BUFFALO LABORERS WELFARE FUND
SUMMARY PLAN DESCRIPTION

Effective January 1, 2014

BUFFALO LABORERS WELFARE FUND PLAN OF BENEFITS

SUMMARY PLAN DESCRIPTION

Introduction

The Board of Trustees of the Buffalo Laborers Welfare Fund (the "Welfare Fund") is pleased to present this revised Summary Plan Description, which describes the benefits and eligibility requirements of the Fund's plan of benefits (the "Plan") beginning January 1, 2014. Also included in this booklet are the procedures that you should follow when filing a claim, and certain information concerning the administration of the Plan as required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

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

The Plan is designed to help you and your family meet the continuing rising costs of medical care as well as provide a measure of protection if you are unable to work due to layoff or disability.

This booklet summarizes the key features of your Welfare Fund benefits program and also functions as a Plan document. Complete details of the program are also contained in the other official Plan documents, including the Trust Agreement, the Fund's contracts with its benefit insurers and health maintenance organizations, and Collective Bargaining Agreements, which legally govern the operation of the program. This document, together with the Insurance Benefit Booklets (defined herein), constitute the summary plan description as required by Section 102 of ERISA. If there is any conflict between this document and the Insurance Benefit Booklets (other than summaries of material modifications to this SPD or the Benefit Booklets), then the Benefit Booklets will control unless otherwise required by law or specified herein.

All official Plan documents are available for your inspection at the Fund Office during normal business hours. All statements made in this booklet are subject to the provisions and terms of those documents. In case of a conflict or inconsistency between the official Plan documents and this booklet, the official documents will govern in all cases.

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

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

If you have questions about the Plan or how to apply for benefits, do not hesitate to contact the Fund Office by phone at (716) 894-8061 or at the Buffalo Laborers Welfare Fund, 25 Tyrol Drive, Suite 200, Cheektowaga, NY 14227.

Sincerely,

Board of Trustees

I. DEFINITIONS

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

1.1. Code: The term "Code" will mean the Internal Revenue Code of 1986, as amended.

1.2. Collective Bargaining Agreement: The term "Collective Bargaining Agreement" will mean any agreement between the Union and an Employer that requires the payment of periodic Contributions to the Fund or other written participation or other agreement acceptable to the Trustees that requires the payment of periodic Contributions to the Fund.

1.3. Contributions: The term "Contributions" will mean those payments made to the Fund as required by the Collective Bargaining Agreement.

1.4. Covered Employment: The term "Covered Employment" will mean employment of a type covered by a Collective Bargaining Agreement and requiring Contributions on your behalf to the Fund.

1.5. Dependent: Except where otherwise noted (such as Section VII of this booklet, which has a special definition), the term "Dependent" means:

(i) Your spouse (as defined for federal tax law purposes);

(ii) For purposes of medical coverage or reimbursements from your Health Care Account under the Plan, each of your children until the end of the month in which he or she reaches age 26, except as provided for by the applicable insurance policy. Such a child is eligible regardless of whether he or she is married or unmarried, regardless of his or her student or employment status, regardless of whether your home is his or her principal place of abode, or regardless of whether you support him or her financially; and

(iii) Each of your children who (i) is age 26 or older, (ii) was physically or mentally disabled prior to attaining age 26, (iii) is unmarried, (iv) was covered under the Plan immediately prior to attaining age 26, (v) is incapable of self-sustaining employment by reason of a mental or physical disability, (vi) is primarily supported by you, and (vii) is allowed to be claimed by you as an exemption for federal income tax purposes.

For purposes of this definition, "child" or "children" includes the following: your biological children; your stepchildren; your legally adopted children; your foster children; any children placed with you for adoption; any children for whom you are responsible under court order; any children for whom you are appointed legal guardianship, and any children for whom you are responsible to provide medical coverage under a Qualified Medical Child Support Order. Participants and beneficiaries can obtain, without charge, a copy of the Plan's procedures governing Qualified Medical Child Support Orders from the Plan Administrator.

1.6. Disability: The term "Disability" will mean a physical or mental condition resulting from bodily injury, disease or mental condition which renders a person incapable of continuing any gainful occupation and which entitles him to benefits under the New York State Disability Benefits Law or Worker's Compensation Act. Disability shall be determined by the Trustees in their sole and absolute discretion. The Trustees may require that an individual provide proof of Disability at any time.

1.7. Employee: The term "Employee" will mean any person employed by an Employer and covered by a Collective Bargaining Agreement.

1.8. Employer: The term "Employer" will mean (i) any one of the employer members of an employer association that enters into a Collective Bargaining Agreement with the Union; (ii) an independent signatory to a Collective Bargaining Agreement that is acceptable to the Board of Trustees; (iii) the Buffalo Laborers Welfare Fund and the Buffalo Laborers Training Fund; (iv) the Union; and (v) any signatory to a participation or other agreement requiring payment of periodic Contributions to the Fund by such person or entity that is acceptable to the Board of Trustees.

1.9. Fund: The term "Fund" will mean the Buffalo Laborers Welfare Fund, which includes all Contributions to the Trustees pursuant to the terms set forth in the Collective Bargaining Agreement, together with all the income, earnings and profits thereon received by the Trustees, less any expenses paid therefrom. The Fund may be used only for the purposes set forth in the Trust Agreement.

1.10. Fund Administrator: The term "Fund Administrator" will mean the person designated by the Trustees to handle certain of their day-to-day administrative duties.

1.11. Group Contract: The term "Group Contract" will mean an insurance contract used by the Trustees to provide health and hospitalization coverage benefits.

1.12. Inactive Employee: The term "Inactive Employee" will mean an Employee who has not worked in the construction industry for a period of twelve consecutive months.

1.13. Insurance Benefit Booklet: A booklet provided by the insurance company insuring benefits provided under the Plan describing the benefits provided pursuant to the Group Contract or another insurance contract.

1.14. Minimum Balance: The term "Minimum Balance" will mean the minimum amount that must be in an Employee's Health Care Account in order to be eligible for benefits.

1.15. Monthly Premium: The term "Monthly Premium" will mean the amount determined by the Trustees to be the reduction to a Participant's Health Care Account for a month of coverage for insured health benefits provided under the Plan.

1.16. Participant: The eligible employee or his spouse or his dependent child(ren) who has enrolled for coverage under the Plan.

1.17. Plan: The term "Plan" will mean the written plan of benefits of the Fund adopted by the Trustees setting forth the eligibility rules for the health and welfare benefits to be paid from the Fund.

1.18. Plan Administrator: The term "Plan Administrator" will mean the Board of Trustees of the Fund. The Plan Administrator will administer the Plan, keep the Plan's records and has discretionary authority to construe the terms of the Plan and make determinations on questions which affect eligibility of benefits.

1.19. Plan Year: The term "Plan Year" will mean the twelve-month period beginning on July 1 and continuing to the following June 30.

1.20. Retirees: The term "Retirees" will mean the persons who have retired from the bargaining unit of Employees covered by the Collective Bargaining Agreement and are receiving a

pension from the Buffalo Laborers Pension Fund (that is not currently being suspended) and retired employees of the Buffalo Laborers Welfare Fund who have received their retirement benefits from the Buffalo Laborers Welfare Fund Staff Pension Plan.

1.21. Retirement: The term "Retirement" will mean the severance of the employment relationship between Participant and Employer other than by reason of death on or after his Normal Retirement Age. Normal Retirement Age means a Participant's sixty-fifth (65th) birthday.

1.22. Trust Agreement: The term "Trust Agreement" will mean the Agreement and Declaration of Trust, Buffalo Laborers Welfare Fund, dated October 17, 1994, together with any amendments made thereto.

1.23. Trustees: The term "Trustees" will mean the Board of Trustees of the Fund.

1.24. Union: The term "Union" will mean Local No. 210 of the Laborers International Union of North America, AFL-CIO, and its successors and assigns.

II. GENERAL INFORMATION ABOUT THE FUND

This Section contains certain general information which you may need to know about the Fund.

A. General Fund Information

The name of the Fund is the Buffalo Laborers Welfare Fund.

Except as otherwise provided, the provisions of the Plan that are described in this booklet became effective on January 1, 2014.

The Fund's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year is the twelve-month period beginning on July 1 and ending the following June 30.

B. Plan Administrator

The Plan is sponsored by the Board of Trustees of the Buffalo Laborers Welfare Fund. The Board of Trustees is also the Plan Administrator. The Board of Trustees is responsible for the overall operation and administration of the Fund.

The employer identification number of the Plan Sponsor is 16-0806902. The Trustees have assigned plan number 501 to the Fund.

The following individuals currently comprise the Board of Trustees:

Employer Trustees:	**Union Trustees:**
D. Ronald Rosser 3 Bruce Drive Orchard Park, NY 14127	**Samuel Capitano** Laborers' Local Union 210 25 Tyrol Drive, Suite 100 Cheektowaga, NY 14227

Employer Trustees:	**Union Trustees:**
James C. Logan CIEA P.O. Box 4189 Buffalo, NY 14217	**John Massaro** Laborers' Local Union 210 25 Tyrol Drive, Suite 100 Cheektowaga, NY 14227
Mark Schober Huber Construction 136 Taylor Drive Depew, NY 14043	**Charles Paladino** Laborers' Local Union 210 25 Tyrol Drive, Suite 100 Cheektowaga, NY 14227
Robert Hill UCC Constructors P.O. Box 648 West Seneca, NY 14224	**Gary Bernardo** Laborers' Local Union 210 25 Tyrol Drive, Suite 100 Cheektowaga, NY 14227

Responsibility for administration of health and hospital insurance claims has been delegated to the insurance company or health maintenance organization providing those benefits. Responsibility for administration of life insurance claims (other than retiree life insurance) has been delegated to the insurance company providing that benefit. The Board has retained responsibility for the administration of other benefits, including the Health Care, Wage Replacement and Vacation Account benefits, disability benefits, dependent care benefits and retiree life insurance benefits.

Please remember that no one except the Board of Trustees (and other Plan fiduciaries and individuals or entities, including any insurance company, to whom the Board of Trustees has delegated responsibility for administration of the Plan) has the authority to interpret the Plan, including this booklet or the other official Plan documents, to make any promises to you about it, or to change the provisions of the Plan. The Board of Trustees (or its duly authorized designee) has the exclusive right and power, in its sole and absolute discretion, to interpret the Plan documents and to decide all matters under the Plan, including, without limitation, the right to make all decisions with respect to eligibility for and the amount of benefits payable under the Plan and the right to resolve any possible ambiguities, inconsistencies or omissions concerning the Fund or the Plan. All determinations by the Board of Trustees (or its duly authorized designee) are final and binding on all persons and will be given full force and effect.

C. Fund Administrator Information

The Trustees have delegated certain day-to-day administrative duties to the Fund Administrator. The name and address of the current Fund Administrator is:

Mr. Thomas Panek, CPA
Buffalo Laborers Welfare Fund
25 Tyrol Drive, Suite 200
Cheektowaga, NY 14227
(716) 894-8061

The Fund Administrator also keeps the records for the Fund. The Board of Trustees has authorized the Fund Administrator to respond in writing to any questions you may have about the Fund. As a courtesy, the Fund Administrator may respond informally to your oral questions. However, oral questions and answers are not binding upon the Board of Trustees and cannot be relied upon in a dispute

concerning your benefits. If you have an important question, you should contact the Fund Administrator for a written response. Keep in mind, however, that the official Plan documents (which include this booklet) govern at all times even if they are inconsistent with advice you receive.

