

**SAN DIEGO ROOFERS
HEALTH & WELFARE TRUST FUND**

SUMMARY PLAN DESCRIPTION

December 1, 2023

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ALERT

The Benefits provided under this Plan may be changed at any time. The Board of Trustees may reduce or eliminate any benefits and may change or eliminate insurance carriers, at any time.

The benefits in this Summary Plan Description are as of the date prepared. Any subsequent amendments will govern the actual benefits payable.

December 1, 2023

Dear Participant:

This booklet known as a Summary Plan Description contains general information regarding your Insurance Benefits and an explanation of the eligibility provisions. We urge you to familiarize yourself with the provisions and benefit structure of your Plan. Please direct any questions you have to the Administration Office at (619) 280-2009.

Si necesita asistencia con este documento en español por favor comuníquese con Coast Benefits al 619-280-2009.

Please remember that this booklet is only a summary. In the event of any dispute, the official language of the group insurance policy, or other master agreements, will prevail.

For details on your medical coverage, please refer to the Kaiser's Evidence of Coverage. This document is the binding document between Kaiser and its participants. You should review the booklet and other documents furnished by Kaiser.

The provider has discretion to make any factual determination concerning your plan.

Only the full Board of Trustees is authorized to interpret the Plan. The Board has the discretionary authority to decide all questions about the Plan, including questions about your eligibility for benefits, the amount of any benefits payable to you, and the interpretation of the Plan. No individual Trustee, Employer, or Union Representative has authority to interpret this Plan on behalf of the Board or to act as an agent of the Board. The Board also has discretion to make any factual determinations concerning your claim.

Open Enrollment is held annually for the purpose of enrolling your dependents that were not previously enrolled when you first qualified for coverage, or within 30 days of their becoming an eligible dependent. Enrollment must be received within the allocated time frame and will be effective the first day of the month following receipt of the required documents.

If a dependent is not enrolled timely, they can be enrolled during the following year's Open Enrollment period.

The Board of Trustees has authorized the Administration Office to respond in writing to your written questions. If you have an important question about your benefits, you should write to the Administration Office for a definitive answer. The Administration Office is located at:

San Diego Roofers Health & Welfare Trust Fund
c/o Coast Benefits
3530 Camino del Rio North. #110
San Diego, CA 92108
(619) 280-2009

Plan rules and benefits may change from time to time. The Plan will provide you with a summary of important material changes.

The Board of Trustees

IMPORTANT NOTICES:

FUTURE PLAN AMENDMENTS

Future amendments to the Plan may be made from time to time to comply with new laws passed by Congress, rulings by federal agencies or courts, and other changes deemed necessary or prudent by the Trustees.

LIMITATION UPON RELIANCE ON BOOKLET AND STATEMENTS

This booklet provides a brief, general summary of the Plan rules and is also the Plan document. You should review the Plan to fully determine your rights.

You are not entitled to rely upon oral statements of Employees of the Trust Fund Office, a Trustee, an Employer, any Union representative, or any other person or entity. As a courtesy to you, the Trust Fund Office may respond orally to questions; however, oral information and answers are not binding upon the Plan and cannot be relied upon in any dispute concerning your benefits.

If you would like an interpretation of the Plan, you should address your request in writing to the Board of Trustees at the Trust Fund Office. **To make their decision, the Trustees must be provided with full and accurate information concerning your situation. You should also ensure that you provide accurate facts in all forms and documents submitted to ensure you are not held liable for coverage of ineligible Dependents and/or claims.**

You should further understand that, from time to time, there may be an error in a payment or on other matters which may be corrected upon audit or review. **The Board of Trustees reserves the right to make corrections whenever any error or overpayment is discovered.**

NO VESTED RIGHTS

Benefits under this Plan are NOT vested. The Board of Trustees may amend, reduce, eliminate or otherwise change the Plan at any time and may change, reduce, or discontinue any Plan benefits, in whole or in part, at any time. Moreover, the Board of Trustees may require new or greater co-payments at any time. The Board of Trustees may change the eligibility requirements and any other Plan rules at any time.

USE OF MASCULINE GENDER WORDS

In all situations, whenever any words are used in the Plan in the masculine gender, they should be construed as though they were also used in the feminine gender where they would so apply.

I. ELIGIBILITY REQUIREMENTS

The class of employees eligible for benefits is made up of each employee of an employer participating in the Group Insurance Plan, provided such employee is covered by a collective bargaining agreement between his participating employer and United Union of Roofers, Waterproofers and Allied Workers Local Union No. 45, and who is performing active work on a full-time basis.

In addition, nonbargaining unit employees of a contributing employer may be covered by the employer on the following basis:

1. All non-bargaining unit employees of the employer are covered;
2. Eligibility is on a month-by-month basis. There is no hour bank for nonbargaining unit employees; and
3. The basis for such participation is set forth in a separate nonbargaining unit participation agreement as approved by the Board of Trustees.

A. Initial Eligibility – Bargaining Unit Employees

Each bargaining unit employee is eligible for benefits under this plan on the first day of the second calendar month, which follows no more than four consecutive calendar months during which you worked at least a total of 400 hours for participating employers. Employees will be charged 100 hours for their initial month of eligibility and hours in excess of 100 will be credited to the employee's reserve account for continuation of eligibility. Example, if you have already earned 300 hours or more in October, November and December and you worked 100 hours or more in January, you are eligible for benefits March 1st and so on.

B. Enrollment Cards

To avoid a delay in accessing your medical and dental benefits, you must complete the Trust Fund's Enrollment/Beneficiary form, and the Kaiser Enrollment application, as soon as you become eligible for benefits. These forms can be obtained at the Local 45 Union hall and can be sent to you by the Administration Office. If you do not receive these forms, contact the Administration Office:

San Diego Roofers
Health and Welfare Trust Fund
c/o Coast Benefits
3530 Camino Del Rio North. #110
San Diego, CA 92108
(619) 280-2009

C. Continuation of Eligibility

Hours worked for a participating employer and paid to the Fund will be added to your reserve account. The maximum you can accumulate is 400 hours. Each month of insurance will draw 100 hours from your reserve account. Your eligibility will continue as long as your reserve account contains 100 hours and Labor Pool Requirements are met.

D. Newly Signatory Employers – Bargaining Unit Employers

For bargaining unit employees of employers who have not contributed to the Plan as an active employer for a period of at least three (3) years, the following rules shall apply on a one-time basis:

1. An initial eligibility month shall be established in collective bargaining. The employer shall be obligated to contribute to the Fund for all bargaining unit employees for all hours worked in the month immediately prior to the month of

initial eligibility and in each month thereafter for which hours are worked.

2. The employer's report and contribution check for the initial month's eligibility shall be due in the office of the Trust Fund by no later than the fifth working day of the month established as the month of initial eligibility. In addition to the report of hours worked for the month immediately preceding the month of initial eligibility and the contribution for those hours, the employer shall certify in a separate report the name, social security number, and number of hours worked for all individuals whose work would have been covered by the collective bargaining agreement had there been one for the months which are respectively the fourth, third and second calendar months immediately preceding the month of initial eligibility.

In order to qualify for active participant status, an individual employee must have:

1. At least 100 hours worked and contributed upon by the employer for the month immediately preceding the month of initial eligibility; as well as
2. A total of 400 hours worked and certified by the employer in the four (4) months immediately proceeding the initial month of eligibility.

The hours certified by the employer for the fourth, third and second months immediately proceeding the month of initial eligibility shall be used only in the determination of initial eligibility. These hours shall have no use in subsequent months, and these hours shall have no impact whatsoever upon the employee's reserve account.

Hours in excess of 100 in the month immediately preceding the month of initial eligibility and which are reported and paid to the Trust Fund will be credited to your reserve account for continuation of eligibility. For the month following your initial month of eligibility, your eligibility will be determined by hours paid for the month immediately preceding the initial month of eligibility and reported by the employer during the month of initial eligibility.

Thereafter, hours worked for a participating employer will be added to your reserve account. The maximum you can accumulate in your reserve account is 400 hours. Each month of coverage will reduce your accumulated account balance by 100 hours until you have purchased four (4) months of eligibility at 100 hours per month. Thereafter, your reserve account will be reduced by 100 hours a month for each month's eligibility. Your eligibility will continue as long as your reserve account contains the required number of hours set forth above (i.e., either 100 for the first four months of eligibility and 100 hours thereafter) and labor pool requirements are met.

E. Labor Pool Requirements

To be eligible for insurance benefits, or for extension of such benefits, an employee must remain in the labor pool of the Roofing Industry. If an employee works for a contractor outside the territory covered by such agreement, his benefits shall terminate on the first day of the month in which the balance of eligible reserve hours do not equal the required 100 hours. However, if employees are sent out of such territory by a participating employer, they are considered to be working in the territory.

An employee shall be considered as remaining in the labor pool of the Roofing Industry as long as he remains in the territory covered by the various agreements, as long as he does not accept permanent employment outside the industry, and as long as he remains available for work within the industry. For purposes of utilizing the hours accumulated in an individual employee's reserve account, the individual must be available for work in the Roofing Industry through the union hiring hall or off work due to disability to be included in the labor pool of the Roofing Industry.

Any individual who is not available for work through the hiring hall, or not off work due to disability, shall not be able to draw on his reserve account to supplement his Health & Welfare eligibility since

he is not in the labor pool of the Roofing Industry.

If a participant's reserve account is suspended but he/she again becomes available for work in the Roofing Industry through the union hiring hall within 12 months, it is their responsibility to contact the Administrative Office to reinstate his/her reserve bank hours.

F. Reinstatement of Eligibility

If an employee's eligibility has been terminated, he can again become eligible on the first day of the second calendar month following any month in which the hours reported and the reserve bank hours equal or exceed 100 hours. Such reinstatement must occur within eight calendar months from the termination date. After eight months from the termination date, the reserve hours in the employee's account are forfeited, and the employee must fulfill the eligibility requirements of new employees.

G. Nonbargaining Unit Participants

The employer shall contribute the amount determined by the Board of Trustees to cover completely the cost of providing nonbargaining unit coverage for each individual nonbargaining unit participant. The employer shall contribute this premium on all nonbargaining unit employees working 100 hours or more per month for the employer.

Employers who are newly signatory and establish initial eligibility for nonbargaining unit employees shall pay twice the established monthly premium to establish initial eligibility for such nonbargaining unit employees during the initial month of eligibility.

Thereafter, the employer shall contribute on a monthly basis on a report form prepared by the Administrative Office the regular monthly premium. Nonbargaining unit employees shall have their eligibility established on the following basis:

- a. Hours worked in month one will be paid to the Trust Fund in month two to establish eligibility in month three;
- b. If an employee who is otherwise eligible fails to work sufficient hours in a month to be reported by the employer, then the insufficient hours in month one result in no payment from the employer in month two, and the employee loses eligibility the first day of month three.

