SUMMARY PLAN DESCRIPTION

OF THE

I.A.T.S.E. LOCAL NO. 6 PROFIT SHARING PLAN

Amended and Restated
Generally Effective as of September 1, 2020

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ABOUT THIS BOOKLET

You should read this booklet carefully. It explains the benefits available to you through the I.A.T.S.E. Local No. 6 Profit Sharing Plan (the "Plan") generally effective as of September 1, 2020. This Summary Plan Description is meant to summarize the Plan in easy-to-understand language. If anything in this Summary Plan Description is not clear to you, please contact the Plan Administrator identified at the end of this Summary Plan Description.

Portions of this Summary Plan Description may be revised from time to time through a "Summary of Material Modification". We recommend that you keep any Summaries of Material Modification and any other notices related to the Plan with this Summary Plan Description. That way, you will be sure to have all of your important Plan papers related to the Plan in once place.

Please keep in mind that the formal terms of the Plan are not changed by this Summary Plan Description, any Summaries of Material Modification and/or any other Plan notices. To the extent that any of the information contained in this Summary Plan Description, any Summary of Material Modification, or any other Plan notice is inconsistent with the Plan's provisions, the Plan's Trust, or applicable collective bargaining, participation or other agreements (collectively "official Plan documents"), the official Plan documents will govern in all cases.

When this Summary Plan Description uses the term "Plan Sponsor", it is referring to the Joint Board of Trustees of the I.A.T.S.E. Local No. 6 Profit Sharing Plan, which sponsors the Plan. When this Summary Plan Description uses the term "Employer", it is referring to your employer. You can obtain from the Plan Administrator, upon written request, information about whether a particular employer is a participating employer in the Plan and, if the employer is a participating employer in the Plan, the participating employer's address.

Please note that the Plan Sponsor reserves the right to change or end the Plan (or any of its benefits) at any time in its sole and absolute discretion as permitted by applicable law. The existence of the Plan is not an offer or contract of employment, nor does it limit your Employer's ability to end your employment.

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ELIGIBILITY

As an employee who is represented by I.A.T.S.E. Local No. 6 (the "Union"), you are eligible to participate in the Plan, provided the terms of the collective bargaining agreement (or other agreement) between the Union and your employer (the "Employer") governing your employment provides for your participation. In addition, common law employees of the Union may also be eligible to participate in the Plan under the terms of the adoption or participation agreement executed by the Union. The Union is considered the "Employer" for employees of the Union who are eligible to participate in the Plan.

Subject to the following paragraph, you will become a participant in the Plan on the date you become an eligible employee under (1) the applicable collective bargaining agreement or (2) the participation or adoption agreement that the Union executed, if you are an employee of the Union who is eligible to participate in the Plan.

As of September 1, 2020 (i.e., the effective date of this Summary), no eligible employees are required to complete a Year of Service to participate in the Plan. However, in the future, it is possible that an agreement with an Employer providing for eligible employees' participation in the Plan could require that an eligible employee reach a certain age (not older than 21) and/or be credited with a certain amount of service (not more than one Year of Service) in order to participate in the Plan. In that case, the eligible employee would become a participant in the Plan no later than the date on which the eligible employee both attains age 21 and is credited with one Year of Service for eligibility purposes. A "Year of Service" for eligibility purposes is defined as a 12-month period in which the employee is credited with at least 1,000 Hours of Service by the Employer. The 12-month period starts on the employee's first day of employment with the Employer. If the employee is not credited with at least 1,000 Hours of Service by the Employer during the employee's first employment year, then, after the first employment year, the Plan will measure the employee's eligibility to participate in the Plan on a calendar year basis.

Rehired Employees

If you terminate employment after becoming a participant in the Plan and later return to employment, you will become a participant immediately upon your reemployment. Also, if you terminate employment after satisfying the Plan's eligibility conditions but before actually becoming a participant in the Plan, you will become a participant in the Plan immediately if you return to employment. If you terminate employment before satisfying an eligibility condition and later return to employment, you must satisfy the eligibility condition before you are eligible to participate in the Plan.

SERVICE

The Plan and this Summary Plan Description include references to "Hours of Service". You will earn an "Hour of Service" for each hour for which you receive or are entitled to receive payment from the Employer for the performance of services for the Employer. In addition, you will earn an "Hour of Service" for regularly scheduled working hours during each period of absence from work for which you are paid, or are entitled to payment, for reasons other than the performance of duties, such as vacation, holiday, illness, jury duty, incapacity (including disability), leave of absence, military duty or layoff, but you will not be credited with more than 501 "Hours of Service" for any single period of absence.