D. Service of Legal Process

The name and address of the Fund's agent for service of legal process is:

Board of Trustees
Buffalo Laborers Welfare Fund
25 Tyrol Drive, Suite 200
Cheektowaga, NY 14227

Legal process may be served on the Plan Administrator or any individual Trustee.

E. Type of Plan

The Plan is a welfare benefit plan providing health, hospitalization, health care reimbursement, supplemental unemployment, life insurance, disability and vacation benefits. The health, hospitalization and life insurance (other than retiree life insurance) benefits are insured through insurers or health maintenance organizations. Other benefits are provided on a self-insured basis.

The Plan is maintained pursuant to one or more collective bargaining agreements. The collective bargaining agreements contain a clause providing for contribution to the Fund. A copy of any such agreement may be obtained by Participants and beneficiaries upon written request to the Plan Administrator, and is available for examination by Participants and beneficiaries. A complete list of the Employers and employee organizations sponsoring the Plan may be obtained by Participants and beneficiaries upon written request to the Plan Administrator, and is available for examination during normal business hours. Participants and beneficiaries may also receive from the Plan's Administrator, upon written request, information as to whether a particular employer is a sponsor of the Plan and, if so, the sponsor's address.

III. PERSONAL ACCOUNTS

A. Tax-Free vs. Taxable Benefits

For purposes of determining your eligibility for benefits under the Plan, the Plan Administrator will create and maintain individual accounts on your behalf – a **Health Care Account, Wage Replacement Account** and **Vacation Account**.

Your Health Care Account will provide you with benefits that are intended to be tax-free.

The following accounts will provide you with the following benefits that are intended to be taxable to you ("Taxable Accounts"):

Wage Replacement Account
Vacation Account

The law prohibits you from transferring your balances or directing Contributions between your Health Care Account and your Taxable Accounts. Additionally, your ability to transfer balances

or direct Contributions from your Wage Replacement Account to your Vacation Account is limited as explained below.

Each account will include a record of Contributions received on your behalf, benefits paid, and expenses charged against the account. Contributions required (and received by the Trustees) for work you perform under the Collective Bargaining Agreement will be credited in accordance with the next section. Generally, Contributions are credited to your account within the week following the week in which they are received by the Trustees; however, in some instances, Contributions may be credited to your account at a later date.

The maintenance of these accounts is for recordkeeping purposes only. You do not have a vested or non-forfeitable right to the balance in the account or any benefit offered by the Plan and, as noted elsewhere in this document, they can be modified or eliminated at any time; accounts are used only to determine your eligibility for benefits and can be modified or reduced at any time. Actual segregation of assets does not occur.

B. Allocation between Health Care and Wage Replacement Accounts

Generally, future Contributions made on your behalf (less an allocation to the Fund's general account) will be credited to your Health Care Account.

However, once your Health Care Account reaches a certain level, a portion of your future Contributions will be directed to your Wage Replacement Account instead provided you have coverage under the Plan or prove that you have acceptable alternative medical coverage in accordance with Section IV.A. below.

The amount that is directed depends on a number of factors, including whether you have single health insurance coverage, 2-person coverage, family coverage or outside coverage (because you showed proof of other health coverage that is not Medicaid or other payer of last resort coverage (which shall not include certain health programs operated by the Indian Health Service, Indian tribes or tribal organizations provided you submit verification from the Indian Health Service, tribe or tribal organization that you disclosed that you had health coverage available under the Plan), or solely catastrophic coverage). For this purpose, if you have health coverage from the Plan but you choose not to cover your eligible Dependents and you do not show proof of other health coverage (in accordance with the preceding sentence) for the Dependents, your allocation will be determined as though you were covering them through the Plan. See also Section IV.K. below. The allocation is illustrated in the following chart, which shows the percentage of future Contributions (less the allocation to the Fund's general account) that goes to your Health Care Account. The remaining percentage goes to your Wage Replacement Account.

		If your Health Care Account balance is:				
		Up to $3,000	**$3,000 to $7,999.99**	**$8,000 to $14,999.99**	**$15,000 to $19,999.99**	**$20,000 or more**
and your coverage from the Plan is:	**Outside coverage**	100% Health	50% Health	0% Health	0% Health	0% Health
	Single	100% Health	50% Health	0% Health	0% Health	0% Health
	2-person	100% Health	85% Health	75% Health	50% Health	0% Health
	Family	100% Health	100% Health	80% Health	50% Health	0% Health

This table applies to contributions for hours that were worked on or after January 1, 2014.

For example, if you have $8,500 in your Health Care Account and 2-person health insurance coverage, your future Contributions will be allocated 75% to the Health Account and 25% to the Wage Replacement Account. If your Health Care Account later drops to $7,900, the future allocation will automatically be changed to 85% to the Health Account and 15% to the Wage Replacement Account.

There is one exception to these rules. Once you have $15,000 in your Taxable Accounts combined, all future Contributions (less the allocation to the Fund's general account) will go to your Health Account.

If you do not have coverage under the Plan and do not prove that you have acceptable alternative medical coverage in accordance with Section IV.A. below, all future Contributions to your account will be credited to your Health Care Account and you will not be able to obtain reimbursement from your Health Care Account or Taxable Accounts during that period (including where you request reimbursement after that period for expenses incurred or events occurring during that period).

If you waive coverage under the Plan for your spouse and eligible Dependents and do not prove that you have alternative medical coverage for them (see Section IV.A.), your allocation to the Health Care Account will be determined as if you had coverage for them under the Plan (unless you fall into the preceding paragraph, in which case those rules apply anyway).

If you are an Inactive Participant or a Retiree, any delinquent Contributions remitted on your behalf by your previous employers after your retirement will be credited only to your Health Care Account.

C. Taxable Account Transfers

You cannot transfer funds from your Wage Replacement Account to your Vacation Account except as follows: You may elect, in the month immediately preceding January 1, April 1, July 1 and October 1 of each year, to transfer funds from your Wage Replacement Account to your Vacation Account. Elections will be effective as follows:

An election made:	**Will be effective:**
during the month of March	April 1
during the month of June	July 1
during the month of September	October 1
during the month of December	January 1

Any election to transfer funds is irrevocable after the date it becomes effective.

You cannot transfer funds from your Vacation Account back to your Wage Replacement Account.

IV. YOUR HEALTH CARE ACCOUNT

Your Health Care Account will be used for two purposes. First, it will be used to determine your eligibility for health and hospitalization insurance coverage from the Fund. Health and hospitalization coverage will be provided through one or more Group Contracts issued by an insurance company or and/or health maintenance organizations, any of which will be selected by the Plan Administrator.

Second, if you meet certain minimum requirements (described below), you may receive reimbursement for amounts you have expended (after tax) for medical care for yourself, your spouse or your Dependents. You must have incurred the service already in order to receive the reimbursement.

A. Eligibility

You will be eligible for health and hospitalization insurance coverage once you have accumulated $500 plus one Monthly Premium (which will vary based on whether you have eligible Dependents) in your Health Care Account, provided you are then working in Covered Employment or have reported to the Union as eligible to work in Covered Employment. In order to obtain such coverage you must complete an enrollment form provided by the Fund Administrator, on which you elect one of the forms of HMO or insurance coverage offered by the Plan. The Trustees will reduce your Health Care Account each month by the amount of the Monthly Premium for the selected coverage.

You will not be entitled to health and hospitalization coverage unless you complete the enrollment forms provided by the Fund Administrator and enroll yourself. You may also enroll your spouse and eligible Dependents in the Plan's medical coverage.

If you wish to waive coverage for yourself, you must present satisfactory proof, prior to your first date of eligibility, of your other health coverage (**not** including Medicaid or other payer of last resort – see Section IV.K below – or solely catastrophic coverage) that provides major medical and hospital benefits. If you choose to not enroll your spouse or eligible Dependents, you must execute a waiver form in accordance with procedures established by the Fund Office, which, among other things, confirms that you are not waiving Plan coverage in order to obtain payer of last resort coverage that is not available to you if you are eligible for the Plan.

For each Plan Year you do not enroll for health care coverage and do not present proof that you either have alternate health care coverage or waive coverage (as set forth above), your Health Care Account (if in excess of $5,000) will be reduced by the premium cost for self-only coverage under the least expensive health and hospitalization insurance coverage option offered to you by the Plan. **If you miss the deadline for enrollment and are charged this penalty, you will not be able to avoid the penalty by enrolling at that time. You will generally need to wait until the next open enrollment period (with certain exceptions as described below).**

Upon enrollment and from time to time thereafter, the Fund Administrator (or any insurer or HMO providing coverage) may require that you present satisfactory (as determined by the Fund Administrator or its delegee, in its sole and absolute discretion) proof of the initial and/or continuing eligibility of your covered spouse or covered Dependent children.

After you first enroll in benefits, in order to maintain benefits, you will again need to enroll during the Plan's open enrollment period, which generally occurs in August of every year for coverage beginning September 1 of that year. If you are enrolled in a Medicare supplemental policy, your open enrollment period generally occurs in December for coverage beginning on January 1 of the following year. **If you do not enroll during the open enrollment period, you will generally not be able to reenroll until the next open enrollment period.**

However, there are exceptions to that general rule. If you are a current employee and you decline enrollment for yourself or your Dependents (including your spouse) because you or the spouse and/or Dependent has coverage elsewhere when you or the spouse or Dependent first becomes eligible but you or the spouse or Dependent child loses that coverage (or the employer stops contributing towards your or your Dependent's other coverage) other than as a result of a failure to pay participant premiums or

termination of coverage for cause (such as fraud), you may subsequently enroll yourself and your Dependents (including your spouse) in the Plan by submitting a completed enrollment form to the Fund Administrator within 30 days after the other coverage ends (or after the Employer stops contributing toward the other coverage). A loss of eligibility for coverage may include, for example, (i) loss of eligibility due to legal separation, divorce, cessation of dependent status (e.g., attaining the maximum age to be eligible as a dependent child), death of the employee, termination of employment, reduction in number of hours of employment; (ii) the individual no longer lives or works in a service area covered by an HMO (or similar arrangement) that does not provide benefits to individuals who do not reside, live or work in the area, and, in the case of a group market, there are no other benefit packages available; (iii) the plan no longer offers any benefits to a class of similarly situated individuals that includes the individual; and (iv) for other than COBRA coverage, employer contributions toward coverage terminate. If the other coverage was COBRA coverage, this exception only applies after the COBRA coverage is exhausted. In most cases, the coverage will be effective as of the first of the following month.

If you acquire a new Dependent during a period of coverage as a result of marriage, birth, adoption or placement for adoption, you may enroll the new Dependent in the Plan, but in order to do so you must request enrollment within 30 days of the marriage, birth, adoption or placement for adoption. In the case of a newly acquired Dependent child (through birth, adoption or placement for adoption), the enrollment will be effective as of the date of birth, adoption or placement for adoption if you do so within 30 days of the birth, adoption or placement for adoption. A child is considered placed for adoption on the date you first become legally obligated to provide support for the child whom you plan to adopt. If the adoption does not become final, coverage for the child will terminate as of the date you no longer have a legal obligation to support the child. In the case of a newly acquired spouse or another Dependent acquired by marriage, coverage is effective on the first day of the month following the date the completed enrollment form is received by the plan. In the case of a newly acquired Dependent child, if you or your spouse were previously eligible to enroll but did not, you may enroll at the same time as the newly acquired child.

