ROOFERS
LOCAL 241

INSURANCE FUND

Summary Plan Description

JULY 1, 2019

I. INTRODUCTION

The Board of Trustees of the Roofers Local 241 Insurance Fund is pleased to present this revised Summary Plan Description, which describes the benefits and eligibility requirements of the Fund's plan of benefits (the "Plan") as of July 1, 2019. Also included in this booklet are the procedures that you should follow when filing a claim, and certain information concerning the administration of the Plan as required by the Employee Retirement Income Security Act of 1974 29 U.S.C. et seq. (ERISA).

This Summary Plan Description amends and replaces any prior statement of the benefits contained in the Plan or any predecessor to the Plan.

The benefits described in this booklet are the result of continuous efforts of the Board of Trustees to offer an excellent program of benefits that will help meet the needs of your entire family. We urge you to read this booklet carefully so that you understand the complete package of benefits available to you and your eligible family members. You should share this booklet with your family and keep it in a convenient place for future reference.

This booklet describes key features of your Welfare Plan. Complete details of the program are also contained in the other official Plan documents, including the Trust Agreement, the Fund's contracts with its administrators and insurers, and collective bargaining agreements, which legally govern the operation of the program. All official Plan documents are available for your inspection at the Fund Office during normal business hours. All statements made in this booklet are subject to the provisions and terms of those documents. In case of a conflict or inconsistency between the official Plan documents and this booklet, the official documents will govern in all cases.

Please note that the Board of Trustees (the "Trustees") reserves the right, within its sole and absolute discretion, to amend, modify or terminate, in whole or in part, any or all of the provisions of this Plan (including without limitation any benefits to retirees, related Plan documents and underlying policies), at any time and for any reason, by action of the Trustees, or any duly authorized agent(s) of the Trustees, in such manner as may be duly authorized by the Trustees.

This booklet is not a contract of employment – it neither guarantees employment or continued employment with your employer or any Contributing Employer, nor diminishes in any way the right of Contributing Employers to terminate the employment of any employee.

If you have questions about the Plan or how to apply for benefits, do not hesitate to contact the Fund Office by phone at (518) 489-3919 or at Roofers Local 241 Insurance Fund, 890 Third Avenue, Albany, NY 12206.

Sincerely,

Board of Trustees

II. GENERAL PLAN INFORMATION

FUND NAME: Roofers Local 241 Insurance Fund

PLAN NUMBER: The Trustees have assigned number 501 to the Plan.

EFFECTIVE DATE: The current provisions of the plan of benefits became effective on July 1, 2019.

PLAN YEAR: Your Plans' records are maintained on a twelve-month period. This is known as the "Plan Year". The Plan Year is the twelve-month period beginning each July 1st and ending each June 30th.

PLAN SPONSOR: The plan is sponsored by the Board of Trustees of the Roofers Local 241 Insurance Fund.

EIN: The Employer Identification Number of the Plan is 51-024401.

TRUSTEES: The following individuals comprise the Board of Trustees:

Union Trustees	**Employer Trustees**
Steven Sawyer	Anthony Pazmino
Michael Rossi	Todd Helfrich
Marcus Harris (Alternate)	Bob Farrell (Alternate)

The principal place of business address for each Trustee may be obtained from the Fund Office.

PLAN ADMINISTRATOR: The name and address of the Plan Administrator are:

Board of Trustees
Roofers Local 241 Insurance Fund
890 Third Avenue
Albany, NY 12206
Phone #: (518) 489-3919

The Plan Administrator keeps the records for the Plan and is responsible for the administration of funds. The Plan Administrator will also answer any questions you may have about the Plan and its plan of benefits. You may contact the Plan Administrator for any further information about the Plan.

FUND ADMINISTRATOR: The name and address of the Fund Administrator are:

Roofers Local 241 Insurance Fund - Kathleen Lee
890 Third Avenue
Albany, NY 12206
Phone #: (518) 489-3919

The Fund Administrator keeps the records for the fund and is responsible for the administration of funds. The Fund Administrator will also answer any questions you may have about the Fund and its plan of benefits. You may contact the administrator for any further information about the fund.

SERVICE OF LEGAL PROCESS: The name and address of the Plans' agent for Service of Legal Process are;

Board of Trustees
Roofers Local 241 Insurance Fund
890 Third Avenue
Albany, NY 12206

LEGAL COUNSEL: The name and address of the Fund's Attorneys are:

Lipsitz Green Scime Cambria, LLP
42 Delaware Avenue, Suite 120
Buffalo, New York 14202-3901

ACTUARY: The name and address of the Fund's Actuaries are:

O'Sullivan Associates
1236 Brace Road, Unit E
Cherry Hill, NJ 08034

ACCOUNTANTS: The name and address of the Fund's Accountants are:

D'Arcangelo & Co., LLP
120 Lomond Court
Utica, New York 13502

II. OTHER IMPORTANT INFORMATION

SOURCES OF CONTRIBUTIONS TO THE FUND

Contributions come into the Fund from Employers who are required to contribute to the Fund pursuant to a collective bargaining agreement with the Union, and in some instances from other welfare funds with whom this Fund may have reciprocal agreements in place.

COLLECTIVE BARGAINING AGREEMENT.

This Fund is maintained in accordance with a collective bargaining agreement. A copy of the collective bargaining agreement may be obtained by you upon written request to the Plan Administrator and is available for examination by you at the Fund Office.

III. IMPORTANT DEFINITIONS

Agreement and Declaration of Trust. The restated Agreement and Declaration of Trust as amended from time to time, which created the Roofers Local 241 Insurance Fund.

Covered Dependent. The term "Covered Dependent" means any of the following persons who are not Employees, but are insured under this Plan:

1) The Participant's Spouse and
2) The Participant's unmarried dependent child. However, for purposes of the Medical Insurance Coverage, your dependent will be defined by the insurance policy or policies chosen by the Plan to provide your health insurance coverage.

Covered Employment. Work of a type covered by a collective bargaining agreement requiring contributions to this Fund.

Employee. A person covered by a collective bargaining agreement between an employer and the union where such collective bargaining agreement provides for contributions to the Plan on behalf of his covered employment to fund the Plan. The term "Employee" also means any employee for whom contributions are made to the Fund to fund the Plan in accordance with an agreement between such employee and the Trustees. The term "Employee" also means each employee of the Fund.

Employer. Any person, firm, association, or corporation, which is bound by the terms of a collective bargaining agreement, to contribute to the Fund to fund the Plan. The term also means any person, association, firm, or corporation which is otherwise bound by agreement with the Trustees to contribute to the Fund. The term, "Employer," also means the Fund.

Fund. The trust estate created by the Agreement and Declaration of Trust and now called Roofers Local 241 Insurance Fund.

Month. The calendar month.

Plan. The system of benefits and rules and regulations contained herein. The name of the Plan is Roofers Local 241 Insurance Fund Plan of Benefits.

Participant. An "Active Participant" is one who is a participant in this Plan, who has satisfied the general eligibility requirements of Article V during his current period of Plan participation and who is not receiving a pension benefit under the Roofers Local 241 Pension Plan. A "Retired Participant" is one who is receiving a pension benefit under the Roofers Local 241 Pension Plan and who was a participant in this Plan on the effective date of such pension benefit and eligible for the Insurance Benefit.

