

**ROOFERS LOCAL UNION NO. 210
JOINT HEALTH & WELFARE PROGRAM**

Summary Plan Description

Effective: January 1, 2024

**ROOFERS LOCAL UNION NO. 210
JOINT HEALTH & WELFARE PROGRAM
PLAN OF BENEFITS
SUMMARY PLAN DESCRIPTION**

Introduction

Read this Summary Plan Description carefully so that you understand the provisions of our Plan and the benefits you will receive. We want you to be fully informed before you enroll in the Plan and while you are a Participant. You should direct any questions you have to the Plan Administrator. If there is a conflict between an insurance contract and this Summary Plan Description, the insurance contract will control.

**I
GENERAL INFORMATION ABOUT OUR PLAN**

This section contains certain general information which you may need to know about the Plan.

A. General Fund Information

Roofers Local Union No. 210 Joint Health & Welfare Program is the name of the Plan.

The Trustees have assigned number 501 to the Plan.

Your Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year is the twelve-month period beginning each January 1 and ending on the following December 31.

B. Plan Sponsor

The Plan is sponsored by the Board of Trustees of the **Roofers Local Union No. 210 Joint Health & Welfare Program Fund** (the "Health Fund").

The Employer Identification Number of the Plan Sponsor is: 25-6390935

The following individuals comprise the Board of Trustees:

Employer Trustees

Patrick McCreary
Tim Dominick
Sean Fennick

Union Trustees

Scott Johnson
Bryan Moody
Michael Morrison

The following individuals are Alternates:

Ryan McCreary
Dan Dominick

C. Plan Administrator Information

The name and address of the Plan Administrator is:

Board of Trustees
Roofers Joint Health & Welfare Program Fund
7454 Edinboro Rd
Erie, Pennsylvania 16509

The Administrator keeps the records for the fund and is responsible for the administration of funds. The 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.

D. Service of Legal Process

The name and address of the Funds' agent for Service of Legal Process are;

Board of Trustees
Roofers Joint Health & Welfare Program Fund
7454 Edinboro Rd
Erie, Pennsylvania 16509

E. 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 14202-3924

F. Fund Accountant

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

Felix & Gloekler, P.C.

2306 Peninsula Drive

Erie, PA 16506

**II
DEFINITIONS**

Certain terms used in this Summary Plan Description have special meanings. These terms will be capitalized and will have the meaning set forth below.

A. Employer

The term "Employer" means any employer who is obligated by a Collective Bargaining Agreement with **United Union of Roofers, Waterproofers and Allied Workers Local Union No. 210** to make contributions to the **Roofers Joint Health & Welfare Program Fund**. The term Employer also includes the Union provided it makes contributions for its employees at the same rate as all other Employers under the Collective Bargaining Agreement.

B. Union

The term "Union" means **United Union of Roofers, Waterproofers and Allied Workers Local Union No. 210**.

C. Employee

The term "Employee" means any individual who is employed in the roofing industry by an Employer, and who is covered by a collective bargaining agreement requiring contributions to the Health Fund.

The term "Employee" also includes any individual employed by the Union provided it makes contributions at the same rate as other Employers under the Collective Bargaining Agreement.

D. Participant

The term "Participant" means any Employee or former Employee who is eligible to receive a benefit of any type from the Health Fund.

E. Collective Bargaining Agreement

The term "Collective Bargaining Agreement" means an agreement between the Union and any Employer providing for the payment of periodic contributions to the Health Fund.

F. Covered Employee

The term “Covered Employee” means any Employee who has completed the necessary application for benefits and is insured under the provisions of this Plan.

G. Covered Employment

The term “Covered Employment” means any employment for which the Employer is obligated by a Collective Bargaining Agreement to make contributions to the Health Fund and shall include the first 500 hours for which no contributions are due.

H. Dependent

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

- (1) The Covered Employee’s spouse; and
- (2) The Covered Employee’s unmarried dependent child as specified pursuant to the applicable insurance policy or policies or health maintenance organization chosen by the Fund to provide your benefits.

I. Fund Administrator

The “Fund Administrator” is the person designated by the Trustees to serve as such.

