ROOFERS' UNIONS
WELFARE TRUST FUND

2340 S. River Road
Suite 305
Des Plaines, Illinois
60018-3251
(847) 827-1029
Fax (847) 827-6358

Office of the Fund Manager

Notice of Important Plan Changes Effective as of January 1, 2011

Please read this Notice carefully and save it with your important documents. The Board of Trustees of the Roofers' Unions Welfare Trust Fund would like to take this opportunity to announce an important benefit change to Plan III.

Plan III – Outpatient Treatment for Mental and Nervous Disorders

Effective for eligible claims incurred on and after January 1, 2011, the limits on outpatient visits for mental and nervous disorder treatment were eliminated. The Roofers' Unions Welfare Trust Fund Summary Plan Description, January 1, 2015 Edition in the "Schedule of Benefits – Plan III" on page 10, however, provides for a maximum limit of 25 visits per calendar year. Please note that this 25 visit limit is a typographical error, and since January 1, 2011, Plan III has not enforced any maximum visitation limit in processing claims for outpatient treatment for mental and nervous disorders.

If you did not submit a claim under Plan III for outpatient treatment for mental and nervous disorders after December 31, 2010 under the belief that a 25 visit maximum applied, you can submit any additional claims to the Fund, and the Fund will process such claims.

Statement of Grandfathered Status

The Board of Trustees believes that Plan III continues to be a "grandfathered health plan" as that term is defined under the Affordable Care Act, which permits Plan III to preserve certain basic health coverage already in effect before the law was passed. As with all grandfathered health plans, Plan III is not required to include certain consumer protections of the Affordable Care Act that apply to other non-grandfathered plans (for example, providing preventative health services without any cost sharing). However, Plan III must comply with certain other provisions of the Affordable Care Act (for example, the elimination of lifetime limits on benefits).

Contact the Fund Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at (866) 444-3272 or www.dol.gov/ebsa/healthreform. The website includes a table summarizing the protections that do and do not apply to grandfathered health plans.

A Final Note

Please call the Fund Office at (847) 827-1029 if you have any questions about these changes or about your benefits in general.

This Notice describes highlights of certain features of Plan III and is intended to be a Summary of Material Modifications to Plan III. Full details are contained in the documents that establish the provisions of Plan III. The Trustees reserve the right to amend, modify or terminate Plan III at any time and from time to time. Receipt of this Notice does not confer or guarantee eligibility for benefits.

ROOFERS' UNIONS
WELFARE TRUST FUND

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Notice of Important Plan Changes Effective as of January 1, 2016

Please read this Notice carefully and save it with your important documents. The Board of Trustees of the Roofers' Unions Welfare Trust Fund would like to take this opportunity to announce important benefit changes to Plans II and III (collectively, the "**Plans**"), effective January 1, 2016.

Fund Right of Subrogation (Reimbursement)

The Roofers' Unions Welfare Trust Fund Summary Plan Description, January 1, 2015 Edition describes certain subrogation and reimbursement rights of the Welfare Trust Fund (the "Fund") on pages 109-110. In addition to those rights, effective January 1, 2016, the Fund is entitled to 100% reimbursement of all medical and Weekly Disability claims paid on your or your Dependent's behalf related to the injury or illness from all "Third Party" recoveries. A Third Party is defined as a person or business entity and shall include, but is not limited to, any person or entity legally responsible for your injury, other benefit plans, an insurance company or any other person or entity that is obligated to make payment, which the Fund would otherwise be obligated to make.

The Fund's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of you or your Dependent, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Therefore, if you or your Dependent receive payment from or on behalf of a Third Party for claims paid by the Fund, you must reimburse the Fund for 100% of benefits paid by the Fund. The proceeds from the settlement or judgment must be divided as follows:

- First, the Fund has priority over all monies recovered. Accordingly, you or your representative must pay a sum sufficient to fully reimburse the Fund for 100% of benefits paid related to the injury or illness. You must pay your own legal fees and other costs of litigation in connection with the recovery from a Third Party. No reductions or deductions are allowed for litigation costs, court costs, or attorneys' fees (*i.e.*, the Illinois Common Fund Doctrine, Make Whole Doctrine, or any other state law affecting these rights are preempted under ERISA by this provision); then
- Any remainder may be paid to you or your Dependent.

The proceeds of any claim against a Third Party must be divided as stated above, even if you or your Dependent are not fully compensated for the loss. The Fund is not entitled to receive reimbursement in excess of the amount you or your Dependent receive from all Third Parties.

You or your Dependents shall be responsible for compliance with these provisions and the provisions of any subrogation agreement. You will also be responsible for compliance by your or your Dependents' agents, representatives and attorneys.

Furthermore, if you or your Dependent receive payment from a Third Party for Plan benefits already received and you do not reimburse the Fund as stated above, the Fund may take any action to recover 100% of the benefits paid. Such action includes, but is not limited to:

- Initiating a claim to compel compliance with these terms or the terms of the subrogation agreement;
- Withholding benefits payable to you or your Dependents until you or your Dependents comply; or
- Initiating such other equitable or legal action it deems appropriate.

The Fund reserves the right to be reimbursed for its court costs and attorneys' fees necessary to recover payment.

To the extent the Fund is required to initiate a formal proceeding against you or your Dependent(s) to enforce its reimbursement rights, you or your Dependent(s) will also be responsible for the Fund's attorneys' fees and costs incurred. In addition, to the extent the expenses, including but not limited to

attorneys' fees and costs, incurred by the Fund exceed the amount you or your Dependent(s) recover from any Third Party, or you or your Dependent(s) refuse or fail to reimburse the Fund from any Third Party recovery, the Fund will have the right to withhold benefits to you or your Dependent(s) until such time that the Fund is reimbursed in full for all expenses, including but not limited to attorneys' fees and costs.

Moreover, you or your Dependent(s) grant the Fund a lien on the monies recovered from any Third Party in the amount of (i) all medical and Weekly Disability claims paid on your or your Dependent's behalf, (ii) any money judgment entered against the Fund in the lawsuit brought by the attorney, and (iii) the Fund's attorneys' fees and costs in defending the lawsuit, regardless of whether the Fund prevails or loses.

Statement of Grandfathered Status

The Board of Trustees believes that the Plans continue to be "grandfathered health plans" as that term is defined under the Affordable Care Act, which permits the Plans to preserve certain basic health coverage already in effect before the law was passed. As with all grandfathered health plans, the Plans are not required to include certain consumer protections of the Affordable Care Act that apply to other non-grandfathered plans (for example, providing preventative health services without any cost sharing). However, the Plans must comply with certain other provisions of the Affordable Care Act (for example, the elimination of lifetime limits on benefits).

Contact the Fund Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at (866) 444-3272 or **www.dol.gov/ebsa/healthreform**. The website includes a table summarizing the protections that do and do not apply to grandfathered health plans.

A Final Note

Please call the Fund Office at (847) 827-1029 if you have any questions about these changes or about your benefits in general.

This Notice describes highlights of certain features of the Plans and is intended to be a Summary of Material Modifications to the Plans. Full details are contained in the documents that establish the provisions of the Plans. The Trustees reserve the right to amend, modify or terminate the Plans at any time and from time to time. Receipt of this Notice does not confer or guarantee eligibility for benefits.

SUMMARY OF MATERIAL MODIFICATIONS
EIN: 36-2226396 PN: 502, 503
March 2016

ROOFERS' UNIONS
WELFARE TRUST FUND

2340 S. River Road, Suite 305
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Office of the Fund Manager

Notice of Important Plan Changes Effective as of July 1, 2016

Please read this Notice carefully and save it with your important documents.

The Board of Trustees of the Roofers' Unions Welfare Trust Fund ("Welfare Trust Fund") would like to take this opportunity to announce important benefits changes to Plans II and III, (collectively, the "Plans"), for claims incurred on and after July 1, 2016.

Increase in Loss of Life and Accidental Death and Dismemberment Benefits

Effective July 1, 2016

Effective for eligible claims incurred on and after July 1, 2016, the Loss of Life and Accidental Death & Dismemberment Benefits will increase from $4,000 to $5,000 for Plan II and from $6,500 to $7,500 for Plan III. The following is a chart detailing the maximum benefits payable under each Plan:

	PLAN II	PLAN III
Loss of Life (Employee only)	$5,000	$7,500
Accidental Death & Dismemberment (non-occupational or non-work connected accidental death or dismemberment-Employee only)		
Loss of Life	$5,000	$7,500
Loss of two hands, two feet or sight of two hands	$5,000	$7,500
Loss of one foot & sight in one eye, or one hand & sight in one eye, or one hand & one foot	$5,000	$7,500
Loss of one hand, one foot, or sight in one eye	$2,500	$3,750

Except for these changes, all other provisions, exclusions and limitations contained in the terms of the Plans remain in full force and effect.

Statement of Grandfathered Status

The Board of Trustees believes that the Plans are "grandfathered health plans" as that term is defined under the Affordable Care Act, which permits the Plans to preserve certain basic health coverage already in effect before the law was passed. As with all grandfathered health plans, the Plans are not required to include certain consumer protections of the Affordable Care Act that apply to other non-grandfathered plans (for example, providing preventive health services without any cost sharing). However, the Plans must comply with certain other provisions of the Affordable Care Act, as described in this Notice.

Contact the Fund Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at (866) 444-3272 or **www.dol.gov/ebsa/healthreform**. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

Over

A Final Note

Please call the Fund Office at (847) 827-1029 if you have any questions about these changes or about your benefits in general.

This Notice describes highlights of certain features of the Plan and is intended to be a Summary of Material Modifications to the Plans. Full details are contained in the documents that establish the provisions of the Plans. The Trustees reserve the right to amend, modify, or terminate the Plan at anytime and from time to time. Receipt of this Notice does not confer or guarantee eligibility for benefits.

SUMMARY OF MATERIAL MODIFICATIONS
EIN: 36-2226396 PN:502, 503
July 2016

ROOFERS' UNIONS
WELFARE TRUST FUND

2340 S. River Road, Suite 305
Des Plaines, Illinois 60018-3251
(847) 827-1029
Fax (847) 827-6358

Office of the Fund Manager

Notice of Important Benefit Improvements

Please read this Notice carefully and save it with your important documents.

The Board of Trustees of the Roofers' Unions Welfare Trust Fund would like to take this opportunity to announce important benefit improvements to Plans of Benefits II and III (the "Plans"). The Plans will now cover genetic testing for breast cancer and certain treatments that relate to that testing (as described below). The Plans are also implementing a utilization management program for prescription medications that contain lidocaine. These changes are explained in this Notice.

New Coverage of Genetic Testing for Breast Cancer Effective January 1, 2017

The Plans will cover the reasonable and customary costs of the genetic tests listed below. The Plans will not cover other genetic tests that the Plan Administrator determines are experimental or investigational.

BRCA1 and BRCA2 Testing. Effective for eligible claims incurred on and after January 1, 2017, the Plans will cover BRCA1 and BRCA2 genetic testing for breast cancer for women who meet one or more of the following criteria:

1. A personal history of breast cancer diagnosed before age 50, breast cancer affecting both breasts, or both breast and ovarian cancers; or
2. A family history of breast cancer in two or more close relatives, such as your parents, brothers, sisters, or children; or
3. A family member who was diagnosed with breast cancer before age 50; or
4. A family history of breast cancer in more than one generation; or
5. A close relative with breast cancer affecting both breasts; or
6. A family member who has both breast and ovarian cancers; or
7. A male relative with breast cancer; or
8. A positive BRCA1 or BRCA2 genetic test in a blood relative; or
9. Eastern European (Ashkenazi) Jewish ancestry on either side of your family

Prophylactic Breast Surgery. Effective for eligible claims incurred on and after January 1, 2017, the Plans will cover Prophylactic Breast Surgery in the event of a positive BRCA test. Following that surgery, the Plan will also cover reconstructive breast surgery.

Oncotype DX Tests. Effective for eligible claims incurred on and after January 1, 2017, the Plans will cover Oncotype DX Tests. The Oncotype DX test is a test administered to women who have been diagnosed with breast cancer. It examines a breast cancer patient's tumor tissue at a molecular level and gives information about a patient's individual disease. This information aids in the determination of each patient's treatment plan.

Over

Prescription Drug Plan: Utilization Management for Lidocaine Effective April 17, 2017

In coordination with CVS Health, the Plans' prescription drug benefit administrator, the Plans are instituting a utilization management program for prescription medications containing lidocaine effective for eligible claims incurred on and after April 17, 2017. The program will help ensure appropriate and safe utilization of prescription medications that include lidocaine, including making sure that the medication usage is consistent with product labeling, FDA guidance, standards of medical practice and evidence-based medicine.

Effective for eligible claims incurred on and after April 17, 2017, FDA-approved prescription medications that are lidocaine or lidocaine-containing formulations will be subject to a quantity limit with a post-limit prior authorization requirement.

CVS Health will send out further notices to affected participants and medical providers to help ensure that you and your medical providers are aware of these changes before April 17, 2017.

Statement of Grandfathered Status

The Board of Trustees believes that the Plans are "grandfathered health plans" as that term is defined under the Affordable Care Act, which permits the Plans to preserve certain basic health coverage already in effect before the law was passed. As with all grandfathered health plans, the Plans are not required to include certain consumer protections of the Affordable Care Act that apply to other non-grandfathered plans (for example, providing preventive health services without any cost sharing). However, the Plans must comply with certain other provisions of the Affordable Care Act, as described in this Notice.

Contact the Fund Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at (866) 444-3272 or **www.dol.gov/ebsa/healthreform**. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

A Final Note

Please call the Fund Office at (847) 827-1029 if you have any questions about these changes or about your benefits in general.

This Notice describes highlights of certain features of the Plans and is intended to be a Summary of Material Modifications to the Plans. Full details are contained in the documents that establish the provisions of the Plans. The Trustees reserve the right to amend, modify, or terminate the Plans at anytime and from time to time. Receipt of this Notice does not confer or guarantee eligibility for benefits.

SUMMARY OF MATERIAL MODIFICATIONS

EIN: 36-2226396 PN: 502, 503

February 2017

ROOFERS' UNIONS
WELFARE TRUST FUND

2021 Swift Road
Suite B
Oak Brook, IL 60523
(847) 827-1029
Fax (847) 827-6358
Office of the Fund Manager

Notice of Important Plan Change Effective as of January 1, 2018

Please read this Notice carefully and save it with your important documents.