For non-bargaining unit participants and their dependents, COBRA rights would become effective the first day of month three in this situation (see page ?).

H. Effective Date Proviso

If at any time during the day immediately preceding the date your benefits would otherwise become effective or be increased you were by reason of injury or sickness unable to perform active work, your benefits would not become effective until such time as you are again able to perform active work on a full-time basis.

I. Covered Dependents

Your Covered Dependents are your lawful spouse (husband or wife), natural children, legally adopted children and stepchildren. Dependents must be listed on the Kaiser beneficiary form in order to be covered under the plan.

The rules for a Dependent child shall be:

1. Blood Descendent: A blood descendent of the first degree;
2. Adopted Child: A legally adopted child, including children living with adopting parents

during the period of probation and children for whom the adopting parents have assumed and retained a legal obligation to provide total or partial support in anticipation of adoption;

3. Stepchild: A stepchild residing in the employee's household;
4. Related Child or Children: A child residing permanently with the employee, who is head of the household, and who is being solely supported by the employee. Except for children who have been or are being adopted by the employee, the child must be related by blood or marriage to the employee, or the employee must be the child's legal guardian;
5. Adding Dependents: During the period you continue to have coverage, any new eligible dependents you acquire may be added in accord with the dependent's eligibility provisions, and any eligible dependents you decline to insure before your continued health coverage began may be added during any open enrollment period provided by the plan. Coverage will be immediate for all dependents without any preexisting condition limitations;

Age Limit for Children/Students: Covered Dependents are eligible for all benefits provided from birth through the last day of the month in which the child attains age 26 years

6. Disabled Children: A dependent child also includes a child after his 19th birthday provided the child is both incapable of self-sustaining employment by reasons of mental or physical disability; and chiefly dependent upon you for support and maintenance. Such qualifications will continue coverage for the child beyond his 19th birthday, up to age 26; and

No dependent can ever be deemed a Covered Dependent unless he or she is a dependent of a Participant.

J. Dependent Effective Date Proviso

If a dependent is confined in a hospital on the date he would otherwise become eligible for benefits, the dependent benefits with respect to that dependent shall not become effective until the day after the date he is discharged from the hospital, except that this proviso shall not apply to a newborn child if the child is otherwise eligible for coverage at birth in accordance with the terms, conditions and limitations of the Plan.

IMPORTANT NOTICE:

WARNING ABOUT FRAUD AGAINST PLAN

It is the Participant's and Dependent's responsibility to notify the Trust Fund Office immediately when a Dependent's status changes. This includes divorce/final dissolution of marriage, legal separation, death, a Dependent child age 26 or older, and any other events which would make your Dependent not eligible for future coverage. If claims are paid for, or premiums are paid on behalf of any Dependent and it is later found that the Dependent was not eligible, you and the Dependent will be responsible for reimbursing the Plan for the actual amount paid out in benefits by the Trust plus interest and any costs and attorney's fees incurred to recover the money.

G. Domestic Partners

A Covered Participant's domestic partner will be covered provided the domestic partnership meets the following criteria:

1. Both persons must file a Declaration of the Domestic Partnership with the Secretary of the State of California and provide a copy to the Administration Office;^{*1}

¹ For those Participants who do not live in the State of California and are, therefore, not eligible to file a Declaration of Domestic Partnership with the Secretary of State's Office, the Fund will accept a properly ¹ For For those Participants who do not live in the State of California and are, therefore, not eligible to file a Declaration of Domestic Partnership with the Secretary of State's Office, the Fund will accept a properly

2. Both persons must have a common residence;
3. Neither person may be married to someone else nor be a member of another domestic partnership with someone else that has not been terminated;
4. The two persons must not be related by blood in any way that would prevent them from being married to each other;
5. Both persons are at least 18 years old;
6. Both persons must be members of the same sex, **or**, if opposite sex, one or more persons must be over age 62; and
7. Both persons must be capable of consenting to the domestic partnership.

In addition to the above requirements, both the Covered Participant and the domestic partner agree to inform the Administration Office of the termination of their domestic partnership as a result of a change in one or more of the above requirements or the death of the domestic partner. The election by a Covered Participant to add a domestic partner may have certain Federal income tax implications. Under Federal tax law, the fair market value of health coverage provided to a domestic partner is a taxable benefit to the Participant. (Please note that domestic partner benefits are not taxable under California law.) Each year the Fund will calculate the fair market value of the domestic partner coverage and this information will be sent to participating employee.

L. Automatic Coverage for a Newborn Child- If Plan Notified Within 31 Days

A newborn or newly adopted child of any age less than 26 years will automatically be covered for the first 31 days of medical benefits on the date the child becomes a Dependent. However, you are required to apply for Dependent coverage for that child within 31 days of the child's birth or of the adopted child's placement in your home in order to continue that child's coverage beyond the first 31 days. You are urged, however, to enroll the new child **immediately**. **If you fail to do so, there is no coverage.**

M. Qualified Medical Child Support Orders (QMCSO)

The Participant must timely provide the Trust Fund Office with a copy of any court order that establishes the Participant's legal obligation to maintain coverage on a Dependent Child including a QMCSO.

A QMCSO recognizes an eligible child's right to receive Plan benefits as a beneficiary of an eligible Plan Participant. The child, to be covered for benefits by this Plan, must meet Plan requirements for an eligible Dependent child including age requirements.

The steps that will be followed to establish and determine whether a court order would qualify as a QMCSO are:

1. The Participant must provide the Administration Office with a copy of the court order and/or QMCSO.
2. Within thirty (30) days after receipt of the QMCSO, the Administration Office or the Plan's legal counsel will notify the Participant in writing if the court order and/or QMCSO is acceptable to the Plan.

completed Affidavit of Domestic Partnership as proof of the domestic partnership so long as the criteria set forth in 2-7 above is met. The Administration Office will provide Participants with the Affidavit upon request.

3. If the Plan determines that the court order and/or QMCSO is not acceptable, or if additional information is required, the Participant will be notified in writing by the Plan or the Plan's legal counsel.
 - a) **If a QMCSO is denied.** The notice will describe the reasons for denial. There is a right to appeal a denial. A summary of the Plan's appeal procedures will be included in the notice of denial. In most instances however, you will simply be asked to revise the order in such a way that it is a proper QMCSO.
 - b) **If additional information is required.** The notice will describe what is needed. There will be sixty (60) days to respond. If you do not respond within the sixty (60) days, the request for the QMCSO will be deemed canceled.

The Plan offers only Kaiser. If a Participant's dependents reside outside of the Kaiser Service area, they will have no coverage.

Please be aware that if a child covered under a QMCSO was enrolled independent of the Participant neither the Participant nor any other Dependents would be considered enrolled in the Plan until such time as the Participant has completed all Enrollment Procedures.

Employee – State Required – California – Coverage - If Labor Dispute

Notice: Arrangements may be made to continue your coverage if you cease Active Work because of a labor dispute. You may continue your coverage up to six months, but only if certain conditions of the Insured arrangements are met. See your *Participating Employer* to make arrangements for continuing your coverage. Your coverage will be terminated unless you make arrangements within 31 days after you cease Active Work due to a labor dispute.

II. TERMINATION OF COVERAGE

Your benefits and those of your dependents under this Plan will terminate on the last day of the calendar month following a month in which the number of hours reported and/or in your reserve account does not equal at least 100; however, if such cessation is due to injury or sickness, you will be given 25 hours of work credit for each week of disability, up to a maximum of 13 weeks per disability, so that your eligibility will continue. You must be disabled at least seven days in order to obtain such work credit. You will be required to have your physician submit verification of your disability, and a copy of your SDI or Workers Compensation check stubs. Inquire at the Trust Office for disability certification forms.

If your eligibility for benefits terminates, you and/or your dependents may continue your medical and dental coverage under the terms of the federal law known as COBRA (see page ?).

III. CONTINUATION OF COVERAGE

A. Military Service

Any eligible person who enters the military service or military training under the laws of the United States may elect to have coverage suspended by freezing reserve hours. This request must be made in writing to the Board of Trustees and will be effective the first day of the month following receipt of the request. See address below.

You should notify the Trustees, in writing, as soon as you are aware that you will resume active work by sending a letter to:

San Diego Roofers
Health and Welfare Trust Fund
c/o Coast Benefits
3530 Camino Del Rio North. #110
San Diego, CA 92108
(619) 280-2009

B. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you enter full-time military service for a period in excess of 30 days, your coverage will terminate immediately. You may purchase coverage for your dependents under the rules included in the COBRA section described on page beginning on page 19. You should notify the Administration Office in the event you enter military service for more than 30 days. However, you may elect to waive your rights under federal law. The months of coverage so applied would no longer be available to provide coverage upon you return to covered employment.

The following procedures are to be followed for participants who are military reservist once called to active duty:

1. Upon notification that a participant has been called to active duty, a Participant's hours will be frozen from the first day of the month following the date the employee begins active duty. Exception: If the Participant begins active duty on the first of any month, the Participant's hours will be frozen as of the first of that month.
2. The Administrator will notify the Participant of availability to elect continuation of Medical, Dental, Disability, AD&D, and Life coverage by self-paying the premium to the Administration Office. Coverage may be continued for a period that is the lesser of 18 months, or a period that ends on the day the individual fails to apply for, or return to a position as an active Participant of San Diego Roofers.

NOTE: Participants and their dependents may be eligible for coverage under CHAMPUS. The Participants should review these coverage's before making a decision to self-pay.

Participants must notify the Administration Office of his/her return from active duty. The Administration Office will restore the Participant's frozen hours, and the Participant will once again be eligible for all benefits that he/she would normally have been eligible for had he/she not been called to active duty.

However, you may elect to waive your rights under federal law. In that case, your Reserve Account may be applied to provide coverage for your dependents at the applicable rate for active members. The months of coverage so applied would no longer be available to provide coverage upon your return to covered employment.

C. Handicapped Child Extension

If your covered child is handicapped when he/she reaches the maximum age for qualified dependents, you may be able to continue his/her dependent coverage past the maximum age for dependent coverage. The term *handicapped* means that the child is incapable of self-sustaining employment by reason of mental retardation or physical handicap incurred prior to age 26. Coverage for such a child can be continued for the duration of incapacity provided such coverage does not terminate for any other reason. Proof of incapacity must be furnished to the Administration Office within 31 days after the child attains the limiting age, which would otherwise apply and must be subsequently furnished as required by the Trustees.

IV. MEDICAL BENEFITS

The Trust Fund provides prepaid medical benefits through Kaiser Permanente. A separate booklet is available at the Administration Office which describes this coverage.

For details on your benefit coverage, please refer to Kaiser Permanente's Evidence of Coverage Booklet. The Evidence of Coverage Booklet is the binding document between the Kaiser Plan and its participants.

V. DENTAL BENEFITS

The Trust Fund provides a self-funded dental plan.

