PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

FOR THE

A.F. OF L. - A.G.C. BUILDING

TRADES DEATH AND DISABILITY

BENEFITS PLAN

Effective January 1, 2003
Revised April 1, 2004
Revised January 1, 2008
Revised May 2, 2012
Revised April 1, 2018
Revised July 21, 2021

A.F. OF L. - A.G.C. BUILDING TRADES
DEATH AND DISABILITY PLAN

801 St. Francis Street
Mobile, AL 36602
(251) 438-4765
(800) 828-8922

BOARD OF TRUSTEES:

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BHA CONSULTING, LLC

July 21, 2021

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To All Employees:

We are pleased to provide you with the Summary Plan Description, which will describe for you the current Plan of Benefits to which you and your family may be entitled as a result of your eligibility in the A.F. of L. - A.G.C. Building Trades Death and Disability Benefits Plan.

This booklet is designed to familiarize you with the highlights of your Plan. It includes the benefits to which you and your family may be entitled; the method by which you may become eligible; and the procedures that you must follow in order to successfully file your claim for benefits. Therefore, you are strongly urged to read this booklet completely and to familiarize yourself with it.

If you have any questions about the Plan, please call or write the Plan office.

Sincerely,

BOARD OF TRUSTEES

TABLE OF CONTENTS

THE PLAN

The A.F. of L. - A.G.C. Building Trades Death and Disability Plan (the "Plan") provides limited disability benefits for employees and death benefits for eligible employees and eligible dependents. The Plan is funded by Employer contributions. In most instances, you are not required to pay contributions to the Plan for the benefits you receive.

PURPOSE OF PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

This summary is to help you understand your rights and benefits under the Plan. You should understand, however, that this document sets forth the complete terms of the Plan.

DEFINITIONS

Accident or Accidental Bodily Injury
The term "Accident or "Accidental Bodily Injury" as used herein shall mean a non-Occupational accidental bodily injury which requires treatment by a Physician. It must result in loss, while eligible under the Plan, independent of sickness and other causes.

Active Work
The term "Active Work" and "Actively at Work" as used herein shall mean the actual expenditure of time and energy by the Employee, performing each and every duty pertaining to his job in the place where and the manner in which such job is normally performed.

Appeals Committee
The term "Appeals Committee" as used herein shall mean the committee created for the purpose of reviewing those disability claims that were initially denied by the Plan and whose denial was properly appealed. The Appeals Committee shall consist of two Trustees, including one Employer Trustee and one Union Trustee, who do not participate in the initial review of the disability claim.

Benefit Quarters
The term "Benefit Quarters" as used herein shall mean the period of the Employee's eligibility for benefits, not the period in which he works to become or remain eligible.

Collective Bargaining Agreement
The term "Collective Bargaining Agreement" as used herein shall mean any collective bargaining agreement between an Employer and a Union, or any stipulation of agreement, and any extension, amendment, modification, renewal, or succession thereof which requires Employers to make payment to the Trust.

Covered Employment
The term "Covered Employment" as used herein shall mean employment for which an Employer is obligated to make contributions to the A.F. of L. - A.G.C. Building Trades Welfare Plan.

Disability or Disabled
The term "Disability" or "Disabled" as used herein shall mean that because of an injury or sickness the Employee is physically unable to perform the duties of his regular trade or occupation and requires regular treatment by a Physician.

Employee
The term "Employee" as used herein shall mean an/a:

Employee represented by a Union and working for an Employer as defined herein, and with respect to whose employment an Employer is required to make contributions into the Trust Fund, under a Collective Bargaining Agreement or other agreement between an Employer and a Union, and who has satisfied the requirements established by the Trustees.

Officer or salaried Employee of a Union, the Plan, or an Employer, who shall have been proposed for benefits, and agrees in writing to contribute to the Trust Fund for at least forty hours per week at the rate fixed for contributions by the Trustees.

Full-time Employee of the Training and/or Apprenticeship Fund of a Participating Union who shall be proposed and accepted for such benefits by the Trustees. For such Employees of the Training and/or Apprenticeship Fund, the Participating Fund shall be deemed to be an Employer, and shall contribute to the Trust Fund for at least forty hours per week at the rate fixed for contribution by the Trustees.

