PLAN AND SUMMARY PLAN DESCRIPTION

IRON WORKERS DISTRICT COUNCIL OF WESTERN NEW YORK AND VICINITY RETIREE SUPPLEMENTAL BENEFIT PLAN

July 1, 2022

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Table of Contents

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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 Retiree Supplemental Benefit Plan ("Retiree Plan"). 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 Retiree Plan has been carefully considered by the members of the Board of Trustees of the Retiree Plan ("Trustees"). 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 the only authorized sources of Retiree Plan information for you. The Trustees of the Retiree Plan have not empowered anyone else to speak for them regarding the Retiree Plan. No employer, union representative, supervisor, or shop steward is in a position to discuss your rights under the Retiree Plan with authority.

COMMUNICATIONS

If you have a question about any aspect of your participation in the Retiree 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.

CHANGE OF MAILING ADDRESS

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

SECTION 1

GENERAL INFORMATION FOR ALL PARTICIPANTS AND ELIGIBLE DEPENDENTS

The Retiree Plan is administered by a Board of Trustees composed of three (3) Union Trustees and three (3) Employer Trustees. The current 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 Road
Rochester, NY 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

The address of the 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 the Retiree Plan. The Fund Office telephone number is (585) 424-3510.

Fund Counsel

Blitman & King LLP
Attorneys and Counselors at Law

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

Franklin Center, Suite 300
443 North Franklin St.
Syracuse, NY 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
Retiree Supplemental Benefit Fund
3445 Winton Place, Suite 238
Rochester, New York 14623
Telephone: (585) 424-3510
Fax: (585) 424-3722

The Retiree Plan's Counsel, Blitman & King LLP, and Laurie Good, Administrative Manager, Iron Workers District Council of Western New York and Vicinity Retiree 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, as amended ("ERISA"). Service of legal process may also be made on any individual Trustee.

The Employer Identification Number assigned by the Internal Revenue Service to the Board of Trustees is 16-1550492. The Plan Number assigned by the Trustees to the Retiree Plan is 502.

Contributions to the Retiree Plan

As set forth in more detail below, eligible Participants receive a contribution to the Retiree Plan on their behalf if they lose eligibility under the Iron Workers District Council of Western New York and Vicinity Supplemental Benefit Plan ("Active Plan") and have a balance remaining in their individual account under the Active Plan at that time.

Income and Reserves

Contributions received by the Retiree Plan are held in a trust fund for the purpose of providing benefits to Participants and their Eligible Dependents and defraying reasonable administrative expenses of the Retiree Plan. The funds, assets, and reserves are held in custody and are invested by the Trustees.

Plan Year

For purposes of governmental reporting and maintaining the Retiree Plan'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 under the Retiree Plan that is maintained through the Fund Office. These benefits, as described more fully below, include coverage of health-related costs not paid by any insurance. All claims for these benefits should be filed with the Fund Office, and the details of eligibility, coverage, and related information concerning these benefits are provided in this Booklet. Please note that, because the Retiree Plan is a retiree-only plan, the Patient Protection and Affordable Care Act does not apply to the Retiree Plan.

SECTION 2

RULES OF ELIGIBILITY

Initial Eligibility

You automatically become a "Participant" in the Retiree Plan and eligible for benefits hereunder when you lose eligibility as an active employee under the Active Plan (including the exhaustion of any coverage under the Active Plan's self-payment provisions), provided that you have a remaining balance in an individual account under the Active Plan on that date. Upon becoming a Participant, the Retiree Plan will establish and maintain an individual account on your behalf.

Contributions to the Retiree Plan

The source of contributions to a Participant's individual account within the Retiree Plan will be the amount transferred to the Retiree Plan from the Active Plan on the date the Participant becomes eligible under the Retiree Plan. Any employer contributions received by the Active Plan after the date of this transfer, for your work in covered employment prior to your retirement, will also be irrevocably transferred to the Retiree Plan upon receipt. Upon the final such transfer occurring, the Participant will no longer have a balance in an individual account under the Active Plan.