The Board of Trustees of the Roofers' Unions Welfare Trust Fund ("Welfare Trust Fund") would like to take this opportunity to announce an important change to Plan III ("Plan") to extend coverage to full-time, non-bargained employees of signatory contractors. Capitalized terms used and not defined in this Notice have the definition set forth in the Roofers' Unions Welfare Trust Fund Plan Document/Summary Plan Description ("SPD").

Non-Bargained Employee Coverage

The Board of Trustees of the Welfare Trust Fund ("Board of Trustees") is pleased to extend Plan III medical, dental and vision coverage to full-time, non-bargained employees of signatory contractors and their eligible dependents. A full-time, non-bargained employee ("Eligible Employee") means an individual who is employed at least 30 hours per week and is not covered under a collective bargaining agreement or alumni participation agreement. The Fund will maintain the prior eligibility status for an employee who becomes disabled or goes on leave so long as the non-bargained individual remains employed and the contractor timely makes the required contribution on behalf of such employee. Eligible Employees are not entitled to crediting of Disability Hours or Self-Payment Hours toward eligibility.

For the requirements to be an eligible dependent covered under the Plan, please see the definition of "Dependent" in the SPD. For details on the medical, prescription drug, dental and vision benefits available under Plan III to Eligible Employees and their Dependents, please review the SPD. Eligible Employees and their Dependents are not entitled to retiree benefits, loss of life benefits, accidental death and dismemberment benefits or any disability benefits under the Plan.

All contributions for Eligible Employees are payable directly to the Welfare Trust Fund. The monthly cost of coverage for an Eligible Employee is the hourly contribution rate for Journeymen then in effect for the Welfare Trust Fund multiplied by 160 hours of work for each Eligible Employee, regardless of the actual hours worked. No partial or pro-rated monthly contributions are permitted. The applicable hourly contribution rate for Journeymen is specified in the current Standard Working Agreement between the Chicago Roofing Contractors Association and the United Union of Roofers, Waterproofers and Allied Workers Local No. 11. When a contractor makes the appropriate contribution for Eligible Employees for a particular month, such Eligible Employees will receive Plan coverage for the second month following the month for which the contribution was made, as outlined below:

Contribution Made for:	Results in Plan Coverage for:
January	March
February	April
March	May
April	June
May	July
June	August
July	September
August	October
September	November
October	December
November	January
December	February

For example, the current contribution rate is $9.73. A contractor makes the required contribution for March 2018 of $1,556.80 (= $9.73 x 160) per Eligible Employee, which results in Plan coverage for Eligible Employees for May 2018. The monthly cost of coverage will change when the hourly contribution rate for the Welfare Trust Fund changes.

To elect coverage for its Eligible Employees, a contractor must execute and return to the Fund Office the Non-Bargaining Unit Employees Participation Agreement. If a contractor enters into a Non-Bargaining Unit Employees Participation Agreement and such agreement is later revoked or terminated, the contractor will not be allowed to elect Plan coverage for its non-bargained employees again.

A contractor's decision to elect coverage for its Eligible Employees applies to all Eligible Employees employed by such contractor, including subsequently hired Eligible Employees, unless an Eligible Employee has ongoing medical coverage through another plan (for example, a spouse's health plan). If satisfactory evidence of other ongoing medical coverage is provided to the Fund Office, such Eligible Employee may be excluded from coverage under the Plan ("Opt-Out Employee"), and the contractor will have no obligation to contribute on behalf of such Opt-Out Employee.

If the Opt-Out Employee subsequently loses his or her other medical coverage and is an Eligible Employee, such employee will receive Plan coverage starting the day after he or she no longer has other coverage if the employee provides to the Fund Office documentation of the date the other coverage expired (for example, certificate of loss of coverage). The contractor is also obligated to make contributions on behalf of such employee within 30 days of invoicing by the Fund Office, retroactive to the month necessary for the Eligible Employee to receive coverage the day after the other coverage expires. No partial or pro-rated monthly contributions are permitted. For example, if the other coverage for an Opt-Out Employee expires April 15, 2018, the employee will receive Plan coverage starting April 16, 2018, and the contractor is obligated to make the full monthly contribution on behalf of the employee for February 2018 and March 2018 within 30 days.

Statement of Grandfathered Status

The Board of Trustees believes that the Plan is a "grandfathered health plan" as that term is defined under the Affordable Care Act, which permits the Plan to preserve certain basic health coverage already in effect before the law was passed. As with all grandfathered health plans, the Plan is not required to include certain consumer protections of the Affordable Care Act that apply to other non-grandfathered plans (for example, providing preventive health services without any cost sharing). However, the Plan must comply with certain other provisions of the Affordable Care Act, as described in this Notice.

Contact the Fund Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at (866) 444-3272 or **www.dol.gov/ebsa/healthreform**. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

A Final Note

Please call the Fund Office at (847) 827-1029 if you have any questions about these changes or about your benefits in general.

This Notice describes highlights of certain features of the Plan and is intended to be a Summary of Material Modifications to the Plan. Full details are contained in the SPD, the document that establishes the provisions of the Plan. The Board of Trustees reserves the right to amend, modify, or terminate the Plan at anytime and from time to time. Receipt of this Notice does not confer or guarantee eligibility for benefits.

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Office of the Fund Manager

Notice of Important Plan Changes Effective as of April 1, 2018

Please read this Notice carefully and save it with your important documents.

The Board of Trustees of the Roofers' Unions Welfare Trust Fund ("Welfare Trust Fund") would like to take this opportunity to announce important changes to Plans II and III ("Plans") regarding procedures for disability claims filed on or after April 1, 2018 to comply with the new disability claim procedures issued by the Department of Labor.

New Disability Claim Procedures

Effective for disability claims filed on or after April 1, 2018, the following additional procedures will apply. Please note that these requirements are in addition to the procedures already specified in the Roofers' Unions Welfare Trust Fund Plan Document/Summary Plan Description ("SPD").

If a disability claim is denied, in whole or in part, on initial review or on appeal, the written notice of denial will include:

- A discussion of the decision, including an explanation for disagreeing with or not following (as applicable): (1) the views presented by the claimant to the Plan of health care and vocational professionals who treated or evaluated the claimant; (2) the views of medical or vocational experts obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the adverse benefit determination; and (3) a disability determination by the Social Security Administration;
- If the denial is based on a scientific or clinical judgment, either an explanation of the scientific or clinical judgment applied to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- Either the specific internal rules, guidelines, protocols, standards or other similar criteria the Plan relied upon in making the denial or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist;
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the applicant's claim for benefits; and
- For a notice of denial on appeal, a description of any contractual limitations period that may apply, including the calendar date of which the Plan's two-year limit for filing suit expires.

The denial notice will be provided in a culturally and linguistically appropriate manner in accordance with the requirements described in the Department of Labor's Regulation §2560.503-1(o).

Before the Review Committee may issue a denial on appeal, the Plan must provide the claimant, free of charge with: (1) any new or additional evidence considered, relied upon, or generated by the Review Committee; and (2) any new or additional rationale for the denial, if such rationale is a basis for the denial on appeal. The evidence or rationale will be provided as soon as possible and sufficiently in advance of the deadline for issuing a decision on appeal so that the claimant has a reasonable opportunity to respond

prior to that deadline. If the additional information is provided to the claimant within 30 days of the next regular meeting of the Review Committee, then the appeal determination will be postponed until the next following Review Committee meeting.

Statement of Grandfathered Status

The Board of Trustees believes that the Plan is a "grandfathered health plan" as that term is defined under the Affordable Care Act, which permits the Plan to preserve certain basic health coverage already in effect before the law was passed. As with all grandfathered health plans, the Plan is not required to include certain consumer protections of the Affordable Care Act that apply to other non-grandfathered plans (for example, providing preventive health services without any cost sharing). However, the Plan must comply with certain other provisions of the Affordable Care Act, as described in this Notice.

Contact the Fund Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at (866) 444-3272 or **www.dol.gov/ebsa/healthreform**. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

A Final Note

Please call the Fund Office at (847) 827-1029 if you have any questions about these changes or about your benefits in general.

This Notice describes highlights of certain features of the Plan and is intended to be a Summary of Material Modifications to the Plans. If you file a claim, please be sure to review the current SPD for the applicable review periods and additional procedures. Full details are contained in the SPD, the document that establishes the provisions of the Plans. The Board of Trustees reserves the right to amend, modify, or terminate the Plans at anytime and from time to time. Receipt of this Notice does not confer or guarantee eligibility for benefits.

SUMMARY OF MATERIAL MODIFICATIONS
EIN: 36-2226396 PN: 503
March 2018

ROOFERS' UNIONS
WELFARE TRUST FUND

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Office of the Fund Manager

Notice of Important Benefit Changes

Please read this Notice carefully and save it with your important documents.

The Board of Trustees of the Roofers' Unions Welfare Trust Fund would like to take this opportunity to announce important benefit changes to Plans of Benefits II and III (the "Plans"). The Plans are implementing an opioid utilization management program effective May 1, 2018. The program is explained in this Notice.

New Opioid Utilization Management Program — Effective May 1, 2018

It's hard to ignore the impact that opioids and other addictive substances have had throughout the U.S. in recent years. Self-medication and non-adherence to treatment plans are becoming a major problem in the management of chronic and severe injuries, and mental health conditions.

- 1.9 million people suffer from substance abuse related to prescription opioids in the United States.
- Substance abusers face $15,500 more in medical costs per year than non-abusers.

As addiction rates continue to rise, the Plans have elected to implement an opioid utilization management program in order to improve your health and safety. The program is based on recommendations from CVS, the Plans' pharmacy benefit manager, and the United States Centers for Disease Control and Prevention (CDC).

The program only targets highly addictive and abused medications. Many controlled substances have a useful and legitimate medical purpose, such as for the treatment of pain. If you need an opioid after having a tooth removed or after surgery, for example, that will not be impacted by this program. Those types of prescriptions are only needed for a short period of time.

However, controlled substances have the potential to be abused and this can lead to overdose deaths and other adverse health consequences. Taking pain medication for long periods of time is a concern that we are addressing with this program. The types of drugs that the program focuses on are the ones that you shouldn't take for extended periods of time or in heavy doses. Drugs that are more addictive or abused will be subject to Prior Authorization, Quantity Limits and/or Step Therapy.

In order to make the introduction of this new program easy and smooth for you, there will be a one-time exception so participants have the time and the ability to adjust the medications that they are taking. You also have the ability to have your doctor provide a letter of medical necessity to continue their prescription as is.

CVS Caremark® Enhanced Opioid Utilization Management Program

The Plans' Opioid Utilization Management Program will contain the following features:

1. Limit Days' Supply
    a. The length of your first prescription fill will be limited to seven days, when appropriate

Over

i. There may be exceptions for participants without claims history of prior opioid use

b. Additional days' supply may be available with Prior Authorization (PA)

2. Limit Quantity of Opioids

a. The quantity of opioids prescribed will be limited to up to a Morphine Milligram Equivalent (MME) of 90 per day (based on a 30-day supply)

i. This includes those mediations combined with acetaminophen, aspirin or ibuprofen

ii. Prior Authorization can be requested for up to 200 MME/day; quantities higher require an appeal

b. Products containing opioids and:

i. Acetaminophen or aspirin are limited to 4 g/acetaminophen or aspirin per day

ii. Ibuprofen is limited to 3200 mg ibuprofen/day

3. Require Step Therapy

a. Use of Immediate-Release (IR) formulation required before moving to Extended-Release (ER) formulation

i. This applies to Extended-Release prescriptions for participants without claims history of prior use of an Immediate-Release opioid or continued use of an Extended-Release opioid

b. Prior Authorization can be requested if claims history does not meet Step Therapy requirements

4. Coverage Duration

a. Post-limit Prior Authorization approvals:

i. 1 month for acute pain

ii. 12 months for chronic pain

b. Prescriber to reassess patient response at least every three months

c. Duration not limited for patients actively fighting cancer

5. Seven-Day Supply Duration Limit

a. Immediate-Release opioids for acute pain are limited to seven-day supply

b. After seven days, a higher quantity may be provided when coverage conditions are met

6. Increase Access to Treat Opioid Addiction

a. Remove Prior Authorization requirement (but retain Quantity Limits) for buprenorphine combo products

b. Prior Authorization with Quantity Limits will be in place for buprenorphine mono products

c. Emergency supply permitted while Prior Authorization processed

Statement of Grandfathered Status

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A Final Note

Please call the Fund Office at (847) 827-1029 if you have any questions about this program or about your benefits in general.

This Notice describes highlights of certain features of the Plans and is intended to be a Summary of Material Modifications to the Plans. Full details are contained in the documents that establish the provisions of the Plans. The Trustees reserve the right to amend, modify, or terminate the Plans at anytime and from time to time. Receipt of this Notice does not confer or guarantee eligibility for benefits.

SUMMARY OF MATERIAL MODIFICATIONS

EIN: 36-2226396 PN: 502, 503

MAY 1, 2018

ROOFERS' UNION
WELFARE TRUST FUND

2021 Swift Drive
Suite B
Oak Brook, Illinois 60523
Telephone: (847) 827-1029
Fax: (847) 827-6358

Office of the Fund Manager

Notice of Important Plan Changes Effective as of January 1, 2019

Please read this Notice carefully and save it with your important documents.

The Board of Trustees of the Roofers' Unions Welfare Trust Fund ("Welfare Trust Fund") would like to take this opportunity to announce important changes to Plans II and III (the "Plans") for prescription drug claims incurred on and after January 1, 2019.

Prescription Drug Formulary Changes

The Welfare Trust Fund is committed to providing you with quality Prescription Drug Benefits coverage. As prescription drug prices increase, both you and the Welfare Trust Fund must pay higher costs. In order to continue offering you comprehensive Prescription Drug Benefits coverage, while keeping costs affordable, CVS/Caremark, the Welfare Trust Fund's Prescription Drug Benefits Administrator, frequently reviews its Preferred Drug List and formulary ("PDL").

As a result of CVS/Caremark's review, there will be changes to the PDL effective for certain prescription drugs filled on and after January 1, 2019. In an effort to promote less expensive but equally effective prescription drugs, the PDL will be modified to exclude coverage of some of the more costly, brand-name prescription drugs. The drugs that are being removed from the PDL were selected by CVS/Caremark because of their high cost, the small number of participants who use these prescription drugs, and the availability of alternative prescription drugs in the same drug class. The list of the prescription drugs that are being removed from the PDL is on page 2 of this Notice ("No Longer Covered List").

