SUMMARY PLAN DESCRIPTION

BUFFALO LABORERS SECURITY FUND

Effective January 1, 2020

Board of Trustees

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Legal Counsel

Proskauer Rose LLP

Auditors

Lumsden & McCormick LLP

BUFFALO LABORERS SECURITY FUND

SUMMARY PLAN DESCRIPTION

I
INTRODUCTION

Local No. 210 of the Laborers International Union of North America, AFL-CIO (the "Union") and the Construction Industry Employer Association entered into an Agreement and Declaration of a Trust (the "Trust Agreement") establishing a profit sharing fund and plan effective July 1, 2001, known as the Buffalo Laborers Security Fund (the "Fund").

Effective July 1, 2001, the Board of Trustees adopted the Plan of Benefits of the Buffalo Laborers Security Fund (called the "Plan") which has been amended from time to time. The Plan was most recently amended and restated effective as of July 1, 2014 to incorporate prior amendments and to reflect legally required changes. The Plan is intended to comply with the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and the Internal Revenue Code of 1986, as amended (the "Code").

The purpose of the Plan is to reward eligible employees for long and loyal service by providing them with retirement benefits. Under the Plan, an individual account (called your "Individual Account") is established for each Participant and is funded by contributions from Contributing Employers. When you retire, you will be eligible to receive the value of the amounts that have accumulated in your account.

This Summary Plan Description (referred to as the "SPD") is a brief description of the Plan and your rights, obligations, and benefits under the Plan. The formal terms of the Plan are set forth in the official Plan documents and are not changed, extended or otherwise interpreted by this SPD. To the extent any information contained in this SPD is inconsistent with the official Plan documents, the provisions of the official documents will control in all cases.

The complete formal terms of the Plan may only be determined accurately by reading the actual Plan document. All official Plan documents are available for your inspection at the Fund Office during normal business hours. Please call the Fund Office at (716) 894-8061 if you have any questions regarding your Plan benefits.

II
GENERAL INFORMATION ABOUT THE FUND

There is certain general information which you may need to know about your Plan. This information has been summarized for you in this section.

Official Name of the Plan
Buffalo Laborers Security Fund

Effective Date
The provisions of the Plan became effective July 1, 2001, which is called the effective date of the Plan.

Plan Sponsor and Plan Administrator

Board of Trustees
Buffalo Laborers Security Fund
25 Tyrol Drive, Suite 200
Cheektowaga, NY 14227
(716) 894-8061

The Board of Trustees has delegated certain day to day administrative duties to the Fund Administrator. The Fund Administrator is:

Thomas L. Panek
25 Tyrol Drive, Suite 200
Cheektowaga, NY 14227
(716) 894-8061

The Board of Trustees has authorized the Fund Administrator to respond in writing to any questions you may have about the Plan. 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.

Employer Identification Number
16-1605100

Plan Number
001

Type of Plan
Defined contribution profit sharing plan

Type of Administration
Jointly-Administered Trust

Plan Year
July 1 - June 30

Certain valuations and distributions are made on a certain date (called the "Valuation Date" of the Plan). This date is June 30th and any other date during the Plan Year, which the Trustees, in their sole discretion, deem to be appropriate.

Agent for Service of Legal Process

Board of Trustees
Buffalo Laborers Security Fund
25 Tyrol Drive, Suite 200
Cheektowaga, NY 14227
(716) 894-8061

Legal process may be made upon the Plan Administrator or any member of the Board of Trustees.

Contributions
Contributions are made to the Fund by Contributing Employers in accordance with the terms of various collective bargaining or other written agreements acceptable to the Trustees. The Plan is financed wholly from those employer contributions and from the income and earnings on the Plan's investments.

Collective Bargaining Agreements
The Plan is maintained pursuant to one or more collective bargaining agreements (or other written agreement acceptable to the Trustees) between the Union and your Contributing Employer requiring contributions to the Fund. A copy of the collective bargaining agreement between the Union and your Contributing Employer may be obtained upon written request to the Fund Office, and is also available for examination at the Fund Office.

