Effective: January 1, 2015

INTERNATIONAL UNION OF OPERATING ENGINEERS
LOCAL 98 HEALTH AND WELFARE PLAN

SUMMARY PLAN DESCRIPTION

INTERNATIONAL UNION OF OPERATING ENGINEERS
LOCAL 98 HEALTH AND WELFARE PLAN

TABLE OF CONTENTS

PAGE NO.

PLAN AND BENEFIT TERMINATIONS, MODIFICATIONS AND CHANGES vii

CAUTION vii

COMMUNICATIONS vii

CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION 1

RULES OF ELIGIBILITY 4

- Who Is Eligible 4
- Initial Eligibility For Benefits 5
- Continuing Eligibility for Benefits 5
- Termination of Eligibility 5
- Reinstatement of Benefits 6
- Exceptions for Disability, Death, and Military Service 6
- Death of a Participant 6
- Military Service 6
- Pre-existing Conditions 7
- Eligible Dependents 7
- Former Spouse 8
- Special Enrollment Rights 8

DEATH, ACCIDENTAL DEATH, AND DISMEMBERMENT BENEFIT 9

- Death Benefit 9
- Accidental Death Benefit 9
- Dismemberment Benefit 9
- Dismemberment Schedule 10
- Applicable Definitions 10

DEPARTMENT OF TRANSPORTATION EXAMINATIONS 11

OPTICAL PLAN 11

- Our Basic Plan 11
- Our Alternative Plan 12

DENTAL PLAN 12

- Dental Benefit 12
- Orthodontic Benefit 12
- Dental Exclusions 12

HEARING AID BENEFIT 13
DISABILITY BENEFIT PLAN 13
Eligibility For Participant Only 13
Disabilities Due to Occupational Causes 13
Disabilities Due to Non-Occupational Causes 14
Exclusions and Terminations 14
WELLNESS PROGRAM 15
MISCELLANY 15
Payments Made To Incompetent Persons 15
Coordination of Benefits 15
Coordination with Medicare 16
Family and Medical Leave Continuation Coverage 16
SUBROGATION 18
General Rights of Subrogation and Reimbursement 18
Rights of Subrogation and Reimbursement 18
Right of Future Subrogation and Reimbursement 20
Assignment of Claim 20
Failure to Disclose and/or Cooperate 20
Automobile Insurance Claims 21
RECIPROCITY AGREEMENTS 21
MEDICARE 21
Extension of Benefits 22
PENSIONERS SPECIAL PLAN 22
CLAIM REVIEW AND APPEALS PROCEDURE 23
FILING OF CLAIMS 23
STATEMENT OF COLLECTIVE BARGAINING AGREEMENT 32
STATEMENT OF ERISA RIGHTS 33
STATEMENT OF TRUSTEES RIGHT TO AMEND 35
DESIGNATION OF AGENT FOR SERVICE OF PROCESS 35
PLAN INTERPRETATION AND DETERMINATIONS 35
COBRA CONTINUATION COVERAGE 36

HEALTH AND WELFARE PLAN
BENEFIT PLAN MANUAL

The following pages of Local 98's Health and Welfare Plan include a description of the Plan as of January 1, 2015, the date the Board of Trustees released the approved and revised Plan. Our Health and Welfare Plan, the first within the International and the second in the United States, began in 1949.

Your coverage under the Benefit Plan may be terminated from time to time due to lack of work within the industry. You will be notified of any such termination and advised as to your eligibility for self-payment under our COBRA-98 Plan. You or your spouse must notify the Fund Office of your divorce or legal separation. The failure to notify the Fund Office will result in the loss of eligibility for COBRA continuation coverage.

You may also work outside the jurisdiction of Local 98; however, the majority of the Local Unions are covered by a reciprocity agreement whereby payments made to another Fund will be returned to our Fund. Keep the Fund Office advised when you are out of the area by submitting your Calendar Cards on a monthly basis.

Changes to the Plan are set forth in this Manual (Summary Plan Description) with all the new benefits in effect to date. The Trustees reserve the right to amend, modify or discontinue all or part of the Plan whenever, in their judgment, conditions so warrant.

Your Board of Trustees

INTERNATIONAL UNION OF OPERATING ENGINEERS
LOCAL 98

HEALTH AND WELFARE PLAN

Plan Number: 501; Employer I.D. Number: 04-2123707
Fiscal Year of the Plan: January 1 through December 31

PLAN SPONSOR

Board of Trustees, International Union of Operating Engineers
Local 98 Health and Welfare Fund

Two Center Square, P.O. Box 217
East Longmeadow, Mass. 01028-0217
Telephone: (413) 525-4221
FAX: (413) 525-7553
Website: iuoelocal98.org

BOARD OF TRUSTEES

EMPLOYER REPRESENTATIVES

DAVID J. TIERNEY, III
David J. Tierney, Jr., Inc.
169 Gale Ave.
Pittsfield, MA 01201

JANET CALLAHAN
Palmer Paving Corp.
25 Blanchard Street
Palmer, MA 01069

UNION REPRESENTATIVES

EUGENE P. MELVILLE, JR.
Chairman
Two Center Square, P.O. Box 217
East Longmeadow, MA 01028

PHILIP CHAFFEE
Two Center Square, P.O. Box 217
East Longmeadow, MA 01028

PAUL WILK
Two Center Square, P.O. Box 217
East Longmeadow, MA 01028

ADMINISTRATOR
Michelle Schweitzer

GENERAL COUNSEL
Blitman & King LLP

AUDITORS
Schultheis & Panettieri, LLP

PLAN ADMINISTRATOR

The Board of Trustees is considered the "Plan Administrator." The Plan is administered by and for the Trustees through the

Health and Welfare Fund Office
Two Center Square, P.O. Box 217
East Longmeadow, Massachusetts 01028

AGENT FOR THE SERVICE OF LEGAL PROCESS

Michelle Schweitzer, Administrator
International Union of Operating Engineers
Local 98 Health and Welfare Fund
Two Center Square, P. O. Box 217
East Longmeadow, Massachusetts 01028
Telephone: (413) 525-4221
FAX: (413) 525-7553

TYPE OF PLAN

This Plan is a jointly managed Multi-employer Welfare Plan under ERISA, subject to HIPAA, providing death, accidental death and dismemberment, disability, and health benefits to Participating Employers' Participants, their Dependents, and Beneficiaries, who meet the qualifications for benefit eligibility.

TYPE OF ADMINISTRATION AND METHOD OF FUNDING BENEFITS

The Plan is administered by the Board of Trustees and their decisions in all matters concerning the Plan are final. Some of the benefits provided by the Fund are fully insured and are provided through the payment of insurance premiums to insurance companies. The Fund's insurance companies are listed below:

Medical and Prescription Drug Benefits:

Blue Cross and Blue Shield of Massachusetts (BCBSMA)
25 Technology Place
Hingham, MA 02043

Death, Accidental Death and Dismemberment Benefits:

Lincoln Financial Group
8801 Indian Hills Drive
Omaha, NE 68114

Other benefits, including Dental and Optical Benefits as described below, are self-insured:

The Fund maintains an agreement with Davis Vision to provide optical benefits to members and their dependents. Davis Vision's address and telephone number is:

Davis Vision
P.O. Box 1525
Latham, NY 12110
Member Services Telephone: 1-800-999-5431

The Fund also maintains an agreement with Delta Dental to provide self-insured dental benefits. The address and telephone number for Delta Dental is:

Delta Dental
P.O. Box 9695
Boston, Massachusetts 02144
Customer Service Department: 1-800-872-0500

COLLECTIVE BARGAINING AGREEMENTS

This Plan is maintained in accordance with Collective Bargaining Agreements. A copy of these agreements may be obtained by you upon written request to the Administrator and are available for examination by you at the Fund Office.

PARTICIPATING EMPLOYERS

You may receive from the Administrator, upon written request, information as to whether a particular Employer participates in the sponsorship of the Plan. If so, you may also request the Employer's address.

FINANCING OF THE PLAN

The cost of the Plan is funded by Participating Employer Payments to the Fund. The amounts and due dates of Contributions to the Fund, and job classifications covered, are stated in the applicable Collective Bargaining Agreement or in a Participation Agreement. Unless you work in a job classification Covered by the Collective Bargaining Agreement or in a Participation Agreement, Contributions cannot legally be made on your behalf. The Participating Employer Payments are received and held in Trust by the Board of Trustees for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses.

IMPORTANT NOTICE

In the event there appears to be a conflict between any Plan provisions in this booklet, and the terms and provisions of any applicable insurance contract or certificate, the language contained in the insurance contract or certificate is the official and governing language.

PLAN AND BENEFIT TERMINATIONS, MODIFICATIONS AND CHANGES

Although it is not currently anticipated that the Trustees will terminate the Plan, the Board of Trustees necessarily reserves the right to terminate it at any indefinite point in the future. The continuation of this Plan is also contingent upon the continuation of employer contributions to the Fund.

