OPERATING ENGINEERS LOCAL 57 HEALTH & WELFARE FUND

857 Central Avenue, Johnston, Rhode Island 02919

Telephone: (401) 331-9191 Fax: (401) 764-0015

Dear Member:

As a member of IUOE Local 57 your Health & Welfare Plan benefits are an important segment of your total compensation package.

The IUOE Local 57 Health and Welfare Plan was first established on December 1, 1953. Over the years, the Plan has been amended to increase benefits and comply with governmental regulations.

The Plan is maintained pursuant to collective bargaining agreement(s) between Participating Employers and the Labor Organization(s). The full cost of the Plan is paid for by the Participating Employers and those monies are invested in the fund to provide benefits to eligible members and pay fund expenses. As a member, you are not required or permitted to make contributions to the Plan.

This booklet describes the Plan as amended through July 1, 2012. It is a summary of the Plan's provisions. It provides answers to the most frequently asked questions and covers the important provisions to give you a good understanding of how the Plan operates. However, it is not intended to replace the official plan documents or explain every technical detail or aspect of the Plan. In the event of any contradictions between this booklet and the official plan documents, the official documents will govern.

Only the full Board of Trustees is authorized to interpret the plan of benefits described in this Summary Plan Description. No Employer or any Union, nor any representative of any Employer or Union, is authorized to interpret this Plan -- nor can such person act as an agent of the Board of Trustees.

The Trustees expect to continue this Plan indefinitely, but they reserve the right to amend or terminate the plan at any time, provided it is not in violation of a collective bargaining agreement already in effect.

Please read this booklet carefully and keep it with your important papers for future reference. If you have any questions about your benefits, your Union Trustee, Plan Administrator or the Plan Administrator will be happy to answer them for you.

Sincerely,

BOARD OF TRUSTEES

GENERAL INFORMATION

Plan Administrator / Plan Sponsor
Trustees of the I.U.O.E. Local 57 Health & Welfare Plan
857 Central Avenue, Johnston, Rhode Island 02919
Telephone: (401) 331-9191

The joint Board of Trustees, which administers the Plan, consists of two Union and two Employer representatives.

Employer Identification Number
05-0269242

Plan Number
501

Fiscal Year End Date
December 31

Type of Plan
The I.U.O.E. Local 57 Health & Welfare Plan is a welfare benefit plan.

Agent for Service of Legal Process
I.U.O.E. Local 57 Health & Welfare Fund
857 Central Avenue, Johnston, Rhode Island 02919
Telephone: (401) 331-9191

You may also serve legal process upon any of the Trustees

Trustees

Employer Trustees

Mr. Stephen A. Cardi
Cardi Corporation
400 Lincoln Avenue
Warwick, RI 02886

Michael D. D'Ambra
D'Ambra Construction
800 Jefferson Blvd
Warwick, RI 02886

Union Trustees

Mr. James J. White
IUOE Local 57
857 Central Avenue
Johnston, RI 02919

Mr. Timothy E. Quillen
IUOE Local 57
857 Central Avenue
Johnston, RI 02919

Labor Organization

I.U.O.E. Local 57
857 Central Avenue
Johnston, Rhode Island, 02919
Telephone: (401)-421-6678

A list of labor organizations covered under the Plan is available from the Plan Administrator upon written request, as is a list of names and addresses of employers who participate in the Plan.

Funding Medium

The Health & Welfare Fund is a separate trust fund for the purpose of paying the benefits provided under the Plan.

Benefits are provided from the Fund's assets which are accumulated under the provisions of the Collective Bargaining Agreements and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses.

Medical and dental benefits are underwritten by Blue Cross & Blue Shield of Rhode Island. Life insurance and accidental death and dismemberment benefits are underwritten by Union Labor Life Insurance Company.

The Fund's assets and reserves are presently invested in U. S. government securities in accordance with the guidelines of the Board of Trustees.

Source of Contributions

All contributions to the Plan are made by Employers in accordance with their collective bargaining agreements with the Labor Organization. The Collective Bargaining Agreements require contributions to the Plan at fixed rates per payroll hour.

Availability of Certain Documents

As a member, a copy of the collective bargaining agreement(s), plan documents, insurance contracts and documents filed with the Department of Labor are available for your inspection during business hours at the labor organization headquarters, 857 Central Avenue, Johnston, Rhode Island. You may also make a written request to receive a copy of these documents from the Plan Administrator.