If You Go Back to Active Status

If, after becoming eligible under the Retiree Plan and having a balance transferred thereto, you return to active service as an employee of an employer who makes contributions to the Active Plan, the Balance of your individual account under the Retiree Plan at that time will be transferred to an individual account under the Active Plan. **It is your responsibility to certify to the Fund Office when you return to active service as soon as practicable.**

If, while you are active, you again qualify as an eligible participant under the Active Plan, you may have new contributions allocated to your individual account established under the Active Plan on your behalf pursuant to the terms of the Active Plan. Upon once again being eligible to participate in the Retiree Plan, any assets remaining in your individual account under the Active Plan at that time will be transferred to your individual account under the Retiree Plan as set forth above.

SECTION 3

ELIGIBLE DEPENDENTS

Eligible Dependents

Your "Eligible Dependents" who may be covered under the Retiree Plan are your spouse and any of your children who are under the age of 26, even if they are eligible for other employer-sponsored health coverage, regardless of whether they are married, are full-time students, or whether you are primarily responsible for their support. You must properly enroll your Eligible Dependents with the Fund Office before you can receive reimbursement from your individual account in connection with their medical expenses.

Coverage For Children

Children who can qualify as an Eligible Dependent under the Retiree Plan include your natural children, step-children, adopted children, and foster children placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

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 Retiree Plan's own choosing, (4) the child is eligible as a disabled dependent under the Social Security Act, and (5) the Retiree Plan's dependent coverage remains in force.

Special enrollment rights are available to you and your children who are under the age of 26 and who are not eligible for their own employer-sponsored health coverage. This special enrollment opportunity will continue for at least 30 days and applies to children whose coverage ended (including those who are currently receiving COBRA), or who were denied coverage, because the availability of dependent coverage of children ended before attainment of age 26.

The Omnibus Budget Reconciliation Act of 1993 requires health plan administrators to recognize qualified medical child support orders ("QMCSOs"). A QMCSO is a court decree under which a court order mandates health coverage for a child. Under a QMCSO, 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 Retiree Plan 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 QMCSO, the child will then be considered a Participant under the Retiree Plan and will receive copies of Summary Plan Descriptions, Summary Annual Reports, and summaries of any amendments made to the Retiree Plan according to current ERISA requirements.

SECTION 4

BENEFITS

Health-Related Benefits

In the event you or your Eligible Dependents incur any health-related expense 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 that is not covered by any other health care plan available to you, the Trustees may authorize reimbursement to you from your individual account. In addition, you may be reimbursed for health insurance premiums paid by you or your Eligible Dependents.

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.

This benefit is intended to qualify as a medical reimbursement plan (health reimbursement arrangement) under Sections 105 and 106 of the Internal Revenue Code of 1986, as amended ("Code"), and regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45. This benefit will be interpreted to accomplish those objectives. The eligible expenses reimbursed under the Retiree Plan are intended to be eligible for exclusion from Participants' gross income under Section 105(b) of the Code. If you have any questions as to whether an expense is reimbursable, you should contact the Fund Office.

Claims will only be reimbursed if you have a sufficient Balance (as defined below) in your individual account to pay the claim. Once your Balance is exhausted, you will no longer be a Participant and will no longer be eligible for reimbursement from the Retiree Plan.

Payment of Benefits

Claims may be submitted at any time during the month pursuant to the procedures set forth below. Payment will be made by the Fund Office as soon as administratively feasible. At minimum, claims are paid on a bimonthly basis. You must submit sufficient proof to the Retiree Plan of the health-related expenses for which you seek reimbursement, including, but not limited to, itemized bills and an Explanation of Benefits ("EOB") from your primary health care plan (if applicable). Claims must be submitted within two years from the date you receive the services for which you are seeking reimbursement.

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.

SECTION 5

CLAIMS AND APPEALS PROCEDURE

Filing Initial Claims

Claims for benefits under the Retiree Plan should be filed directly with the Fund Office. You will be provided with an application form, which will indicate the types of benefits for which you are applying, and any special requirements associated with approval of these benefits. Please refer to Section 4 of this Booklet for further details concerning the types of expenses which are reimbursable 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 Retiree Plan's control if, before the end of the initial 30-day period, the Retiree Plan notifies you of the reasons for the extension and of the date by which the Retiree 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 an adverse benefit determination, the notification you are sent by the Retiree Plan will set forth:

1. The specific reasons for the adverse determination;

2. Reference to the specific Retiree 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 Retiree 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;

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 Retiree 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 Trustees. To appeal an adverse benefit determination, you must write to the Trustees within 180 days after you receive the Retiree 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 will have the opportunity to submit written comments, documents, records, and other information related to the claim for benefits. You will 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 Retiree 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 Trustees 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 Retiree Plan will be identified, without regard to whether the advice was relied upon in making the adverse benefit determination.