If the Plan is terminated for any reason, the assets remaining in the Fund will be utilized to pay necessary administration costs and remaining benefits, until such assets are depleted. If all assets were so expended, no further benefits would be provided by the Fund. Participants and beneficiaries would have no rights or vested interest in the Plan.

The Board of Trustees also reserves the right to amend, modify, or terminate (i) the Plan, (ii) the types and amounts of benefits provided under this Plan; and/or (iii) the eligibility, even if extended eligibility has already been accumulated. Furthermore, the benefits provided by this Plan are not guaranteed, are not vested upon retirement or at any other time, and are not deferred income. Additionally, the benefits provided by this Plan are subject to modification or termination by the Trustees, even if such action is not financially necessary. Thus, the continuation of benefits for all participants and beneficiaries, and the eligibility rules for benefits under this Plan are subject to modification and revision by the Trustees.

No participant, beneficiary, or eligible dependent has a vested right or contractual interest in the benefits provided. The provision of benefits to individuals under this Plan will be reviewed periodically by the Trustees.

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

CAUTION

This booklet and the personnel at the Fund Office are authorized sources of Plan information for you. The Trustees of the Plan have not empowered anyone else to speak for them with regard to the Health and Welfare Plan. No employer, local business agent, supervisor or steward is in a position to discuss your rights under the Plan with authority.

COMMUNICATIONS

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

CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION

A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), requires that health plans protect the confidentiality of your Protected Health Information ("PHI") effective April 14, 2003. A summary of your rights under HIPAA can be found in the Plan's privacy notice, which will be distributed to you in accordance with HIPAA and which is available from the Plan's Privacy Official, Michelle Schweitzer, Fund Administrator.

This Plan, and the Plan Sponsor (the Plan Sponsor for HIPAA purposes is the Board of Trustees of the International Union of Operating Engineers Local 98 Health and Welfare Fund), will not use or disclose your PHI except as necessary for treatment, payment, health care operations and plan administration, or as permitted or required by law.

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

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

(b) coordination of benefits;

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

(d) subrogation of health benefit claims;

(e) COBRA contributions;

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

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

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

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

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

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

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

(m) reimbursement to the plan.

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

(a) quality assessment;

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

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

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

(e) business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;

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

(1) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements

(g) resolution of internal grievances; and

(h) 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.

The employees of the International Union of Operating Engineers Local 98 Health and Welfare Fund who assist in the Plan's administration and the Board of Trustees of the International Union of Operating Engineers Local 98 Health and Welfare Fund will have access to your PHI. However, these individuals may only have access to use and disclose your PHI for plan administration functions. This Plan provides a complaint mechanism for resolving noncompliance matters. If these individuals do not comply with the above rules, they will be subject to disciplinary sanctions.

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

The Plan will not, without your authorization, use or disclose your PHI for employment related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

HIPAA provides that this Plan may disclose your PHI to the Plan Sponsor only upon receipt of a Certification by the Plan Sponsor that it agrees to the following: (a) not use or further disclose the information other than as permitted or required by the plan documents or as required by law; (b) ensure that any agents, including a subcontractor, to whom it provides PHI received from this Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information; (c) not use or disclose the information for employment related actions and decisions unless authorized by you; (d) not use or disclosure the information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by you; (e) report to this Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware; (f) make PHI available to you in accordance with HIPAA's access requirements; (g) make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA; (h) make available the information required to provide an accounting of disclosures; (i) make its internal practices, books, and records relating to the use and disclosure of PHI received from this Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by this Plan with HIPAA; (j) if feasible, return or destroy all PHI received from this Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and (k) maintain adequate separation between the Plan and the Plan Sponsor. The Plan Sponsor has made such Certification to the Plan.

To ensure the protection of your PHI, the Plan Sponsor will:

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

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

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

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

This Plan's privacy notice provides a summary of your rights under HIPAA's privacy rules. Please contact, Michelle Schweitzer, Fund Administrator and Privacy Official at (413) 525-4221 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.

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

RULES OF ELIGIBILITY

Who Is Eligible...

The following employees are deemed to be engaged in covered employment and may be eligible for benefits pursuant to the terms and conditions of this Plan: (1) all present and future bargaining unit employees on whose behalf contributions are made pursuant to a Collective Bargaining Agreement negotiated by Local Union No. 98; (2) all non-bargaining unit employees on whose behalf contributions are made pursuant to a written Participation Agreement that has been authorized and approved by the Board of Trustees; (3) all Business Representatives of the Union on whose behalf contributions are made pursuant to a written agreement that has been authorized and approved by the Board of Trustees; (4) all full time employees of the Union, Fund Office, and Training Fund on whose behalf contributions are made pursuant to a written agreement that has been authorized and approved by the Board of Trustees; and (5) each present and future employee of Employers as defined within the meaning of the Agreement and Declaration of Trust of the Fund.

All such employees shall be referred to as Participants.

Initial Eligibility For Benefits...

You will first be eligible for coverage on the first of the month following the receipt of contributions for a minimum of 450 hours in covered employment in a consecutive twelve (12) month period. This will provide you coverage for three months. Your continuing coverage will be determined by receipt of contributions for a minimum of 225 hours in covered employment in each three month period and will provide you coverage for the next three months. After one year or four consecutive quarters, you will be subject to the semi-annual test described under Continuing Eligibility for Benefits.

Continuing Eligibility for Benefits…

Continuing eligibility for coverage will be determined on a semi-annual basis as follows:

(1) A minimum of 450 hours must be paid on your behalf from January 1 through June 30 to provide coverage under the Plan for the following September 1 through February 28;

(2) A minimum of 450 hours must be paid on your behalf from July 1 through December 31 to provide coverage under the Plan for the following March 1 through August 31.

(3) If 450 hours are not paid on your behalf in an eligibility period (January 1 through June 30, or July 1 through December 31) but 450 hours were paid on your behalf during the immediately preceding semi-annual eligibility period, you will have available a bank of hours not to exceed 225 from the excess hours paid during the immediately preceding semi-annual eligibility period (January 1 through June 30, or July 1 through December 31). This bank of hours plus hours paid on your behalf during the present semi-annual eligibility period must total at least 450 hours in order to maintain your coverage under the semi-annual rule. Effective July 1, 2011, such banking of hours is not available if your eligibility is determined on a quarterly basis.

Notwithstanding anything to the contrary in this SPD, if at least 225 hours (but less than 450 hours) were paid on your behalf in an eligibility period, you will remain covered for three months and will be subject to the quarterly eligibility rules.

Termination of Eligibility…

Eligibility for any and all Plan benefits from the Health & Welfare Plan shall terminate commencing 12:01 A.M. on the first day of the month following the month in which your

Employer ceases its obligation to tender contributions to the Plan as a result of collective bargaining, regardless of the number of hours banked.

Reinstatement of Benefits..(Within Two (2) Years)…

If you have been terminated from the Plan less than two (2) years, your coverage will be reinstated on the first of the month following the receipt of contributions for a minimum of 225 hours of work in covered employment in a consecutive two (2) month period. This will provide you coverage for three months. Your continuing coverage will be determined by the receipt of contributions for a minimum of 225 hours of work in covered employment in each three month period and will provide you coverage for the next three months. After one year or four consecutive quarters, you will be subject to the semi-annual test.

Reinstatement of Benefits..(More Than Two (2) Years)…

If you have been terminated from the Plan more than two (2) years, your coverage will be reinstated on the first of the month following the receipt of contributions for a minimum of 450 hours of work in covered employment in twelve (12) consecutive months. This will provide you coverage for three months. Your continuing coverage will be determined by the receipt of contributions for a minimum of 225 hours of work in covered employment in each three month period and will provide you coverage for the next three months. After one year or four consecutive quarters, you will be subject to the semi-annual test.

Exceptions for Disability, Death, and Military Service…

Disability…

If a Participant becomes totally disabled while covered by the Plan, his coverage and the coverage of his eligible dependents will be continued for a period not to exceed two and a half (2-½) years from the initial date of the disability or up to the eligibility date for Medicare, if earlier. All benefits will terminate at that time.

Death of a Participant…

The coverage of surviving eligible dependents of a deceased Participant who are covered by the Plan at the time of the Participant's death will continue for a maximum of five (5) years or until the dependent becomes eligible for Medicare benefits, if earlier, or, in the case of eligible children, until they reach the age of twenty-six. All benefits will terminate at that time.

Military Service…

If you leave employment for full-time Qualified Military Service, as defined by Federal Law, you and your eligible dependents are permitted to elect to continue health care coverage under the Plan, subject to certain limitations under Federal Law. This coverage, subject to the

provisions of the Plan, will last for up to twenty-four (24) months beginning on the date of your absence from employment. However, the coverage will terminate before the end of the twenty-four (24) month period if you enter Qualified Military Service and are discharged earlier and you fail to make a timely application for re-employment upon discharge.