J. Plan

The “Plan” is this written plan of benefits adopted by the Trustees setting forth the eligibility rules for the health and welfare benefits to be paid from the Fund.

K. Plan Year

The Plan Year shall be the 12-month period beginning January 1 and ending December 31.

L. Retired Employee

A “Retired Employee” is any employee who has retired from the roofing industry and is receiving a pension or disability retirement benefit from the **National Roofing Industry Pension Fund**.

M. Trust Agreement

The “Trust Agreement” is the Agreement and Declaration of Trust, **Roofers Joint Health & Welfare Program Fund**, together with any amendments made thereto.

N. Trustees

The “Trustees” are those persons named to serve as such in accordance with the provisions of the Trust Agreement.

O. Fund

The “Fund” is the **Roofers Joint Health & Welfare Program Fund**.

III ELIGIBILITY FOR BENEFITS

A. Initial Eligibility

You will become eligible for coverage under the Plan upon your completion of 500 hours of Covered Employment. Once you are eligible, your coverage will begin on the first day of the month following the month of receipt of 120 hours of contributions on your behalf or 400 hours of contributions in total, provided you have completed and submitted the necessary application.

If you do not complete and submit the necessary application, you will not be entitled to health and hospitalization coverage and you will not receive credit for any hours of Covered Employment worked in the prior month.

If you are eligible for health coverage through the Plan, you may waive that coverage only if you provide proof of health insurance coverage under a spouse’s or parent’s plan. If you are enrolled in your spouse’s or parent’s plan, that 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). You must present your enrollment card in your spouse’s or parent’s 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.

Please note that health insurance coverage under Tricare, Indian Health Services, Medicare, or Medicaid is not considered group health insurance.

If you waive health and hospitalization coverage from the Plan, or if you fail to maintain your eligibility for health and hospitalization coverage from the Plan, you may not again enroll until the next January 1st open enrollment date, unless you are entitled to an earlier special enrollment

date as described under paragraph D, Special Enrollment Rights, below. In order to re-enroll, you must request enrollment 30 days prior to the January 1 open enrollment, pay the required contribution and be eligible for work in Covered Employment.

B. Continuing Eligibility

Once you have become a Covered Employee you will remain eligible for coverage for the basic plan for each month following a month you are credited with 120 hours or more in Covered Employment. If you have 400 or more hours banked, you may draw on those hours to maintain coverage. Or you may pay the required contribution as set forth in paragraph C, below. The required contribution is based on your marital status, choice of plan, and hours worked in the month. You should contact the Plan Administrator for the current required contribution.

The monthly hour requirement for eligibility for health care coverage is subject to change based on the cost of coverage and the contractor contribution rate under the collective bargaining agreement.

Payment of the required contribution is due by the last business day of the month prior to the month of coverage.

C. Layoff; Leave of Absence

If you have qualified for coverage under the Plan, but lose your eligibility due to layoff, you may continue to receive coverage under the Plan provided you are available for work in the industry and pay the required contribution. Your right to maintain coverage by paying the required premium will run concurrently with the COBRA periods set forth under Paragraph G of this Article III. You may continue to self-pay the required premium and maintain your coverage beyond the COBRA period, so long as you remain available for work in the industry.

In order to establish this availability, you must register on the available for work list maintained by the Union. The Fund Office may periodically ask you to confirm in writing that you are ready, willing, and available for work.

If you leave the jurisdictional area of the Union, but are employed under the terms of a collective bargaining agreement of another local union, and contributions are being reciprocated to the Plan, your coverage will continue provided you have accumulated the necessary hours of Covered Employment.

If you take a leave of absence under the Family and Medical Leave Act of 1993, you will be credited with hours of Covered Employment equal to the number of hours for which your employer would have been obligated by a collective bargaining agreement to make contributions to the Fund had you remained in Covered Employment.

D. Retired Employees

If you are a Retired Employee, you will be eligible for coverage and benefits under the Plan if at the time you retired you were covered by this plan, and in addition you are receiving a retirement benefit from the National Roofing Industry Pension Fund.

