be filed with the Internal Revenue Service or the Department of Labor, and distribute such information to Employees, Participants, and others, as required by law.

7.5 Information From Board of Trustees

The Board of Trustees shall supply full and timely information to the Administrator on all matters relating to Employees and Participants, including, but not limited to, their retirement, death, disability or termination of employment, and such other pertinent facts as the Administrator may require. The Administrator may rely upon such information as is supplied by the Board and shall have no duty or responsibility to verify such information.

7.6 Payment of Expenses

All expenses of administration shall be paid by the Board from the assets of the Trust Fund. Such expenses shall include any expenses incident to the functioning of the Administrator, including, but not limited to, the fees of accountants, counsel and other specialists, and other costs of administering the Plan.

ARTICLE VIII

MISCELLANEOUS PROVISIONS

8.1 No Guarantee of Employment

Nothing contained in the Plan shall be construed as a:

- contract of employment between an Employer and an Employee,
- right of any Employee to be continued in the employment of an Employer, or

- limitation of the right of an Employer to discharge any of its Employees with, or without, cause.

8.2 Claims of Other Persons

In no event shall the provisions of the Plan be construed as giving any person, firm or corporation any right, legal or equitable, against the Board of Trustees, the Union or any Employer, including their officers, employees or directors, except any such rights as are, or in the future may, arise under the Plan; provided, however, that the terms of the Plan are deemed to be legally enforceable.

8.3 Designation of Beneficiary

A Participant may file written notice with the Trust Fund office designating his Beneficiary or Beneficiaries to receive any life or accidental death insurance, or other death benefits, payable under the Plan. The Participant may change his Beneficiary designation, from time to time, by filing succeeding written notices with the Trust Fund office, and, in such case, each succeeding designation will revoke all prior designations.

If any Participant shall have failed to designate a Beneficiary or Beneficiaries, as herein provided, (or if a deceased Participant is not survived by a designated Beneficiary), the applicable benefits shall be paid in the following order:

- first, to such deceased Participant's surviving legal spouse;

- if none, then to such deceased Participant's surviving children (including legally adopted children) in equal shares;

- if none, then to such deceased Participant's surviving parents in equal shares;

- if none, then to such deceased Participant's surviving brothers and sisters in equal shares; and

- if none, then to such deceased Participant's estate.

Any designation of Beneficiary made by a Participant, hereunder, shall be in such form as may be specified or approved by the Board of Trustees. These provisions nonetheless shall be subject to any contrary designation or provision for payment under any insurance policy or Contract providing for the payment of benefits, hereunder.

8.4 Facility of Payment

A Participant or Beneficiary who is entitled to a benefit under the Plan shall make an application, in writing, to the Trust Fund office for such benefits. If any Participant or Beneficiary entitled to receive benefits, hereunder, is a minor, or is physically or mentally incapable of receiving said benefits, or acknowledging receipt thereof, and the Board is not aware of any legal representative having been appointed for such Participant or such Beneficiary, the Board may cause any benefit otherwise payable to him to be paid to such one or more as may be chosen by the Board from among the following: any institution maintaining the Participant or Beneficiary; and/or the Participant's or Beneficiary's spouse, parent, children and/or other relative by blood or marriage; and/or any person whom the Board reasonably determines is caring for the Participant or Beneficiary or otherwise

providing him with support and maintenance. Any payment so made shall be a complete discharge of any and all Liability under the Plan with respect to such payment.

8.5 Absence of Liability

No liability shall arise against any member of the Board of Trustees, or any officer, agent or employee of the Board, for any act or action, hereunder, whether of commission or omission, taken by any such member, officer, agent or employee, except in circumstances involving actions of bad faith.

8.6 Effectuation of Intent

If, at any time, it should become impossible for the Board of Trustees to perform any act required by the Plan, the Board may implement such other act, in lieu thereof, as it determines, in good faith, will most nearly carry out the intent and purpose of the Plan.

8.7 Severability

In the event any provision of the Plan shall be held invalid or illegal for any reason, such invalidity or illegality shall not affect the remaining parts of the Plan, but the Plan shall be construed and enforced as if said invalid provision or said illegal provision had never been included in the Plan, and the Board of Trustees shall have the privilege and opportunity to correct and remedy such questions of invalidity or illegality by amendment, as provided in the Plan.