If you or your dependents incur covered dental expenses in excess of the deductible, the Plan will pay a maximum of the amount shown in the *Table of Allowance for Dental Procedures*. A complete *Table of Allowance* is available through the Administration Office.

DEDUCTIBLE AMOUNT

The deductible is \$50 per person. You must satisfy this amount of covered dental expense before benefits become payable under the Plan. The deductible is applied once in each calendar year for each covered person (up to a maximum deductible of \$150 per family). **The deductible does not apply to charges for the following preventative care services: exam, cleanings, fluoride treatment, x-rays, sealants for children to age 14.**

Any amount of the deductible, which is applied in October, November or December of any year will be credited toward your deductible in the next calendar year.

MAXIMUM PAYMENT

The maximum payment for all dental procedures is **\$1,500** per calendar year for each covered person. **There is no maximum per family.**

ORTHODONTIA BENEFITS

Orthodontic services are payable at 50% of reasonable charges. The maximum lifetime covered charges for orthodontic services are **\$2,000 (\$1,000 paid)**. **This** applies to services rendered on or after January 1, 2019.

COVERED DENTAL EXPENSE

Covered Dental Expense means only the expense, which is incurred while covered for this ***Dental Expense Benefit*** for necessary treatment, which you or your dependents receive from a licensed dentist. However, the amount considered as Covered Dental Expense with respect to the dental procedures undergone by you or your covered dependents will not exceed the total of the amounts specified for such procedures in the ***Table of Allowance for Dental Procedures***.

If the dental procedure is not listed in the ***Table***, the Plan will determine the applicable amount for such procedure on the basis of a dental procedure of equivalent gravity and severity listed in the ***Table***.

If the required treatment plan is not submitted, at its sole discretion, the Plan Administrator may limit the amount it considers covered dental charges to a maximum of \$250; or to the covered dental charges for the least expensive alternative procedures which will produce a result that meets professionally recognized standards; or, in the absence of satisfactory dental proof, may deny the claim.

In determining the benefits payable, the Plan reserves the right to examine all x-rays relating to this plan of treatment.


Course of Treatment means all treatment performed in the oral cavity during one or more sessions as the result of the same diagnosis, including examinations, x-rays, prophylaxis, and any complications arising during such treatment.

EXCLUSIONS

Dental Expense Benefits are **not** payable:

- X for more than one oral examination and preventive services during any period of six consecutive months;
- X for any dental procedure for cosmetic reasons;
- X for replacement of an existing denture, which, in the opinion of the attending dentist, is or can be made satisfactory;
- X for a temporary full denture;
- X for replacement of a denture for which benefits were paid by the Plan if such replacement occurs within five years from the date expense was incurred for denture, unless:
 - (a) such replacement is made necessary by the initial placement of an opposing full denture or the extraction of natural teeth;
 - (b) the denture is a stayplate, or similar temporary partial denture, and is being replaced by a permanent denture; or
 - (c) the denture, while in the oral cavity, has been damaged beyond repair as a result of accidental injury while covered;
- X for any procedure, which commenced before the date the person became covered under this Dental Expense Benefit or any supplies furnished in connection with such procedure, except that for purposes of this Excluded Expense item, x-rays and prophylaxis treatment shall not be deemed to commence a dental procedure;
- X for replacement of a lost or stolen appliance;
- X for any prosthetic device to replace teeth, which were absent on the initial effective date of the member until the member has been covered under the Plan for 24 months.

VI. HEALTH REIMBURSEMENT ACCOUNT

Effective with hours worked on/after February 1, 2019, Health Reimbursement Account (“HRA”). The HRA Plan is designed to supplement the hospital, medical, and dental benefits available to Participants plus provide reimbursement for eligible expenses not covered elsewhere. 

Employer contributions are sent to the San Diego Roofers Health Reimbursement Account (HRA) Plan. Employees who are participants in the Plan have established individual accounts based on the employer contributions paid on your behalf for each hour you work in Covered Employment.

The monies in your HRA will accumulate on a tax-free basis. A portion of the employer contributions may be used to reimburse you and your eligible dependents for qualified medical expenses while you are covered as an active employee under this Plan. These monies will be held on your behalf and will be available for you and your eligible dependents for qualified medical expenses.

A. HRA Rules

The following rules are required by IRS regulations:

1. Your account can be used to pay for eligible expenses incurred while you are eligible for benefits in the plan. Expenses are considered incurred on the day of service, not when you are billed or pay.
2. Your account cannot be used to pay for expenses incurred while you are not eligible for benefits under the plan.
3. Your account can only be used to pay for medically necessary and eligible health care expenses for which you have not and will not seek reimbursement from any other health plan or source.
4. Each time you use the card, you certify that you are paying for eligible expenses incurred by you or an eligible dependent while you are eligible for benefits.
5. You cannot take a deduction or a tax credit on your tax return form for any health care expense paid for through this account.
6. You are responsible for maintaining documentation (e.g., detailed receipts) to verify your expenses (the nature of each expense, the amount and the date incurred). Keep it with your other important tax papers for the calendar year. You may be requested to submit the documentation per your monthly statement.

B. Initial Eligibility

1. **Participants.** Each Participant on whose behalf employer contributions are made to this Plan will become a Participant of this Plan when they become eligible for Health benefits. The Spouse and the eligible Dependents of the Participant will also be covered. See Eligible Dependents previously discussed.

If a Participant ceases to be eligible under the Health Plan, HRA funds will continue to be available upon proof of coverage with another plan that meets the Affordable Care Act (ACA) minimum value standards, including but not limited to group health coverage through your spouse, another union and/or Local, but no new contributions to the HRA will be made unless the Participant becomes eligible again. (Premiums for Marketplace insurance coverage, such as coverage obtained through Covered California, are not eligible for HRA reimbursement from this Plan.)

2. **Death of a Participant.** If a Participant dies with an account balance in the Plan, his or her surviving Spouse and eligible Dependents may continue to use the remaining account balance to pay qualified expenses (including the cost of COBRA continuation coverage obtained following the Participant's death), even if they do not elect COBRA coverage.

Eligible claims for benefits under the Plan received from the Participant's Spouse and/or Dependents after the Participant's death will be paid from the account balance until the balance is reduced to zero. If your Health Reimbursement Account falls below the monthly charge-off prior to the ending of COBRA continuation coverage, the surviving dependent(s) will have the right to self-pay the remainder of COBRA eligibility.

If a Participant dies and there are no surviving dependents eligible for coverage, the Participant's remaining account balance will be forfeited to the general assets of the Plan.

C. Eligible Health Care Expenses

You can pay for eligible expenses that require basic proof using your HRA card or online, as explained below. For expenses requiring more than basic proof, you may need to use an alternative payment method and then file a claim online to get reimbursed.

The following is a list of permissible expenses that may be reimbursed out of this Plan:

- Abortion
- Acupuncture
- Alcoholism – inpatient treatment at a therapeutic center for alcohol addiction, including treatment and lodging provided by the center during treatment; amounts paid for transportation to and from Alcoholics Anonymous meetings in your community if the attendance is pursuant to medical advice that membership in Alcoholics Anonymous is necessary for the treatment of a disease involving the excessive use of alcoholic liquors.
- Ambulance
- Artificial Limb
- Artificial Teeth
- Autoette
- Bandages
- Breast Reconstruction Surgery – following a mastectomy for cancer
- Birth Control Pills
- Braille Books and Magazines – the part of the cost of Braille books and magazines for use by a visually impaired person that exceeds the cost of regular printed editions
- Capital Expenses – amounts paid for special equipment installed in a home, or for improvements, if their main purpose is medical care for you, your spouse, or your dependent; the cost of the permanent improvements that increase the value of your property may be partly included as a medical expense; the cost of the improvement is reduced by the increase in the value of your property. Certain improvements do not usually increase the value of a home and can be included in full as medical expenses including, but not limited to:
 - Constructing entrance or exit ramps for your home
 - Widening doorways at entrances or exits to your home
 - Widening or otherwise modifying hallways and interior doorways
 - Installing railings, support bars, or other modifications to bathrooms
 - Lowering or modifying kitchen cabinets and equipment
 - Moving or modifying electrical outlets and fixtures
 - Installing porch lifts and other forms of lifts (but elevators generally add value to the house)
 - Modifying fire alarms, smoke detectors, and other warning systems
 - Modifying stairways
 - Adding handrails or grab bars anywhere (whether or not in bathrooms)
 - Modifying hardware on doors
 - Modifying areas in front of entrance and exit doorways
 - Grading the ground to provide access to the residence
 - Car – the cost of special hand controls and other special equipment installed in a car for the use of a person with disability; the price difference between the cost of a regular car and a car specially designed to hold a wheelchair
- Chiropractor
- Christian Science Practitioner
- COBRA Continuation Health Coverage
- Contact Lenses – needed for medical reasons, including the costs of equipment and materials required for using contact lenses, such as saline solution and enzyme

- cleaner
- Crutches
- Dental Treatment – including x-rays, fillings, braces, extractions, dentures, etc., but not including teeth whitening
- Diagnostic Devices
- Disabled Dependent Care Expenses
- Drug Addiction – inpatient treatment at a therapeutic center for drug addiction, including meals and lodging at the center during treatment
- Drugs, see Medicines
- Eyeglasses – needed for medical reasons, including fees paid for eye examinations
- Eye Surgery
- Fertility Enhancement
- Guide Dog or Other Animal – the costs of buying, training, and maintaining a guide dog or other animal to assist a visually-impaired or hearing-impaired person, or a person with other physical disabilities
- Health Institute – treatment at a health institute only if the treatment is prescribed by a physician and the physician issues a statement that the treatment is necessary to alleviate a physical or mental defect or illness of the individual receiving the treatment
- Health Maintenance Organizations (HMO) – out-of-pocket expenses
- Hearing Aids
- Home Care, see Nursing Expenses
- Home Improvements, see Capital Expenses
- Hospital Services
- Insurance Premiums – insurance premiums you pay for policies that cover medical care. However, premiums for individual Marketplace insurance coverage, such as coverage obtained through Covered California, are not eligible for HRA reimbursement from this Plan.
- Laboratory Fees
- Lead-Based Paint Removal – the cost of removing lead-based paints from surfaces in your home to prevent a child who has or has had lead poisoning from eating the paint; these surfaces must be in poor repair (peeling or cracking) or within the child's reach (the cost of repainting the scraped area is not a medical expense); if, instead, the area is covered with wallboard or paneling, treat as a capital expense (the cost of painting the wallboard is not included as a medical expense)
- Learning Disability, see Special Education
- Legal Fees – necessarily incurred to authorize treatment for mental illness; cannot include fees for the management of a guardianship estate, fees for conducting the affairs of the person being treated, or other fees that are not necessary for medical care
- Lifetime Care – Advance Payments – e.g., under an agreement with a retirement home
- Lodging – provided during medical treatment services
- Long-Term Care Contracts, Qualified
- Meals – provided during medical treatment services
- Medical Conferences – amounts paid for admission and transportation to a medical conference if the medical conference concerns the chronic illness of yourself, your Spouse, or your Dependent; the costs of the medical conference must be primarily for an necessary to the medical care or you, your Spouse, or your Dependent; the majority of the time spent at the conference must be spent attending sessions on medical information
- Medical Information Plan – amounts paid to a plan that keeps medical information in a computer data bank and retrieves and furnishes the information upon request to an attending physician
- Medical Services – amounts paid for legal medical services provides by physicians, surgeons, specialists, or other medical practitioners
- Medicines – amounts paid for prescribed medicines and drugs; a prescribed drug is one that requires a prescription by a doctor for its use by an individual; you can also include amounts paid for insulin; except for insulin, you cannot include in medical

