INTERNATIONAL ASSOCIATION OF HEAT AND FROST INSULATORS AND ALLIED WORKERS LOCAL NO. 26 WELFARE PLAN

SUMMARY PLAN DESCRIPTION

This Summary Plan Description
Reflects Terms of the Plan
as of May 1, 2019

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INTRODUCTION

Effective July 3, 1952, the International Association of Heat and Frost Insulators and Allied Workers Local No. 26 (formerly the International Association of Heat and Frost Insulators and Asbestos Workers Local No. 26) and the Master Insulators' Association of Rochester, NY established the International Association of Heat and Frost Insulators and Allied Workers Local No. 26 Welfare Plan (formerly the Asbestos Workers Local No. 26 Welfare Plan). This Summary Plan Description highlights the features of the Plan as of May 1, 2019.

This Summary Plan Description is not meant to interpret, extend, or change the official Plan documents (including the related insurance policies and contracts). ***If there is any inconsistency between this Summary Plan Description and official Plan documents, the official Plan documents will govern your rights to benefits.***

To prevent misunderstandings, you may wish to review the Plan in its entirety. It is available for review in the Local No. 26 Benefit Funds Office at 4348 Culver Road, Suite 3, Rochester, New York 14622, during regular business hours. In addition, the Local No. 26 Benefit Funds Office will provide you with a copy of the Plan document upon your written request. There may be a charge for reproducing the Plan document, but not more than $0.25 per page.

The information in this Summary Plan Description may be modified by a "Summary of Material Modification" attached. Check to see if there is any Summary of Material Modification attached when you refer to this Summary Plan Description.

Any questions concerning the Plan should be directed to the Joint Board of Trustees.

SECTION 1
IMPORTANT PLAN INFORMATION YOU SHOULD KNOW

Plan Name:	International Association of Heat and Frost Insulators and Allied Workers Local No. 26 Welfare Plan
Plan Number:	501
Plan Type:	Welfare Benefit Plan
Plan Year:	Begins on January 1 and ends on December 31
Employee Organization:	International Association of Heat and Frost Insulators and Allied Workers Local No. 26 (the "Union")
Employer Organization:	Master Insulators' Association of Rochester, New York (the "Association")
Tax ID Number:	22-3050907
Plan Sponsor:	Joint Board of Trustees of the International Association of Heat and Frost Insulators and Allied Workers Local No. 26 Welfare Plan 4348 Culver Road, Suite 3 Rochester, NY 14622 (585) 323-2110
Administration:	The Board is the Plan Administrator. The Board consists of members appointed by the Union and the Association. Contact the Local No. 26 Benefit Funds Office for the names of the current Board members.

Plan Agent for Service of Legal Process:

Joint Board of Trustees of the International Association of Heat and Frost Insulators and Allied Workers
Local No. 26 Welfare Plan
4348 Culver Road, Suite 3
Rochester, NY 14622
(585) 323-2110

Collective Bargaining Agreement:

The Plan is maintained pursuant to a collective bargaining agreement between the Association and the Union. Upon written request to the Board, employees may obtain copies of the collective bargaining agreement. The collective bargaining agreement is also available for inspection at the Local No. 26 Benefit Funds Office.

Funding:

Contributions to the Plan are made by employers pursuant to a collective bargaining agreement, which provides for employers to pay to the Plan a fixed amount for hours worked by an employee. Eligible employees are also required to pay a portion of the premium for their health insurance under the Plan. Employees, their spouses and dependents who elect to continue coverage after their Regular Health Coverage expires may be required to pay a greater portion of the premium for their health insurance.

Upon written request, employees may receive information from the Board as to whether a particular employer is a contributing employer and, if so, the contributing employer's address.

All contributions are held by the Trustees in a trust and are used (together with earnings on the contributions) to pay premiums for insurance coverage and the cost of administering the Plan.

SECTION 2
DEFINITIONS

Agreement means the collective bargaining agreement in effect from time to time between the Union and the Association, or between the Union and an individual Contributing Employer.

Applicable Premium means the monthly premium charged by an Insurer to the Plan for Health Coverage for an Employee, his Spouse (or Domestic Partner) and/or his Children. The Applicable Premium varies with the type of Health Coverage and the level of Health Coverage (e.g., family, two-person or single Health Coverage). The Schedule attached to this Summary Plan Description (or a subsequent Summary of Material Modification) lists current Applicable Premiums for Regular Health Coverage.

Association means the Master Insulators' Association of Rochester, New York.

Board means the Joint Board of Trustees of the Plan.

Child means a child of an Employee or Retiree who satisfies the requirements for coverage under an applicable Policy and the Plan. "Child" does not include, and no health or other insurance coverage is provided under the Plan for, the child of an Employee's Domestic Partner unless the child is also the Employee's child.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985.

COBRA Continuation Coverage means group health coverage made available to an Employee, his Spouse or Child after Regular Health Coverage ends, as described in Section 8 and required under COBRA.

Contributing Employer means any employer who is required to make contributions to the Plan for hours worked by an Employee pursuant to the Agreement (or another collective bargaining agreement between the Contributing Employer and the Union, or agreement between the Contributing Employer and the Board). It also means the Union, the Plan, and other employee benefit plans sponsored by the Union and the Association, with respect to their own Employees.

Contribution Period means each four consecutive calendar month period beginning on January 1, May 1 or September 1.

Coverage Period means each four consecutive month period beginning with the ***third calendar month*** after a Contribution Period (i.e., each four consecutive month period beginning on March 1, July 1 or November 1).

Domestic Partner means a person who, with an Employee, satisfies the following requirements:

(i) they both must be eighteen (18) years of age or older;

(ii) they must be each other's sole Domestic Partner and intend to remain so indefinitely;

(iii) they must share a close personal relationship and be responsible for each other's common welfare;

(iv) they cannot be married to each other or anyone else, and cannot have been married to anyone or have had another Domestic Partner within the prior six (6) months;

(v) they cannot be related by blood closer than would bar marriage in the State of New York;

(vi) they must share the same regular and permanent residence, and intend to do so indefinitely;

(vii) they must be jointly financially responsible for each other's basic living expenses (i.e., the cost of basic food, shelter, and other expenses); and

(viii) they be must have been mentally competent to consent to contract when they became Domestic Partners.

In addition:

(i) the Employee and Domestic Partner must certify that they have met the requirements above for at least six (6) consecutive months;

(ii) the Employee and Domestic Partner must agree to notify the Local No. 26 Benefit Funds Office if they no longer satisfy any of the requirements above;

(iii) upon the request of the Plan or applicable Insurer(s), the Employee and his Domestic Partner must provide evidence of joint responsibility satisfactory to the Board and applicable Insurer(s); and

(iv) The Employee must certify to the Plan whether or not the Domestic Partner is the Employee's federal income tax dependent.

Failure to satisfy any of these requirements may subject the Employee and/or claimed Domestic Partner to civil action to recover benefits paid for or provided to the claimed Domestic Partner, and any other losses suffered by the Plan or applicable Insurer(s), including reasonable attorney's fees.

Note:

- ***Notwithstanding any other provision in this Summary Plan Description, a Domestic Partner's Health Coverage will terminate whenever any of the requirements above are not satisfied.***

- ***If an Employee's Domestic Partner is not the Employee's federal income tax dependent, the fair market value of the Domestic Partner's Health Coverage (less any amount paid for the Domestic Partner's Health Coverage on an after-tax basis) is treated as taxable income to the Employee.***

Employee means (i) an employee of a Contributing Employer who performs services within the jurisdiction of the Union and for whom the Contributing Employer is required under the Agreement to make contributions to the Plan; (ii) any other person working for a Contributing Employer and for whom the Contributing Employer is required under the Agreement (or agreement between the Contributing Employer and the Board) to make contributions to the Plan; and (iii) an employee of the Union, the Plan, or other employee benefit plan sponsored by the Union and the Association.