If you are absent from employment due to maternity or paternity leave, you will receive credit for unpaid hours of service related to your leave, not to exceed 501 hours. The Plan Administrator will credit these hours of service to the first period during which you otherwise would incur a one year Break in Service (a Plan Year in which you are not credited with more than 500 Hours of Service) as a result of the unpaid absence. An absence for maternity or paternity leave means an absence because of (1) your pregnancy, (2) the birth of your child, (3) placement of a child with you for adoption, or (4) your caring for a child for a period beginning immediately following birth or placement for adoption.

If you are absent from employment with the Employer because of military service, you may receive credit under the Plan for your military service. You will be provided with a written explanation of the effect under the Plan of your absence from employment with the Employer resulting from military service.

EMPLOYER CONTRIBUTIONS

Your Employer will make a contribution on your behalf to your Plan account equal to a uniform percentage of your compensation during the Plan Year. The amount of the contribution will be determined under the terms of the applicable collective bargaining agreement then in effect. This is true unless your Employer is the Union, in which case the amount of the contribution will be determined under the terms of the participation or adoption agreement executed by the Union.

TOP-HEAVY PLAN

A retirement plan that primarily benefits "key employees" is called a "top heavy plan." Key employees are certain owners or officers of your Employer. A plan is generally a "top heavy plan" when more than 60% of the plan assets are attributable to key employees. If these rules apply, the Plan Administrator is responsible for determining whether the Plan is a "top heavy plan" each year.

If the Plan becomes top heavy in any Plan Year, then non-key employees may be entitled to certain "top heavy minimum benefits," and other special rules will apply. These top heavy rules include the following:

- Your Employer may be required to make a contribution on your behalf in order to provide you with at least "top heavy minimum benefits."

- If you are a participant in more than one Plan, you may not be entitled to "top heavy minimum benefits" under both Plans.

COMPENSATION

For purposes of determining the allocation of any Employer contributions, "compensation" means your W-2 wages. Compensation includes elective deferrals that are not currently includible in your gross income under a cafeteria plan, a 401(k) plan, a 457(b) plan, a simplified employee pension plan, a tax sheltered annuity under Code section 403(b), or a qualified transportation fringe benefit program. In addition, note that Compensation generally does not include amounts paid to you following termination of employment.

If you become a participant during the Plan Year, the Plan will only count the Compensation that you earned during the portion of the Plan Year in which you were actually a participant in the Plan. In addition, the amount of annual compensation that can be taken into account for purposes of the Plan cannot exceed an Internal Revenue Code limit (the limit is $285,000 for 2020 and is subject to cost of living adjustments in future years).

LIMITATIONS ON CONTRIBUTIONS

The Internal Revenue Code includes various limits that apply to contributions which may be made to the Plan on behalf of any one participant. For example, the law limits the amount of "additions" (other than trust earnings) which the Plan may allocate on your behalf under the Plan. Your additions may never exceed 100% of your compensation for a particular Plan Year, but may be less if 100% of your compensation exceeds a dollar amount announced by the Internal Revenue Service each year ($57,000 for 2020). The Plan may need to reduce this limitation if you participate (or have participated) in any other plans maintained by the Employer.

No contributions may be made to the Plan which exceed any of the limits imposed by the Plan or by the Internal Revenue Code.

INVESTMENT OF CONTRIBUTIONS

The contributions made to the Plan are deposited in your Plan account and invested in one or more of the investment vehicles available under the Plan.

You are entitled to direct the manner in which your Plan account is invested by selecting, in accordance with guidelines established by the Plan Administrator, among investment alternatives designated by the Plan Administrator. The Plan Administrator will follow any properly submitted investment direction elections. If you do not provide proper investment election choices to the Plan Administrator, you will be deemed to have elected investment in a default investment option determined by the Plan Administrator, in accordance with applicable law. You will be given the opportunity to obtain written confirmations of your investment instructions.

> Important Note: The Plan's participant direction of investment feature is intended to satisfy the requirements of section 404(c) of the Employee Retirement Income Security Act of

1974. The effect of this status is twofold. First, you will not be deemed a "fiduciary" by virtue of your exercise of investment discretion. Second, no person who otherwise is a fiduciary (for example, the Plan Administrator) is liable under the fiduciary responsibility provisions of Employee Retirement Income Security Act of 1974 for any loss which results from your exercise of control over the assets in your Plan account.