8.8 Governing Law

Subject to preemption by applicable federal law, the Plan, and all matters arising thereunder, shall be governed by the laws of the State of Ohio.

8.9 Gender and Number

Wherever any words are used herein in the masculine gender, they shall be construed as though they were also used in the feminine gender in all cases where they would so apply, and wherever any words are used herein in the singular form, they shall be construed as though they were also used in the plural form in all cases where they would so apply. Likewise, wherever any words are used herein in the plural form, they shall be construed as though they were also used in the singular form in all cases where they would so apply.

8.10 Headings

The headings and subheadings of the Plan have been inserted for convenience of reference and are to be ignored in any construction of the provisions hereof.

8.11 Uniformity

All provisions of the Plan shall be interpreted and applied in a uniform and nondiscriminatory manner.

8.12 Incorporation By Reference

The provisions of the Trust Agreement are incorporated herein by reference, to the same extent as if they had been set forth in full herein. In addition, the provisions of any Contracts entered into between any Insurers and the Board of Trustees, to provide certain Plan benefits, are incorporated herein by reference; and the Board is bound by the terms of such Contracts to the same extent as if they had been set forth in full herein.

IN WITNESS WHEREOF, the Plan has been approved by the Plan's Board of Trustees on May 16, 2023 but is effective, for all purposes of the Plan, as of the Effective Date, May 1, 2023.

UNION TRUSTEES:	**EMPLOYER TRUSTEES:**
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

OTHER IMPORTANT INFORMATION

1.	Name, Address, and Telephone Number of Plan Administrator:	Board of Trustees of the Roofers and Waterproofers Local 44 Welfare Plan 1651 East 24th Street Cleveland, Ohio 44114 (216) 771-8220
2.	Agent for Service of Legal Process:	Board of Trustees of the Roofers and Waterproofers Local 44 Welfare Plan 1651 East 24th Street Cleveland, Ohio 44114 (216) 771-8220
3.	Federal Tax ID Number for the Plan and Trust:	34-6621298
4.	Plan Number:	501
5.	Source of Funding:	Contributions by participating employers and by Plan participants
6.	Type of Plan:	This is a health and welfare plan maintained for the purpose of providing hospitalization, medical, surgical, prescription, dental, vision, death, dismemberment, loss of time and other benefits to eligible participants and their dependents.
6.	Type of Plan:	This Plan is administered by the Board of Trustees with day-to-day administrative services being provided by Roofers Local 44 Fringe Benefit Funds, Inc.
7.	Plan Administrator:	Board of Trustees of the Roofers and Waterproofers Local 44 Welfare Plan 1651 East 24th Street Cleveland, Ohio 44114 (216) 771-8220
8.	Custodian for Holding Plan Assets:	PNC Bank
9.	Plan Legal Counsel:	Pofok Crampton LLC
10.	Plan Auditor:	Ciuni & Panichi, Inc.

YOUR ERISA RIGHTS

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

> Examine, without charge, at the Plan Administrator's office and at other locations, such as worksites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
>
> Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.
>
> Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
>
> Obtain a statement telling you whether you have a right to receive Plan benefits, and if so, what your benefits would be. If you do not have a right to Plan benefits, the statement will tell you how many more years you have to work to get a right to Plan benefits. This statement must be requested in writing and is not required to be given more than once a year. The Plan must provide the statement free of charge.
>
> In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining Plan benefits or exercising your rights under ERISA. If your claim for Plan benefits is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim to be frivolous. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

NOTICE OF PRIVACY PRACTICES

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

The Board of Trustees, as the Plan Administrator, have adopted a comprehensive set of rules to protect your health information. Under the federal law called HIPAA, the Plan and its Trustees are limited in the ways that it can use and disclose Protected Health Information (called "PHI"). PHI covers a person's individually identifiable health information, such as, name, address, date of birth, gender, race, unique identification numbers like a Social Security Number in addition to medical claims information which is created by or received by the Plan or any of the insurance carriers providing coverage. Under the Privacy and Security Rules, the Trustees must have written procedures in place to protect the privacy and security of the Participants PHI from unauthorized uses or disclosures. The Board of Trustees adopted written rules and amended the Plan Document as required by HIPAA to protect the use, storage or disclosure of your PHI by the Trustees, Plan, insurance carrier or any Business Associate of the Plan which includes the Administrative Manager, Legal Counsel, Consultants and Auditors.