If you are an active employee and otherwise eligible for coverage under the Plan, and either (i) you or your dependent's coverage under Medicaid or a State Children's Health Insurance Program (CHIP) is terminated as a result of loss of eligibility for such coverage, or (ii) you or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and/or your dependent(s) in the Plan if you request coverage under the Plan sixty (60) days after the date that Medicaid or CHIP coverage ends or the date you (or your dependent) are determined to be eligible for such assistance. If you qualify for this special enrollment opportunity, coverage under the Plan will be effective beginning on the first day of the first calendar month following the month in which a completed request for enrollment is received by the Fund Office.

To request special enrollment or obtain more information, contact the Fund Office at (716) 894-8061.

The health and hospitalization insurance or HMO coverage in which you enroll may offer the opportunity to cover your domestic partner under certain conditions. (Please review your insurance company's plan document to determine whether domestic partner coverage is available and, if so, under what conditions.) If your insurance company provides for spouse or domestic partner coverage and you enroll your domestic partner, the value of the benefit coverage for your domestic partner is considered taxable income to you under federal law (unless your domestic partner qualifies as a tax-dependent for health care purposes under the Code. You should contact the Fund Office if you believe that to be the case). As a result, your share of Medicare and Social Security tax withholdings plus federal tax withholdings will be deducted from your Health Care Account. (Note that you cannot obtain

reimbursements from your Health Care Account for your domestic partner.) You should consult a tax advisor before adding a domestic partner.

B. Benefits

The Group Contract of the insurance company whose product is then being used will control in defining the specific health and hospitalization benefits to which you and your covered Dependents are entitled including any deductibles, co-payments, lifetime or annual caps (other than essential health benefits), network providers, and any other conditions or limitations on benefits. You will be provided with an Insurance Benefit Booklet, which provides a detailed description of your benefits directly from the insurance company and you may obtain additional copies, free of charge, from the Fund Office.

You must comply with the terms of the applicable Insurance Benefit Booklet to obtain any Plan benefits insured by that insurance company. You will not be eligible for benefits for any period in which you are not in compliance with the terms of the Insurance Benefit Booklet even if you later become compliant.

C. Benefit Extension on Disability, Workers' Compensation and No-Fault Insurance

In the event you incur a Disability or become entitled to workers' compensation or no-fault insurance benefits (providing wage replacement benefits) after you have accumulated $500 in your Health Care Account, you worked at least 500 Hours of Service in the 12-month period immediately preceding the month in which you became disabled or injured (and for which you are receiving such workers' compensation or no-fault benefits), and you are covered under a Group Contract for health insurance offered by the Plan at the time you became disabled or entitled to workers' compensation or no-fault insurance benefits, you will be entitled to continued health and hospitalization coverage without charge to your Health Care Account for as long as you are disabled or receiving worker's compensation or no-fault insurance benefits (providing wage replacement benefits), but not in excess of six months for each Disability or injury for which you are entitled to such worker's compensation or no-fault insurance benefits. You will continue to receive the same form of coverage (i.e., single or family), under the same Group Contract or HMO, as you were receiving immediately prior to your Disability or injury (for which you are receiving workers' compensation or no-fault benefits providing wage replacement benefits). To receive health coverage while you are disabled or receiving workers' compensation or no-fault insurance benefits under this Section, you must provide adequate proof of your Disability or receipt of workers' compensation or no-fault benefits (providing wage replacement benefits) to the Fund Office. For additional information on what proof may be required, contact the Fund Office.

D. Benefit Extension on Death

In the event you die and you worked at least 500 Hours of Service in the 12-month period immediately preceding the month of your death, your spouse and Dependents who were covered by a Group Contract for health insurance offered by the Plan immediately prior to your death will receive six months of extended, health coverage from the Health Plan (as long as they remain eligible) without any deduction from the Health Care Account.

E. Health Care Reimbursement

If your Health Care Account balance is at least $3,000, you may receive reimbursement for amounts you have expended (after tax) for medical care for yourself, your spouse (but not your domestic partner), or your Dependents, provided, however, that such amounts are not covered under any insurance policy or plan of the Fund or any employer or under any federal or state law. In order to receive

reimbursement, your claim must be submitted within 90 days from the end of the calendar year in which the related expense was incurred and paid. As part of your claim, you will be required to certify that the expense for which you are requesting reimbursement are eligible expenses under the Code, were incurred by you or your Dependents, and has not been or will not be reimbursed from any other source.

IMPORTANT: Notwithstanding anything in this document to the contrary, in order to obtain reimbursement for yourself or your Dependents, you must be either (1) covered by the Plan's health and hospitalization insurance coverage or (2) covered by other group health insurance coverage that provides "minimum value" under Code Section 36B and satisfies the health reform law's preventive service requirements and annual limit prohibitions. Under the law, your other coverage can **not** be individual market coverage, such as coverage provided in the Health Insurance Marketplace created by health reform law. If your coverage is from a group health plan other than the Plan, you can find out from that other plan whether its coverage provides "minimum value" and satisfies the other requirements. The Plan may require you to provide proof, in accordance with its procedures of the other coverage and that it provides "minimum value" and complies with health reform's preventive service requirements and annual limit prohibitions.

The amount of the reimbursement is limited to the amount that the balance of your Health Care Account exceeds $3,000. For example, if your Health Care Account balance is $4,000, you will only be entitled to reimbursement for $1,000 of reimbursable expenses.

However, if you are classified by the Social Security Administration as totally and permanently disabled (as conclusively evidenced by a Social Security disability award letter stating that it has concluded that you are totally and permanently disabled) and you are eligible for reimbursements, you may receive reimbursement for amounts expended for medical care incurred on behalf of yourself or your Dependents to the extent remaining in your Health Care Account. This means that if you have a Social Security disability award concluding that you are totally and permanently disabled, the maximum amount of Health Care reimbursement is no longer limited to the amount that the balance of your Health Care Account exceeds $3,000. (You are not considered totally and permanently disabled for this purpose unless you have a Social Security disability award stating that you are.)

Reimbursable expenses include amounts you paid for medical care that would otherwise be deductible by you in calculating your federal income tax. This would include, but would not be limited to, amounts you paid for medical and dental bills, prescription drugs, eyeglasses, dental and health insurance paid with after-tax dollars and transportation primarily for, and essential to, medical care.

See Section X for information on when Inactive Employees and surviving spouses of Inactive Employees and Retirees may receive reimbursements.

F. Reimbursement by the Plan of Hospital Co-Pays up to $150

If you are actively working for an employer and you have hospitalization insurance coverage through the Fund, the Plan will reimburse you (or your Dependent covered by that insurance) for up to $150 for an in-patient hospital co-payment you (or your Dependent covered by that insurance) incur under that coverage. This reimbursement will not result in a deduction from your Health Care Account.

This reimbursement is only for the in-patient hospitalization co-payment under the HMO or insurance (through a Group Contract) offered by the Plan; if you (or your Dependent) have insurance coverage outside of the options provided for under the Plan, you (or your Dependent) are not eligible for this reimbursement. You must apply for the reimbursement in the same manner as applications for Health Care Reimbursements.

G. Termination of Eligibility

Unless you are entitled to continue coverage in accordance with Section X.A, you will cease to be eligible for health insurance benefits or health care reimbursement from the Fund on the last day of the month in which you are no longer available for work in Covered Employment or, if earlier, your Health Care Account balance falls below $500 or would fall below $500 if the Monthly Premium were deducted. To avoid termination of your coverage if your Health Care Account would be less than $500 if your Monthly Premium is deducted, you can pay the amount of your Monthly Premium to the Fund prior to the deduction of your Monthly Premium from your Health Care Account.

If you demonstrate that your Employer is delinquent in making Contributions on your behalf for Covered Employment, you have at least $500 in your Health Care Account, and you are forced to pay out-of-pocket for a portion of your Plan health and hospital insurance coverage as a result of the delinquency, then once your Employer makes all the past due Contributions on your behalf, you will be reimbursed for the amount you had to pay out-of-pocket for the coverage (to the extent you would not have had to pay it if your Employer's Contribution was timely made) during that period. You must demonstrate to the Plan Administrator's satisfaction (in its sole discretion) that you engaged in Covered Employment for which your Employer was required, but failed, to make contributions.

H. Forfeiture of Health Care Account

Your Health Care Account balance will be reduced by 50% if it is inactive for a period of three (3) consecutive years and will be completely forfeited after the fourth year of inactivity. For the purposes of this paragraph, your Health Care Account is inactive if there has been no activity, including any written correspondence from you regarding your account, for the specified period of time.

Any balance remaining in your Health Care Premium Account upon your death (if you are not survived by a spouse or eligible Dependents) or (if later) upon the death of your surviving spouse or eligible Dependent will be forfeited and added to the Fund's reserves.

I. Family and Medical Leave Act

If you are eligible for, and are granted leave by your Employer under the Family and Medical Leave Act of 1993, (the "FMLA"), you will be entitled to health and hospitalization insurance coverage under the plan throughout the duration of your FMLA leave, but your Employer must continue to contribute to the Plan during that period in order for you to continue your coverage in that way. You will receive the type of coverage (i.e., family or single) you were receiving prior to the leave, subject to any change you may have in family status.

You may be entitled to up to a maximum of 12 weeks of unpaid leave for specified family or medical purposes, such as the birth or adoption of a child, or to provide care for a spouse, child or parent who is ill. Effective January 16, 2009, you may also be entitled to up to a maximum of 12 weeks of unpaid leave because of any qualifying exigency (as defined in Department of Labor Regulations) arising out of the fact that your spouse, son, daughter or parent is on active duty or has been notified of an impending call to active duty status, in support of a contingency operation. (If you believe you are entitled to leave due to a qualifying exigency, you should contact your employer.)

You may also be entitled to up to 26 weeks during a 12-month period to take care of a service member who is your spouse, child, parent, or next-of-kin and is undergoing medical treatment or

recuperating from serious illness or injuries as a result of his or her service. You generally are eligible if you work for an Employer who has 50 or more employees at a worksite, and you worked at least 12 months for that Employer and at least 1,250 hours in the 12 months preceding the leave.

If you fail to return to work after your FMLA leave entitlement has been exhausted or expires, your Health Care Account will be reduced by the costs to maintain health and hospitalization insurance coverage (even if greater than what your Employer contributed during your leave) for the term of the leave, unless the reason you did not return is due to:

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

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

J. USERRA

If you are covered by the Plan and enter the United States armed forces (including the United States Armed Forces, the Coast Guard, the Army National Guard, the commissioned corps of the Public Health Service, and certain other categories of service), you may be entitled to continue your (and your Dependent's) health coverage under the Plan during your military service.

If that happens, you will have two options:

Option 1: You may elect to continue your health coverage without having deductions taken from your Health Care Account. If you elect this option and your military service is 30 days or less, your health insurance coverage continues without any deduction to your Health Care Account (and you will only be required to pay the normal employee contribution). If you elect this option and your military service exceeds 30 days, you will be required to pay the applicable COBRA premium to remain covered, but your Health Care Account will not be reduced. You can receive this self-pay coverage for a period of up to 24 months total (or, if earlier, until the day after the date you fail to apply for or return to covered employment). Payments would generally need to be made under the same procedures required for COBRA premiums.