Spouse. Your lawful spouse

Trustee. One of the Trustees named in the Agreement and Declaration of Trust and his successor.

Union. Roofers Local 241.

Week. The seven consecutive days, Monday through Sunday.

Plan Year. The 12 consecutive calendar month period, July through the following June.

IV. GENERAL PROVISIONS GOVERNING THE PLAN

The Roofers Local 241 Insurance Fund has been an "individual account" type of plan since 1983. No more will be paid out to a member (or his beneficiary) than has come into his individual accounts in the way of contributions made on his work.

Each employee who has contributions made to the plan, on behalf of his work after June 30, 1983, in accordance with a collective bargaining agreement between his employer and Roofers Local 241 will be a participant in this plan. Such contributions will be credited to an individual account for the employee.

The Plan Administrator will create and maintain two individual accounts, or "personal" accounts, on your behalf. Each account will include a record of contributions received on your behalf, benefits paid, and expenses charged against the account. The maintenance of these accounts is for record keeping purposes only. You do not have a vested right to the balance in the account or any benefit offered by the Plan; accounts are used only to determine your eligibility for benefits and actual segregation of assets does not occur.

One account, your "Health Account", will be used only for health expenses. These include premiums for health insurance and for most other health expenses not covered by insurance. Distributions from this account are general nontaxable. Your second account, your "Welfare Account," will be used for supplemental unemployment, disability benefits, holiday, dependent care, scholarship and educational benefits, life insurance and vacation benefits and is generally taxable. If you die while there is a balance in your Welfare Account, it will be forfeited.

Your account will grow with additional contributions that are made to it in the future. Your account will be decreased by any benefit distribution made from your account. Once your account is reduced to zero, you will no longer be a participant in this Plan.

Administrative charges may be levied against your (and each participant's) account, on an equitable basis, if, for instance, the investment yield on the Plan reserves is not sufficient to offset the costs of administration of the Plan. In addition, the Trustees may deduct administrative costs directly from contributions as they are received by the Fund or from benefits as they are paid. Thus, you may not always be credited with the full amount of contributions otherwise paid on your behalf. The Trustees likewise retain the right to use any contributions for the purposes of establishing reserve accounts from which administrative expenses may be paid.

In the following sections you will see what is required to become eligible for the benefits that now exist in the plan; there is also a description of each of the benefits.

V. ELIGIBILITY FOR BENEFITS AND ALLOCATION OF CONTRIBUTIONS

GENERAL ELIGIBILITY REQUIREMENT

Before you are eligible for any of the benefits under this Plan, you must satisfy the general eligibility requirement in your current period of plan participation. You can become eligible for Life Insurance after you accumulate $350 in your "Welfare Account."

If contributions are made to the Plan for you before you have satisfied the general eligibility requirement and such contributions cannot be used to satisfy the general eligibility requirement (because they were made more than thirty-six (36) months before you became eligible), such contributions will be forfeited and used for plan administrative costs.

In addition to having satisfied the general eligibility requirement, you will have to satisfy special eligibility requirements depending upon which of the benefits you are currently using. Further, **you must be working in Covered Employment or you must be eligible for work in Covered Employment to be entitled to medical insurance coverage benefit under the Plan.** However, if you have retired and are receiving a pension from the Roofers Local 241 Pension Plan, you remain eligible for insurance coverage.

Once you have accumulated $2,000 in your Health Account, you are eligible for health insurance coverage under the Plan. You may elect single, two person, or family coverage at that time. However, you must pay the difference between the premium for single coverage and the two person premium until your Health Account reaches $3,500, when the full two person premium will be deducted monthly from your account. You may also elect family coverage, but you must pay the difference between the premium for single coverage and the family premium until your Health Account reaches $4,000, when the full family premium will be deducted monthly from your account.

If you fail to make an election, you will automatically be enrolled in the least expensive single coverage program offered.

You may not use your Health Account for the Health Care Reimbursement Benefit if your account falls below either $2,000, $3,500, or $4,000, as applicable to your type of coverage. It may only be used for the monthly premium under the Plan.

ALLOCATION OF CONTRIBUTIONS

Generally, future contributions made on your behalf (less an administrative charge as determined by the Trustees) will be credited to your Health Account.

However, once your Health Account reaches a certain level, a portion of your future contributions will be directed to your Welfare Account instead. This will depend on whether you have single health coverage, family coverage or no coverage (because you showed proof of other health coverage). *If you have retired from Covered Employment and return to work on a part-time basis (less than 40 hours per month) all contributions made on your behalf will be allocated to your Health Account.*

Effective January 1, 2016, the Plan requires that the first $2,000 of contributions to the Fund on your behalf be allocated to your Health Account. This is the current estimate of the amount necessary to cover six months of self-only coverage under a program that will provide the minimum required value of coverage. If your Health Account should fall below $2,000, you may use it only to maintain self-only coverage.

Once you accumulate $2,000 in your Health Account, you will be enrolled in coverage through the Fund unless you provide proof of health insurance coverage through your spouse's or parent's employer.

The following chart will continue to determine the allocation of contributions to your Health Account and Welfare Account until your Welfare Account balance reaches $8,000. At that point, all future contributions will be allocated to your Health Account.

		If your Health Account balance is:				**WRA** balance
		Up to $2,000	$2,000 to $3,000	$3,000 to $10,000	Over $10,000	Over $8000
and your coverage from the Plan is:	Outside Coverage	100% Health	80% Health	20% Health	0% Health	100% Health
	Single	100% Health	80% Health	50% Health	0% Health	100% Health
	Two-Person	100% Health	100% Health	100% Health	0% Health	100% Health
	Family	100% Health	100% Health	100% Health	20% Health	100% Health

LIMITATION ON BENEFITS

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

Other limitations, if any, will be listed where the individual benefit is described hereunder.

FORFEITURE OF CERTAIN INITIAL CONTRIBUTIONS.

On the first of each month the account of each participant who has not satisfied the requirements for general eligibility for benefits during his current period of Plan participation, as of such date, shall be examined. If any contributions have been credited to such participant's account and were received by the Fund more than 12 months prior to such date, the amount of such contributions shall be subtracted from such participant's account and forfeited, unless already forfeited.

BENEFITS

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

VI. BENEFITS – HEALTH ACCOUNT

MEDICAL INSURANCE COVERAGE

In order to be eligible for insurance coverage, you must be working in Covered Employment or you must be eligible for work in Covered Employment. Further, if you have retired and are receiving a pension from the Roofers Local 241 Pension Plan, you remain eligible for insurance coverage.

You and your Covered Dependents will be provided with hospitalization benefits, medical, surgical and anesthetic benefits, prescription drug coverage, and major medical coverage through an insurance policy or policies or health maintenance organization selected by the Plan to provide those benefits. The insurance policies will control as to those persons who will be eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured (if any), and the benefits and circumstances under which insurance terminates, if different from this Summary Plan Description.

Amounts necessary to provide the insurance coverage will be automatically deducted from your account at the beginning of each month of coverage. In the event that your account is reduced to a balance of zero, you will be notified of your right to continue coverage on a self-payment basis. You may continue your health care coverage on a self-payment basis so long as you remain eligible to participate in the Plan, and for as long as required by law. (See Article IX, COBRA.)