A complete list of the Contributing 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 at the Fund Office. In addition, Participants and Beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular employer or employee organization is a sponsor of the Plan (and, if so, the sponsor's address).

III
PARTICIPATION IN THE PLAN

You are eligible to participate under the Plan (i.e., to become a Participant) if you work for either:

(i) an employer who contributes to the Plan on your behalf according to the terms of a collective bargaining agreement between the

employer and the Union; or

(ii) an employer who contributes to the Plan on your behalf according to the terms of a written agreement between the employer and the International Union; or

(iii) the Union, the Buffalo Laborers Training Fund or the Buffalo Laborers Welfare Fund but only if the organization has become obligated to contribute on your behalf pursuant to a collective bargaining or participation agreement.

Any such employer is referred to in this SPD as a "Contributing Employer." You will become a Plan participant on the first day you work for a Contributing Employer and for which you are paid, or entitled to payment (i.e., covered employment) and for which a contribution to the Plan is required pursuant to the terms of a collective bargaining agreement or other applicable written agreement.

You are not eligible to receive contributions under the Plan during any period for which you are not employed by a Contributing Employer not covered under the terms of a collective bargaining agreement with the Union (or other written agreement acceptable to the Trustees) requiring contributions to the Plan. If, for any reason, you separate from service with a Contributing Employer and you are rehired by a Contributing Employer before your account is distributed to you, you shall continue to participate in the Plan; otherwise, you will participate in the Plan immediately upon your return to covered employment.

The Fund generally determines the amount of, and eligibility for, benefits based on remittance reports and other information submitted by Contributing Employers for whom you work. While the Fund conducts payroll reviews of Contributing Employers that sometimes provide information regarding the accuracy of remittance reports and other information submitted by Contributing Employers, these reviews may not reveal every instance in which a Contributing Employer may have failed to provide complete and/or accurate information concerning your employment.

You have the right to inquire into your credited service at any time. If you believe that you worked in covered employment that was not properly credited under the Fund or not reported at all, you have the right to submit a claim in accordance with the Fund's claims procedures. Please note that, in the event of a discrepancy between the information received by the Fund from Contributing Employers (or obtained during payroll reviews) and the credit to which you believe you are entitled, it will be your responsibility to prove that the work in question was both actually performed by you for a Contributing Employer and was covered employment for which contributions were required to be made to the Fund. You will not receive credit under the Fund unless a Contributing Employer actually makes contributions on your behalf to the Fund even if you performed covered work. Accordingly, it is important that you retain adequate records of your covered employment (e.g., pay stubs and other documentary evidence)

that would assist you in demonstrating: (i) the amount of work you performed for each Contributing Employer, (ii) that the work constituted covered employment, and (iii) that a contribution was received by the Fund. Please also note that the longer you wait to file a claim to correct any issue, the more difficult it may be for you to provide, and for the Fund to verify, the necessary documentation.

IV
CONTRIBUTIONS TO YOUR PLAN

Your Contributing Employer pays the full cost of the Plan. The amount your Contributing Employer contributes to the Plan is set by the terms of the collective bargaining (or other applicable) agreement that requires your Contributing Employer to contribute to the Plan. All contributions that are made on your behalf are placed in an "Employer Contribution Account," which will be part of your Individual Account.

You are not required (nor are you allowed) to make contributions to the Plan. At the discretion of the Trustees, you may, however, be permitted to transfer into the Plan any portion of an eligible rollover paid to you from another employer's qualified plan, a Code Section 403(b) annuity contract, certain governmental Code Section 457(b) eligible plans, or individual retirement account or annuity (if the distribution is eligible for rollover and included in taxable income). Rollovers made on your behalf will be placed in a separate account called a participant's "Transfer Account" which will be part of your Individual Account.

If you are employed by a Contributing Employer following a period of uniformed service in the United States Armed Forces and meet certain requirements, you may have additional rights under the Uniformed Services Employment and Reemployment Act of 1994 (USERRA). If you are entitled to rights under USERRA, upon return to covered employment your employer may be required to make contributions to your Employer Contribution Account for the period of your military service. You may contact the Fund Office for more information.