If you elect such continuation coverage, you will not be required to pay any premium for the first six (6) months of such coverage. However, thereafter, and until the cessation of such coverage, you will be required to make a monthly premium payment to the Plan, which will be based on the average cost that the Plan incurs annually per participant plus a two percent (2%) administrative charge.

If you elect such continuation coverage and have banked hours sufficient to qualify for coverage under the Plan at the time you leave employment for full-time Qualified Military Service, you may utilize those hours in lieu of paying for USERRA continuation coverage after the first six months of service. As indicated above, the Plan pays for the first six months of USERRA continuation coverage, if elected. You must notify the Fund Office within 60 days of beginning military service of your intention to utilize your hour bank in this manner. Otherwise, your hour bank will freeze during your service. If you choose to utilize your hour bank while on leave and your hour bank becomes depleted, you must then pay directly for continuation coverage as described above. Upon timely application for reemployment, you may resume usage of any remaining banked hours.

Pre-existing Conditions…

The Plan does not exclude from coverage any expenses which you incur due to a pre-existing condition.

Eligible Dependents...

Your eligible dependents are your legal spouse and all your children under the age of twenty-six (26) (coverage ends on the last day of the month in which the child attains age 26) including step-children, foster children, legally adopted children or children placed with you for adoption by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction, provided they have not attained age twenty-six (26).

All eligible dependents must be listed on the dependent and beneficiary records with the Fund Office on your Effective Date and thereafter on the Effective Date of your dependents' eligibility.

In cases of Legal Separation or Divorce from your spouse, you must provide a copy of any Separation Agreement or Divorce Decree to the Fund Office. The coverage of the eligible children of the Participant will be continued as set forth above, and as may be provided for in the Separation Agreement or Divorce Decree, or in accordance with a Qualified Medical Child Support Order, subject to any applicable Coordination of Benefits provisions. Note, coverage for step-children will be terminated in the event of a divorce. A copy of the Fund's procedure

regarding a Qualified Medical Child Support Order is available upon request and at no charge from the Fund Office.

The coverage of a child who is physically or mentally incapable of self-support may be continued by the Plan after attaining age twenty-six (26) provided the child otherwise meets the requirements of an eligible dependent and written proof of the disability is submitted to the Fund Office when the child reaches the age of twenty-six (26). Any applicable Coordination of Benefits provision will also be in effect. If or when the child age 26 or older becomes eligible for benefits under any state or federal program, his/her coverage will terminate.

Former Spouse…

In the event of your divorce or legal separation, your former spouse will remain eligible for coverage under your membership **only** until you are no longer required by the judgment to provide health insurance for your former spouse or you or your former spouse remarry, whichever comes first. (In these situations, Blue Cross and Blue Shield must be notified within 30 days of a change to your former spouse's address. Otherwise, Blue Cross and Blue Shield will not be liable for any acts or omissions due to having your former spouse's incorrect address on file.)

Note: In the event you remarry, your former spouse may continue coverage under a separate membership by purchasing COBRA with the Plan, provided the divorce judgment requires that you provide health insurance for your former spouse. This is true even if your new spouse is not enrolled under your membership.

Special Enrollment Rights…

Coverage under this Plan is automatic upon your eligibility. However, by law, the Plan must provide the following description of special enrollment rights to anyone who becomes eligible for coverage: If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

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

You and your dependents may also enroll in this plan if you (or your dependents) become eligible for a premium assistance program through Medicaid or CHIP. However, you

must request enrollment within 60 days after you (or your dependents) are determined to be eligible for such assistance.

DEATH, ACCIDENTAL DEATH, AND DISMEMBERMENT BENEFIT

This Plan provides Death, Accident Death, and Dismemberment Benefits pursuant to an insurance policy with Lincoln Financial Group. A copy of the policy may be obtained from the Fund Office upon request. To the extent the terms of this SPD conflict with the terms of the applicable Lincoln Financial Group insurance policy, incorporated by reference herein, the terms of the insurance policy control.

Death Benefit…

If a Participant (see Applicable Definitions below) is covered by the Benefit Plan at the time of his death from any cause, his listed beneficiary will receive a lump sum benefit of $15,000. A Participant may change his beneficiary at any time in writing with the Fund Office.

Accidental Death Benefit…

If a Participant (see Applicable Definitions below) is covered by the Benefit Plan at the time of his Accidental Death from any cause, his listed beneficiary will receive an additional lump sum benefit of $15,000. Accidental Death Benefits will not be paid for any loss caused or contributed to by intentionally self-inflicted injury, combat, war or any act of war, declared or undeclared or by participation in the commission of any illegal or criminal act.

Dismemberment Benefit…

If a Participant (see Applicable Definitions below) is covered by the Benefit Plan at the time of the accidental dismemberment of any of the below listed, he will receive either 100% or 50% of the total $15,000 provided by this benefit if the loss occurs within ninety (90) days of the accidental injury. Payment will be made regardless of any other benefits you may receive.

Loss shall mean, with regards to hands and feet, dismemberment by severance through or above wrist or ankle joints; with regard to eyes, the irrecoverable and entire loss of sight. Irrecoverable and entire loss of sight shall be defined in this section as vision that cannot be corrected to better than 20/200.

Dismemberment Schedule...

$15,000 FOR LOSS OF:	$7,500 FOR LOSS OF:
Both Hands Both Feet Sight of Both Eyes One Hand & One Foot One Hand & Sight of One Eye	One Hand One Foot Sight of One Eye

Applicable Definitions...

Definitions that apply to the Death Benefit, Accidental Death Benefit, or Dismemberment Benefit provisions of the Plan include:

Participant: A Participant is defined on page 4 under the Rules of Eligibility. Spouses and dependents are not eligible for these benefits.

Beneficiary: A "beneficiary" means the individual designated by the Participant in writing and filed at the Fund Office where the records of coverage and eligibility are maintained. If you do not name a Beneficiary, or if the person you named dies before you, any benefit payable upon your death will be paid as follows:

(1) First – To your widowed spouse; or if your widowed spouse is not living, then

(2) Second – To your children in equal shares; or if you do not have any children, then

(3) Third – To your parents in equal shares or to your brothers and sisters in equal shares, if your parents are deceased, then

(4) Fourth – To your duly appointed and qualified executor and administrator or, if no executor or administrator is appointed and qualified within 60 days following receipt by the Trustees of notice of the death of the Participant, then

(5) Fifth – The Trustees, or their designee, will take appropriate action to obtain a judicial determination as to the distribution of any death benefit.

If your Beneficiary is a minor, your benefit may be paid, at the option of the Trustees, or their designee, in one sum or in installments, to such person as is, in the opinion of the Trustees, caring for and supporting him.

THE HEALTH CARE BENEFIT PLAN

The medical benefits, including prescription drug coverage, of the Plan are provided through Blue Cross and Blue Shield of Massachusetts (BCBSMA). Detailed descriptions of the medical and prescription drug benefits are provided to you by the carrier. In case of any conflict between this Summary Plan Description and the applicable Blue Cross and Blue Shield policy/contract, incorporated by reference herein, the provisions of the policy/contract control. A copy of the contract may be obtained from the Fund Office upon request. Note, Blue Cross and Blue Shield may change these benefits. If this is the case, the change is described in a rider. Blue Cross and Blue Shield will supply you with any riders that apply to your benefits. Please keep any riders with your Blue Cross and Blue Shield materials for reference.

DEPARTMENT OF TRANSPORTATION EXAMINATIONS

Federally required DOT examinations will be paid at the following rates:

(1) Plan authorized providers -- 100% of the covered charges. For a current list of authorized providers, please contact the Fund Office. Claims need not be submitted as the billing is resolved at the point of service.

(2) All other providers -- 100% of the first $50. Thereafter, the Plan will reimburse at the rate of 80% of covered charges. You must submit claims to the Fund Office for reimbursement, as this benefit is not part of the Blue Cross-Blue Shield Plan.

Reimbursement is limited to charges related to a routine physical examination (for a Participant only) by a qualified and licensed physician.

There is no reimbursement for drug testing required and ordered by the Employer.

OPTICAL PLAN

Out-of-Network…Routine Vision Exam (one every 24 months) by an Optometrist or Ophthalmologist Reimbursable through Davis Vision with a maximum examination benefit of $100.00

You may select any Optometrist and/or Optician for your glasses or contacts.

Each Participant and eligible dependent will be allowed a maximum benefit of $250 every two (2) years for all costs of frames, lenses and contact lenses. This $250 maximum benefit is not a part of the Blue Cross-Blue Shield Plan. Claims should be submitted directly to Davis Vision at Vision Care Processing Unit, P.O. Box 1525, Latham, NY 12110. Any expense incurred over the $250 maximum allowance is your responsibility.