These rules, which are described below, let you know how your PHI can be used and disclosed and how you can get access to it. Please review this information carefully. This information is intended to comply with the Plan's Notice of Privacy Practices, so it will explain the type of information that we collect, how we use that information, how we protect that information, your rights as they relate to your information, and our legal duties and privacy practices.

As part of these procedures, the Trustees have designated a Privacy Official responsible for the monitoring and enforcement of these rules. The Privacy Official is the Administrative Manager.

A. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Plan and its Business Associates may use your protected health information without authorization, consent or opportunity to agree or object for purposes of making or obtaining payment for your care and conducting health care operations.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR PROTECTED HEALTH INFORMATION MAY BE USED AND DISCLOSED:

To Make or Obtain Payment. The Plan may use or disclose your protected health information to make payment to or collect payment from third parties, such as other health plans or health care providers, for the care you receive. For example, the Plan may provide information regarding your coverage or health care treatment to a health care provider to confirm your coverage at the time of treatment or to other health plans to coordinate payment of benefits.

To Conduct Health Care Operations. The Plan may use or disclose protected health information for its own operations to facilitate the administration of the Plan and as necessary to provide coverage and services to all of the Plan's participants. Health care operations includes such activities as:

- Quality assessment and improvement activities.
- Activities designed to improve overall health or reduce health care costs, including evaluation of eligibility for the wellness program, case management or disease management.
- Contacting health care providers and participants with information about treatment alternatives and other related functions.

- Review or evaluation of the competency or qualifications of health care professionals, including performance evaluation.
- Accreditation, certification, licensing or credentialing activities.
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits under a health insurance contract.
- Clinical guideline and protocol development, case management and care coordination.
- Conducting or arranging for review or auditing functions, including compliance reviews, medical reviews, legal services, audit services, fraud and abuse detection programs, and compliance programs.
- Business planning and development including cost management and planning related analyses and formulary development.
- Business management and general administrative activities of the Plan, including customer service and resolution of internal grievances.

For example, the Plan may use your protected health information to conduct case management, quality improvement and utilization review, and provider credentialing activities or to engage in customer service and grievance resolution activities. In addition, the Fund may use your protected health information to refer you to disease management or wellness programs, project future costs related to benefits or audit the accuracy of claims processing functions.

For Participation in a Wellness Program. The Plan may use treatment information for purposes of determining your eligibility to participate in the Wellness Program. The information will never be disclosed either publicly or to your employer. The Plan may use the aggregate information collected under the Wellness Program to evaluate and modify the design based upon identified health risks. Since the Plan does not provide any of your individual information to your Employer, the medical claims and forms used to verify your eligibility for the Wellness Plan will not be kept with any of your personnel records. Information that is stored electronically, will be encrypted and no information you provide the wellness program will be used in making employment decisions regarding your employment.

For Treatment Alternatives/Appointment Reminders. The Plan may use and disclose your protected health information to provide information to you about or to recommend possible treatment options or alternatives that may be of interest to you, or to provide appointment reminders.

For Distribution of Health-Related Benefits and Services. The Plan may use or disclose your protected health information to provide you information regarding health-related benefits and services that may be of interest to you.

To Business Associates**.** The Plan may disclose your protected health information to third parties that it hires to provide administrative services with respect to your benefits under the Plan, including assistance with the Payment and Health Care Operations functions described above. These third parties are referred to as Business Associates. In order to perform the necessary functions and provide the necessary services to the Plan, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after agreeing in writing to protect the privacy, security and confidentiality of all protected health information that it uses, discloses or maintains of behalf of the Plan. Examples of Business Associates are the attorneys

who perform legal services on behalf of the Plan and the consultants who provide utilization reviews and cost analysis with respect to specific benefits provided by the Plan.

For Disclosure to the Plan Sponsor**.** The Board of Trustees for the Trust is the Plan Sponsor. The Plan may disclose your protected health information to the Plan Sponsor for plan administrative functions performed by the Plan Sponsor on behalf of the Plan. In addition, the Plan may provide summary health information to the Plan Sponsor so that the Plan Sponsor may solicit premium bids from health insurers or modify, amend or terminate the plan. The Plan also may disclose information to the Plan Sponsor regarding whether you or your Dependents are participating in the health plan. Your protected health information cannot be used for employment purposes without your specific authorization.