> The **PDL** is a list of covered prescription drugs. The list, also known as a **formulary**, is maintained by CVS/Caremark.

A participant who continues to fill prescriptions for the drugs on the No Longer Covered List on and after January 1, 2019, will be required to pay 100% of the retail price of the prescription drug.

If you currently use one of the prescription drugs on the No Longer Covered List and want to avoid paying the full cost of the prescription, talk with your physician about switching to an alternative prescription drug. The PDL continues to cover a number of brand-name and generic alternative prescription drugs for each of the excluded brand-name prescription drugs on the No Longer Covered List. There is also a procedure which participants and their physicians can utilize, called Prior Authorization, to have prescription drugs which are not in the PDL, approved by CVS/Caremark under certain clinical protocols and if so approved, they will be considered as if these prescription drugs were in the PDL. You or your physician should contact CVS/Caremark at 1-855-240-0536 to initiate the Prior Authorization process.

CVS/Caremark is contacting all participants who have prescriptions for one or more of the drugs on the No Longer Covered List. If this is the case for you, you should have already received a letter from CVS/Caremark. The letter from CVS/Caremark lists alternative prescription drugs that are on the PDL, so you can discuss them with your physician. If you take one of the prescription drugs on the No Longer Covered List and have not received a letter, please contact CVS/Caremark at (800) 824-6349 as soon as possible.

Please visit CVS/Caremark's website, **www.caremark.com**, to view the most current version of the PDL, as well as to review your Prescription Drug Benefits coverage information, request mail service orders and research drug information.

> **Generic alternatives provide equally effective treatment and cost less.** By law, all generic equivalents of brand-name drugs must prove to be as effective as their brand-name counterpart in order to be sold. Switching to a lower-cost alternative can save you and the Welfare Trust Fund money.

Over

The following is the list of medications that are on the No Longer Covered List and therefore are no longer covered by the Plans starting January 1, 2019. If you continue using one of the prescription drugs on the No Longer Covered List after this date, you will be required to pay 100% of the retail price of the prescription drug. If you are currently using one of these prescription drugs, ask your physician about other options, either a covered generic or brand-name drug or whether a request should be made to CVS/Caremark for Prior Authorization.

List of Formulary Drug Removals - *New for 1-1-2019 (the "No Longer Covered List")*					
Zuplenz	Sorilux	Norditropin	Cambia	Fasenra	Tirosint
Acticlate, Targadox	Vanatol LQ/Vantol S	Eloctate	Avenova	Invokana & Invokamet/XR	Acanya, Benzaclin, Onexton, Veltin, Ziana
Contrave	Jentadueto/XR, Tradjenta	Alprolix	Prolastin C, Zemaira	One-Touch	

The following is the list of medications that are being added back to the formulary list as of January 1, 2019.

List of Formulary Drug Added Back - *New for 1-1-2019*
Xeljanz/XR
Genotropin
Jardiance, Synjardy/XR
Accu-Chek

Statement of Grandfathered Status

The Board of Trustees believes that the Plans are "grandfathered health plans" as that term is defined under the Affordable Care Act, which permits the Plans to preserve certain basic health coverage already in effect before the law was passed. As with all grandfathered health plans, the Plans are not required to include certain consumer protections of the Affordable Care Act that apply to other non-grandfathered plans (for example, providing preventive health services without any cost sharing). However, the Plans must comply with certain other provisions of the Affordable Care Act, as described in this Notice.

Contact the Fund Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at (866) 444-3272 or **www.dol.gov/ebsa/healthreform**. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

A Final Note

Please call the Fund Office at (847) 827-1029 if you have any questions about these changes or about your benefits in general.

This Notice describes highlights of certain features of the Plan and is intended to be a Summary of Material Modifications to the Plans. Full details are contained in the documents that establish the provisions of the Plans. The Trustees reserve the right to amend, modify, or terminate the Plan at anytime and from time to time. Receipt of this Notice does not confer or guarantee eligibility for benefits.

SUMMARY OF MATERIAL MODIFICATIONS

EIN: 36-2226396 PN:502, 503

October 2018

ROOFERS' UNION
WELFARE TRUST FUND

2021 Swift Drive
Suite B
Oak Brook, Illinois 60523
Telephone: (847) 827-1029
Fax: (847) 827-6358

Office of the Fund Manager

Please read this carefully and save it with your important documents.

Changes to the Continuing Eligibility Rules for 2019 Self-Pay Program – For Plans II and III

The Board of Trustees of the Roofers' Unions Welfare Trust Fund ("Welfare Trust Fund") are pleased to announce the eligibility requirements for making a Regular Self-Payment for Plan II and Plan III coverage for the 2019 Calendar Year. The Board of Trustees will evaluate this change again next year for the 2020 Self-Pay Program. This announcement explains the 2019 Self-Pay Program requirements.

If you are currently eligible for Plan II or Plan III coverage in 2018, you generally will be eligible to pay for continued coverage from the Welfare Trust Fund beginning January 1, 2019 through self-payment, depending on your hours of work in covered employment, as described below. For Regular Self-Payments in both Plan II and Plan III, the hourly contribution rate will be $9.73. The $100 special service charge for the privilege of making a Regular Self-Payment will not be charged for 2019.

- To continue **Plan II** coverage for calendar year 2019, you must be credited with at least **900** hours from work in covered employment and/or disability hours during the Contribution Period (the twelve month period from October 2017 through September 2018). Additionally, you must be credited with a minimum of 600 hours during the Contribution Period to continue your Plan II coverage through self-payment for the 2019 Calendar Year. Consequently, the maximum number of hours for which you may make a self-payment for Plan II coverage in 2019 is 300 hours. For example:

> Mike is currently eligible for Plan II coverage for 2018 and was credited with 625 hours from October 2017 through September 2018. If he elects to continue Plan II coverage through self-payment for 2019, his required payment would be calculated as follows:
>
> 900 hours – 625 hours = 275 hours
>
> 275 hours x $9.73 hourly contribution rate equals a $2,675.75 self-payment

- To continue **Plan III** coverage for calendar year 2019, you must be credited with at least **1,300** hours from work in covered employment and/or disability hours during the Contribution Period (the twelve month period from October 2017 through September 2018). Additionally, you must be credited with a minimum of 900 hours during the Contribution Period to continue your Plan III coverage through self-payment for the 2019 Calendar Year. Consequently, the maximum number of hours for which you may make self-payment for Plan III coverage in calendar year 2019 is 400 hours. For example:

> Jose is currently eligible for Plan III coverage for 2018 and was credited with 925 hours from October 2017 through September 2018. Here's how his self-payment would be calculated:
>
> 1,300 hours – 925 hours = 375 hours
>
> 375 hours x $9.73 hourly contribution rate equals a $3,648.75 self-payment
>
> If Jose wanted Plan II coverage for 2019 instead, no self-payment would be required because his 2018 hours are greater than the minimum of 900 hours required for Plan II coverage.

If these changes affect you, you will be sent a letter by the Fund Office in mid-November explaining your eligibility for the 2019 Self-Payment Program and the self-payment amount due. **This letter will arrive by U.S. Postal Service Priority mail. Signatures will not be required.** To continue coverage through self-payment for calendar year 2019, the Fund Office **must** receive your payment in full on or before December 31, 2018. If you believe you are eligible to make self-payments and you do not receive your explanatory letter, or if you have any questions about these changes or your benefits in general, please call the Fund Office at (847) 827-1029.

The following is the list of medications that are on the No Longer Covered List and therefore are no longer covered by the Plans starting January 1, 2019. If you continue using one of the prescription drugs on the No Longer Covered List after this date, you will be required to pay 100% of the retail price of the prescription drug. If you are currently using one of these prescription drugs, ask your physician about other options, either a covered generic or brand-name drug or whether a request should be made to CVS/Caremark for Prior Authorization.

List of Formulary Drug Removals - *New for 1-1-2019 (the "No Longer Covered List")*					
Zuplenz	Sorilux	Norditropin	Cambia	Fasenra	Tirosint
Acticlate, Targadox	Vanatol LQ/Vantol S	Eloctate	Avenova	Invokana & Invokamet/XR	Acanya, Benzaclin, Onexton, Veltin, Ziana
Contrave	Jentadueto/XR, Tradjenta	Alprolix	Prolastin C, Zemaira	One-Touch	

The following is the list of medications that are being added back to the formulary list as of January 1, 2019.

List of Formulary Drug Added Back - *New for 1-1-2019*
Xeljanz/XR
Genotropin
Jardiance, Synjardy/XR
Accu-Chek

Statement of Grandfathered Status

The Board of Trustees believes that the Plans are "grandfathered health plans" as that term is defined under the Affordable Care Act, which permits the Plans to preserve certain basic health coverage already in effect before the law was passed. As with all grandfathered health plans, the Plans are not required to include certain consumer protections of the Affordable Care Act that apply to other non-grandfathered plans (for example, providing preventive health services without any cost sharing). However, the Plans must comply with certain other provisions of the Affordable Care Act, as described in this Notice.

Contact the Fund Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at (866) 444-3272 or **www.dol.gov/ebsa/healthreform**. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

A Final Note

Please call the Fund Office at (847) 827-1029 if you have any questions about these changes or about your benefits in general.

This Notice describes highlights of certain features of the Plan and is intended to be a Summary of Material Modifications to the Plans. Full details are contained in the documents that establish the provisions of the Plans. The Trustees reserve the right to amend, modify, or terminate the Plan at anytime and from time to time. Receipt of this Notice does not confer or guarantee eligibility for benefits.

SUMMARY OF MATERIAL MODIFICATIONS

EIN: 36-2226396 PN:502, 503

October 2018

ROOFERS' UNIONS
WELFARE TRUST FUND

2021 Swift Drive, Suite B
Oak Brook, IL 60523
(847) 827-1029
Fax (847) 827-6358

Office of the Fund Manager

Notice of Important Benefit Improvements for Actives, Pre-Medicare Retirees and Medicare-Eligible Retirees

Please read this Notice carefully and save it with your important documents.

The Board of Trustees of the Roofers' Unions Welfare Trust Fund would like to take this opportunity to announce important benefit improvements to Plans of Benefits II and III (the "Plans"). The Plans are improving dental benefits for active participants and their covered dependents, and adding dental and vision coverage for eligible pre-Medicare and Medicare-eligible retirees and their covered dependents (as described below).

These changes are effective for eligible claims incurred on and after January 1, 2019.

Improved Dental Benefits for Active Participants

Effective for eligible claims incurred on and after January 1, 2019, the Plans are improving dental benefits for eligible active participants and their covered dependents by increasing the calendar year individual and family maximums to $2,000 and $5,000, respectively.

Dental Benefits	PPO Provider	Non-PPO Provider
Calendar Year Maximum		
Individual	$2,000	
Family	$5,000	
Calendar Year Deductible		
Individual	$10	
Family (3 Individual Deductibles)	$30	
Routine Services	Plan pays 100% every 6 months; Deductible does not apply	
Basic Services	Plan pays 80%	
Complete Denture Replacement	Plan pays 50% once every 60 consecutive months, after 12 months of eligibility	
Orthodontia Benefit	Plan pays 50%	
Lifetime Maximum	$6,000 per Covered Person	
Periodontal Benefit	Plan pays 80%	
Lifetime Maximum	$2,000 per Covered Person	

NEW! Dental, Periodontal and Vision Benefits for Pre-Medicare and Medicare-Eligible Retirees

Effective for eligible claims incurred on and after January 1, 2019, retirees and their covered dependents who are eligible for medical and Medicare reimbursement benefits ("Covered Persons") will be eligible for new dental and vision coverage under the Plans.

The following is a summary description of these new benefit programs.

<u>Dental and Periodontal Expense Benefits</u>

Dental Preferred Provider Organization (Dental PPO). To keep your dental expenses down, the Fund has contracted with a dental preferred provider organization, Dental Network of America (DNOA), that charges negotiated rates for services. When Covered Persons use a DNOA network dentist, your expenses generally will be lower than if you use a dentist who is not in the DNOA network.

The copay percentages that you pay for certain services after meeting the dental Calendar Year deductible will be the same whether you use a DNOA network dentist or a Non-DNOA Network dentist.

Periodontal Treatment. Covered Persons are each entitled to the lifetime maximum benefit for periodontal treatment. There is no deductible. See the chart below for more information.

Dental Schedule of Benefits

Dental Benefits	PPO Provider	Non-PPO Provider
Calendar Year Maximum Individual	$500	
Calendar Year Deductible Individual Family (3 Individual Deductibles)	$10 $30	
Routine Services	Plan pays 100% every 6 months; Deductible does not apply	
Basic Services	Plan pays 80%	
Complete Denture Replacement	Plan pays 50% once every 60 consecutive months, after 12 months of eligibility	
Periodontal Benefit	Plan pays 80%	
Lifetime Maximum	$500	

Vision Care Expense Benefits

The Fund has contracted with EyeMed Vision Care, a vision care network of providers, to provide Covered Persons with vision benefits. EyeMed network providers include select private practitioners and optical retailers.

Covered Vision Care Expenses include charges for an eye examination performed by an ophthalmologist or optometrist, lenses and frames, and contact lenses, as outlined in the chart below.

Network Benefits. When you use EyeMed providers, you pay a copay per service or supply, and then the Plan pays the specific allowance for Covered Expenses. You pay any amounts that exceed the allowances; however, network providers offer discounted prices on many services and supplies.

Non-Network Benefits. If you use a provider that does not participate in the EyeMed network of providers, you must pay the non-network provider the full cost for any services or supplies when you receive them and then submit a claim to EyeMed for reimbursement. The Plan pays specific allowances for covered non-network expenses. Any amounts that exceed the Plan allowances will not be covered under the Plan and are not available at discounted prices.

