PLAN AND SUMMARY PLAN DESCRIPTION

FOR THE

IRON WORKERS DISTRICT COUNCIL OF WESTERN NEW YORK AND VICINITY SUPPLEMENTAL BENEFIT PLAN (ACTIVE PARTICIPANTS)

July 1, 2022

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(ACTIVE PARTICIPANTS)

Table of Contents

Page

SECTION 1 GENERAL INFORMATION FOR ALL PARTICIPANTS AND BENEFICIARIES 1

SECTION 2 RULES OF ELIGIBILITY 5

SECTION 3 ELIGIBLE DEPENDENTS 8

SECTION 4 BENEFITS 9

SECTION 5 FILING CLAIMS FOR BENEFITS 12

SECTION 6 ALLOCATIONS TO INDIVIDUAL ACCOUNTS 19

SECTION 7 OPTING OUT 22

SECTION 8 COBRA CONTINUATION COVERAGE 23

SECTION 9 CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION 29

SECTION 10 PLAN INTERPRETATIONS AND DETERMINATIONS 33

SECTION 11 OVERPAYMENTS 34

SECTION 12 TERMINATION AND MODIFICATION OF PLAN AND SUMMARY PLAN DESCRIPTION 35

SECTION 13 STATEMENT OF ERISA RIGHTS 36

SECTION 14 TECHNICAL DETAILS 38

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FOR THE
IRON WORKERS DISTRICT COUNCIL OF WESTERN NEW YORK AND VICINITY
SUPPLEMENTAL BENEFIT PLAN
(ACTIVE PARTICIPANTS)

Dated: July 1, 2022

Dear Participant:

This Booklet, called a Plan and Summary Plan Description, has been prepared to describe the benefits, rules of eligibility, and other special provisions concerning your benefits under the Iron Workers District Council of Western New York and Vicinity Supplemental Benefit Plan for Active Participants. We have made every effort to present the information in this Booklet in clear and simple language, so that you can fully understand the plan of benefits under which you are covered.

We suggest that you read the Plan and Summary Plan Description on the following pages very carefully, in order to understand their application to your specific case.

Your Supplemental Benefit Plan has been carefully considered by the members of the Board of Trustees, and every effort has been made to provide additional health related benefits. We sincerely hope that this benefit plan will provide a high level of security for you and your family, since it has been specifically designed to cover your health related expenses which may be payable from your individual account. If you have any questions concerning the plan of benefits, please contact the Fund Office.

Very truly yours,

BOARD OF TRUSTEES

CAUTION

This document and the personnel at the Fund Office are authorized sources of Plan information for you. The Trustees of the Plan have not empowered anyone else to speak for them regarding the Supplemental Benefit Plan. No employer, Union representative, supervisor, or shop steward, is in a position to discuss your rights under this Plan with authority.

COMMUNICATIONS

If you have a question about any aspect of your participation in the Plan, you should, for your own permanent record, write to the Trustees. You will then receive a written reply which will provide you with a permanent reference.

NO GUARANTEE OF INCOME TAX CONSEQUENCES

Neither the Board of Trustees nor the Fund Office makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for Federal or State income tax purposes, or that any other Federal or State tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each Payment under the Plan is excludable from the Participant's gross income for Federal and State income tax purposes, and to notify the Fund Office if the Participant has reason to believe that any such Payment is not so excludable.

SECTION 1

GENERAL INFORMATION FOR ALL PARTICIPANTS AND BENEFICIARIES

The Iron Workers District Council of Western New York and Vicinity Supplemental Benefit Plan is administered by a Board of Trustees composed of three (3) Union Trustees, and three (3) Employer Trustees. The address of the Board of Trustees and Plan Administrator is The Design Center, 3445 Winton Place, Suite 238, Rochester, New York 14623. Please contact the Fund Office if you need further information about your Supplemental Benefit Fund. The Fund Office telephone number is: (585) 424-3510.

Members of the Board of Trustees are as follows:

Union Trustees

Scott Brydges, Trustee
c/o Iron Workers Local Union No. 9
412 39th Street
Niagara Falls, New York 14303

Timothy Starwald, Trustee
c/o Iron Workers Local Union No. 33
650 Trabold Street
Rochester, New York 14624

Robert Cole, Trustee
c/o Iron Workers Local Union No. 440
10 Main Street, Suite 100
Whitesboro, New York 13492

Employer Trustees

Kelly Gilligan, Trustee
c/o Rochester Rigging & Erectors, Inc.
7819 State Route 5 & 20
Bloomfield, New York 14469

H.L. (Chip) Stephenson, Trustee
c/o BVR Construction Co., Inc.
8 King Road
Churchville, New York 14428

Thomas Dickey, Trustee
c/o Ace Architectural
5285 Upper Mt. Road
Lockport, New York 14094

Fund Counsel

Blitman & King LLP

The Powers Building, Suite 500
16 West Main
Rochester, New York 14614

Franklin Center, Suite 300
443 North Franklin St.
Syracuse, New York 13204

Fund Accountant

Arcara Lenda Eusanio & Stacey CPAs
5214 Main Street, Suite 200

Williamsville, New York 14221

Administrative Manager

Laurie Good
Iron Workers District Council of Western New York and Vicinity Supplemental Benefit Fund
3445 Winton Place, Suite 238
Rochester, New York 14623
Telephone: (585) 424-3510
Fax: (585) 424-3722

Fund Counsel, Blitman & King LLP, and Laurie Good, Administrative Manager, Iron Workers District Council of Western New York and Vicinity Supplemental Benefit Fund have been designated as the agents for the service of legal process, in accordance with the regulations under the Employee Retirement Income Security Act of 1974. Service of legal process may also be made on any individual member of the Board of Trustees.

The Employer Identification Number assigned by the Internal Revenue Service to the Board of Trustees is 16-1550492. The Plan Number assigned by the Board of Trustees to the Iron Workers District Council of Western New York and Vicinity Supplemental Benefit Plan for Active Participants ("Plan") is 501.