No Liability for Practice of Medicine

The Plan, Plan Administrator or any of their designees are not engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, of any health care services provided or delivered to you by any health care provider. Neither the Plan, Plan Administrator, nor any of their designees, will have any liability whatsoever for any loss or injury caused to you by any health care provider by reason of negligence, by failure to provide care or treatment, or otherwise.

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ACTIVE PARTICIPANT- MEDICAL, DENTAL AND LIFE ELIGIBILITY

As an active Employee, you are eligible for insurance if you have worked a sufficient number of hours in Covered Employment. Covered Employment is any hours you have worked for a Participating Employer, which is an Employer who is required to contribute to the Health & Welfare Fund by the terms of a collective bargaining agreement with Operating Engineers Local 57.

Initial Eligibility

You will become eligible for insurance on the first day of an Insurance Period immediately following:

- the Eligibility Period in which you have accumulated at least 500 hours of Covered Employment
- or a 12-month period in which you have accumulated at least 1,000 hours of Covered Employment

An *Insurance Period* is a period of 6 consecutive calendar months commencing on the first day of any January or July.

An *Eligibility Period* is a period of 6 consecutive calendar months commencing on the first day of any January or July.

Continuation of Eligibility

Your insurance will continue during each Insurance Period if you have:

- at least 500 hours of Covered Employment in the last Eligibility Period
- **or** at least 1,000 hours of Covered Employment in the last 2 preceding Eligibility Periods.

Termination of Eligibility

Your active insurance will terminate on the last day of any Insurance Period if you do not have at least

- 500 hours of Covered Employment in the most recent Eligibility Period
- **or** if within the preceding 12-month period you do not have at least 1,000 hours of Covered Employment.

If you are employed by a Participating Employer in a job classification for which the Union is the collective bargaining agent and you move from the employ of one Participating Employer to that of another Participating Employer, your insurance will continue if you otherwise meet the rules for eligibility.

RETIRED PARTICIPANT- MEDICAL AND LIFE ELIGIBILITY

Eligibility

As a retiree you will be eligible for medical coverage and life insurance if you have worked the required number of hours in Covered Employment just prior to your retirement date and satisfy the other requirements described below.

- ***If you are age 65 or older on your retirement date*** from the Local 57 Pension Plan, you are Medicare eligible and not eligible for retiree medical insurance. You are eligible for life insurance if you:
  - were eligible for coverage (other than COBRA coverage) at any time during the 12 months immediately before your retirement date; and
  - worked at least 3,500 hours in Covered Employment during the 5 years immediately before your retirement date.
- ***If you are age 62, 63 or 64 on your retirement date*** from the Local 57 Pension Plan, you are eligible if you:
  - were eligible for coverage (other than COBRA coverage) at any time during the 12 months immediately before your retirement date; and
  - worked at least 3,500 hours in Covered Employment during the 5 years immediately before your retirement date.
- ***If you are age 60 or 61 and have 30 service credits on your retirement date*** from the Local 57 Pension Plan, you are eligible if you:
  - were eligible for coverage (other than COBRA coverage) at any time during the 6 months immediately before your retirement date; and

- worked at least 3,500 hours in Covered Employment during the 5 years immediately before your retirement date.

- ***Regardless of your age at retirement, if you retire on or after January 1, 1998 and you have 35 service credits on your retirement date*** from the Local 57 Pension Plan, you are eligible if you:
  - were eligible for coverage (other than COBRA coverage) at any time during the 6 months immediately before your retirement date; and
  - worked at least 3,500 hours in Covered Employment during the 5 years immediately before your retirement date.

If you qualify with 35 service credits, once you have exhausted active medical coverage, you will be eligible for retiree medical coverage for three years at no expense. Thereafter, you may continue coverage on either the retiree or the active medical insurance until the earlier of Medicare eligibility or age 65 by making a 25 percent co-payment of the monthly cost. The co-payment is due on the 15th of the month *preceding* the month of coverage. However, you will have a 30-day grace period from that due date to make the monthly payment. ***Note: Service credits earned in the hour bank are not counted toward eligibility for retiree medical coverage.***

Termination of Eligibility

Effective September 1, 2014, your medical insurance will terminate on the first of the month of your 65th birthday. Your spouse, if under age 65, will have the opportunity to purchase medical insurance at Local 57 group rates under the COBRA plan. The purchased COBRA coverage will continue until your spouse reaches age 65, or for 36 months, whichever comes first. The same right to purchase medical insurance under the COBRA plan applies for any other Eligible Dependent covered by your insurance.