The Plan Administrator (or its designee) will designate in writing to each participant (and each former participant or applicable death benefit beneficiary with a vested Plan account) the investment alternatives available under the Plan. There will be at least three investment alternatives having materially different risk and return characteristics. You will be permitted to elect to have your Plan account, or a portion thereof, invested in one or more of these investment alternatives. Your elections, and changes in your elections, will be permitted to be made on any business day (subject to any rules established by an entity serving as a manager of any of the investment funds). Elections, and changes in elections, shall be given effect as soon as administratively feasible.

If you make a written request for confirmation of your investment instructions, written confirmation will be provided. In addition, if you direct the Plan Administrator to set up the initial investments for your Plan account(s), written confirmation of your initial investment instructions will be provided to you. Once written confirmation has been provided to you, it is your responsibility to review the written confirmation to be certain that your Plan account has been invested as you have directed. If there are discrepancies between the written confirmation provided to you and your investment instructions, you must notify the Plan Administrator immediately. The Plan Administrator is not responsible for any losses resulting from failing to carry out your investment instructions if you have received written confirmation indicating the investments in which your Plan account(s) were actually invested, even if the written confirmation does not correspond with your investment instructions.

The Plan Administrator (or its designee) will send to participants, former participants and applicable death benefit beneficiaries from time to time information relating to the investment alternatives available under the Plan, including short summaries of each designated investment option, with a general description of investment objectives and risk and return characteristics of each option. You also will receive information relating to the type and diversification of assets comprising the portfolios of each designated option. In addition, you will receive descriptions of transaction fees and expenses, if any, that affect your account balance in connection with the purchase and sale of investment alternatives available under the Plan.

Also, the following information, based on the latest information available to the Plan, will be available to you upon written request to the Plan Administrator:

-A description of the annual operating expenses of each designated investment alternative which reduce the rate of return to participants and the aggregate amount of such expenses expressed as a percentage of average net assets of the alternative.

-Copies of any prospectuses, financial statements, reports and other materials relating to the Plan's investment alternatives to the extent such information and materials are made available to the Plan Administrator or Trustees.

-The name of the issuer of any fixed rate option, its term and its rate of return.

-Information concerning the value of shares or units in designated investment alternatives, as well as the past and current performance of such alternatives, determined, net of expenses, on a reasonable and consistent basis and information concerning the value of shares or units in designated investment alternatives held in the participant's account.

-A list of assets comprising the portfolio of each designated investment option which constitutes Plan assets.

If you have any questions concerning the Plan's investment options, contact the Plan Administrator.

ADMINISTRATIVE CHARGES

The Plan generally will pay Plan administration expenses using forfeitures and/or by assessing the expense against participants' accounts. The Plan also may assess to an individual participant's account certain expenses incurred by, or attributable to, an individual participant.

The Plan Administrator (or its designee) will provide to you:

1. an explanation of any fees and expenses for general plan administrative services (e.g., legal, accounting, recordkeeping) which may be charged against your account and the method by which the charge will be allocated to (e.g., pro rata, per capita), or affect the balance of, your account, and

2. an explanation of any fees and expenses that may be charged against your account on an individual basis (e.g., fees related to plan loans, QDROs, hardship distributions, investment advice, brokerage windows, redemption fees, transfer fees and similar expenses).

Actual fees and expenses that are charged to your account will be reported to you on a quarterly basis.

The Plan Administrator, from time to time, may change the manner in which the Plan allocates expenses. The Plan Administrator also may, from time to time, change the type of expenses the Plan will assess against an individual participant's account. You will be notified of any changes at least 30 days prior to the effective date of the change (unless there is an unforeseeable circumstance beyond the control of the Plan Administrator).

VESTING OF ACCOUNTS

You are always 100% vested in any rollover contributions you make to the Plan and in any Employer contributions, and the earnings thereon. This means that you do not have to satisfy any further conditions in order to protect your right to these amounts.

DISTRIBUTION FOLLOWING TERMINATION OF EMPLOYMENT OR AT AGE 65

The amount which you will receive from the Plan when you become entitled to a distribution is the value of your Plan account. The value of your Plan account is determined by the Plan Administrator.

You are eligible for a distribution of your Plan account following your termination of employment with the Employer. For this purpose, you will be considered to have had a "termination of employment" if you have not been employed for a period of at least 8 months by any participating employer in the Plan.

You are also eligible for a distribution from the Plan when you reach age 65 (even if you have not had a termination of employment).