Vision Benefits	PPO Provider	Non-PPO Provider
Standard Exam (Once every calendar year)	Plan Pays 100%	Plan Pays 100% up to $30
Exam Options Standard Contact Lens Fit & Follow-Up Premium Contact Lens Fit & Follow-Up	Plan pays 100% up to $40 Covered Person pays 100% at a 10% discount off of retail	Not covered Not covered
Frames (Once every calendar year)	Plan pays 100% up to $100; Covered Person pays remaining amount at a 20% discount off of retail price	Plan Pays 100% up to $30
Standard Plastic Lenses (Once every calendar year) Lens Options UV Coating Tint (solid and gradient) Standard Scratch Resistance Standard Polycarbonate Standard Anti-Reflective Coating Standard Progressive (add-on) Other Add-Ons and Services	Plan pays 100% after $5 copay for single vision lenses, $12.50 for bifocals and $32.50 for trifocals Covered Person pays: $15 $15 $15 $40 $45 $65 Entire amount at 20% discount off of retail price	Plan Pays 100% up to $50 Not covered

Vision Benefits	PPO Provider	Non-PPO Provider
Contact Lenses (Once every calendar year)		
Conventional Lenses	Plan pays 100% up to $100; Covered Person pays remaining amount at a 20% discount off of retail price	Plan Pays 100% up to $50
Disposable Lenses	Plan pays 100% up to $100	Plan Pays 100% up to $50
Medically Necessary Lenses	Plan pays 100%	Plan Pays 100% up to $200

Important Contact Information

If You Need Information About . . .	Contact . . .	Contact Information . . .
Eligibility	**Fund Office** Roofers' Unions Welfare Trust Fund 2021 Swift Drive, Suite B Oak Brook, IL 60523 Call 8:00 am to 4:00 pm, Central Time (Monday through Friday)	Phone: (847) 827-1029 Fax: (847) 827-6358
Dental Benefits	**Dental Network of America** Call 8:00 am to 6:00 pm, Central Time (Monday through Friday)	Phone: 866-LABOR-L-U (866-522-6758) Website:
Vision Benefits	**EyeMed Vision Care** Call 7:00 am to 10:00 pm, Central Time (Monday through Saturday) and 10:00 am to 7:00 pm, Central Time (Sunday)	Customer Service: 866-723-0513 Website: To find a network provider: 800-988-4221

A Final Note

Please call the Fund Office at (847) 827-1029 if you have any questions about these changes or about your benefits in general.

This Notice describes highlights of certain features of the Plans and is intended to be a Summary of Material Modifications to the Plans. Full details are contained in the documents that establish the provisions of the Plans. The Trustees reserve the right to amend, modify, or terminate the Plans at anytime and from time to time. Receipt of this Notice does not confer or guarantee eligibility for benefits.

Statement of Grandfathered Status

The Board of Trustees believes that the Plans are "grandfathered health plans" as that term is defined under the Affordable Care Act, which permits the Plans to preserve certain basic health coverage already in effect before the law was passed. As with all grandfathered health plans, the Plans are not required to include certain consumer protections of the Affordable Care Act that apply to other non-grandfathered plans (for example, providing preventive health services without any cost sharing). However, the Plans must comply with certain other provisions of the Affordable Care Act, as described in this Notice.

Contact the Fund Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at (866) 444-3272 or www.dol.gov/ebsa/healthreform. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

SUMMARY OF MATERIAL MODIFICATIONS

EIN: 36-2226396 PN: 502, 503

October 2018

ROOFERS' UNIONS
WELFARE TRUST FUND

2021 Swift Drive
Suite B
Oak Brook, Illinois 60523
Telephone: (847) 827-1029
Fax: (847) 827-6358

Office of the Fund Manager

IMPORTANT NOTICE

TO
PARTICIPANTS AND BENEFICIARIES
IN THE
ROOFERS' UNIONS WELFARE TRUST FUND

Under the terms of the component benefit plans (Plans II and III) offered under the Roofers' Unions Welfare Trust Fund (the "Benefit Plans"), coverage for mastectomies is currently provided to eligible participants and beneficiaries. The Benefit Plans also cover reconstructive surgery and other related services following a mastectomy. The Board of Trustees of the Benefit Plans desires to remind participants and beneficiaries of the availability of this important coverage, which is the purpose of this notification.

Specifically, in the case of any participant or beneficiary who is receiving benefits under the Benefit Plans for a mastectomy and who elects (in consultation with their physician) breast reconstruction while receiving benefits in connection with such mastectomy, the Benefit Plans will provide coverage (subject to all applicable provisions of the Benefit Plans, including, but not limited to, deductibles and coinsurance) for:

(1) all stages of reconstruction of the breast on which the mastectomy has been performed;

(2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) prostheses and treatment of physical complications relating to all stages of mastectomy, including lymphedemas.

If you have any questions, please contact the Fund Office.

The Board of Trustees believes that the Benefit Plans are "grandfathered health plans" as that term is defined under the Affordable Care Act, which permits the Benefit Plans to preserve certain basic health coverage already in effect before the law was passed. As with all grandfathered health plans, the Benefit Plans are not required to include certain consumer protections of the Affordable Care Act that apply to other non-grandfathered plans (for example, providing preventive health services without any cost sharing). However, the Benefit Plans must comply with certain other provisions of the Affordable Care Act, as described in this Notice. Contact the Fund Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at (866) 444-3272 or www.dol.gov/ebsa/healthreform. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

November, 2018

ROOFERS' UNIONS
WELFARE TRUST FUND

2021 Swift Drive, Suite B
Oak Brook, Illinois 60523
(847) 827-1029
Fax (847) 827-6358

Office of the Fund Manager

Notice of Important Benefit Improvement

Please read this Notice carefully and save it with your important documents.

The Board of Trustees of the Roofers' Unions Welfare Trust Fund is pleased to announce an important benefit improvement to Plans of Benefits II and III (the "Plans"). The Plans will now cover contraceptive devices (as described below).

Coverage of Contraceptive Devices

Effective for eligible claims incurred on or after January 1, 2018, the Plans will cover the reasonable and customary costs of contraceptive devices. This includes, but is not limited to, non-prescription drug forms of contraceptives, including IUDs, injectable birth control and cervical caps. This new coverage also includes office visits associated with the addition of contraceptive coverage for injections, and insertion and removal of birth control devices. Coverage for contraceptive devices is subject to a 20% coinsurance cost sharing payment when received from PPO Providers and a 30% coinsurance cost sharing payment when received from Non-PPO Providers. The Plans' prescription drug benefit already covers oral contraceptives.

A Final Note

Please call the Fund Office at (847) 827-1029 if you have any questions about this change or about your benefits in general.

This Notice describes highlights of certain features of the Plans and is intended to be a Summary of Material Modifications to the Plans. Full details are contained in the documents that establish the provisions of the Plans. The Trustees reserve the right to amend, modify, or terminate the Plans at anytime and from time to time. Receipt of this Notice does not confer or guarantee eligibility for benefits.

Statement of Grandfathered Status

The Board of Trustees believes that the Plans are "grandfathered health plans" as that term is defined under the Affordable Care Act, which permits the Plans to preserve certain basic health coverage already in effect before the law was passed. As with all grandfathered health plans, the Plans are not required to include certain consumer protections of the Affordable Care Act that apply to other non-grandfathered plans (for example, providing preventive health services without any cost sharing). However, the Plans must comply with certain other provisions of the Affordable Care Act, as described in this Notice.

Contact the Fund Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at (866) 444-3272 or www.dol.gov/ebsa/healthreform. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

SUMMARY OF MATERIAL MODIFICATIONS

EIN: 36-2226396 PN: 502, 503

NOVEMBER 2018

Roofers' Unions Welfare Trust and Pension Funds

2021 Swift Drive
Suite B
Oak Brook, Illinois 60523
Telephone: (847) 827-1029
Fax: (847) 827-6358

Office of the Fund Manager

Roofers' Unions Welfare Trust Fund
Roofers' Pension Fund

IMPORTANT NOTICE

PLEASE READ THIS NOTICE CAREFULLY AND SAVE IT WITH YOUR IMPORTANT DOCUMENTS

The Boards of Trustees of the Roofers' Pension Fund and the Roofers' Unions Welfare Trust Fund, the Chicagoland Roofers' Joint Apprenticeship and Training Fund, the Roofing Industry Advancement and Research Fund and the Roofers' Local No. 11 Promotional and Organizational Fund (the "Funds") have extended the contribution requirements for Owners of Roofing Contractors and their spouses that were in effect last year. (The Trustees will determine whether to extend these rules to cover future years.)

These rules affect Owners of Roofing Contractors and their spouses, as defined below. Health coverage under the Welfare Trust Fund's Plan of Benefits for 2020, based on work performed in 2019, for each Owner Participant will be conditioned on the payment of employer contributions in compliance with these rules.

Definitions:

a. Owner – means an individual who has any ownership interest in a Roofing Contractor, whether as a sole proprietor, partner, shareholder or otherwise, which is signatory to a collective bargaining agreement with Local No. 11.

b. Owner Participant – means an Owner or his or her spouse who performs work under the jurisdiction of the Local No. 11 collective bargaining agreement.

c. Roofing Contractor – means any entity, whether a sole proprietor, partner, shareholder, or a member of a Limited Liability Company or similar form of business, which is signatory to a collective bargaining agreement with Local No. 11.

Owner Participant Contribution/Eligibility Requirements:

In order to be eligible for Welfare Trust Fund benefits in 2020, based on covered work performed in 2019, each Owner Participant must have employer contributions paid to the Funds by a Roofing Contractor for the actual number of hours worked, but no fewer than 1,300 hours in a calendar year for initial eligibility and continuing eligibility for Plan 2 coverage and 1,700 hours for Plan 3 coverage for continuing eligibility only. Such contributions shall be paid at the contribution rate required for each Fund from time to time under the Roofers' Local No. 11 collective bargaining agreements.

If an Owner Participant also performs collective bargaining work for a Roofing Contractor in which he is not an Owner, those hours worked will be considered independently to establish eligibility for coverage under the Welfare Trust Fund under either Plan 2 or Plan 3, as applicable. If the Owner Participant does not have sufficient number of these hours to establish eligibility for Plan 2 (900 hours) or Plan 3 (1,300 hours), the Owner Participant may use a combination of hours (worked for a Roofing Contractor in which he is not an Owner and for a Roofing Contractor in which he is an Owner) to satisfy the 1,300 or 1,700 hours Owner Participant threshold for eligibility.

Type of Coverage under the Welfare Trust Fund:

For initial eligibility and continuing eligibility, an Owner Participant for whom 1,300 but less than 1,700 hours of contributions are made to the Welfare Trust Fund in 2019 shall be eligible for Plan 2 coverage for 2020, subject to all applicable Plan provisions. For continuing eligibility only, an Owner Participant for whom 1,700 or more hours of contributions are made to the Welfare Trust Fund in 2019 shall be eligible for Plan 3 coverage for 2020, subject to all applicable Plan provisions. Unless such contributions are received, an Owner Participant shall not be eligible for any other type of health coverage under the Welfare Trust Fund in 2020.

Certification and Reporting Procedures

Further details regarding the procedures for identifying each Roofing Contractor's Owner Participants and the mechanics of reporting and contributing on behalf of Owner Participants to the Funds will be provided with the contribution reporting forms for the month of January, 2019.

If you have any questions regarding these changes, please contact the Fund Office at (847) 827-1029 Monday through Friday from 8 a.m. to 4 p.m.

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PLEASE NOTE: This Summary is written in non-technical terms. If any inconsistency exists between this Summary and the Plan documents governing the Funds, the terms of the Plan documents shall govern and no benefits shall exist under this Summary unless such benefits exist under the terms of the Plan.

Statement of Grandfathered Status

The Board of Trustees believes that the Plans are "grandfathered health plans" as that term is defined under the Affordable Care Act, which permits the Plans to preserve certain basic health coverage already in effect before the law was passed. As with all grandfathered health plans, the Plans are not required to include certain consumer protections of the Affordable Care Act that apply to other non-grandfathered plans (for example, providing preventive health services without any cost sharing). However, the Plans must comply with certain other provisions of the Affordable Care Act, as described in this Notice.

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SUMMARY OF MATERIAL MODIFICATIONS

ROOFERS' UNIONS WELFARE TRUST FUND
EIN: 36-2226396 PN: 001

ROOFERS' PENSION FUND
EIN: 36-6485998 PN: 001

December 2018

Roofers' Unions Welfare Trust Fund

Fund Office
2021 Swift Drive, Suite B
Oak Brook, IL 60523

Phone: (847) 827-1029
Fax: (847) 827-6358

October 2019

Notice of Important Benefit Changes

Please read this Notice carefully and save it with your important documents.

The Board of Trustees of the Roofers' Unions Welfare Trust Fund would like to take this opportunity to announce two important benefit changes to Plans of Benefits II and III (the "Plans"). The Plans are making it easier to get a physical for adult participants and are implementing an opioid utilization management program for children. The changes are explained in this Notice.

Annual Adult Physicals Covered at 100% — Effective January 1, 2020

The Trustees are improving the Plans' adult routine physical examination benefit for covered persons age 19 and older. Currently, adult physicals are covered at 100% once every 36 months. Effective for eligible claims incurred on and after January 1, 2020, the Plans will cover adult routine physicals at 100% once every 12 months, measured from the date of the last routine physical. Annual physicals are an important part of staying healthy and identifying and treating potential illnesses early on.

Important Reminder: You may have to pay for services that the Plans do not consider preventive. Ask your provider if the services needed are preventive. Then check your coverage.

New Opioid Utilization Management Program for Covered Persons Age 19 or Younger — Effective January 1, 2020

The opioid crisis in our country continues to worsen and take its toll on families and communities throughout the United States. Last year, the Fund introduced an opioid utilization management program in order to improve your health and safety. The program is based on recommendations from CVS Health, the Plans' pharmacy benefit manager, and the United States Centers for Disease Control and Prevention ("CDC").

While the program has been effective, the national crisis continues to grow. As a result, effective October 1, 2019, the Fund is introducing similar guidelines and programs for covered persons age 19 and younger. The program's goal is to offer protection for children and adolescents age 19 years and younger only. This new program is also based on recommendations from CVS Health and the CDC.

The new opioid utilization management program will limit opioid drugs to opioid-naïve patients age 19 years and younger to no more than a three-day supply of short-acting opioids. Opioid prescriptions for cancer, sickle cell anemia, or palliative care are exempt from this three-day limit. For patients whose clinical diagnosis may require a longer day supply for ongoing therapy, prescribers may apply for prior authorization on a case-by-case basis.