In-Network Plan...

Under the In-Network Plan, a Participant and eligible dependents must use an In-Network Optometrist. Davis Vision maintains the list of In-Network Optometrists. You will have no out-of-pocket expense if you select In-Network Plan eyewear. Your provider will need to call Davis Vision for authorization. However, there are optional frames, lens types, and coatings available at your own expense. A two (2) year benefit period, starting with the eye examination, applies to this benefit. If you do not select a frame from "the collection", you will receive a $14.00 credit toward the frame you do select. If you do not purchase Davis Vision contacts you will receive a $45.00 credit towards the provider's supply of contacts.

This In-Network Plan includes single vision, conventional bifocal, safety glasses, trifocal and contact lenses. Also included at no additional cost are gradient and fashion tints, oversize lenses, cataract lenses, a choice of plastic or glass lenses, glass-gray #3, prescription sunglasses, photogray lenses and blended invisible bifocals.

DENTAL PLAN...$1,000

Dental Benefit…

Subject to a $1,000 calendar year maximum per individual, covered dental expenses are payable at the corresponding rates and subject to deductibles shown in the applicable Delta Dental Coverage Summary (supplied to you by the Fund Office and incorporated by reference herein), for usual, customary and reasonable charges. (Note, there is a separate $1,000 calendar year maximum for Oral Surgery.)

Orthodontic Benefit (Braces)...$1,000…

The Orthodontic Benefit will provide you and all your eligible dependents a maximum lifetime benefit of $1,000 each.

Your coverage under the Plan must be in effect at the inception of the first visit with the Orthodontist.

Dental Exclusions...

Please refer to your Delta Dental brochure, contact Delta Dental, P.O. Box 9695, Boston, Massachusetts 02144, or call the Delta Customer Service Department at 1-800-872-0500.

HEARING AID BENEFIT

The Plan will provide benefits for Hearing testing and evaluation provided by your Physician (M.D.) under the Blue Cross-Blue Shield Plan. Each Participant and eligible dependent will be allowed a maximum Hearing Aid benefit of $1,000 per ear every three (3) years to be applied to payment for a hearing aid and any fitting or related service. The cost of replacement batteries and the fitting of replacement batteries will not be covered. This benefit is not a part of the Blue Cross-Blue Shield Plan and claims must be submitted directly to the Fund Office within one year from the date of service.

DISABILITY BENEFIT PLAN

Eligibility For Participant Only...

A Participant who is totally disabled may apply for a Disability Benefit. The claim or application for benefits must be filed within twelve months following the date of disability. Claims filed after the twelve month time period will result in the claim being untimely and accordingly being rejected.

The Board of Trustees shall determine the effective date of any disability and whether or not a Participant is totally disabled. The Board's determination, made after consideration of pertinent medical reports, shall be final and conclusive. No payment will be made for injuries or sickness that occurs prior to the Participant's individual effective date of coverage under the Plan. All disability benefits will terminate when the Participant is eligible and receives a Pension Benefit from the I.U.O.E. Local 98 Pension Fund or any other Pension Benefit. If the Participant's eligibility terminates for any reason including a return to employment, the Disability Benefit will terminate.

A disabled Participant may not perform any work for remuneration, wage or profit unless the purpose of the work is rehabilitative and the Participant remains under the continuing care of a duly licensed Physician or Surgeon (M.D). Part-time employment may be allowed if the Board determines such employment to provide a rehabilitative benefit to the Participant. The Board of Trustees may from time to time cause a Participant who is receiving Disability Benefits to be examined by a qualified physician or physicians (M.D.s) selected by the Board for the purpose of re-determining eligibility. No further disability benefits shall be payable hereunder if a Participant refuses to be so examined.

Disabilities Due to Occupational Causes...

An eligible Participant may apply for and receive a credit in the amount of six (6) hours per day, up to thirty (30) hours per week if the participant is determined to be totally disabled from an occupational cause. The credit for hours will be provided during the period of disability up to a maximum of twenty-six (26) weeks. Eligibility for other Plan benefits will continue

during the period of disability for up to a total of two and one-half (2-1/2) years or until the Participant becomes covered by Medicare, whichever occurs first.

Successive disabilities, from the same cause or otherwise, shall be considered a continuance of the same disability unless separated by a return to active employment or availability for employment for at least two (2) consecutive weeks. There is a fifty-two (52) week aggregate maximum lifetime limit for this credit. Disabilities resulting in the course of employment will be determined to have an occupational cause. For example, if the Participant is entitled to any benefit under the Workers' Compensation Law or similar Act the cause will be determined to be occupational.

Disabilities Due to Non-Occupational Causes...

An eligible Participant may apply for and receive a credit in the amount of six (6) hours per day, up to thirty (30) hours per week and a net Disability Income benefit of $400 per week if the participant is determined to be totally disabled from a non-occupational cause, such as an accident or sickness. The credit for hours and weekly net benefit of $400 will be provided during the period of disability up to a maximum of twenty-six (26) weeks. Payment will be made for each full week from the first (1st) day in the case of an accident where hospitalized and the eighth (8th) day of a sickness. Eligibility for other Plan benefits will continue during the period of disability for up to a total of two and one-half (2-1/2) years or until the Participant becomes covered by Medicare, whichever occurs first.

Successive disabilities, from the same cause or otherwise, shall be considered a continuance of the same disability unless separated by a return to active employment or availability for employment for at least two (2) consecutive weeks. There is a fifty-two (52) week aggregate maximum lifetime limit for this credit. No more than an aggregate lifetime maximum of seventy-eight (78) weekly benefits will be paid for a related injury or sickness.

Coordination of Benefits provisions will be in effect for all accidents and illnesses caused by a wrongdoer whereby medical benefits or loss of income benefits may be available. However, in lieu of any settlement for any reason, our Plan may pay the weekly benefit to the participant and will expect reimbursement at the time of the settlement and a written letter to that effect shall be required.

Exclusions and Terminations...

No payment will be made for any intentional self-inflicted injury or sickness, for any accident or sickness that may have occurred while under the influence of alcohol or drugs not prescribed by a licensed physician (M.D.), for unlicensed or uninsured automobile/motorcycle or any licensed motor vehicle, or for injuries or sicknesses resulting from any hazardous activity.

WELLNESS PROGRAM

The Plan has adopted a wellness program administered by KGA, Inc. This program is designed to provide a wide-range of services and programs to Participants outlined in the KGA informational materials distributed to you. Copies of those materials may also be obtained from the Fund Office upon request. You should contact KGA at 1-800-648-9557 with any questions regarding the program.

MISCELLANY

Payments Made To Incompetent Persons…

If the Trustees (or their designee) determine that a person entitled to benefits from the Plan is unable to care for his affairs because of illness, accident, or incapacity (either physical or mental), payment which would otherwise be made to that person shall be made to that person's duly appointed legal representative. In the event no legal representative shall have been appointed, such payment shall, in the discretion of the Trustees (or their designee), be made to that person's spouse, child or such person who shall have care and custody of that person.

Coordination of Benefits...

Coordination of Benefits is a series of rules, which apply if a person is eligible under another plan providing medical benefits as well as under this Plan. This frequently happens when both the Participant and the Participant's spouse work. The Coordination of Benefits rules determines the portion of the expenses, which will be paid by each Plan. They will not reduce your total benefit in any way.

This set of rules is used to determine whether this Plan or the other Plan will be the "primary plan" and pay benefits first. If this Plan is the primary plan, it determines the benefit payable regardless of the provisions of any other plan. If this Plan is the secondary plan, it will pay benefits only after the primary plan has determined what it will pay.

If you or your dependent is covered under another health care plan, the total amount received from all plans will never be more than 100% of Allowable Charges. Benefits are reduced only to the extent necessary to prevent any person from making a profit on his coverage. Allowable Charges are any necessary and reasonable expenses for medical services, treatment, or supplies, covered by one of the plans under which you or your dependents are covered.

A "health care plan" is any group providing health care coverage on an insured or uninsured basis. This includes but is not limited to group Blue Cross, group Blue Shield, labor-management trustee plans, union welfare plans, employer plans, and any coverage under governmental programs, student insurance plans, and no-fault auto insurance.

If the other plan does contain a Coordination of Benefits provision, this Plan will be the primary plan if the person incurring the expense is covered by this Plan as an employee. If the person incurring the expense is covered by this Plan as a dependent, this Plan will be the secondary plan if the other plan covers such person as a covered employee.

In cases involving the children of a Participant, benefits are determined by reference to the parents' birthdays. If your children are eligible for coverage under this Plan and a plan provided by your spouse's employer, this Plan will be the primary plan if your birthday falls earlier in the year than your spouse's birthday. If you happen to have the same birthday, this Plan will be the primary plan if it has covered you longer than your spouse's plan has covered your spouse. If a court order requires someone or some entity (other than this plan or its Participant) to provide health coverage, then such court order shall be honored.