The law provides certain maximum limitations that apply to Contributing Employer contributions that are made on your behalf to the Plan. If your benefit exceeds those limitations, you will be notified.

V
VESTING

You are always fully vested in the entire amount of your Individual Account. That means that you have a nonforfeitable right to the contributions and investment earnings allocated to your Individual Account and, as a result, if you permanently leave covered employment before you are eligible to retire, you will be entitled to a benefit from the Plan at the appropriate time.

VI
INVESTMENT OF PLAN ASSETS

The Trustees will invest all amounts held under the Plan pursuant to the Trust Agreement establishing the Plan. (You do not direct the investment of your Individual Account.) As a general matter, each quarter, the Trustees will determine the fair market value of all the assets held by the Plan. This is known as the Valuation Date. Your Individual Account will share in the net income, gain or loss on the Plan's assets since the last Valuation Date on a pro rata basis (based on your Individual Account balance on the Valuation Date) with the Individual Accounts of other Participants in the Plan.

Each quarter, a fee of fifteen dollars ($15.00) will be debited from each Participant's Individual Account to pay for the Trust Fund's administrative expenses. In the event that the Trust Fund's administrative expenses exceed the monthly fees, the remaining expenses will be allocated proportionally to each Participant's Individual Account in connection with the valuation of the account, as determined by the Plan Administrator.

VII
DISTRIBUTION OF BENEFITS

1. When you may receive benefits

You will be entitled to a distribution of your Individual Account balance when you:

- Terminate employment with all Contributing Employers;
- Retire at or after age 65;
- Become Disabled; or
- Retire from the Buffalo Laborers Pension Fund under an Early Retirement Date or Special Retirement Date.

Termination of Employment: Termination of employment will occur under the Plan if you do not work at least one hour for a Contributing Employer (in covered employment or non-covered employment) for which you are paid, or entitled to payment, for twelve (12) consecutive months.

Retirement: If you retire at or after age 65, you will be entitled to apply for a distribution of your Individual Account. You must present documentary evidence satisfactory to the Trustees of your retirement.

Disability: Disability is defined as a physical or mental condition resulting from bodily injury, disease or mental disorder, which renders you incapable of continuing your normal covered work with a Contributing Employer, as determined by the Trustees in their sole and absolute discretion, based upon medical evidence. The Trustees may

require you to submit to an independent medical examination (at the Plan's expense) to determine whether you are disabled.

Retirement from the Buffalo Laborer's Pension Fund: If you retire from the Buffalo Laborers Pension Plan (the "Pension Plan") under an Early Retirement Date or Special Retirement Date you are entitled to receive a distribution of your Individual Account balance on the second month after the end of the first quarter of your retirement.

2. Distribution of Benefits

Generally, if you become entitled to a benefit from the Plan, the value of your Individual Account will be payable to you as soon as administratively practical after the end of the quarter in which you submit a completed application for your benefit (including any required documentation). The standard method of benefit payment is a single lump sum payment.

If you terminate employment prior to your normal retirement age (age 65), you may elect to postpone distribution of your benefits until you reach age 65 by not completing a benefit application. You must take distribution of your account at that time. If you don't elect to postpone your distribution, it will begin not later than 60 days after the end of the Plan Year in which your termination of employment occurred.

If you continue to be employed after you reach normal retirement age, you will continue to be credited with the employer contributions made on your behalf. Distribution of your account will be deferred until you actually retire, or if earlier, until your "required distribution date". If you are a 5% owner of a Contributing Employer, your "required distribution date" is the April 1 following the close of the calendar year in which you reach age 70-1/2, whether or not you are employed. Otherwise, it is the April 1 following the close of the year in which you reach age 70-1/2 or, if later, you terminate employment.

3. Beneficiary

If you die before commencement of benefits under the Plan, your Individual Account balance will be distributed to your designated Beneficiary in a single lump sum payment as soon as practicable after the end of the calendar year in which you die (or, if later, when the Plan receives notice of your death and can locate the Beneficiary).