Over

Roofers' Unions Welfare Trust Fund

Fund Office
2021 Swift Drive, Suite B
Oak Brook, IL 60523

Phone: (847) 827-1029
Fax: (847) 827-6358

October 2019

Notice of Important Benefit Changes

Please read this Notice carefully and save it with your important documents.

The Board of Trustees of the Roofers' Unions Welfare Trust Fund would like to take this opportunity to announce two important benefit changes to Plans of Benefits II and III (the "Plans"). The Plans are making it easier to get a physical for adult participants and are implementing an opioid utilization management program for children. The changes are explained in this Notice.

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Over

Statement of Grandfathered Status

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Contact the Fund Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") at (866) 444-3272 or **www.dol.gov/ebsa/healthreform**. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

A Final Note

Please call the Fund Office at (847) 827-1029 if you have any questions about this program or about your benefits in general.

This Notice describes highlights of certain features of the Plans and is intended to be a Summary of Material Modifications to the Plans. Full details are contained in the documents that establish the provisions of the Plans. The Trustees reserve the right to amend, modify, or terminate the Plans at anytime and from time to time. Receipt of this Notice does not confer or guarantee eligibility for benefits.

SUMMARY OF MATERIAL MODIFICATIONS

EIN: 36-2226396 PN: 502, 503

October, 2019

5871023v1/03946.003

ROOFERS' UNIONS WELFARE TRUST FUND

2021 Swift Drive, Suite B
Oak Brook, Illinois 60523
(847) 827-1029
Fax (847) 827-6358

Office of the Fund Manager

September 2020

Notice of Important Benefit Changes

Please read this Notice carefully and save it with your important documents.

The Board of Trustees of the Roofers' Unions Welfare Trust Fund would like to take this opportunity to announce important improvements to your benefits. We also wanted to remind you about some features of your benefits that are designed to support you during the ongoing coronavirus (COVID-19) health crisis. We have been working with our health care partners—like BlueCross BlueShield of Illinois (BCBS), ComPsych, and CVS Caremark (CVS)—to make sure that our benefits are available to support you and your family.

The changes described in this Notice apply to benefits under the Plans of Benefits II, II-PA, and III ("Plans"). Capitalized terms not defined in this Notice have the meaning as defined in the Roofers' Unions Welfare Trust Fund Plan Document/Summary Plan Description, effective January 1, 2015, as amended ("SPD").

New Coverage For Vaccinations

Effective for eligible claims incurred on or after September 1, 2020, the Plans will provide coverage for three common vaccinations, as follows:

Vaccination	**Copayment**	**Age Recommendations** (per Centers for Disease Control (CDC))
Flu Shots	100% covered	The CDC recommends everyone 6 months of age and older get vaccinated every flu season.
Shingles Vaccinations	$25 copay	The CDC recommends that healthy adults 50 years and older get two doses of the shingles vaccine called Shingrix (recombinant zoster vaccine), separated by two to six months, to prevent shingles and the complications from the disease.
Pneumonia Vaccinations	$25 copay	The CDC recommends that all infants receive a pneumonia vaccination in a series of four doses. For children and adults two years and older, the CDC recommends the pneumococcal vaccination for those who have certain medical conditions or who smoke.

The above coverage will apply to vaccinations received at your doctor's office, at a CVS Pharmacy, or at any other retail pharmacy that participates in the Retail Pharmacy Card Program. We encourage you to contact your doctor to determine if you should get vaccinated, whether you are getting the vaccination in his or her office or at a retail pharmacy. Your doctor can determine when you were last vaccinated and will know your medical history and can use that information to determine if it medically necessary for you to get vaccinated.

Flu shots and other vaccines may not be available at all times. Flu shots are generally available from August through April of each year. We encourage you to call your doctor or pharmacy in advance to find out their office visit/vaccination procedures, to check on vaccine availability and to make an appointment, if needed. Most vaccines require a prescription (except for the flu shot).

Smoking Cessation Program Coverage

The Plans will pay for a Smoking Cessation Program with no cost sharing when services are provided by a BCBS PPO provider, effective as stated below.

Coverage includes screening for tobacco use and the following interventions for Eligible Participants who use tobacco products. Eligible Participants are entitled to two cessation attempts per calendar year. A cessation attempt includes coverage for:

- Four tobacco counseling sessions of at least ten minutes each (including telephone counseling, group counseling, and individual counseling) without prior authorization; and

- All FDA-approved cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health provider without prior authorization.

This coverage is effective for eligible claims incurred on or after January 1, 2021.

COVID-19 (Coronavirus) Testing Covered At 100% For Eligible Participants

Effective for eligible claims incurred on or after March 18, 2020, the Plans will cover the following items and services related to individualized diagnosis of COVID-19, as determined by a health care provider, without cost sharing, prior authorization, or other medical management requirements.

COVID-19 tests include:

- In vitro diagnostic tests as approved under the Federal Food, Drug, and Cosmetic Act;

- Tests that have not been FDA-approved, but are or will be subject to emergency use authorization as deemed by the FDA;

- Tests developed in and authorized by a State that has notified the Secretary of Health and Human Services (HHS) of its intent to review tests;

- Other tests that the Secretary of HHS determines appropriate in guidance it issues.

The Plans will cover any in-network and out-of-network visits that result in an order for or administration of a COVID-19 test described above, including office and telehealth or virtual visits, urgent care visits, emergency room visits, and visits in non-traditional settings (such as drive thru testing sites where licensed providers administer tests), as well as other items or services (such as blood tests) provided during those visits to the extent that they relate to the furnishing or administration of the COVID-19 diagnostic test or the evaluation of whether the test is needed.

The Plans will provide the above items and services throughout the duration of the COVID-19 Public Health Emergency, the length of which is determined by the Secretary of HHS.

Tests that are not for individualized diagnosis of COVID-19, including tests for employment or public health surveillance purposes, will not be covered by the Plans.

Coverage For Telehealth Visits

Effective for eligible claims incurred on or after March 18, 2020, the Plans will cover telehealth and virtual visits with no cost sharing for both in-network and out-of-network providers up to the allowed amount under the terms of the Plans. Telehealth and virtual visits may include the use of electronic information and communication technologies such as a telephone, smartphone, tablet or computer with a web cam, for treatment by your doctor if your doctor offers such capabilities.

The Plans will provide the above items and services throughout the duration of the COVID-19 Public Health Emergency.

The Employee Assistance Program Is Available If You Need It

As news of COVID-19 continues to evolve, you may find yourself growing concerned about dependent care, personal finances or even your family's preparedness. If so, rest assured you're not alone. Remember, the Plans' Employee Assistance Program offered through ComPsych (EAP) is here to provide you and your household members support during challenging times. Under the EAP, you have confidential access to help on many topics, including child care, adult care, stress management, community resources, legal issues, parenting, and education issues.

ComPsych provides participants with Employee Assistance Program services and ComPsych can be contacted at 877-327-7798 or www.compsych.com.. Need support? Reach out to ComPsych today!

CVS Pharmacy Mail Order Prescriptions

Remember that you can utilize CVS Pharmacy's mail order service. During the COVID-19 health crisis, CVS Pharmacy has waived charges for home delivery of all prescription medications. Almost all CVS Pharmacy locations offer delivery within one to two days. If you need your prescription on the same day you order it, look for an "on-demand delivery" option when you check out. To order your prescriptions by mail, visit cvs.com/pharmacy.

Fund Office Hours Of Operation Updates

The Fund Office is an essential business under Illinois Governor Pritzker's Stay-at-Home Order and is continuing to operate, but is closed to visitors. The Fund Office staff is working remotely and remains dedicated to assisting you and your family with your benefits needs. During the COVID-19 health crisis, the Fund Office is operating from 8:00 am to 5:00 pm, Monday through Friday. The Fund Office continues to answer phone calls, process benefits and maintain daily operations, and you can also fax forms and other information to the Fund Office using fax number (847) 827-6358.

A Final Note

We wish you and your family well during this difficult time. If you have questions about how to use your benefits during the COVID-19 health crisis, call the Fund Office at (847) 827-1029.

This Notice describes highlights of certain features of the Plans and is intended to be a Summary of Material Modifications to the Plans. Only the provisions described in this Notice are changing; no other Plan changes are being made at this time. Full details of the Plans are contained in the SPD. The Trustees reserve the right to amend, modify, or terminate the Plans at anytime and from time to time. Receipt of this Notice does not confer or guarantee eligibility for benefits.

Sincerely,

The Board of Trustees

Statement Of Grandfathered Status

The Board of Trustees believes that the Plans are "grandfathered health plans" as that term is defined under the Affordable Care Act, which permits the Plans to preserve certain basic health coverage already in effect before the law was passed. As with all grandfathered health plans, the Plans are not required to include certain consumer protections of the Affordable Care Act that apply to other non-grandfathered plans (for example, providing preventive health services without any cost sharing). However, the Plans must comply with certain other provisions of the Affordable Care Act, as described in this Notice.

Contact the Fund Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration at (866) 444-3272 or **www.dol.gov/ebsa/healthreform**. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

SUMMARY OF MATERIAL MODIFICATIONS

EIN: 36-2226396 PN: 502, 503

September 2020

5950485v4/03946.038

ROOFERS' UNIONS
WELFARE TRUST FUND

2021 Swift Drive, Suite B
Oak Brook, Illinois 60523
(847) 827-1029
Fax (847) 827-6358

Office of the Fund Manager

January 2021

COVID-19 Vaccine Coverage

Please read this Notice carefully and save it with your important documents.

The Board of Trustees ("Trustees") of the Roofers' Unions Welfare Trust Fund ("Welfare Trust Fund") is pleased to announce coverage for COVID-19 vaccinations as explained below.

The coverage described in this Notice applies to benefits under the Welfare Trust Fund's Plans II and III (the "Plans"). Capitalized terms not defined in this Notice have the meaning as defined in the Roofers' Unions Welfare Trust Fund Summary Plan Description/Plan Document, effective January 1, 2015, as amended ("SPD/Plan Document").

COVID-19 VACCINE COVERAGE

The Plans will cover the cost of COVID-19 vaccinations and related administrative services with no cost sharing (no deductibles or coinsurance) for all eligible participants whether received from a network or out of network provider. The coverage is subject to all other Plan provisions. The coverage is effective as soon as the vaccines became available. We encourage you to get vaccinated as soon as you are able to do so.

The Illinois Department of Public Health has many resources to help you find out about vaccine availability and distribution. Visit the Department's website (https://www.dph.illinois.gov/) to learn more. You can also get information on your local (county or city, for example) health department's website or from the Centers for Disease Control (https://www.cdc.gov/coronavirus/2019-nCoV/index.html).

This coverage will stay in effect throughout the national emergency. We are relying on guidance from our service providers, BlueCross BlueShield of Illinois and Caremark, as well as our local, state and federal governments, the Centers for Disease Control (CDC) and the World Health Organization (WHO).

A Final Note

If you have questions about the coverage explained in this notice or about your benefits generally, call the Fund Office at (847) 827-1029.

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Contact the Fund Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") at (866) 444-3272 or **www.dol.gov/ebsa/healthreform**. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

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SUMMARY OF MATERIAL MODIFICATIONS

EIN: 36-2226396 PN: 502, 503

January 2021

ROOFERS' UNIONS
WELFARE TRUST FUND

2021 Swift Drive, Suite B
Oak Brook, Illinois 60523
(847) 827-1029
Fax (847) 827-6358

Office of the Fund Manager

April 2021

Dental Benefit Improvements

Please read this Notice carefully and save it with your important documents.

The Board of Trustees ("Trustees") of the Roofers' Unions Welfare Trust Fund ("Welfare Trust Fund") is pleased to announce two improvements to the Welfare Trust Fund's dental benefits as explained below.

Coverage for Implants and Increased Calendar Year Maximums

The coverage described in this Notice applies to benefits under the Welfare Trust Fund's Plans II and III (the "Plans") for Active Participants and for Pre-Medicare and Medicare-Eligible Retirees. Capitalized terms not defined in this Notice have the meaning as defined in the Roofers' Unions Welfare Trust Fund Summary Plan Description/Plan Document, effective January 1, 2015, as amended ("SPD/Plan Document").

- Effective June 1, 2021, **the Plans will cover dental implants and related services at 50%**, subject to the deductible.
- In addition, also effective June 1, 2021, the Plans are improving dental benefits by **increasing the calendar year maximums:**
    - For eligible **Active Participants and their covered Dependents, the individual and family calendar year maximums will be $3,000 and $7,500**, respectively;
    - For eligible **Retirees and their covered Dependents, the calendar year maximum will be $1,000**.

The improved schedules are shown below. (The changes are shaded in gray.)

Dental Schedule of Benefits for Active Participants and Dependents (Effective June 1, 2021)

Dental Benefits	PPO Provider	Non-PPO Provider
Calendar Year Maximum		
Individual	$3,000	
Family	$7,500	
Calendar Year Deductible		
Individual	$10	
Family (3 Individual Deductibles)	$30	
Routine Services	Plan pays 100% every 6 months; Deductible does not apply	
Basic Services	Plan pays 80%	
Complete Denture Replacement	Plan pays 50% once every 60 consecutive months, after 12 months of eligibility	
Dental Implants	Plan pays 50%	
Orthodontia Benefit	Plan pays 50%	
Lifetime Maximum	$6,000 per Covered Person	
Periodontal Benefit	Plan pays 80%	
Lifetime Maximum	$2,000 per Covered Person	

Dental Schedule of Benefits for Pre-Medicare and Medicare-Eligible Retirees and Dependents (Effective June 1, 2021)

Dental Benefits	PPO Provider	Non-PPO Provider
Calendar Year Maximum		
Individual	$1,000	
Calendar Year Deductible		
Individual	$10	
Family (3 Individual Deductibles)	$30	
Routine Services	Plan pays 100% every 6 months; Deductible does not apply	
Basic Services	Plan pays 80%	
Complete Denture Replacement	Plan pays 50% once every 60 consecutive months, after 12 months of eligibility	
Dental Implants	Plan pays 50%	
Periodontal Benefit	Plan pays 80%	
Lifetime Maximum	$500	

Dental Network Reminder

To keep your dental expenses down, the Fund has contracted with a dental network provider or organization, Dental Network of America (DNOA), that charges negotiated rates for services. When you and your Dependents use a DNOA network dentist, your expenses generally will be lower than if you use a dentist who is not in the DNOA network. The copay percentages that you pay for certain services after meeting the dental Calendar Year deductible will be the same whether you use a DNOA network dentist or a Non-DNOA Netwok dentist. For more information about DNOA or to find a provider, you can contact DNOA (866-522-6758 or www.dnoa.com).