Other Disclosures**:** Other disclosures of protected health information that the Plan may make:

- To your personal representative appointed by you or as designated by law.
- To a family member, friend or other person, for the purpose of helping you with our health care or health care payment if you are in an emergency situation and you cannot give your agreement to the Fund to do so.

When Legally Required**.** The Plan will disclose your protected health information when it is required to do so by any federal, state or local law. For example, we may disclose your protected health information when required by a court order in a litigation proceeding such as a malpractice action.

To Conduct Health Oversight Activities. The Plan may disclose your protected health information to a health oversight agency for authorized activities including audits, inspections, licensure, civil administrative or criminal investigations, or disciplinary action. The Plan, however, may not disclose your protected health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In Connection with Judicial and Administrative Proceedings. As permitted or required by state law, the Plan may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Plan makes reasonable efforts to either notify you about the request or to obtain an order protecting your protected health information.

For Law Enforcement Purposes. As permitted or required by state law, the Plan may disclose your protected health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Plan has a suspicion that your death was the result of criminal conduct or in an emergency to report potential criminal activity.

In the Event of a Serious Threat to Health or Safety. The Plan may, consistent with applicable law and ethical standards of conduct, disclose your protected health information if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the general public. For example, we may disclose your medical information in a proceeding concerning the licensure of a physician.

For Specified Government Functions. In certain circumstances, federal regulations require the Plan to use or disclose your protected health information to facilitate specified government

functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

For Workers' Compensation. The Plan may release your protected health information to the extent necessary to comply with laws related to workers' compensation or similar programs. These programs provide benefits for injuries or illnesses that are work-related.

B. REQUIREMENTS OF OHIO LAW OR OTHER FEDERAL LAWS MAY BE MORE RESTRICTIVE THAN HIPAA

Certain provisions of Ohio state law may be, either at this time or upon future determination, more stringent than HIPAA. If such provisions are more stringent than HIPAA and apply to the Plan, then HIPAA requires that the Plan comply with the more stringent Ohio state law provisions.

Ohio and certain federal laws require special privacy protections for certain highly sensitive and confidential information about your health, including portions of your PHI that: (1) are maintained in psychotherapy notes; (2) relate to your mental health; (3) relate to alcohol and/or drug abuse (including the prevention, treatment or referral for same); or (4) relate to HIV/AIDS testing, diagnoses and treatment. In order to disclose PHI subject to these protections, such disclosure must either be permitted by law or explicitly approved by your written authorization.

C. USES AND DISCLOSURES THAT REQUIRE THE PLAN TO PROVIDE YOU WITH THE ABILITY TO REVIEW AND OPT-OUT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, the Plan may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. For purposes of this Plan, information on any minor dependent will be provided to the Participant unless the minor provides written notice to the Privacy Official opting out of this procedure.

Disaster Relief. The Plan may disclose your protected health information to disaster relief organizations that seek your protected health information to coordinate your care, or notify family and friends of your location or condition in a disaster. The Plan will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

D. AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Other than as stated above, the Plan will not disclose your protected health information other than with your written Authorization Form. If you authorize the Plan to use or disclose your protected health information, you may revoke that authorization in writing at any time.

E. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right to see and get copies of your records. In most cases, you have the right to review or get copies of your record. You must make the request in writing and you may be charged a fee for copying costs. Any request for records kept by the Vendor or insurance carriers, must be made to them directly as the Administrative Manager does not maintain that information.

Right to request a correction or update to your records. You may ask the Plan to change (amend) or add missing information to your records if you think there is a mistake. Your request must be made in writing

and the information you seek to change must be created and maintained by the Plan. A request for an amendment of records must be made in writing to the Privacy Official and include the protected health information that you are requesting be amended as well as an explanation as to why you believe the protected health information is incorrect or incomplete. The Plan may deny the request if it does not include a reason to support the amendment. *The Plan cannot amend protected health information that it did not create and will refer you to the provider of the health care service, Vendor or insurance carrier, if you are requesting an amendment to diagnosis or treatment information.* You have the right to an appeal if your request for an amendment is denied.