Option 2: You may elect to continue your health coverage by having deductions taken from your Health Care Account for the normal cost of the coverage (as if you were working). If your Health Care Account falls below the Minimum Balance while you are in military service, you will be able to purchase continued coverage described under Option 1. In addition, if that happens, once you are reemployed (within the time periods prescribed by law), your health coverage may be reinstated but you will be required to pay the cost of the coverage until your Health Care Account has the Minimum Balance.

Separation from uniformed service that is dishonorable or based on bad conduct, on grounds less than honorable, AWOL, or ending in a conviction under court martial would disqualify you from any rights under USERRA. Please contact the Fund Office for more information regarding your options under USERRA.

K. Government Programs and Your Health Benefits

1. Coordination of Benefits.

Under federal law, if you or your spouse become eligible for Medicare while you are in "current employment status" the Plan cannot take into account any Medicare benefits to which you are entitled. This means that the Plan and your health and hospitalization insurance coverage must be your primary insurance and if you or your spouse choose to drop coverage under the Plan, and elect Medicare, the Plan and your health and hospitalization insurance coverage is prohibited from supplementing any Medicare-covered services. The Plan cannot reimburse you for any deductibles, co-insurance, or co-payments for a Medicare covered service. The Plan will continue to cover services that Medicare doesn't cover such as hearing aids, routine dental care, and routine physical exams.

Also, federal law prohibits the Plan from providing any incentive for you or your spouse to drop Plan coverage and elect Medicare while you are in "current employment status." It also prohibits reimbursement of premiums other than group health premiums. Thus, the Plan cannot reimburse Medicare Part B or Part D premiums.

"Current employment status" means (a) you are actively working for an Employer, (b) you are receiving disability benefits from the Fund for up to six months; or (c) you retain employment rights in the industry, are not receiving disability benefits from the Fund for more than six months or from Social Security, and you have group health coverage other than COBRA coverage.

Similar rules also apply to TRICARE (the government health program for military personnel), veterans and their families, and to any health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and Urban Indian organizations (except in limited circumstances as indicated below).

2. Waiver of Coverage.

The Plan permits you to waive health insurance coverage if you have alternative coverage meeting certain requirements. Generally, federal law requires that Medicaid (including organizations that are funded through Medicaid), and certain health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and Urban Indian organizations be the payer of last resort (unless you provide verification from the Indian Health Service, tribe or tribal organization that you disclosed that you had health coverage available under the Plan). This means that the Plan cannot accept these programs as alternative coverage for purposes of a waiver.

You should also note that if you decide to waive coverage for yourself or any Dependents, you will need to sign a waiver that, among other things, confirms that you are not doing so for purposes of obtaining eligibility for Medicaid or any coverage (such as payer of last resort coverage) for which you or they would not be eligible as a result of your or their eligibility for Fund coverage.

Please note that this SPD describes above significant limitations on your ability to receive Health Care Reimbursements in certain circumstances if you waive coverage. You should review these limitations before deciding whether to waive coverage.

You should contact the Fund Office at (716) 894-8061 if you have any questions.

L. Special Health Insurance and Healthcare Reform Rules

GRANDFATHERED STATUS

From January 1, 2013 through March 31, 2013 (and thereafter with respect to the health reimbursement arrangement portion of the Plan), group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at (716) 894-8061. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or http://www.dol.gov/ebsa/healthreform/. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

This next section contains information regarding various health coverage requirements provided by law, including the Patient Protection and Affordable Care Act. In all cases, you should see the Insurance Benefit Booklet for more information.

1. Reconstructive Breast Surgery.

If a Participant or beneficiary is receiving treatment in connection with a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For Participants and covered Spouses and Dependents receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- all stages of reconstruction of the breast on which mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications at all stages of mastectomy, including lymphedema.

This coverage is subject to all of the Fund's rules regarding benefits, including the same deductibles and copayment provisions that apply to other medical and surgical benefits provided under the Plan, which are described in this booklet or in your Insurance Benefit Booklet. If you would like more information on WHCRA benefits, call the Fund Office or your insurer.

2. Hospital Stays In Connection With Childbirth.

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

If you are pregnant, please call your insurer to arrange for hospitalization for the delivery of your baby. In all cases, you will be certified for hospitalization for at least 48 hours for a normal delivery and 96 hours for a Cesarean section. Federal law requires that you be informed that you have a right to at least a stay of these lengths without certification, although you and your doctor may still decide that you can leave the hospital sooner. Certification for longer periods will generally be required.

3. Notice Regarding Lifetime and Annual Dollar Limits.

Effective April 1, 2013, in accordance with applicable law, any lifetime dollar limits and annual dollar limits in your health insurance coverage shall not apply to "essential health benefits," as such term is defined under Section 1302(b) of the Patient Protection and Affordable Care Act of 2010. The law defines "essential health benefits" to include, at a minimum, items and services covered within certain categories including emergency services, hospitalization, prescription drugs, rehabilitative and rehabilitative services and devices, and laboratory services, but currently provides little further information. Accordingly, a determination as to whether a benefit constitutes an "essential health benefit" will be based on a good faith interpretation by the Plan Administrator (or, where applicable, the insurance company) of the guidance available as of the date on which the determination is made. If your coverage ended by reason of reaching a lifetime limit under the Plan, you are eligible to re-enroll. Contact the Fund Office for more information on how to re-enroll.

4. Recommended Preventive Services.

The Plan's health and hospitalization insurance coverage must provide (subject to reasonable medical management) certain Recommended Preventive Services on an in-network basis at no cost to you and your dependents. To determine which services provided on an in-network basis are Recommended Preventive Services for which no co-payments may be charged and no cost-sharing may be imposed, please refer to Insurance Benefit Booklet.

5. Emergency Care.

The Plan's health and hospitalization insurance coverage will have certain requirements that apply to out-of-network emergency care, pursuant to which there will be similar levels of cost-sharing as in-network facilities.

6. Preexisting Conditions.

To the extent any Plan health and hospitalization insurance coverage includes provisions which provide for coverage exclusions relating to preexisting conditions, such provisions will not apply to any dependent who is enrolled in such coverage and who is under the age of 19 and, effective July 1, 2014, to any participant or dependent who is enrolled in coverage.

7. Designation of Primary Care Providers.

If the Plan health and hospitalization insurance coverage requires you and your dependents to designate a primary care provider, you and your dependents will be permitted to designate any participating primary care provider who is accepting new patients. With respect to your child, that Plan will permit any participating physician who specializes in pediatrics to be designated as his or her primary care provider. If you or your dependents receive or seek to receive obstetrical or gynecological care and are enrolled in the Plan, the Plan will not require you or your dependents to obtain authorization or referral if the obstetrical or gynecological care is provided by an in-network OB/GYN specialist.

8. Genetic Information Nondiscrimination Act of 2008 (GINA).

GINA prohibits health coverage and employment discrimination against employees based on their (or their family members') genetic information. Genetic information includes genetic tests of employees and their family members and the manifestation of a disease or disorder in family members of employees.

Under GINA, group health plans and health insurers providing group health plan coverage cannot use genetic information to set premiums or contribution amounts. They also cannot request, require, or purchase genetic information prior to an individual's enrollment in the Plan or request or require genetic testing of an individual or family member for underwriting purposes.

9. Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

MHPAEA requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations for mental health and substance use disorder benefits are no more restrictive than the requirements and limitations applied to medical or surgical benefits. The MHPAEA supplements prior provisions under the Mental Health Parity Act of 1996, which required equal benefits with respect to lifetime and annual dollar limits for mental health benefits.

M. Permanent Waiver of Coverage

You have the right to opt out of and waive any future reimbursements under your Health Care Account. You have this right at least annually and upon termination of your employment with Contributing Employers. If you do so, the remaining amounts in your Health Care Account will be forfeited and you will be **permanently** opting out of and waiving future reimbursements from the Health Care Account.

V. WAGE REPLACEMENT AND RELATED BENEFITS

A. Wage Replacement Account

1. Wage Replacement Benefit.

You will be eligible for a weekly income replacement benefit payable from your Wage Replacement Account if you are laid off by an Employer and, further, if you satisfy all of the following conditions:

- You must be involuntarily laid off from your employer;
- You must have a balance in your Wage Replacement Account;
- You must present proof that you are entitled to New York State Unemployment benefits (or substantially similar unemployment benefits of another state) or a written denial stating you are ineligible due to lack of prior employment or exhaustion of benefits; and
- You must not refuse to accept work as a laborer that has been offered by the Union or by an Employer.

- You must have coverage through the Fund or prove that you have acceptable alternative medical coverage in accordance with Section IV.A. above.

The amount of the weekly benefit will be $400 or, if less, the balance remaining in your Wage Replacement Account.

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

You may not receive this benefit if you have voluntarily terminated employment or retired. Upon your retirement, or if you should die prior to retirement, any balance remaining in your Wage Replacement Account (see below for vacation forfeiture rules) will be forfeited and added to the Fund's reserves. In addition, your Wage Replacement Account balance will be completely forfeited if it is inactive for a period of thirty-six (36) consecutive months. For the purposes of this paragraph, your Wage Replacement Account is inactive if there has been no activity, including any written correspondence from you regarding your account, for the specified period of time.

You may not receive this benefit if you do not have coverage under the Plan or have not proved that you have acceptable alternative medical coverage in accordance with Section IV.A. above.

2. Disability Benefits.

You will be entitled to a weekly disability benefit payable from your Wage Replacement Account for each week you are unable to work due to a Disability entitling you to a New York disability or workers' compensation benefit. You will also be entitled to this benefit for each week you are unable to work due to a Disability entitling you to no-fault insurance benefits (providing wage replacement benefits), as long as the no-fault insurance award specifies the period for which payment is made as a result of an inability to work. The amount of the benefit is $400 per week, but in no event greater than the balance in your Wage Replacement Account.

3. Jury Duty Benefits.

You will be eligible for a daily benefit payable from your Wage Replacement Account for each day you are unable to work as a result of being called to jury duty. The amount of the benefit will be $100 per day, but in no event greater than the balance in your Wage Replacement Account. To be entitled to this benefit, you must provide adequate proof that you were called to jury duty and served, by presenting a slip from the Office of Court Administration.

B. Vacation Account

Once you have transferred money to your Vacation Account, you will be entitled to a vacation benefit payable from your Vacation Account for each weekday you are on vacation and do not receive wages from an Employer, provided you completed at least 500 Hours of Service in the twelve (12) consecutive months immediately preceding your vacation. The Trustees will presume that you are on vacation for any day you are not working for an Employer.

You are entitled to up to 15 vacation days per calendar year. The amount of the benefit shall be $400 per day (less applicable withholding), but shall not exceed the balance of your Vacation Account. If, in any week, you apply for benefits for more than one vacation day, you will receive one check for all vacation days applied for that week. Any Vacation Benefit to which you are entitled, but for which you have not applied, shall be paid to you at the end of the calendar year. When you take your vacation benefit, your account will also be reduced by (as applicable) the employer Social Security, Medicare and unemployment taxes.

You may not receive this benefit if you do not have coverage under the Plan or have not proved that you have acceptable alternative medical coverage in accordance with Section IV.A. above.