A Final Note

If you have questions about the coverage explained in this Notice or about your benefits generally, call the Fund Office at (847) 827-1029. This Notice describes highlights of certain features of the Plans and is intended to be a Summary of Material Modifications to the SPD/Plan Document. Only the provisions described in this Notice are changing; no other Plan changes are being made at this time. Full details of the Plans are contained in the SPD/Plan Document. The Trustees reserve the right to amend, modify, or terminate the Plans at anytime and from time to time. Receipt of this Notice does not confer or guarantee eligibility for benefits.

Sincerely,

The Board of Trustees

Statement of Grandfathered Status. The Board of Trustees believes that the Plans are "grandfathered health plans" as that term is defined under the Affordable Care Act, which permits the Plans to preserve certain basic health coverage already in effect before the law was passed. As with all grandfathered health plans, the Plans are not required to include certain consumer protections of the Affordable Care Act that apply to other non-grandfathered plans (for example, providing preventive health services without any cost sharing). However, the Plans must comply with certain other provisions of the Affordable Care Act, as described in this Notice. Contact the Fund Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") at (866) 444-3272 or **www.dol.gov/ebsa/healthreform**. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

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Roofers' Unions Welfare Trust Fund

Fund Office
2021 Swift Drive, Suite B
Oak Brook, IL 60523

Phone: (847) 827-1029
Fax: (847) 827-6358

Notice of Important Plan Changes Effective as of January 1, 2021

Please read this Notice carefully and save it with your important documents.

The Board of Trustees of the Roofers' Unions Welfare Trust Fund ("Welfare Trust Fund") would like to take this opportunity to announce important changes to Plans II and III (the "Plans") for prescription drug claims incurred on and after January 1, 2021.

Prescription Drug Formulary Changes

The Welfare Trust Fund is committed to providing you with quality Prescription Drug Benefits coverage. As prescription drug prices increase, both you and the Welfare Trust Fund must pay higher costs. In order to continue offering you comprehensive Prescription Drug Benefits coverage, while keeping costs affordable, CVS/Caremark, the Welfare Trust Fund's Prescription Drug Benefits Administrator, frequently reviews its Preferred Drug List and formulary ("PDL").

As a result of CVS/Caremark's review, there will be changes to the PDL effective for certain prescription drugs filled on and after January 1, 2021. In an effort to promote less expensive but equally effective prescription drugs, the PDL will be modified to exclude coverage of some of the more costly, brand-name prescription drugs. The drugs that are being removed from the PDL were selected by CVS/Caremark because of their high cost, the small number of participants who use these prescription drugs, and the availability of alternative prescription drugs in the same drug class. The list of the prescription drugs that are being removed from the PDL is on page 2 of this Notice ("No Longer Covered List").

> The **PDL** is a list of covered prescription drugs. The list, also known as a **formulary**, is maintained by CVS/Caremark.

A participant who continues to fill prescriptions for the drugs on the No Longer Covered List on and after January 1, 2021, will be required to pay 100% of the retail price of the prescription drug.

If you currently use one of the prescription drugs on the No Longer Covered List and want to avoid paying the full cost of the prescription, talk with your physician about switching to an alternative prescription drug. The PDL continues to cover a number of brand-name and generic alternative prescription drugs for each of the excluded brand-name prescription drugs on the No Longer Covered List. There is also a procedure that participants and their physicians can utilize, called Prior Authorization, to have prescription drugs that are not in the PDL, approved by CVS/Caremark under certain clinical protocols and if so approved, they will be considered as if these prescription drugs were in the PDL. You or your physician should contact CVS/Caremark at 855-240-0536 to initiate the Prior Authorization process.

CVS/Caremark is contacting all participants who have prescriptions for one or more of the drugs on the No Longer Covered List. If this is the case for you, you should have already received a letter from CVS/Caremark. The letter from CVS/Caremark lists alternative prescription drugs that are on the PDL, so you can discuss them with your physician. If you take one of the prescription drugs on the No Longer Covered List and have not received a letter, please contact CVS/Caremark at (800) 824-6349 as soon as possible.

> **Generic alternatives provide equally effective treatment and cost less.** By law, all generic equivalents of brand-name drugs must prove to be as effective as their brand-name counterpart in order to be sold. Switching to a lower-cost alternative can save you and the Welfare Trust Fund money.

Please visit CVS/Caremark's website, **www.caremark.com**, to view the most current version of the PDL, as well as to review your Prescription Drug Benefits coverage information, request mail service orders and research drug information.

The following is the list of medications that are on the No Longer Covered List and therefore are no longer covered by the Plans starting January 1, 2021. If you continue using one of the prescription drugs on the No Longer Covered List after this date, you will be required to pay 100% of the retail price of the prescription drug. If you are currently using one of these prescription drugs, ask your physician about other options, either a covered generic or brand-name drug or whether a request should be made to CVS/Caremark for Prior Authorization.

Over

List of Formulary Drug Removals - New for January 1, 2021 (the "No Longer Covered List")		
ACCU-CHEK AVIVA PLUS, ACCU-CHEK COMPACT PLUS, ACCU-CHEK GUIDE, ACCU-CHEK SMARTVIEW	CIPRO HC, CIPRODEX	MIRVASO
ADZENYS ER/ XR-ODT, APTENSIO XR, DAYTRANA	DARAPRIM	NEULASTA/NEULASTA ONPRO, UDENYCA
AMITIZA	doxycycline monohydrate delayed-rel capsule	NUVARING
APOKYN	ESTRING, FEMRING, INTRAROSA, PREMARIN CREAM	oxymorphone ext-rel
APTIOM, BRIVIACT, FYCOMPA	GEL-ONE, VISCO-3	PAXIL/ PAXIL CR, PEXEVA, VIIBRYD
ARALAST NP, GLASSIA	GOLYTELY, SUPREP	PROLENSA
AZELEX, DIFFERIN LOTION, FABIOR, TAZORAC	HUMATROPE	SANDOSTATIN LAR DEPOT, SIGNIFOR LAR, SOMAVERT
BEPREVE	INCRUSE ELLIPTA	TECFIDERA
BEVESPI AEROSPHERE	INVEGA SUSTENNA	TRACLEER
BORTEZOMIB, KYPROLIS	isosorbide dinitrate 40MG	TRULANCE
calcipotriene/betamethasone	LACRISERT	ZIRGAN
	MENEST, OSPHENA, PREMARIN	
	metaxalone 400mg	

The following is the list of medications that are being added back to the formulary list as of January 1, 2021.

List of Formulary Drug Added Back - New for January 1, 2021		
EUFLEXXA (preferred)	LAMICTAL (non-preferred)	NORDITROPIN (preferred)
FLAREX (non-preferred)	ONETOUCH ULTRA, ONETOUCH VERIO (preferred)	TOUJEO (preferred)

A Final Note

Please call the Fund Office at (847) 827-1029 if you have any questions about these changes or about your benefits in general.

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ROOFERS' PENSION FUND

2021 Swift Drive
Suite B
Oak Brook, Illinois 60523
Telephone: (847) 827-1029
Fax: (847) 827-6358

NOTICE OF IMPORTANT PLAN CHANGES

Please read this Notice carefully and save it with your important documents. The Board of Trustees of the Roofers' Pension Fund would like to take this opportunity to announce an important benefit improvement to the Roofers' Pension Plan ("Plan").

Benefit Accrual Rate Increase to $125.00 – Effective January 1, 2022

Effective for covered hours worked on or after January 1, 2022, the benefit accrual rate increases from $103.00 to $125.00 per year of credited service.

A Final Note

Please contact the Fund Office at (847) 827-1029 if you have any question about this Notice or about your pension benefits.

This Notice describes highlights of certain features of the Plan and is intended to be a Summary of Material Modifications to the Plan. If any inconsistency exists between this Notice and the Roofers' Pension Plan document ("Plan Document"), the terms of the Plan Document shall govern, and no benefits shall exist under this Notice unless such benefits exists under the terms of the Plan Document.

SUMMARY OF MATERIAL MODIFICATIONS
EIN: 36-6485998 PN: 001
October 2021

ROOFERS' UNIONS
WELFARE TRUST FUND

2021 Swift Drive
Suite B
Oak Brook, Illinois 60523
Telephone: (847) 827-1029
Fax: (847) 827-6358

Office of the Fund Manager

Please read this carefully and save it with your important documents.

Changes to the Continuing Eligibility Rules for 2022 Self-Pay Program – For Plans II and III

The Board of Trustees of the Roofers' Unions Welfare Trust Fund ("Welfare Trust Fund") are pleased to announce the eligibility requirements for making a Regular Self-Payment for Plan II and Plan III coverage for the 2022 Calendar Year only. The Board of Trustees will evaluate this change again next year for the 2023 Self-Pay Program. This announcement explains the 2022 Self-Pay Program requirements.

If you are currently eligible for Plan II or Plan III coverage in 2021, you generally will be eligible to pay for continued coverage from the Welfare Trust Fund beginning January 1, 2022 through self-payment, depending on your hours of work in covered employment, as described below. For Regular Self-Payments in both Plan II and Plan III, the hourly contribution rate will be $11.23. The $100 special service charge for the privilege of making a Regular Self-Payment will not be charged for 2022.

- To continue **Plan II** coverage for calendar year 2022, you must be credited with at least **750** hours from work in covered employment and/or disability hours during the Contribution Period (the twelve-month period from October 2020 through September 2021). Additionally, you must be credited with a minimum of 500 hours during the Contribution Period to continue your Plan II coverage through self-payment for the 2022 Calendar Year. Consequently, the maximum number of hours for which you may make a self-payment for Plan II coverage in 2022 is 250 hours. For example:

> Mike is currently eligible for Plan II coverage for 2021 and was credited with 525 hours from October 2020 through September 2021. If he elects to continue Plan II coverage through self-payment for 2022, his required payment would be calculated as follows:
>
> 750 hours – 525 hours = 225 hours
>
> 225 hours x $11.23 hourly contribution rate equals a $2,526.75 self-payment

- To continue **Plan III** coverage for calendar year 2022, you must be credited with at least **1,200** hours from work in covered employment and/or disability hours during the Contribution Period (the twelve-month period from October 2020 through September 2021). Additionally, you must be credited with a minimum of 900 hours during the Contribution Period to continue your Plan III coverage through self-payment for the 2022 Calendar Year. Consequently, the maximum number of hours for which you may make self-payment for Plan III coverage in calendar year 2022 is 300 hours. For example:

> Jose is currently eligible for Plan III coverage for 2021 and was credited with 925 hours from October 2020 through September 2021. Here's how his self-payment would be calculated:
>
> 1,200 hours – 925 hours = 275 hours
>
> 275 hours x $11.23 hourly contribution rate equals a $3,088.25 self-payment
>
> If Jose wanted Plan II coverage for 2022 instead, no self-payment would be required because his 2021 hours are greater than the minimum of 750 hours required for Plan II coverage.

If these changes affect you, you will be sent a letter by the Fund Office explaining your eligibility for the 2022 Self-Payment Program and the self-payment amount due. **This letter will arrive by U.S. Postal Service Priority mail. Signatures will not be required.** To continue coverage through self-payment for calendar year 2022, the Fund Office **must** receive your payment in full on or before December 31, 2021. If you believe you are eligible to make self-payments and you do not receive your explanatory letter, or if you have any questions about these changes or your benefits in general, please call the Fund Office at (847) 827-1029.

Statement of Grandfathered Status

The Board of Trustees believes that the Plans are "grandfathered health plans" as that term is defined under the Affordable Care Act, which permits the Plans to preserve certain basic health coverage already in effect before the law was passed. As with all grandfathered health plans, the Plans are not required to include certain consumer protections of the Affordable Care Act that apply to other non-grandfathered plans (for example, providing preventive health services without any cost sharing). However, the Plans must comply with certain other provisions of the Affordable Care Act, as described in this Notice.

Contact the Fund Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at (866) 444-3272 or **www.dol.gov/ebsa/healthreform**. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

A Final Note

Please call the Fund Office at (847) 827-1029 if you have any questions about these changes or about your benefits in general.

This Notice describes highlights of certain features of the Plan and is intended to be a Summary of Material Modifications to the Plans. Full details are contained in the documents that establish the provisions of the Plans. The Trustees reserve the right to amend, modify, or terminate the Plan at anytime and from time to time. Receipt of this Notice does not confer or guarantee eligibility for benefits.

SUMMARY OF MATERIAL MODIFICATIONS
EIN: 36-2226396 PN: 502, 503
November 2021

ROOFERS' UNIONS
WELFARE TRUST FUND

2021 Swift Drive, Suite B
Oak Brook, Illinois 60523
(847) 827-1029
Fax (847) 827-6358

December, 2021

Notice of Important Benefit Changes

Please read this Notice carefully and save it with your important documents.

The Board of Trustees ("Trustees") of the Roofers' Unions Welfare Trust Fund are pleased to announce important, benefit enhancements to the Weekly Disability Benefit under the Plans of Benefits II, II-PA and III (the "Plans") as explained in this Notice. Capitalized terms not defined in this Notice have the meaning as defined in the Roofers' Unions Welfare Trust Fund Summary Plan Description/Plan document effective January 1, 2015 ("SPD").

Changes to the Weekly Disability Benefit

Effective for Weekly Disability Benefit claims filed on or after January 1, 2022, the Weekly Disability Benefit will increase to $450.00 per week for Plan of Benefits II and Plan of Benefits II-PA and $600.00 per week for Plan of Benefits III.

Important Reminder: The terms and requirements of the SPD currently applicable and not otherwise discussed in this Notice continue to apply in full force and effect. For example, to be eligible for a Weekly Disability Benefit, you must still satisfy the requirements of being an Eligible Employee, and any Weekly Disability Benefit is still subject to the maximum limits, exclusions and limitations set forth in the SPD.

Statement of Grandfathered Status

The Board of Trustees believes that the Plans are "grandfathered health plans" as that term is defined under the Affordable Care Act, which permits the Plans to preserve certain basic health coverage already in effect before the law was passed. As with all grandfathered health plans, the Plans are not required to include certain consumer protections of the Affordable Care Act that apply to other non-grandfathered plans (for example, providing preventive health services without any cost sharing). However, the Plans must comply with certain other provisions of the Affordable Care Act, as described in this Notice.