Your Health Care Account will be charged by the amount established by the Trustees to maintain coverage, and when your Health Care Account has been exhausted, you must pay the required amount directly to the Fund. Your right to maintain coverage by paying the required premium will run concurrently with the COBRA periods set forth under Paragraph G of this Article III.

You may continue retiree coverage under the Plan until age 65.

E. Special Enrollment Rights

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage For Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this Plan, you may be able to enroll yourself and your dependents in this Plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

F. Dependent Coverage

Your Dependents are eligible for coverage under the Plan during the period in which you are eligible for coverage under the Plan. At the end of this period, your Dependent spouse (and/or Dependent children, if otherwise eligible under the insurance policy or health maintenance organization) may be eligible to continue coverage under the provisions of the Consolidated Omnibus Budget Reconciliation Act (“COBRA”).

G. COBRA Rights

If your coverage, or the coverage of your Dependent, is terminated due to one of the reasons set forth below, you, or your Dependent, 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 Plan 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 Plan Administrator of a determination by the Social Security Administration that you are no longer disabled within 30 days of such determination.

Your Dependent spouse and/or child 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 you’re 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 Dependent spouse or child experience multiple qualifying events, coverage may be continued but for no more than 36 months. The Trustees may determine to 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 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 Plan Administrator mails or otherwise provides you with a notification of rights, to elect coverage. However, each covered person is required to notify the Plan 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 Plan Administrator with all information needed to meet its obligation of providing notice and continuing coverage. If you do not provide the Plan 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 contribution 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 under another group health plan without being subject to any exclusions or limitations with respect to a pre-existing condition;
- 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.

H. Surviving Spouse

If you die while you are an active Participant and you are covered under the Plan, your spouse and/or your dependent children will continue to be eligible for benefits under the Plan for a period of one year from the first of the month immediately following your death, as explained in Article III. At the expiration of the one-year period, your surviving spouse may elect to continue coverage under the Plan by self-paying a monthly amount equal to 102% of the monthly premium paid by the Plan for single person coverage. Your surviving spouse remains eligible to self-pay for coverage under the Plan indefinitely. However, the Plan reserves the right to terminate coverage if the surviving spouse fails to self-pay the required amount on a timely basis.

IV 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 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.

V BENEFITS

A. Hospital, Medical, Prescription, Surgical and Major Medical Benefits

You and your Dependents will be provided with hospitalization, medical, surgical and anesthetic benefits, prescription drug coverage, and major medical coverage under a self-insured arrangement administered by Highmark Insurance Company. The exact benefits are as set forth in the attached booklet and are incorporated by reference in this SPD.

These booklets will control as to those persons who will be eligible for coverage, the dates of their eligibility, the conditions which must be satisfied to become insured (if any), and the benefits and circumstances under which coverage terminates, if different from this Summary Plan Description.

Although Highmark pays claims under the plan on behalf of the Fund, Highmark does not insure or guarantee that claims will be paid. Rather, Highmark relies on the Fund and if necessary, your contributions, to provide it with money to pay the claims. Highmark cannot pay the claims if the Fund doesn't provide the money to Highmark.

B. Health Care Account and Medical Reimbursement Benefit

The Plan Administrator will maintain an individual account (a "Health Care Account") on your behalf equal to the dollar value of your hour bank and will include a record of contributions received on your behalf, benefits paid, and fees 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.

Once who have accumulated a Minimum Balance of \$3,000 in your Health Care Account you will be entitled to receive reimbursement for Qualified Medical Expenses. However, you will not be entitled to medical reimbursement benefits from your Health Care Account unless you are enrolled in health coverage through the Plan or through your spouse's or parent's employer. This

applies even after your retirement. In addition, your spouse and Dependents must be covered by qualifying employer group coverage, or you may not submit their medical expenses for reimbursement.

1. **Eligible Benefits**

Qualified Medical Expenses eligible to be reimbursed from the Health Care Account 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 Care Account 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 child is 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 both a legally adopted individual and an individual lawfully placed with you for legal adoption.