The balance in your Vacation Account will be forfeited after you have retired and have not worked for an Employer at least 500 hours in the immediately preceding consecutive twelve (12) months. In addition, your Vacation Account balance will be completely forfeited if it is inactive for a period of twelve (12) consecutive months. For the purposes of this paragraph, your Vacation Account is inactive if there has been no activity, including any written correspondence from you regarding your account, for the specified period of time.

VI. GROUP LIFE INSURANCE

You will be eligible for a group term life insurance benefit in the calendar quarter immediately following a calendar quarter in which you complete 150 Hours of Service. The life insurance benefit pays a benefit of $50,000 in the event of your death.

You will remain eligible for coverage in a quarter if you have completed 150 Hours of Service in the prior calendar quarter, 300 Hours of Service in the two preceding calendar quarters, 450 Hours of Service in the three preceding calendar quarters, or 600 Hours of Service in the four preceding calendar quarters. Further, you may also maintain coverage for up to a year by paying the premium to the Fund (although you must make the payment before your coverage would run out).

The group life policy will otherwise control in determining the dates of eligibility, the conditions which must be satisfied to become insured (if any), and the benefits and the circumstances under which insurance terminates.

Retirees are eligible for a $5,000 death benefit that would be paid through the Welfare Fund rather than a separate insurance company. To qualify for this death benefit, you must have a surviving designated beneficiary and you must have at least ten (10) years of Vesting Service with the Buffalo Laborers' Pension Fund as of the date of your retirement. You should be sure to keep your records up to date because no benefits will be paid if you do not have a designated beneficiary or your designated beneficiary does not survive you. Your claim for your retiree death benefit is subject to the claims and appeals procedures set forth in Section XII(a) for claims other than Dependent Care Reimbursement and Disability claims. Your designated beneficiary must submit his or her claim for benefits within twelve (12) months of a Participant's death. If your designated beneficiary does not submit a claim for benefits within twelve months of a Participant's death, his or her rights to the death benefit shall cease. A Retiree who is covered under the Group Life Waiver premium is not eligible for the retiree death benefit.

VII. DEPENDENT CARE BENEFITS

You may receive reimbursement for certain Dependent Care Expenses you incurred up to $2,000 per calendar year, if you submit the necessary documentation. In order to be eligible for this benefit, you must have worked at least 500 hours for Contributing Employers in the prior 12 months and you and your dependent must have health and hospitalization insurance through the Plan. A Dependent Care Expense is treated as incurred at the time the services to which the expenses relate are rendered.

In order to receive this reimbursement, you must submit your claim for dependent care reimbursement no later than April 1 of the calendar year following the calendar year in which the expense is incurred.

An expense is a "Dependent Care Expense" if it meets **all** of the following conditions:

1. It is incurred by you for the care of your Dependent and which enable you to be gainfully employed with a Contributing Employer. You must be working for a signatory employer (or actively looking for work with a signatory employer) at the time of day that the day care was provided. Your spouse must also be working or attending school at the time of the day that the day care was provided. In order to obtain reimbursement, you will be required to provide proof of that fact to the Fund Office.

2. It is incurred at a New York State licensed day care facility. (The Plan will not reimburse Dependent Care Expenses for a sitter or housekeeper in your home.)

3. It is incurred for a Dependent who is covered by the Plan's health and hospitalization insurance.

4. The expense is for a Dependent that regularly spends at least eight (8) hours each day in your household.

5. The expense is incurred for a Dependent for whom you have or share equal custody pursuant to a court order.

6. The expense is not for a related individual (as described in Section 129(c) of the Code), which generally means that the expense cannot be paid or incurred to someone you claim as a dependent or to your child under the age of 19. In addition, you cannot be reimbursed for expenses for which you claim a credit under Section 21 of the Code.

7. The expense would be excludible from income under Section 129 of the Code.

For purposes of this Section VII, a "Dependent" will mean any individual who is your dependent under the age of thirteen (13) with respect to whom you are entitled to a deduction under Section 151(c) of the Internal Revenue Code.

You can include the full amount you pay to a nursery school, even though part of it is for lunch and education expenses (as long as the expense meets the conditions above). The expense is not incurred in connection with a camp where the Dependent stays overnight. Assuming a summer camp meets the conditions above, the portion of the cost of summer camp that is attributable to day care can be included (but no other portion of the cost can); camp deposits made in the Winter or Spring cannot be reimbursed until the expense is incurred (i.e., the services are actually provided).

The maximum amount which you may receive from dependent care assistance in any calendar year will be the smaller of (a) your earned income for the calendar year, (b) the earned income of your spouse for the calendar year, if you are married, or (c) $5,000.00 ($2,500 if married filing separately). If your spouse is a full-time student at an educational institution or is physically or mentally incapable of caring for himself or herself, your spouse will be deemed to have earned income of not less that $250.00 per month if you have one (1) Dependent and $500.00 per month if you have two (2) or more Dependents.

VIII. GRANDFATHERED BENEFITS

If you were a Participant in the Plan on December 31, 2000 and the balance in your former P.A.P. and S.U.B. accounts on that date exceeded $5,000, you may be entitled to a distribution of your remaining Health Care Account and Wage Replacement Account balances at separation from employment or upon your death. Separation from employment shall mean your retirement or the end of a twelve-month period during which you were not employed in the industry.

You will be entitled to a distribution from your Health Care Account, Vacation Account, and Wage Replacement Account to the extent that the total of these accounts exceeds $5,000 at the time of your separation from employment, or retirement, or upon your death prior to your separation from employment. The amount of the distribution shall be the total of your P.A.P. and S.U.B. accounts on December 31, 2000, less the $5,000.

At your death, distribution shall be made to your surviving spouse, or if you do not have a surviving spouse, to your surviving children, or if you have no surviving children, to your named beneficiary. If you have no named beneficiary, surviving spouse, or surviving children, your accounts will be forfeited and added to the reserves of the Fund. For this purpose, your beneficiary shall be that person or persons designated by you on the form provided by the Administrator. Your spouse, children, or your named beneficiary must apply for distribution of your accounts within one year of your death or otherwise forfeit the balance of your accounts.

IX. AMENDMENT AND TERMINATION

The Trustees may amend, modify or terminate the Plan, in whole or in part, at any time and for any reason. Any amendment may reduce or eliminate any benefit provided under the Plan and may result in the forfeiture of the balance of your accounts. Under no circumstances will any Plan benefit become vested or non-forfeitable at any time with respect to any Participant (active, inactive or retired) or beneficiary.

The Trustees have established this Plan with the intent that it will be maintained for an indefinite period of time. However, the funding for the Plan is conditioned on a Collective Bargaining Agreement remaining in effect that provided for continued Employer Contributions to the Fund. Therefore, the Trustees reserve the right to terminate the Plan, in whole or in part, at any time.

X. CONTINUATION COVERAGE

A. Continuation Coverage Beyond COBRA

1. Health and Hospitalization Coverage.

In lieu of COBRA coverage, an Employee, a former Employee who has terminated employment (both Covered Employment and employment within the industry), Retiree, or surviving spouse (and dependent child) of an Employee or Retiree may continue to receive health and hospitalization insurance coverage under the Plan for as long as he or she has a balance remaining in his or her Health Care Account, provided that he or she resides within the coverage area of the HMO or other insurance contract then being offered by the Plan. This continuation coverage is subject to the terms of the HMO or other insurance contract.

If the individual continuously maintains coverage in accordance with the preceding paragraph, he or she may continue to pay monthly for that coverage through deductions from the Health Care Account and, once that balance is reduced to $500 (or would be upon payment of the Monthly Premium), through direct self-payments of the applicable Monthly Premium. Inactive Employees, Retirees, and surviving spouses (and dependent children) of Employees and Retirees need not maintain a $500 minimum balance.

If you discontinue coverage on or after termination of employment, you may re-enroll effective September 1 of each year (during the Fund's annual enrollment), but not at any other time. If that happens, unless you are a Retiree, you will only be entitled to pay the applicable Monthly Premium through deductions from your Health Care Account, and you will not be able to maintain coverage on a self-payment basis beyond your COBRA coverage period.

2. Health Care Reimbursement.

In lieu of COBRA coverage, active Employees, surviving spouses of Employees, Inactive Employees and Retirees may receive reimbursement (in accordance with Section IV.E, including the requirement that they have other group health coverage) for amounts they expend for medical care incurred on behalf of themselves or the Dependents of the Employee to the extent of the balance remaining in the Employee's Health Care Account. For active Employees, but not surviving spouses of Employees, Inactive Employees and Retirees, the amount of the reimbursement is limited to the amount that the balance of the Health Care Account exceeds $3,000.

B. Continuation Coverage Under COBRA

1. Introduction.

This Section contains important information about your right to COBRA continuation coverage, which is a temporary extension of group health coverage under the Plan. **This Section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it**.

The right to elect COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group heath coverage.

Continuation coverage is available only in connection with health and hospitalization benefits. It is not available in connection with any other benefits described in this booklet (e.g., life insurance, dependent care, wage replacement, vacation benefits, etc.) or any other benefits you may have been receiving prior to the date your coverage terminates.

This notice gives only a summary of your continuation coverage rights under the Plan. For more information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

2. Plan Contact Information.

If you wish to receive such information, please contact the Fund Office as follows:

Buffalo Laborers Welfare Fund
25 Tyrol Drive, Suite 200
Cheektowaga, NY 14227
(716) 894-8061

3. What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed in the bullets below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your Dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an Employee Participant, you will become a qualified beneficiary if you lose coverage under the Plan (by virtue of your failure to maintain a Minimum Balance in your Health Care Account) because one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an Employee Participant, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced, resulting in your spouse's failure to maintain a Minimum Balance in your spouse's Health Care Account;
- Your spouse's employment ends for any reason other than his or her gross misconduct, resulting in your spouse's failure to maintain a Minimum Balance in his or her Health Care Account;
- You become divorced or legally separated from your spouse; or
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both).

Your Dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-Employee dies;

- The parent-Employee's hours of employment are reduced, resulting in the parent-employee's failure to maintain a Minimum Balance in the Health Care Account;
- The parent-Employee's employment ends for any reason other than gross misconduct, resulting in the parent-employee's failure to maintain a Minimum Balance in the Health Care Account;
- The parents become divorced or legally separated;
- The parent-Employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- The child stops being eligible for coverage under the Plan as a "Dependent child."

Children who are born to or placed for adoption with a covered Employee during the period of the Employee's continuation coverage also are qualified beneficiaries entitled to COBRA continuation coverage. Once the newborn or adopted child is enrolled in continuation coverage pursuant to the Plan's rules, the child will be treated like all other qualified beneficiaries with respect to the same qualifying event. The maximum coverage period for such a child is measured from the same date as for other qualified beneficiaries with respect to the same qualifying event (and not from the date of the child's birth or adoption).

Sometimes, filing a bankruptcy under Title 11 of the United States Code can be a qualifying event. If a bankruptcy proceeding is filed with regard to your Employer and that bankruptcy results in the loss of coverage of any retired Employee covered under the Plan, then the retired Employee is a qualified beneficiary with respect to the bankruptcy. The retired Employee's spouse, surviving spouse and Dependent children will also be qualified beneficiaries if the bankruptcy results in the loss of their health coverage under the Plan.

4. When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment, death of the Employee, or the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both) or commencement of a bankruptcy proceeding with respect to the employer, your Employer must notify the Plan Administrator of the qualifying event. However, you or your family should also notify the Fund Office if such an event occurs in order to avoid confusion as to your status. When the qualifying event is the reduction in hours, the Plan Administrator has assumed the duty to notify the Fund Office.