- expenses amounts you pay for a drug that is not prescribed
- Mentally Retarded, Special Home for – the costs of keeping a mentally retarded person in a special home, not the home of a relative, on the recommendation of a psychiatrist to help the person adjust from life in a mental hospital to community living
- Nursing Home – the cost of medical care in a nursing home, home for the aged, or similar institution, for yourself, your spouse, or your dependents, including the cost of meals and lodging in the home if a principal reason for being there is to get medical care
- Nursing Services
- Operations – amounts paid for legal operations that are not for unnecessary cosmetic surgery
- Optometrist, see Eyeglasses
- Organ Donors, see Transplants
- Osteopath
- Oxygen – amounts paid for oxygen and oxygen equipment to relieve breathing problems caused by a medical condition
- Prosthesis, see Artificial Limb
- Psychiatric Care
- Psychoanalysis
- Psychologist
- Special Education – fees paid on a doctor's recommendation for a child's tutoring by a teacher who is specially trained and qualified to work with children who have learning disabilities cause my mental or physical impairments, including nervous system disorders. You can include in medical expenses the cost (tuition, meals, and lodging) of attending a school that furnishes special education to help a child to overcome learning disabilities; a doctor must recommend that the child attend the school and overcoming the learning disabilities must be a principal reason for attending the school; special education includes teaching Braille to a visually impaired person, teaching lip reading to a hearing impaired person, or giving remedial language training to correct a condition caused by a birth defect.
- Sterilization
- Stop-Smoking Programs – does not include drugs that do not require a prescription, such as nicotine gum or patches, that are designed to help stop smoking
- Surgery, see Operations
- Telephone – the cost of special telephone equipment that lets a hearing-impaired person communicate over a regular telephone
- Television – the cost of equipment that displays the audio part of television programs as subtitles for hearing-impaired persons
- Therapy – received as medical treatment
- Transplants
- Transportation – amounts paid for transportation primarily for, and essential to, medical care
- Trips – amounts paid for transportation to another city if the trip is primarily for, and essential to, receiving medical services
- Tuition – in special circumstances: see Special Education; charges for a health plan included in a lump-sum tuition fee if the charges are separately stated or can readily be obtained from the school
- Vasectomy
- Vision Correction Surgery
- Weight-Loss Program – if it is a treatment for a specific disease diagnosed by a physician (such as obesity, hypertension, or heart disease); this includes fees you pay for membership in a weight reduction group and attendance at periodic meetings; this does not include membership dues in a gym, health club, or spa as medical expenses, or the cost of diet food or beverages
- Wheelchair – used mainly for the relief of sickness or disability
- Wig – purchased upon the advice of a physician for the mental health of a patient who has lost all of his or her hair from disease

- X-ray

D. Eligible COBRA Premiums

COBRA premiums for continuation coverage under the San Diego Roofers Health Plan is a permissible expense that may be paid out of this HRA Plan for Active Employees. To have COBRA premiums paid from this Plan you must make an election on an approved form and submit it to the Administrative Office. When there are insufficient funds available to make any such payments that may become due, the Administrative Office will notify the Participant of the insufficient funds. In the event of the death of the Participant, the Participant's Spouse and/or Dependents may elect to pay their COBRA premiums for continuation coverage under the Health Plan out of this HRA Plan to the extent remaining funds are available.

E. Non-Covered Expenses

The following is a list of items that are not eligible for reimbursement under this HRA Plan. This list is not all-inclusive:

- Baby Sitting, Childcare, and Nursing Services for a Normal, Healthy Baby
- Controlled Substances
- Cosmetic Surgery
- Dancing Lessons
- Diaper Service
- Electrolysis or Hair Removal
- Flexible Spending Account
- Funeral Expenses
- Future Medical Care
- Hair Transplant
- Health Club Dues
- Health Coverage Tax Credit
- Health Savings Accounts
- Household Help
- Illegal Operations and Treatments
- Insurance Premiums other than premiums you pay for policies that cover medical care (however, premiums for Marketplace insurance coverage, such as coverage obtained through Covered California, are not eligible for HRA reimbursement from this Plan)
- Maternity Clothes
- Medical Savings Account (MSA)
- Medicines and Drugs From Other Countries
- Nonprescription Drugs and Medicines
- Nutritional Supplements
- Personal Use Items
- Swimming Lessons
- Teeth Whitening
- Veterinary Fees
- Weight-Loss Programs, other than as provided for above

F. How to Use Your HRA Benefits

You can pay for eligible expenses using your HRA card, online or reimbursement request forms.

1. **Using Your HRA Card.** You can pay for eligible items at the point of sale with your HRA card and funds are deducted automatically from your HRA.
 - a. **Why use the card?**
 - No claims to file, no need to get reimbursed

- Works like a credit card
- Deducts automatically from your HRA account
- Most convenient way to pay for most eligible health care products and services.

b. When to use the card:

- Pay for eligible health care expenses incurred by you or an eligible Dependent
- The IRS prohibits you from using this card to pay for services when you are not covered under the plan
- Once all of the funds in your account have been used you will be unable to use your card until your individual account has been replenished by employer contributions as a result of your working in Covered Employment.

c. Where to use the card:

- Doctor and dentist offices
- Pharmacies
- At most merchants who sell health care products or services and accept Visa debit cards

d. If you lose your card or if it is stolen.

Contact Coast Benefits immediately at (844) 739-7956 and to order additional cards. One set of replacement cards will be provided free of charge; any additional replacement cards will incur a charge, which is currently \$10.

e. Tips for using your HRA card:

1. You must activate your HRA card before you use it. Follow the instructions that arrive with your card. If you have any questions, please call Coast Benefits at (844) 739-7956.
2. Use your card for eligible health care expenses only. A list of current eligible IRS expenses as detailed above. This card can only be used in places where health care products and services are likely to be sold.
3. Do not use your card to pay for past services received prior to becoming a Participant or for future services not yet incurred. The IRS prohibits you from using this card to pay for services you received before you are a Participant or those you plan to receive in the future and have not yet incurred.
4. Each time you use your card, you certify that you are paying for eligible health care expenses incurred by you or an eligible Dependent and that you have not and will not seek reimbursement for these expenses from any other health plan or source.
5. Save all receipts that describe exactly what you paid for with your card. You may be asked to submit receipts to show you used your card for eligible health care expenses.
6. Debit or credit? Choose credit. Even though this is not a credit card, choose the credit option. Your card has no PIN.
7. You are required to reimburse your account for the amount of any card purchase if you cannot show the card was used for eligible health care products or services. Your HRA card is a prepaid card that can be used at most merchants who sell health care products or services and accept VISA debit cards. A member financial institution of Visa USA issues the card.

8. There is no minimum dollar amount that you can charge on your card. Obviously, in using your card you cannot exceed the amount of money in your account for any eligible medical expense.

f. Using Your Health Reimbursement Account Portal

You can manage your account and get help conveniently online.

- View your account activity and balance
- File Claims
- Check status of claims and payments
- Receive statements
- Add banking information for direct deposit

Complete the simple online HRA registration process.

1. Go to <https://CoastBenefitsInc.lh1ondemand.com>
2. Your username will be: First Name Initial + Full Last Name + Last 4 digits of SSN, i.e. jsmith6789
3. The default password is “Coast1” and is case sensitive.
4. You will have 30 days to create a new password. After 30 days, contact Coast Benefits at (844) 739-7956 to create a new password.

Once you have registered you can log in to the system to create a payment or request a reimbursement:

- 1, After you have logged in, click on the **File a Claim** button.
2. On the next screen, select the **Pay From** drop-down menu and select **Medical**.
Then go to the **Pay To** drop-down and:
To reimburse yourself for a previous expense, select **Me**.
To pay a provider, select **Someone Else**.
Follow the prompts.

g. Proof of Expenses

You must provide proof for each expense listed on your reimbursement claims. Your proof should be appropriate for the type of expense and can include:

- Pharmacy receipt for prescriptions and other pharmacy purchases
- Doctor’s office receipts for office visits
- Explanation of Benefits (EOB) from your insurance or health plan, for covered medical and dental expenses
- Bill or invoice from doctor or dentist for expenses not covered by your insurance or health plan
- Payment contract, monthly payment coupon or statement from your orthodontist
- Receipt from your optometrist or other medical service provider

VII. LIFE INSURANCE BENEFIT & ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

The Trust provides active participants with Life/AD&D benefits according to the schedule listed below in any month you are eligible. This benefit is underwritten by Lincoln Financial Insurance.

Member under age 65	\$20,000
Legal Spouse.....	\$ 5,000
Dependent children to age 21 or to 25 if full-time student	\$ 2,500

All benefits are reduced 35% at ages 65, 70 and 75.

The Accidental Death and Dismemberment benefit applies to the member only.

For details on your benefit coverage, please refer to Lincoln Financial Evidence of Coverage Booklet. The Evidence of Coverage Booklet is the binding document between the Life Insurance & AD&D Plan and its participants.

VIII. WEEKLY DISABILITY BENEFITS (provided to participants only)

The weekly disability benefits are payable to an otherwise eligible participant only for the weeks during which the participant’s treating physician executes a certificate that the participant is disabled from his usual and customary occupation in the roofing industry, subject to the amounts and limitations set forth below.

Weekly Benefit (\$13 per day, Monday through Friday)	\$65
Maximum Benefit Period	26 weeks, (130 workdays)
Benefits Commence:	
For disability due to injury	The first day
For disability due to sickness or disease	The eighth day

A copy of your SDI check stubs must be submitted. Benefits are paid only for non-work related disabilities.

The Plan may require evidence of continued disability and dependent status at any time.

IX. COBRA

IF YOUR COVERAGE ENDS BECAUSE OF:	COVERAGE MAY CONTINUE FOR UP TO:
Termination of employment (for any reason other than gross misconduct) or reduction in work hours	18 Calendar Months* (*29 Calendar Months (18 Calendar Months plus an additional 11 Calendar Months), if employment ends due to termination of employment or reduction in hours, and at any time during the first 60 days of continuation coverage, the Member or his or her Dependent is totally disabled (as determined by Social Security). Under CAL-COBRA, participants receive an additional 18 calendar months of coverage.
Death of Member Member's entitlement to health care coverage under Medicare Legal separation, divorce, cessation of domestic partnership Dependent Child no longer qualifies for Dependent coverage under the Plan	36 Calendar Months for Dependent

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, requires that the Trust Fund participants (covered employees and dependents) be allowed to continue their medical and dental coverage under the Trust Fund at their own expense following certain qualifying events, which request in a loss of coverage. The premium is 102% of the cost of coverage and administrative expenses.