Distributions from the Plan generally are made in the form of a lump sum distribution or a direct rollover, subject to the required minimum distribution rules. For more information about the required minimum distribution rules, please see "POSTPONING DISTRIBUTION FROM THE PLAN" below.

DISABILITY BENEFITS

If you terminate employment because of disability, you may elect a lump sum distribution from the Plan as soon as practicable following the date that you provide proof of your disability to the Plan Administrator (and after arrangements for payment have been made).

In general, disability under the Plan means that you are unable to engage in any substantially gainful activity because of a medically determinable physical or mental impairment which can be expected to result in death or to be of long and indefinite duration. In order to be considered disabled under the Plan, you must submit proof of a determination by the Social Security Administration that you qualify to receive Social Security disability benefits.

PAYMENT OF BENEFITS UPON DEATH

If you die prior to receiving a distribution of your Plan account, the Trustee will pay your Plan account balance to your designated beneficiary. If you are married, your spouse will be your beneficiary, unless you designate a different beneficiary and your spouse consents to that designation. Distribution will be made to your designated beneficiary in a lump sum as soon as administratively practicable after your death.

If you die while performing military service, you will be treated as if you had resumed employment on the day before your death, and then had terminated employment on the actual date of your death.

POSTPONING DISTRIBUTION FROM THE PLAN

You generally must commence distribution of your vested account balance by April 1 of the calendar year following the calendar year in which you attain age 72 (age 70½ if you reached age 70

½ prior to January 1, 2020) or, if later, terminate employment. There is an exception to this rule, however. In general, if you are a more than 5% owner of the Employer, you must commence distribution of your Plan account by Apri1 1 of the calendar year following the calendar year in which you attain age 72 (age 70½ if you reached age 70 ½ prior to January 1, 2020) even if you have not terminated employment with the Employer. (Note that the required minimum distribution rules are different for beneficiaries if the payment is a death benefit.) These required distribution dates override any contrary distribution dates described in this Summary Plan Description.

Notwithstanding the preceding, the Plan may have suspended or waived required minimum distributions for or during the 2020 calendar year as permitted under the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act"), which was signed into law on March 27, 2020. If you would like to see how or if this CARES Act change impacts you, please contact the Plan Administrator.

REVIEW AND UPDATE CONTACT INFORMATION AT LEAST ANNUALLY

As explained in more detail above, the Plan requires that distribution be made to you or your beneficiary by certain deadlines. In order for the Plan to make distribution to you or your beneficiary timely, however, *you must provide the Plan Administrator with current contact information for both you and your beneficiary/ies*. Each year, you are responsible for reviewing the contact information that the Plan has on file for both you and your beneficiary/ies and notifying the Plan Administrator of any updates.

If you do not update the contact information for you and your beneficiary/ies and distribution cannot be made to you under the Plan, additional fees may be charged to your Plan account and/or your Plan account balance may be forfeited. Please see the next Section for more details.

MISSING PARTICIPANTS AND BENEFICIARIES

If the Plan Administrator is unable to locate you or your beneficiary/ies at a time when distribution is to be made under the Plan, two things may happen: (1) fees that the Plan incurs to locate you or your beneficiary may be charged to your Plan account and (2) your Plan account balance may be forfeited. If you or your beneficiary/ies later submit a valid claim for Plan benefits, your Plan account balance will be restored (unadjusted for any earnings) so that distribution may be made.

ROLLOVERS AND TRANSFERS

To the extent permitted by the Plan and applicable law, you may make a rollover or direct transfer of amounts from certain retirement accounts to the Plan.

In addition, when you are entitled to a distribution (other than a hardship distribution) from the Plan (or when your spouse beneficiary is entitled to a distribution under the Plan), you (or your spouse beneficiary) may transfer some or all of the distribution to another tax qualified retirement plan, a 403(b) tax sheltered annuity plan, a governmental 457(b) plan, an IRA (including a Roth IRA) or to certain annuity contracts (if that plan or IRA will accept the rollover).

The Plan also permits a non-spouse beneficiary who receives an eligible rollover distribution from the Plan to make a direct rollover to an IRA. The IRA accepting the direct rollover must be set up solely to receive the death benefit, will be subject to the minimum required distribution rules applicable to beneficiaries and cannot accept additional contributions or permit the rollover of distributions from the IRA.

You should contact the Plan Administrator to obtain more information and its approval before taking steps to have a rollover or direct transfer made to or from the Plan.