Employee, if any, of this Trust Fund who is not employed by an Employer as defined below, but who shall be proposed and accepted for such benefits by the Trustees. For such Employees of the Trust Fund, the Trustees shall be deemed to be an Employer, and shall contribute to the Trust Fund for at least forty hours per week at the rate fixed for contribution by the Trustees.

Person, represented by or under the jurisdiction of a Union, who shall be employed by a governmental unit or agency, and on whose behalf payment of contributions shall be made at the times and rate of payment equal to that paid by an Employer in accordance with a written agreement, ordinance or resolution, or a person who had been so employed and who is temporarily making self-payments under rules established by the Trustees.

Employer
The term "Employer" as used herein shall mean an/a:

Employer who is a member of or is represented in collective bargaining by the Gulf Coast Contractors Association and who is bound by a Collective Bargaining Agreement with a Union providing for the making of payments to the A.F. of L. - A.G.C. Welfare Plan with respect to Employees represented by the Unions.

Employer who is a member of or is represented in collective bargaining by the Gulf Coast Contractors Association, but who has duly executed, or may execute, or is bound by a Collective Bargaining Agreement with one of the Local Unions providing for the making of payments to the Trust Fund on behalf of Employees represented by the Unions.

Union, which for the purpose of making the required contributions into the Trust Fund, shall be considered as the Employer of the salaried officers and/or Employees of the Union, for whom the Union contributes to the Trust Fund.

Apprenticeship and/or Training Fund of a Participating Union, which for the purpose of making the required contributions into the Trust Fund, shall be considered as the Employer of the Full-time Employees for whom the Participating Fund contributes to the Trust Fund.

Employer who, while not generally recognizing the Union as the representative of its Employees, is bound to make contributions on behalf of certain of its Employees as agreed in writing with the Trustees.

Board of Trustees of the A.F. of L. - A.G.C. Building Trades Welfare Plan who, with the consent and approval of the Trustees, shall make like payments or contributions to the Trust Fund on behalf of the Employees of the Trust Fund.

Employer who is an original party to this Agreement and Declaration, or as described in this Section, shall by the making of payments to the Trust Fund pursuant to such collective bargaining or other written agreements, be deemed to have accepted and be bound by the Trust Agreement.

Employer Contributions
The term “Employer Contributions" as used herein shall mean payments required of any Employer by a Collective Bargaining Agreement or other such agreement to this Fund.

Initial Review Committee
The term “Initial Review Committee” as used herein shall mean the committee created for the purpose of determining if disability claims are covered by the Plan. The Initial Review Committee shall consist of those Trustees who do not serve on the Appeals Committee.

Participant
The term "Participant” as used herein shall mean any Employee or former Employee of an Employer who is or may become eligible to receive a benefit under this Plan. The term “Participant" shall not include any Employee or former Employee who has not been credited with the required number of hours of Covered Employment in a specified period, under the Eligibility Rules established by the Trustees as stated on page 10.

Physician
The term "Physician" as used herein shall mean an individual who is operating within the scope of his license and is licensed to prescribe and administer drugs or to perform surgery. Notwithstanding the foregoing, licensed chiropractors, licensed optometrists, and licensed ophthalmologists are included in the definition of a physician.

Qualifying Quarters
The term "Qualifying Quarters"' as used herein shall mean the three-month quarters of 1) September, October, and November; 2) December, January, and February; 3) March, April, and May; and 4) June, July, and August during which the Employee works the required hours in Covered Employment to be eligible for a Benefit Quarter.

Sickness
The term "Sickness" as used herein shall mean a non-occupational disease, disorder, or condition which requires treatment by a Physician. It includes both childbirth and pregnancy.

Trust Agreement
The term "Trust Agreement" as used herein shall mean the Declaration of Trust established in 1953 establishing the A.F. of L. - A.G.C. Building Trades Welfare Fund including all amendments and modifications as may be made from time to time.

Trustees
The term "Trustees" as used herein shall mean the Trustees designated in the Trust Agreement, together with their successors, designated and appointed in accordance with the terms of the Trust Agreement.