Employer Contributions

The Plan is maintained through Collective Bargaining Agreements between the Upstate Iron Worker Employers Association, Inc. and the International Association of Bridge, Structural, Ornamental & Reinforcing Iron Workers, Local Union No. 9, Local Union No. 33, and Local Union No. 440. These Collective Bargaining Agreements provide that employers must contribute to the Fund on behalf of each employee on the basis of a fixed rate per hour worked. In addition, other employers may be allowed by the Trustees to contribute on behalf of their employees and other Iron Workers Local Unions may also be allowed by the Trustees to have contributions made to this Fund for their Apprentices and Journeymen.

The Fund Office will provide you, upon written request, information as to whether a particular employer is contributing to this plan on behalf of participants working under any Collective Bargaining Agreement or any other arrangement. If you believe that your employer has underreported or failed to report your hours of work in "covered employment", defined as employment for which contributions are required to be remitted to this Plan, you must present evidence satisfactory to the Trustees to receive credit for such hours. The burden of proof lies with you [in other words, it is your responsibility] to show entitlement to underreported or unreported hours of covered employment.

Income and Reserves

Income received by the Fund from contributing employers is held in a Trust Fund for the purpose of providing benefits to participants and their dependents, and defraying reasonable administrative expenses. The funds, assets, and reserves are held in custody and are invested by the Board of Trustees.

Plan Year

For purposes of governmental reporting and maintaining the Fund's fiscal records, the fiscal year ends June 30, and the Plan Year is July 1 – June 30.

Benefits

Various benefits may be paid to you directly from your individual account maintained through the Fund Office. These benefits include coverage of health related costs not paid by any insurance. All claims for these benefits should be filed with the Iron Workers District Council of Western New York and Vicinity Supplemental Benefit Fund Office, and the details of eligibility, coverage, and related information concerning these benefits, are provided in this Booklet. The Benefits provided by this Plan are not guaranteed, are not vested, and are not deferred income.

SECTION 2

RULES OF ELIGIBILITY

Employee

The term "employee" is hereby defined to mean all employees upon whose behalf contributions are made by any of the employers contributing to this Trust Fund or to the Trust Fund of the Iron Workers District Council of Western New York and Vicinity Welfare Fund; all employees who are members of Iron Workers Local Union No. 9, Iron Workers Local Union No. 33, or Iron Workers Local Union No. 440, or who are covered by Collective Bargaining Agreements between Iron Workers Local Union No. 9, Iron Workers Local Union No. 33, or Iron Workers Local Union No. 440, and an employer; or those who are covered by a Collective Bargaining Agreement between any other Iron Workers Local Union and an employer which provides for contributions to this Trust Fund.

Employer

The term "employer" means any employer which makes contributions to the Fund.

Employer Contributions

Employer payments are made to the Supplemental Benefit Fund by each employer, for each hour worked by or paid to an employee, pursuant to the Collective Bargaining Agreement or, in some cases, by voluntary action on their part. Employees will also receive credit for all hours for which payments are required to be remitted to the Fund and which contributions are not received by the Fund.

Eligibility

An employee must work one or more hours for which contributions are made to the Fund on his or her behalf. Once this has occurred, you will be a Participant in the Plan.

However, in order to be eligible for an employer contribution to be made to the Supplemental Benefit Fund on your behalf, you must actually be enrolled in the health benefit provided under the Iron Workers District Council of Western New York and Vicinity Welfare Fund or in another employer-sponsored health plan that has been certified to the Plan Administrator as providing "minimum value," as defined under the Affordable Care Act (collectively referred to as "Group Coverage"). Your eligible dependents must also enroll in Group Coverage to participate in the Individual Account.

If you leave covered employment for reasons other than retirement under the Iron Workers District Council of Western New York and Vicinity Pension Fund or the Pension Fund of

any other Local affiliated with the International Association of Bridge, Structural, Ornamental and Reinforcing Iron Workers, or you lose Group Coverage, you (and your eligible dependents) may continue to receive reimbursements from the Supplemental Benefit Fund as long as the required balance is maintained in your Individual Account. However*,* utilization of benefits will be applicable to only those contributions made prior to your loss of coverage. If a dependent, otherwise eligible, loses Group Coverage, contributions earned after the loss of coverage will not be available to that eligible individual until he or she enrolls in Group Coverage again*.*

Retirees

Notwithstanding anything to the contrary in this Plan, individuals that retire under the Iron Workers District Council of Western New York and Vicinity Pension Fund or the Pension Fund of any other Local affiliated with the International Association of Bridge, Structural, Ornamental and Reinforcing Iron Workers are not eligible for benefits under this Plan. If, upon your loss of eligibility for benefits under this Plan due to retirement, you still have a balance in your personal HRA, this balance will be transferred to the Iron Workers District Council of Western New York & Vicinity Retiree Supplemental Benefit Plan ("Retiree Plan"). At that time, you will no longer be a participant in or have an HRA under this Plan and any rights you or your dependents may have with respect to the HRA will be subject to the terms of the Retiree Plan. If, after this transfer, you return to work that makes you eligible to once again participate in this Plan, you may have an HRA established on your behalf pursuant to the terms and conditions set forth above; your remaining account balance in the Retiree Plan will then be transferred back to this Plan.

Family and Medical Leave

Under the Family and Medical Leave Act (FMLA), you may qualify for benefits during a period you are on leave for the purposes described in the Act. For more information concerning the FMLA, you may contact the Fund Office.

Military Service

When a participant leaves employment for full-time military service, as defined by Federal Law, the participant and his or her eligible dependents may be eligible to continue participation in the Fund as required by Federal Law.

You may contact the Fund Office for more information.

Special Enrollment Rights

By law, the Plan must provide the following description of special enrollment rights to anyone who becomes eligible for coverage: If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request

enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption and provide proof of dependency (e.g. birth certificate, marriage certificate).

You and your dependents may also enroll in this plan if you (or your dependents) have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends.

You and your dependents may also enroll in this plan if you (or your dependents) become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after you (or your dependents) are determined to be eligible for such assistance.

SECTION 3

ELIGIBLE DEPENDENTS

Eligible Dependents

Your Eligible Dependents who may be covered under this Plan are your spouse, and any of your children who are under the age of 26.

Coverage For Children

Child includes your natural children, as well as step-children, adopted children, and foster children placed with the participant by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction. No employee eligible to participate in the Plan may be covered as a spousal dependent.