IN-SERVICE DISTRIBUTIONS AT AGE 59 ½ OR OLDER

You may elect to receive a distribution of all or any portion of your vested Plan account while you are employed if you are age 59 ½ or older.

IN-SERVICE DISTRIBUTIONS FOR HARDSHIP

You may withdraw amounts from your Plan account while you are employed by the Employer if you incur a financial hardship for one of the "Hardship Reasons" listed below. However, you may not take more than one hardship withdrawal for the same Hardship Reason during any 12 month period. A distribution will be on account of a financial hardship if the distribution is made on account of one of the following Hardship Reasons:

(1) Deductible medical expenses previously incurred or necessary to obtain medical care for you, your spouse, your dependent (as defined in Code §152, without regard to Code §§152(b)(1), (b)(2), or (d)(1)(B)), or your primary beneficiary;

(2) Costs directly related to the purchase of your principal residence, provided, however, that the amount of your hardship withdrawal may not exceed 20% of the purchase price of your principal residence, plus reasonable closing costs;

(3) The payment of tuition and related educational fees for you, your spouse, your dependent (as defined in Code §152, without regard to Code §§152(b)(1), (b)(2), or (d)(1)(B)), or your primary beneficiary for up to the next twelve months of post-secondary education following the withdrawal;

(4) Payments necessary to prevent your eviction from your principal residence or foreclosure on the mortgage of your principal residence;

(5) Payments for burial or funeral expenses for your deceased parent, spouse, children, dependent (as defined in Code §152, without regard to Code §§152(d)(1)(B)), or your primary beneficiary;

(6) Expenses for the repair of damage to your principal residence that would qualify for the casualty deduction under Internal Revenue Code §165 (determined without regard to Code §165(h)(5) and whether the loss exceeds ten percent (10%) of adjusted gross income);

(7) Expenses and losses (including loss of income) that you incurred on account of a disaster declared by the Federal Emergency Management Agency (FEMA) under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, Public Law 100–707, provided that your principal residence or principal place of employment at the time of the disaster was located in an area designated by FEMA for individual assistance with respect to the disaster; and

(8) Any federal, state, or local income taxes or penalties that may result on account of the hardship distribution.

A hardship withdrawal cannot exceed the amount necessary to meet the financial hardship. You must first take all distributions available under the Plan and/or any other plans sponsored by your Employer. In addition, you must make a representation in the format required by the Plan Administrator that you have insufficient cash or other liquid assets reasonably available to satisfy your hardship need and the Plan Administrator cannot have actual knowledge that is contrary to your representation.

CORONAVIRUS-RELATED DISTRIBUTIONS FOR A LIMITED TIME DURING 2020

As permitted under the CARES Act, eligible participants were permitted to take a coronavirus-related distribution from the Plan (1) of up to $15,000 during the period beginning April 1, 2020 through June 30, 2020 and (2) of up to $100,000 total (counting any prior coronavirus-related distributions made to the eligible participant) in the later part of 2020 (and prior to December 31, 2020).

In general, an "eligible participant" for purposes of a coronavirus-related distribution means a participant:

- Who is diagnosed with the virus SARS-CoV-2 or with coronavirus disease 2019 (COVID-19) by a test approved by the Centers for Disease Control and Prevention;
- Whose spouse or dependent (as defined in section 152 of the Internal Revenue Code of 1986) is diagnosed with such virus or disease by such a test; or
- Who experiences adverse financial consequences due to SARS-CoV-2 or COVID-19 as a result of: being quarantined; being furloughed or laid off or having reduced work hours; being unable to work due to lack of childcare; a business that the individual owns or operates either closed or was forced to operate under reduced hours; or other factors as determined by the Secretary of the Treasury (or the Secretary's delegate).

For more information regarding coronavirus-related distributions under the Plan, please contact the Plan Administrator. You may also visit http://www.tici.com/iaste6.htm or request a paper distribution form by calling (913) 236-5490 or by email to IATSEAnnuity@tici.com.

AMENDMENT OR TERMINATION OF PLAN

The Plan Sponsor expects to continue the Plan indefinitely. However, the Plan Sponsor evaluates the Plan periodically, and reserves the right at any time to modify or amend, retroactively if deemed necessary, any or all of the provisions of the Plan, subject to the terms of any applicable

collective bargaining agreements, participation agreements, or the like. In addition, the Plan Sponsor reserves the right to discontinue or terminate the Plan at any time, subject to the terms of any applicable collective bargaining agreements, participation agreements, or the like. In the event of the dissolution, merger, consolidation or reorganization of an Employer, the Plan will terminate as to that Employer unless it is continued by a successor to the Employer. Any amendment, discontinuance or termination of the Plan will be effective at a date determined by the Plan Sponsor.