Trust Fund
The term “Trust", "Trust Fund", and “Fund” as used herein shall mean the entire trust estate of the A.F. of L. - A.G.C. Building Trades Welfare Plan as it may from time to time be constituted, including but not limited to all funds received in the form of contributions, together with all contracts (including dividends, interest, refunds, and other sums payable to the Trustees on account of such contracts), all investments made and held by the Trustees by reason of their acceptance of the Agreement and Declaration of Trust, for the uses and purposes of the Trust.

Union or Local Union
The term "Union" or “Local Union" as used herein shall mean one of the Local Unions affiliated with the Mobile-Pensacola Building and Construction Trades Council and their successors and assigns. The term shall include such other Union or Unions which have a Collective Bargaining Agreement with an Employer, where the Union and Employer may from time to time be accepted to participate and become party to the Trust Agreement under such terms and conditions as may be required by the Trustees.

Weekly Disability Benefits Plan
The term "Weekly Disability Benefits Plan" as used herein shall mean the Rules and Regulations governing the eligibility of Employees for the benefits to be provided, as the Plan may from time to time be amended.

ELIGIBILITY RULES

INITIAL ELIGIBILITY: NEW EMPLOYEES

Employees who are not eligible for benefits may become eligible as follows:

A new Employee will qualify for benefits on the first day of the Benefit Quarter immediately following the month in which he works four hundred eighty (480) hours in a four (4) consecutive month period or less. Eligibility will remain in effect until the end of such Quarterly Benefit Period as described below:

QUALIFYING PERIOD:	QUARTERLY BENEFIT PERIOD:
480 hours in any 4 or less consecutive months	1. January, February, March 2. April, May, June 3. July, August, September 4. October, November, December

CONTINUING ELIGIBILITY

Once you become initially eligible, your benefits will continue provided you have accumulated a total of 380 or more hours of Covered Employment within the Qualifying Quarter. Benefits will continue until the end of the benefit quarter.

TABLE OF CONTINUING QUALIFYING AND BENEFIT QUARTERS

380 hours worked during this QUALIFYING QUARTER	Provides benefits during this BENEFIT QUARTER
1. September, October, November	1. January, February, March
2. December, January, February	2. April, May, June
3. March, April, May	3. July, August, September
4. June, July, August	4. October, November, December

CUMULATIVE ELIGIBILTY: THE HOUR BANK

The purpose of the hour bank (bank hours) is to assist you in retaining your benefits during short periods of illness or seasonably low periods of employment provided you are actively at/or available for work with a Contributing Employer. After establishing initial eligibility, any hours of Covered Employment you work, in excess of 380 hours in a Qualifying Quarter, will be credited to your account in the Hour Bank. The maximum number of hours that you may accumulate in the Hour Bank at any one time is 840.

If you do not work at least 380 hours of Covered Employment in a Qualifying Quarter, the necessary number of hours will, if available in your hour bank, automatically be withdrawn to continue your coverage in the next Benefit Quarter after eligibility termination.

SELF PAY FOR CONTINUING ELIGIBILITY

If an Eligible Employee works at least one hundred (100) hours in a Qualifying Quarter he will be permitted to make Self Pay for the next Benefit Quarter. The amount of the Self Pay will be determined by subtracting his hours worked in the Qualifying Quarter including any bank hours from 380 hours. Each hour shall be paid at the current contribution rate. Initial Eligibility may not be established through Self Pay.

Payments are due by the tenth (10th) day of the first month of the Continuing Benefit Quarter during which coverage is being provided.

TERMINATION OF ELIGIBILITY

Your benefits will terminate on the last day of any Benefit Quarter if in the Qualifying Quarter you do not work at least 380 hours, supplemented by your reserve from the Hour Bank and/or utilization of the Self Pay Provision

REINSTATEMENT OF ELIGIBILITY

Your coverage will be reinstated for benefits as of the first day of any Benefit Quarter following a Qualifying Quarter in which you have accumulated 380 or more hours of Covered Employment. If, however, you have no eligible hours (including Self Pay hours) reported for a period of consecutive Qualifying Quarters, you will be required to again meet the Initial Eligibility requirements.

ELIGIBILITY AFTER MILITARY SERVICE

If you are eligible under the Plan at the time you enter military service, you will be reinstated as an Eligible Employee at the time of your application provided you apply for employment within 90 days of your discharge and present written proof of your term of service and your honorable discharge.