5. You Must Give Notice of Some Qualifying Events.

For all other qualifying events (i.e., divorce or legal separation of the Employee and spouse, or a Dependent child losing eligibility for coverage as a Dependent child), **you (or your family member) must notify the Plan Administrator within 60 days after the qualifying event occurs**. The notice must be in writing and must be sent to the Plan Administrator. When you submit this notice, you must also submit evidence of the qualifying event. For example, in the case of divorce, you must provide the Fund Office with the divorce decree. The Employee or family member can provide notice on behalf of themselves as well as other family members affected by the qualifying event.

6. How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

7. How Long Does COBRA Continuation Coverage Last?

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. However, if the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

However, there are two ways in which an 18-month period of COBRA continuation coverage can be extended, which are discussed in the next two sections.

8. Disability Extension of 18-month Period of Continuation Coverage.

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. When you submit this notice, you must also submit evidence of the fact that you received the Social Security Administration award. The notice and evidence must be provided before the date that is 60 days after the latest of: (i) the date of the Social Security Administration's disability determination, (ii) the date of the qualifying event, (iii) the date on which the qualified beneficiary loses coverage as a result of the qualifying event, or (iv) the date on which the qualified beneficiary is informed of the responsibility to provide notice of the Social Security Administration and of the Plan's procedures for providing the notice.

9. Second Qualifying Event: Extension of 18-month Period of Continuation Coverage.

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any Dependent children receiving continuation coverage if the Employee or former Employee dies, gets divorced or legally separated, becomes entitled to Medicare benefits (under Part A, Part B, or both) or if the Dependent child stops being eligible under the Plan as a Dependent child, only if the event would have caused the spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

10. How COBRA Coverage Can End Before the Maximum Period.

The rules above describe the maximum period of continuation coverage available to the qualified beneficiaries. However, continuation coverage will be terminated before the end of the maximum period if:

- any required payment for COBRA coverage is not paid in full on time;
- the qualified beneficiary first becomes, after electing COBRA coverage, covered under another group health plan (as an Employee or otherwise) that does not impose any preexisting condition exclusion or limitation applicable to the individual;
- the qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B or both) after electing continuation coverage; or
- the group health coverage provided to you is terminated (and the plan sponsor is not required by COBRA to provide you with other group health coverage that it maintains, if any).
- in the case of an individual receiving 29 months of COBRA continuation coverage due to a Social Security Administration determination of disability, the Social Security Administration determines that the individual is no longer disabled.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a Participant or beneficiary not receiving continuation coverage (such as fraud).

You do not have to prove insurability to be entitled to continuation coverage. However, continuation coverage is provided subject to your (and your family members') eligibility for coverage under the Plan. The Plan Administrator (and the insurers) reserves the right to terminate continuation coverage retroactively if you (or a member of your family) are determined to be ineligible for coverage (except to the extent that the retroactivity would be considered a prohibited rescission under governing law). Once your continuation coverage terminates for any reason, it cannot be reinstated.

11. TAA Eligible Individuals.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) ("TAA Eligible Individuals"). Under these tax provisions, TAA Eligible Individuals can either take a tax credit or get advance payment of a percentage (72.5%) of premiums paid for qualified health insurance, including COBRA continuation coverage. You should be aware, however, that unless it is extended, this tax credit is due to expire on December 31, 2013.

TAA Eligible Individuals who did not previously elect continuation coverage during the original 60-day COBRA election period related to the TAA-related loss of coverage may elect continuation coverage during a second 60-day election period. This second 60-day election period begins on the first day of the month in which he or she is determined to be a TAA Eligible Individual, provided that such election may not be made later than 6 months after the date of the TAA-related loss of coverage. TAA Eligible Individuals may elect continuation coverage for themselves and their eligible family members. Any continuation coverage elected will begin with the first day of the second 60-day election period, and not on the date the coverage originally was lost. However, the time between the loss of coverage and the

start of the second election period will not be counted for purposes of determining whether the individual has a 63-day break in coverage under HIPAA. You should be aware that like the tax credit discussed above, unless it is extended, TAA benefits are due to expire on December 31, 2013. Thus, the second COBRA election right afforded TAA Eligible Individuals effectively expires on such date.

If you have questions about these tax provisions or you are not sure whether you are a TAA Eligible Individual, contact the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at http://www.irs.gov/individuals/article/0,,id=185800,00.html.

12. If You Have Questions.

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified above. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

13. Keep Your Plan Informed of Address Changes.

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members and any changes in your marital status or the status of your Dependents. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

XI. CERTIFICATES OF CREDITABLE COVERAGE

To the extent provided by law, when your (and your covered Dependents') coverage under the Plan ends, you will be provided with a Certificate of Creditable Coverage for each individual or family member whose coverage under the Plan ends. The Certificate provides the documentation of prior coverage and/or waiting periods that you and/or your family may need to reduce pre-existing condition limitations when enrolling in a new employer-sponsored health plan.

You must be provided with a Certificate:

- when you lose coverage under the Plan or COBRA continuation coverage terminates; or
- if requested, before losing coverage or within 24 months of losing coverage.

The Certificate of Creditable Coverage indicates:

- either a statement that you and/or your family had up to 18 months of creditable coverage under the Plan (disregarding days of creditable coverage before a significant break) or the date any waiting period began and the date creditable coverage began; and
- the coverage end date under the plan.

If, within 62 days after your coverage under the Plan ends, you and/or your eligible Dependents become eligible for coverage under another group health plan, or if you buy an individual insurance policy, the Certificate of Coverage may be necessary to reduce a preexisting limitation or limitation period that may apply under that Plan.

For more information on how to obtain a copy of your and/or your eligible Dependent's Certificate of Coverage, contact the Fund Administrator.

XII. CLAIMS AND APPEALS PROCEDURE

This section explains to you the steps you must take to file a claim for benefits, and how to file an appeal if your claim is denied, in whole or in part. As you will see, different claim procedures apply depending on the type of benefits claimed. It is very important that you follow these procedures carefully because your failure to do so may delay or reduce your ability to obtain benefits. In addition, keep in mind that must exhaust your rights under these procedures (including requesting and receiving a determination on review) before you commence any litigation, arbitration or administrative proceeding regarding an alleged failure by the Plan to pay benefits or any matter within the scope of the appeals process.

What is a claim for benefits?

A "claim for benefits" is a request for a Plan benefit made in accordance with the Plan's procedures for filing benefit claims. If you make an inquiry unrelated to a specific benefit claim, such as an inquiry regarding benefits available under the Plan, or the circumstances under which benefits might be paid, or eligibility for benefits, this generally won't be treated as a "claim for benefits" subject to these provisions. In addition, if you request prior approval of a benefit that does not require prior approval under the Plan, this is not considered a "claim for benefits" under these procedures.

A. Claims for Dependent Care Reimbursement, Vacation, Jury Duty or Weekly Wage Replacement, Death Benefits or Disability Benefits

If you are filing a claim for any of the following benefits, you must follow the claim procedures described in this section:

- Dependent Care Reimbursement
- Vacation
- Jury Duty
- Wage Replacement
- Disability
- Death Benefit for beneficiaries of eligible retirees.

In order to make a claim for benefits for any of these benefits, you are generally required to submit to the Fund Office a completed claim form available from the Fund Office, along with any required documentation.

IMPORTANT NOTE: Claims for Dependent Care Reimbursement **must** be submitted no later than April 1 of the calendar year following the calendar year in which the expense is incurred.

If your claim for benefits is denied, in whole or in part, or any other adverse benefit determination has been made, the Fund Administrator will notify you (or your duly authorized representative) within 90 days of receiving your claim (or within 45 days if it is a claim for disability benefits).

For all claims other than disability benefit claims, the 90-day period may be extended for an additional 90 days if special circumstances require extra time to process your claim. You will receive written notice of the extension and the reasons for it, as well as the date by which the Fund Administrator expects to make the benefit determination, before the end of the initial 90-day period.

In the case of a claim for disability benefits, there may be two extension periods of up to 30 days each, provided that the Fund Administrator determines that such an extension is necessary due to circumstances beyond the control of the Plan. In the event of such an extension, notice of the extension will be provided to you before expiration of the initial 45-day period (or before expiration of the first 30-day extension, in the case of a second extension). The notice will explain the circumstances requiring the extension and inform you of the date by which the Fund Administrator expects to make a decision. The notice will also specifically explain the standards on which entitlement to the benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and you will be afforded at least 45 days in which to provide the specified information.

In the case of a claim for disability benefits, if an extension is required due to your failure to submit information necessary to decide the claim, the period for making the determination will be tolled from the date on which the extension notice is sent to you until the earlier of: (i) the date on which you respond to the Fund Administrator's request for additional information, or (ii) expiration of the 45-day period within which you must provide the requested additional information.

If your claim for a benefit is denied, in whole or in part, or any other adverse benefit determination has been made, you will be sent written notice explaining:

- the specific reason(s) for the denial or other adverse benefit determination;
- the exact plan provision(s) on which the decision was based;
- what additional material or information is needed to process your claim and why such material or information is needed;
- what procedures you should follow to get your claim reviewed again by the Board of Trustees, and the time limits applicable to such procedures;
- a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;
- for disability claims, if an internal rule, guideline or protocol was relied upon in deciding your claim, a copy of the rule or a statement that it is available upon request at no charge; and
- for disability claims, if the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

If your claim is denied, or any other adverse benefit determination is made, you have a right to request a review of that determination. In order to do so, you (or your authorized representative) must, **within 60 days** after you receive the notice of denial (or **within 180 days** if your claim is for a disability benefit), submit your written request for review to the Board of Trustees.

In connection with your request for review, you (or your authorized representative) may submit written comments, documents, records or other information relating to your claim. The review will take into account all comments, documents, records and other information you submit relating to your claim, regardless of whether they were submitted in connection with your initial claim for benefits.

In addition, you will be provided, upon written request and free of charge, with reasonable access to (and copies of) all documents, records and other information relevant to your claim. A document, record or other information is considered relevant to your claim if it was relied upon by in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon); it demonstrates compliance with the organization's administrative processes for ensuring consistent decision-making; or, in the case of disability benefits, it constitutes a statement of Plan policy regarding the denied treatment or service.

For disability benefit claims, a different person will review your claim than the one who originally denied the claim and the reviewer will not be a subordinate of the person who originally denied the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you. In addition, if your claim was denied on the basis of a medical judgment, a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted. The health care professional will not be the same person who was consulted with respect to the initial adverse benefit determination (or a subordinate of such person).

A decision on review will be made by no later than the date of the meeting of the Board of Trustees immediately following the plan's receipt of your request for review, unless the request is received within 30 days of the meeting, in which case the determination will be made by no later than the date of the second meeting following the plan's receipt of the request. If the Board of Trustees determines that special circumstances require an extension of time for processing, then the decision on review will be made by no later than the third meeting following the Plan's receipt of the request for review. You will be notified of the extension in writing before the extension begins, and the extension notice will indicate the special circumstances requiring the extension as well as the date by which the Board of Trustees expects to make the determination on review. You will be notified of the determination on review within 5 days after the determination is made.