Contact the Fund Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") at (866) 444-3272 or **www.dol.gov/ebsa/healthreform**. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

Over

A Final Note

Please call the Fund Office at (847) 827-1029 if you have any questions about this program or about your benefits in general.

This Notice describes highlights of certain features of the Plans and is intended to be a Summary of Material Modifications to the Plans. Full details are contained in the documents that establish the provisions of the Plans. The Trustees reserve the right to amend, modify, or terminate the Plans at anytime and from time to time. Receipt of this Notice does not confer or guarantee eligibility for benefits.

SUMMARY OF MATERIAL MODIFICATIONS

EIN: 36-2226396 PN: 502, 503

DECEMBER 2021

ROOFERS' UNIONS
WELFARE TRUST FUND

2021 Swift Drive, Suite B
Oak Brook, Illinois 60523
(847) 827-1029
Fax (847) 827-6358

April 2023

Notice of Important Benefit Changes

Please read this Notice carefully and save it with your important documents.

The Biden Administration (the "Administration") recently announced its intention to end the public health emergency and the national emergency periods related to COVID-19 will end on May 11, 2023. If the Administration goes through with this plan, the Board of Trustees ("Trustees") of the Roofers' Unions Welfare Trust Fund will make certain benefit changes to the Plans of Benefits II and II-PA (the "Plans") as explained in this Notice. Capitalized terms not defined in this Notice have the meaning as defined in the Roofers' Unions Welfare Trust Fund Summary Plan Description/Plan document effective January 1, 2015 ("SPD").

COVID-19 Diagnostic Testing

The Plans have been providing coverage for COVID-19 diagnostic testing, including services and supplies related to the furnishing or administration of the test during health care provider visits, urgent care center visits and emergency room visits, without any cost-sharing.

Effective May 12, 2023, the Plans will no longer provide coverage for COVID-19 diagnostic testing without any cost-sharing. The Plans will, however, provide coverage for COVID-19 diagnostic testing in accordance with the Plans' normal cost-sharing requirements for "diagnostic services." Any COVID-19 testing that is not for diagnostic purposes (including but not necessarily limited to testing that is required for attendance at work or school or for travel purposes) will not be covered.

Over-the-Counter COVID-19 Testing

The Plans have been providing coverage for over-the-counter ("OTC") COVID-19 diagnostic testing without any cost-sharing for the duration of the public health emergency.

Effective May 12, 2023, the Plans will no longer provide coverage for OTC COVID-19 tests.

Elimination of Telehealth Visits for Physical Therapy and Chiropractic Care

The Plans have been providing coverage for telehealth visits without cost-sharing for both PPO and Non-PPO providers up to the allowed amounts under the terms of the Plan.

Effective May 12, 2023, the Plans will continue to provide coverage for telehealth and virtual visits without cost-sharing for both PPO and Non-PPO providers **except** for medical expenses related to physical therapy and chiropractic care. In other words, beginning May 12, 2023, the Plans have eliminated coverage of telehealth and virtual visits for physical therapy and chiropractic care.

COVID-19 Vaccinations

The Plans have been providing coverage for COVID-19 vaccinations without any cost-sharing for the duration of the public health emergency.

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Effective May 12, 2023, the Plans will no longer provide coverage for COVID-19 vaccinations without any cost-sharing. The Plans will, however, provide coverage for COVID-19 vaccinations under the normal cost-sharing provisions of the Plans.

Statement of Grandfathered Status

The Board of Trustees believes that the Plans are "grandfathered health plans" as that term is defined under the Affordable Care Act, which permits the Plans to preserve certain basic health coverage already in effect before the law was passed. As with all grandfathered health plans, the Plans are not required to include certain consumer protections of the Affordable Care Act that apply to other non-grandfathered plans (for example, providing preventive health services without any cost sharing). However, the Plans must comply with certain other provisions of the Affordable Care Act, as described in this Notice.

Contact the Fund Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") at (866) 444-3272 or **www.dol.gov/ebsa/healthreform**. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

A Final Note

Please call the Fund Office at (847) 827-1029 if you have any questions about this program or about your benefits in general.

This Notice describes highlights of certain features of the Plans and is intended to be a Summary of Material Modifications to the Plans. Full details are contained in the documents that establish the provisions of the Plans. The Trustees reserve the right to amend, modify, or terminate the Plans at any time and from time to time. Receipt of this Notice does not confer or guarantee eligibility for benefits.

SUMMARY OF MATERIAL MODIFICATIONS

EIN: 36-2226396 PN: 502, 503

APRIL 2023

ROOFERS' UNIONS
WELFARE TRUST FUND

2021 Swift Drive, Suite B
Oak Brook, Illinois 60523
(847) 827-1029
Fax (847) 827-6358

August 2024

Notice of Important Benefit Changes

Please read this Notice carefully and save it with your important documents.

The Board of Trustees ("Trustees") of the Roofers' Unions Welfare Trust Fund are pleased to announce important changes to the Plans of Benefits II and III (the "Plans") as explained in this Notice. Capitalized terms not defined in this Notice have the meaning as defined in the Roofers' Unions Welfare Trust Fund Summary Plan Description/Plan document effective January 1, 2015 ("SPD").

Maternity Leave Benefit

The Trustees are pleased to announce a new Maternity Leave Benefit under the Plans for active Eligible Employees, effective July 1, 2024. The Maternity Leave Benefit is not available for Pre-Apprentices, Eligible Retirees, Non-Bargained Employees, Eligible Employees covered under a Participation Agreement, Spouses or Dependents.

Eligibility for the Maternity Leave Benefit

To be eligible for the Maternity Leave Benefit, an Eligible Employee must meet all of the following conditions:

1. The Eligible Employee must be eligible under the Plan during the period for which the employee seeks to receive Maternity Leave Benefits (not including COBRA continuation coverage period);

2. The Eligible Employee must be pregnant and under the care of a Doctor;

3. The Eligible Employee must provide medical proof of pregnancy certified by a Doctor that is satisfactory to the Trustees or their delegated claims administrator for Maternity Leave Benefits.

Maternity Leave Benefits are not available for foster care, surrogacy or adoptions. The Maternity Leave Benefit does not change depending on whether the pregnancy is for one or multiple children (i.e., twins, triplets, etc.). The Maternity Leave Benefit may be modified or terminated by the Trustees at any time.

Amount of the Maternity Leave Benefit

Eligible Employees will be entitled to a weekly benefit in an amount of $800 per week for a maximum of twenty-six (26) consecutive weeks. Maternity Leave Benefits may begin no earlier than thirteen (13) weeks before the Eligible Employee's expected due date, except if delivery ultimately occurs prior to the date that was thirteen (13) weeks before the expected due date, then Maternity Leave Benefits may begin on the date of delivery. The Maternity Leave Benefit is not available in any event after twenty-six (26) weeks have passed following a delivery. An Eligible Employee who receives Maternity Leave Benefits related to a pregnancy will not be entitled to receive Maternity Leave Benefits for any subsequent pregnancy until 24 months have passed since the last day for which Maternity Leave Benefits were paid in relation to the previous pregnancy.

Over

Social Security and Medicare taxes will automatically be withheld from any weekly Maternity Leave Benefit payments. Federal income and state taxes may also need to be withheld from the benefit upon written request from the Eligible Employee or as determined necessary to comply with applicable withholding requirements.

Maintaining Coverage While Receiving Maternity Leave Benefits

Eligible Employees receiving Maternity Leave Benefits will receive credit for up to five (5) hours of work in Covered Employment per day (Monday through Friday), for each day for which Maternity Leave Benefits are paid, up to a maximum of twenty-five (25) hours of work in Covered Employment per week.

Coordination with the Weekly Disability Benefit

For any weeks during which an Eligible Employee is entitled to and receives the Maternity Leave Benefit, the Maternity Leave Benefit paid for such week(s) will be in full replacement of any weekly disability benefits that would otherwise be payable to the Eligible Employee under the Plans for such week(s), and will count towards the weekly limit for the weekly disability benefit that may otherwise be payable related to the pregnancy or delivery. In the event an Eligible Employee is receiving weekly disability benefits related to the pregnancy prior to thirteen weeks before the expected due date, the member will transition to the Maternity Leave Benefit once the Eligible Employee is within thirteen weeks of the expected due date. In the event an Eligible Employee qualifies for weekly disability benefits upon the conclusion of the Maternity Leave Benefit, the Eligible Employee may resume the weekly disability benefit (if eligible for the weekly disability benefit at that time) subject to the remaining time limits of that the weekly disability benefit.

New Broad Vaccination Network Program

Currently, the Plan's Prescription Drug Benefit covers routine seasonal vaccines, such as the influenza and COVID-19 vaccines, and the Respiratory Syncytial Virus (RSV) vaccine at zero cost-sharing.

Effective for claims incurred on or after July 1, 2024, the Welfare Trust Fund has implemented a new broad vaccination network program through its Prescription Drug Benefits Manager, CVS/Caremark. Under this program, non-seasonal vaccines are covered at zero cost-sharing. Non-seasonal vaccines include diphtheria, tetanus, pertussis, meningococcal, measles, mumps, and rubella. You will continue to be responsible for any applicable cost of the office visit. Please note, however, that travel vaccines are excluded.

Initial Eligibility for New Apprentices

Effective for apprentices first hired on or after January 1, 2025, to become initially eligible for coverage under Plan II benefits, the minimum hours you must work in Covered Employment is **reduced from 600 hours to 500 hours**, during a continuous period of no more than 12 months.

This change does not apply to pre-apprentices and does not modify the requirements to maintain continued eligibility under the Plan.

Statement of Grandfathered Status

The Trustees believes that the Plans are "grandfathered health plans" as that term is defined under the Affordable Care Act, which permits the Plans to preserve certain basic health coverage already in effect before the law was passed. As with all grandfathered health plans, the Plans are not required to include certain consumer protections of the Affordable Care Act that apply to other non-grandfathered plans (for example, providing preventive health services without any cost sharing). However, the Plans must comply with certain other provisions of the Affordable Care Act, as described in this Notice.

Contact the Fund Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") at (866) 444-3272 or **www.dol.gov/ebsa/healthreform**. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

A Final Note

Please call the Fund Office at (847) 827-1029 if you have any questions about this program or about your benefits in general.

This Notice describes highlights of certain features of the Plans and is intended to be a Summary of Material Modifications to the Plans. Full details are contained in the documents that establish the provisions of the Plans. The Trustees reserve the right to amend, modify, or terminate the Plans at any time and from time to time. Receipt of this Notice does not confer or guarantee eligibility for benefits.

SUMMARY OF MATERIAL MODIFICATIONS

EIN: 36-2226396 PN: 502, 503

August 2024

ROOFERS' UNIONS
WELFARE TRUST FUND

2021 Swift Drive, Suite B
Oak Brook, Illinois 60523
(847) 827-1029
Fax (847) 827-6358

Office of the Fund Manager

Notice of Important Benefit Improvement

Please read this Notice carefully and save it with your important documents.

The Board of Trustees of the Roofers' Unions Welfare Trust Fund is pleased to announce an important benefit improvement to Plans of Benefits II and III (the "Plans"), as described below:

Medicare Retirees
Medical and Prescription Drug Benefit Changes

The Trustees are pleased to announce the Welfare Fund started working with BlueCross BlueShield of Illinois to provide eligible Medicare Retirees with medical and prescription drug coverage under the BlueCross BlueShield of Illinois Medicare and Prescription Drug ("MAPD") Plan PPO, effective **January 1, 2024**.

Non-Medicare Retirees will continue to receive the same medical and prescription drug benefits under the Plan, but you **should read this notice carefully** because you **MUST** take certain actions upon your eligibility for Medicare.

To assist you with this transition, the Trustees have retained **Retiree First**, a firm that specializes in the implementation and ongoing service of retiree medical and prescription programs. This change is meant to enhance post-Medicare retiree benefits, improve operational and administrative workflow, and to strengthen the financial position of the Welfare Fund.

What is the MAPD Plan?

The MAPD Plan provides all the benefits of original Medicare Parts A and B and Medicare Part D prescription drug coverage. The MAPD Plan also provides extra benefits such as Silver Sneakers, Preferred Diabetic Supplies, Telehealth and 24/7 NurseLine access.

You **MUST** be enrolled in **Medicare Parts A and B** and continue to pay your **Medicare Part B** monthly premium to the Social Security Administration, including any income-related surcharges, to be eligible for coverage under the MAPD Plan.

What are my Out-of-Pocket Costs under the MAPD Plan?

Below is a summary of the medical and prescription drug benefits that Medicare Retirees will receive under the BlueCross BlueShield of Illinois MAPD Plan:

Medical Benefit under the MAPD Plan		
Calendar Year Deductible	$0 per person	
Out-of-Pocket Maximum per Calendar Year	Not Applicable	
Your Co-Payment Amount under the MAPD Plan		
Primary Care Office Visit	$0 copay	
Specialist Office Visit	$0 copay	
Emergency Care	$0 copay	
Urgent Care	$0 copay	
Ambulance	$0 copay	
Outpatient Surgery	$0 copay	
Inpatient Hospital Care	$0 copay per stay	
Inpatient Mental Health & Substance Abuse	$0 copay per stay, 190 days lifetime maximum	
Emergency Room	$0 copay	
Skilled Nursing Care	$0 copay, Days 1-100	
Durable Medical Equipment	$0 copay	
Prescription Drug Benefit under the MAPD Plan		
Calendar Year Deductible	$0	
Out-of-Pocket Maximum per Calendar Year	Not Applicable	
Your Co-Payment Amount During Initial Coverage and Coverage Gap	***Retail (30-day supply)***	***Mail (90-day supply)***
Generic	$10	$25
Preferred Brand	$20	$50
Non-Preferred Brand	$30	$75
Specialty	$100, limited to one-month supply	

The benefits listed above are provided exclusively through a **fully insured contract** with BlueCross BlueShield of Illinois. This means your medical and prescription drug benefits provided under the MAPD Plan will be paid in accordance with the BlueCross BlueShield of Illinois policy.