Right to get a list of disclosures. You have the right to ask the Plan for a list of disclosures made after April 1, 2005 when the Privacy policy was created. This is a list of the disclosures we made of medical information about you, **other than** for treatment, payment or healthcare operations. We are not to account for information releases that you requested, that you agreed to have released because you signed an Authorization Form, or that are given to your friends and family because they were involved in your care. The request must be made in writing to the Privacy Official and should state the time period for the list. The request for these disclosures are limited to a period of six years or less and can only be provided for disclosures made by the Plan through its Administrative Manager. Any information relating to disclosures of PHI from the Vendor or insurance carriers, must be made to them directly as the Administrative Manager does not maintain that information.

Right to request limits on uses or disclosures of PHI. You have the right to ask that the Plan limit how your information is used or disclosed for purposes of treatment, payment and healthcare operations. You must make the request in writing to the Privacy Official explaining what information you want to limit and to whom you want the limits to apply. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. You have the right to request, in writing, that we restrict communication of any specific treatment or service that you or someone on your behalf has paid for in full, out-of-pocket. The Plan is not allowed to deny this specific type of request. Any information relating to PHI kept by the Vendor or insurance carriers, must be made to them directly as the Administrative Manager does not maintain that information.

Right to revoke permission. If you are asked to sign an authorization to use or disclose information, you can cancel that authorization at any time. You must make the request in writing. This will not affect information that has already been shared. Any information relating to PHI kept by the Vendor or insurance carriers, must be made to them directly as the Administrative Manager does not maintain that information.

Right to choose how we communicate with you. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at home or by mail. To request confidential communications, you must request in writing to the Privacy Official. Your request must specify how or where you wish to be contacted. We will not ask you the reason for the request. We will attempt to accommodate all reasonable requests.

Right to get a paper copy of this Plan's Notice of Privacy Practices. This version of the notice is being provided in this Booklet, however, you also have the right to obtain a separate copy of just the Plan's Notice of Privacy Practices by making the request of the Privacy Official at any time and at no cost.

Right to receive a privacy breach notice. You have the right to receive a written notification if the Plan discovers a breach of your unsecured protected health information, and determines through a risk assessment that notification is required under the HIPAA regulations.

Right to file a complaint. You have the right to file a complaint if you do not agree with how the Plan has used or disclosed information about you. You may contact the Plan at the address and phone number

listed at the beginning of the Booklet. You also have the right to contact the U.S. Department of Health and Human Services, Office for Civil Rights at (206) 615-2290 or (800) 363-1019 if you want to file a complaint or report a problem with how the Plan has used or disclosed information about you. Your benefits will not be affected by any complaint you make. The Trustees, Plan or any Business Associate on behalf of the Plan, are unable to retaliate against you for filing a complaint, cooperating in an investigation, or refusing to agree to something that you believe to be unlawful.

F. HIPAA SECURITY PROVISIONS

The Board of Trustees, as Plan Sponsor, also established a series of rules and procedures to protect any PHI it creates, maintains or transmits electronically in compliance with the Security Standards under HIPAA. In all cases where electronic Protected Health Information (ePHI) is created, received, maintained or transmitted to or by the Plan, administrative, physical and technical safeguards have been adopted to protect the confidentiality, integrity and availability of the ePHI. The Trustees have specific agreements with all of their Vendors and Insurance carriers, along with any other Business Associate, to ensure that each entity also has reasonable and appropriate security measures in place to protect your ePHI. The Health Information Technology for Economic and Clinical Health (HITECH) Act is a related federal law that expanded the HIPAA privacy, security, breach notifications and enforcement requirements. Accordingly, the Trustees will also comply with applicable requirements under the HITECH Act which include providing notice to affected individuals if the Plan or its Business Associate discovers a breach involving unsecured PHI or ePHI.

G. DUTIES OF THE PLAN

The Plan is required by law to maintain the privacy of your PHI and ePHI and to provide to you this notice of its privacy and security practices. The Plan is required to abide by the terms of the privacy and security rules, which may be amended from time to time. The Plan reserves the right to change the terms of its privacy and security rules and to make the new Notice provisions effective for all PHI and ePHI that it creates and/or maintains. If the Plan changes its policies and procedures, the Plan will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. The Plan encourages you to express any concerns you may have regarding the privacy or security of your information. You will not be retaliated against in any way for filing a complaint.

Please note that since some benefits are provided under a fully insured arrangement, you may also receive a Notice of Privacy Practices from the insurance carriers explaining their privacy rules directly.