Health Coverage means Regular Health Coverage, COBRA Continuation Coverage, and/or Retiree Health Coverage, as the context indicates.

Hour of Service means an hour of work performed by an Employee for a Contributing Employer for which the Contributing Employer is required under the Agreement (or agreement between the Contributing Employer and the Board) to make contributions to the Plan.

Insurer means Excellus (d/b/a BlueCross Blue Shield) or MVP Health Care with respect to Health Coverage, and Aetna Life Insurance Company with respect to Life, Accident & Disability Coverage.

Life, Accident & Disability Coverage means coverage described in Section 7 and made available to an eligible Employee at no cost to the eligible Employee.

Policy means a policy or contract issued by an Insurer for Health Coverage or for Life, Accident & Disability Coverage.

Plan means the International Association of Heat and Frost Insulators and Allied Workers Local No. 26 Welfare Plan as herein set forth, and any amendment hereof.

Plan Year means each twelve consecutive month period beginning on January 1 and ending on December 31.

Retiree Health Coverage means Health Coverage described in Section 6, and made available to a Retiree at a cost to the Retiree equal to the percentage of the Applicable Premium specified in Section 8(C).

Regular Health Coverage means Health Coverage described in Section 6, and made available to an eligible Employee at a cost to the eligible Employee equal to the percentage of the Applicable Premium specified in Section 3.

Retiree means a former Employee who qualifies for normal or early pension benefits under the Union Pension Plan at the time he ceases to be an Employee.

Spouse means a person who is considered the spouse of an Employee or Retiree under federal tax law and the applicable Policy.

Union means the International Association of Heat and Frost Insulators and Allied Workers Local No. 26.

SECTION 3
INITIAL ELIGIBILITY REQUIREMENTS FOR REGULAR HEALTH COVERAGE

An Employee is eligible for Regular Health Coverage on his Initial Eligibility Date. An Employee's Initial Eligibility Date is the first day of the ***third calendar month***

immediately following any four consecutive calendar month period during which he has at least 400 Hours of Service with at least one Hour of Service in each of those four months. With the consent of the Insurers, the Board may change this 400 Hours of Service requirement when, in the Board's sole judgment, the reserve funds accumulated under the Plan warrant such a change.

Regular Health Coverage may begin on the Employee's Initial Eligibility Date if he completes and files the appropriate applications and forms for Regular Health Coverage by that date (or any earlier date required, or later date permitted, by the Insurer). If an Employee does not complete and file the appropriate applications and forms for Regular Health Coverage by that date, Regular Health Coverage will not begin until the Coverage Period on which he is employed by a Contributing Employer, has at least 400 Hours of Service during the immediately preceding Contribution Period (with at least one Hour of Service in each of the four months during that Contribution Period), and has timely completed and filed the appropriate applications and forms, unless the Insurer allows Regular Health Coverage to begin as of the first day of an earlier calendar month following the Contribution Period during which the Employee has at least 400 Hours of Service (with at least one Hour of Service in each of the four months during that Contribution Period).

> Example: An Employee first begins working for a contributing employer in July 2019, and has a total of at least 400 hours of service over the months of August, September, October and November 2019 (with at least one hour of service in each of those months). His coverage will begin February 1, 2020.

Special Initial Coverage Transition Rule

Notwithstanding the above, if prior to May 1, 2019 you qualified for four months of initial coverage extending past April 30, 2019, you will be entitled to coverage through that four month period. Thereafter, you must satisfy the requirements described in Section 4 to continue Regular Health Coverage.

Important Note: It is the Employee's responsibility to complete and file the appropriate applications and forms required for coverage by the deadlines described above. The required applications and forms are available from the Local No. 26 Benefit Funds Office. Each Employee should keep track of his Hours of Service so he knows when he is eligible for Regular Health Coverage.

If an Employee's Spouse (or Domestic Partner) or Child is confined in a hospital, other institution or home, on the date Regular Health Coverage for the Spouse (or Domestic Partner) or Child would otherwise begin, coverage for the Spouse (or Domestic Partner) or Child may be delayed under the terms of the applicable Policy.

Unless the special rule below applies, an Employee who satisfies the eligibility requirements in this Section 3 for Regular Health Coverage must pay fifteen percent (15%) of the Applicable Premium in order for his Regular Health Coverage to begin and remain in effect.

> Example 1: John is eligible for Regular Health Coverage and elects single coverage (i.e., employee only). Assume the Applicable Premium is $585.78 per month. John's cost is $87.87 per month (15% of $585.78).
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> Example 2: Paul is eligible for Regular Health Coverage and elects two-person coverage (i.e., employee plus spouse or domestic partner). Assume the Applicable Premium is $1,171.56 per month. Paul's cost is $175.73 per month (15% of $1,171.56).
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> Example 3: Bob is eligible for Regular Health Coverage and elects family coverage with no spouse or domestic partner (i.e., employee and children only). Assume the Applicable Premium is $995.83 per month. Bob's cost is $149.37 per month (15% of $995.83).
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> Example 4: Gary is eligible for Regular Health Coverage and elects family coverage (i.e., employee plus spouse or domestic partner, and children). Assume the Applicable Premium is $1,669.47 per month. Gary's cost is $250.42 per month (15% of $1,669.47).

Note that the Applicable Premiums in the examples above may not necessarily be the current Applicable Premium for your Regular Health Coverage. See the Schedule attached to this Summary Plan Description (or a subsequent Summary of Material Modification) for the current Applicable Premiums for Regular Health Coverage.

SECTION 4
REQUIREMENTS FOR CONTINUATION OF
REGULAR HEALTH COVERAGE

Except as provided below, an Employee's Regular Health Coverage will end at the end of a Coverage Period unless he had at least 400 Hours of Service during the immediately preceding Contribution Period or at least 1,500 Hours of Service during the 12 consecutive months ending with that Contribution Period.

> Example 1: Assume an Employee qualified for and had coverage through April 30, 2019 and has at least 400 hours of service during the Contribution Period beginning May 1, 2019 and ending August 31, 2019. He qualifies for coverage during the Coverage Period beginning November 1, 2019 and ending the last day of February 2020.
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> Example 2: Assume an Employee qualified for and had coverage through April 30, 2019 and does not have at least 400 hours of service during the Contribution Period beginning May 1, 2019 and ending August 31, 2019. However, he has at least 1,500 hours of service during the 12 consecutive months ending August 31, 2019. He qualifies for coverage during the Coverage Period beginning November 1, 2019 and ending the last day of February 2020.
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> Example 3: Assume an Employee qualified for and had coverage through April 30, 2019, he does not have at least 400 hours of service during the Contribution Period beginning May 1, 2019 and ending August 31, 2019, and he also does not have at least 1,500 hours of service during the 12 consecutive months ending August 31, 2019. He does not qualify for coverage during the Coverage Period beginning November 1, 2019 and ending the last day of February 2020.

The table below shows the correlation between Contribution Periods and the new Coverage Periods.

400 Hours Of Service During This Contribution Period	Qualifies You For Coverage During This Coverage Period
January 1 – April 30	July 1 – October 31
May 1 – August 31	November 1 – February 28 (or 29)
September 1 – December 31	March 1 – June 30

With the consent of the Insurers, the Board may change this 400 Hours of Service or 1,500 Hours of Service requirement when, in the Board's sole judgment, the reserve funds accumulated under the Plan warrant such a change.