If you should die prior to reaching age 65 while you are eligible for coverage, medical insurance for your Eligible Dependents will be continued by the Health & Welfare Fund for an additional 90 days after your death.

DEPENDENTS- MEDICAL AND DENTAL ELIGIBILITY

If you are eligible for medical and/or dental benefits your eligible dependents may qualify as well.

Eligible Dependents

- your legal spouse
- your dependent children to the child's 26th birthday
- your unmarried dependent handicapped children if handicap occurred before age 19 (through special application and medical certification)
- Legally adopted children, step-children and foster children permanently living with you will be considered Eligible Dependents, provide you provide the Plan Administrator with acceptable proof of their dependency status.

Eligibility for Dependents

Normally, coverage for your Eligible Dependent starts on the date your coverage starts or on the date you acquire an Eligible Dependent. However, if your Eligible Dependent is in the hospital on the date his coverage would normally start, coverage under this Plan will not start until the day after he has been finally discharged from the Hospital.

Termination of Eligibility

Dependent eligibility will terminate at the earlier of

- The participant eligibility terminates or
- The dependent no longer qualifies as eligible dependent

OTHER ELIGIBILITY INFORMATION

Change in Family Status

After your insurance becomes effective, it is necessary to notify the Plan Administrator of any change in your family status by reason of marriage, birth of a child, adoption of a child, death, divorce or legal separation. Failure to file the required information may delay payment of benefits, or you could be

required to refund all monies paid in error.

No Medical Examination or Age Restriction

No medical examination is required of any employee or dependent to secure this insurance, and all new employees who become eligible will be insured regardless of age.

Family and Medical Leave Act (FMLA)

Under this federal law, you may have a right to take up to 12 weeks of unpaid leave each year for your serious illness, after the birth or adoption of a child, or to care for your seriously ill spouse, parent or child. FMLA requires certain Employers to maintain health care coverage during the leave period. If you think that this law may apply to you, please contact your Employer or the Plan Administrator.

Military Service

If you go into active military service for up to 31 days, your medical and dental coverage will be continued during that leave period. If you go into active military service for more than 31 days, you may be able to continue your medical and dental coverage at your own expense for up to 18 months. Questions regarding your entitlement to this leave and to the continuation of medical and dental coverage should be referred to the Plan Administrator.

Qualified Medical Child Support Orders (QMCSOs)

A QMCSO is a court judgment, decree or order that creates or recognizes an alternative recipient-such as a child or stepchild-to be eligible for coverage under this Plan. The Plan must honor the terms of a QMCSO, provided it meets certain requirements. If the Plan receives an order which may be a QMCSO, the Plan Administrator will notify you (and all parties covered by the order), determine whether the order is QMCSO and, if it is, ensure that the alternative recipients are treated as beneficiaries under the Plan for ERISA reporting and disclosure. If you have any questions about QMCSOs, please contact the Plan Administrator.

COBRA CONTINUATION COVERAGE

You and your Eligible Dependents have the right to continue your medical coverage (and dental, if applicable) under this Plan on a self-pay basis, if coverage would otherwise terminate due to a qualifying event. This provision does not apply to Life Insurance, Accidental Death and Dismemberment. ***Qualifying event*** means one of the following occurrences which would otherwise terminate your or your Eligible Dependent's coverage in the absence of this provision:

- your loss of eligibility;
- your retirement;
- your death;
- your entitlement to Medicare;
- your divorce or legal separation;
- with respect to your Dependent child, his/her ceasing to satisfy the Plan's definition of an Eligible Dependent.

It is your or your Eligible Dependent's responsibility to notify the Plan Administrator, in writing, of any of the following qualifying events: your death, your divorce or legal separation, or your Dependent child's ceasing to satisfy the Plan's definition of an Eligible Dependent. You and/or your Eligible Dependents must provide such notification within 60 days after the later of:

- the date of the qualifying event; or
- the date your Eligible Dependent would otherwise lose coverage due to the qualifying event.

If the Plan does not receive written notice of any such event within that 60-day period, your Eligible Dependent(s) will not be eligible for COBRA continuation coverage.