If your child reaches age 26 and is, at that time, incapable of self-sustaining employment due to a permanent and total physical or mental disability, the child may continue to be an eligible dependent as long as the child's condition remains the same. You must provide the Trustees with satisfactory proof of this condition. The coverage for the child may only be continued as long as (1) the incapacity and dependency continues, (2) proof of such continued disability is submitted upon request, (3) the child submits, upon request, to a medical examination by a provider of the Fund's own choosing, (4) the child is eligible as a disabled dependent under the Social Security Act, and (5) the Fund's dependent coverage remains in force.

The Omnibus Budget Reconciliation Act of 1993 requires health plan administrators to recognize qualified medical child support orders ("QMSCOs"). A QMSCO is a court decree under which a court order mandates health coverage for a child. Under a QMSCO, children who might otherwise lose rights to benefits under a group health plan will be entitled to enrollment in a parent's group health plan as "alternate recipients".

Upon receipt of a Medical Child Support Order, the Plan Administrator will promptly notify the participant and each child of receipt of the Order. The Participant and each child will be notified within a reasonable period of time whether the order is qualified. A child may designate a representative to receive copies of any notices that are sent to the child. If it has been determined that the order is a Qualified Medical Child Support Order, the child will then be considered a participant under the Plan and will receive copies of Summary Plan Descriptions, Summary Annual Reports, and summaries of any amendments made to the Plan according to current ERISA requirements.

SECTION 4

BENEFITS

Health Related Benefits

In the event you or your dependents incur any health related expense as described in Internal Revenue Code § 213(d) including, but not limited to, charges by any doctor, dentist, optometrist, ophthalmologist, hospital, or other health facility, pharmacy, optical dispensing service, or hearing aid provider, which is not covered by the Iron Workers District Council of Western New York and Vicinity Welfare Fund or any other health care plan, the Trustees may authorize payment to you of such part of your account as the Trustees consider advisable in view of the circumstances existing at the time such application for benefits is made.

In accordance with Federal Law, the Plan may not restrict benefits for any hospital length of stay in connection with child birth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section, or require that a provider obtain authorization from the Plan (or insurance issuer) for prescribing a length of stay not in excess of the above periods. However, Federal Law does not prohibit the mothers' or newborns' attending provider, after consulting with the mother, from discharging the mother or her newborn at an earlier time.

The Trustees may also authorize payment to you for reimbursement for (1) insulin, (2) over-the-counter medicines and drugs, (3) over-the-counter medical devices and supplies, such as crutches, bandages and blood sugar test kits, and (4) menstrual care products. You must provide itemized receipts evidencing the purchase of drugs, medicine, medical care items, or menstrual care products.

In the event you lose eligibility for benefits under the Iron Workers District Council of Western New York and Vicinity Welfare Fund because of unemployment, the Trustees may authorize reimbursement to you from your account of your self-payment to the Iron Workers District Council of Western New York and Vicinity Welfare Fund for such health insurance. As an alternative to reimbursing you, upon receipt by the Fund Office of a written request and authorization, the Fund Office will withdraw from your account the monies necessary to purchase the health insurance and remit payment on your behalf directly to the Iron Workers District Council of Western New York and Vicinity Welfare Fund. To qualify for such withdrawal and payment, you must have worked a minimum of 100 hours in covered employment, but less than 200 hours during a 3-month eligibility period. Reimbursement may also be made to you to pay premiums for coverage under another recognized group health plan on an after-tax basis. However, notwithstanding anything to the contrary in this Plan, HRA balances may not be used to purchase individual market health insurance coverage.

Payment of Benefits

Claims under this benefit may be submitted at any time during the month. Payment will be made by the Fund Office as soon as administratively feasible. At minimum, claims are paid on a semimonthly basis. Such health related expenses must be provided in the form of itemized bills and Explanation of Benefits ("EOB") from your primary health care plan. Claims must be submitted within two years from the date such services are provided.

All payments and reimbursements under this Plan are subject to, and may never exceed, the balance in your account. Under no circumstances may any money be drawn from your account once the level of your account has reached zero.

In no event will any benefits be paid from your account if such payment would reduce your account below ONE HUNDRED FIFTY DOLLARS ($150.00). The foregoing shall not apply to the following: (1) any payment to an individual who has an account balance due to work as a traveler in the jurisdiction of Iron Workers Local No. 9, Iron Workers Local No. 33, or Iron Workers Local 440; or (2) any payment to a participant who has not had contributions made to his or her account as a result of not having worked in the jurisdictions of Iron Workers Local No. 9, Iron Workers Local Union No. 33, or Iron Workers Local Union No. 440, for a period of twelve consecutive months.

Substantiation of Claims – Debit Card

Like all claims, claims paid for with a Plan debit card must be substantiated. Substantiation is documentation, such as an explanation of benefits (EOB) or itemized statement, showing that your debit card transaction is for a qualified medical expense under Internal Revenue Code Section 213(d). Proper documentation will contain the patient's name, type of service or product, date of service, name and address of the service provider, amount of the expense, and proof of payment. In some cases, a letter of medical necessity will be required.

If, within 60 days of the debit card transaction, you fail to either provide appropriate substantiation documentation for the debit card expense or repay the Plan the full amount of the expense, you and your spouse's (if applicable) debit card will be suspended (frozen) and the amount of any future valid manual claims that you submit will be used to offset the amount of the unsubstantiated debit care expense. If you continue to fail to either provide the appropriate documentation or repay the Plan, the Plan may treat and report to the Internal Revenue Service the amount of the claim as a taxable distribution to you.

Transfer of Account

In the event you leave the work jurisdictions of Iron Workers Local Unions No. 9, 33, and 440 for a period of six (6) consecutive months during which time no contributions are made to

your individual account and you work in employment for which contributions are required to be made to the benefit plan(s) sponsored by another Iron Workers Local Union which maintains a supplemental benefit plan or other similar welfare benefit plan, the Trustees may authorize a direct transfer of your individual account balance to that other Local's plan. You must submit a written Request and Authorization for Transfer of Account to the Fund Office and waive any and all present and future claims you may have for benefits from this Fund. In addition, the appropriate representative of the welfare benefit plan to which you wish to transfer your individual account balance must sign the Request and Authorization for Transfer of Account to acknowledge that it will accept the monies and be responsible for payment of all benefits due to you. You may contact the Fund Office to request the necessary Request and Authorization for Transfer of Account form.