It is your obligation to notify the Plan if you, your spouse, or any of your dependents are covered by another health care plan. If you fail to do so, any amount by which the Plan overpays benefits will be recovered from you, either directly, or through a reduction in future benefits.

Coordination with Medicare…

In general, to the extent required by applicable law, if you are covered by this Plan as an active Employee and this Plan is receiving Employer contributions on your behalf, then this Plan will be primary and Medicare will be secondary, to the extent you are also entitled to coverage under Medicare. If you suffer from end stage renal disease before age 65, Medicare will be primary after the coordination period described in the regulations of the Department of Health and Human Services.

Family and Medical Leave Continuation Coverage…

Under the Family and Medical Leave Act, you may be eligible for up to 12 weeks of unpaid leave for any of the following reasons:

(1) To care for your newly born or adopted child;

(2) To care for your spouse, child or parent who has a serious health problem; or

(3) If you have a serious health problem which prevents you from performing your job.

In order for you to be eligible for such a leave, your Employer must have been obligated to make contributions to the Fund on your behalf for at least 1,250 hours in the preceding twelve (12) month period. You must also have worked for that Employer for at least twelve (12) months immediately preceding the date your leave will commence.

However, not all employers are covered by the Family and Medical Leave Act. To be subject to the Act, an Employer must have at least fifty (50) employees for each working day for each of twenty (20) work weeks in the current or preceding calendar year. Additionally, you must:

(1) Work at a location where the Employer has at least 50 employees; or

(2) Work within 75 miles of one or more work sites where the Employer has 50 or more employees.

Your Employer must notify the Fund that you are on leave for one of the purposes described in the Act, must continue to include you on its monthly remittance report to the Fund, and must continue to make contributions on your behalf. The number of hours to be reported and for which contributions are to be made shall be those hours that would have been reported but for your exercising your right under the Act for a leave of absence.

While you are on leave, you (and your eligible dependents, if any) will continue to participate in the Plan just as if your employment had not stopped, unless your Employer fails to make the required contributions for you.

Your eligibility for continued benefits under the Family and Medical Leave Act will be terminated upon the occurrence of any of the following events:

(1) Your Employer fails for any reason to make the required contributions to the Fund on your behalf while you are on leave; or

(2) You exhaust the twelve (12) weeks of leave which you are entitled to under federal law; or

(3) You or your Employer notify the Fund that you do not intend to return to the Employer's employment. (NOTE: If you do not return to work for your Employer at the end of your leave, you may be responsible for repaying the Employer contributions made for you during the leave.)

In the event your Employer ceases to make contributions on your behalf, you will be provided an opportunity to elect continuation coverage in accordance with the provisions of the section of the Summary Plan Description entitled **COBRA CONTINUATION COVERAGE**.

SUBROGATION

General Rights of Subrogation and Reimbursement…

NOTE: This provision applies to all Participants and their covered spouses and dependents, with respect to all of the Benefits provided under this Plan. For the purposes of this provision, the terms "you" and "your" refer to all Participants, covered spouses, and covered dependents.

Occasionally, a third party may be liable for your medical expenses. This may occur when a third party is responsible for causing your illness or injury or is otherwise responsible for your medical bills or other benefits provided from the Plan. The rules in this section govern how this Plan pays Benefits in such situations.

These rules have two purposes. First, the rules ensure that your Benefits will be paid promptly. Often, where there is a question of third party liability, many months pass before the third party actually pays. These rules permit this Plan to pay your covered expenses and provide any other benefits to which you are entitled until your dispute with the third party is resolved. However, the Trustees, in their discretion, may determine not to provide benefits under the Plan for you if a third party may be responsible for the Payment of benefits, until a determination is made by the proper and final decision-maker regarding the third party's responsibility to you.

Second, the rules protect this Plan from bearing the full expense in situations where a third party is liable. Under these rules, once it is determined that a third party is liable in any way for the injuries giving rise to these expenses, this Plan must be reimbursed for the Benefits it has advanced to you out of any recovery whatsoever that you receive that is in any way related to the event which caused you to incur the medical expenses. Reimbursement to the Plan shall take place regardless of how the recovery is characterized, including, but not limited to, pain and suffering. The Plan's rights of subrogation and reimbursement will not be affected, reduced or eliminated by the make-whole doctrine, comparative fault or the common-fund doctrine. The Trustees have the right to seek all available relief to the extent permitted by applicable law. In enforcing the Plan's rights to subrogation and reimbursement, the Trustees are not bound by any determination made by any other person or entity including, but not limited to, the Court, Arbitrator, Hearing Officer or similar person or entity with regard to the Fund's entitlement. In other words, the Trustees will be the sole determiners of the Plan's right to subrogation and reimbursement.

Rights of Subrogation and Reimbursement…

If you incur covered expenses for which a third party may be liable or if you become entitled to other benefits as a result of the same events which cause you to incur the covered expenses, you are required to advise the Plan of that fact. By law, the Plan automatically acquires any and all rights, which you may have against the third party.

You and/or your attorney must keep the Administrator of the Fund apprised in writing of the status of the third party action. Additionally, you and/or your attorney agree that, prior to any settlement of the third party matter, the Fund must consent to the terms and conditions of the settlement. The Participant or dependent and the attorney must authorize such third party or its insurance company to pay the Fund directly out of the proceeds of any recovery, verdict, judgment or settlement, prior to the payment of any such proceeds to the Participant or dependent, their agent or attorney.

In addition to its subrogation rights, the Plan has the right to be reimbursed in full for payments made to you or on your behalf under these circumstances. The Plan must be reimbursed from any settlement, judgment, or other payment that you obtain from the liable third party, before any other expenses, including attorneys' fees, are taken out of the payment regardless of how you or the court characterize the nature of the recovery. Your attorney must agree that no attorney fees, expenses or costs of any kind will reduce the Fund's lien in this matter.

The Plan has no responsibility to contribute to the Payment of your attorneys' fees and costs with respect to any aspect of your representation including the third party action itself, the reimbursement action or any other matter.

The Trustees may, in their sole discretion, require the execution of this Plan's lien forms by you (or your authorized representative if you are a minor or if you cannot sign) before this Plan pays you any Benefits related to such expenses. If the Trustees have required execution of the Plan's lien forms, no Benefits will be provided unless you and your attorney (if any) sign the form. You must also notify the Plan before you retain another attorney or an additional attorney since that attorney must also execute the form

IN NO EVENT SHALL THE FAILURE OF THE TRUSTEES TO REQUIRE EXECUTION OF THE LIEN FORMS DIMINISH OR BE CONSIDERED A WAIVER OF THE PLAN'S RIGHTS OF SUBROGATION AND REIMBURSEMENT.

The Plan's Subrogation Agreement must be signed by you and your attorneys and received at the Fund Office on the earlier of either (1) one year from the date of your accident; or (2) thirty (30) days after the date of the letter from the Fund Office forwarding the Subrogation Agreement to be signed or no Benefits will be paid by the Plan for the expenses related to that accident.

You must also: (1) provide the Fund Office with quarterly reports regarding status of your third party claim or action including, but not limited to, motions, depositions, pretrial conferences, trial dates, settlement conferences, etc.; and (2) promptly respond to any inquiries from the Fund regarding the status of the third party claim or action including, but not limited to, motions, depositions, pretrial conferences, trial dates, settlement conferences, etc. Your duty to provide this information to the Plan is a continuing one.

Right of Future Subrogation and Reimbursement…

In addition to satisfaction of the existing lien from any recovery received by the Participant, spouse and/or dependent, the Fund is also entitled to a future credit for future related plan expenses equal to the net monies received by the Participant, spouse, and/or dependent. As such, the Participant, spouse, and/or dependent must spend the net recovery on related plan expenses until the amount of said net recovery is exhausted.

It is only at that point that the Participant's, spouse's, and/or dependent's further related plan benefits will again be the responsibility of the Fund pursuant to the terms of the Plan. The Fund will not resume payment of medical and related benefits until such time as you have provided the Fund with proof that you have utilized the net proceeds of the recovery and/or judgment to pay for medical and related expenses arising out of or related to the injuries which were the subject of the third party settlement or action. The Fund Office will determine the net monies available for a future credit.

Assignment of Claim…

You may not assign any rights or causes of action that you may have against any third-party tortfeasor without the express written consent of the Plan. The Trustees, in their sole discretion, may require you to assign your entire claim against the third party to this Plan. If this Plan recovers from the third party any amount in excess of the Benefits paid to you, plus the expenses incurred in making the recovery, then the excess will be paid to you.