Changes to Reimbursement of Medicare Premiums

Prior to January 1, 2024, the Welfare Fund provided for full reimbursement of Medicare Parts B and D premiums and a portion of the premium for a Medicare supplement policy to Medicare-eligible retirees and their eligible spouses ages 65 and over. Effective January 1, 2024, the Fund will only reimburse fifty percent (50%) of you and your eligible spouse's Medicare Part B payments.

Hearing, Vision and Dental Benefits

The MAPD Plan includes the following Hearing, Vision and Dental Benefits.

Hearing Aid Benefit under the MAPD Plan	
Routine Hearing Exam	$0 copay, one per year ($40 allowance for out-of-network)
Hearing Aid Allowance	$2,000 per ear every 36 months
Vision Benefit under the MAPD Plan	
Routine Eye Exam	$0 copay, one per year ($40 allowance for out-of-network)
Eyewear Allowance	$150 per 24 months
Dental Benefit under the MAPD Plan	
Calendar Year Deductible	$0
Preventive & Diagnostic	$0 copay
Basic Restorative	$0 copay
Major Restorative	$0 copay
Dental Allowance	$1,000 per year

Statement of Grandfathered Status

The Board of Trustees believes that the Plans are "grandfathered health plans" as that term is defined under the Affordable Care Act, which permits the Plans to preserve certain basic health coverage already in effect before the law was passed. As with all grandfathered health plans, the Plans are not required to include certain consumer protections of the Affordable Care Act that apply to other non-grandfathered plans (for example, providing preventive health services without any cost sharing). However, the Plans must comply with certain other provisions of the Affordable Care Act.

Contact the Fund Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at (866) 444-3272 or www.dol.goviebsa/healthreform. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

SUMMARY OF MATERIAL MODIFICATIONS

EIN: 36-2226396 PN: 502, 503

August 2024

ROOFERS' UNIONS
WELFARE TRUST FUND

2021 Swift Drive, Suite B
Oak Brook, Illinois 60523
(847) 827-1029
Fax (847) 827-6358

September 2024

Notice of Important Benefit Changes

Please read this Notice carefully and save it with your important documents.

The Board of Trustees ("Trustees") of the Roofers' Unions Welfare Trust Fund are pleased to announce important changes to the Plans of Benefits II and III (the "Plans") as explained in this Notice. Capitalized terms not defined in this Notice have the meaning as defined in the Roofers' Unions Welfare Trust Fund Summary Plan Description/Plan Document effective January 1, 2015 ("SPD").

Enhanced Speech Therapy Benefit

Currently, the Plan's Comprehensive Medical Expense Benefit provides coverage for speech therapy services when provided by a registered speech therapist, but only if the therapy is required as a result of massive brain injury, congenital defect of the mouth and/or palate, or surgery on the mouth, palate, larynx, and/or vocal cords.

Effective for claims incurred on or after September 12, 2024, the Welfare Trust Fund will provide coverage for speech therapy services related to restorative and developmental conditions under the Comprehensive Medical Expense Benefit at 80% for PPO and Non-PPO providers. ***Note there is a limit of twenty-six (26) visits per calendar year per Covered Person for all speech therapy services.***

Periodontal Benefit Increased

Effective for claims incurred on or after September 12, 2024, the Trustees eliminated the $2,000 lifetime maximum for the Periodontal Benefit. The Welfare Trust Fund will still provide coverage for eligible expenses under the Periodontal Benefit at 80% for PPO and Non-PPO dental providers. However, these expenses will now count towards the calendar year Dental Benefit maximum.

Gene Therapy and Cellular Therapy Exclusions

Effective for claims incurred on or after January 1, 2025, the Welfare Trust Fund will exclude gene therapy and cellular therapy as covered expenses under the Comprehensive Medical Expense Benefit and Prescription Drug Benefit. As such, any charge incurred for or in connection with gene therapy or cellular therapy will not be covered.

Statement of Grandfathered Status

The Trustees believes that the Plans are "grandfathered health plans" as that term is defined under the Affordable Care Act, which permits the Plans to preserve certain basic health coverage already in effect before the law was passed. As with all grandfathered health plans, the Plans are not required to include certain consumer protections of the Affordable Care Act that apply to other non-grandfathered plans (for example, providing preventive health services without any cost sharing). However, the Plans must comply with certain other provisions of the Affordable Care Act, as described in this Notice.

Over

Contact the Fund Office if you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") at (866) 444-3272 or **www.dol.gov/ebsa/healthreform**. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans.

A Final Note

Please call the Fund Office at (847) 827-1029 if you have any questions about this program or about your benefits in general.

This Notice describes highlights of certain features of the Plans and is intended to be a Summary of Material Modifications to the Plans. Full details are contained in the documents that establish the provisions of the Plans. The Trustees reserve the right to amend, modify, or terminate the Plans at any time and from time to time. Receipt of this Notice does not confer or guarantee eligibility for benefits.

SUMMARY OF MATERIAL MODIFICATIONS
EIN: 36-2226396 PN: 502, 503
September 2024

ROOFERS' UNIONS
WELFARE TRUST FUND

2021 Swift Drive, Suite B
Oak Brook, Illinois 60523
(847) 827-1029
Fax (847) 827-6358

December 2024

Notice of Important Benefit Changes

Please read this Notice carefully and save it with your important documents.

The Board of Trustees ("Trustees") of the Roofers' Unions Welfare Trust Fund are pleased to announce important changes to the Plans of Benefits II and III (the "Plans") as explained in this Notice. Capitalized terms not defined in this Notice have the meaning as defined in the Roofers' Unions Welfare Trust Fund Summary Plan Description/Plan Document effective January 1, 2015 ("SPD").

End of Grandfathered Status

Effective January 1, 2025, the Plans will no longer be considered "grandfathered" health plans under the Patient Protection and Affordable Care Act of 2010, as amended ("ACA"). Accordingly, the Board of Trustees adopted additional changes to the Plans to comply with the ACA, as detailed below.

Statement of Grandfathered Status

Effective January 1, 2025, the Statement of Grandfathered Status in the Plans is removed.

Out-of-Pocket Maximums

Effective January 1, 2025, the Plans will implement a prescription drug out-of-pocket maximum as follows:

- **Plan II** – The prescription drug out-of-pocket maximum is $7,400 per person and $15,400 per family per calendar year.

- **Plan III** – The prescription drug out-of-pocket maximum is $8,200 per person and $16,900 per family per calendar year.

If you reach the prescription drug out-of-pocket maximum for expenses subject to the maximum, the Fund pays 100% of all covered prescription drug expenses for the rest of the calendar year. Families can meet the out-of-pocket maximums without each family member meeting his or her individual out-of-pocket maximum.

Preventive Services

Effective for claims incurred on or after January 1, 2025, the Plans will cover in-network and out-of-network Preventive Services at 100% (not subject to Plan deductibles, copay amounts or copay percentages). Please be aware that if a Preventive Service reveals symptoms or conditions that require further testing or treatment, benefits for the additional tests and/or treatment are paid the same as any other accident or sickness.

Preventive services are defined by federal law and may be subject to frequency limits and medical necessity recommendations and coverage is provided for the following services:

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- Services described in the United States Preventive Services Task Force (USPSTF) A and B recommendations;
- Services described in the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC); and
- Health Resources and Services Administration (HRSA) Guidelines including the American Academy of Pediatrics Bright Futures guidelines.

The list of Preventive Services can be found at www.healthcare.gov/coverage/preventive-care-benefits and is subject to change as updated by federal regulations. In some cases, federal guidelines are unclear about which preventive benefits must be covered under the ACA. In that case, the Trustees will determine whether a particular benefit is covered as a Preventive Service. For more information on Preventive Services, please contact the Fund Office.

Hospice Care

Effective for claims incurred on or after January 1, 2025, the Trustees eliminated the Plans' $10,000 Lifetime Maximum per Covered Person for hospice care.

Occupational Therapy

Effective for claims incurred on or after January 1, 2025, the Trustees eliminated the Plans' $5,000 per Covered Person Calendar Year limit for occupational therapy expenses. Occupational therapy expenses will now be subject to a twenty-six (26) visit limit per Covered Person per Calendar Year.

Claims and Appeals Procedures

Effective for claims incurred on or after January 1, 2025, the Plans' claims and appeal procedures will change pursuant to the ACA. Most notably, the Welfare Fund is expanding the external review appeal process. The Plans were previously amended to provide for external review for claims covered under the No Surprises Act. Now, in addition to claims involving compliance with the cost-sharing and surprise billing protections under the No Surprises Act, if your health care claim involves medical judgment or rescission of coverage and was denied, resulting in an Adverse Benefit Determination, you have the right to file a request for an external review by an independent review organization ("IRO") within four (4) months of the notice of the final internal denial decision.

Your Explanation of Benefits and internal appeal decisions will inform you of your right to request an external review appeal, your external review rights, and your right to file suit in federal court under the Employee Retirement Income Security Act of 1974, as amended.

Clinical Trials

Effective for claims incurred on or after January 1, 2025, the Plans will not deny participation in a Phase I, II, III, or IV approved clinical trial for which you or your dependent is a qualified individual with respect to the treatment of cancer or another life-threatening disease or condition, or deny (or limit or impose additional conditions on) the coverage of routine patient costs for drugs, devices, medical treatment, or procedures provided or performed in connection with participation in such an approved clinical trial. You or your dependent participating in such an approved clinical trial will not be discriminated against on the basis of his or her participation in the approved clinical trial.

The Experimental or Investigative definition in the Plans is updated to clarify that any such approved clinical trial will not be considered Experimental or Investigative.

A Final Note

Please call the Fund Office at (847) 827-1029 if you have any questions about this program or about your benefits in general.

This Notice describes highlights of certain features of the Plans and is intended to be a Summary of Material Modifications to the Plans. Full details are contained in the documents that establish the provisions of the Plans. The Trustees reserve the right to amend, modify, or terminate the Plans at any time and from time to time. Receipt of this Notice does not confer or guarantee eligibility for benefits.

SUMMARY OF MATERIAL MODIFICATIONS

EIN: 36-2226396 PN: 502, 503

Decemnber 2024

ROOFERS' UNIONS
WELFARE TRUST FUND

2021 Swift Drive, Suite B
Oak Brook, Illinois 60523
(847) 827-1029
Fax (847) 827-6358

July 2025

Notice of Important Benefit Change

Please read this Notice carefully and save it with your important documents.

The Board of Trustees ("Trustees") of the Roofers' Unions Welfare Trust Fund are pleased to announce an important change to the Plans of Benefits II and III (the "Plans") as explained in this Notice. Capitalized terms not defined in this Notice have the meaning as defined in the Roofers' Unions Welfare Trust Fund Summary Plan Description/Plan Document effective January 1, 2015 ("SPD").

Cranial Prothesis (Wigs) Benefit

Effective July 1, 2025, the Welfare Trust Fund will provide up to $1,000 in coverage each year for cranial prostheses (wigs) for individuals undergoing chemotherapy and experiencing related hair loss.

A Final Note

Please call the Fund Office at (847) 827-1029 if you have any questions about this change or about your benefits in general.

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SUMMARY OF MATERIAL MODIFICATIONS
EIN: 36-2226396 PN: 502, 503
July 2025

ROOFERS' UNIONS
WELFARE TRUST FUND

2021 Swift Drive, Suite B
Oak Brook, Illinois 60523
(847) 827-1029
Fax (847) 827-6358

November 2025

Notice of Important Benefit Change

Please read this Notice carefully and save it with your important documents.

The Board of Trustees ("Trustees") of the Roofers' Unions Welfare Trust Fund are pleased to announce an important change to the Plans of Benefits II and III (the "Plans") as explained in this Notice. Capitalized terms not defined in this Notice have the meaning as defined in the Roofers' Unions Welfare Trust Fund Summary Plan Description/Plan Document effective January 1, 2015 ("SPD").

Infertility Treatment Benefit Changes

Effective January 1, 2026, the Plan is amended to remove (i) the $5,000 Maximum Calendar Year Benefit and (ii) the $25,000 Maximum Lifetime Benefit, for infertility treatment. In their place, the Trustees are implementing a Maximum Lifetime Benefit for you and a spouse in the combined amount of $30,000. The coinsurance requirements for infertility treatment have not changed. This means the Plan will continue to pay 80% of eligible infertility expenses for PPO providers and 70% of eligible infertility expenses for non-PPO providers incurred by you and/or a spouse of yours, up to a combined lifetime maximum of $30,000. This combined lifetime limit applies to both you and any spouse of yours effective for claims incurred on and after January 1, 2026.

Infertility treatment includes diagnostic testing, surgical or medical treatment and prescription drugs to promote conception by natural or artificial means of any kind. Non-spouse dependents are <u>not</u> eligible to receive the Infertility Benefit.

A Final Note

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SUMMARY OF MATERIAL MODIFICATIONS
EIN: 36-2226396 PN: 502, 503
October 2025

Roofers' Union Welfare Trust Fund

Fund Office
2021 Swift Drive, Suite B
Oak Brook, IL 60523

Phone: (847) 827-1029
Fax: (630) 928-1677

January 2026

Notice of Important Benefit Change

Please read this Notice carefully and save it with your important documents.

The Board of Trustees ("Trustees") of the Roofers' Unions Welfare Trust Fund are pleased to announce an important change to the Plans of Benefits II and III (the "Plans") as explained in this Notice. Capitalized terms not defined in this Notice have the meaning as defined in the Roofers' Unions Welfare Trust Fund Summary Plan Description/Plan Document effective January 1, 2015 ("SPD").

Increase to Contact Lenses Allowance under Vision Benefit

Effective January 1, 2026, the Trustees increased the contact lenses allowance from $100 per person to $150 per person for PPO providers. The Plan will now pay benefits as follows:

Contact Lenses (Once every calendar year)	**PPO Provider**	**Non-PPO Provider**
Conventional Lenses	Plan pays 100% up to $150 allowance; Covered Person pays remaining amount at a 15% discount off of retail price	Plan pays 100% up to $50
Disposable Lenses	Plan pays 100% up to $150 allowance	Plan pays 100% up to $50
Medically Necessary Lenses	Plan pays 100%	Plan pays 100% up to $200

A Final Note

Please call the Fund Office at (847) 827-1029 if you have any questions about this change or about your benefits in general.

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SUMMARY OF MATERIAL MODIFICATIONS
EIN: 36-2226396 PN: 502, 503
January 2026