BENEFITS

The Plan provides only those benefits shown in the "Benefit Schedule". The Benefit Schedule, which is set out at the beginning of this booklet, shows the maximum benefits available under the Plan. You should carefully review the Benefit Schedule on page 13. Below is more detailed information concerning these benefits.

Disability Benefit

If you suffer a non-occupational accidental bodily injury, an illness, or another disability (including pregnancy, childbirth, and related medical conditions) that; (i) renders you physically unable to work in your regular trade or occupation, and (ii) requires regular treatment by a Physician (called a "disability period"), a Disability Benefit is available at the weekly amount and for the maximum number of weeks (“duration") shown in the Benefit Schedule. Daily benefits will be calculated based on a seven-day work week. The Plan requires you to furnish a Physician's certificate certifying that you are physically unable to work. If your disability period results from an accidental bodily injury, your Disability Benefit begins on the first work day lost. For any other disability period, the Disability Benefit begins on the eighth day after you become disabled. The Disability Benefit will be paid each week, not to exceed the maximum number of weeks for Disability Benefits in the Benefit Schedule. Successive disability periods related to the same disability will be treated as one disability period, unless you return to work with an Employer(s) and accumulate a total of at least one hundred (100) Credit Hours during four successive weeks prior to the second disability period.

The Plan does not provide a Disability Benefit if (i) the bodily injury, illness, or other disability is covered by the Worker’s Compensation or occupational disease laws of any state, or (ii) you are retired or otherwise not available for Active Work in your regular trade or occupation.

The Plan does not furnish Disability Benefits for Dependents.

BENEFIT SCHEDULE

EMPLOYEE:

Death Benefit	$5,000
Accidental Death & Dismemberment	$5,000
Disability Benefit (13 week maximum)	$250

DEPENDENTS:

Death Benefits:	Eligible Spouse:	$5,000
	Eligible Child:	$1,000

BENEFIT CLAIMS, REVIEW, AND PAYMENT

Claim for Benefits

A claim for benefits must be delivered or mailed to the Plan Office at 801 St. Francis Street, Mobile, Alabama 36602. The claim must be in writing on a form approved by the Plan. Upon receipt of your benefit claim, the Plan Administrator will review your claim and may require that you furnish additional information to support your claim. If the Plan Administrator denies your claim, in whole or in part, you are entitled to request the Trustees to review and decide your claim.

Disability Benefits for an Employee will be paid each week.

How to File Your Claims

When submitting a claim for weekly disability benefits, you should send a written claim for benefits to the Fund Office and attach proof of disability.

When to File a Claim

All claims must be filed within 90 days of the date you become disabled. If it is not reasonably possible to file your claim within this 90-day period because of the circumstances, the Plan may permit you to file your claim later provided however, that you do so as soon as is reasonably possible and in no event later than 12 months after the date you become disabled. Please be sure to file your claims timely, as any claim filed after the deadline will not be payable under the Plan.

Types of Claims

The following are the basic types of claims under the new rules that apply to your plan:

> Disability Benefits Claims: A Disability Benefits Claim is a claim for benefits that is conditioned on a determination of disability made by the Plan.
>
> Other Claims: This includes claims for benefits that are conditioned on a determination of disability made by a party other than the Plan for non-Plan purposes (such as a Social Security determination of total disability for purposes of Social Security benefits).

Initial Claims Review and Decision

All claims filed with the Plan will be reviewed anonymously to determine if they are covered by the Plan. Claims will first be reviewed by the Initial Review Committee who will review claims in accordance with the time limits provided herein.

The Plan will notify you of its initial decision within a reasonable period of time in accordance with the time frames shown in the following chart. The chart also indicates the time frames for

the Plan to obtain an extension of time or to request additional information if necessary, and for you to provide any requested information. For an extension of time involving a claim that is due to your failure to submit information necessary to decide the claim, the time frame for the Plan to respond will be suspended (or tolled) from the date the notice of extension is given to you until the date you respond or, if earlier, your deadline to respond (which must be at least 45 days).