1. Termination of Employment or Reduction in Hours

If your employment terminates or your hours are reduced so that you become ineligible for coverage, you and your eligible dependents may elect COBRA continuation coverage for up to 18 months from the date your coverage would otherwise have ended. Under CAL-COBRA, participants receive additional 18 months coverage.

2. Employer Decertification

If an employer decertifies from Local Union 45 and you choose to continue your employment with the non-signatory employer, you will not qualify for COBRA coverage.

3. Disability-Extended Coverage

If you or an eligible dependent are determined by Social Security to be disabled within 60 days of the date on which COBRA coverage commenced, the disabled individual is entitled to extend the regular 18-month COBRA continuation coverage to 29 months. Eligible dependents of the individual electing this coverage may also receive additional coverage during this special 11-month extension. The premium for the additional 11 months of extended coverage is 102% of the cost of that coverage.

To be eligible for the special 11-month extension, the disabled individual must notify the Plan within 60 days following the later of the date on which the individual receives the initial COBRA notice following a qualifying event or the date Social Security determines that the individual is disabled and in all events before the end of the initial 18-month period of COBRA continuation coverage.

4. Dependent/Domestic Partner COBRA Coverage

Children born to you or placed with you for adoption during your continuation coverage are eligible to participate in your COBRA coverage, but there may be an additional premium required for their participation. Should you desire this additional coverage, you must promptly notify the Administration Office at the time of birth or placement for purposes of adoption.

If you first become entitled to Medicare while on COBRA coverage which was elected following a termination of employment or a reduction in hours, your eligible dependents may elect to extend their initial 18-month COBRA continuation coverage period to 36 months from the date you initially became covered due to a COBRA election.

If your dependents/domestic partner lose coverage due to your death, your surviving spouse, domestic partner and/or other covered dependents may elect COBRA continuation coverage lasting for up to 36 months from the date their coverage would otherwise have ended.

If a child ceases to be eligible for benefits due to a loss of dependent status, that former dependent may elect COBRA continuation coverage lasting up to 36 months from the date his or her coverage would otherwise have ended.

If your spouse/domestic partner ceases to be an eligible dependent because of a divorce, legal separation or termination of the domestic partner relationship, your former spouse/domestic partner may elect COBRA continuation coverage lasting for up to 36 months from the date your spouse's/domestic partner's coverage would otherwise have ended.

A parent electing COBRA continuation coverage may elect to continue coverage for dependent children. An employee electing COBRA continuation coverage may elect to continue coverage for the employee's lawful spouse.

To be eligible for COBRA coverage on any grounds other than termination of employment or due to a reduction in hours, you or your dependents must provide notice of the qualifying event within 60 days of the qualifying event. This means that you or your dependents are responsible for notifying the Administration Office if you or any of your dependents will be losing coverage because of any of the following qualifying events:

- a) Your death;
- b) Divorce or legal separation;
- c) A child ceasing to qualify as an eligible dependent for any reason, including age, termination of enrollment in a qualifying educational program, or ceasing to be disabled; or
- d) Your loss of COBRA coverage on the grounds of becoming eligible for Medicare.

Once you receive a COBRA notice, you will have 60 days to respond if you wish to elect COBRA coverage. You or your dependents must also pay your COBRA premiums within 45 days after you or your dependents signed the election form and returned it to the Administration Office. You must pay the premium retroactively to your qualifying event.

5. Cost of COBRA

If you elect COBRA continuation coverage, you must pay the cost of such coverage. The COBRA continuation coverage premiums are adjusted annually by the Trust and reflect 102% of the cost of coverage as of the date the premiums are set for the coverage. If you are totally disabled and qualify for the special extension of an additional 11 months of coverage, the premium for the 19th through 29th months of the extended coverage will be 150% of the cost of that coverage and administrative expenses.

Please note: It is the Participant's responsibility to meet the deadlines of COBRA coverage. You and/or your dependents will lose your right to COBRA coverage if you or they fail to give a required notice of a qualifying event, or fail to make a COBRA election in the time allowed, or fail to make a payment on time.

6. Election of COBRA Coverage

You will have at least 60 days in which to elect COBRA continuation coverage. If individuals who have lost coverage and are eligible for COBRA continuation coverage fail to make an election within the 60-day time period, rights to COBRA continuation coverage will be waived.

At the end of the COBRA continuation period elected, you may be allowed to enroll in an individual conversion health plan provided to the Plan by Kaiser. Information related to individual conversion health plans may be obtained from the Administration Office or from Kaiser.

If you or your spouse or dependent have COBRA continuation coverage through one of the Kaiser Plans and you are terminated from the program because you move out the Kaiser's service area before the applicable COBRA period expires you or your spouse or dependent will lose coverage. Under no circumstances would such a transfer prolong the period of your COBRA continuation coverage. Please call the Administration Office for additional details.

In order to assure receipt of COBRA materials and other announcements describing changes in the Plan, you and your dependents should advise the Administration Office of any and all changes in your address.

Your self-payment for COBRA continuation coverage is payable on a monthly basis. It is your responsibility to pay the self-payment directly to the Administration Office in a timely fashion. You must make your first payment within 45 days after the date that COBRA continuation coverage is elected. If you fail to timely pay your COBRA premium, you will immediately lose your coverage.

7. Termination of COBRA Coverage

COBRA continuation coverage terminates on the earliest of the following events:

- a) Last day of the period for which COBRA continuation coverage may be elected;
- b) Date a required COBRA premium payment is due and not received by the Administration Office;
- c) Date the Plan is terminated;
- d) Date the individual receiving coverage pursuant to COBRA first becomes covered under another group medical plan, which does not contain any exclusion or limitation with respect to any preexisting condition of such person. This date may vary for different employees of the same family;
- e) Date the person on COBRA continuation coverage first becomes entitled to Medicare coverage. The right to COBRA continuation coverage terminates only for the person who becomes entitled to Medicare coverage;
- f) Individuals who are receiving the special 11-month extended coverage period due to disability,

the first day of the month that begins more than 30 days after such a person is no longer disabled; and

g) Expiration of the applicable 18-month, 29-month, or 36-month COBRA continuation period.

If your coverage ends because of the termination of employment or reduction of hours or because of your death, you or your dependents will receive information from the Administration Office within 60 days of the date of loss of coverage. The Trust Fund will then transmit a notice of COBRA continuation rights and an application related to the coverage.

The materials transmitted by the Plan will explain your available options. The materials transmitted will also explain the application process and the premium rates applicable to coverage's elected.

X. FAMILY AND MEDICAL LEAVE ACT

The Federal Family and Medical Leave Act (FMLA) enacted by Congress in 1993 provides that in certain situations certain employers are required to grant leave to employees and that in such situations the employer is required to continue medical coverage for the employees.

Certain employers must continue to pay for your health coverage during any approved leave. In general, you may qualify for up to 12 weeks of unpaid FMLA leave per year if:

1. Your employer has at least 50 employees;
2. You worked for the employer for at least 12 months and for a total of at least 1,250 hours during the most recent 12 months; and
3. You require leave for one of the following reasons:
 - a) Birth or placement of a child for adoption or foster care;
 - b) To care for your child, spouse or parent with a serious medical condition; or
 - c) Your own serious health condition. Details concerning FMLA leave are available from your employer.

Requests for FMLA leave must be directed to your employer; the health plan cannot determine whether or not you qualify. If a dispute arises between you and your employer concerning your eligibility for FMLA leave, you may continue your health coverage by making COBRA self-payments.

If the dispute is resolved in your favor, the health plan may obtain the FMLA-required contributions from your employer and will refund the corresponding COBRA payments to you.

If your employer continues your coverage during a FMLA leave and you fail to return to work, you may be required to repay the employer for all contributions paid to the Plan for your coverage during this leave.

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

To the extent that participants are entitled to leave with continuing medical coverage pursuant to federal and state law or provisions contained within collective bargaining agreement, the Trust Fund will provide continuing medical coverage so long as required monthly contributions are received from the contributing employer.

XI. RIGHTS OF STATES

Payment of benefits with respect to a participant shall be made in accordance with any assignment of rights made by or on behalf of such participant or beneficiary of a participant as required by a state plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of that Act.

To the extent that payment has been made under a state plan for medical assistance approved under the Title XIX of the Social Security Act in any case in which the Plan has a legal liability to make payments for items or service constituting such assistance, payment for benefits under the Plan shall be made in accordance with any state law which provides that the state has acquired rights with respect to a participant to such payment for such items or services.

XII. FEDERAL NOTICES

A. Newborns' and Mothers' Health Protection Act of 1996

Pursuant to the Newborns' and Mothers' Health Protection Act of 1996, the Medical Plans in which you may enroll may not restrict benefits for any hospital length of stay for the mother or newborn child to less than 48 hours following normal delivery or less than 96 hours following a cesarean section delivery.

In accord with Federal Law, those Plans do not require that a provider obtain preauthorization under those Plans for either of the foregoing lengths of stay. However, Federal Law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother and/or her newborn earlier than the applicable time period.

B. Women's Health and Cancer Rights Act of 1998

Your Plan covers medical and surgical benefits for mastectomies. This coverage includes:

1. Reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; or
3. Prosthesis and physical complications of all stages of mastectomy, including lymphedemas.

The coverage is subject to the Plan's annual deductibles and coinsurance provisions.

C. Certification of Creditable Coverage Under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this Fund provide written certification of creditable coverage to you when your coverage ceases (under employer coverage and/or COBRA coverage) or when requested by you if your coverage is still in effect or if requested by you within two years after your coverage ends. The certification will specify the period(s) of creditable coverage under this Fund (including COBRA, if applicable) disregarding periods of coverage before a 63-day break. The 63-day break will not include any days between the loss of coverage and any secondary opportunity date to elect COBRA under the Trade Act of 2002.

If your coverage ends (under employer coverage and/or COBRA coverage), the certificate of creditable coverage will be provided to you automatically within a reasonable period of time after your coverage ceases. If you or someone on your behalf (including another health plan or issuer) wants to request a certificate of creditable coverage, please advise the Trust in writing at the following address:

San Diego Roofers
Health and Welfare Trust Fund
c/o Coast Benefits
3530 Camino Del Rio N. #110
San Diego, CA 92108
(619) 280-2009

You (or someone on your behalf) should provide your name and the name(s) of your dependent(s) and an address(es) to which the certificate(s) should be sent. The notice will then be processed and sent on the earliest date that the Fund, acting in a reasonable and prompt fashion, can provide it. If you request, in writing, that the Fund send the certificate to another health plan or issuer and the other plan or issuer agrees, the certificate can be processed by means other than in writing, such as by telephone.