If you are married at the time of your death, your surviving spouse will automatically be your Beneficiary, unless you designate a different beneficiary in writing on a form to be furnished to you by the Fund Administrator in accordance with the terms of the Plan. **IF YOU WISH TO DESIGNATE A BENEFICIARY OTHER THAN YOUR SPOUSE, YOUR SPOUSE MUST CONSENT TO WAIVE ANY RIGHT TO THE DEATH BENEFIT OR YOU MUST PROVE THAT YOUR SPOUSE CANNOT BE LOCATED.** Your spouse's consent must be in writing, witnessed by a notary or Plan representative and acknowledge the non-spouse beneficiary. If you later

decide to change your beneficiary designation and you are married, you would need your spouse's written consent again.

In order to designate a Beneficiary, you must fully complete and return to the Fund Administrator a form provided to you for this purpose by the Fund Administrator. If you wish to change your Beneficiary, you must complete a second form and return it to the Fund Administrator. The latest form you have properly completed and returned before your death will control. Beneficiary designations and revocations are not valid unless they are made in a form and manner required by the Fund Administrator.

If you do not have a Beneficiary living at the time of your death, your death benefit will be distributed to your surviving issue (children or grandchildren) per stirpes, or if none, to the personal representative of your estate. If you designate a class of Beneficiaries and upon your death none of the members of the class can be located after reasonable efforts, the members shall cease to be entitled to benefits under the Plan.

Please note: Every time the term "spouse" or "married" is used in this SPD, the term refers to the person to whom you are legally married under the Code (or to whom you are treated as married pursuant to a valid qualified domestic relations order).

4. Treatment of Distributions From Your Plan.

Whenever you receive a distribution from your Plan, it will normally be subject to income taxes. An automatic 20% withholding applies to a lump sum distribution. Further, if you are under age 55 when you receive your distribution, you may also be subject to an IRS tax penalty of 10%. You may, however, reduce, or defer entirely, the tax due on your distribution, as well as the withholding tax and tax penalty, through the use of a "rollover". Spouses and (with certain conditions on how the rollover can be made) non-spousal Beneficiaries can also rollover distributions.

When you receive a distribution, the Fund Office will provide you with a detailed explanation of rollovers. HOWEVER, THE RULES THAT DETERMINE WHETHER YOU QUALIFY FOR FAVORABLE TAX TREATMENT ARE VERY COMPLEX. THEREFORE, IT IS A GOOD IDEA TO CONSULT WITH A QUALIFIED TAX ADVISOR BEFORE RECEIVING A PLAN DISTRIBUTION.

5. Domestic Relations Order

As a general rule, your interest in your Individual Account may not be alienated. This means that your interest may not be sold, used as collateral for a loan, given away or otherwise transferred. In addition, your creditors may not attach, garnish or otherwise interfere with your Individual Account.

However, the law provides certain limited exceptions to this general rule. One exception is that the Plan Administrator may be required by law to assign your benefits

pursuant to a "qualified domestic relations order." A "qualified domestic relations order" is generally defined as a decree or order issued pursuant to state domestic relations law that requires distribution of a portion of your benefits under the Plan to provide child support, alimony or spousal rights to a spouse, former spouse, child or other dependent. A qualified domestic relations order may not require the Plan to provide any type or form of benefit or any option not otherwise provided under the Plan. The Plan Administrator will determine the validity of any domestic relations order received in accordance with the Plan's rules for determining whether an order constitutes a qualified domestic relations order. A copy of these rules can be obtained upon written request to the Fund Office.

6. Pension Benefit Guaranty Corporation

Benefits provided by your Plan are NOT insured by the Pension Benefit Guaranty Corporation (the "PBGC"), which is a Federal agency that insures certain pension plan benefits upon plan termination, because the benefits you receive under this type of plan are based upon the amount in your Plan account.

7. Overpayment

A Participant or a Beneficiary who receives any payment in excess of the amount which such individual is entitled to receive (including, without limitation, due to mistake of fact or law, reliance on false or fraudulent statements, information or proof submitted by a claimant ("Excess Payments")), shall be obligated to repay such Excess Payments upon receipt of a written notice by the Board of Trustees (or any designee duly authorized by the Board of Trustees) requesting such payment.