In the event you are disabled due to an injury which entitles you to a New York workers compensation or disability insurance benefit, you will remain eligible for continued health and hospitalization coverage without charge to your Health Care Account for the three consecutive months beginning after the first week for which you receive the benefit. You must have completed five (5) full, consecutive Plan Years (July to June) of 1,000 hours in Covered Employment prior to the injury in order to be entitled to this benefit.

PHYSICAL EXAM BENEFIT

If you are required to take a physical examination in order to be employed by a contributing Employer, the cost of such physical examination will be paid by the Fund subject to the following limitations:

Limitations On Physical Examination Benefit – No more than two such physical examinations will be covered per plan year, and no more than $300.00 will be paid for such benefit per plan year.

No Reduction In Individual Account – The Physical Examination Benefit described above will be paid out of the unallocated assets of the Insurance Fund and, therefore, will not diminish your individual account.

DRUG TESTING

Charges for mandatory drug testing required as part of employment will be reimbursed by the Plan. The following limitations will apply: If you test negative, the charges will be reimbursed from the general assets of the Plan. If you test positive, the charges will not be reimbursed through the general assets of the Plan. However, you will be able to get reimbursement through your personal account.

HEALTH CARE REIMBURSEMENT BENEFIT

Eligibility. You will be eligible for Health Reimbursement coverage under your Health Account only after you have accumulated $2,000 and you are enrolled and participating under a group health insurance plan offered through the Fund.

You may submit medical expenses of your spouse and Dependents for reimbursement only if they also are covered under a health insurance plan offered through the Fund or by other employer group coverage. **Coverage through the New York State of Health Marketplace, New York Child Health Plus, TRICARE, or any health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and Urban Indian organizations will not qualify.** Further your spouse's or Dependent's plan must provide "Minimum Value." A health plan provides Minimum Value if the health plan's share of the total allowed cost of benefits is at least 60 percent (i.e., has an actuarial value of at least 60 percent). If your spouse or Dependents are not enrolled in coverage through the Fund, you will be eligible to use your Health Account for their unreimbursed medical expenses only if you present their enrollment card in their group health plan and provide a copy of that plan's Summary of Benefits and Coverage (SBC) indicating that it meets the Minimum Value standard.

Once you become eligible for coverage under this Health Care Reimbursement benefit, you may file a claim for a distribution for the reimbursement of any Qualified Medical Expenses. Distributions reduce your Health Account on a dollar for dollar basis.

Qualified Medical Expenses. Qualified Medical Expenses are those that are not eligible for reimbursement under any other plan or any other source, including another health reimbursement account or flexible spending account, and are medically necessary expenses that are incurred by you, your spouse, and your Dependents during the Plan Year for medical care as defined in Section 213(d) of the Internal Revenue Code. You may include all medical, dental, and vision expenses for the diagnosis, cure, treatment or prevention of disease, and for treatments affecting any part or function of the body that are not covered or not reimbursed by insurance or any other source.

Expenses may also be to alleviate or prevent a physical defect or illness. Expenses incurred solely for cosmetic reasons or expenses that are merely beneficial to a person's general health are not eligible for reimbursement. Medical expenses qualify for reimbursement based on when they are incurred and are considered incurred at the time the drugs, medical equipment, or medical care service is provided, not at the time you pay for them.

For purposes of this Health Expense benefit only, Dependents include your spouse and any child of yours who will be under age 27 as of the end of the calendar year, provided your spouse and child are covered under your policy or your spouse's policy. For this purpose, a "child" is an individual who is your son, daughter, stepson, or stepdaughter, and includes a legally adopted individual, an individual lawfully placed with you for legal adoption, and a foster child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

As a result of the health care reform law, expenses incurred for medicines or drugs (other than insulin) are subject to an additional requirement. Those expenses may be reimbursed on a tax-free basis only if the medicine or drug is prescribed, even if the medicine or drug is an over-the-counter (OTC) medicine or drug that may be purchased without a prescription. For purposes of the new restrictions, a prescription for a medicine or drug must be a written or electronic order that satisfies the legal requirements for a prescription in your state (including that it be issued by someone authorized to issue prescriptions in that state). The restrictions do not apply to OTC items other than medicines and drugs (e.g., equipment, supplies, and medical devices, including items such as crutches, bandages, blood sugar test kits, and eyeglasses).

Once your Health Account falls below $2,000, you may not use it for any purpose other than the payment of premiums for single coverage for yourself. You may, however, save any Qualified Medical Expenses incurred while you are enrolled in coverage for later reimbursement.

Carryover of Health Account. If any balance remains in your Health Account after all reimbursements have been made for a Plan Year, that balance will be carried over to reimburse you for Qualified Medical Expenses incurred during a subsequent Plan Year. You will remain eligible for the Health Care Reimbursement benefit if you leave Covered Employment or retire, but only to the extent of the balance remaining in the Health Account, and provided you maintain group employer health coverage.

The balance in your Health Account will be forfeited and added to the Fund's reserves at the end of a period of twenty-four (24) consecutive months in which there is no contribution to, or distribution from your Health Account. Further, any balance remaining in your Health Account upon your death (if you are not survived by a spouse or eligible Dependents), or upon the death of the survivor of your spouse or eligible Dependents, will be forfeited and added to the Fund's reserves.

You will have the option each year at open enrollment, and upon your retirement or termination of employment, to permanently opt out of Health Account coverage. If you do so prior to retirement or termination of employment, the balance in your Health Account may only be used for the payment of group health insurance coverage through the Fund. If you opt out of Health

Account coverage at retirement, or after a period of 12 months without any Employer Contributions, then your entire Health Account will be forfeited.

Claims. You may submit your claim for reimbursement by completing a claim form and providing one of the two types of acceptable documentation. First, you may submit a claim under a medical, dental or vision care plan, which covers the person for whom the medical expense was incurred. The insurer will issue you an Explanation of Benefits (EOB), and the EOB should be provided with your claim as documentation of an unreimbursed medical expense along with evidence that your payment has been made for the total amount you are requesting. Second, for unreimbursed medical expenses not documented by an EOB, you may provide the Fund Administrator with a receipt of the medical expense, which includes: name of the recipient of the service; date of the service (not the paid date); description of the service; cost of the service; and name, address, and Tax I.D. number of the provider; and record that shows payments made by insurance or denial by insurance and evidence that payment has been made by the claimant.

Claims Procedure. Claims will be administered in accordance with the claims procedure set forth in Article X of this Summary Plan Description.

Submission of claims under this Benefit must be made within two (2) years from when the expense was incurred.

DEATH BENEFIT

If you die while in active employment, your surviving spouse and dependent children who are covered under the Plan at that time will be eligible to receive a Special Death Benefit Allocation until the spouse remarries, or the dependent children no longer qualify as dependents under the Plan.

The Special Death Benefit Allocation will be equal to the monthly premium for health insurance coverage under the Medical Insurance Benefit. Continuation of the Special Death Benefit Allocation is subject to review and approval of the Trustees, and may be reduced or eliminated at their discretion.

VII. BENEFITS – WELFARE ACCOUNT

Important Note: Once you die or retire, unlike your Medical Account, any amounts that you may have in your Wage Account will be forfeited. Further, you will not be entitled to receive any benefit from your Welfare Account if you cease to be eligible to work in Covered Employment. Each benefit listed below is subject to eligibility requirements that must be met for you to be entitled to said benefit. Benefits payable from your Welfare Account may be subject to an administrative fee as determined by the Trustees.