SECTION 5

FILING CLAIMS FOR BENEFITS

Claims to be filed at the Supplemental Benefit Fund Office

Claims for benefits under this Plan should be filed directly with the Fund Office. You will be provided with an Application, which will indicate the types of benefits for which you are applying, and any special requirements associated with approval of these benefits, at the time you apply. Please refer to Section 4 of this Plan and Summary Plan Description, for further details concerning the types of benefits which are handled directly by the Fund Office, and payable from your personal individual account.

Claim Review and Appeal Procedures

Initial Decisions – Time Frames

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

Content of Notification of Initial Adverse Benefit Determination

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

1. The specific reasons for the adverse determination;

2. Reference to the specific plan provisions (including any internal rules, guidelines, protocols, criteria, etc.) on which the determination is based;

3. A description of any additional material or information necessary for you to complete the claim and an explanation of why such material or information is necessary;

4. A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under § 502(a) of ERISA following an adverse benefit determination on review;

5. If an internal rule, guideline, or protocol was relied upon in making the adverse determination, the rule, etc., or a statement that the rule was relied upon and that a

copy of it will be provided free of charge upon request; and

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

Appeals of Adverse Benefit Determinations

If you are not satisfied with the reason or reasons why your claim was denied, then you may appeal to the Board of Trustees. To appeal an adverse benefit determination of a Health Expense Benefit, you must write to the Trustees within 180 days after you receive this Plan's initial determination.

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

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

In addition, in regard to all appeals: (1) the review will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination nor the subordinate of such individual; (2) insofar as the adverse benefit determination is based on medical judgment, the Board will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment; (3) such health care professional shall not be the individual, if any, who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; and (4) medical or vocational experts whose advice was obtained on behalf of

the plan, without regard to whether the advice was relied upon in making the adverse benefit determination, will be identified.

Determinations on Appeal – Time Frames

The Trustees at their next regularly scheduled meeting will make a determination of the appeal. However, if the appeal is received less than 30 days before the meeting, the decision may be made at the second meeting following receipt of the request. If special circumstances require an extension of time for processing, then a decision may be made at the third meeting following the date the appeal is made. Before an extension of time commences, you will receive written notice of the extension, describing the special circumstances requiring the extension and the date by which the determination will be made. The Plan will notify you of the benefit determination no later than 5 days after the determination is made.

Content of Adverse Benefit Determination on Review

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

1. The specific reasons for the adverse benefit determination;

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

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

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

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

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

The Trustees' Decision is Final and Binding

The Trustees' final decision with respect to their review of your appeal, *or*, if you are eligible for, and pursue, External Review, the External Reviewer's final decision with respect to

its review of your claim, will be final and binding upon you because these decision-makers have exclusive authority and discretion to determine questions of eligibility and entitlement under the plan. Any legal action against this plan must be started within 180 days from the date the adverse benefit determination denying your appeal, or external reviewer's determination, is deposited in the mail to your last known address, and may only be started after all administrative procedures set forth in the Plan have been exhausted by you.

Additional Internal Appeal Procedures

Additional internal appeal procedures include the following:

1. An "Adverse Benefit Determination" includes a "rescission of coverage." "Rescission" is defined as a cancellation or discontinuance of coverage that has a retroactive effect.

2. You will be provided, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with the denied claim; such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided.

3. Before a final internal adverse benefit determination is issued based on new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided.

4. Notice of an adverse benefit determination will be made in a "culturally and linguistically appropriate manner" when required by law.

5. Notice of an adverse benefit determination will now include:

   (a) Information sufficient to identify the claim involved. This information includes the date of service, health care provider, and the claim amount (if applicable);

   (b) The denial code, if any, and its corresponding meaning;

   (c) A description of the plan's or issuer's standard, if any, that was used in denying the claim. If the notice involves a final internal adverse benefit determination, the description will also include a discussion of the decision;

(d) If applicable, a detailed description of the available external review processes, including information regarding how to initiate external review;

(e) The availability of, and the contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act Section 2793 to assist enrollees with the internal claim and appeal and external review processes; and

(f) If applicable, a statement describing the participant's right to request any diagnosis code, treatment code, and the corresponding meanings of those codes in connection with adverse benefit determinations.

External Review

You may have the right to external review of a final internal adverse benefit determination. For purposes of external review eligibility, an adverse benefit determination is a determination that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, based upon the information provided, it is determined that the treatment is experimental or investigational or does not meet the plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated. A rescission of coverage is an adverse determination.

The external review will be made by an independent review organization with health care professionals that have no conflict of interest with respect to the benefit determination. Except for approved expedited external reviews this external review is only available once you have exhausted the Fund's internal grievance process. Any request for external review must be in writing and submitted to the Fund Office at 3445 Winton Place, Suite 238, Rochester, NY 14623-2950 within four months after receipt of the notice of the final adverse benefit determination. Upon application and approval of the request for external review, the Fund Office will assign an independent review organization. Please do not hesitate to contact the Fund Office with any questions regarding external review.

COVID-19 Pandemic

The Iron Workers District Council of Western New York and Vicinity Supplemental Benefit Fund will suspend certain deadlines detailed below that fall during the "COVID-19 Outbreak Period" (March 1, 2020, until sixty (60) days after the announced end of the COVID-19 National Emergency) until the earlier of: (a) one year from the applicable deadline; or (b) the end of the COVID-19 Outbreak Period. This means that every time that one of the following deadlines occurs on or after March 1, 2020, that deadline will be suspended for up to a year, as long as the COVID-19 Outbreak Period continues:

1. The 30-day deadline to request special enrollment in the Plan due to a loss of other coverage, your marriage, or the birth, adoption, or placement for adoption, with you of a new dependent.

2. The 60-day deadline to request special enrollment due to the loss of Medicaid or CHIP coverage.

3. The 60-day period to elect COBRA continuation coverage, the initial 45-day COBRA premium payment deadline, and the subsequent 30-day deadlines for making COBRA premium payments for each month thereafter.

4. The deadline for individuals to notify the Plan of a qualifying event or determination of disability for purposes of COBRA.

5. The deadline to file an initial benefit claim under the Plan's claims procedures.

6. The deadline to file an appeal of an adverse benefit determination under the Plan's appeals procedures.

7. The deadline to file a request for external review.

8. The deadline to submit information to perfect a request for external review upon a finding that the request was incomplete.