Special Regular Coverage Transition Rule

Notwithstanding the above, if an Employee has at least 400 Hours of Service in the Contribution Period ending April 30, 2019, or at least 1,500 Hours of Service during the 12 consecutive month period ending April 30, 2019, he will qualify for coverage from May 1, 2019 through June 30, 2019. Thereafter, he must satisfy the requirements described above to continue Regular Health Coverage.

Special Rule When Employee Fails to Complete Minimum Hours of Service to Continue Regular Health Coverage

If an Employee does not have the minimum number of Hours of Service required for Regular Health Coverage during a Coverage Period, then the Employee, may continue Regular Health Coverage for himself, his Spouse (or Domestic Partner) and his Children during that Coverage Period at a cost equal to 15% of their Applicable Premium, plus the difference between (i) the contributions the Plan would have received on behalf of the Employee if he had 400 Hours of Service in the immediately preceding Contribution Period, and (ii) the contributions owed to the Plan for his actual hours in the immediately preceding Contribution Period. However, in no event will the cost exceed 102% of the Applicable Premium.

Note that this special rule: (i) applies only to continue Regular Coverage (i.e., it does not apply for purposes of starting Regular Coverage; and (ii) applies for a maximum period of eighteen (18) consecutive months.

However, a Domestic Partner's Health Coverage will terminate whenever the Employee and Domestic Partner fail to satisfy any of the Domestic Partner requirements listed in the definition of "Domestic Partner" in Section 1.) Also, Regular Health Coverage for an Employee, Spouse or Child under this special rule replaces any COBRA Continuation Coverage they could have elected because the Employee did not have the minimum number of Hours of Service required for Regular Health Coverage without this special rule.

The due date for payment of an Employee's portion of the Applicable Premium for a month is the last day of the prior month. Invoices are mailed to Employees for their portion of the Applicable Premium approximately two weeks before the due date for the payment. All payments should be mailed to the Local No. 26 Benefit Funds Office, 4348 Culver Road, Suite 3, Rochester, NY 14622. If the Benefit Funds Office does not receive an Employee's payment for a month by the last day of the prior month, his insurance coverage will be terminated as of the end of the prior month.

SECTION 5
REINSTATEMENT OF REGULAR HEALTH COVERAGE

If an Employee's Regular Health Coverage terminates, he will not again be entitled to Regular Health Coverage until he again satisfies all of the rules and conditions for Regular Health Coverage set forth in Section 3.

SECTION 6
HEALTH COVERAGE

The Plan pays the difference between: (i) the total Applicable Premium; and (ii) the percentage of the Applicable Premium that must be paid by an Employee (or Retiree), his Spouse (or Domestic Partner) or Children. The Plan does not pay or provide actual health benefits. All actual health benefits are paid or provided only by Insurers pursuant to the terms of the applicable Policy.

The Health Coverage available under the Plan to eligible Employees and to eligible Retirees under age 65 is "four tier" Excellus SimplyBlue Plus Gold 5 coverage or "four tier" Excellus SimplyBlue Plus Gold 17 coverage. "Four tier" means coverage offered at the following levels:

(i) single - i.e., Employee (or Retiree) only;
(ii) two-person - i.e., Employee (or Retiree) and Spouse (or Domestic Partner) only;

(iii) family with no Spouse (or Domestic Partner) - i.e., Employee (or Retiree) and Children only; and
(iv) family with Spouse (or Domestic Partner) - i.e., Employee (or Retiree), Spouse (or Domestic Partner) and Children.

MVP Preferred Gold HMO-POS 2019 Medicare supplemental coverage is the only Health Coverage available to an eligible Retiree age 65 or older. Please note that you must live in the MVP Preferred Gold HMO-POS 2019 Medicare supplemental coverage area to enroll in that coverage.

At the times permitted by the Insurers and subject to the terms of the Policies, an Employee who is eligible for Health Coverage may select the type and level of Health Coverage for himself, his Spouse (or Domestic Partner) and Children. However, the following special enrollment rules apply if, at the time of enrollment, the Employee satisfies the rules and conditions for Regular Health Coverage set forth in Section 3.

- If an Employee initially declined Regular Health Coverage because he had other health care coverage, but he later loses that other coverage through no fault of his own, he can enroll himself, his Spouse (or Domestic Partner) and his Children in Regular Health Coverage within thirty (30) days after losing the other health care coverage. Note, in order for this special enrollment rule to apply, at the time the Employee initially declines Regular Health Coverage the Insurer may require that he provide, in writing, his reason for declining it.

- If an Employee initially declined Regular Health Coverage because he had other health care coverage from another employer, but that employer stops contributing toward the cost of that other coverage, he can enroll himself, his Spouse (or Domestic Partner) and his Children in Regular Health Coverage within thirty (30) days after that employer stops contributing toward the cost of the other health care coverage. Note, in order for this special enrollment rule to apply, at the time the employee initially declines Regular Health Coverage the Insurer may require that he provide, in writing, his reason for declining it.

- If an Employee declined Regular Health Coverage and he later acquires a new Spouse (or new Domestic Partner) or a new Child (through birth or adoption of a Child), he can enroll himself, his Spouse (or Domestic Partner) and his Children in Regular Health Coverage within the thirty (30) day period after the marriage, commencement of the Domestic Partner relationship, birth, adoption or placement for adoption.

- If an eligible Employee, his Spouse (or Domestic Partner) or his Child loses eligibility for Medicaid coverage or coverage under a State Children's Health Insurance Program, he can enroll himself, his Spouse (or Domestic Partner) and his Children in Regular Health Coverage within the sixty (60) day period following the loss of that coverage.

- If an eligible Employee, his Spouse (or Domestic Partner), or his Child becomes eligible to participate in a premium assistance program under Medicaid or a State Children's Health Insurance Program, he can enroll himself, his Spouse (or Domestic Partner) and his Children in Regular Health Coverage within the sixty (60) day period following that eligibility determination.

Full descriptions of the benefits provided with each type of Health Coverage are contained in booklets and other materials issued by the Insurers and available from the Insurers or the Local No. 26 Benefit Funds Office. Excellus (d/b/a BlueCross BlueShield) guarantees benefits and is responsible for processing all claims under Excellus SimplyBlue Plus Gold 5 and Excellus SimplyBlue Plus Gold 17 Health Coverage. MVP Health Care guarantees benefits and is responsible for processing all claims under MVP Preferred Gold 2019 HMO-POS Medicare coverage. Their addresses are:

BlueCross BlueShield
165 Court Street
Rochester, NY 14647

MVP Health Care
259 Monroe Avenue
Rochester, NY 14607

If an Employee, his Spouse (or Domestic Partner) or Child is eligible to receive any benefit provided under a Policy which is also provided under another health plan, group or individual insurance policy or program, the Policy benefit will be coordinated with the other plan, policy or program benefit so that no more than 100% of the benefit will be paid jointly by both the Policy and the other plan, policy or program.

The Board and the Insurers reserve the right to obtain from and exchange benefit information with other plans, organizations, carriers and individuals, and to recover any over-payment made to an Employee, his Spouse (or Domestic Partner), or Child as a result of a failure to report other coverage. Also, a person's Health Coverage may be rescinded (i.e., retroactively cancelled or discontinued) if that person (or another person who sought the Health Coverage for that person) performed an act, practice, or omission that constitutes fraud, or made an intentional misrepresentation of fact, to get the Health

Coverage. Any person whose Health Coverage is rescinded will receive at least 30 days prior written notice of the rescission. Rescission of Health Coverage is considered an adverse benefit determination for purposes of the Plan's claims procedures.