Re: Updates to the Welfare Plan

Dear Welfare Plan Participants:

As you know, last year, the Board of Trustees amended and restated the Welfare Plan effective May 1, 2023. Since then, after receiving feedback from participants, the Trustees have made important changes to the Plan, which are summarized below:

- **Increase to Retiree Medical Reimbursement Limits.** The Trustees have amended the Plan to increase the medical reimbursement spending limits available to participants who are retired under the Pension Plan. Previously, retired participants' medical reimbursements were limited to $3,500 (less any supplemental vacation payments taken) per calendar year. Beginning in 2024, the medical reimbursement cap has been increased to $10,000 (less any supplemental vacation payments taken) per year for retirees.

- **Reduction to the Frequency of Health Credit Forfeiture**. Previously, for non-retired participants, health credits were forfeited if there were no Health Credit contributions added to a participant's balance for a 9-month period (not including months in which the participant is receiving short-term disability benefits under the Plan, on FMLA leave, in active military service, or on Trustee-approved leave). The Trustees have amended the plan to reduce the frequency of health credit forfeitures: now, credits are forfeited if there are no new Health Credits added to a participant's balance for a 12-month period (with the same exceptions regarding leave, etc.).

- **Reduction in Work-Hour Requirement for Life and AD&D Eligibility.** The Trustees have amended the Plan to reduce the number of hours a participant is required to work to be eligible for the Life and AD&D benefits under the plan. Previously, participants were required to work 500 hours in the prior 12-month period to be eligible for these benefits; now, participants are only required to work 300 hours in the prior 12-month period.

- **Elimination of Call-a-Doctor Plus**. Due to underutilization, the Trustees have eliminated the Call-a-Doctor Plus telehealth benefit effective May 1, 2024. As of that date, participants will no longer be assessed the $7.50 monthly telehealth premium to their Health Credit balance. Telehealth benefits continue to be offered through your health policy with Medical Mutual, which we encourage participants to take advantage of. Information on Medical Mutual's telehealth offerings is enclosed.

- **Addition of a Health Credit Administrative Fee**. Previously, the Plan's professional fees were paid for, in part, by commission arrangements which resulted in higher health premiums. These commission arrangements have been eliminated, resulting in lower health premiums to participants but increased professional fees to the Plan. To address these and other increased costs of administering the Plan, the Trustees approved assessing a $30 monthly administrative assessment to each active participant's Health Credit balance beginning in May 2024. Going forward, the Trustees will monitor the impact of and adjust (including potentially eliminating) this Health Credit fee, as needed to ensure the long-term financial stability of the Fund.

Separately, as you may know, the Trustees elected to change carrier for the AD&D and Life Insurance benefit from New York Life to Medical Mutual beginning this calendar year. We've enclosed Medical Mutual's Life Insurance Beneficiary Form with this letter. To ensure your Life Beneficiary information is complete and up to date, we strongly encourage you to complete and return this Beneficiary Form to the Fund Office.

In closing, we appreciate your feedback and patience throughout the process of implementing changes to the Welfare Plan. We are confident that these changes will lead to an improved experience, the continuation of high-quality benefits, and the ongoing financial well-being of the Plan. If you have any questions about these changes or the Plan generally, please do not hesitate to contact us through the Fund Office.

Sincerely,

BOARD OF TRUSTEES
ROOFERS & WATERPROOFERS LOCAL 44 WELFARE PLAN

AMENDMENT
TO THE
ROOFERS AND WATERPROOFERS LOCAL 44
WELFARE PLAN
AND
SUMMARY PLAN DESCRIPTION

WHEREAS, the Board of Trustees of the Roofers and Waterproofers Local No. 44 Welfare Plan adopted the Roofers and Waterproofers Local 44 Welfare Plan and Summary Plan Description as amended and restated effective May 1, 2023;

WHEREAS, the Board of Trustees currently administers and maintains the Plan for the benefit of the participants covered thereunder; and

WHEREAS, the right to further amend the Plan has been reserved to the Board of Trustees under Section 5.6 of the Plan; and

WHEREAS, the Board of Trustees desires to adjust the conditions under which Health Credits are forfeited under the Plan; and

NOW THEREFORE, the Plan is hereby amended effective as follows:

ARTICLE III, SECTION 3.2(C) OF THE PLAN SHALL BE AMENDED IN ITS ENTIRETY TO READ AS FOLLOWS:

C. Health Credit Forfeiture: Under the certain circumstances of Health Credit inactivity, the entirety of an Active Participant's Health Credit balance may be forfeited in order to defray the reasonable costs of Plan administration and to provide benefits under the Plan.