Election Period

You and/or your Eligible Dependents may elect to continue coverage within 60 days of the later of:

- the date you and/or your Eligible Dependents would otherwise lose coverage due to the qualifying event; or
- the date you and/or your Eligible Dependents are notified of your right to elect the continuation coverage.

Such election must be in writing, on a form provided by the Plan Administrator. Elected benefits will be continued provided:

- the election form is duly completed and returned to the Plan Administrator within the 60-day period noted above; and
- the initial required premium is paid to the Plan Administrator within 45 days of your and/or your Eligible Dependent's election and is subsequently remitted to the Plan Administrator on a timely basis for your and/or your Eligible Dependent's behalf.

Continuation Period

Coverage may continue on a self-pay basis as follows:

A Coverage for you and/or your Eligible Dependents may be continued for up to 18 months,* if coverage terminated due to your:

- loss of eligibility; or
- retirement.

B Coverage for your Eligible Dependents may be continued for up to 36 months, if coverage terminated due to:

- your death;
- your entitlement to Medicare;
- divorce or legal separation; or
- with respect to your Dependent child, his ceasing to satisfy the Plan's definition of an Eligible Dependent.

C Coverage may be continued for up to 29 months if:

- you or any of your Dependents were totally disabled before your COBRA continuation coverage started or within the first 60 days of that coverage; and
- the disabled person is determined by the Social Security Administration to have been Totally Disabled within the 18-month COBRA continuation period; and
- the Plan Administrator is notified of that determination during the 18-month COBRA continuation period.

If your Dependent's coverage is continued for reasons listed under paragraph (A) of this section, and, during the initial Continuation Period, a Qualifying Event occurs which entitles the Dependent to continue coverage under paragraph (B) of this section, your Dependent may elect to continue coverage for up to a combined maximum of 36 months--in other words, the total period of coverage will never exceed 36 months from the date of the first qualifying event.

COBRA Premium

- The Trustees will set premium payments according to federal law, which allows the premium to cover the full cost to the Plan plus administrative expenses. If the cost changes, the Plan Administrator will revise the charge you are required to pay. In addition, if the benefits change for active Members, your coverage will change as well.
- You and/or your Eligible Dependent(s) who elect to continue coverage, will be solely responsible for the payment of the monthly premium for such continued coverage. If an election is made after the qualifying event, premium payment for continuation coverage during the period preceding the election must be made within 45 days of the date of the election. Thereafter, the premium may be paid

in monthly installments within 30 days after the first of the month in which coverage is provided.

UNDER NO CIRCUMSTANCES WILL THE OPTION TO MAKE SELF-PAYMENT TO THE HEALTH & WELFARE FUND BE PERMITTED ON A RETROACTIVE BASIS. PAYMENTS MUST BE MADE CONTINUOUSLY AND WITHOUT INTERRUPTION, FAILURE TO MAKE THE MONTHLY PAYMENT WHEN DUE WILL RESULT IN THE TERMINATION OF YOUR HEALTH COVERAGE. THE FUND INTENDS TO PROVIDE YOU WITH NOTIFICATION OF YOUR LOSS OF ACTIVE COVERAGE BY FIRST CLASS MAIL TO YOUR LAST ADDRESS ON FILE AT THE PLAN ADMINISTRATOR. THE FUND ASSUMES NO RESPONSIBILITY OR LIABILITY IF YOU ALLOW YOUR COVERAGE TO TERMINATE. IF YOU HAVE ANY REASON TO BELIEVE THAT YOUR ELIGIBILITY WILL OR HAS TERMINATED, IT IS YOUR RESPONSIBILITY TO CONTACT THE PLAN ADMINISTRATOR TO VERIFY YOUR ELIGIBILITY STATUS.YOU HAVE THE RIGHT TO ELECT SELF-PAYMENT ONLY FOR THE HEALTH COVERAGE (PLAN OF BENEFITS) YOU WERE COVERED UNDER PRIOR TO THE TERMINATION OF ELIGIBILITY.

Termination of COBRA Coverage

Coverage under COBRA will cease on the first of the following dates:

- the date the Plan terminates;
- the date the required premium is due and unpaid after the applicable grace period;
- the date you and/or your Dependents become eligible for Medicare; or
- the date the applicable period of continuation is exhausted; or
- the date you and/or your Eligible Dependents become insured under another group plan. Please contact the Plan Administrator for additional information, when you and/or your Eligible Dependents become insured under another group plan.