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 Retiree Plan will notify you of the benefit determination not later than 5 days after the determination is made.

Content of Adverse Benefit Determination on Review

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

1. The specific reasons for the adverse benefit determination;

2. Reference to specific Retiree 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 ERISA;

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 a 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 Retiree 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 will be final and binding upon you because the Trustees have exclusive authority and discretion to determine all questions of eligibility and entitlement under the Retiree Plan.

You must timely pursue all of the claim and appeal rights described above before you may seek any other legal recourse regarding claims for benefits under plans covered by ERISA. You may not bring any action at law or in equity to recover benefits unless and until the appeal rights described above have been exercised and the benefits requested in such appeal have been denied in whole or in part (or there is any other adverse benefit determination). Any legal action against the Retiree Plan must be started with 180 days from the date the adverse benefit determination denying your appeal is deposited in the mail to your last known address.

Mistaken Payments and Overpayments

In the event that you or a third party are paid benefits from the Retiree Plan in an improper amount or otherwise receive Retiree Plan assets not in compliance with the Retiree Plan (hereinafter an "Overpayment"), the Retiree Plan has the right to start paying the correct benefit amount or take other appropriate action, including the right to recover any Overpayment made to your or to a third party. You, the third party, or the other individual or entity receiving the Overpayment must return the Overpayment to the Retiree Plan with interest at 18% per annum. Such a recovery may be made by reducing other payments sought by you or your Eligible Dependents from your HRA. The recovery might also be made by commencing a legal action or by such other methods as the Trustees, in their sole discretion, determine to be appropriate. You, the third party, or the other individual or entity, will be required to reimburse the Retiree Plan for attorneys' fees and paralegal fees, court costs, disbursements, and any expenses incurred by the Retiree Plan in attempting to collect and in collecting the Overpayment. The determination as to these matters is solely made by the Trustees.

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 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

Initial Contributions

Your individual account will have credited to it the full amount of all contributions made to the Retiree Plan in connection with the transfer of your account balance under the Active Plan to the Retiree Plan as of the date you become eligible under the Retiree Plan.

Income

Allocation of Net Income will be made to the individual accounts of all Participants and Eligible Dependents who have undistributed Balances in their individual accounts, effective on the Valuation Date. Regarding such income allocation, the following definitions shall apply:

1. **Balance**. The "Balance" of a Participant's individual account as of any Valuation Date shall be computed as follows:

   a. The balance in your individual account as of the first day of the Plan Year, after Net Income and contribution allocations as of the previous Valuation Date; plus

   b. The contributions made to your individual account during the Plan Year; less

   c. The payments from your individual account during the Plan Year for benefits and Administrative Expenses.

2. **Net Income**. "Net Income" includes dividends, interest, profits (realized and unrealized), and liquidated damages and interest charges related to such damages, reduced by losses (realized and unrealized) and Administrative Expenses during the Plan Year. The portion of Net Income allocated to your individual account will be determined by dividing the balance of your individual account by the sum of the balances in all individual accounts, effective on the applicable Valuation Date.

3. **Administrative Expenses**. "Administrative Expenses" shall include all costs and charges paid by the Retiree Plan during the Plan Year, including, but not limited to, service provider fees and investment expenses. To defray the cost of Administrative Expenses, the Retiree Plan will assess an administrative fee of $75 per Participant account per Plan 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 Valuation Date. The Trustees also retain discretion to charge additional amounts to Participant accounts to defray the costs of the Administrative Expenses of the Retiree Plan.

4. **Valuation Date**. The "Valuation Date" is June 30 of each Plan Year.