Special Enrollment Rights

There are no special enrollment (or late enrollee) requirements under HIPAA because Employees and/or dependents cannot decline coverage under this Trust and new dependents may be added at any time subject to proof of birth, marriage, etc. One composite employer contribution is paid by the participating employer regardless of whether the employee is single, married, or has dependents.

D. HIPAA Special Enrollment Rights under SCHIP

Effective April 1, 2009, you and your dependents may enroll in this Plan if you (or your dependents) have coverage through Medicaid or a State Children's Health Insurance Program (SCHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or SCHIP coverage ends.

Also effective April 1, 2009, you and your dependents may also enroll in this Plan if you (or your dependents) become eligible for a premium assistance program through Medicaid or a State Children's Health Insurance Program (ASCHIP). However, you must request enrollment within 60 days after you (or your dependents) are determined to be eligible for such assistance.

E. Privacy of Protected Health Information under HIPAA

This Plan will use and disclose protected health information ("PHI") in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

PHI is defined as individually identifiable health information that is maintained or transmitted by this Plan in any form or medium (oral, written, or electronic). Individually identifiable health information is health information, including demographic information, that is created or received by a health care provider, employer, health care clearinghouse or this Plan and relates to the past, present or future physical or mental health condition of you or your eligible dependents, including payment information for the provision of health care. When held by this Plan, it also means information that either identifies you or your eligible dependents directly or indirectly, in that one has a reasonable belief that you or your eligible dependents can be identified using the information. For example, your name, address, birth date, marital status, Social Security Number, and choice of health plan would be considered PHI. Other examples are the amount of contributions paid by your employer for your coverage, or whether you are an active employee, retiree, or Medicare enrollee.

THE FOLLOWING USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI) AND CORRESPONDING RIGHTS AND DUTIES APPLY TO YOU AND YOUR ELIGIBLE DEPENDENTS:

1. Permitted Uses and Disclosures of PHI

This Plan and its Business Associates will use and disclose PHI without your authorization for purposes of treatment, payment and health care operations, but only the minimum amount of PHI necessary to accomplish these activities. Treatment includes but is not limited to the provision, coordination or management of health care among health care providers or the referral of a patient from one health care provider to another. Payment includes but is not limited to actions concerning eligibility, coverage determinations, coordination of benefits, and adjudication of health benefit claims (including appeals), determinations of cost-sharing amounts, utilization reviews, medical necessity reviews, preauthorization reviews, and billing and collection activities. Health care operations include but are not limited to performing quality assessment reviews, implementing disease management programs, reviewing the competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes legal services and auditing functions for the purpose of creating and maintaining fraud and abuse programs, compliance programs, business planning programs, and other related administrative activities.

2. Required Uses and Disclosures of PHI

This Plan must disclose PHI to you upon request to access your own PHI, with limited exceptions, or to request an accounting of PHI disclosures. Use and disclosure of PHI may be required by the Secretary of U.S. Department of Health and Human Services (“HHS”) and its Office of Civil Rights (“OCR”) or other authorized government organizations to investigate or determine this Plan’s compliance with the Privacy Rule.

3. Agreed to uses and disclosures of PHI by you after an opportunity to agree or object to the Disclosure

This Plan will disclose PHI to family members, other relatives or close personal friends if the information is directly relevant to the family or friend’s involvement with your health care or payment for such care and you have either agreed to uses the disclosure or been given an opportunity to object and have not objected.

4. Allowed uses and disclosures of PHI for which authorization or opportunity to object is not required

This Plan will use or disclose PHI without your authorization or opportunity to object when required by law, or to law enforcement officials, public health agencies, research facilities, coroners, funeral directors and organ procurement organizations, judicial and administrative agencies, military and national security agencies, worker’s compensation programs and correctional facilities. These uses and disclosures are more fully described in this Plan’s Privacy Policy Statement and Notice of Privacy Practices for Protected Health Information. Additional copies of these documents may be obtained from the Administration Office.

5. Your Individual Rights

HIPAA and the Privacy Rule afford you the following rights:

- You (or your personal representative) have the right to request restrictions on how this Plan will use and/or disclose PHI for treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified who are involved in your health care or payment for such care. However, this Plan is not required to agree to such a request. If this Plan agrees, it is bound by the restriction except when

otherwise required by law, in emergencies, or when the restricted information is necessary for treatment. You will be required to complete a form requesting any restriction.

- You (or your personal representative) have the right to request to receive communications of PHI from this Plan either by alternative means or at alternative locations. This Plan may agree to accommodate any such request if it is reasonable. This Plan, however, must accommodate such a request if you clearly state that the disclosure of all or a part of the PHI could endanger you. You will be required to complete a request form to receive communications of PHI by alternative means or at alternative locations.
- You (or your personal representative) have the right to request access to your PHI contained in a Designated Record Set, for inspection and copying, for as long as this Plan maintains the PHI. A Designated Record Set includes the medical billing records about you maintained by or for a covered health care provider, enrollment, payment, billing, claims adjudication, and case or medical management record systems maintained by or for this Plan or other information used in whole or in part by or for this Plan to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you are not in the Designated Record Set and therefore not subject to access. The right to access does not apply to psychotherapy notes or information compiled in anticipation of litigation. You must complete a request form to access PHI in a Designated Record Set. If access to inspect and copy PHI is granted, the requested information will be provided within 30 days if the information is maintained onsite or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if this Plan is unable to comply with the deadline. This Plan may charge a reasonable fee for the costs of copying. If access to inspect and copy your PHI is denied, a written denial will be provided setting forth the basis for the denial, a description of how you may have the denial reviewed, if applicable, and a description of how you may file a complaint with this Plan or the HHS or its OCR.
- You (or your personal representative) have the right to request an amendment to your PHI in a Designated Record Set for as long as the PHI is maintained in a Designated Record Set. You will be required to complete a request form to amend PHI in a Designated Record Set. This Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if this Plan is unable to comply with the deadline. If the request is denied in whole or in part, the Plan must provide a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.
- You (or your personal representative) have the right to request an accounting of disclosures of PHI by this Plan. This Plan will provide such an accounting only for the six-year period preceding the date of the request. However, such accounting will not include PHI disclosures made to carry out treatment, payment or health care operations or made to you about your own PHI. Also, this Plan is not required to provide an accounting of disclosures pursuant to an authorization request or disclosures made prior to the compliance date of the Privacy Rule. You will be required to complete a request form to obtain an accounting of PHI disclosures within 60 days of the request. If the accounting cannot be provided within 60 days, an additional 30 days is allowed if you are given a written statement of the reasons for the delay and the date by which the account will be provided. If more than one request for an accounting is made within a 12-month period, this Plan will charge a reasonable, cost-based fee for each subsequent accounting.

6. Access by Personal Representatives to PHI

This Plan will treat your personal representative as you with respect to uses and disclosures of PHI, and all the rights afforded you by the Privacy Rule, under certain circumstances, but only to the extent such PHI is relevant to their representation. For example, a personal representative with limited health care power of attorney regarding specific treatment, such as use of artificial life support, is your representative only with respect to PHI that relates to decisions concerning this treatment. The

personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to PHI or allowed to take any action.

Proof of such authority may take the form of a notarized power of attorney for health care purposes (general, durable or health care power of attorney), a court order of appointment as your conservator or guardian, an individual who is the parent, guardian or other person acting in loco parentis with legal authority to make health care decisions on behalf of a minor child, or an executor of the estate, next of kin, or other family member on behalf of a decedent.

This Plan retains discretion to deny a personal representative access to PHI if this Plan reasonably believes that you have been or may be subjected to domestic violence, abuse, or neglect by the personal representative or that treating a person as your personal representative could endanger you. This also applies to personal representatives of minors. Also, there are limited circumstances under state and other applicable laws when the parent is not the personal representative with respect to a minor child's health care information.

7. This Plan's Duties

In accordance with the Privacy Rule, only certain employees may be given access to your PHI. The Administration Office has designated this group of employees to include Mail Clerks, Eligibility Certifiers, Supervisors and Managers. The employees described above may only have access to and use and disclose PHI for plan administration functions. A mechanism shall be provided for resolving issues of noncompliance, including disciplinary sanctions or termination, to any person who does not comply with the Privacy Rule.

This Plan is required by law to provide you with its Notice of Privacy Practices ("Notice") by April 14, 2003, and thereafter, upon request. Also, the Notice must be distributed by this Plan to new employees and dependents upon enrollment. You will be advised at least once every three years of the availability of the Notice and how to obtain a copy of it. This Plan is required to comply with the terms of the Notice as currently written. However, this Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by this Plan prior to the date of the change. This Plan will promptly revise and distribute the Notice within 60 days if there is a material change in its privacy policies and procedures.

This Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. This minimum necessary standard, however, will not apply to disclosures to or requests by a health care provider for treatment purposes, disclosures made to you, uses or disclosures pursuant to your authorization, disclosures made to HHS or its OCR for enforcement purposes, uses or disclosures that are required by law, and uses or disclosures that are required for this Plan's compliance with HIPAA's Administration Simplification Rules.

8. Miscellaneous

This Plan may disclose de-identified health information. Health information is considered de-identified if it does not identify you and there is no reasonable basis to believe the information can be used to identify you, such as your name and Social Security Number.

This Plan may disclose summary health information to the Board of Trustees or a Business Associate. Summary health information is PHI, which includes claims history and claims experience, and from which identifying information has been deleted in accordance with the Privacy Rule.

This Plan will not use and/or disclose PHI for purposes of marketing. Marketing is defined as a communication that encourages the purchase or use of a product or service, such as sending a brochure detailing the benefits of a certain medication that encourages its use or purchase. However, this Plan may use PHI without authorization in certain situations, including but not limited to sending information describing the participating providers in its provider network(s), and the benefits provided

under the plan, providing information for the management of treatment, or recommending alternative treatment, providers, or health coverage.

9. Duties of the Board of Trustees With Respect to PHI

This Plan will also disclose PHI to the Board of Trustees for Plan administration purposes. The Trustees have amended this Plan's Trust Agreement and signed a certification agreeing not to use or disclose your PHI other than as permitted by the plan documents, the Privacy Rule, or as required by law. The Trustees' uses and disclosures are more fully described in this Plan's Privacy Policy Statement, Notice of Privacy Practices for Protected Health Information, and Board of Trustees' Certificate. Additional copies of these documents can be obtained from the Administration Office.

10. Complaints

If you wish to file a complaint with this Plan or have any questions regarding the uses or disclosures of your PHI (i.e., access, amendment or accounting of PHI), you may contact the Privacy Officer at the following address:

San Diego Roofers Health and Welfare Trust Fund
c/o Coast Benefits
3530 Camino Del Rio N. #110
San Diego, CA 92108
(619) 280-2009

A complaint may also be filed with the HHS or its OCR, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, DC 20201.