2. **Carryover of Health Care Account**

The unused balance in your Health Care Account will carry forward from Plan Year to Plan Year and may be used by your Dependents after your death. Any amount remaining upon the death of you and your Dependents will be forfeited.

If, during a period of five (5) consecutive Plan Years, no Employer contributions are received by the Fund on your behalf, and no benefit distributions are made on your behalf, any balance remaining in your Health Care Account shall be forfeited and used for defraying administration costs of the Fund.

If you have any balance in your Health Care Account, you are prohibited from receiving a premium assistance tax credit to purchase health insurance coverage through the new health insurance Marketplace. You may wish to forfeit the balance in your Health Care Account if the premium assistance tax credit is more valuable. You will have the option each year at open enrollment, and upon your retirement or termination of employment, to permanently opt out of the Healthcare Reimbursement Benefit. If you do so prior to retirement or termination of employment, the balance in your Health Care Account may only be used for the payment of group health insurance coverage under the Plan.

3. **Claims**

You must submit a claim for reimbursement to the Plan Administrator no later than thirty (30) days prior to the next quarterly Trustees meeting. Claims may only be submitted for medical expenses incurred after you have accumulated the Minimum Balance in your Health Care Account. You may submit your claim for reimbursement to the Plan Administrator 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 to the Plan Administrator as documentation of an unreimbursed medical expense. Second, for unreimbursed medical expenses not documented by an EOB, you may provide the Plan Administrator with a receipt of the medical expense which includes: name of the recipient of the service; date of the service; description of the service; cost of the service; and name, address, and tax I.D. number of the provider.

The Fund will process your claim and deduct funds from your account to reimburse you. Reimbursement checks will be issued in amounts no less than \$25. If your medical expenses do not total \$25, you should wait to submit a claim until your medical expenses reach at least \$25.

If a claim for reimbursement under this HRA is wholly or partially denied, claims shall be administered in accordance with the claims procedure set forth in Article VIII of this Summary Plan Description.

C. Disability Benefits

Once you have become eligible for benefits under the Plan, as set forth in Article III, above and you are working in, or available for work in Covered Employment, you are eligible and covered for disability benefits. Retired Employees are not eligible for a disability benefit. The disability benefit is provided under a group disability insurance policy selected by the Trustees. That policy will control and define the dates of eligibility, the conditions which must be satisfied to become insured (if any), and the circumstances under which insurance terminates.

The disability benefit is Four Hundred Dollars (\$400.00) per week for a maximum of fifty-two weeks.

To be eligible for disability benefits, you must:

(i) Be disabled from working in the roofing industry because of sickness and/or accident which is not intentionally self-inflicted; and

(ii) At the time of disability, be eligible for benefits under the Plan as set forth in Article III, above.

Your disability benefits will continue until the termination of the disability or the fifty-second week of benefits, whichever occurs first.

The Plan Administrator may require you to undergo a medical examination by a physician designated by the Plan Administrator in order to prove disability. The Plan Administrator may require that you provide certification from a doctor of your disability. If the

physician designated by the Plan Administrator disagrees with your physician as to disability, you will be examined by a third doctor mutually agreed upon by the Plan Administrator's physician and your physician. The opinion of this third physician will be binding on you and the Plan.

D. Group Life Insurance Benefit

Once you are eligible for benefits under the Plan, as set forth in Article III, above, and you are working in, or available for work in Covered Employment, you are eligible and covered for group life insurance coverage in the following amounts:

Active Employee- \$20,000

Spouse - \$5,000

Child under 18 - \$2,500

Retired Employees are not eligible for a group life insurance benefit.

This group life insurance benefit will be provided under a group life insurance policy selected by the Trustees. That policy will control and define the dates of eligibility, the conditions which must be satisfied to become insured (if any), and the circumstances under which insurance terminates.

If you become disabled while eligible for the group life insurance benefit under the Plan, you will remain eligible for the benefit for so long as your disability continues. Disability for this purpose will be an inability to perform your normal duties for a contributing employer. Continuing disability will be determined by the Plan Administrator based upon such proof as the Plan Administrator deems appropriate and may include an independent determination by a physician of the Plan Administrator's choice at the Participant's expense.