SECTION 7
LIFE, ACCIDENT & DISABILITY COVERAGE

An Employee, other than an Employee classified as an apprentice or pre-apprentice, is eligible for Life, Accident & Disability Coverage under the same eligibility rules and conditions in Section 3 (for Regular Health Coverage). His Life, Accident & Disability Coverage will start when his Regular Health Coverage starts (provided he has timely completed and filed the appropriate applications and forms required by the Insurer).

An Employee classified as an apprentice or pre-apprentice is not eligible for Life, Accident & Disability Coverage until: (i) he completes 1,000 Hours of Service; and (ii) satisfies the same rules and conditions as are in Section 3 (for Regular Health Coverage). His Life, Accident & Disability Coverage will start on the first day of the calendar month after he satisfies these requirements (provided he has timely completed and filed the appropriate applications and forms required by the Insurer).

Important Note: An Employee must be working within the United States to be eligible for Life, Accident & Disability Coverage. Also, it is the Employee's responsibility to request, complete and file the appropriate applications and forms required for coverage by the deadlines described above. The required applications and forms are available from the Local No. 26 Benefit Funds Office. Each Employee should keep track of his Hours of Service so he knows when he is eligible for Life, Accident & Disability Coverage.

Life, Accident & Disability Coverage is provided for Employees only, except for: (i) limited life insurance on the life of an Employee's Spouse and Children; and (ii) reduced life insurance on the life of a Retiree with Retiree Health Coverage. (No life insurance is provided for Domestic Partners, and no accident or disability coverage is provided for Spouses, Domestic Partners, Children and Retirees.)

An Employee's Life, Accident & Disability Coverage will end when he is no longer a Union member (or is no longer an employee of the Union, the Plan, or other employee benefit plan sponsored by the Union and the Association); or, if later, when his Health

Coverage ends. (However, as noted above, the amount of life insurance is reduced when an Employee qualifies for Retiree Health Coverage.)

However, when an Employee's Life, Accident & Disability Coverage ends, he may have the ability, at this own cost, to convert the group term life insurance he had under the Plan to individual whole life insurance (without evidence of insurability). The cost of individual life insurance coverage is determined and billed directly by the by the Insurer. Contact the Funds Office if you would like more information about this option.

All Life, Accident & Disability Coverage benefits are provided by, and are subject to the terms and conditions of, the Policy. A full description of Life, Accident & Disability Coverage benefits is contained in a booklet issued by the Insurer. If you do not have the booklet, you can request a copy from the Local No. 26 Benefit Funds Office.

SECTION 8
CONTINUATION OF HEALTH COVERAGE
AFTER REGULAR HEALTH COVERAGE ENDS

The Plan will make COBRA Continuation Coverage available to Employees, Spouses and Children who are eligible for COBRA Continuation Coverage at a cost equal to the Applicable Premium plus a two percent (2%) administrative fee. Note that COBRA Continuation Coverage consists of only Health Coverage. However, under the special rules below, the cost to an Employee, his Spouse and/or Child for COBRA Continuation Coverage may be lower. In addition, instead of electing COBRA Continuation Coverage, certain Retirees may be able eligible for Retiree Health Coverage, which is available at a lower cost and may be last longer than COBRA Continuation Coverage.

Note that none of the rules in this Section:

(i) apply to an Employee, Spouse or Child who does not qualify for COBRA Continuation Coverage;

(ii) prevent an Employee, Spouse or Child from exercising his right to elect and receive COBRA Continuation Coverage for the maximum period required under COBRA;

(iii) require an Employee, Spouse or Child to pay more for COBRA Continuation Coverage or Retiree Health Coverage than the Plan is permitted to charge under COBRA; or

(iv) apply to Health Coverage for an Employee's Domestic Partner. (Domestic Partners are not eligible for COBRA Continuation Coverage or Retiree Health Coverage.)

(A) Lower Cost in the Event of Total Disability

If an Employee does not complete the minimum number of Hours of Service for continued Regular Health Coverage because he is totally disabled, then for the first 26 weeks the Employee, his Spouse and Children may elect COBRA Continuation Coverage at a cost equal to 15% of the Applicable Premium and, thereafter, at a cost equal to 65% of their Applicable Premium.

This special rule will apply until the earlier of the date: (i) the Employee is no longer totally disabled; or (ii) the maximum period for COBRA Continuation Coverage ends.

For purposes of the Plan, an Employee will be considered totally disabled when he qualifies for disability benefits under this Plan (see Section 7 - Life, Accident & Disability Coverage).

(B) Lower Cost in the Event of Death

The Spouse and Children of an Employee who are eligible for COBRA Continuation Coverage because of the Employee's death, may elect COBRA Continuation Coverage for two years following the Employee's death at a cost equal to 15% of their Applicable Premium and, thereafter, at a cost equal to 65% of their Applicable Premium.

This special rule will apply until the earlier of the date: (i) the Spouse remarries; or (ii) the maximum period for COBRA Continuation Coverage ends.

(C) Retiree Health Coverage

If an Employee qualifies for normal or early pension benefits under the Union Pension Plan when he retires, then in lieu of COBRA Continuation Coverage, the Retiree, his Spouse and Children may continue Health Coverage for four months at a cost equal to 15% of their Applicable Premium and, thereafter, at a cost equal to 65% of their Applicable Premium. This Health Coverage is referred to as "Retiree Health Coverage." If a Retiree who has elected Retiree Health Coverage dies, coverage will be available to

his surviving Spouse and Children at this rate until the surviving Spouse or Child no longer qualifies for coverage under the applicable Policy.

If a Retiree with Retiree Health Coverage divorces his Spouse before the end of the 36 month period following his retirement date, the Spouse will be entitled to continue Health Coverage through the end of that 36 month period only. Her cost for Health Coverage after the divorce will be 100% of her Applicable Premium plus a two percent (2%) administrative fee. If a Retiree divorces his Spouse after he has 36 months of Retiree Health Coverage, that Spouse will no longer be entitled to Health Coverage under the Plan.

Important Notes:

1. ***Retiree Health Coverage is available only to an Employee who qualifies for Early or Normal Retirement under the terms of the Union Pension Plan.***

2. ***If a Retiree declines or discontinues Retiree Health Coverage, he will no longer qualify for Retiree Health Coverage under the Plan.***

3. ***If a Retiree's Spouse or Child declines or discontinues Retiree Health Coverage, he or she will no longer qualify for Retiree Health Coverage under the Plan.***

4. ***If a Retiree's surviving Spouse discontinues Retiree Health Coverage, he or she will no longer qualify for Retiree Health Coverage under the Plan.***

COBRA Continuation Coverage

Introduction

Below is important information about your right to COBRA Continuation Coverage, which is a temporary extension of Health Coverage under the Plan. **It explains COBRA Continuation Coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA Continuation Coverage, you may also become eligible for other health coverage options that may cost less than COBRA Continuation Coverage.

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA Continuation Coverage can become available to you and other members of your family

when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review this entire Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in health coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA Continuation Coverage is a continuation of Plan Health Coverage when it would otherwise end because of a life event. This is also called a "Qualifying Event." Specific Qualifying Events are listed below. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." You, your Spouse, and your dependent Children could become Qualified Beneficiaries if Health Coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage.

If you're an Employee, you'll become a Qualified Beneficiary if you lose your Health Coverage under the Plan because of the following Qualifying Events:

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

If you're the Spouse of an Employee, you'll become a Qualified Beneficiary if you lose your Health Coverage under the Plan because of the following Qualifying Events:

- Your Spouse dies;
- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

- You become divorced or legally separated from your Spouse.