The Board of Trustees shall have full authority, in its sole and absolute discretion, to the extent permitted by law, to recover the amount of any Excess Payments (plus interest and costs) paid by the Fund to or on behalf of any Participant or Beneficiary. Such authority (either individually or in combination) shall include, but shall not be limited to, the right to seek the Excess Payment in a lump sum from such individual and initiate legal action or take such other legal action as may be necessary or appropriate to recover any overpayment (plus interest and costs).

VIII
CLAIMS BY PARTICIPANTS AND BENEFICIARIES

Generally, to request distribution of Plan benefits, you (or your Beneficiary) must file a written application with the Trustees. Set forth below are the Plan's special rules regarding the determination on your claim and your right to request a review if an adverse benefit determination is made on your initial claim. These rules differ for claims for disability benefits and all other claims.

When you see the term "adverse benefit determinations," you should understand that this includes not only claim denials, but also reductions or terminations of benefits and failures to make payment (in whole or in part) for a benefit, including determinations that are based on decisions relating to a participant's or beneficiary's eligibility to participate in the Fund.

1. All Claims Other than for Disability Benefits

The Initial Claim

You will be notified of the acceptance or denial of your claim for benefits within 90 days from the date the Plan Administrator receives your claim. In some cases, your request may take more time to review and an additional processing period of up to 90 days may be required. If that happens, you will be notified in writing. The written notice of extension will indicate the special circumstances requiring the extension of time and the date by which the Plan Administrator expects to make a determination with respect to the claim. If the 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 date on which you respond to the Plan's request for information.

If your claim is wholly or partially denied, or any other adverse benefit determination is made with respect to your claim, the Plan Administrator will furnish you with a written notice of this determination. This written notice will be provided to you within a reasonable period of time (generally 90 days) after the receipt of your claim by the Plan Administrator. The written notice will contain the following information:

(a) the specific reason or reasons for the determination;
(b) reference to the specific Plan provisions on which the determination is based;
(c) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; and
(d) a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

If notice of the denial of a claim is not furnished to you in accordance with the above within a reasonable period of time, your claim will be deemed denied. You will then be permitted to proceed to the review stage described in the following paragraphs.

The Appeal of Adverse Benefit Determinations

If your claim has been denied, or any other adverse benefit determination is made with respect to your claim, and you wish to submit your claim for review, you must

file your claim for review, in writing, with the Plan Administrator. **You must file the claim for review no later than 60 days after you have received written notification of the denial of your claim for benefits (or, if none was provided, no later than 60 days after the deemed denial of your claim).** In connection with the request for review, you (or your duly authorized representative) may submit to the Plan Administrator written comments, documents, records, and other information relating to the claim. 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 the claim. The review by the Trustees will take into account all comments, documents, records, and other information you submit relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination.

The Board of Trustees will make a final written decision on a claim review at its next regularly scheduled meeting following receipt of your request for review, unless the request is filed less than thirty (30) days prior to the next regularly scheduled meeting, in which case a decision will be made by no later than the date of the second regularly scheduled meeting following receipt of the request for review. If special circumstances require an extension of time for processing the request for review, the decision may be made at the third meeting following receipt of such request. You will be notified in advance of any such extension. The notice will describe the special circumstances requiring the extension, and will inform you of the date as of which the determination will be made. If the 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 date on which you respond to the Plan's request for information.

You will be notified in writing of the determination on review within 5 days after the determination is made. If an adverse benefit determination is made, this notice will include (i) the specific reason(s) for the adverse benefit determination; (ii) reference to the specific Plan provisions on which the determination is based; (iii) 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 the claim; and (iv) a statement of your right to bring a civil action under Section 502(a) of ERISA.

2. Claims for Disability Benefits

These procedures apply to claims in which the Plan Administrator (or other claims adjudicator) must make a determination of disability in order to decide your claim. For the purposes of this section, the SPD refers to such claims as "claims for disability benefits."