Full details of COBRA continuation coverage will be furnished to you or your Eligible Dependents, when the Plan Administrator receives notice that one of the qualifying events shown above has occurred. Therefore, we urge you and your Eligible Dependents to contact the Plan Administrator as soon as possible after one of those events.

MEDICAL PLAN BENEFITS -Active and Retirees and Dependents

IUOE Local 57 Health & Welfare medical coverage for Active and Retired employees is HealthMate Coast to Coast from Blue Cross Blue Shield of RI. A Benefit Summary and other medical coverage information can be found under Appendix A. A full description of coverage can be found in the Blue Cross Blue Shield Health Mate Coast to Coast Subscriber Agreement. A copy of the full agreement can be found at the Blue Cross of RI website BCBSRI.COM with other valuable information or by contacting the plan administrator. Medical Insurance includes the following:

- Blue Cross Blue Shield HealthMate Coast to Coast ($250 individual deductable)
- Prescription Drug Coverage (20% co-insurance)
- Prescription Eyewear ($100 max per member per year)

DENTAL PLAN BENEFITS -Active Employees and Dependents only

IUOE Local 57 Dental coverage for Active employees is Delta Dental PPO Plus Premier. A Benefit Summary and other dental coverage information can be found under Appendix B. Delta Dental Insurance includes the following:

- Annual Maximum $2000
- Orthodontic Lifetime Maximum $2000
- Implant Lifetime Maximum $3500
- Maximum Lifetime Cap unlimited

LIFE INSURANCE BENEFITS -Active and Retiree participants only

IUOE Local 57 Life coverage is covered by Union Labor Life Insurance Company. A Benefit Summary and other information can be found under Appendix C. If you die from any cause while you are insured, the proceeds, as shown below, will be paid to your beneficiary:

- Active Employees (who die on or after July 1, 2012) $40,000
- Retirees (who die on or after August 1, 2010) $ 5,000

Active employees who die on after July 1, 2012 have Accidental Death & Dismemberment coverage for up to $20,000.

COORDINATION OF BENEFITS WITH MEDICARE

Medicare Benefits at Age 65

If you are an Active Member and you or your Eligible Dependent are entitled to benefits under Medicare because of attainment of age 65, this Plan will be the primary Plan to Medicare.

Medicare Benefits Due to Total Disability

You or your Eligible Dependent may become entitled to Medicare benefits prior to age 65 due to total disability or end stage renal disease. The following rules apply with respect to coordination of benefits with Medicare due to total disability or end stage renal disease prior to age 65.

- *During Medicare Waiting Period* - This Plan will be a primary Plan to Medicare during any waiting period for Medicare benefits due to total disability or end stage renal disease.
- *After Medicare Waiting Period* - After the Medicare waiting period has been met, and you or your Eligible Dependent are entitled to Medicare benefits, this Plan will be:
  - a primary Plan to Medicare for an Active Member, or his or her Eligible Dependent, who is entitled to Medicare benefits due to total disability for other than end stage renal disease; and
  - a secondary Plan to Medicare for an Active Member, or his or her Eligible Dependent, who is entitled to Medicare benefits due to end stage renal disease.

Electing Medicare as Primary Plan

If you or your Dependent is entitled to Medicare benefits as a result of total disability, you or your Dependent may elect to have Medicare as the Primary Plan by giving notice to the Contributing Employer. If Medicare is elected as the primary Plan, health insurance under this Plan will cease."Medicare" means the medical benefits provided by Title XVIII of the Federal Social Security Act, as amended to date.

Retired Members and Their Eligible Dependents

Your benefits under the Retiree Health Benefits Program terminate at the earlier of age 65 or entitlement to Medicare. Therefore, if you fall into this category there would not be any coordination of benefits with Medicare as you would no longer be eligible for benefits.

RESTRICTIONS ON PAYMENT OF BENEFITS

Workers' Compensation

This Plan does not provide benefits if the medical or dental expenses are covered by workers' compensation or occupational disease law. If the employer contests the application of workers' compensation law for the illness or injury for which expenses are incurred, this Plan will pay benefits, subject to its right to recover those payments if and when it is determined that they are covered under a workers' compensation or occupational disease law. However, before such payment will be made, you and/or your Eligible Dependent must execute a subrogation and reimbursement agreement acceptable to the Plan Administrator.