The Plan's deadline to provide a COBRA election notice is also subject to the above Tolling Period.

SECTION 6

ALLOCATIONS TO INDIVIDUAL ACCOUNTS

Payments

Your Individual Account will have credited to it, the full amount of all contributions made to the Fund with respect to your hours of work.

Income

Allocation of Net Income will be made to the Individual Accounts of all participants and beneficiaries who have undistributed balances in their Accounts, as of the Valuation Date. Regarding such income allocation, the following definitions shall apply:

(a) **Balance**. The "Balance" of a participant's Individual Account as of any Valuation Date shall be computed as follows:

(1) The balance in your Individual Account as of the first day of the Plan Year, after Net Income and Employer contribution allocations as of the previous Valuation Date; plus

(2) The contributions made to your Individual Account during the Plan Year; less

(3) The benefit payments from your Individual Account during the Plan Year.

(b) **Net Income**. "Net Income" shall include dividends, interest, and profits (realized and unrealized) and liquidated damages and interest charges related to such damages, reduced by losses (realized and unrealized), investment expenses and administration expenses, during the Plan Year. There shall be allocated to your Individual Account that portion of Net Income determined by dividing the Balance in your Account by the sum of the Balances in all Individual Accounts, effective on the applicable Valuation Date.

(c) **Administrative and Investment Expenses**. "Administrative Expenses" shall include all items of administration costs and charges paid during the Plan Year, including, but not limited to, an administrative fee of $75 per participant account per year. The $75 administrative fee shall also be assessed at the time of a final account distribution that occurs after July 1 and before the date of any interest or other administrative expense allocations to participant accounts. Administrative Expenses shall also include unpaid and withheld contributions arising as a result of employer delinquencies. "Investment Expenses" shall include all items of investment expenses paid during the Plan Year.

(d) **Valuation Date**. The "Valuation Date" shall be June 30 of each Plan Year.

Accountant Determinations

Net Income and Administrative and Investment Expenses, as defined herein, shall be determined by the Fund's accountant, and such information shall be furnished to the Board of Trustees, or to their designee, for purposes of performing the annual allocations to Individual Accounts, as provided above.

Interim Date Value

The "Interim Date Value" or "Net Value" of an Individual Account between Valuation Dates, shall consist of the balance in your Individual Account, as computed at the Valuation Date preceding the event requiring such determination (after allocation of Net Income for the year ending on such Valuation Date), plus payments credited, if any, and minus charges and benefits paid, if any, after such Valuation Date.

SECTION 7

OPTING-OUT

You may permanently opt-out of and waive all future reimbursements from your Individual Account. If you are performing work in covered employment, this means that you will be choosing to forego your benefits despite the fact that contributions will continue to be made to the Supplemental Benefit Fund for your work. Depending on the amount of work you perform in covered employment, choosing to permanently forego your Individual Account could result in adverse financial and tax consequences for you and your family. Therefore, you should carefully consider the consequences of permanently opting to forego your Individual Account balance, and should discuss any such decision with a qualified tax professional. If you opt to waive your Individual Account balance, and then continue working in covered employment, you will be required to re-establish Plan eligibility. However, if you elect to opt-out of and permanently waive future reimbursements from your Individual Account, you will not be eligible to have your Individual Account reinstated pursuant to these provisions. For more information regarding opting-out, please contact the Fund Office.

SECTION 8

COBRA CONTINUATION COVERAGE

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") provides that you, your spouse, and your other dependents, are entitled to elect to continue coverage on a self-pay basis under the Plan, under certain circumstances, if coverage would otherwise stop.

This notice contains important information about your right to continue your health care coverage in the Iron Workers District Council of Western New York and Vicinity Supplemental Benefit Plan (the Plan), as well as other health coverage alternatives that may be available to you through the Health Insurance Marketplace. Please read the information contained in this notice very carefully.

However, notwithstanding anything to the contrary in this Plan, regardless of whether an individual elects COBRA, no Health Reimbursement Account will be available under this Plan if an individual has been credited with a Health Reimbursement Account under the Retiree Plan pursuant to the procedure set forth above.

Qualifying Events for Participants

For individuals covered by the Plan as participants, COBRA continuation coverage may be elected when your Individual Account balance has been exhausted (no monies remain in the account).

Spousal Eligibility for COBRA Coverage

Your spouse may elect COBRA continuation coverage upon the loss of coverage due to the occurrence of any of the following events:

1. Your death.

2. Your Individual Account balance has been exhausted (no monies remain in the account).

3. Divorce or judicial order of legal separation.

4. Your enrollment in Part A or Part B of Medicare.

If your spouse has a COBRA Qualifying Event as a result of your death or your enrollment in Part A or Part B of Medicare, your spouse is NOT required to elect COBRA continuation coverage or pay COBRA premiums to continue to receive reimbursements from your Individual Account. Your spouse will continue to have access to your Individual Account

and to receive reimbursements from your Individual Account so long as the account balance is sufficient to cover the claims and exceeds the minimum account balance.

In the event your spouse has a COBRA Qualifying Event as a result of divorce or judicial order of legal separation or because your Individual Account balance has been exhausted, to continue to have access to your Individual Account and to receive reimbursements from your Individual Account, your spouse MUST elect COBRA continuation coverage and pay COBRA premiums.

If you lose coverage under the Plan and are credited with a Health Reimbursement Account under the Retiree Plan (as set forth above), your spouse will have the right to have access to your Health Reimbursement Account under the Retiree Plan, provided that the rules of the Retiree Plan concerning spousal coverage (including, if applicable, those with respect to COBRA) are complied with.

Dependent Eligibility for COBRA Coverage

Your dependent children can elect COBRA continuation coverage upon the loss of coverage due to the occurrence of any of the following events:

1. Your death.
2. Your Individual Account balance has been exhausted (no monies remain in the account).
3. Divorce or judicial order of legal separation of the child's parents.
4. Your enrollment in Part A or Part B of Medicare.
5. The child ceases to qualify as an "eligible dependent".

If your dependent child has a COBRA Qualifying Event as a result of your death or your enrollment in Part A or Part B of Medicare, your dependent child is NOT required to elect COBRA continuation coverage or pay COBRA premiums to continue to receive reimbursements from your Individual Account. Your dependent child will continue to have access to your Individual Account and to receive reimbursements from your Individual Account so long as the account balance is sufficient to cover the claims and exceeds the minimum account balance.