THE LISTED ACTION MUST OCCUR WITHIN THESE TIME LIMITS	**Disability Benefits Claims and Other Claims**
For Plan to make initial claim Determination	Notification of denials only will be given no later than 45 days after filing for Disability Benefits Claims, and 90 days after filing for Other Claims
For Plan to obtain extension of time if necessary due to matters beyond Plan's control (notice of extension must be given before the end of initial response period)	For Disability Benefits Claims, 30 days, plus a second 30-day extension, if needed; for Other Claims, 90 days
For Plan to request *missing* information from claimant (measured from receipt of claim by Plan)	For Disability Benefits Claims, 45 days; for Other Claims, 90 days
For claimant to provide missing information *in* response to Plan request (must be within reasonable response time given by Plan and no shorter than the time noted)	For Disability Benefits Claims, 45 days; for Other Claims, 90 days

If a Claim is Denied

If your claim is denied in whole or part, the Plan will provide you with a written notice of determination which will include the following information:

1. The specific reason(s) for the determination;

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

3. A description of any additional information or material necessary to perfect your claim and the reasons why it is needed;

4. A copy of the Plan's Claims Review Procedure including the time periods to appeal the initial determination;

5. A statement of your right to bring a lawsuit under ERISA if benefits are denied after review; and

6. A statement that:

a. the claimant is entitled to receive, upon request, the entire claim file and other relevant documents;
b. details the internal rules, guidelines, protocols, standards, or other similar criteria of the Plan that were used in denying the claim, or a statement that none were used; and
c. contains a discussion of the basis for disagreeing with the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

Claims Review Procedure

Appealing a Denied Claim

If your claim is denied, reduced or terminated, or otherwise not fully paid, you have the right to have the initial decision reviewed by filing an appeal with the Plan in accordance with the time limits provide below. If you appeal the Plan's denial of your claim, your appeal will be reviewed anonymously by the Appeals Committee. The Appeals Committee will review all relevant written comments, documents, records, and other information relating to your claims.

You may request an opportunity to appear before the Appeals Committee in person or by an authorized representative (including an attorney, at your expense). If you authorize a representative to appear on your behalf, notification authorizing the representative must be given to the Fund Office at least seven (7) days prior to the meeting in which the appeal will be considered. If you do not request to appear before the Trustees, the Trustees will consider your appeal based on the written information already submitted.

A document, record, or information is considered relevant if it was relied on by the Plan in making the decision; was submitted, considered, or generated in the course of making the decision (regardless of whether it was relied on); demonstrates compliance with the claims processing procedures that ensure a consistent application of the Plan and that claims determinations are made in accordance with the Plan; or is a statement of Plan policy or guidance concerning a denied treatment option or benefit for the claimant's diagnosis (regardless of whether it was relied on).

You cannot pursue your claim in court by filing a lawsuit under ERISA unless and until you have exhausted this internal appeals process.

In order to appeal the initial decision, you must send a written request for appeal to the Fund Office within the following time periods:

1. Within 180 days after you receive a decision on a Disability Benefits Claim; and

2. Within 60 days after you receive a decision on Other Claims.

When you file your appeal, you should explain the reasons why you disagree with the initial decision on your claim. If you do not file a written request for appeal timely, the initial decision on your claim will be final.

If you make a timely appeal, you may submit written comments, documents, records, and other information relating to your claim. You may also review, or obtain free of charge copies of, all documents, records, and other information relevant to your claim, as well as the names of any medical or vocational experts whose advice was obtained by the Plan in connection with the initial determination, regardless of whether it was relied upon by the Plan. The consideration of your claim and appeal will take into account everything that you submit, even if it wasn't considered in the initial determination.

The following chart indicates the time limits for you to request an appeal of an initial decision on your claim, and for the Plan to make a determination on appeal and to obtain an extension of time in which to respond if necessary:

THE LISTED ACTION MUST OCCUR WITHIN THESE TIME LIMITS	**Post-Service Claims & Disability Benefits Claims**	**Other Claims**
For claimant to request appeal	180 days	60 days
For Plan to make determination on appeal	Next monthly Trustees' meeting after appeal filed or, if filed within 30 days of meeting, 2nd monthly meeting. Claimant to be notified within 5 days of Plan decision.	Next monthly Trustees' meeting after appeal filed or, if filed within 30 days of meeting, 2nd monthly meeting. Claimant to be notified within 5 days of Plan decision.
For Plan to obtain extension of time if needed due to special circumstances (notice of extension must be given prior to end of initial response period)	Plan may obtain an extension to 3rd monthly meeting. Claimant to be notified within 5 days of Plan decision.	Plan may obtain an extension to 3rd monthly meeting. Claimant to be notified within 5 days of Plan decision.