SUPPLEMENTAL UNEMPLOYMENT BENEFIT

You may receive a weekly Supplemental Unemployment Benefit payable from your Welfare

Account if you satisfy the following conditions:

(a) You must be involuntarily laid off from a unit covered by the Collective Bargaining Agreement;
(b) You must present proof that you are entitled to New York State Unemployment; and
(c) You must not refuse to accept work as a roofer that has been offered by the Union or by an Employer.

The amount of the benefit will be $300 per week or $75 per day ($400 for the initial waiting week) for any week or day that you are unemployed.

If you fail to report on the date indicated on the notice to report for referral card, you will forfeit all future benefits until such time as you return to work and are again laid off by an Employer after satisfying the eligibility requirements set forth above. If you refuse employment which is offered to you, you forfeit the benefit for that week and will continue to forfeit benefits in any following week in which you refuse employment.

You may not receive this benefit if you have voluntarily terminated employment or retired.

DISABILITY BENEFIT

You will be entitled to a weekly disability benefit payable from your Wage Replacement Account for each week you are unable to work due to a Disability entitling you to a New York disability or workers' compensation benefit.

You will be eligible to draw $175.00 from your account for each whole week that you remain totally disabled. For this purpose, you are "totally disabled" if you are unable to work at any occupation for the five work days (Monday through Friday) of a particular week.

Application for a Disability Benefit must be made within 30 days following the week of disability, unless the disability prevents you from making the application.

This benefit is only payable if you have enough money in your account to cover a whole week of coverage.

SCHOLARSHIP BENEFIT

If you, your spouse, or your dependent children attend school as a degree candidate, at an institution which is a qualified "Educational Organization", the tuition costs of this schooling can be reimbursed from your account.

For the purposes of this Scholarship Benefit, an institution is an "Educational Organization" if it is an institution of learning which normally maintains a regular faculty and normally has a regularly enrolled body of pupils or students in attendance at the place where its educational activities are regularly carried on. However, "Educational Organization" will not include primary or secondary schools, trade schools, or any non-degree schools.

EDUCATIONAL ASSISTANCE BENEFIT

In the event you have satisfied the general eligibility requirements and incur expenses for job related education or training including but not limited to tuition, fees and similar payments, books, supplies, and equipment, you are entitled to an Educational Assistance Benefit.

If you incur expenses for job related education or training including but not limited to tuition, fees, and similar payments, books, supplies, and equipment, these costs can be reimbursed from your account.

It does not include reimbursement for payment for, or the provision of, tools or supplies which may be retained after the completion of a course of instruction, or meals, lodging, or transportation. Educational assistance also does not include any payment for, or the provision of any benefits with respect to, any course or other education involving sports, games, or hobbies.

Claims under this benefit may be submitted only if they total at least $100.00. You may add several bills together in order to reach the $100.00. In any event, regardless of the size of your unpaid covered bills, in the month of June you may submit such bills to the plan.

VACATION BENEFIT

You are entitled to two vacation withdrawals from your Welfare Account each calendar year. Depending on the balance in your Welfare Account, you may receive a $1,100 or a $2,000 benefit for each vacation withdrawal. You must take the maximum benefit available at the time of the withdrawal.

Effective January 1, 2017, if you fail to apply for both vacation benefits by December 1 of a calendar year, the remaining benefits (up to the balance in your Welfare Account) will be paid to you prior to December 31.

LIFE INSURANCE BENEFIT

As long as you remain available for Covered Employment, each month the premium for your life insurance coverage will be subtracted from your account so long as your account balance is big enough to cover the total monthly premium. In the event your account is no longer big enough to cover the monthly premium for your insurance coverage, you will be allowed to self-pay the difference in order to **continue** this coverage. You must remain available for Covered Employment (unless disabled) in order to have this privilege of self-payment; and may not start and stop again such self-payment. The maximum length of time for this self-payment will be 12 months.

HOLIDAY BENEFIT

You are entitled to a Holiday Benefit of $400 for each qualified unpaid holiday after June 1, 2016 listed in the current collective bargaining agreement. You must apply for this benefit by the last day of February immediately following the calendar year of the holiday.

DEPENDENT CARE BENEFIT

You may receive reimbursement for dependent care expenses incurred during the calendar year for which you submit documentation as set forth below. Only dependent care expenses incurred after June 1, 2016 may be reimbursed.

You must complete an application by the last day of February immediately following the calendar year for which you wish to receive the Dependent Care Benefit. The application must include:

(a) The amount, week ending date and nature of each expense with respect to which a benefit is requested;
(b) The name, address, telephone number, and Federal I.D./Social Security Number of the person, organization or entity to which the expense was or is to be paid;
(c) Such other information as the Fund Administrator may from time to time require.

Your application must be accompanied by bills, invoices, receipts, cancelled checks or other statements or certifications showing the amounts of such expenses, together with any additional documentation which the Fund Administrator may request. Your application may be made after you have paid the expenses.

The maximum amount which you may receive in the form of dependent care assistance in any calendar year will be the smaller of (a) your earned income for the calendar year, (b) if you are married, the lesser of (i) your earned income for the calendar year or (ii) the earned income of your spouse for the calendar year, or (c) $5,000 (or, if you do not certify to the Trustees that you are either unmarried or will file a joint federal tax return, $2,500). If your spouse is a full-time student at an educational institution or is physically or mentally incapable of caring for himself/herself, your spouse will be deemed to have earned income of not less than $200.00 per month if you have one (1) dependent and $400.00 per month if you have two (2) or more dependents.

For purposes of the Dependent Care Benefit, a "Dependent" means: (a) a dependent who is under the age of 13 and with respect to whom you are entitled to a deduction under Section 151(c) of the Internal Revenue Code, or (b) a dependent or spouse who is physically or mentally incapable of caring for himself or herself, for whom you provide more than one-half of their support for their year, who resides with you 8 or more hours per day, and with respect to whom you are entitled to a deduction under Section 151(c) of the Internal Revenue Code, In determining whether an individual is a dependent, the special rules of Code Section 21(e)(5) will be taken into account where applicable.

Under a special rule for children of divorced or separated parents, a child is a Dependent with respect to the custodial parent when the noncustodial parent is entitled to claim the dependency exemption for the child.

Eligible Dependent Care Expenses

Your child care expenses can be for a sitter or housekeeper in your home, a family day care home, or a day care center. You can include the full amount you pay to a nursery school, even though part of it is for lunch and education expenses. Only the portion of the cost of summer camp that is attributable to day care can be included, and camp deposits made in the winter or spring cannot be reimbursed until the full bill is due. Summer school and tutoring program expenses don't qualify because they are considered to be primarily for education rather than for care.

If you use a child care center providing care for more than six children, it must comply with applicable state and local licensing regulations.

To use your Dependent Care Benefit for expenses for a disabled or elderly person, that person must be physically or mentally unable to care for himself/herself. The person must be your dependent for tax purposes, and you must provide more than half of his/her living expenses. He/she must reside in your home at least eight hours a day.

You cannot claim payments to a relative for dependent care unless (a) the relative is not your dependent for the tax year, and (b) the relative is providing child care as an employee of another organization, or as a self-employed person in his/her own home, or as your employee for whom you are withholding Social Security taxes.