Your dependent Children will become Qualified Beneficiaries if they lose Health Coverage under the Plan because of the following Qualifying Events:

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
- The parent-Employee's employment ends for any reason other than his or her gross misconduct;
- The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or

Note that an Employee's Domestic Partner is not eligible for COBRA Continuation Coverage, and a Domestic Partner's child is not eligible for COBRA Continuation Coverage unless he or she is also the Employee's Child.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of any Retiree's Health Coverage under the Plan, the Retiree will become a Qualified Beneficiary. The Retiree's Spouse, his surviving Spouse, and dependent Children will also become Qualified Beneficiaries if bankruptcy results in the loss of their Health Coverage under the Plan.

When is COBRA Continuation Coverage available?

The Plan will offer COBRA Continuation Coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. Your employer must notify the Plan Administrator of the following Qualifying Events:

- The end of employment or reduction of hours of employment;
- Death of the Employee;
- Commencement of a proceeding in bankruptcy with respect to the employer;]; or
- The Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other Qualifying Events (divorce or legal separation of the Employee and Spouse or a dependent Child's losing eligibility for Health Coverage under the Plan

as a dependent Child), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice to the Local No. 26 Benefit Funds Office, 4348 Culver Road, Suite 3, Rochester, NY 14622. The notice must be in writing, and must contain your name and address, a description of the Qualifying Event, and the date of the Qualifying Event. You may be asked to provide additional documentation or information after you have submitted the notice.

How is COBRA Continuation Coverage provided?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA Continuation Coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their Spouses, and parents may elect COBRA Continuation Coverage on behalf of their Children.

COBRA Continuation Coverage is a temporary continuation of Health Coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Event during the initial period of COBRA Continuation Coverage, may permit a Qualified Beneficiary to receive a maximum of 36 months of COBRA Continuation Coverage.

There are also ways in which this 18-month period of COBRA Continuation Coverage can be extended:

Disability extension of 18-month period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA Continuation Coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. You must provide this notice to the Local No. 26 Benefit Funds Office, 4348 Culver Road, Suite 3. The notice must be in writing, and must contain your name and address, the name and address of the disabled Qualified Beneficiary, and the date the disability was determined to have begun. You must also attach a copy of the Social Security Administration's determination. You may be asked to provide additional documentation or information after you have submitted the notice.

Second Qualifying Event extension of 18-month period of COBRA Continuation Coverage

If your family experiences another Qualifying Event during the 18 months of COBRA Continuation Coverage, the Spouse and dependent Children in your family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if the Plan is properly notified about the second Qualifying Event. This extension may be available to the Spouse and any dependent Children getting COBRA Continuation Coverage if the Employee or former Employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent Child stops being eligible under the Plan as a dependent Child. This extension is only available if the second Qualifying Event would have caused the Spouse or dependent Child to lose Health Coverage under the Plan had the first Qualifying Event not occurred. You must provide notice of second Qualifying Even to the Local No. 26 Benefit Funds Office, 4348 Culver Road, Suite 3, Rochester, NY 14622. The notice must be in writing, and must contain your name and address, a description of the second Qualifying Event, and the date of the second Qualifying Event. You may be asked to provide additional documentation or information after you have submitted the notice.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA Continuation Coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA Continuation Coverage. You can learn more about many of these options at www.healthcare.gov. In addition, instead of electing COBRA Continuation Coverage, certain Retirees may be able to elect Retiree Health Coverage, which is available at a lower cost and may be available and for a period longer period, than the maximum period COBRA Continuation Coverage would be available.

If you have questions

Questions concerning your Plan or your COBRA Continuation Coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit

www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Funds Manager, Local No. 26 Benefit Funds Office, 4348 Culver Road, Suite 3, Rochester, NY 14622 (Tel. No. (585) 323-2110).

SECTION 9
AMENDMENT AND TERMINATION OF THE PLAN

The Board may amend the Plan at any time when it deems it necessary or advisable, including any amendment that reduces or eliminates benefits for active employees, Retirees, or any other group or class of employees or former employees. No person has a vested right to Health Coverage (including Retiree Health Coverage) or to Life, Accident or Disability Coverage under the Plan. However, no amendment may provide for the use of the Trust funds for any purpose other than the exclusive benefit of Employees, their Spouses (or Domestic Partners) and Children. It is expected the Plan will continue indefinitely but it may be discontinued at any time if maintenance of the Plan is no longer called for under any collective bargaining agreement, or the Board determines that funding of the Plan is insufficient to provide benefits.

SECTION 10
CLAIMS PROCEDURE

The Insurers have discretionary authority to make claim, eligibility and other administrative determinations regarding their Policies, and to interpret the meaning their Policies' terms and language. However, this authority is limited to their Policies and does not extend to other aspects of the Plan.

Each Insurer is responsible for processing claims and paying the specific benefits under its Policies, and has discretion and authority to: (i) carry out all actions involving claims

procedures for benefits under its Policies; (ii) grant or deny any and all claims for benefits; and (iii) construe any and all Policy issues relating to eligibility for benefits. The procedures and time limits for claims are subject to required ERISA claims procedures. To the extent there is any inconsistency between an Insurer's procedures and rules and the following ERISA procedures, the ERISA procedures apply.

Health Claims

If you have questions about eligibility for Health Coverage or the cost of Health Coverage, you should contact the Local No. 26 Benefit Funds Office. If you believe you are entitled to specific health care benefits you should submit a benefit claim directly to the appropriate Insurer at the address below. You should also contact the Insurer if you have questions concerning your specific health care benefits.

BlueCross BlueShield	MVP Health Care
165 Court Street	259 Monroe Avenue
Rochester, New York 14647	Rochester, New York 14607

You may appoint someone to file a benefit claim and act on your behalf, provided you give the Insurer signed written notification of the appointment.

The health claim procedures are different for "concurrent claims," "pre-service claims," "post-service claims," and "urgent claims." A concurrent claim is a request for an extension of health treatment (i.e., treatment provided over a period of time or a number of treatments). A pre-service claim is a claim requiring advance approval to receive all or part of the benefit. A post-service claim is any claim that is not a pre-service claim. An urgent claim is any claim for medical care or treatment that, if non-urgent claim procedures were followed, could seriously jeopardize the life or health of the patient or his ability to regain maximum function, or in the opinion of a physician with knowledge of the patient's medical condition would subject the patient to severe pain that cannot be adequately managed without the care or treatment requested.

You may appoint someone to file a claim and act on your behalf; provided you give the Plan signed written notification of the appointment. In the case of an urgent claim, a health care professional with knowledge of your medical condition will be permitted to act as your representative.

Post-service claims must be filed within 24 months after the service or expense claimed was incurred. All claims must be filed on forms provided by the Insurer and submitted by mail, except urgent claims may be made orally and information may be transmitted by telephone or by facsimile at the following numbers, provided that any necessary written forms are later completed and filed.

BlueCross BlueShield	MVP Health Care
Telephone (585) 454-4810	259 Monroe Avenue
Facsimile (585) 238-3659	Rochester, New York 14607

If you make a request for benefits that does not comply with the Plan's procedure for pre-service claims, you will be notified of the proper procedure within 24 hours if it involves an urgent pre-service claim, or within five days if it involves a non-urgent pre-service claim. (This notification may be oral, unless you request written notification.)

If a claimant fails to submit sufficient information for a determination on an urgent claim, he will be notified of the specific information necessary to complete the claim within 24 hours after the Plan receives the claim. He may then submit the additional information within 48 hours, and will be notified of the determination on his claim within 48 hours after the earlier of the receipt of the additional information or the end of the period the additional information could have been submitted.