All complaints must be in writing and filed within 180 days of the date you knew or should have known of the violation. This time limit can be waived if good cause is shown. This Plan will not retaliate against you for filing a complaint.

11. Security Standards Under HIPAA

The Board of Trustees will implement reasonable and appropriate safeguards to protect the confidentiality, integrity, and availability of electronic protected health information that the Fund creates, receives, maintains, or transmits on behalf of the Plan. The Trustees will ensure that the adequate separation required by the Privacy Rule is supported by reasonable and appropriate security measures. The Trustees will ensure that any agent, including a sub-contractor, to whom it provides electronic protected health information, agrees to implement appropriate safeguards to protect the information. The Trustees will report to the Plan any security incident of which it becomes aware.

XIII. GENERAL PROVISIONS

1. Acts of Third Parties

If a Participant (including an eligible dependent) is injured through the act or omission of another party, Plan benefits are provided only on the following conditions:

- a. The Participant or dependent will be required to pay to the Plan or any entity providing benefits (such as Kaiser) immediately any proceeds received by way of judgment, settlement or otherwise (including receipt of proceeds under any uninsured motorists coverage or other insurance) arising out of any claims for damages by the individual or his or her heirs, parents or legal guardians, to the extent of the payments made or to be made by the Plan for which the third party may be responsible;
- b. Any Participant or dependent who accepts payments from the Plan agrees that by doing so he

or she is making a present assignment of his or her rights against such third party to the extent the payments made by the Plan. These rules are automatic, but the Plan may require that any participant or dependent sign an Agreement to Reimburse and/or Assignment of Recovery in such form or forms as the Plan may require; and

- c. Any Participant or dependent who refuses to sign an Agreement to Reimburse and/or Assignment of Recovery in a form satisfactory to the Plan shall not be eligible for Plan benefit payments related to the injury involved. Any Participant or dependent who receives benefit payments and later fails to reimburse the Plan as set forth above will be ineligible for any future Plan benefit payments until the Plan has withheld an amount equal to the amount which the employee or dependent has failed to reimburse, including reasonable interest on such unpaid funds.

By accepting benefit payments from the Plan, any Participant or dependent agrees that the Plan may intervene in any legal action brought against the third party or any insurance company, including the employee's own carrier for uninsured motorist's coverage. A lien shall exist in favor of the Plan upon all sums of money recovered by the Participant or dependent against the third party. The lien may be filed with the third party, the third party's agents, or the court. The Participant or dependent shall do nothing to prejudice the Plan's right as described above without the Plan's written consent.

If the Participant or dependent settles or compromises a third party liability claim in such a manner that the plan is reimbursed in an amount less than its lien, or which results in a third party or its insurance carrier being relieved of any future liability for medical costs, then the Participant or dependent shall receive no further benefits from the Trust Fund in connection with the medical condition forming the basis of the third party liability claim unless the Board of Trustees or its duly authorized representative has previously approved the settlement or compromise, in writing, as one which is not unreasonable from the standpoint of the Trust Fund.

2. Coordination of Benefits

General Coordination of Benefits Rule: If a covered participant or dependent is entitled to benefits from another plan, the HMOs, insurance companies or other entities likely have rules on which plan is primary or secondary and who pay first. You should consult with these entities to determine the rule. The benefits provided herein shall be paid in accordance with the standardized coordination of benefits provisions of the National Association of Insurance Commissioners.

You may not reject coverage under another Plan, HMO and/or insurance company and/or not enroll in such other Plan, HMO and/or insurance company and then expect this Plan to be primary with respect to payment of your benefits. The other Plan, HMO and/or insurance company would be primary (or you would be responsible for such claims/payments if they refuse such given your failure to enroll or action of unenrolling).

3. Benefit Continuation (Amendment and Termination)

It is the intent of the Trustees to continue this plan indefinitely, although they reserve the right to modify or discontinue this coverage at any time. Thus, benefits may be reduced or eliminated entirely. Moreover, participants could be asked to pay a portion or all of the required premium.

4. Exclusion for Fraud

No benefits are paid for fraudulent claims or services or supplies by a covered Participant, eligible dependent or any other person. If a fraudulent claim has been paid by the Plan or by any entity on behalf of the Plan for any person, both the Participant and any person on whose behalf a fraudulent claim was submitted or paid is liable to the Plan for repayment of benefits paid and the amount of any premium paid to an HMO, PPO, insurance company or any other entity. This does not preclude the Plan, HMO, PPO, insurance company or other entity from bringing a lawsuit against any person who commits fraud to recover improperly paid benefits, services or supplies, including reimbursement for

any attorney's fees and costs incurred to recover such amounts.

By way of example, if a Participant improperly signs up a person as a dependent who is not lawfully a dependent under the Plan, both the Participant and such unlawful dependent will be liable to the Plan and the Plan's providers for any claims paid, any premium paid by the Plan, and any attorneys fees and costs incurred by the Plan and any provider in recovering such improperly paid claims.

5. Source of Financing of the Plan

The Plan is funded by payments made to the Trust by employer's signatory to a Collective Bargaining Agreement with Roofers Local Union #45 in accordance with the provisions of any of the Collective Bargaining Agreements and, in the case of certain non-bargaining unit employees, in accordance with the terms of the appropriate Employer Participation Agreements.

6. Disclaimer

The Trust Fund has established the current Plan for the exclusive benefit of eligible participants and their dependents. The Plan is intended to be maintained for an indefinite period of time. The Plan, however, may be amended by the Board of Trustees from time to time as to both eligibility requirements, benefit structures and selection of service providers as may be deemed necessary. The Board further reserves the right to terminate the Plan should contributions from contributing employers become insufficient to provide benefits.

7. Not in Lieu of Workers' Compensation

The Plan is not in lieu of and does not affect any requirements for coverage by Workers' Compensation insurance.

8. Appeal Procedures

The following describes the process to appeal actions of the Administration Office with regard to the Trust's self-funded benefits or its eligibility provisions, or an action of the Board of Trustees. This Appeals Procedure does not apply to benefits obtained through Kaiser.

1. No employee, dependent, beneficiary or other person shall have any right or claim to benefits under the Plan other than as specified in policies or contract procured by the Board of Trustees or in the rules and regulations of the Board, or any right to claim to payments from the fund, other than as specified herein.

Any dispute as to eligibility, type, and amount or duration of benefits, or any right or claim to payments from the Fund shall be resolved by the Board under and pursuant to the Plan and the Trust Agreement except that any dispute as to type or amount of benefits which are provided pursuant to a contract of insurance or service contract entered into by the Board of Trustees shall be resolved under the terms of such contract.

The Board shall have full discretionary authority to decide all other matters and its decision of the dispute, right or claim shall be final and binding upon all parties thereto, subject only to such judicial review as may be in harmony with federal labor policy. No action may be brought to enforce any right under the Plan until a claim therefore has been submitted to and determined by the Board of Trustees and thereafter the only action which may be brought is one to enforce the decision of the Board or to clarify the rights of the claimant under such decision.

2. Any person whose application has been denied in whole or in part by the Board of Trustees shall be notified of such decision in writing by the Board of Trustees and may petition the Board of Trustees to reconsider its decision. A petition for reconsideration shall be in writing, shall state in clear and concise terms the reason for disagreement with the decision of the

Board of Trustees and shall be filed with or received by the Administration Office within 60 days after the date shown on the notice to the petitioner of the decision of the Board of Trustees.

3. Upon good cause shown, the Board of Trustees may permit the petition to be amended or supplemented. The failure to file a petition for reconsideration within such 60-day period shall constitute a waiver of the claimant's right to reconsideration of the decision. Such failure shall not, however, preclude the applicant or claimant from establishing his or her entitlement at a later date based on additional information and evidence, which was not available to him or her at the time of the decision of the Board of Trustees.
4. Upon receipt of a petition for reconsideration, the Board of Trustees, a committee or an Agent appointed by the Board and authorized to act on such petitions shall grant a hearing on the petition and receive and hear any evidence or argument which cannot be presented satisfactorily by correspondence.

A decision of the Board of Trustees shall be made promptly and shall be rendered as soon as possible, but no later than 120 days after receipt of the request for review. The petitioner shall be advised of the decision of the Board of Trustees or its Agent in writing.

5. The decision of the Board of Trustees with respect to petition for reconsideration shall be final and binding upon all parties, including the petitioner and any person claiming under the petitioner.
6. No action may be brought to enforce any rights under the Trust or the Plan until after the claim therefore has been submitted and determined by the Board of Trustees and, thereafter, the only action that may be brought is one to enforce the decision of the Board of Trustees.
7. Any dispute as to the type or level of benefits provided under a contract of insurance or a service contract entered into by the Board of Trustees shall be resolved in accordance with the terms of such contract including any appeals provisions of such contract.

Finality of Decision on Claim – Right to File Lawsuit

The denial of an application or claim after the right to review has been waived or the decision of the Trustees on appeal has been issued is final and binding upon all parties, including the claimant.

No lawsuit may be filed without first exhausting the above appeals procedure. No legal action may be commenced or maintained against the Plan or any Trustee or legal fiduciary, person or entity involved in the decision more than two years after a claim has been denied on appeal.

When a Lawsuit may be started

No Participant, Dependent, Beneficiary or other person shall have any right or claim to benefits under these Rules and Regulations or any right or claim to payments from the Fund, other than as specified herein. A Participant may not start a lawsuit to obtain benefits until after either: (1) the Participant has submitted a Claim pursuant to these Rules and Regulations, requested a review after an Adverse Benefit Determination, and a final decision has been reached on review; or (2) the appropriate time frame described above has elapsed since Participant filed a request for review and Participant has not received a final decision or notice that an extension will be necessary to reach a final decision.

No lawsuit may be filed (started) more than two years after services were provided or benefits partially or totally denied or an otherwise adverse determination was made against you or, if the Claim is for short term disability benefits, more than 2 years after the onset of the disability. The provisions of this Section shall apply to and include any and every claim to benefits from the Fund, and any claim or right asserted under the Plan or against the Fund, regardless of the basis asserted for the claim, and regardless of when the act or omission upon which the claim is

based occurred, and regardless of whether or not the claimant is a "Participant" or "Beneficiary" of the Plan with the meaning of those terms as defined in ERISA. Such claim shall be limited to benefits due to him under the terms of the Plan, or to clarify his rights to future benefits under the terms of the Plan, and shall not include any claim or right to damages, either compensatory or punitive.

9. Decision by Trustees

Under the Plan of Benefits and the Trust Agreement creating the Fund, the Trustees or persons acting for them, such as a claims appeal committee, have sole authority to make final determinations regarding any application for benefits and the interpretation of the Plan of Benefits, the Trust Agreement and any other regulations, procedures or administrative rules adopted by the Trustees. Decision of the Trustees (or, where appropriate, decision of those acting for the Trustees) in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees or those acting for the Trustees is challenged in court, it is intention of the parties to the Trust that such decision is to be upheld unless it is determined to be arbitrary or capricious.