With regard to disability benefit claims, if an extension is required due to your failure to submit information necessary to decide the claim, the period for making the determination on review will be tolled from the date on which the extension notice is sent to you until the earlier of: (i) the date on which you respond to the Board of Trustees' request for additional information, or (ii) expiration of the 45-day period within which you must provide the requested additional information.

You will be notified in writing of the determination on review. If an adverse benefit determination is made on review, the notice will include the specific reason(s) for the determination, with references to the specific plan provisions on which it is based. All decisions on review are final and binding on all parties.

B. Claims for Health Care Account Reimbursement Benefits and Hospitalization Co-Payment Reimbursement Benefits

You must follow the procedures in this Section if you are filing a claim for (i) reimbursement under your Health Care Account (under Section IV.E of this SPD); or (ii) reimbursement of your hospitalization co-payment (under Section IV.F of this SPD).

Generally, group health claims are grouped into one of four categories. Your claim can be: (i) a pre service claim, (ii) a post service claim, (iii) an urgent care claim, or (iv) a concurrent care claim.

Generally, a "pre service claim" is any claim for a benefit under the Plan that must be approved (in whole or in part) *before* you can receive the medical care. An "urgent care claim" is a claim for medical care or treatment with respect to which application of the time periods for making non urgent care claim decisions (as described above): (i) could seriously jeopardize your life, health, or ability to regain maximum function, or (ii) in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the treatment that you are requesting in your claim. A "concurrent care claim" is a claim relating to an ongoing course of treatment approved by the plan, which is provided to you over a period of time or for a specified number of treatments.

A "post service claim" is any claim that is not deemed a "pre service claim" (as defined above). These are claims for which you do not need *advance* approval before receiving medical care. Essentially, all claims for Health Care Account reimbursement benefits will be post-service claims because you must have already incurred an expense and received the services before you are entitled to benefits.

In order to make a claim for a Health Care Account reimbursement benefit, you are generally required to submit to the Fund Office the required documentation of your expense. **You must submit the claim within 90 days after the end of the calendar year in which the related expense was incurred.**

The Fund Administrator will notify you of an adverse benefit determination no later than 30 days after receipt of your claim. If the Fund Administrator determines that an extension of time is necessary due to matters beyond the control of the plan, this period may be extended for up to an additional 15 days. You will be notified of the extension before the initial 30-day period expires, and the notice will describe the circumstances requiring the extension and inform you of the date by which the Fund Administrator expects to make a decision on your claim. If the extension is necessary because you failed to submit information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will have 45 days from your receipt of the notice to provide the requested information.

If an extension is required due to your failure to submit information necessary to decide the claim, the period for making the determination will be tolled from the date on which the extension notice is sent to you until the earlier of: (i) the date on which you respond to the Fund Administrator's request for additional information, or (ii) expiration of the 45-day period within which you must provide the requested additional information.

If your claim is denied, in whole or in part, or any other adverse benefit determination has been made, the Fund Administrator will notify you (or your authorized representative) of the benefit determination in writing within the time periods described above. This notification will include:

- the specific reason(s) for the denial or other adverse benefit determination;
- references to the specific Plan provisions on which the determination was based;
- a description of any additional material or information necessary for you to perfect your claim, and an explanation of why that material or information is necessary;
- a description of the Plan's review procedures and the applicable time limits;

- a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;
- if an internal rule, guideline or protocol was relied upon in deciding your claim, either a copy of the rule or a statement that it is available upon request at no charge; and
- if the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

If your claim is denied, in whole or in part, or any other adverse benefit determination has been made, you have the right to request a review of that determination. In order to do so, you (or your authorized representative) must, **within 180 days** after you receive the notice of denial, submit your written request for review to the Board of Trustees. In connection with your request for review, you (or your authorized representative) may submit written comments, documents, records or other information relating to your claim. The review will take into account all comments, documents, records and other information you submit relating to your claim, regardless of whether they were submitted in connection with your initial claim for benefits.

In addition, you will be provided, upon written request and free of charge, with reasonable access to (and copies of) all documents, records and other information relevant to your claim. A document, record or other information is considered relevant to your claim if it was relied upon by in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon); it demonstrates compliance with the organization's administrative processes for ensuring consistent decision-making; or it constitutes a statement of Plan policy regarding the denied treatment or service.

A different person will review your claim than the one who originally denied the claim and the reviewer will not be a subordinate of the person who originally denied the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you. If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted. The health care professional will not be the same person who was consulted with respect to the initial adverse benefit determination (or a subordinate of such person).

The decision on review will be made by no later than the date of the meeting of the Board of Trustees immediately following the plan's receipt of your request for review, unless the request is received within 30 days of the meeting, in which case the determination will be made by no later than the date of the second meeting following the plan's receipt of the request. If the Board of Trustees determines that special circumstances require an extension of time for processing, then the decision on review will be made by no later than the third meeting following the plan's receipt of the request for review. You will be notified of the extension in writing before the extension begins, and the extension notice will indicate the special circumstances requiring the extension as well as the date by which the Board of Trustees expects to make the determination on review. You will be notified of the determination on review within 5 days after the determination is made.

If an extension is required due to your failure to submit information necessary to decide the claim, the period for making the determination on review will be tolled from the date on which the

extension notice is sent to you until the earlier of: (i) the date on which you respond to the Board of Trustees' request for additional information, or (ii) expiration of the 45-day period within which you must provide the requested additional information.

If your claim for benefits is denied on appeal, you will receive a written notice of the claim denial including the same information set forth in the initial notice of denial, as well as a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim. All decisions on review are final and binding on all parties. You and the Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

Voluntary External Review

If you are enrolled in a non-grandfathered group health plan that is not subject to a State external review process, and your internal appeal of a claim for benefits (not related to employee classifications) under such plan is denied for: (a) an adverse benefit determination (including a final internal adverse benefit determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer; and (b) a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time), you will have the right to request an external (i.e., independent) review if you do so within four months after receiving notice of an adverse benefit determination or final internal adverse benefit determination. Within five business days after receiving your request, a preliminary review will be completed to determine whether: (i) you are/were covered under the Plan; (ii) the denial was based on your ineligibility under the terms of the Plan; (iii) you exhausted the Plan's internal process, if required; and (iv) you provided all information necessary to process the external review. Within one business day after completing the preliminary review, you will be notified in writing if your appeal is not eligible for an external review or if it is incomplete. If your appeal is complete but not eligible, the notice will include the reason(s) for ineligibility. If your appeal is not complete, the notice will describe any information needed to complete the appeal. You will have the remainder of the four month filing period or 48 hours after receiving the notice, whichever is greater, to cure any defect. If eligible for an external review, your appeal will be assigned to an independent review organization (IRO). If the IRO reverses the Plan's denial, the IRO will provide you written notice of its determination.

In addition, you will have the right to an expedited external review in the following situations:

- Following an adverse benefit determination involving a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; and
- Following a final internal adverse benefit determination involving (i) a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function or (ii) an admission, availability of care, continued stay, or health care item or service for which you received emergency services but have not been discharged from a facility.

The IRO will provide notice of its final external review decision as expeditiously as your medical condition or circumstances require, but not more than 72 hours after the IRO receives the request.

C. Judicial Review

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

D. Insured Health Benefits

Claims for health benefits that are insured (e.g., health insurance coverage purchased through your Health Care Account), as well as requests for review of adverse benefit determination with respect to those claims, are made and reviewed in accordance with the procedures contained in the insurance contracts with those insurers.

These procedures for all types of claims (including urgent care claims, pre-service claims, post-service claims and concurrent care claims) are set forth in the Insurance Benefit Booklet provided by the insurance companies. If you have any questions regarding making or processing of claims and/or requests for review, you should review a current copy of the Insurance Benefit Booklet from the applicable insurance company. If you need an additional copy of the booklet, you may obtain one free of charge from the Fund Office.

E. Active Employee's Life Insurance Benefits

Claims for insured Life Insurance Benefits, as well as requests for review of adverse benefit determination with respect to those claims, are made and reviewed in accordance with the procedures contained in the insurance contracts with those insurers. These procedures are set forth in the Insurance Benefits Booklet provided by the life insurance company. If you need an additional copy, you may obtain one free of charge from the Fund Office.

The following is a description of the current general procedure for claims and requests for review with respect to Life Insurance Benefits. To the extent anything herein conflicts with the Insurance Benefit Booklet provided by the life insurance company, that Insurance Benefit Booklet will control.

In order to make a claim for Life Insurance Benefits, you should submit to the Fund Office an original death certificate (and any other required documentation). The Fund Office will forward a claim form to the life insurance company for a determination.

If your claim for benefits is denied by the life insurance company, in whole or in part, or any other adverse benefit determination has been made, the life insurance company will notify you (or your duly authorized representative) within 90 days of receiving your claim. The 90-day period may be extended for an additional 90 days if special circumstances require extra time to process your claim. You will receive written notice of the extension and the reasons for it, as well as the date by which the life insurance company expects to make the benefit determination, before the end of the initial 90-day period.

If your claim for a benefit is denied, in whole or in part, or any other adverse benefit determination has been made, you will be sent written notice explaining:

- the specific reason(s) for the denial or other adverse benefit determination;
- the exact plan provision(s) on which the decision was based;
- what additional material or information is needed to process your claim and why such material or information is needed;
- what procedures you should follow to get your claim reviewed again by the life insurance company, and the time limits applicable to such procedures;
- a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;

If your claim is denied, or any other adverse benefit determination is made, you have a right to request a review of that determination. In order to do so, you (or your authorized representative) must, **within 60 days** after you receive the notice of denial, submit your written request for review directly to the life insurance company.

In connection with your request for review, you (or your authorized representative) may submit written comments, documents, records or other information relating to your claim. The review will take into account all comments, documents, records and other information you submit relating to your claim, regardless of whether they were submitted in connection with your initial claim for benefits.

In addition, you will be provided, upon written request and free of charge, with reasonable access to (and copies of) all documents, records and other information relevant to your claim. A document, record or other information is considered relevant to your claim if it was relied upon by in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon); or it demonstrates compliance with the organization's administrative processes for ensuring consistent decision-making.

A decision on review will be made by the life insurance company no later than 60 days after receipt of a request for a review. If the life insurance company determines that special circumstances require an extension of time for processing, then an additional processing period of up to 60 days may be required. You will be notified of any extension in writing before the extension begins, and the extension notice will indicate the special circumstances requiring the extension as well as the date by which the life insurance company expects to make the determination on review.

You will be notified in writing of the determination on review. If an adverse benefit determination is made on review, the notice will include the specific reason(s) for the determination, with references to the specific plan provisions on which it is based. All decisions on review are final and binding on all parties.

F. A Special Note

You should keep in mind that you are allowed to designate an authorized representative to act on your behalf in pursuing a benefit claim or appeal of an adverse benefit determination. You can obtain a form for doing so from the Fund Office or, for insured benefits, the insurance company. Of course, the Plan may request additional information to verify that this person is authorized to act on your behalf. For insured benefits, you should review the booklets you received from your insurance company for more information on their procedures for designating a representative. Note that, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without you having to complete an authorization form.

XIII. ADDITIONAL PLAN INFORMATION

A. Your Rights Under ERISA

As a Participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

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

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

B. Cooperation

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

C. Information, Proof and Overpayments

There are times that you will be required to furnish information or proof necessary to determine your or your Dependent's (or dependent's) right to a Plan benefit. When inaccurate information and/or

proof is provided, this ultimately can result in the improper use of Plan assets, which adversely affects the ability of the Plan to provide the highest possible level of benefits and puts the Plan's favorable tax status in jeopardy.