A claimant will be notified of the determination on his claim within: 24 hours in the case of a concurrent claim involving urgent health care if the request is received at least 24 hours before the scheduled expiration of the treatments; 72 hours in the case of any other urgent claim (or earlier if possible); 15 days in the case of a non-urgent pre-service claim; or 30 days in the case of a post-service claim. However, if an extension to make a determination on a non-urgent claim is necessary due to reasons beyond the Plan's control, the time to make the determination may be extended for up to another 15 days. In that case, the claimant will receive written notice of the reasons for the extension, any additional information required from him to make the determination, and the date the determination is expected. Also, if the extension is necessary because additional information is needed from the claimant, the claimant will be given 45 days from the date he receives the notice to provide the information.

If an adverse determination is made, the claimant will be sent a notice containing: (i) the specific reasons for the adverse determination; (ii) references to the specific Plan provisions on which it is based; (iii) the names of any medical or vocational experts whose advice was obtained by the Plan in connection with the determination; (iv) a

description of any additional material or information necessary to complete the claim and an explanation of why it is necessary; (v) a description of the Plan's review procedures and time limits; (vi) a statement that the claimant has a right to sue under the Employee Retirement Income Security Act of 1974 following an adverse determination upon review; (vii) if the Plan relied upon an internal rule, guideline, protocol or similar criterion in making the determination, either the criterion relied upon or a statement that the Plan relied upon such criterion and that a copy of the criterion is available free of charge upon request; (viii) if the determination was based upon a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to the claimant's medical circumstances), or a statement that such explanation will be provided free of charge upon request; and (ix) for urgent claims, a description of the expedited review procedure for such claims. This notice may be provided orally for an urgent claim, but will then be sent to the claimant in writing within three days after oral notification.

Within 180 days after receiving an adverse determination, a claimant may file a written appeal to the Insurer for a full and fair review of the claim and determination. He may submit written comments, documents and other information relating to the claim, and may have reasonable access to, and copies of, all documents, records, and other information relevant to the claim. For an urgent claim, the claimant may request, in writing or orally, an expedited review of the initial determination, and information may be transmitted by telephone or by facsimile at the following numbers.

BlueCross BlueShield	MVP Health Care
Telephone (585) 454-4810	259 Monroe Avenue
Facsimile (585) 238-3659	Rochester, New York 14607

A reduction or termination of health treatment (other than by Plan amendment or termination) will be treated as an adverse determination, and the participant or beneficiary will be notified sufficiently in advance to allow him to appeal before the reduction or termination occurs.

The review on appeal will take into account all documents, records and information submitted by the claimant, and will be conducted by an appropriate named fiduciary who did not make the initial determination and who is not a subordinate of the person who did. For a claim based on medical judgment (e.g., whether a treatment or drug is experimental, investigational, or medically necessary or appropriate), the person conducting the review will consult with a state licensed or certified independent health

care professional with appropriate training and experience in the field who was not consulted in connection with the initial determination and is not a subordinate of any health care professional who was consulted.

The claimant will be notified of the determination on review within 72 hours after the Plan receives the request for review of an urgent claim (or earlier if possible), 30 days after the Plan receives a request for review of a non-urgent pre-service claim, or 60 days after the Plan receives a request for review of a post-service claim.

The notice of an adverse determination on review will contain: (i) the specific reasons for the adverse determination; (ii) reference to the specific Plan provisions on which the determination is based; (iii) a statement that, upon request, the claimant is entitled free of charge to reasonable access to, and copies of, all documents and records relevant to the claim; (iv) if the Plan relied upon some internal rule, guideline, protocol, or similar criterion in making the determination, either the criterion relied upon or a statement that the Plan relied upon such criterion and a copy of the criterion is available free of charge upon request; (v) if the determination is based upon a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and (vi) a statement that the claimant has a right to sue under the Employee Retirement Income Security Act of 1974; (vii) the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

An external claim review procedure applies to adverse benefit determinations and final internal adverse benefit determinations for Health Coverage claims. Contact the appropriate Insurer for information on how to make a request for an external claim review and other external claim review procedures.

Life, Accident & Disability Claims

If you believe you are entitled to Life, Accident & Disability Coverage benefits, you should submit a benefit claim to the Local No. 26 Benefit Funds Office at the address below. You should also contact the Benefit Funds Office if you have questions about eligibility for Life, Accident & Disability Coverage or about specific Life, Accident & Disability Coverage benefits.

International Association of Heat and Frost Insulators and Allied Workers
Local No. 26 Welfare Plan
4348 Culver Road, Suite 3
Rochester, NY 14622

You may appoint someone to file a benefit claim and act on your behalf, provided you give the Insurer signed written notification of the appointment.

The claim procedures are different for Life and Accident Coverage benefits and for Disability Coverage Benefits.

For Life and Accident Benefits

A claimant will be notified of the determination on his claim within 90 days. However, if an extension to make a determination is necessary due to reasons beyond the Plan's control, the time to make the determination may be extended for up to another 90 days. In that case, the claimant will receive written notice of the reasons for the extension, any additional information required from him to make the determination, and the date the determination is expected.

If an adverse determination is made, the claimant will be sent a notice containing: (i) the specific reasons for the adverse determination; (ii) references to the specific Plan provisions on which it is based; (iii) a description of any additional material or information necessary to complete the claim and an explanation of why it is necessary; (iv) a description of the Plan's review procedures and time limits; and (v) a statement that the claimant has a right to sue following an adverse determination upon review.

Within 60 days after receiving an adverse determination, a claimant may file a written appeal for a full and fair review of the claim and determination. He may submit written comments, documents and other information relating to the claim, and may have reasonable access to, and copies of, all documents, records, and other information relevant to the claim. The review on appeal will take into account all documents, records and information submitted by the claimant. The claimant will be notified of the determination on review within 60 days after the Plan receives a request for review. However, if an extension to make a determination on review is necessary due to reasons beyond the Plan's control, the time to make the determination may be extended for up to another 60 days. In that case, the claimant will receive written notice of the reasons for the extension, any additional information required from him to make the determination, and the date the determination is expected.

The notice of an adverse determination on review will contain: (i) the specific reasons for the adverse determination; (ii) reference to the specific Plan provisions on which the determination is based; and (iii) a statement that, upon request, the claimant is entitled free of charge to reasonable access to, and copies of, all documents and records relevant to the claim; and (iv) a statement that the claimant has a right to sue under the Employee Retirement Income Security Act of 1974.

For Disability Benefits

A claimant will be notified of the determination on the claim within 45 days, unless an extension is necessary due to reasons beyond the Insurer's control. In that case, the determination may be extended for up to another 30 days and, before the end of the initial 45 day period, the claimant will receive written notice of the reasons for the extension. If a second extension is necessary due to reasons beyond the Insurer's control, the time to make the determination may be extended for up to an additional 30 days and the claimant will receive written notice of the second extension before the end of the first extension period. All extension notices will also explain: (i) the standards on which entitlement to a benefit is based; (ii) the unresolved issues that prevent a decision on the claim; and (iii) any additional material or information needed from the claimant to resolve those issues. The claimant will have 45 days to provide such materials or information. If the extension was due to the claimant's failure to submit information necessary to decide the claim, the period for making the determination will be tolled from the date on which notification of the extension is sent to the claimant until the date the claimant responds to the request for additional information.