VI AMENDMENT OR TERMINATION OF PLAN

A. 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.

B. 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.

VII CLAIMS PROCEDURES

You must file claims for major medical and hospital benefits with Highmark. The attached booklet describes the procedure for filing those claims and the procedure for requesting a review of denied claims. Highmark will make the final decision on denied claims, although you may then seek an independent review under the procedure outlined in the booklet.

Please note that the following shall only apply with respect to medical reimbursement and disability benefits that are self-insured under the Plan. For the group life insurance benefit, the claims procedures provisions of the applicable insurance policy will govern.

A. Disability Claims

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

The Fund Administrator shall notify you within forty-five (45) days after receipt of a claim for disability benefits if the claim has been denied or modified. If the Fund Administrator determines that an extension of time is necessary for processing the claim (due to circumstances beyond the control of the Fund), the 45-day period will be extended for an additional 30 days, if additional time is still needed to make a determination, there may be an additional extension of 30 days. In such case the Fund Administrator must notify you (within the initial 45-day period or prior to the expiration of the first 30-day extension) of the circumstances requiring the extension, the date by which the Plan expects to render a determination, the standard, on which entitlement to benefits is based, the unresolved issues that prevent a decision on the claim and additional information needed to resolve those issues. You will have 45 days from receipt of the notice to provide the Fund Administrator with any additional information needed.

B. Medical Reimbursement Claims

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

If your Claim is denied in whole or in part, the Fund Administrator will notify you in writing within 30 days after receipt of your claim. Under special circumstances this time may be extended one time for an additional 15-day period. The Fund Administrator will notify you of the extension in writing prior to the expiration of the initial 30-day period. Such notification will include the special circumstances requiring the extension and the date by which the Plan expects to render a determination. If extension of time is needed because of your failure to provide

sufficient information to make a determination, the notification will specify all required information. You will have 45 days from your receipt of the notification to provide such information.

C. Notification Requirements

The Fund Administrator will notify you of the determination of your claim within the specified time limits mentioned above. With regards to all initial benefit claims such notification shall be in writing or electronically transmitted and contain the following information:

- The specific reason or reasons for the adverse benefit determination;
- Reference to the specific Plan provisions on which the determination is based;
- A description of any material or information necessary for you to perfect the claim and an explanation of why such information is necessary;
- 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 Section 502(a) of the Act following an adverse benefit determination on review.
- If an internal rule, guideline, protocol, or other similar criteria was used in making the adverse benefit determination; specify what was used and that it will be provided to you free of charge upon request; and
- If adverse benefit determination is based on a medical necessity or experimental treatment, the Plan must provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

D. Claims Review Procedure

If the claim is denied (in whole or in part), you shall thereafter have one hundred eighty (180) days within which to appeal the Fund Administrator's determination to the Trustees. Such appeal shall be in writing, shall be delivered to the Trustees, and shall specify in detail the basis for the objection to the Fund Administrator's determination. The Board of Trustees shall thereby afford you or your duly authorized representative the opportunity to review (free of charge) all documents, records and other information pertinent to the claim, to submit issues and comments in writing and discuss such documents and issues with the Trustees; and

The Trustees shall act upon the appeal as soon as possible but no later than the date of the first Board meeting following the date the Plan receives a request for review, unless the request for review is filed within thirty (30) days prior to the date of such meeting. In such case, a determination will be made no later than the date of the second Board meeting following the date the Plan receives a request for review. If special circumstances (such as the need to hold a

hearing) require a further extension of time for processing, the Fund Administrator shall notify you in writing describing the special circumstances and the date by which a determination will be rendered. The determination shall be rendered no later than the date of the third Board meeting following the date the Plan receives a request for review. The Fund Administrator shall notify you of the Trustees determination as soon as possible but no later than five (5) days after the determination is made. Such notification shall include all of the information described in C. above, as well as a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents. In addition to this requirement, notification shall also include the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance agency."