In the event your dependent child has a COBRA Qualifying Event as a result of your divorce or judicial order of legal separation, because your Individual Account has been exhausted, or because your child ceases to qualify as an "eligible" dependent, to continue to have access to your Individual Account and to receive reimbursements from your Individual Account, your dependent child MUST elect COBRA continuation coverage and pay COBRA premiums.

If you lose coverage and are credited with a Health Reimbursement Account under the Retiree Plan, your dependent child will have the right to have access to your Health Reimbursement Account under the Retiree Plan, provided that the rules of the Retiree Plan concerning dependent child coverage (including, if applicable, those with respect to COBRA) are complied with.

Notifications to the Fund Office

Your employer has the obligation to notify the Fund Office of your death or your enrollment in Part A or Part B of Medicare. The Trustees will determine when your Individual Account balance has been exhausted.

You have the responsibility to inform the Administrative Manager using the Fund's "Participant's Notice to Fund Administrator" form which can be obtained from the Fund Office of a divorce, judicial order of legal separation, a child's loss of status as an eligible dependent, the birth or adoption of a dependent, or of a determination by the Social Security Administration that a qualified beneficiary is disabled. This notice must be given within 60 days after the occurrence of the qualifying event or the date coverage would be lost because of the event, whichever is later. Failure to give notice to the Administrative Manager within the time limits may result in your ineligibility for COBRA continuation coverage.

In addition to giving notice of certain qualifying events, you have the responsibility to inform the Fund in the event that the Social Security Administration has determined you or one of your qualified beneficiaries to no longer be disabled. This notification must be made within 30 days of the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled.

Finally, if, while you are receiving COBRA continuation coverage, you have a newborn child or a child is placed with you for adoption, the child may be added to your coverage. You must, however, notify the Fund Office immediately of such a change.

Notification of COBRA Rights

After the Administrative Manager receives notice of the occurrence of one of the above qualifying events, the Administrative Manager will notify each eligible individual whether he or she has the right to elect COBRA continuation coverage and will send the materials necessary to make the proper election. In general, the Administrative Manager will notify eligible individuals of their COBRA rights within 14 days after receiving notice of the occurrence of one of the qualifying events described above or after it has determined that your Individual Account balance has been exhausted.

Election of COBRA Coverage

The participant, spouse and dependent children each has independent election rights. Covered employees may elect COBRA continuation coverage on behalf of their spouses and parents may elect COBRA continuation coverage on behalf of their children. Each individual will have 60 days from the date he or she would lose coverage because of one of the qualifying events described above or the date on which he or she is advised of the right to elect continuation coverage, whichever date is later, to inform the Administrative Manager that he or she wants COBRA continuation coverage. If no election of COBRA continuation coverage is made, the individual's coverage will terminate. You will not have another opportunity to elect continuation coverage. However, you may change your election within the 60-day period described above as long as the completed COBRA Election Form, if mailed, is post-marked no later than the due date. If the election is hand-delivered, the date of delivery must be on or before the due date. If you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date the completed Election Form, if mailed, is post-marked. If the election is hand-delivered, your COBRA continuation coverage will begin on the date of delivery.

Benefits Provided Under COBRA Coverage

The benefits an eligible individual is allowed to elect to receive will include all benefits the individual was entitled to before the occurrence of the event making the individual eligible for COBRA continuation coverage. However, no life insurance (death benefits), or disability benefits, or accidental death and dismemberment benefits or other non-health benefits will be included.

Consequences of Failing to Elect or Waive COBRA Continuation Coverage

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Duration and Termination of COBRA Coverage

If the election is due to the exhaustion of your Individual Account, COBRA continuation coverage will end 18 months after your other coverage ended. However, if you, your spouse, or one of your dependent children, is determined by the Social Security Administration to be disabled on the day regular coverage terminates or within 60 days thereafter, each of you can receive a total of 29 months of COBRA continuation coverage. For all other situations, such

coverage is available for 36 months. COBRA continuation coverage will end at an earlier time for any of the following reasons:

1. The employer no longer provides group health coverage.

2. Failure to pay the monthly premium on time.

3. The individual becomes covered under another group health plan (other than one sponsored by the employer) except for any period the other group health plan limits coverage of your pre-existing conditions. (Note: There are limitations on plans' imposing a preexisting condition exclusion and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act).

4. The individual enrolls in Part A or Part B of Medicare.

5. Circumstances are such that the individual's participation could be canceled if the individual were an active employee.

If any of these events occur, the Fund Office will send you a Notice of Termination of Coverage, explaining the reason the COBRA coverage terminated early, the date coverage terminated, and any rights the employee, spouse or dependent child may have under the Plan to elect alternate coverage.

There may be other coverage options for you and your family such as the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Cost and Payment of COBRA Coverage

Each month, any individual electing COBRA continuation coverage will be required to make a payment to the Fund Office to continue COBRA continuation coverage. The first payment must be made within 45 days of the date written election of coverage is made. After the first payment is made, future payments must be made within thirty (30) days after the first day of the month.

The monthly premium will be based on the average cost which the Plan incurs annually per participant plus a two percent administrative charge. The extra 11 months of COBRA

continuation coverage available to disabled participants are at a monthly charge based on one and one-half times the average annual per participant cost incurred by the Plan.

Additional Information about COBRA Coverage

COBRA continuation coverage is described in greater detail in a letter sent out by the Fund Office to each participant when the participant becomes eligible to participate in the Fund or when COBRA first became applicable to the Fund, if later. If you have any questions concerning COBRA continuation coverage, you should contact the Administrative Manager.

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, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

Keep your Fund Informed of Address Changes

In order to protect your family's rights, you should keep the Fund Office informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund Office.

SECTION 9

CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION

A federal law, the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), requires that health plans protect the confidentiality of your Protected Health Information (“PHI”) effective April 14, 2004. A summary of your rights under HIPAA can be found in the Plan’s privacy notice, which was distributed to you in accordance with HIPAA and which is available from the Plan’s Privacy Official, Administrative Manager Laurie Good.