If an adverse determination is made, the claimant will be sent a notice containing: (i) the specific reasons for the adverse determination; (ii) references to the specific Plan provisions on which it is based; (iii) a description of any additional material or information necessary to complete the claim and an explanation of why it is necessary; (iv) a description of the Plan's review procedures and time limits; (v) a statement that the claimant has a right to sue under ERISA following an adverse determination upon review; (vi) if the Insurer relied upon an internal rule, guideline, protocol or similar criterion in making the determination, either the criterion relied upon or a statement that the Insurer relied upon such criterion and that a copy of the criterion is available free of charge upon request (otherwise, a statement that such criteria does not exist); (vii) if the adverse benefit determination is based on a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to the claimant's medical

circumstances), or a statement that such explanation will be provided free of charge upon request; and the names of the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse determination.

For claims for disability income benefits filed on or after January 1, 2018, the notice of an adverse benefit determination will be provided in a culturally and linguistically appropriate manner and will also contain: (i) a discussion of the decision, including an explanation of the basis for disagreeing with or not following the views presented by the claimant of health care professionals treating the claimant and vocational professionals who evaluated the claimant, the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination (without regard to whether the advice was relied upon in making the benefit determination), or any disability determination regarding the claimant made by the Social Security Administration and presented by the claimant; and (ii) a statement that, upon request, the claimant is entitled (free of charge) to, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

The term "adverse benefit determination" includes any rescission of insurance coverage under the Plan (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term "rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Within 180 days after receiving an adverse determination, a claimant may file a written appeal for a full and fair review of the claim and determination. The claimant may also submit written comments, documents and other information relating to the claim for benefits, and may have (free of charge) reasonable access to, and copies of, all documents, records, and other information relevant to the claim. The review on appeal will: (i) take into account all comments, documents, records and information submitted by the claimant (without regard to whether such information was submitted or considered in the initial benefit determination); (ii) not afford deference to the initial adverse benefit determination; and (iii) be conducted by a person who did not make the initial determination and who is not a subordinate of the person who did. For a claim based in whole or in part on medical judgment (including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the person conducting the review will consult with a health care professional who has appropriate training and experience in the field of medicine

involved in the medical judgment and who was not consulted in connection with the adverse benefit determination and is not the subordinate of any such individual.

The claimant will be notified of the determination on review within 45 days after the Insurer receives a request for review, unless an extension to make a determination on review is necessary due to reasons beyond the Insurer's control. In that case, the time to make the determination may be extended for up to another 45 days, and the claimant will receive written notice of the extension before the end of the first 45 day period. The notice will explain the reasons for the extension and any additional material or information required from the claimant to make the determination. It will also state the date the determination is expected.

A notice of an adverse determination on review will contain: (i) the specific reasons for the adverse determination; (ii) references to the specific Plan provisions on which the determination is based; (iii) if the adverse benefit determination is based on a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to the claimant's medical circumstances), or a statement that this explanation will be provided free of change upon request; (iv) the names of the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; (v) if the Insurer relied upon an internal rule, guideline, protocol or similar criterion in making the determination, either the criterion relied upon or a statement that the Insurer relied upon such criterion and that a copy of the criterion is available free of charge upon request (otherwise, a statement that such criteria does not exist); and (vi) a statement that, upon request, the claimant is entitled (free of charge) to reasonable access to, and copies of, all documents and records relevant to the claim.

For claims for disability income benefits filed on or after January 1, 2018, the notice of an adverse benefit determination on review will be provided in a culturally and linguistically appropriate manner and will also contain a discussion of the decision, including an explanation of the basis for disagreeing with or not following the views presented by the claimant of health care professionals treating the claimant and vocational professionals who evaluated the claimant, the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination (without regard to whether the advice was relied upon in making the benefit determination), or a disability determination regarding the claimant made by the Social Security Administration and presented by the claimant.

SECTION 11
RECIPROCAL AGREEMENTS

From time to time, the Plan may participate in reciprocal agreements with other local unions that provide for the exchange of contributions made on behalf of an employee when he is temporarily working in the jurisdiction of the Union or another local union. When this happens, an employee temporarily working in the jurisdiction of the Union will not participate in this Plan during the period the reciprocal agreement is in effect, unless the reciprocal agreement so provides, and an employee temporarily working in the jurisdiction of another local union may be credited with Hours of Service under this Plan for work performed in the other jurisdiction. The following rules apply to Hours of Service attributable to contributions remitted by another plan to this Plan pursuant to a reciprocal agreement.

- When contributions are remitted to this Plan for hours worked by one or more employees, the Hours of Service credited to each such employee under this Plan will equal the total contributions remitted multiplied by a fraction, the numerator of which is the amount of contributions that should have been remitted for that employee's hours and the denominator of which is the total amount of contributions that should have been remitted for all such employees' hours.

- Hours of Service attributable to contributions remitted to this Plan are credited under this Plan when the contributions are actually received by this Plan.

You can request from the Board a list of the local unions with reciprocal agreements and specific information on the exchange of credits and/or contributions under an agreement with a particular local union.

SECTION 12
POWERS OF THE TRUSTEES

In addition to the other powers conferred upon it by law, subject to the rights of the Insurers, the Board has the power and discretion to:

- Establish, amend or revoke any rule, term or provision of the Plan, at any time, provided that no such amendment or revocation may provide or result in the use of the trust fund assets for any purpose other than the exclusive benefit of the participants and their beneficiaries and to pay necessary and reasonable expenses for the administration of the Plan.

- Administer the Plan in all of its details, including the authority to: (i) decide any issues of fact relevant to the eligibility of any person to participate in the Plan; (ii) interpret the terms of the Plan; (iii) supply any omission, interpret any ambiguous or uncertain provisions of the Plan, and reconcile any inconsistency that may appear in the Plan; and (iv) make and enforce such rules and regulations as it deems necessary or proper for the administration of the Plan.

SECTION 13
YOUR RIGHTS

USERRA Participation Rights

The Uniformed Services Employment and Reemployment Rights Act ("USERRA") also gives an employee who is absent from work due to service in the uniformed services (including active or reserve duty, whether voluntary or involuntary, and time off for training or instruction) the right to continuation coverage under the Plan if the employee is covered under the Plan when the period of military service begins, and certain other requirements are satisfied. For example, the period of military service generally cannot exceed five years, and the employee (or an appropriate officer) must give advance oral or written notice of the absence to the employee's employer as early as is reasonable under the circumstances, unless notice is prevented by military necessity or is otherwise impossible or unreasonable under the circumstances.

An employee entitled to USERRA continuation coverage may elect continuation coverage (for him/herself and his/her covered dependents) for a period of up to 24 months. However, USERRA continuation coverage will terminate if the employee's military service ends because of: (i) separation from service with a dishonorable or bad-conduct discharge; (ii) separation from service under certain less-than-honorable conditions; or (iii) for a commissioned officer, dismissal in connection with a court-martial or, in time of war, by the President, or dropping of the commissioned officer from the rolls as a result of an unauthorized absence for at least three months or as a result of a sentence imposed after a court-martial or a conviction in another court. USERRA continuation coverage will also terminate if the employee fails to report back to work or apply for reemployment within the time period required under USERRA after completion of military leave.

All election and premium payment procedures, rules and deadlines for USERRA continuation coverage under the Plan are the same as the COBRA continuation coverage election and premium payment procedures, rules and deadlines described in this Summary Plan Description, except to the extent any of those procedures, rules or deadlines conflict with USERRA regulations (e.g., if compliance with any particular procedure, rule or deadline is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances).

An employee also has the right to reinstatement in the Plan, without any exclusions or waiting periods due to the military leave, when he/she timely returns to work after a military leave, assuming he/she is otherwise eligible for Plan coverage. If the employee timely returns to work after a military leave before the maximum USERRA continuation coverage period but the employee is not reinstated in the Plan because he/she is not eligible for coverage at that time (for reasons unrelated to the military leave), then the employee has a right to continuation coverage for the entire 24 month USERRA continuation coverage period (or, if sooner, the date he/she is reinstated).