The Initial Claim

You will be notified in writing of the acceptance or denial of your claim for benefits within 45 days from the date the Plan Administrator receives your claim. If the Plan Administrator determines that an extension of time is necessary for processing your

claim (due to circumstances beyond the control of the Fund), the 45-day period may be extended for up to an additional 30 days and, if additional time is still needed after that period ends, there may be one more extension of an additional 30 days. If an extension is needed, you will be notified (within the initial 45-day period) of the circumstances requiring the extension and the date by which a decision is expected to be made. The notice will inform you of the standards for entitlement to disability benefits and the issues that are delaying a decision on your claim, as well as the additional information needed to resolve those issues. You will have 45 days to provide the Fund with the requested information.

If your claim is wholly or partially denied, or any other adverse benefit determination is made with respect to your claim, the Plan Administrator will furnish you with a written notice of this determination. This written notice will include:

(a) the specific reasons for the determination;

(b) reference to the specific Plan provisions on which the determination is based;

(c) a description of any additional information or material needed to complete your claim (including an explanation of why the information is needed);

(d) a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

   a. the views you present the Plan of health care professionals treating you and vocational professionals who evaluated you;
   b. the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination (without regard to whether the advice was relied upon in making the benefit determination); or
   c. a disability determination you present to the Plan made about you by the Social Security Administration;

(e) a statement that you have the right to submit written comments, documents, records and other information relating to the claim, and 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 for benefits;

(f) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist;

(g) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of

the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(h) a description of the Plan's appeal procedure and applicable time limits, as well as a statement of your right to bring suit under federal law (Section 502(a) of ERISA) following an adverse determination on appeal; and

(i) in the case of an adverse determination on appeal, a description of any applicable contractual limitations period that applies to your right to file the claim in court, including the date on which the contractual limitations period expires for the claim.

The Appeal of Adverse Benefit Determinations

You (or your authorized representative) may appeal the Fund's adverse benefit determination in writing to the Fund's Board of Trustees. **You must file the claim for review within 180 days after you receive notice of the determination (or, if none was provided, no later than 180 days after the deemed denial of your claim).**

In connection with the request for review, you (or your duly authorized representative) may submit to the Plan Administrator written comments, documents, records, and other information relating to the claim. 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 the claim. The review by the Trustees will take into account all comments, documents, records, and other information you submit relating to the claim.

In considering your appeal, the Board of Trustees will review all information that you submit, even if it was not submitted or considered in the initial benefit determination made by the Fund. In addition, upon your written request and free of charge, the Fund will provide you (or your authorized representative) with access to, or copies of, all documents, records and other information relevant to your claim.

In reviewing your appeal, deference shall not be afforded to the initial claim decision and the review shall be conducted by an appropriately named Plan fiduciary who is neither the individual who made the initial decision on your claim for Disability benefits, nor a subordinate of such individual. If the initial decision on your claim for Disability benefits was based (in whole or in part) on a medical judgment, in deciding your appeal, the Board of Trustees will consult with a health care professional who has training and experience in the relevant field of medicine and who is not the same person as the individual consulted by the Fund in making the initial decision on your claim (or subordinate to that person).

The Board of Trustees will review your appeal during its next regularly scheduled meeting, provided that your appeal is received by the Fund Office at least 30 days before

the meeting date. If your appeal is received by the Fund Office less than 30 days before the next regularly scheduled meeting of the Board of Trustees, your appeal will be reviewed at the second regularly scheduled meeting following the Fund's receipt of your appeal. If special circumstances require an extension of time for processing your appeal, then the Trustees will make a decision on your appeal during the third regularly scheduled meeting following receipt of your appeal. If this extension is needed, you will be notified in writing (before the extension begins) of the circumstances requiring the extension and the date as of which the appeal determination will be made.

Before issuing an adverse decision on your appeal, the Plan will provide you with any new or additional evidence considered, relied upon, or generated by or at the direction of the Board of Trustees or its designee, and any new or additional rationale upon which an adverse decision is based. This information will be provided to you free of charge and sufficiently in advance of the decision to provide you with a reasonable opportunity to respond.