This Plan, and the Plan Sponsor (the Plan Sponsor for HIPAA purposes is the Board of Trustees of the Iron Workers District Council of Western New York and Vicinity Supplemental Benefit Plan), will not use or disclose your PHI except as necessary for treatment, payment, health care operations and plan administration, or as permitted or required by law.

“Payment” includes activities undertaken by the Plan to determine or fulfill its responsibility for coverage and the provision of plan benefits that relate to an individual to whom health care is provided. The activities include, but are not limited to, the following:

(a) determination of eligibility, coverage, and cost sharing amounts (for example, cost of a benefit, plan maximums, and co-payments as determined for a participant’s claim);

(b) coordination of benefits;

(c) adjudication of health benefit claims (including appeals and other payment disputes);

(d) subrogation of health benefit claims;

(e) establishing contributions to the Plan;

(f) risk adjusting amounts due based on enrollee health status and demographic characteristics;

(g) billing, collection activities, and related health care data processing;

(h) claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes, and responding to participant inquiries about payments;

(i) obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

(j) medical necessity reviews or reviews of appropriateness of care or justification of charges;

(k) utilization review, including pre-certification, preauthorization, concurrent review, and retrospective review;

(l) disclosure to consumer reporting agencies related to reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number, and name and address of the provider and/or health plan); and

(m) reimbursement to the plan.

“Health Care Operations” include, but are not limited to, the following activities:

(a) quality assessment;

(b) population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;

(c) rating provider and plan performance, including accreditation, certification, licensing, or credentialing activities;

(d) underwriting, premium rating, and other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess loss insurance);

(e) conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection, and compliance programs;

(f) business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration,

development or improvement of payment methods, or coverage policies;

(g) business management and general administrative activities of the Plan, including, but not limited to:

i. management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements

ii. customer service, including the provision of data analyses for policy holders, Plan sponsors, or other customers

(h) resolution of internal grievances; and

(i) due diligence regarding a merger with a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the merger, will become a covered entity.

Only the employees of the Iron Workers District Council of Western New York and Vicinity Welfare Fund who assist in the Plan's administration and the Board of Trustees of the Iron Workers District Council of Western New York and Vicinity Supplemental Benefit Plan will have access to your PHI. These individuals may only have access to use and disclose your PHI for plan administration functions. This Plan provides a complaint mechanism for resolving noncompliance matters. If these individuals do not comply with the above rules, they will be subject to disciplinary sanctions.

By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules.

The Plan will not, without your authorization, use or disclose your PHI for employment related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor. HIPAA provides that this Plan may disclose your PHI to the Plan Sponsor only upon receipt of a Certification by the Plan Sponsor that it agrees to the following: (a) not use or further disclose the information other than as permitted or required by the plan documents or as required by law; (b) ensure that any agents, including a subcontractor, to whom it provides PHI received from this Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information; (c) not use or disclose the information for employment related actions and decisions unless authorized by you; (d) not use or disclose the information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by you; (e) report to this Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware; (f) make PHI available to you in accordance with HIPAA's access requirements; (g) make PHI available for amendment and incorporate any amendments to PHI in accordance with

HIPAA; (h) make available the information required to provide an accounting of disclosures; (i) make its internal practices, books, and records relating to the use and disclosure of PHI received from this Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by this Plan with HIPAA; (j) if feasible, return or destroy all PHI received from this Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and (k) maintain adequate separation between the Plan and the Plan Sponsor. The Plan Sponsor has made such Certification to the Plan.

Under HIPAA, you have certain rights with respect to your PHI, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information, and, under certain circumstances, amend the information. You also have the right to file a complaint with this Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan's privacy notice provides a summary of your rights under HIPAA's privacy rules. Please contact Administrative Manager Laurie Good, the Fund's Privacy Official, at (585) 424-3510 if: (a) you wish to obtain a copy of the notice; (b) you have questions about the privacy of your health information; or (c) you wish to file a complaint under HIPAA.

The Plan Sponsor will:

(a) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;

(b) ensure that the adequate separation between the Plan and the Plan Sponsor, as required by HIPAA, with respect to electronic protected health information, is supported by reasonable and appropriate security measures;

(c) ensure that any agent, including a subcontractor, to whom it provides electronic protected health information, agrees to implement reasonable and appropriate security measures to protect the information; and

(d) report to the Plan any security incident of which it becomes aware concerning electronic protected health information.

SECTION 10

PLAN INTERPRETATIONS AND DETERMINATIONS

The Trustees are responsible for interpreting this Plan and for making determinations under this Plan. In order to carry out this responsibility, the Trustees shall have exclusive authority and discretion to determine whether an individual is eligible for any benefits under this Plan; to determine the amount of benefits, if any, an individual is entitled to from the Supplemental Benefit Fund; to interpret all of this Plan's provisions; and to interpret all of the terms used in this Plan. All such determinations and interpretations made by the Trustees, or their designee, shall be final and binding upon any individual claiming benefits from the Supplemental Benefit Fund; shall be given deference in all courts of law, to the greatest extent allowed by applicable law; and shall not be overturned or set aside by any court of law unless found to be arbitrary and capricious, or made in bad faith. All such determinations shall be based exclusively upon clearly defined and ascertainable criteria contained in this Plan.

Benefits under this Plan will be paid only if the Trustees decide in their discretion that you are entitled to them.

SECTION 11

OVERPAYMENTS

In the event that a Participant or a third party on a Participant's behalf is paid benefits from the Fund in an improper amount or otherwise receives Plan assets not in compliance with the Plan (hereinafter overpayments or mistaken payments), the Fund has the right to start paying the correct benefit amount. In addition, the Trustees have the right to recover any overpayment or mistaken payment made to you or to a third party on your behalf. The claimant receiving the overpayment or mistaken payment must pay back the overpayment or mistaken payment back to the Fund with interest at 18% per annum. Such a recovery may be made by reducing other benefit payments made to or on behalf of you or your Spouse or dependents, by commencing a legal action or by such other methods as the Trustees, in their discretion, determine to be appropriate. The claimant shall reimburse the Fund for attorneys' fees and paralegal fees, court costs, disbursements, and any expenses incurred by the Fund in attempting to collect and in collecting the overpayment or mistaken payment of benefits. The determination as to these matters is solely made by the Trustees.