In the case of a claim denied on the grounds of a medical judgment, the Trustees will consult with a health care professional that has appropriate training and experience in the field of medicine pertinent to your claim. Such health care professional will not have been involved in the determination of your initial claim for benefits. The Trustees will make their determination based in whole or in part on such health care professionals' medical judgment. If the Trustees make an adverse benefit determination with regards to your appeal, you have the right to request the identification of any medical or vocational expert whose advice was obtained, without regard to whether or not the Trustees relied on this advice to make their determination.

E. Cooperation

Every claimant will 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, the failure on the part of the claimant to comply with such requests promptly and in good faith will be sufficient grounds for delaying payment 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 formulae, methods and procedures, as they may see fit.

VIII FAMILY AND MEDICAL LEAVE ACT (FMLA)

If the Family Medical Leave Act (FLMA) applies to your Employer and you qualify for an approved family or medical leave of absence (as defined in the FMLA), eligibility may continue for the duration of the leave if required contributions are paid toward the cost of the coverage. Your Employer has the responsibility to provide you with prior written notice of the terms and conditions under which payment must be made. Failure to make payment within 30 days of the due date established by your Employer will result in the termination of coverage. Subject to certain exceptions, if you fail to return to work after the leave of absence, your Employer has the right to recover from you any contributions toward the cost of coverage made on your behalf during the leave, as outlined in the FMLA.

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. Any waiting period for pre-existing conditions or other waiting periods will not apply. However, all accumulated annual and lifetime maximums will apply.

If you do not return to work at the end of an FMLA 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).”

IX UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

A. 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.

B. 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.

C. 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 –

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

D. Premiums

You may use your Health Care Account to continue coverage under the Plan for the time period set forth in Paragraph C of this Article or you may pay the required premium out of pocket. 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.

E. Notification of Intent to Return to Work

It is important that you notify your employer or the Union 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.

XI ADDITIONAL PLAN INFORMATION

A. Your Rights Under ERISA

As a participant in the **Roofers Local Union No. 210 Joint Health & Welfare Program Fund**, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Fund Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Social Security Administration.

Obtain, upon written request to the Fund 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), if any, and updated summary plan description. The Administrator may make a reasonable charge for the copies.

If an annual report is filed by the Plan, to receive a summary of such report.

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.

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 twenty-four (24) months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for twelve (12) months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such 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 or a medical child support 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 your claim is frivolous.

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, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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.

B. 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.

C. Plan Interpretations, Determinations, and Amendments

Notwithstanding any other provisions of this document, the Board of Trustees, or their designee, 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, or their designee 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.

D. Third Party Liability Cases

NOTE: This provision applies to all employees (and pensioners) and their covered Spouses and 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, Pensioners, covered Spouses, 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 Administrator of the Fund 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 Fund 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 being retained 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 Fund 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 Fund 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 Administrator.

XII HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

The Plan is required by law to maintain the privacy of your personal health information and to provide you with written notice of the Plan's privacy practices and legal duties as stated in this Summary Plan Description. The Plan's privacy practices are also available for review at the Fund Office. If any changes are made to the privacy practices currently in effect, the Plan will notify you within sixty (60) days after the changes become effective. Most of your health benefits under the **Roofers Local Union No. 210 Joint Health & Welfare Program Fund** are provided through an insurance policy or policies purchased by the Fund to provide those benefits. To the extent that your health information may be used pursuant to those policies, your rights under HIPAA will be determined under those policies. You may want to contact your insurer for more information with regard to that entity's duties under HIPAA.

The Plan is required to abide by the terms of this privacy policy. However, the Plan reserves the right to change the terms of this policy and to make new provisions effective to all of the personal health information that it maintains about you.

A. HIPAA Restrictions

Employees of the Trust Fund have access to the individually identifiable health information of Plan participants for administration functions of the Plan. When this health information is provided from the Plan to the Plan Sponsor, it is Protected Health Information (PHI) and, if it is transmitted by or maintained in electronic media, it is Electronic PHI.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Plan Sponsor's ability to use and disclose PHI and Electronic PHI. The following HIPAA definitions of PHI and Electronic PHI apply to this Article:

Protected Health Information (PHI). Protected Health Information (PHI) means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe that the information can be used to identify the individual. Protected health information includes information of persons living or deceased.