NO DEATH BENEFIT

There is no Death Benefit under your Welfare Account. In the event you pass away while there is still a balance in your account, your account will be forfeited.

VIII. COORDINATION OF BENEFITS

If you or your spouse work for a contributing or non-contributing employer, and you are covered under that employer's health and welfare plan or medical and health insurance plan, benefits will be provided in accordance with the coordination of benefits rules set forth in the group insurance contract or policy. In most cases, if you or any of your Dependents are covered by any other plan providing the same benefits as provided under the self-insured portion of this Plan, this Plan will become secondary. In addition, this Plan will not provide benefits for any illness or injury occurring on the job and covered by a State Workers' Compensation Law or occurring as a result of a vehicular accident and covered by a No-Fault Insurance program.

IX. COBRA CONTINUATION COVERAGE

If your coverage, or the coverage of your Covered Dependent(s), is terminated due to one of the reasons set forth below, you, or your Covered Dependent(s), will have the right to continue coverage on a self-payment basis. A child who is born and placed for adoption during continuation of coverage is also eligible. The individual electing to continue coverage must pay the full cost of the coverage.

If you lose your coverage for failing to satisfy the eligibility requirements, you may continue coverage on a self-payment basis for up to 18 months. This period is extended to 29 months if you become disabled, pursuant to a determination under the Social Security Act, within 60 days after the date you lose coverage for failing to meet the eligibility requirements. You must provide the Fund Administrator notice of the disability within 60 days of the determination by the Social Security Administration and before the end of the 18-month COBRA coverage period. You must also notify the Fund Administrator of a determination by the Social Security Administration that you are no longer disabled within 30 days of such determination.

Your Covered Dependent(s) may continue coverage on a self-payment basis for up to 36 months if they lose coverage for any of the following reasons:

- Your death;
- Divorce or legal separation;
- Loss of eligibility due to age, marriage or change in student status; or
- Loss of eligibility due to your becoming covered by Medicare as a result of total disability or choosing Medicare in place of this Plan at age 65.

If you or your Covered Dependent(s) experience multiple qualifying events, coverage may be continued but for no more than 36 months. The Trustees may provide your surviving Spouse with coverage on a self-payment basis beyond the 36 months if coverage was lost due to your death or your disability, if the insurance company or HMO then underwriting coverage so permits. If you become covered by Medicare, but no loss of coverage results for you or a Covered Dependent, and you then lose coverage for one of the reasons set forth above, the duration of coverage for all dependents other than you must be at least 36 months from the date on which you became covered by Medicare.

You have 60 days from the date you lose coverage, or if later, 60 days from the date the Fund Administrator mails or otherwise provides you with a notification of rights, to elect coverage. However, each covered person is required to notify the Fund Administrator within 60 days of any event which will cause the loss of coverage of which the Administrator would not otherwise be aware, such as divorce, legal separation, or loss of Dependent status by a Dependent child. The covered person is also required to provide the Fund Administrator with all information needed to meet its obligation of providing notice and continuing coverage. If you do not provide the Fund Administrator with such notice, within such 60-day period, you or your Dependent spouse or child

will lose the right to continuation coverage under COBRA.

The cost of continuation coverage for each covered person is an amount equal to the monthly premium for coverage for Covered Employees plus an administrative fee, if applicable.

Payment of the initial monthly contribution is not required until the 45th day after the election. All subsequent payments for coverage are subject to a 30-day grace period.

Continuation coverage is not available or will terminate for any of the following reasons:

- The maximum covered continuation period has expired for the corresponding reason;
- The Plan is terminated;
- The covered individual fails to make the required contribution to continue coverage.
- The covered individual becomes covered by Medicare;
- With respect to coverage, in excess of 18 months by reason of disability, the covered individual is no longer eligible for Social Security disability benefits. In this case, the coverage will end on the first of the month that begins after a final determination that he is no longer eligible.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. Enrolling in Medicaid is another option. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

X. CLAIM PROCEDURES

CLAIM PROCEDURE UNDER THE INSURANCE BENEFIT

Each insurance company underwriting a coverage under the Insurance Benefit has its own procedures for claim handling. This procedure is described in the certificate that is distributed to you by that insurance company. If you are not satisfied with the handling of any claim provided by an insurance carrier, there is also a claim appeal procedure outlined in the certificate which you should follow.
If you need help with regard either a claim procedure, or an appeal of a denied claim, please contact the Plan Administrator.

CLAIM PROCEDURE UNDER OTHER BENEFITS

In the event you want to make a claim under the other benefits (or your beneficiary wants to make a claim under the Death Benefit), a claim form can be secured from the Plan Administrator by phone, letter, or in person. The address of the Plan Office is:

Roofers Local 241 Insurance Fund
890 Third Avenue
Albany, NY 12206

All claims shall be made to the Plan Administrator in writing and shall set forth the basis of the claim and shall authorize the Plan Administrator to conduct such examinations as may be necessary to facilitate the payment of any benefit to which you may be entitled under the terms of the Plan.

You are encouraged to submit your claims to the Office as soon as possible to avoid failing to meet the deadline for submitting claims. Claims must be submitted within two (2) years from the date of service).

In the event a claim is denied (or partially denied), you may appeal to the Trustees for reconsideration of the claim. In order to do so, you must **write** to the Trustees (at the Plan Office) within 60 days of the denial asking for a review of the claim. You may also request a hearing (or you may just present your views in writing). After the Trustees have reviewed the claim (and held a hearing if you desire one) they will tell you of their decision.

MAILING ADDRESS OF CLAIMANT

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

COOPERATION

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

CLAIM REVIEW AND APPEAL PROCEDURES

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

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

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

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

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

INITIAL DECISIONS – TIMES FRAMES

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

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

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

Urgent Care Claims. The rules are slightly different for Pre-Service Claims involving urgent care. Such claims are called Urgent Care Claims. An urgent care claim is a Pre-Service Claim for treatment in which application of the time periods for making non-urgent care determinations

could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. For Urgent Care Claims, you will be notified either by the insurance company, for any insured benefits (otherwise by the Plan) regarding the benefit determination (whether adverse or not) as soon as possible, and not later than 72 hours after receipt, unless you fail to provide sufficient information to decide the claim. In the case of a failure to provide sufficient information or to follow filing procedures, you will be notified of the failure as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information needed to complete the claim. Notification of the decision on that claim will then be provided within 48 hours after the earlier of the receipt of the specified information or the end of the additional period afforded you to provide such information. Notification can be made orally, provided a written or electronic communication is provided within 3 days of the oral notification.

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

Non-Medical Welfare Benefits. The Plan Administrator will notify you of the determination of your claim within 90 days after receipt, unless your claim is for a disability benefit, in which case the Fund Administrator will notify you of the determination within 45 days after receipt. This period may be extended for an additional 30 days if you are notified prior to the initial 90- or 45-day period, and the notice explains the circumstances for the extension.