Failure to Disclose and/or Cooperate…

If you fail to tell this Plan that you have a claim against a third party; if you fail to assign your claim against the third party to this Plan when required to do so (and to cooperate with the Fund's subsequent recovery efforts); if you fail to require any attorney you subsequently retain to sign the Fund's lien forms; if you and/or your attorneys fail to reimburse this Plan out of any payment you obtain from the third party; if you fail to provide the Plan with medical or other authorization to obtain the necessary information; if you or your attorneys fail to file written quarterly reports regarding your case with the Fund Office; and/or if you fail to fully reimburse the Fund (out of any settlement you receive, or otherwise, even if this Fund reduces the amount of its lien or otherwise limits it rights); then you are personally liable to this Plan for the reimbursement owed to this Plan by the third party as well as for the Plan's attorney's fees and costs incurred in recovering that amount. This Plan may offset the amount you owe from any future benefit claims, or, if necessary, take legal action against you. The reimbursement owed to the Plan shall also, in the Trustees' discretion, be considered an overpayment or mistaken payment and must be repaid as provided in the section of this Plan dealing with "Overpayments and Mistaken Payments." **The Board of Trustees has the sole discretion to determine whether you and your attorney have cooperated with the Fund's efforts to recover the entire amount of its lien.**

Automobile Insurance Claims...

If you or one of your eligible dependents are injured in a motor vehicle or motorcycle accident and you or they are covered by medical benefits through your automobile policy or another driver's insurance benefits, this Plan will pay last as a Reimbursement Plan. When such claims are covered by Personal Injury Protection (P.I.P.) the claim must be submitted to the P.I.P. carrier before any payments may be made by the Fund Office.

If a delay in payment occurs due to legal requirements, our Plan may reimburse you under the terms of a Subrogation Agreement for the claim as submitted and, if and when the claim is settled by your automobile insurance company or any other insurance company, reimbursement to our Plan will be required under the terms of the Subrogation Agreement.

RECIPROCITY AGREEMENTS

From time to time, Participants may be required to work outside the territorial jurisdiction of their home Local. When this occurs, they must work under the rules and regulations in effect in those areas and in many cases, payments to the Away Plan are reciprocated (transferred) to the Local 98 Health and Welfare Fund.

In order to facilitate the continuation of coverage to all participants, your Trustees have entered into Reciprocity Agreements covering other Locals.

Therefore, all the payments received on your behalf by the Funds covered under the Agreements, regardless of the different rates, will be returned to your home Fund and you will be credited with the contributions by the Plan in your home Local.

To guarantee your continued coverage by your home Plan, it is absolutely necessary that you notify the Fund Office when you are working outside the jurisdiction of Local 98 and file monthly work records. If you are in doubt as to where your fringe benefit payments are going or if there is a Reciprocity Agreement in the area you are working or intend to work, we urge you contact the Fund Office as soon as possible.

MEDICARE

Most persons 65 years of age or older are entitled to Medicare, a broad program of health benefits under the Social Security Act that provides Hospitalization Benefits (Part A) at no cost and Medical Benefits (Part B) and Prescription Drugs (Part D) on a voluntary basis.

Disabled persons of any age who have been receiving Social Security Disability Benefits for at least 24 months and anyone with chronic kidney disease which requires hemodialysis or kidney transplant, are entitled to Medicare Benefits prior to age sixty-five.

If you are still working for a contributing employer when you reach the age of 65 or your spouse reaches the age of sixty-five and becomes eligible for Medicare Benefits while you are so employed, you will continue to be eligible for all the Benefits under the Benefit Plan and under the Coordination of Benefits provision, you can apply to Medicare for reimbursement for any expense not paid by the Benefit Plan.

It is extremely important that every person enroll in Medicare Parts A and B during the three months before your 65th birthday to guarantee your coverage. Plan A is generally free, but there is a monthly charge for Part B that pays the fees of Physicians and Surgeons.

Part D is voluntary. There is a monthly charge for the prescription drug coverage. You should contact the Center for Medical Services (CMS) for more information.

Extension of Benefits...

All Participants who retire under the Pension Plan of Local 98 on or after age 62, are covered under the Health and Welfare Plan of Local 98 at the time of their retirement and pay the required monthly premium, will have certain of their benefits continued under a Pensioners Special Plan up to their sixty-fifth (65th) birthday. Coverage for the dependent spouse of the Participant will also be extended to the spouse's age 65 or for a maximum of ten (10) years, whichever comes first.

PENSIONERS SPECIAL PLAN

When the qualified Participant retires on or after age sixty-two (62) and was covered by the Plan at retirement, coverage for the participant and spouse will continue as follows: (1) until they each reach the age of sixty-five (65) or (2) for a maximum of ten (10) years, whichever comes first. Thereafter they become eligible for Medicare Benefits provided they pay the required monthly premium to Medicare.

First, the full Plan in effect at that time, excluding the Dental Benefit, Optical Benefit, Participants' Death Benefit, the Accidental Death Benefit, and the Dismemberment Benefit, will be available based on the hours accumulated in the immediate past year or months prior to his retirement but not to exceed eight (8) months.

On the first of the month following the above period, this self-pay coverage will continue under the Pensioner Special Plan until the participant and spouse both reach the age of sixty-five (65), however, no Death Benefit, Accidental Death Benefit, Dismemberment Benefit, Optical Benefit or Dental Benefit will be payable.

CLAIM REVIEW AND APPEALS PROCEDURE

FILING OF CLAIMS

Claims for the insured benefits should be filed in accordance with certificates/policies issued by the respective carrier. Self-Insured Vision Care claims that are not resolved at the point of service must be submitted within one year from the date of service to Davis Vision, Vision Care Processing Unit, P.O. Box 1525, Latham, NY 12110. Self-Insured Dental Care claims that are not resolved at the point of service must be submitted within one year from the date of service to Delta Dental, P.O. Box 9695, Boston, Massachusetts 02144. Claims for the Hearing Aid Benefit and Disability Benefit must be submitted to the Fund Office in accordance with the terms of this SPD.

The Trustees of this Plan, their designee or the insurance company providing benefits have the right and opportunity to examine any claimant when and as often as they may reasonably require. The claimant will furnish to the Trustees, their designee, or the insurance company providing benefits such information in writing as may be reasonably requested by them for the purpose of establishing, maintaining and administering the Plan. The failure on the part of the claimant to comply with such requests properly and in good faith will be sufficient grounds for delaying or denying the payment of benefits. The Trustees, their designee or the insurance company providing benefits will be the sole judge of the standard of proof required in any case and they may from time to time adopt or modify such formulas, methods and procedures as they consider advisable.

Claims for death benefits must include certified copies of the death certificate and only the beneficiary listed on file in the Fund Office will be eligible for the benefit. A Participant may change his beneficiary at any time, in writing, with the Fund Office.

As described below, if your claim for a benefit has been denied, you may appeal in writing for a review of that decision in accordance with the following procedures.

To the extent there is any conflict between the procedures in this SPD and the insurance policy or certificate for the benefit in question, the terms of that policy or certificate control. You should check the appropriate policy or certificate prior to filing any claim or appeal.

Claim Denial and Appeal

Initial Decisions

Time Frames

Insured Health Care Benefit and Dental, Optical and Hearing Aid Benefits

Note, for these health care claims, the rules that apply depend on the type of claim. There are four types of claims: Pre-Service, Urgent, Concurrent, and Post-Service. A Pre-Service

Claim is any claim with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. An Urgent Care Claim is a Pre-Service Claim for medical care or Treatment in which application of the time periods for making nonurgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or the Treatment that is the subject of the claim. A Concurrent Care Claim is a claim involving a pre-approved, ongoing course of Treatment, including a request for extension of a course of Treatment. A Post-Service Claim means any claim that is not a Pre-Service claim, i.e., prior Plan approval is not a prerequisite to obtaining medical care and payment is being requested for medical care already rendered to the claimant.

Post-Service Claims

In general, you will be notified of any adverse benefit determination by the insurance company (BCBSMA) for any insured benefits and by the Fund Office, or its designee, for any self-insured benefits 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 insurance company's or the Fund Office's control if, before the end of the initial 30-day period, the insurance company or the Fund Office, or its designee, notifies you of the reasons for the extension and of the date by which the insurance company or the Fund Office, or its designee, 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.

Pre-Service and Urgent Care Claims

For pre-service claims generally, you will be notified by BCBSMA (or the Fund Office, or its designee, if the claim involves the Dental, Optical or Hearing Aid Benefit) regarding the benefit determination (whether adverse or not) within a reasonable period, but not later than 15 days after receipt of the pre-service claim. The 15-day period may be extended for up to 15 days for matters beyond BCBSMA's (or the Fund Office, or its designee) control if, before the end of the initial 15-day period, you are notified of the reasons for the extension and of the date by which BCBSMA (or the Fund Office, or its designee) 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 the claimant will have 45 days from receipt of the notice to provide the specified information. A decision will then be made within 15 days after the earlier of the date you supply the requested information or the date by which you must provide the additional information. In addition, if the claim is improperly filed, BCBSMA (or the Fund Office, or its designee) will provide notice of the failure within 15 days.