Motor Vehicle Coverage

If you or your Eligible Dependent is involved in an automobile accident covered by a motor vehicle

insurance policy, the automobile insurance carrier will initially be liable for lost wages, medical, surgical, hospital, and related charges and expenses up to the greater of:

- the maximum amount of basic reparation benefit required by applicable law; or
- the maximum amount of the applicable insurance coverage in effect.

The Plan will, thereafter, consider any excess charges and expenses under the applicable provisions of the respective Plan in which you are provided coverage. Before related claims will be paid under this Plan, you and your Eligible Dependent will be required to sign a Reimbursement Agreement. If you or your Eligible Dependent fails to secure insurance or fails to have such insurance in force at the time of an accident, you and your Eligible Dependent will be considered as being self-insured and must pay the amount of the expenses for yourself and/or your Eligible Dependents arising out of any accident.

Reimbursement Agreements

The Plan does not cover, and the Fund is not liable for, any medical or dental expenses incurred by you or your Eligible Dependent, as a result of an accident or injury for which one or more third parties are or may be legally liable. The Trustees, however, may at their discretion pay some or all of your medical or dental expenses, even where a third-party liability may exist, provided that you and/or your Eligible Dependent sign a Reimbursement Agreement and Consent to Lien, before any payment is made. Where the Plan has made payments for an injury, irrespective of any signed, written agreement, the Plan will have a right to recover from you and/or your Eligible Dependent (the "claimant") the full amount of benefits paid, without deductions or adjustments of any kind, if the claimant obtains any settlement, judgment, arbitration, or recovery from a third party. In such event, the Plan must be promptly reimbursed in full, or the claimant will have additional liability for interest and all costs of collection, including reasonable attorney's fees. The Plan will have a priority lien against the proceeds of any such settlement, judgment, arbitration, or recovery to assure that reimbursement is promptly made. In the event you or your Eligible Dependent fail to reimburse the Plan from proceeds received from a third party, the Plan will also have the right to withhold future benefits equal to the amount otherwise due the Plan, plus interest, attorney fees, court costs, and any costs of collection, etc.

CLAIM FILING AND REVIEW PROCEDURES

Claim Filing Procedure

All claims must be filed in writing with the Plan Administrator within 90 days of their occurrence. A claim may be accepted beyond the 90-day filing period, if there are exceptional reasons for the failure to file the claim within the 90-day period.

Review Procedure if a Claim is Denied

- The Plan will notify you in writing if payment of your claim is denied in whole or in part. It will explain the reasons why, with reference to the Plan provisions on which the denial was based. When applicable, you will be told what additional information is required from you and why it is needed.
- You will be told what steps you make take to submit your claim for review and reconsideration. Your request for review or reconsideration must be made in writing to the office where the claim was originally submitted within 60 days after you receive notice of denial. The review process works as follows:
  - If your claim is denied, or if you disagree with the amount paid on a claim, you may ask for a review.
  - You have the right to review documents applicable to the denial and to submit your own
  - Comments in writing.
  - Your claim will be reviewed by the Board of Trustees. If any additional information is needed to process your request for review, it will be requested promptly.
  - The decision on any review of your claim will be given to you in writing. It will explain the reasons for the decision, with reference to the applicable provisions of the Plan.

Ordinarily, a decision will be reached within 90 days after receipt of your request for review. However, in special circumstances, up to an additional 60 days may be necessary to reach a final decision. You will be advised in writing within the 90 days after receipt of your request for review if an additional

period of time will be necessary to reach a final decision.

YOUR ERISA RIGHTS

As a Participant in the Operating Engineers Local 57 Health & Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Trustees' office and at other specified locations, such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U. S. Department of Labor, such as detailed annual reports and plan descriptions.
- Obtain copies of all plan documents and other plan information upon written request to the Trustees. The Trustees may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Trustees are required by law to furnish a copy of this summary annual report.

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

If your claim for a welfare benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial You have a right to have the Trustees review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you make written request for materials from the Trustees 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 Trustees to provide the materials and pay you up to $100.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Trustees. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

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, for example, if it finds your claim is frivolous.

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U. S. Labor-Management Services Administration, Department of Labor.