CONTENT OF NOTIFICATION OF INITIAL ADVERSE BENEFIT DETERMINATION

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

1. The specific reasons for the adverse determination;
2. Reference to the specific Plan provisions (including any internal rules, guidelines, protocols, criteria, etc.) on which the determination is based;
3. A description of any additional material or information necessary for you to complete the claim and an explanation of why such material or information is necessary;
4. A description of the Plan's review procedures and the time limits, applicable to such procedures, including a statement of your right to bring a civil action under § 502(a) of ERISA following an adverse benefit determination on review;
5. In the case of an adverse determination involving the claim for urgent care, a description of the expedited review process applicable to such claims;

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

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

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

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

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

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

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

In addition, in regard to all medical and disability claim appeals: (1) the review will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate

named fiduciary of the Plan who is neither the individual who made the adverse benefit determination nor the subordinate of such individual; (2) insofar as the adverse benefit determination is based on medical judgment, the Board will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment; (3) such health care professional shall not be the individual, if any, who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; and (4) medical or vocational experts whose advice was obtained on behalf of the Plan, without regard to whether the advice was relied upon in making the adverse benefit determination, will be identified.

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

DETERMINATIONS ON APPEAL

Time Frames

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

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

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

CONTENT OF ADVERSE BENEFIT DETERMINATION ON REVIEW

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

1. The specific reasons for the adverse benefit determination;

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

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

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

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

6. If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, the written notice shall contain an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided upon request.

THE TRUSTEES' DECISION IS FINAL AND BINDING

The Trustees' final decision with respect to their review of any appeal will be final and binding upon you because the Trustees have exclusive authority and discretion to determine all questions of eligibility and entitlement under the Plan. You and the Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

JUDICIAL REVIEW

You (or an appointed representative) must timely pursue all the claim and appeal rights described above before you may file a lawsuit under Section 502(a) of ERISA. This rule means that you may not bring any action to recover benefits under the terms of the Plan, to enforce your rights under the terms of the Plan, or to clarify your right to future benefits under the terms of the Plan unless and until the applicable claim and appeal rights described above have been exercised and the benefits (current or future) or rights requested in such appeal have been denied in whole or in part (or there is any other adverse benefit determination). If you wish to seek judicial review of the denial of any appeal under the Plan, unless the documents governing a fully-insured plan provide for a different length of time, you must file a lawsuit under Section 502(a) of ERISA (to the extent applicable) within one year after the date on which all administrative remedies under the Plans are exhausted, that is by the earlier of the date on which

an adverse benefit determination on review is issued by the appeals review, or you will be forever prohibited from commencing such action.

NO LIABILITY FOR PRACTICE OF MEDICINE

The Plan, the Trustees, or any of their designees are not engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care, or lack thereof, or any health care services provided or delivered to you by any health care provider. Neither the Plan, the Trustees, nor any of their designees will have any liability whatsoever for any loss or injury caused to you by any health care provider by reason of negligence, by failure to provide care or treatment, or otherwise.

XI. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY

A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), gives you certain rights with respect to your health information, and requires that employee welfare plans, like the Fund, that provide health benefits, protect the privacy of your personal health information. A description of your rights under HIPAA will be found in the Plan's Notice of Privacy Practices, which has already been provided to you. (This statement is not intended to be, and cannot be, considered the Plan's Notice of Privacy Practices. If you wish to review the Plan's Notice of Privacy Practices but cannot find your copy, please contact the Fund Office.)

HIPAA PRIVACY AND SECURITY

The provisions below related to HIPAA Privacy and Security shall apply to the Plan. For purposes of this section entitled "HIPAA Privacy and Security," the following terms have the following meanings:

- "Business Associate" means a person or entity that performs a function or activity regulated by HIPAA on behalf of the Plan provided under the Plan and involving individually identifiable health information. Examples of such functions or activities are claims processing, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation and financial services. A subcontractor of a Business Associate may be treated as a Business Associate. A Business Associate may be a Covered Entity. However, insurers and health maintenance organizations are not Business Associates of the plans they insure.

- "Covered Entity" means a group health plan (including an employer plan, multiemployer plan, insurer, HMO and government coverage such as Medicare); a health care provider (such as a doctor, hospital or pharmacy) that electronically transmits any health information in connection with a transaction for which the U.S. Department of Health and Human Services has established an electronic data interchange standard; and a health care clearinghouse (an entity that translates electronic information between nonstandard and HIPAA standard transactions).

- "Protected Health Information" or "PHI" means individually identifiable health information

created or received by a Covered Entity. Information is "individually identifiable" if it names the individual person or there is a reasonable basis to believe components of the information could be used to identify the individual. "Health Information" means information, whether oral or recorded in any form or medium, that (i) is created by a health care provider, health care plan, employer, life insurer, public health authority, health care clearinghouse, or school or university; and (ii) relates to the past, present, or future physical or mental health or condition of a person, the provision of health care to a person; or the past, present or future payment for health care.

- "Electronic Protected Health Information" or "ePHI" is protected health information that is transmitted or maintained in electronic media including, but not limited to, hard drives, disk, on the internet, or on an intranet.

USES AND DISCLOSURES OF PHI

The Plan may disclose a covered employee's PHI or ePHI to the Board of Trustees (or its designee) for the plan administration functions, to the extent not inconsistent with the HIPAA regulations. The Plan will not disclose PHI or ePHI to the Board of Trustees except upon receipt of a certification by the Board of Trustees that the Plan incorporates the agreements of the section of this document entitled "Privacy Agreements with the Board of Trustees", except as otherwise permitted or required by law.

PRIVACY AGREEMENTS WITH THE BOARD OF TRUSTEES.

As a condition for obtaining PHI from the Plan and its Business Associates, the Board of Trustees agrees it will:

- To the extent not inconsistent with the Privacy Rule, the Board of Trustees will use and disclose protected health information only for purposes related to Plan Administration;

- Not use or further disclose such PHI other than as permitted by the Fund's plan documents or as required by law;

- Ensure that any of its agents, including a subcontractor, to whom it provides the PHI agree to substantially the same restrictions and conditions that apply to the Board of Trustees with respect to such information;

- Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Board of Trustees; 43

- Report to the Plan's Privacy Officer any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for in the Plan of which the Board of Trustees becomes aware;

- Make the PHI of a particular Participant available based on HIPAA's access requirements in accordance with 45 C.F.R. § 164.524;

- The Board of Trustees will make available PHI for amendment and incorporate any

amendments to PHI in accordance with 45 C.F.R. § 164.526;

- The Board of Trustees will make available PHI required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528;

- Make the Board of Trustees' internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;

- If feasible, return or destroy all PHI received from the Plan that the Board of Trustees still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Board of Trustees agrees to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

- Ensure that there is adequate separation between the Plan and the Board of Trustees as required by 45 C.F.R. § 164.504(f)(2)(iii).

EMPLOYEES WITH ACCESS TO PHI

The following categories of employees under the control of the Board of Trustees are the only employees who may obtain protected health information in the course of performing the duties of their job:

- Fund Administrator
- Administrative Assistants

MECHANISM FOR RESOLVING NONCOMPLIANCE

The employees listed above will be subject to disciplinary action and sanctions for any use or disclosure of protected health information that violates the rules set forth in this summary. If the Board of Trustees becomes aware of any such violations, the Board of Trustees will promptly report the violation to the Plan and will cooperate with the Plan to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects to the Participants whose privacy has been violated.

SECURITY AGREEMENTS OF THE BOARD OF TRUSTEES.