An Active Participant that is not a surviving spouse, Retired Participant, or Disabled Retired Participant shall have their Health Credit balance forfeited if there have been no Health Credit additions to their balance in the immediately preceding 12-month period. For the purposes of this Section 3.2(C) the "immediately preceding 12-month period" shall mean the immediately preceding 12 months in which the Participant was not:

i. receiving Short-Term Disability Benefits under Section 2.4 of the Plan;

ii. taking leave under the Family and Medical Leave Act of 1993 (FMLA);

iii. in active military service; or

iv. taking a leave of absence approved by the Trustees under their complete discretion; such leaves of absence may be granted under unique circumstances and only upon an Employee's written request to the Trustees.

An Active Participant that is a surviving spouse shall have their Health Credit balance forfeited if there have been no Health Credit deductions to their balance in the immediately preceding 24-month period.

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EXCEPT as herein amended or modified, all of the terms and provisions of the Plan are hereby affirmed.

Adopted on this 20th day of September 2023 by action of the Board of Trustees.

UNION TRUSTEES	EMPLOYER TRUSTEES
______________________	______________________, Trustee
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AMENDMENT
TO THE
ROOFERS AND WATERPROOFERS LOCAL 44
WELFARE PLAN
AND
SUMMARY PLAN DESCRIPTION

WHEREAS, the Board of Trustees of the Roofers and Waterproofers Local No. 44 Welfare Plan adopted the Roofers and Waterproofers Local 44 Welfare Plan and Summary Plan Description as amended and restated effective May 1, 2023;

WHEREAS, the Board of Trustees currently administers and maintains the Plan for the benefit of the participants covered thereunder; and

WHEREAS, the right to further amend the Plan has been reserved to the Board of Trustees under Section 5.6 of the Plan; and

WHEREAS, the Board of Trustees desires to adjust the medical reimbursement benefits made available to Retired and Disabled Retired Participants under the Plan; and

NOW THEREFORE, the Plan is hereby amended effective as follows:

ARTICLE III, SECTION 3.4(B)(iii) AND (iv) OF THE PLAN SHALL BE AMENDED IN ITS ENTIRETY TO READ AS FOLLOWS:

iii. Supplemental Vacation Benefit Plan: A Participant may enroll in the supplemental vacation benefit payment plan. The supplemental vacation benefit payments will be automatically paid in November or December of each year. The annual maximum amount of this benefit shall be as follows:

- For Retired or Disabled Retired Participants: $3,500 per calendar year, less the amount of Medical Reimbursements received above $6,500 in the calendar year under Section 3.4(B)(iv).

- For all other Participants: $3,500 per calendar year, less the amount of Medical Reimbursements received in the calendar year under Section 3.4(B)(iv).

Enrollment in the supplemental vacation benefit payment plan shall be made on such form or forms and at such times as may be required by the Board of Trustees, with such forms submitted to the Fund office for processing and benefit payment. Payment may be made only from such portion of a member's Optional Plan credit balance as is comprised of employer contributions; no payment may be made from any portion comprises of a member's self-payments. Payments are subject to withholding of all applicable federal, state and local income, payroll, employment and other taxes and the Board of Trustees may require such additional information and documentation as it deems necessary or appropriate with respect to any withholding and reporting obligations to governmental agencies as to such taxes.

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iv. Medical Reimbursements: A Participant may be reimbursed for 100% of covered medical expenses up to the maximum benefit as follows:

- For Retired or Disabled Retired Participants: $10,000 per calendar year, less the amount of any Supplemental Vacation Benefit Plan benefits received in the calendar year under Section 3.4(B)(iii).

- For all other Participants: $3,500 per calendar year, less the amount of any Supplemental Vacation Benefit Plan benefits received in the calendar year under Section 3.4(B)(iii).