Accordingly, if you or your Dependent (or dependent) fails to submit the requested information or proof, makes a false statement, or furnishes fraudulent or incorrect information (including, for example, submitting fraudulent or altered bills in order to receive reimbursement from the Health Care Account), your or your Dependent's (or dependent's) benefits under the Plan (and participation in the Plan – even if you or your dependent would otherwise meet the eligibility requirements) may be denied, suspended or discontinued at any time and for any length of time (including permanently) by duly authorized representatives of the Fund Office, the Trustees (or any of their designees) in their sole and absolute discretion.

Pursuant to the Patient Protection and Affordable Care Act of 2010 (the "Affordable Care Act"), health coverage will not be rescinded (within the meaning of the Affordable Care Act) retroactively (as opposed to prospectively) except in the circumstances permitted by law, such as the failure to pay premiums or the commission of fraud or intentional misrepresentation (for example, in enrollment materials, a claim or appeal for benefits or in response to a question from the Fund Administrator or its delegates) by you, your covered Dependent(s), or someone seeking coverage on your behalf. In such cases of fraud or intentional misrepresentation, your coverage may be rescinded retroactively upon 30 days notice.

The Fund has also adopted a rule that provides that, if a Participant or beneficiary makes a false statement or furnishes false or fraudulent information (such as fraudulent or altered bills in order to receive reimbursement a Health Care Account), at a minimum (in addition to any action taken under the preceding paragraph), the Fund will deduct $500 from the Participant's Health Care Account for a first offense and $1,000 for a second offense.

Of course, if the Fund makes payment for benefits that are in excess of expenses actually incurred or in excess of allowable amounts, due to error (including for example, a clerical error) or fraud or for any other reason (including for example, your failure to notify the Fund Office regarding changes in family status), the Fund reserves the right to recover such overpayment through whatever means are necessary, including, without limitation, deduction of the excess amounts from future claims and/or legal action.

D. Plan Interpretations, Determinations, and Amendments

No individual other than the Plan Administrator or its duly authorized designee(s) has any authority to interpret the Plan documents, including this Summary Plan Description or the official Plan documents, or to make any promises to you about the Plan, or your benefits under the Plan, or to change the provisions of the Plan.

The Plan Administrator and its duly authorized designee(s) has the exclusive right, power, and authority, in its sole and absolute discretion, to administer, apply and interpret the Plan, including this booklet, the Trust Agreement, any Collective Bargaining Agreement or participation agreement, and any other Plan documents, and to decide all matters arising in connection with the operation or administration of the Plan or Fund. Without limiting the generality of the foregoing, the Plan Administrator and/or its duly authorized designee(s) shall have the sole and absolute discretionary authority to:

- Take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Plan;

- Formulate, interpret and apply rules, regulations and policies necessary to administer the Fund in accordance with the terms of the Plan;
- Decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan;
- Resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan, including this booklet, the Trust Agreement or other Plan documents;
- Process and approve or deny benefit claims; and
- Determine the standard of proof required in any case.

All determinations and interpretations made by the Plan Administrator and/or its duly authorized designee(s) shall be final and binding upon all Participants, beneficiaries and any other individuals claiming benefits under the Plan, and shall be given deference in all courts of law, to the greatest extent permissible by law.

E. Third Party Liability Cases

NOTE: This provision applies to all Employees and Retirees and their covered Spouses and Dependents, with respect to all of the benefits provided under this Plan.

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

These rules have two purposes. First, the rules insure that your and your Spouse's and Dependent's benefits will be paid promptly. Often, where there is a question of third party liability, many months pass before the third party actually pays. These rules permit this Plan to advance covered expenses until his dispute with the third party is resolved. Second, the rules protect this Plan from paying the full expenses in situations where a third party is liable.

Thus, benefits payable by the Fund for the treatment of an illness or injury will be limited in the following ways when the illness or injury is the result of an act or omission of another (including a legal entity) and when you or your Dependent pursues or has the right to pursue a recovery for such act or omission.

The Fund will pay benefits for covered expenses related to such illness and injury only to the extent not paid by the third party and only after you or your Dependent (and the attorneys, if applicable) has entered into a written subrogation and reimbursement agreement with the Fund.

By accepting benefits related to such illness or injury, and whether or not there is a written agreement to this effect, you agree:

- ❑ that the Fund has established a lien on any recovery received by you (or your Spouse, Dependent, legal representative or agent);
- ❑ to hold any reimbursement or other recovery received by you (or your Dependent, legal representative or agent) in trust on behalf of the Fund to cover all benefits paid by the Fund with respect to such illness or injury and to reimburse the Fund promptly for the benefits paid, even if you are not fully compensated ("made whole") for your loss;

- that the Fund has the right of first reimbursement against any recovery or other proceeds of any claim against the other person (whether or not you or your Dependent is made whole), and that the Fund's claim has first priority over all other claims and rights;

- to reimburse the Fund in full up to the total amount of all benefits paid by the Fund in connection with the illness or injury from any recovery received from a third party, regardless of whether the recovery is specifically identified as a reimbursement of medical expenses. All recoveries from a third party, whether by lawsuit, settlement, insurance or otherwise, must be turned over to the Fund as reimbursement up to the full amount of the benefits paid.

- that the Fund's claim is not subject to reduction for attorneys' fees or costs under the "common fund" doctrine or otherwise;

- to notify any third party responsible for your illness or injury of the Fund's right to reimbursement for any claims related to your illness or injury."

- that, in the event that you or your Dependent elect not to pursue your claim(s) against a third party, the Fund shall be equitably subrogated to your right of recovery and may pursue your claims;

- to assign, upon the Fund's request, any right or cause of action to the Fund;

- not to take or omit to take any action to prejudice the Fund's ability to recover the benefits paid and to cooperate in doing what is reasonably necessary to assist the Fund in obtaining reimbursement;

- to cooperate in doing what is necessary to assist the Fund in recovering the benefits paid or in pursuing any recovery;

- to forward any recovery to the Fund within ten days of disbursement by the third party or to notify the Fund as to why you are unable to do so; and

- to the entry of judgment against you and, if applicable, your Dependent, in any court for the amount of benefits paid on your behalf with respect to the illness or injury to the extent of any recovery or proceeds that were not turned over as required and for the costs of collection, including but not limited to the Fund's attorneys' fees and costs.

The Fund explicitly rejects all equitable defenses, including without limitation, the make-whole rule, the double recovery rule, and the common fund doctrine.

No benefits will be payable for charges and expenses which are excluded from coverage under any other provision of the Plan. The Fund may enforce its right to reimbursement by filing a lawsuit, recouping the amount owed from your or your Dependent's future benefit payments (regardless of whether benefits have been assigned by a Participant or covered Dependent to the doctor, hospital or other provider), or any other remedy available to the Fund.

The Fund may permit you or your Dependent to turn over less than the full amount of benefits paid and recovered as it determines in its sole discretion. Any reduction of the Fund's claim is subject to prior written approval by the Fund.

F. No Liability for the Practice of Medicine

None of the Fund, the Plan, the Plan Administrator, the Fund Administrator nor any of their designees are engaged in the practice of medicine; nor does any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you or your Dependents by any health care provider; nor will any of them have any liability whatsoever for any loss or injury caused to you or your Dependents by any health care provider by reason of negligence, failure to provide care or treatment, or otherwise.

G. Facility of Payment

Every person receiving or claiming benefits through the Plan will be presumed to be mentally and physically competent and of age. However, in the event the Plan Administrator (or its designee) determines that the covered person is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the covered person has not provided the Fund Office with an address at which he or she can be located for payment, the Fund may pay any amount otherwise payable to such person to his spouse, relative or any other person or entity determined by the Plan Administrator (or its designee), in its sole and absolute discretion, to be equitably entitled thereto. Any such payment will discharge entirely the obligation of the Fund.

H. Late Payments

Interest will not be paid on benefits that are paid later than provided for in the Plan, regardless of the reason that the payment was delayed.

I. Board of Trustees HIPAA Statement

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

1. HIPAA Privacy and Security.

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

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

- "Covered Entity" means a group health plan (including an employer plan, multiemployer plan, insurer, HMO and government coverage such as Medicare); a health care provider (such as a doctor, hospital or pharmacy) that electronically transmits any health information in connection with a transaction for which the U.S. Department of Health and Human Services has established an electronic data interchange standard; and a health care clearinghouse (an entity that translates electronic information between nonstandard and HIPAA standard transactions).
- "Protected Health Information" or "PHI" means individually identifiable health information created or received by a Covered Entity. Information is "individually identifiable" if it names the individual person or there is a reasonable basis to believe components of the information could be used to identify the individual. "Health Information" means information, whether oral or recorded in any form or medium, that (i) is created by a health care provider, health care plan, employer, life insurer, public health authority, health care clearinghouse, or school or university; and (ii) relates to the past, present, or future physical or mental health or condition of a person, the provision of health care to a person; or the past, present or future payment for health care.
- "Electronic Protected Health Information" or "ePHI" is protected health information that is transmitted or maintained in electronic media including, but not limited to, hard drives, disk, on the internet, or on an intranet.

2. Uses and Disclosures of PHI.

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

3. Privacy Agreements with the Board of Trustees.

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

- To the extent not inconsistent with the Privacy Rule, the Board of Trustees will use and disclose protected health information only for purposes related to Plan Administration;
- Not use or further disclose such PHI other than as permitted by the Fund's plan documents or as required by law;
- Ensure that any of its agents, including a subcontractor, to whom it provides the PHI agree to substantially the same restrictions and conditions that apply to the Board of Trustees with respect to such information;
- Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Board of Trustees;

- Report to the Plan's Privacy Officer any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for in the Plan of which the Board of Trustees becomes aware;
- Make the PHI of a particular Participant available based on HIPAA's access requirements in accordance with 45 C.F.R. § 164.524;
- The Board of Trustees will make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526;
- The Board of Trustees will make available PHI required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528;
- Make the Board of Trustees's internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;
- If feasible, return or destroy all PHI received from the Plan that the Board of Trustees still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Board of Trustees agrees to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- Ensure that there is adequate separation between the Plan and the Board of Trustees as required by 45 C.F.R. § 164.504(f)(2)(iii).

4. Employees with Access to PHI.

The following categories of employees under the control of the Board of Trustees are the only employees who may obtain protected health information in the course of performing the duties of their job with or for the Board of Trustees who obtained such health information: Buffalo Laborers Welfare Fund's health and welfare staff, including (without limitation) the:

- Fund Administrator
- Office Manager
- Collection Coordinator
- Computer Operator
- Plan Representatives
- Secretaries and Administrative Assistants of Each Trustee

5. Mechanism for Resolving Noncompliance.

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

6. Security Agreements of the Board of Trustees.

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

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that the adequate separation between the Plan and the Board of Trustees is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information;
- Report to the appropriate party any security incident of which it becomes aware. For purposes of the Plan, security incident shall mean successful unauthorized access, use, disclosure, modification or destruction of, or interference with, the e-PHI; and
- Upon request from the Plan, the Board of Trustees agrees to provide information to the Plan on unsuccessful or attempted unauthorized access, use, disclosure, modification or destruction of the e-PHI to the extent such information is available to the Board of Trustees.