Accountant Determinations

Net Income and Administrative Expenses will be determined by the Retiree Plan's accountant, and such information shall be furnished to the Trustees or their designee for purposes of performing the annual allocations to individual accounts, as provided above.

Interim Date Value

The 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

The government requires that you are given the option to permanently opt out of and waive all future reimbursements from your individual account at least annually. 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, you will no longer be a Participant in the Retiree Plan and you will be required to re-establish Retiree Plan eligibility to once again become a Participant.

SECTION 8

COBRA CONTINUATION COVERAGE

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") provides that your spouse and other Eligible 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 Section contains important information about their right to continue their health care coverage in the Retiree Plan, as well as other health coverage alternatives that may be available to them through the Health Insurance Marketplace. Please read the information contained in this Section very carefully.

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. Divorce or judicial order of legal separation.

If your spouse has a COBRA qualifying event as a result of your death, 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.

In the event your spouse has a COBRA qualifying event as a result of divorce or judicial order of legal separation, 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.

Dependent Eligibility for COBRA Coverage

Your Eligible 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. Divorce or judicial order of legal separation of the child's parents.

3. The child ceases to qualify as an Eligible Dependent under the Retiree Plan.

If your dependent child has a COBRA qualifying event as a result of your death, 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.

In the event your dependent child has a COBRA qualifying event as a result of your divorce, judicial order of legal separation, 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.

Notifications to the Fund Office

You have the responsibility to inform the Administrative Manager of a divorce, judicial order of legal separation, a child's loss of status as an Eligible Dependent, or the birth or adoption of a dependent. Your spouse or child has the responsibility to inform the Administrative Manager of your death. 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.

If your spouse has a newborn child, adopts a child, or has a child placed with him or her for adoption during the COBRA continuation period, this child will be eligible for COBRA continuation coverage. The Fund Office must be notified as soon as possible but within 60 days after the birth or placement in order for the child to be added to the COBRA continuation coverage.

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.

Election of COBRA Continuation Coverage

The Participant, spouse, and dependent children each have independent election rights. Participants 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 Continuation 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. The Retiree Plan only provides reimbursement for eligible medical expenses under its individual account benefits, as described above, and no other coverage.

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 Continuation Coverage

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

1. The Retiree Plan no longer provides group health coverage.

2. Failure to pay the monthly premium on time.

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

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 spouse or dependent child may have under the Retiree Plan to elect alternate coverage.

There may be other coverage options for you and your family. You will be able to buy coverage through 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 Continuation 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 the written election of coverage is made. After the first payment is made, future payments must be made within 30 days after the first day of the month. The monthly premium will be based on the average cost which the Retiree Plan incurs annually per participant plus a two percent administrative charge.

Additional Information about COBRA Continuation 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.

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"). A summary of your rights under HIPAA can be found in the Retiree Plan's privacy notice, which was distributed to you in accordance with HIPAA and which is available from the Retiree Plan's Privacy Official, Laurie Good.

The Retiree 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 Retiree 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 Retiree 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 Retiree 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 Retiree 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 Retiree Plan, including formulary development and administration, development or improvement of payment methods, or coverage policies;

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

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

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 Retiree Plan who assist in the Retiree Plan's administration and the Trustees will have access to your PHI. These individuals may only have access to use and disclose your PHI for plan administration functions. The Retiree 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 Retiree Plan has required all of its business associates to also observe HIPAA's privacy rules.

The Retiree 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 the Retiree 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 the Retiree 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 the Retiree 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 the Retiree 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 the Retiree 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 Retiree Plan and the Plan Sponsor. The Plan Sponsor has made such Certification to the Retiree 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 the Retiree 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.

The Retiree Plan's privacy notice provides a summary of your rights under HIPAA's privacy rules. Please contact Laurie Good, the Retiree Plan'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 Retiree Plan;

(b) ensure that the adequate separation between the Retiree Plan and the Plan Sponsor with respect to electronic protected health information, as required by HIPAA, 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 Retiree Plan any security incident of which it becomes aware concerning electronic protected health information.