You will be notified in writing of the Board's decision on your appeal within 5 days after the decision is made. If your appeal is denied, the written notice will include all of the information described above (in the section regarding notice of initial claim determinations), as well as a statement regarding the availability of other voluntary alternative dispute resolution options (if any).

You have the right to bring a civil action under Section 502(a) of ERISA. However, 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, 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 Plan is exhausted, that is by the earlier of the date on which an adverse benefit determination on review is issued by the appeals reviewer or the last day on which a final decision should have been issued, or you will be forever prohibited from commencing such action.

* * *

Important Claims-Related Information

Please remember that, with respect to all Plan benefits, no one except the Board of Trustees (or its duly authorized designees) has the authority to interpret the Plan, including this SPD or any other official Plan documents, to make any promises to you about it, or to change the provisions of the Plan. As described below, the Board of

Trustees (or its duly authorized designee) has the sole discretion in making its decisions on all claims, and its determinations are final, conclusive and binding.

If the Plan Administrator determines that a person entitled to payments under the Plan is incompetent by reason of physical or mental illness, accident, or incapacity, the Plan Administrator may cause any payments due under the Plan to be paid to the person's spouse, legal custodian, or other individual with power of authority over the person entitled to payments.

IX
STATEMENT OF ERISA RIGHTS

1. Your Rights Under ERISA

As a participant in the Buffalo Laborers Security Fund, 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:

2. Receive Information About Your Plan and Benefits

Examine, without charge, at the Fund 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 Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report.

3. 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 pension benefit or exercising your rights under ERISA.

4. Enforce Your Rights

If your claim for a pension 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 the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

5. Assistance with Your Questions

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

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PLAN INTERPRETATIONS, AMENDMENTS AND TERMINATION

1. Amendment

The Trustees reserve the right, in their sole and absolute discretion, to amend the Plan at any time, in whole or in part, for any reason. In no event, however, will any amendment:

(a) authorize or permit any part of the Plan assets to be used for purposes other than the exclusive benefit of the participants or their beneficiaries; or

(b) cause any reduction in your accrued benefit, other than forfeitures, under the Plan.

2. Termination

The Plan is intended to remain in effect and is not expected to terminate. However, the Trustees may terminate the Plan when there is no longer a collective bargaining agreement, or other written agreement acceptable to the Trustees, between a Contributing Employer and the Union.

If the Plan is amended, modified or terminated, in whole or in part the ability of Employees to participate in the Plan and/or receive benefits thereunder, as well as the type of benefits provided under the Plan, may be modified or terminated.

3. Plan Interpretations and Determinations

The Board of Trustees and/or 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 and any other Plan documents, and to decide all matters arising in connection with the operation or administration of the Plan or trust underlying it. Without limiting the generality of the foregoing, the Board of Trustees and/or its duly authorized designee(s) shall have the sole and absolute discretionary authority to:

(a) Take all actions and make all determinations with respect to the eligibility for and the amount of benefits payable under the Plan;

(b) Decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan;

(c) Formulate, interpret and apply rules, regulations and policies necessary to administer the Plan in accordance with its terms;

(d) Interpret the provisions of all Plan documents, this SPD, any collective bargaining or participations agreement, the Trust Agreement and any other document or instrument involving or impacting the Plan;

(e) Resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan, including this SPD, the Trust Agreement or other Plan documents;

(f) Process and approve or deny benefit claims and rule on any benefit exclusions; and

(g) Determine the standard of proof in any case.

All such determinations and interpretations made by the Trustees shall be final and binding upon any individual claiming benefits under the Plan, upon all Employees, all Contributing Employers, and the Union, and shall be given deference in all courts of law, to the greatest extent allowable by applicable law.

IMPORTANT REMINDER ON KEEPING PLAN RECORDS UP TO DATE

In order for you to receive the benefits to which you may be entitled under the Plan, you should keep your Plan records up to date. You should notify the Plan Administrator immediately if, among other things, you:

- Have a change of address or telephone number;
- Have a change in marital status; or
- Wish to change your beneficiary.