As a condition of obtaining or maintaining e-PHI from the Plan, its Business Associates, insurers or HMOs, the Board of Trustees agrees it will:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan;

• Ensure that the adequate separation between the Plan and the Board of Trustees is supported by reasonable and appropriate security measures;

• Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information;

• Report to the appropriate party any security incident of which it becomes aware. For purposes of the Plan, security incident shall mean successful unauthorized access, use, disclosure, modification or destruction of, or interference with, the e-PHI; and

• Upon request from the Plan, the Board of Trustees agrees to provide information to the Plan on unsuccessful or attempted unauthorized access, use, disclosure, modification or destruction of the e-PHI to the extent such information is available to the Board of Trustees

XII. FAMILY AND MEDICAL LEAVE ACT (FMLA)

If you are eligible for, and are granted leave by your Employer under the Family and Medical Leave Act of 1993, (the "FMLA") and/or the New York Paid Family Leave Law (the "PFLL") you will be entitled to health and hospitalization insurance coverage under the Plan throughout the duration of your leave, but your Employer must pay the premium established by the Plan for your type of coverage (i.e. single, two-person, or family). You will receive the type of coverage you were receiving prior to the leave, subject to any change you may have in family status.

If you fail to return to work after a period of unpaid FMLA leave entitlement has been exhausted or expires, your Health Care Account will be reduced by the costs to maintain health and hospitalization insurance coverage for the term of the unpaid leave, unless the reason you did not return is due to:

- a continuation, recurrence, or onset of a serious health condition, which entitles you to leave under the FMLA; or
- other circumstances beyond your control as defined in the FMLA and the regulations thereunder.

Questions regarding your entitlement to FMLA or PFLL leave should be referred to your Employer.

Questions about the continuation of medical and dental coverage during leave, if available, should be referred to the Fund Office.

If coverage is terminated for failure to make payments while you are on an approved family or medical leave of absence, coverage for you and your eligible dependents will be automatically reinstated on the date you return to employment if you and your dependents are otherwise eligible under the plan. However, all accumulated annual and lifetime maximums will apply.

If you do not return to work at the end of an FMLA of PFLL leave, you may be entitled to elect COBRA Continuation Coverage, even if you were not covered under the Plan during the leave. Coverage continued under this provision is in addition to coverage described below under the section entitled "Continuation Coverage (COBRA).

XIII. UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

PURPOSE

Congress enacted the Uniformed Services Employment and Reemployment Rights Act (USERRA) on December 12, 1994. The purpose of USERRA is to encourage non-career service in the Uniformed Services, to provide for the prompt reemployment of persons who serve in the uniformed services and to prohibit discrimination against such persons.

DEFINITIONS

The terms listed below have special meanings relevant to this section.

(i)Service in the Uniformed Services. The phrase "Services in the Uniformed Services" will mean the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

(ii)Uniformed Services. The term "Uniformed Services" will mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

HEALTH CARE COVERAGE

In the event that you are absent from work due to Service in the Uniformed Services you will be entitled to continue your health care coverage for you, your spouse and your eligible Dependent's for the lesser of –

- 18 months beginning on the day your absence of employment begins;
- the day after you fail to notify your Employer of your intent to return to work; or
- the day after you fail to return to a position of employment.

PREMIUMS

If you choose to continue coverage for the length of your Service in the Uniformed Services you will be required to pay 102% of the full premium under the Plan. You will not be required to pay such premium if your length of service is less than 31 days. For detailed information on premium amounts and application for such coverage, please contact the Fund Administrator.

NOTIFICATION OF INTENT TO RETURN TO WORK

It is important that you notify your employer of your intent to return to work within specified time periods. The time periods and notification requirements are specified below:

LENGTH OF SERVICE	**NOTIFICATION REQUIREMENTS**
30 days or less	Notification must occur no later than the beginning of your first full, regularly scheduled workday. Under special circumstances this time period may be extended to as soon as possible after the expiration of eight (8) hours of your first full, regularly scheduled workday.
31 days – 180 days	Notification must occur no later than 14 days after the completion of your length of service. Under special circumstances this time may be extended.
181 days or more	Notification must occur no more than 90 days after the completion of your length of service.

XIV. YOUR RIGHTS UNDER THE PLAN

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

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

A. Receive Information About Your Plan and Benefits

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

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

B. 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 the summary annual report.

C. Continue Group Health Plan Coverage

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

D. Reduction or elimination of exclusionary periods of coverage

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

E. Prudent Actions by Plan Fiduciaries

In addition to creating rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

F. Enforce Your Rights

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

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

it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

G. Assistance with Your Questions

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

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

BENEFITS FOR MOTHERS AND NEWBORNS

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the Plan. You should refer to the benefit booklet provided by the insurer for more information.

XV. MISCELLANEOUS PROVISIONS

PLAN INTERPRETATIONS AND DETERMINATIONS

Notwithstanding any other provisions of this document, the Board of Trustees shall have exclusive authority and discretion to:

(a) Determine whether an individual is eligible for any benefit under this Plan;
(b) Determine the amount of benefits, if any, an individual is entitled to from this Plan;
(c) Determine or find facts that are relevant to any claim for benefits from this Plan;
(d) Interpret all of this Plan's provisions;
(e) Interpret all the provisions of the Summary Plan Description booklet;
(f) Interpret the provisions of any collective bargaining agreement or written participation agreement involving or impacting the Plan;
(g) Interpret the provisions of the Trust Agreement governing the operation of this Plan;
(h) Interpret all the provisions of any other document or instrument involving or impacting this Plan; and
(i) Interpret all the terms used in this Plan, the Summary Plan Description Booklet, and all of the other previously mentioned Agreements, documents, and instruments.

All such determinations and interpretations made by the Trustees and the Fund Administrator shall be final and binding upon any individual claiming benefits under the Plan, upon all Employees, all Employers, the Union and any party who has executed an Agreement with the Trustees or the Unions; shall be given deference in all courts of law, to the greatest extent allowable by applicable law, shall not be overturned or set aside by any court of law unless the court finds that the Trustees, or the designee, abused their discretion in making such determination or rendering such interpretation.

RIGHT TO RECLAIM OVERPAYMENT OR TO OFFSET

If this plan has overpaid benefits, then it may reclaim the overpayment from you and/or your Dependent(s), or any relevant person, company, or organization. You and your Dependent(s) must sign any document which the Trustees determine is needed to help them reclaim the over-payment. Additionally, if the payment is made to you or your Dependent (or on your behalf) in error, you or your Dependent must repay the amount of the erroneous payment to this Plan. If the Plan owes you or your Dependent a payment for other claims incurred, then it has the right to subtract the amount you or your Dependent owe them from any payment they owe you or your Dependent.

THIRD PARTY LIABILITY CASES

NOTE: This provision applies to you and your Covered Dependents, with respect to all of the Benefits provided under this Plan. For the purpose of this provision, the term "Claimant" refers to all Employees, Participants, and Covered Dependents.

General. Occasionally, a third party may be liable for a Claimant's medical expenses. This may occur when a third party is responsible for causing a Claimant's illness or injury or is otherwise responsible for the medical bills. The rules in this Section govern how this Plan pays Benefits in such situations.

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

Second, the rules protect this Plan from paying the full expenses in situations where a third party is liable. Under these rules, once it is determined that a third party is liable in any way for the injuries giving rise to these expenses, this Plan must be reimbursed for the relevant Benefits advanced to the Claimant out of any recovery whatsoever that he receives that is in any way related to the event which caused him to incur the medical expenses.