SECTION 10

PLAN INTERPRETATION AND DETERMINATIONS

The Trustees are responsible for interpreting the Retiree Plan and for making determinations under the Retiree 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 the Retiree Plan; to determine the amount of benefits, if any, an individual is entitled to from the Retiree Plan; and to interpret all of the terms and provisions used in this Plan and Summary Plan Description and all other instruments and documents affecting or involving the Retiree 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 Retiree Plan; 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. Benefits under the Retiree Plan will only be paid if the Trustees in their discretion determine that a claimant is entitled to them.

SECTION 11

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 and Eligible Dependents, and the circumstances which may result in disqualification or ineligibility for, or denial, loss, forfeiture, or suspension of benefits that a Participant or Eligible Dependent might otherwise reasonably expect the Retiree Plan to provide.

The benefits and eligibility rules applicable to Participants and Eligible Dependents have been established by the Trustees as part of an overall benefit plan. The right to amend or modify the eligibility rules and plan of benefits is reserved by the Trustees in accordance with the Agreement and Declaration of Trust establishing the Retiree Plan. The continuance of benefits for Participants and Eligible 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 the Retiree Plan and the Trust Agreement, no Participant, Eligible Dependent, or other individual has a vested right or contractual interest in the benefits provided. In addition to the right to terminate the Retiree Plan as a whole at any time, the Trustees also reserve the right to terminate the plan of benefits for Participants and/or Eligible Dependents, and Participants and Eligible Dependents will not have any vested right or contractual rights after the disposition of all Retiree Plan assets and the termination of the Retiree Plan. Participants and Eligible Dependents shall have no priority with respect to the disposition of the Retiree Plan's assets in connection with the termination of the Retiree Plan.

SECTION 12

STATEMENT OF ERISA RIGHTS

As a Participant in the Retiree Plan you are entitled to certain rights and protections under ERISA. ERISA provides that all Retiree Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine without charge, at the Fund Office, all documents governing the Retiree Plan, including insurance contracts and collective bargaining agreements (as applicable), and a copy of the latest annual report (Form 5500 Series) filed by the Retiree 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 Retiree 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 Retiree Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Retiree Plan. The people who operate the Retiree Plan, called "fiduciaries" of the Retiree Plan, have a duty to do so prudently and in the interest of you and other Retiree 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 13

TECHNICAL DETAILS

As Required by ERISA:

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

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

3. PLAN SPONSOR: Board of Trustees of the Iron Workers District Council of Western New York and Vicinity Retiree Supplemental Benefit Plan.

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

5. PLAN NUMBER: 502.

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 Retiree Supplemental Benefit Plan, 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 Retiree 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 Retiree Plan Trustee or the Retiree Plan's Counsel, Blitman & King LLP.

10. TYPE OF PLAN ADMINISTRATION: Third party administration by a related welfare fund and its employees.

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

12. SOURCES OF CONTRIBUTIONS TO PLAN: All contributions to the Retiree Plan are made in accordance with transfers of assets allocated to Participants' individual accounts under the Active Plan upon them becoming eligible under the Retiree Plan.

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 Fund Office.

14. PLAN BENEFITS PROVIDED BY: Iron Workers District Council of Western New York and Vicinity Retiree Supplemental Benefit Plan.

15. ELIGIBILITY REQUIREMENTS, BENEFITS & TERMINATION PROVISIONS OF THE PLAN: See Sections 2, 3, 4 and 11 of this Booklet.

16. HOW TO FILE A CLAIM: See Section 5 of this Booklet.

17. REVIEW OF CLAIM DENIAL: If you submit a benefit application to the Fund Office and it is denied, in whole or in part, you will be so notified. If your application is denied, you are entitled to appeal the decision. See Section 5 of this Booklet.

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

19. TRUSTEES: The Plan Sponsor and Plan Administrator is the Board of Trustees of the Iron Workers District Council of Western New York and Vicinity Retiree Supplemental Benefit Plan. The current Trustees are set forth above.

20. NO LIABILITY FOR PRACTICE OF MEDICINE OR DENTISTRY. The Retiree Plan, Trustees, and their designees are not engaged in the practice of medicine or dentistry, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any health care provider. Neither the Retiree Plan, Trustees, nor any of their designees will have any liability whatsoever for any loss or injury caused to you by any health care provider by reason of negligence, by failure to provide care or treatment, or otherwise.