For the purpose of this Section, "covered medical expenses" are defined as co-payments, coinsurance, and deductibles, as well as medical care (as defined under Internal Revenue Code § 213(d)) that does not constitute essential health benefits. Claims for Medical Reimbursements must be accompanied by: 1) receipts for the services provided and 2) an attestation that the reimbursement request is for a co-payment, coinsurance, or deductible under non-HRA group coverage, or is for medical care (as defined under Internal Revenue Code § 213(d)) that does not constitute an essential health benefits. Reimbursements will be made only for those services for which a Participant has already made payment (payments will not be made directly to doctors, hospitals, or other service providers).

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EXCEPT as herein amended or modified, all of the terms and provisions of the Plan are hereby affirmed.

Adopted on this 14th day of December 2023 by action of the Board of Trustees.

UNION TRUSTEES

EMPLOYER TRUSTEES

Trustee

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AMENDMENT
TO THE
ROOFERS AND WATERPROOFERS LOCAL 44
WELFARE PLAN
AND
SUMMARY PLAN DESCRIPTION

WHEREAS, the Board of Trustees of the Roofers and Waterproofers Local No. 44 Welfare Plan adopted the Roofers and Waterproofers Local 44 Welfare Plan and Summary Plan Description as amended and restated effective May 1, 2023;

WHEREAS, the Board of Trustees currently administers and maintains the Plan for the benefit of the participants covered thereunder; and

WHEREAS, the right to further amend the Plan has been reserved to the Board of Trustees under Section 5.6 of the Plan; and

WHEREAS, the Board of Trustees desires to ensure that the Plan's Life Insurance and Accidental Death and Dismemberment Benefits are covered by the insurance policies secured by the Plan; and

NOW THEREFORE, the Plan is hereby amended effective as follows:

<u>ARTICLE II, SECTION 2.1(A) OF THE PLAN SHALL BE AMENDED IN ITS ENTIRETY TO READ AS FOLLOWS:</u>

A. **Eligibility Terms**: Subject to the other provisions of Section 2.1, an Employee is considered an Active Participant for the purposes of Section 2.2 (Life Insurance Benefits) and 2.3 (Accidental Death and Dismemberment Benefits) if they:

   - Have 300 Welfare Credited Hours of Service in the immediately preceding 12-month period ("Work Requirement"); and

   - Are actively working or available for work in Covered Employment ("Availability Requirement").

   Subject to the other provisions of Section 2.1, an Employee is considered an Active Participant for the purposes of Section 2.4 (Short-Term Disability, Bereavement, and Jury Duty Benefits) if they:

   - Have 500 Welfare Credited Hours of Service in the immediately preceding 12-month period ("Work Requirement"); and

   - Are actively working or available for work in Covered Employment ("Availability Requirement").

ARTICLE II, SECTION 2.2(A) OF THE PLAN SHALL BE AMENDED IN ITS ENTIRETY TO READ AS FOLLOWS:

A. **Active Participants**: In the event of the death of an Active Participant, such Participant's Beneficiary shall be entitled to receive a death benefit in the amount of $20,000. However, such benefit shall be subject to any age-based reductions (typically beginning at age 65) provided under the group life insurance Contract that covers the life insurance benefit for the Plan.

ARTICLE II, SECTION 2.3 OF THE PLAN SHALL BE AMENDED TO INCLUDE SUBSECTION (D) WHICH SHALL READ AS FOLLOWS:

D. **Age-Based Reductions to Benefits:** The Accidental Death and Dismemberment Benefits provided under Section 2.3(A) and (B) of the Plan shall be subject to any age-based reductions (typically beginning at age 65) under the group accidental life and dismemberment Contract that covers the accidental life and dismemberment benefits for the Plan.

ARTICLE II, SECTION 3.4(B)(i) OF THE PLAN SHALL BE AMENDED IN ITS ENTIRETY TO READ AS FOLLOWS:

i. Supplemental Life and Accidental Death and Dismemberment Policy: A Participant who is not a Retired Participant or Disabled Retired Participant may secure $30,000 of life and accidental death and dismemberment insurance coverage in addition and pursuant to the same terms as the benefits provided under Sections 2.2 and 2.3 of the Plan.

***

EXCEPT as herein amended or modified, all of the terms and provisions of the Plan are hereby affirmed.

Adopted on this 14th day of December 2023 by action of the Board of Trustees.

UNION TRUSTEES

Trustee

EMPLOYER TRUSTEES

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