Except for Other Claims, the following requirements also apply to reviews on appeal:

1. No deference will be given to the initial determination;

2. The review will be conducted by the Appeals Committee, consisting of named fiduciaries of the Plan who did not make, and are not subordinates of the person who made, the initial determination;

3. If the initial determination is based in whole or part on medical judgment, including the determination of whether a treatment, drug, or other item is experimental or investigational, or not medically necessary or appropriate, the Appeals Committee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted, and is not a subordinate of any health care professional who was consulted, in connection with the initial determination; and

4. A decision denying benefits on appeal which is based on new or additional evidence, or rationales, not included when the benefit claim was denied at the claims stage will not be made without the claimant being given notice and a fair opportunity to respond.

Notification Requirements for Adverse Determination on Appeal

If your claim is denied in whole or part on appeal, the Plan will notify you of its adverse determination, which shall include the following:

1. The specific reasons for the determination, including a reference to the specific Plan provisions on which it is based;

2. A statement that you have the right, upon request, to examine and to receive copies, free of charge, of all documents, records, and other information relevant to your claim;

3. Information relating to any additional voluntary appeal or alternative dispute resolution options offered by the Plan;

4. A statement that you may bring a civil action suit under ERISA;

5. A statement that:

   a. details the internal rules, guidelines, protocols, standards, or other similar criteria of the Plan that were used in denying the claim, or a statement that none were used; and

   b. contains a discussion of the basis for disagreeing with the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

   and

6. If the determination is based on medical necessity, experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment or a statement that it is available to you at no cost upon request.

The determination made on review of your claim following an appeal shall be final and binding on all persons.

Time Limit on Legal Actions

In no event may you or your beneficiary or any other person on your behalf bring an action in court to recover benefits under the Plan unless you or such other person has first fully complied with and timely exhausted all of the requirements of the claims filing and claims review procedures under the Plan. Furthermore, in no event may legal action be brought later than one (1) year following a final determination of a claim under the Plan or, if and only if one (1) year is determined not to be reasonable under the circumstances, within a reasonable time following a final determination of your claim not to exceed, in any event, one year.

HIPAA PRIVACY AND SECURITY PRACTICES

Plan's Designation of Entity to Act on Its Behalf

The Plan has determined that it is a group health plan within the meaning of the HIPAA Privacy Rule, and the Plan designates Mr. Matthew J. Stringer, A.F. of L. -A.G.C. Building Trades Welfare Fund, Mobile, AL to take all actions required to be taken by the Plan in connection with the HIPAA Privacy Rule.

Definitions

All terms defined in the HIPAA Privacy Rule, shall have the meaning set forth therein. The following additional definitions apply to the provisions set forth in this Plan.

1. Plan means the A.F. of L.-A.G.C. Building Trades Welfare Plan.

2. Plan Documents means the Plan's governing documents and instruments (i.e., the documents under which the Plan was established and is maintained), including but not limited to this Plan Document.

Plan's Disclosure of Protected Health Information - Required Certification of Compliance

As provided below with respect to the Plan's disclosure summary health information, the Plan will (a) disclose PHI or (b) provide for or permit the disclosure of PHI by a health insurance issuer or HMO or PPO with respect to the Plan, consistent with the "504" provisions.

Permitted Disclosure of Protected Health Information by the Plan

The Plan and any business associate acting on behalf of the Plan, or any health issuer, HMO, or PPO servicing the Plan will disclose individual's PHI to the Plan Administrator only to carry out plan administration functions.

All disclosures of the PHI of the Plan's individuals by the Plan's business associate, health issuer, HMO, or PPO to the Plan Administrator will comply with the restrictions and requirements set forth in the "504" provisions.

The Plan and any business associate acting on behalf of the Plan may not permit a health issuer, HMO, or PPO to disclose individual's PHI for employment related actions and decisions, or in connection with any other benefit or employee benefit plan of the Employer.

The Plan will not use or further disclose individual's PHI other than as described in the Plan Documents and permitted by the "504" provisions.