10. Relations Between Plan & Health Care Providers

No health care provider is an agent or representative of the Plan or the Board of Trustees. The plan does not control or direct the provision of health care services and/or supplies to Plan participants and beneficiaries by anyone. The Plan makes no representation or guarantee of any kind that any provider will furnish health care service or supplies that are malpractice-free. This statement also applies to all entities (and their agents, employees, and representatives), which contract with the Plan to offer health-related services or supplies to participants and beneficiaries. Nothing in this Plan affects the ability of any provider to disclose alternative treatment options to a participant or beneficiary.

11. Miscellaneous Provisions

The benefits payable hereunder shall not be subject to any manner of anticipations, alienation, sale or transfer.

Self-funded plan benefits shall be paid only if notice of a claim is made within 90 days from the date on which covered charges were incurred. The claimant must submit properly completed claim forms and itemized statements as authorized by the Board of Trustees. Any exceptions to the submission of the claims later than 90 days are subject to the approval of the Board of Trustees, but in no event may claims be considered for payment later than 15 months from the date on which covered charges were incurred.

In the event the Plan determines that the Covered Person is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Covered Person has not provided the Plan with an address at which they can be located for payment, the Plan may, during the lifetime of the Covered Person pay any amount otherwise payable to the Covered Person, to the spouse, or relative by blood of the Covered Person, or to any other person or institution determined by the Plan to be equitably entitled thereto; or in the case of the death of the Covered Person before all amounts payable have been paid, the Plan may pay any such amount to one or more of the following surviving relatives of the Covered Person: Lawful spouse, child or children, mother, father, brothers or sisters, or to the Covered Person's estate, as the Board of Trustees, in its sole discretion, may designate. Any payment in accordance with the provision shall discharge the obligation of the Plan hereunder to the extent of such payment.

No participant, dependent or other beneficiary shall have any right to claim to benefits from the Plan, except as specified. Any dispute as to eligibility, type, amount or duration of the benefits under this Plan or any amendment or modification thereof shall be resolved by the Board of Trustees. The Trustees shall have discretion in any such determination. Participants may seek review of any adverse decision of the Trustees in Federal District Court as prescribed by law.

The benefits provided by the Plan are not in lieu of and do not affect any requirement for covered by Workers' Compensation Insurance laws or similar legislation.

The provisions of the Plan are subject to and controlled by the provisions of the Trust Agreement, if applicable, and in the event of any conflict between the provisions of the Trust Agreement and the provisions of this Plan, the Trust Agreement shall prevail.

Certain benefits are self-funded and any references to "insurance" are inapplicable to Self-Funded benefits.

It is recognized that the self-funded benefits provided by the Plan can be paid only to the extent that the Fund has available adequate resources for such payment. No contributing employer, the Local Union nor any individual trustee or the Board of Trustees has any liability, directly or indirectly to provide the self-funded benefits established hereunder beyond the assets available in the Fund and the obligation of contributing employers to make contributions as stipulated in the collective bargaining unit agreements.

WARNING: BENEFITS CAN BE REDUCED OR ELIMINATED.

The Board of Trustees reserve the right to reduce or modify any and all benefits of the Plan, in part or in whole, and may change or eliminate any or all insurance carriers, HMOs and any other provider or entity. The Board may also require contributions for any increases to the Plan from time to time from the Participants of the Plan. Any such changes are at the discretion of the Board of Trustees.

XIV. POTENTIAL LOSS OF BENEFITS

You and/or your eligible Dependent(s) could lose your benefits and/or have payments delayed in at least the following circumstances:

1. Inadequate or Improper Evidence

The Plan grants the Board of Trustees the power to deny, suspend or discontinue benefits to a Participant who fails to submit at the request of the Trust Fund Office any information or proof of coverage reasonably required to administer the Plan.

2. Prohibited Employment in the Roofing Industry

If you engage in certain kinds of work in the Roofing Industry, known as Prohibited Employment, you will no longer be entitled to Health and Welfare benefits.

3. Subrogation Third Party Claims

The Plan does not cover any illness, injury, disease or other condition or claim for which a third party may be liable or legally responsible. See page 31 for Third Party Liability.

4. Coordination of Benefits

If Dependents are covered by more than one Plan, this Plan may not be responsible for many claims. Please refer to page 32 for the rules of Coordination of Benefits.

5. Work-Related Injuries

The Plan is not responsible for paying any claims incurred as a result of a work-related injury. This applies even if you have not filed a claim with workers compensation.

6. Right to Recover Claims Paid or Offset of Future Claims

The Plan has the right to recover any amounts improperly paid. The Plan may offset any amounts owed to the Plan against any claims that you and/or a Dependent incur in the future.

7. Plan Exclusions/Co-Payments

The Plan and the insurance providers contain exclusions and exceptions for coverage. You should be aware of the Plan's and the insurance provider's limitations, exclusions, co-payments and other facets of the Plan in which you may not receive full payment on a claim or reimbursement or for which there is a co-payment.

8. Failure to Complete Application

Benefits may not be payable until a completed application and other forms required by the Trust Fund Office are received by the Trust Fund Office.

9. Incomplete Information/False Statements

If you fail to provide requested information or give false information to verify disability, age, beneficiary information, marital status or other vital information, coverage under the Plan or benefits provided may be postponed or cancelled.

If you make a false statement to the Plan or other officials regarding the payment of benefits or other issues related to the Plan, you will be liable to the Plan for any benefits paid in reliance on such false statements or information. This includes but is not limited to costs incurred by the Trust Fund Office, reasonable attorneys' fees, and interest charges. The Plan may deduct any such fees and costs from any benefits otherwise payable to you, your estate or a beneficiary.

10. Plan Termination

If the Plan terminates, benefits will no longer be provided.

XV. GENERAL INFORMATION

(As Required by ERISA)

1. Name and Address of the Plan: San Diego Roofers Health & Welfare Trust Fund, 3530 Camino del Rio North, Suite 110, San Diego, CA 92108.

2. Type of Plan: This is a Health Care Plan, providing the following Health Care Benefits Plan – Hospital, Surgical, Medical, Disability, Dental, Life, and AD&D coverage's.

3. Type of Administration and Method of Fund Benefits: This Plan is administered by the Joint Board of Trustees. The Plan is funded by employer contributions as provided for in the collective bargaining agreement. Claims not related to HMO and insured providers are processed by a contract administrator.

4. Sponsoring Organizations: The Plan is maintained in accordance with collective bargaining agreements between the participating employer and United Union of Roofers, Waterproofers and Allied Workers Local Union No. 45, AFL-CIO. By writing to the Union, participants and beneficiaries may determine whether a particular employer is a sponsor of the Plan, and if so, the employer's address.

5. Contributions: Contributions to provide Plan benefits are paid by the sponsoring employers in accordance with their bargaining agreements "on a cents-per-hour basis".

6. Appeal Procedure: The procedure for file appealing denials are set forth on page 34 and in the separate booklets furnished by the insurance companies and other entities.

7. Fiscal Year: The fiscal year of the Trust is the twelve-month period ending each November 30th, and the Trust's records are maintained on that basis.

8. Employer Identification Number: 95-6052814

9. Plan Number: 501

10. ERISA Rights: As a participant in this 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 all documents governing the Plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, Internal Revenue Service and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies of some of these documents.
- 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 at no cost to the participant.
- Continued health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as the result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description on the rules governing your COBRA continuation coverage rights.

You should be provided a certificate of creditable coverage free of charge, from your Group Health Plan or Health Insurance Issuer as follows:

- when you leave coverage under that Plan, when you become entitled to elect COBRA continuation coverage;
- when your COBRA continuation coverage ceases;
- if you request a certificate of creditable coverage before losing coverage; or
- if you request a certificate of creditable coverage up to 24 months after losing coverage.

You may be subject to any pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for Plan participants, ERISA imposes duties upon the individuals who are responsible for the operation of the Employee Benefit Plan. The individuals who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining benefits under the plan or exercising your rights under ERISA. If your claim for benefits is denied or ignored, in whole or in part,

you must receive a written explanation 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 a copy of plan documents or the latest summary annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal Court. In such a case the Court may require the Plan Administrator to provide the materials and pay you up to \$110.00 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits, which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available under the plan, you may file suit in a State or Federal Court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order or domestic relations order, you may file suit in Federal Court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal Court.

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

If you have any questions about the 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 office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA. For single copies of publications, contact the EBSA Brochure Request Line at (866) 444-3272 or contact the EBSA field office nearest you.

You may find answers to your questions and a list of EBSA offices at www.dol.gov/ebsa/welcome.html.

11. Names and Addresses of the Board of Trustees:

Employer Trustees:

Michelle Mosqueda
A Good Roofer
11651 Riverside Drive, Ste. 145
Lakeside, CA 92040

Mitchell Roe
Roejack Construction Services, Inc.
9168 Birch Street
Spring Valley, CA 91977

Mark Miller
A Good Roofers, Inc.
11651 Riverside Drive, Ste. 145
Lakeside, CA 92040

Employee Trustees:

Paul Colmenero
Roofers Local Union #45
3737 Camino Del Rio South, Suite 202
San Diego, CA 92108

Adrian Lopez-Rojas
Roofers Local Union #45
3737 Camino Del Rio South, Suite 202
San Diego, CA 92108

12. Name and Address of Contract Administrator:

Coast Benefits
3530 Camino Del Rio North #110
San Diego, CA 92108
Main: (619) 280-2009
Fax: (619) 501-3250

13. Name and Address of Agent for Service of Legal Process:

Richard Prochazka
Richard D. Prochazka, A.P.C.
2525 Camino del Rio South, Suite 209
San Diego, CA 92168
(619)296-7676

XV. HIPAA

In accordance with the new disclosure requirements of the Health Insurance Portability and Accountability Act, we are informing you of the names and addresses of all Health Providers for the Trust Fund and their roles (i.e., whether they guarantee the payment of benefits or provide administrative services).

List of Providers

Kaiser Permanente

Southern California Region
10992 San Diego Mission Road, #100
San Diego, CA 92108
Provides prepaid medical benefits.

Lincoln Financial

8801 Indian Hills Drive
Omaha, NE 68114
Fully insures life, accidental death and dismemberment, and dependent life benefits for eligible participants.

Coast Benefits

3530 Camino Del Rio North, Suite 110
San Diego, CA 92108

Administers the self-funded dental and self-funded weekly disability program; does not guarantee payment of benefits.

The Act also requires that we inform you of the Department of Labor address in Washington, D.C. If you have any questions about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W. Washington, D.C. 20210. Additional information regarding your ERISA rights may be found in your Summary of Benefits booklet under "Statement of ERISA Rights".