Information concerning your USERRA rights is available from the Local No. 26 Benefit Funds Office at 4348 Culver Road, Suite 3, Rochester, New York 14622.

New York Extended Dependent Child Coverage and New York Continuation Coverage

Under New York law, if a Child has reached the maximum age for dependent Child coverage under the Plan he may be entitled to extended health insurance coverage until he reaches age 29 ("New York extended dependent Child coverage"). This coverage is provided directly by the insurer providing Health Coverage under the Plan for the Child's parent, and the cost for this coverage is billed by the insurer directly to the Child.

To be eligible for New York extended dependent Child coverage, the Child must be unmarried and satisfy certain other requirements. If you have reached, or are about to reach, the maximum age for dependent Child coverage under the Plan and are interested in New York extended dependent Child coverage, you should contact the insurer providing your parent's health coverage for more information.

Under New York law, if the maximum period a person is entitled to federal COBRA continuation coverage is less than 36 months and he receives federal COBRA continuation coverage through that period, he may be entitled to continued health insurance coverage under New York law ("New York continuation coverage"). The

maximum period of combined federal COBRA continuation coverage and New York continuation coverage is 36 months. For example, if your maximum federal COBRA continuation coverage period is 18 months, the longest New York continuation coverage would be available is another 18 months. Note that the same circumstances and events that would trigger termination of a person's federal COBRA continuation coverage also trigger termination of New York continuation coverage. The cost for New York continuation coverage is equal to 102% of the full premium for Health Coverage and must be paid by the person receiving the New York continuation coverage.

Family and Medical Leave Act Leave

If you are eligible for and take a leave of absence under the Family and Medical Leave Act ("FMLA Leave"), you may continue Plan coverage during the FMLA Leave, provided you would have been continuously employed during the entire FMLA Leave and you pay the participant cost for Plan coverage during the FMLA Leave. Plan coverage will continue as if you were actively employed by your Contributing Employer until the earlier of the date (1) the FMLA Leave ends, or (2) you notify your Contributing Employer that you will not return to work. If you choose not to continue Plan coverage during an FMLA Leave, you may resume Plan coverage when you return to work (provided you return when the FMLA Leave expires), and any pre-existing condition exclusion rules under the Plan will be waived.

You are also eligible to elect COBRA Continuation Coverage after the FMLA Leave if you:

- were covered under the Plan on the day before the FMLA Leave,
- do not return to work at the end of the FMLA Leave, and
- would otherwise lose coverage under the Plan.

You also may be able to elect COBRA Continuation Coverage even if you choose not to continue regular Plan coverage during the FMLA Leave, or you stop paying your cost for Plan coverage during the FMLA Leave.

Information concerning your right to and obligations during a leave is available from your Contributing Employer.

Women's Health and Cancer Rights Act

The Plan provides coverage in connection with a mastectomy (in the manner determined by the attending physician and the patient) for:

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

The Plan may not deny eligibility to enroll, renew or continue group health plan coverage to avoid providing coverage for breast reconstruction or mastectomy complications. Deductible and co-payment amounts for covered care will be consistent with those established for other Plan benefits. In addition, the law prohibits penalizing or otherwise reducing or limiting the reimbursement of an attending provider for the required care, or providing any incentive (monetary or otherwise) to induce the attending provider to provide care that would be inconsistent with the law.

If you have any questions about this coverage, please contact your Plan Administrator.

Newborn Mothers and Minimum Maternity Stay

The Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarian section, or require that a health care provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods. If you choose to leave the hospital earlier, your inpatient coverage will be extended to include at least one home care visit. Check with the appropriate Insurer for more details on maternity coverage.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order (QMCSO) is an order by a court for one parent to provide a Child or Children with Health Coverage. If the Plan receives a QMCSO for your Child or Children, you will be contacted about the procedure for the QMCSO. A copy of the QMCSO procedure is available from the Plan Administrator.

HIPAA Privacy Rules

The Plan has responsibilities under Health Insurance Portability and Accountability Act ("HIPAA") regarding the use and disclosure of your protected health information ("PHI"). Your PHI is any information that: (i) identifies you or may reasonably be used to identify you; (ii) is created or received by a health care provider, health plan, employer or health care clearinghouse; and (iii) relates to your past, present or future physical or mental health or condition, or the provision of or payment for health care. The Plan is required maintain the privacy of your PHI. It is also required to provide you with a notice of its legal duties and privacy practices, and to follow the terms of the privacy notice. However, the Plan is also permitted by law to use and disclose your PHI in certain ways, which are described in the privacy notice.

If you believe your PHI has been impermissibly used or disclosed, or that your privacy rights have been violated in any way, you may file a complaint with the Plan or with the Secretary of United States Department of Health and Human Services. If you want a copy of the Plan's privacy notice or more information about the Plan's privacy practices, or you want to file a privacy violation complaint, please contact the Local No. 26 Benefit Funds Office**.**

Your Rights Under ERISA

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

This includes the ability to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series), if applicable, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective

bargaining agreements, and copies of the latest annual report (Form 5500 Series), if applicable, and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

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

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

Prudent Actions By Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance With Your Questions

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

APPLICABLE PREMIUM AND EMPLOYEE COST SCHEDULE FOR REGULAR HEALTH COVERAGE (Effective 1/1/2019)

Excellus SimplyBlue Plus Gold 5 Coverage:

For Single coverage
Applicable Premium: $585.78 per month
Employee Cost: $87.87 per month

For Two-person coverage - i.e., Employee and Spouse (or Domestic Partner)
Applicable Premium: $1,171.56 per month
Employee Cost: $175.73 per month

For Family with no Spouse (and no Domestic Partner)
Applicable Premium: $995.83 per month
Employee Cost: $149.37 per month

For Family with Spouse (or Domestic Partner)
Applicable Premium: $1,669.47 per month
Employee Cost: $250.42 per month

Excellus SimplyBlue Plus Gold 17 Coverage

For Single coverage
Applicable Premium: $590.07 per month
Employee Cost: $88.51 per month

For Two-person coverage - i.e., Employee and Spouse (or Domestic Partner)
Applicable Premium: $1,180.14 per month
Employee Cost: $177.02 per month

For Family with no Spouse (and no Domestic Partner)
Applicable Premium: $1,003.12 per month
Employee Cost: $150.47 per month

For Family with Spouse (or Domestic Partner)
Applicable Premium: $1,681.70 per month
Employee Cost: $252.26 per month

See page 11 of the Summary Plan Description for a special rule that may lower an Employee's cost when he fails to complete the minimum number of Hours of Service required to continue Regular Health Coverage during a Contribution Period.

An Employee's COBRA Continuation Coverage cost is normally 102% of Applicable Premium, but see page 17 of the Summary Plan Description for a special rule that may lower an Employee's cost when he fails to complete the minimum number of Hours of Service required to continue Regular Health Coverage because he is totally disabled. Also see page 17 for a special rule that may lower the cost for a Spouse or Child when they are eligible for COBRA Continuation Coverage because of the Employee's death.

MVP Preferred Gold HMO-POS 2019 Medicare supplemental coverage (individuals age 65 or older)

Applicable Premium: $342.15 per month per individual

See page 17 of the Summary Plan Description for the cost of Retiree Health Coverage (i.e., when an Employee qualifies for normal or early pension benefits under the Union Pension Plan).

THE APPLICABLE PREMIUM IS SUBJECT TO CHANGE