For urgent care claims, you will be notified by BCBSMA (or the Fund Office, or its designee, if the claim involves the Dental, Optical or Hearing Aid Benefit) regarding the benefit

determination (whether adverse or not) as soon as possible, and not later than 72 hours after receipt, unless you fail to provide sufficient information to decide the claim. In the case of a failure to provide sufficient information or to follow filing procedures, you will be notified of the failure as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information needed to complete the claim. BCBSMA (or the Fund Office, or its designee) will then provide notification of the decision on that claim within 48 hours after receipt of the specified information or the end of the additional period afforded you provide such information.

Concurrent Care Claims

While other claims have certain deadlines throughout the claim and appeal process, there is no formal deadline to notify you of the reconsideration of a previously approved claim. However, you will be notified as soon as possible and in time to allow you to have an appeal decided before the benefit is reduced or terminated. If you request an extension of approved urgent care treatment, your request will be treated in the same manner as urgent care claims.

Disability Benefit

If your claim for a Disability Benefit is denied in whole or in part for any reason, then within 45 days after the Plan receives your claim, the Plan will send you written notice of its decision. This period may be extended for up to two 30-day periods due to matters beyond the control of the Plan. For any extensions, the Plan will provide advance written notice indicating the circumstances requiring the extension and the date by which the Plan expects to render a decision. Any notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues (if any), and you shall be afforded at least 45 days within which to provide specified information (if applicable).

Accidental Death and Dismemberment Benefit and Death Benefit

If your claim for Accidental Death and Dismemberment Benefits or Death Benefits is denied in whole or in part for any reason, then within 90 days after the Insurer receives your claim, the Insurer will send you written notice of its decision, unless special circumstances require an extension, in which case the Insurer will send you written notice of the decision no later than 180 days after the Insurer receives your claim. If an extension is necessary, you will be given written notice of the extension before the expiration of the initial 90-day period, which shall indicate the special circumstances requiring the extension of time and the date by which the Insurer expects to render the benefit determination. However, any decision regarding life insurance coverage that is based on a finding of total and permanent disability is subject to the same rules that apply to Disability Benefit claims.

Content of Notification of Initial Adverse Benefit Determination

Depending on the type of benefit involved with the claim, this notice will either come from the insurance carrier or the Fund Office (or its designee). The initial notification of adverse benefit determination shall include:

1. The specific reasons for the adverse determination;

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

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

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

5. In a case of an adverse determination involving a claim for urgent care, a description of the expedited review process applicable to such claims;

6. 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

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

For the Insured Health Care Benefit and Hearing Aid Benefit, the notice will also include the following:

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

2. The denial code, if applicable, and its corresponding meaning;

3. A statement of your right to request any diagnosis code, treatment code, and the corresponding meanings of those codes in connection with adverse benefit determinations. However, a request for this information will not be treated as a request for a voluntary appeal or external review;

4. A description of the plan's or issuer's standard that was used in denying the claim;

5. A detailed description of the available internal appeals and external review processes, including information regarding how to start an appeal; and

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

Further, for the Insured Health Care Benefit and Hearing Aid Benefit, additional internal appeal procedures include the following:

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

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

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

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

5. If any of the internal appeal rules are not followed, you may be deemed to have exhausted the internal claims and appeals process, and may initiate any available external review process or remedies available under ERISA or under State law unless the Plan's violation is: (a) de minimus, (b) non-prejudicial, (c) attributable to good cause or matters beyond the Plan's control, (d) in the context of an ongoing good-faith exchange of information, and (e) not reflective of a pattern or practice of non-compliance. You may request a written explanation of the violation and we will provide such explanation within 10 days, including, if applicable, a specific description of the basis for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted.

Appeals of Adverse Benefit Determinations

If you are not satisfied with the reason or reasons why your claim was denied, then you may appeal the initial adverse benefit determination. To appeal an insured benefit, you must follow the procedures set forth in the underlying insurance policy which may be obtained from the Fund Office upon request. (You must be given at least 180 days to file such appeal.)

To appeal an adverse benefit determination of any other benefit, you must write to the Trustees (or their designee--for Dental Benefits, appeals must be submitted to Delta Dental; for Optical Benefits, appeals must be submitted to Davis Vision) within 180 days after you receive this Plan's initial determination.

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

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

In addition: (1) the review will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination nor the subordinate of such individual; (2) insofar as the adverse benefit determination is based on medical judgment, the Board will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment; (3) such health care professional shall not be the individual, if any, who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; and (4) medical or vocational experts whose advice was obtained on behalf of the plan, without regard to whether the advice was relied upon in making the adverse benefit determination, will be identified.

Determinations on Appeal

Time Frames

Insured Benefits: Please note that appeals involving the insured portion of your benefits will be decided in accordance with ERISA regulations and the appeal procedures contained in the appropriate underlying insurance policy which may be obtained from the Fund Office upon request.

All Other Appeals: Except as described below, the Trustees at their next regularly scheduled meeting, or their designee, will make a determination on appeal. For appeals decided by the Trustees, 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 Trustees will notify you of the benefit determination not later than 5 days after the determination is made.

Pre-Service and Urgent Care Self-Insured Claims. Pre-Service claims, except for urgent care claims, are subject to a distinct appeal process. For most Pre-Service claims, the Trustees, or their designee, will notify you of the decision on appeal within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the request for review.

For urgent care claims, however, the Trustees, or their designee, will decide and communicate to you the decision concerning any appeals related to Pre-Service Claims taking into account medical exigencies, but not later than 72 hours after receipt of the request for review.

For Concurrent Care Claims: A determination will be made before termination of your benefit.

Content of Adverse Benefit Determination Notice on Review

Depending on the type of benefit involved with the claim, this notice will either come from the insurance carrier or the Trustees (or their designee). This notice will include the following:

1. The specific reasons for the adverse benefit determination;

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

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

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

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

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

In addition, for the Insured Health Care Benefit and Hearing Aid Benefit, the following information will be included:

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

2. The denial code, if applicable, and its corresponding meaning;

3. A statement of your right to request any diagnosis code, treatment code, and the corresponding meanings of those codes in connection with adverse benefit determinations. However, a request for this information will not be treated as a request for a voluntary appeal or external review;

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

5. A detailed description of the available internal appeals and external review processes, including information regarding how to start an appeal; and

6. The availability of, and the contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Public

Health Service Act section 2793 to assist enrollees with the internal claim and appeal processes and external review processes.

External Review

Insured Health Care Benefits

You should inquire with the insurance carrier for details regarding its external review program and your eligibility for the program.

Hearing Aid Benefit

You have the right to file for external review of an adverse benefit determination within 4 months after receipt of the notice of the adverse benefit determination denying your appeal.

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

The external review will be made by an independent review organization with health care professionals that have no conflict of interest with respect to the benefit determination. Except for approved expedited external reviews this external review is available once you have exhausted the internal appeal process.

You may make a request for an expedited external review at the time you receive:

An adverse benefit determination if the adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal;

or

A final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from the facility.

Any request for external review must be in writing and submitted to the Fund Office at Two Center Square, P.O. Box 217, East Longmeadow, MA 01028 within four months after receipt of the notice of the adverse benefit determination denying your appeal. Upon application and approval of the request for external review, the Fund Office will assign an independent review organization. Please do not hesitate to contact the Fund Office with any questions regarding external review.

The Trustees' Decision is Final and Binding

The Trustees' (or their designee's) final decision with respect to their review of your appeal, or, if you are eligible for, and pursue, External Review, the External Reviewer's final decision with respect to its review of your claim, will be final and binding upon you because they have exclusive authority and discretion to determine all questions of eligibility and entitlement under the plan. Any legal action against this plan must be started within 180 days from the date the adverse benefit determination denying your appeal is deposited in the mail to your last known address by the Trustees (or their designee) or, if you pursue External Review, by the External Reviewer; such action may only be started after all administrative procedures set forth in the Plan have been exhausted by the Participant.

Overpayments and Mistaken Payments…

In the event that a participant or a third party is paid benefits from the Fund in an improper amount or otherwise receives Plan assets not in compliance with the Plan (hereinafter overpayments or mistaken payments), the Fund has the right to start paying the correct benefit amount. In addition, the Trustees have the right to recover any overpayment or mistaken payment made to a claimant (you) or to a third party. The claimant, third party, or other individual or entity receiving the overpayment or mistaken payment must pay back the overpayment or mistaken payment to the Fund with interest at 12% per annum. Such a recovery may be made by reducing other benefit payments made to or on behalf of you or your spouse or dependents, by commencing a legal action or by such other methods as the Trustees, in their discretion, determine to be appropriate. The claimant, third party, or other individual or entity shall reimburse the Fund for attorneys' fees and paralegal fees, court costs, disbursements, and any expenses incurred by the Fund in attempting to collect and in collecting the overpayment or mistaken payment of benefits. The determination as to these matters is solely made by the Trustees.