The Plan will ensure that any agent(s), including a subcontractor, to whom it provides Participants' PHI received from the Plan or from the Plan's health insurance issuer or HMO, agrees to the restrictions and conditions that apply with respect to such PHI.

Disclosure of Protected Health Information to Individuals

The Plan will make the PHI of the Participant who is the subject of the PHI available to such Participant in accordance with 45 C.F.R. § 164.524.

The Plan will make Participants' PHI available for amendment and incorporate any amendments to Participants' PHI in accordance with 45 C.F.R. § 164.526.

The Plan will make and maintain an accounting so that it can make available those disclosures of Participants' PHI that it must account for in accordance with 45 C.F.R. § 164.528.

The Plan will make its internal practices, books, and records relating to the use and disclosure of Participants' PHI available to the U. S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule.

The Plan will, if feasible, return or destroy all Participants' PHI received in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the Plan will not retain copies of such PHI after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the Plan sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

The Plan will ensure that the required adequate separation, described below, is established and maintained.

Disclosures of Summary Health Information and Enrollment and Disenrollment lnformation

The Plan, health insurance issuer, HMO, or PPO with respect to the Plan may disclose summary health information as provided for in the "504" provisions for, including but not limited to, the purpose of:

1. Obtaining premium bids for providing health insurance coverage under the Plan; or

2. Modifying, amending, or terminating the Plan.

Disclosure of Plan Employees Permitted to Access Protected Health Information

In accordance with the "504" provisions, the Plan must disclose those individuals who may be given access to Participants' PHI. Administrative and clerical personnel in the Plan Administrator's office may receive Participants' PHI relating to payment under health care operations, or other matters pertaining to plan administration functions of the Plan.

The individuals will have access to Participants' PHI solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions, including termination of employment or affiliation with the Employer for any use or disclosure of Participants' PHI in violation of, or noncompliance with, the provisions of the Privacy Rule.

The Plan will take immediate action to correct any violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.

HIPAA NOTICE OF PRIVACY PRACTICES

Effective March 23, 2013

Plan's Designation of Entity to Act on Its Behalf

The Plan has determined that it is a group health plan within the meaning of the HIPAA Privacy Rule, and the Plan designates Mr. Matthew J. Stringer, A.F. of L. -A.G.C. Building Trades, Mobile, AL as the Privacy Official to take all actions required to be taken by the Plan in connection with the HIPAA Privacy Rule.

Matthew J Stringer
AF of L - AGC Building Trades Welfare & Pension Plans
801 Saint Francis St
Mobile, AL 36602
(251) 438-4765
mattstringer@afl-agc.com

Purpose of this Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.

We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.

We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

You can ask us not to use or share certain health information for our operations.

Get a list of those with whom we've shared information

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

You can complain if you feel we have violated your rights by contacting the Plan's Privacy Official.
You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

Share information with your family, close friends, or others involved in your claim for benefits

Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we *never* share your information unless you give us written permission:

Marketing purposes

Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways:

Help administer the Plan and your claim for benefits

We can obtain your health information and discuss it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can make a determination about your eligibility for benefits.

Run our organization

We can use and disclose your information to run our organization and contact you when necessary.

We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to process our claim for benefits and determine eligibility.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

Preventing disease
Helping with product recalls
Reporting adverse reactions to medications
Reporting suspected abuse, neglect, or domestic violence
Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

We can share health information about you with organ procurement organizations.
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

For workers' compensation claims
For law enforcement purposes or with a law enforcement official
with health oversight agencies for activities authorized by law
For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information.

We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

We must follow the duties and privacy practices described in this notice and give you a copy of it.

We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request.

IMPORTANT INFORMATION ABOUT THE PLAN

1. Name of Plan.

This Plan is known as the A.F. of L.-A.G.C. Building Trades Disability Benefits Plan.

2. Plan Type.

This Plan is a welfare benefit plan which is maintained for the purpose of providing compensation in the event of disability. You may refer to the Benefit Schedule.

3. Board of Trustees.

A Board of Trustees is responsible for the operation of the Plan. The Board of Trustees consists of Employer and Employee representatives, selected by the Employers and the unions who have entered into collective bargaining agreements which relate to the Plan. The day-to-day administration is handled by the Board of Trustees.