SECTION 12

TERMINATION AND MODIFICATION OF PLAN AND SUMMARY PLAN DESCRIPTION

This Plan and Summary Plan Description includes information concerning the benefits provided by the Trustees to participants, including dependents and the circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture, or suspension of benefits that a participant or dependent might otherwise reasonably expect this plan to provide.

The benefits and eligibility rules applicable to participants and dependents have been established by the Trustees as part of an overall benefit plan for participants. The right to amend or modify the eligibility rules and plan of benefits for participants and dependents is reserved by the Trustees in accordance with the Agreement and Declaration of Trust. The continuance of benefits for participants and dependents and the eligibility rules relating to qualification therefore are subject to modification and revision by the Trustees in accordance with their responsibilities and authority contained in the Agreement and Declaration of Trust.

In accordance with the rules and regulations of this Plan and the Trust Agreement, no participant or dependent has a vested right or contractual interest in the benefits provided under this Plan. In addition to the right to terminate benefits of participants and/or dependents at any time, in the event of termination of the Plan, the Trustees also reserve the right to terminate the plan of benefits for participants and/or dependents and there shall not be any vested right by any participant or dependent or beneficiary nor contractual rights after the disposition of all plan assets and the termination of the Plan. Participants and dependents shall have no priority with respect to the disposition of plan assets in connection with the termination of this Plan. The provision for participants' and defendants' coverage shall be reviewed periodically by the Trustees.

SECTION 13

STATEMENT OF ERISA RIGHTS

As a participant in the Iron Workers District Council of Western New York and Vicinity Supplemental Benefit Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

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.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, a court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a suit in a state or 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 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 claims are frivolous.

Venue of any legal action, including, but not limited to, any challenge to an appeal denial, in connection with this Plan shall lie exclusively in the Federal District Court in Monroe County, New York and all legal actions against this Plan and its Trustees may only be brought in the Federal District Court in Monroe County, New York.

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, of if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, JFK Federal Building, Room 3575, Boston, Massachusetts 02203, (617) 565-9600, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your personal rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

SECTION 14

TECHNICAL DETAILS

(AS REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974)

1. PLAN NAME: Iron Workers District Council of Western New York and Vicinity Supplemental Benefit Plan for Active Participants.

2. EDITION DATE: This Plan and Summary Plan Description is produced as of July 1, 2022.

3. PLAN SPONSORS: Board of Trustees of the Iron Workers District Council of Western New York and Vicinity Supplemental Benefit Plan for Active Participants.

4. PLAN SPONSOR'S EMPLOYER IDENTIFICATION NUMBER: 16-1550492.

5. PLAN NUMBER: 501.

6. TYPE OF PLAN: Welfare Plan.

7. PLAN YEAR ENDS: June 30th.

8. PLAN ADMINISTRATOR: Board of Trustees of Iron Workers District Council of Western New York and Vicinity Supplemental Benefit Plan for Active Participants, The Design Center, 3445 Winton Place, Suite 238, Rochester, New York 14623.

9. AGENT FOR SERVICE OF LEGAL PROCESS: Ms. Laurie Good, Administrative Manager Iron Workers District Council of Western New York and Vicinity Supplemental Benefit Plan, The Design Center, 3445 Winton Place, Suite 238, Rochester, New York 14623. Telephone Number is (585) 424-3510.

   In addition to the person designated as agent for legal process, service of legal process may also be made upon any Plan Trustee or the Fund Counsel, Blitman & King LLP.

10. TYPE OF PLAN ADMINISTRATION: Direct employees of the Board of Trustees.

11. TYPE OF FUNDING: Self-administered and self-insured.

12. SOURCES OF CONTRIBUTIONS TO PLAN: Employers required to contribute to the Iron Workers District Council of Western New York and Vicinity Supplemental Benefit Plan, certain welfare plans with whom this Plan has reciprocal agreements from time to time,

and, in certain circumstances, individual participants and other employers who voluntarily elect to participate in the Plan and who do so with the consent of the Board of Trustees.

13. COLLECTIVE BARGAINING AGREEMENTS: This Plan is maintained in accordance with collective bargaining agreements. A copy of an agreement may be obtained by you upon written request to the Administrative Manager and is available for examination by you at the Plan Office.

14. PARTICIPATING EMPLOYERS: You may receive from the Administrative Manager, upon written request, information as to whether a particular employer participates in the sponsorship of the plan. If so, you may also request the employer’s address.

15. PLAN BENEFITS PROVIDED BY: Iron Workers District Council of Western New York and Vicinity Supplemental Benefit Plan for Active Participants.

16. ELIGIBILITY REQUIREMENTS, BENEFITS & TERMINATION PROVISIONS OF THE PLAN: See Sections 2, 3, 4 and 12 of this booklet.

17. HOW TO FILE A CLAIM: See Section 5 of this booklet.

18. REVIEW OF CLAIM DENIAL: If you submit a benefit application to the Plan Office and it is denied, in whole or in part, you will be so notified.

    If a denial takes place, you are entitled to appeal the decision. See Section 5 of this booklet.

19. RIGHTS AND PROTECTIONS: As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) as described in Section 13 “Statement of ERISA Rights.”

20. NO INSURANCE UNDER THE PBGC: Since this Plan is not a defined benefit pension plan, it does not enjoy coverage under the Pension Benefit Guaranty Corporation.

21. TRUSTEES: The Plan Sponsor and Plan Administrator is the Board of Trustees of the Iron Workers District Council of Western New York and Vicinity Supplemental Benefit Plan for Active Participants. The following are the individual Trustees that make up the Board as of July 1, 2022:

Union Trustees	**Employer Trustees**
Scott Brydges, Trustee c/o Iron Workers Local Union No. 9	Kelly Gilligan, Trustee c/o Rochester Rigging & Erectors, Inc.

412 39th Street Niagara Falls, New York 14303	7819 State Route 5 & 20 Bloomfield, New York 14469

Timothy Starwald, Trustee c/o Iron Workers Local Union No. 33 650 Trabold Street Rochester, New York 14624	H.L. (Chip) Stephenson, Trustee c/o BVR Construction Co., Inc. 8 King Road Churchville, New York 14428
Robert Cole, Trustee c/o Iron Workers Local Union No. 440 10 Main Street, Suite 100 Whitesboro, New York 13492	Thomas Dickey, Trustee c/o Ace Architectural 5285 Upper Mt. Road Lockport, New York 14094