Reimbursement to the Plan shall take place regardless of how the recovery is characterized, including, but not limited to, pain and suffering. You and/or your attorney must keep the Plan Administrator apprised in writing of the status of the third-party action. Additionally, you and/or your attorney agree that, prior to any settlement of the third-party matter, the Plan must consent to the terms and conditions of the settlement. Your attorney must agree that no attorneys' fees, expenses or costs of any kind will reduce the Fund's lien in this matter.

Rights of Subrogation and Reimbursement. By law, the Plan automatically acquires any and all rights which the claimant may have against the third party. If the claimant incurs covered expenses for which a third party may be liable, he is required to advise the Plan of that fact.

In addition to its subrogation rights, the Plan has the right to be reimbursed for payments made on the Claimant's behalf under these circumstances. The Plan must be reimbursed from any settlement, judgment, or any other payment that he obtains from the liable third party, before any other expenses, including attorneys' fees, are taken out of the payment.

No Plan Benefits will be advanced unless the Claimant (or his authorized representative if he is a minor or if he can not sign), and his attorney (if any) sign a lien form. If litigation is commenced, the Claimant must give five (5) days' prior notice to the Plan of any pre-trial conference, and the Plan has the right to attend any such conference. The Claimant must also notify the Plan before be retains another attorney or an additional attorney since that attorney must also execute the form. IN NO EVENT SHALL THE FAILURE OF THE TRUSTEES TO REQUIRE EXECUTION OF THE LIEN FORM DIMINISH OR BE CONSIDERED A WAIVER OF THE PLAN'S RIGHTS OF SUBROGATION AND REIMBURSEMENT.

If any disability benefits are paid by the Plan, Section 227 of the New York Workers' Compensation Law requires that the Claimant give notice to the Plan within ninety (90) days of the commencement of any action against the liable third party. The Claimant is also required to obtain the written consent of the Plan prior to the compromise of any cause of action.

Right of Future Subrogation and Reimbursement. In addition to satisfaction of the existing lien from any recovery received by the participant, spouse and/or dependent, the Fund is also entitled to future credit for future related Plan expenses equal to the monies received by the participant, spouse, and/or dependent. As such, the participant, spouse and/or dependent must spend the net recovery on related plan expense until the amount of said net recovery is exhausted. It is only at that point that the participant's, spouse's and/or dependent's claim for the related Plan Benefits will again be the responsibility of the Fund pursuant to the terms of the Plan. The Plan Office will determine the net monies available for future credit.

Under certain circumstances, the Trustees may decide that you should assign your entire claim against the third party to the Fund. If the Plan recovers from the third party any amount in excess of the benefits paid to you plus the expenses incurred in making the recovery, the excess will be paid to you.

If you have any questions, please contact the Plan Administrator.

ADMINISTRATIVE ADJUSTMENT

Subtraction of Adjustment. On the first day of each month there shall be subtracted from the account of each participant an Administrative Adjustment.

Amount. The amount of such Administrative Adjustment shall be determined by the Trustees and may be changed from time to time.

Priority. Such Administrative Adjustment shall be subtracted from the participant's account on such day before any benefit distributions are made on that day.

Additional Adjustment. Any participant who has not worked in Covered Employment that calls for contributions to the Roofers Local 241 Insurance Fund for a period of 12 months or more and has not claimed the balance in their account will be assessed a $50.00 administrative fee.

The fee will be deducted each year at July 1 until the account has been depleted or the balance has been claimed.

BENEFIT PAYMENT

Gross Distribution and Net Distributions. The amounts of benefit distribution determined in this Plan are gross figures. Any withholding, payroll taxes, FICA Contributions, or any other taxes or payments required by law shall be deducted from the gross distribution calculated before such distribution is indeed made. The actual payments shall be net.

Employer Payroll Tax. Subject to pertinent laws, employers shall not be assessed, by the Fund, for any payroll taxes normally payable by any employer, resulting from benefit payments hereunder.

Indirect Payment of Benefits. If any participant is, in the judgment of the Trustees, legally, physical, or mentally incapable of personally receiving and receipting for any payment due hereunder, payment may be made to the guardian, or other legal representative of such participant, or his beneficiary, or, if none, to such other person, or institution, who, in the opinion of the Trustees is then maintaining or has custody of such participant. Such payment shall constitute a full discharge of the Trustees with respect thereto.

Assignment and Levy. No benefit under this Plan shall be subject in any manner to anticipation, alienation, sale transfer, assignment, pledge, encumbrance, levy or charge and any attempt so to anticipate, alienate, sell, transfer, assign, pledge, encumber, levy upon or charge the same shall be void; nor shall any such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagement or torts of the persons entitled to such benefit.

Alternate Application. If any participant or beneficiary under this Plan becomes bankrupt or attempts to anticipate, alienate, sell, transfer, assign, pledge, encumber or charge any benefit under this Plan, contrary to the terms hereof, or if any benefit is levied upon, garnished or attached, then such benefit shall, in the discretion of the trustees, cease and in that event the Trustees may hold or apply the same or in any part thereof to or for the benefit of such participant or beneficiary, his spouse, children, or other dependents, or any of them in such manner and in such proration as the Trustees may deem proper.

Inactive Accounts. If, during a period of five consecutive years, no Employer contributions are received by the Fund for a Participant and no Benefit distributions are made on his behalf hereunder, any balance he may have hereunder shall be forfeited and used for defraying administration costs of the Plan and/or Fund.

MISCELLANEOUS

Separability. The Articles and Sections of this Plan shall be deemed separable so that the invalidity of any portion hereof shall not affect the validity of the remainder.

Recovery of Certain Payments. The Trustees shall have the right to recover any benefit payments made in reliance on any false or fraudulent statement, information, or proof submitted, as well as any benefit payments made in error.

Binding Force. This Plan and acts and decisions made by the Trustees hereunder shall be binding upon the heirs, executors and administrator of any employee or any person claiming any benefit hereunder.

Number and Gender. Wherever appropriate, words used in this Plan in the singular may mean the plural, the singular, the masculine the feminine, and the feminine the masculine.

Legal Jurisdiction. Except to the extent preempted by federal law, the Plan shall be construed, administered and enforced in accordance with the laws of the State of New York.

XVI. AMENDMENT AND TERMINATION

Amendment. The Trustees reserve the right to amend any and all of the provisions of this Plan, or reduce or eliminate any benefit provided hereunder, without the consent of any participant.

In the event that any revision in this Plan is necessary to obtain or retain the approval by the Internal Revenue Service of the Fund as qualified for tax-exemption under applicable provisions of the Internal Revenue Code as now in effect or hereafter amended, the Trustees shall make such changes as are necessary to receive or retain such approval, adhering as closely as possible to the intent of the parties hereto, as expressed in this Plan and the Agreement and Declaration of Trust.

Termination. The Trustees have established this Plan with the intent that it will be maintained for an indefinite period of time, but with the knowledge that funding for the Plan is conditioned on Employer contributions under a Collective Bargaining Agreement with the Union. Therefore, the Trustees reserve the right to terminate the Plan, in whole or part, at any time, in accordance with the Trust Agreement.

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

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

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

Benefits provided by the Plan:

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