STATEMENT OF COLLECTIVE BARGAINING AGREEMENT

The Health and Welfare Plan, (commonly called the Benefit Plan or Plan), is maintained pursuant to a Collective Bargaining Agreement. A copy of the Agreement may be obtained upon written request to the Trustees and is available for inspection at the Fund Office. Participants may receive from the Fund Office, upon written request, information as to whether a particular employer or employee organization participates in the Plan and if so, the address of the employer or employee organization.

The Plan is administered by a Board of Trustees comprised of equal representatives from Contractors Associations and representatives appointed by the Business Manager of Local Union 98.

Financing of the Plan is provided by Employer contributions based on an hourly rate negotiated by the Union and the Employer associations and interest earned from investments together with COBRA Premiums and other self-pay premiums authorized by the Trustees.

To the extent your Employer's obligation to tender contributions to the Fund ceases as a result of collective bargaining, please note the section entitled "Termination of Eligibility", that appears after the section entitled "Continuing Eligibility for Benefits" on page 5 of the Plan, regarding the impact of such cessation on your entitlement to benefits.

The Plan is and has been amended from time to time to update and improve the benefits based on the contributions and claims paid experience.

STATEMENT OF ERISA RIGHTS

As a participant in the International Union of Operating Engineers Local 98 Health and Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine without charge, at the Plan Administrator's Office or at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

Continue Group Health Plan Coverage

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

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lost 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 a 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 the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, 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 the 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, 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 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 after exhausting the Plan's internal claims procedures. 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, 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 575, 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 rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

The Department of Labor requires that this Summary Plan Description contain this description of your ERISA rights. Its inclusion in this Summary Plan Description is not, and should not be considered to be offered as legal advice of any kind. For legal advice, you should consult with a licensed attorney.

STATEMENT OF TRUSTEES RIGHT TO AMEND

The Trustees reserve the right to amend, modify or discontinue all or part of the Plan whenever, in their judgment, conditions so warrant.

DESIGNATION OF AGENT FOR SERVICE OF PROCESS

The Trustees have designated Michelle Schweitzer, Administrator, as their agent for service of legal process. Process may be served on Michelle Schweitzer at the Fund Office at:

Two Center Square, East Longmeadow, Massachusetts 01028

PLAN INTERPRETATION AND DETERMINATIONS

The Trustees are responsible for interpreting this Plan and for making determinations under the Health and Welfare Plan. In order to carry out this responsibility, the Trustees have exclusive authority and discretion to: determine whether an individual is eligible for any benefits from the Plan; to determine the amount of benefits, if any, an individual is entitled to from the Plan; to determine or find facts that are relevant to any claim for benefits from the Plan; interpret all of this booklets provisions; to interpret the provisions of any Collective Bargaining Agreement or written Participation Agreement involving or impacting this Plan; to interpret all the provisions of any other document or instrument involving or impacting this Plan; and to interpret all of the terms used in this Plan and in all other previously mentioned agreements, documents and instruments.

All interpretations and determinations made by the Trustees, or their designee shall be final and binding upon any individual claiming benefits under this Plan and upon all Employees, and all Employers, the Union, and any party who has executed any Agreement with the Trustees or the Union; will be given deference in all courts of law, to the greatest extent allowed by applicable law; and will not be overturned or set aside by any court of law unless the court finds that the Trustees, or their designee, abused their discretion in making such determination or rendering such interpretation.

COBRA CONTINUATION COVERAGE

COBRA Continuation Coverage

1. ***What is COBRA continuation coverage?***

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

2. ***Which employees are eligible for COBRA continuation coverage?***

For individuals covered by the Plan as employees, COBRA continuation coverage may be elected upon loss of coverage under the Plan due to voluntary or involuntary termination of employment (except for gross misconduct) or because the employee no longer meets the eligibility requirements of the Plan due to a reduction in hours worked, including a strike, walkout or layoff.

3. ***When is my spouse eligible for COBRA continuation coverage?***

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

1. Your death.

2. Your spouse's loss of coverage under the Plan due to voluntary or involuntary termination of your employment (except for gross misconduct) or because you no longer meet the eligibility requirements of the Plan due to a reduction in hours worked including a strike, walkout or layoff.

3. Divorce or judicial order of legal separation.

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

4. ***When does my dependent child become eligible for COBRA continuation coverage?***

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

1. Your death.

2. Your dependent child's loss of coverage under the Plan due to termination of your employment (for reasons other than gross misconduct) or because you no

longer meet the eligibility requirements of the Plan due to a reduction in hours worked including a strike, walkout or layoff.

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

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

5. The child ceases to qualify as an "eligible dependent" as described on page 7.

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

5. ***How is a person eligible for COBRA continuation coverage notified of his or her eligibility?***

Your employer has the obligation to notify the Fund Office of your death or your enrollment in Part A or Part B of Medicare. The Trustees have determined that because employees frequently work for more than one employer making contributions to the Plan and because of the difficulty which this causes employers in providing this notice, employment will be deemed to have terminated and/or the number of hours worked will be deemed to have been reduced when your regular group health care coverage terminates.

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

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

After the Fund Administrator receives notice of the occurrence of one of the above qualifying events, the Fund Administrator 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 Fund Administrator will notify eligible individuals of their COBRA rights within 14 days after receiving notice of the occurrence of one of the qualifying events described above or after it has determined that your regular group health care coverage has terminated.

6. ***When must the election be made?***

The employee, spouse and dependent children each have independent election rights. Covered employees may elect COBRA continuation coverage on behalf of their spouses and parents may elect COBRA continuation coverage on behalf of their children. Each individual will have at least 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 Fund Administrator that he or she wants COBRA continuation coverage. If no election of COBRA continuation coverage is made, the individual's group health coverage will terminate, except for any other extended coverage for which the individual may be eligible under the Plan. 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 is received by the Fund Administrator 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 is received by the Fund Administrator.

7. ***What type of benefits are available in 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. However, no life insurance (death benefits) or disability benefits or accidental death and dismemberment benefits or other non-health benefits will be included.

8. ***What are the consequences of failing to elect or waiving COBRA continuation coverage?***

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, 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. Please note that pursuant to the Affordable Care Act, for plan years starting on and after January 1, 2014, health plans will no longer be allowed to enforce pre-existing condition exclusions.

9. ***How long does COBRA continuation coverage last?***

If the election is due to termination of your employment or a reduction in hours worked, COBRA continuation coverage will end 18 months after your other coverage ended. However, if you, your spouse or one of your dependent children is determined by the Social Security Administration to be disabled on the day regular coverage terminates or within 60 days thereafter, the disabled person can receive a total of 29 months of COBRA continuation coverage. If you are the disabled person, your spouse and your dependent children also qualify for 29 months of this coverage. For all other situations, such coverage is available for 36 months. COBRA continuation coverage will end at an earlier time for any of the following reasons:

1. The employer no longer provides group health coverage.

2. Failure to pay the monthly premium on time.

3. The individual becomes covered under another group health plan (other than one sponsored by the employer) except for any period the other group health plan limits coverage of your pre-existing conditions.

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

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

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

10. ***What is the cost of COBRA continuation coverage and how is the cost computed?***

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 monthly premium will be based on the average cost which the Plan incurs annually per participant plus a two percent administrative charge. The extra 11 months of COBRA continuation coverage available to disabled participants are at a monthly charge based on one and one-half times the average annual per participant cost incurred by the Plan.

11. ***Is there anything else I should know 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 Fund Administrator.

There may also be alternative health insurance coverage options for you and your family other than purchasing COBRA coverage from this Plan. When key parts of the health care law took effect in 2014, you became able to buy coverage through the Health Insurance Marketplace. The Marketplace is designed to help people without employer sponsored coverage find health insurance that meets their needs and fits their budget. More information about the Health Insurance Marketplace generally is available at: HealthCare.gov. In considering whether coverage through the Marketplace is better for you than COBRA coverage, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away. Information about the Marketplace can help you 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 coverage for a tax credit through the Marketplace. In addition to the options available from the Marketplace, you may qualify for a special enrollment opportunity to obtain coverage from another group health plan for which you are eligible (such as a spouse's plan). Even if the other plan generally does not accept late enrollees, you may still qualify if you request enrollment within 30 days. If you would like more information regarding the Marketplace, you should contact the Health Benefit Exchange Marketplace in your state of residence.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website @ www.dol.gov/ebsa. (Addresses and telephone number of Regional and District EBSA Offices are available through EBSA's website).

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