The Plan Trustees are:

UNION TRUSTEES:

Allen Steadham
801 Springhill Avenue
Mobile, AL 36602

Tim Miller
7920 Crary Station Road
Semmes, AL 36575

Wayne Jennings
201 Oporto Madrid Blvd. North
Birmingham, AL 35206

Bart Maddox
2828 4th Ave S
Birmingham, AL 35233

EMPLOYER TRUSTEES:

Allan Smith
P.O. Box 380217
Birmingham, AL 380217

Adam Brooks
3225 Pasadena Blvd.
Pasadena, TX 77503

Lee Bailey
P.O. Box 1460
Tuscaloosa, AL 35403

Lloyd Hicks
100 Commerce Dr.
Pelham, AL 35124

Gavin Redbone
P. o. Box 5563
Birmingham, AL 35207

4. Plan Sponsor and Administrator.

The Board of Trustees is both the Plan Sponsor and the Plan Administrator.

5. Identification Numbers.

The Plan number assigned to this Plan by the Board of Trustees pursuant to instruction of the Internal Revenue Service is 001.

6. Agent for Service of Legal Process.

The Board of Trustees is the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise any legal documents should be served upon any individual Trustee at the address of the Board of Trustees, 801 St. Francis St., Mobile, AL 36602.

7. Collective Bargaining Agreements.

This Plan is maintained pursuant to Collective Bargaining Agreements with the Local Unions and Employers in the industry.

8. Source of Contributions.

The benefits described in this Plan Booklet are provided through Employer contributions. The amount of Employer contributions and the Employees on whose behalf contributions are made are determined by the provisions of the collective bargaining or other agreement.

9. Organizations Accumulating Fund Assets.

Investment and management of the Fund's assets and reserves is done under the direction of the Board of Trustees. Pursuant to the authority granted by ERISA to the Board of Trustees, the Board may delegate certain investment responsibilities to registered investment advisors.

10. Plan Year.

The records of the Plan are kept separately for each Plan year. The Plan year begins the 1st of July of each year and ends on June 30 of the following year.

CHANGE OR DISCONTINUANCE OF THE PLAN

At any time and without prior notice to you, the Trustees may make such changes in benefits as the Trustees deem necessary to achieve the Plan's purpose. Such changes may include an increase or decrease in benefits, the elimination or modification of an existing benefit, or the addition of a new booklet.

Insofar as the future can be anticipated, every effort has been made to design and maintain the Plan to safeguard your interests and to meet future conditions. Although the Trustees anticipate that the Plan will continue indefinitely, the Trustees necessarily reserve the right to change, modify, or discontinue the Plan entirely.

STATEMENT OF YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

As a participant of the A.F. of L. - A.G.C. Building Trades Disability Benefits Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all Plan participants shall be entitled to:

> Examine, without charge, at the Fund Office, all Plan documents, including annual reports, 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. Examination of these documents may be made at the Fund Office during normal business hours provided you have given reasonable prior written notice and specified what materials you wish to inspect. This procedure permits the Fund Office to process your request and have the requested information available when you arrive.
>
> Obtain, at a reasonable charge, copies of all Plan documents upon written request to the Administrative Manager. The Manager may make a reasonable charge for the copies.
>
> Receive, each year, a summary of the Plan's annual financial report. The Administrative Manager is required by law to furnish each Participant with 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 Employee Benefit Plan. The people who operate your Plan, called the "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or from exercising your rights under ERISA. If your claim for a benefit is denied in whole or part, you must receive a written explanation of the reason for denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights, for instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a Federal court. Of course, before taking such action you will want to check the Fund Office to make sure that your request was received and the materials mailed to the correct address. If you are still unable to get the information you want, you may wish to take legal action. 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 control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in State or Federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S.

Department of Labor, or you may file suit in Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds you claim is frivolous. 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, you should contact the Plan Administrator or the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, whose information can be found on the internet or in a telephone directory, or the Division of Technical Assistance and Inquiries, at Employee Benefits Security Administration, US Department of Labor, 200 Constitution Ave, NW, Washington, DC 20210.

This Plan Document and Summary Plan Description outlines the principal Plan features and it describes all rights and benefits under the Plan. Once again, the Plan does not necessarily provide all benefits you may want or need. You should carefully read this booklet, so you are familiar with the benefits that are available under the Plan.