Electronic Protected Health Information. Electronic Protected Health Information (Electronic PHI) means Protected Health Information that is transmitted by or maintained in electronic media.

The Plan Sponsor will have access to PHI and Electronic PHI from the Plan only as permitted under this Article or as otherwise required or permitted by HIPAA.

B. Provision of Protected Health Information to Plan Sponsor

Permitted Disclosure of Enrollment/Disenrollment Information

The Plan may disclose to the Plan Sponsor information on whether the individual is participating in the Plan.

Permitted Uses and Disclosure of Summary Health Information

The Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose Summary Health Information to the Plan Sponsor, provided that the Plan Sponsor requests the Summary Health Information for the purpose of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (2) modifying, amending, or terminating the Plan.

“Summary Health Information” means information (1) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under the Plan; and (2) from which the information described at 42 CFR §164.514(b)(2)(i) 42 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR § 164.514(b)(2)(i)(B) 42 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes

Unless otherwise permitted by law, and subject to the conditions of disclosure described below in paragraph C and obtaining the written certification of the Plan Sponsor, the Plan may disclose PHI and Electronic PHI to the Plan Sponsor, provided that the Plan Sponsor uses or discloses such PHI and Electronic PHI only for Plan administration purposes. “Plan administration purposes” means administration functions performed by the Plan Sponsor on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor or any employment-related actions or decisions.

Notwithstanding any provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI or Electronic PHI in a manner that is inconsistent with 45 CFR §164.504(f) 45 CFR §164.504(f).

C. Conditions of Disclosure for Plan Administration Purposes

The Plan Sponsor agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR § 164.508 45 CFR § 164.508, which are not subject to these restrictions) disclosed to it by the Plan (or a health insurance issuer or HMO on behalf of the Plan), Plan Sponsor shall:

Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;

Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan, agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI;

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 Plan Sponsor;

Report to the Plan any use or disclosure of the PHI of which it becomes aware that is inconsistent with the uses or disclosures provided for;

Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR §164.524 45 CFR §164.524;

Make available PHI for amendment, and incorporate any amendments to PHI, in accordance with 45 CFR § 164.526 45 CFR § 164.526;

Make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528 45 CFR § 164.528;

make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;

if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor 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, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

Ensure that the adequate separation between Plan and Plan Sponsor (i.e., the firewall), required by 45 CFR § 504 45 CFR § 504(f)(2)(iii), is established.

Plan Sponsor further agrees that if it creates, receives, maintains, or transmits any Electronic PHI (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508 45 CFR §164.508, which are not subject to these restrictions) on behalf of the Plan, it will:

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

ensure that the adequate separation between the Plan and Plan Sponsor (i.e., the firewall), required by 45 CFR § 504(f)(2)(iii) 45 CFR § 504(f)(2)(iii) is supported by reasonable and appropriate security measures;

ensure that any agent, including a subcontractor, to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and

report to the Plan any security incident of which it becomes aware, as follows: Plan Sponsor will report to the Plan, with such frequency and at such times as agreed, the aggregate number of unsuccessful, unauthorized attempts to access, use, disclose, modify, or destroy Electronic PHI or to interfere with systems operations in an information system containing Electronic PHI; in addition, Plan Sponsor will report to the Plan as soon as feasible any successful unauthorized access, use, disclosure, modification, or destruction of Electronic PHI or interference with systems operations in an information system containing Electronic PHI.

D. Adequate Separation between Plan and Plan Sponsor

The Plan Sponsor shall allow Trust Fund employees access to the PHI. No other persons shall have access to PHI. These employees shall only have access to and use of PHI to the extent necessary to perform the plan administration functions needed for successful operation of the Plan. In the event that any of these specified employees does not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor's employee discipline and termination procedures.

The Plan Sponsor shall ensure that the provisions of this paragraph D are supported by reasonable and appropriate security measures to the extent that the persons designated above create, receive, maintain, or transmit Electronic PHI on behalf of the Plan.