APPLYING FOR BENEFITS THAT DO NOT INVOLVE A DISABILITY DETERMINATION

To receive Plan benefits that do not require an independent determination by the Plan Administrator of disability status, you must follow the procedures established by the Plan Administrator, as described in this section and, if necessary, in the "REVIEW OF DENIAL" section. The following summary of those procedures is intended to reflect the Department of Labor's claims procedures Regulations and should be interpreted accordingly. In the event of any conflict between the summary and those Regulations, those Regulations will control. In addition, any changes in those Regulations shall be deemed to amend this summary automatically effective as of the date of those changes.

For purposes of the time periods described in this section and in the "Review of Denial" section, the period of time during which a benefit determination is required to be made begins when you file your claim (or your request for review of a claim denial) in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the claim. If a period of time is extended because you have not submitted all information necessary, the period for making the determination is "frozen" from the date the notification is sent to you until you respond.

Initial claims for Plan benefits are made to the Plan Administrator. The Plan Administrator will review the claim itself or appoint an individual or an entity to review the claim, following the procedures described below.

If your claim does not require an independent determination by the Plan Administrator of disability status, you will be notified within 90 days after the claim is filed whether your claim is allowed or denied, unless you receive written notice from the reviewer prior to the end of the 90 day period stating that circumstances require an extension of the time for decision, in which case the extension will not extend beyond 180 days after the day the claim is filed.

If the reviewer denies your claim, it must provide to you, in writing or by electronic communication:

- The specific reasons for the denial;
- A reference to the Plan provision upon which the denial is based;
- A description of any additional information or material that you must provide in order to perfect the claim;

- An explanation of why the additional material or information is necessary;

- Notice that you have a right to request a review of the claim denial and information on the steps to be taken if you wish to request a review;

- A statement of your right to bring a civil action under a Federal law called "ERISA" following any denial on review of the initial denial.

Review of Denial. If you submit a claim for Plan benefits and it is initially denied under the procedures described above, you may request a review of that denial under the following procedures.

If your claim does not require an independent determination by the Plan Administrator of disability status, a request for review of a denied claim must be made in writing to the Plan Administrator within 60 days after you receive notice that your initial claim was denied. The decision on review will be made within 60 days after the Plan Administrator's receipt of a request for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered not later than 120 days after receipt of a request for review.

The reviewer will provide you an opportunity to review and receive, without charge, all relevant documents, information and records and to submit issues and comments in writing to the Plan Administrator. The reviewer will take into account all comments, documents, records and other information submitted that you submit relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

When the reviewer completes its review of an adverse initial claim determination, it will provide to you, in writing or by electronic notification, a notice containing:

- its decision;

- the specific reasons for the decision;

- a reference to the relevant Plan provisions on which its decision is based;

- a statement that the Claimant is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information in the Plan's files which is relevant to the Claimant's claim for benefits;

- a statement describing your right to bring an action for judicial review under ERISA Section 502(a); and

- if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge to you upon request.

If the Plan fails to follow the claims procedures described above, you will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any

available remedy under ERISA on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. A Claimant's compliance with the foregoing provisions is a mandatory prerequisite to the Claimant's right to commence any legal action with respect to any claim for benefits under the Plan.

APPLYING FOR BENEFITS THAT INVOLVE A DISABILITY DETERMINATION

The following procedures apply to claims for disability benefits under the Plan after April 1, 2018. These procedures are limited to claims where benefits are based on disability and the Plan Administrator is determining whether you satisfy the Plan's definition of disability (e.g., where the Plan is not relying on an independent determination, such as qualifying for Social Security disability benefits).

These procedures are intended to meet ERISA requirements set forth in DOL Regulation §2560.503-1 and will be interpreted in accordance with such regulations. The procedures are designed to ensure that claimants are not unduly inhibited from making claims; that claimants may appoint an authorized representative in accordance with Plan rules; determinations will be made in accordance with the Plan documents; that Plan provisions are applied consistently; and that decisions are made by impartial and independent decision makers.

The "claimant" refers to you, your authorized representative, or anyone else entitled to benefits under the Plan (such as a beneficiary).

For purposes of these procedures, a document, record, or other information shall be considered relevant to a claim if it:

- was relied upon in making the benefit determination;
- was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
- demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

Submitting a Claim for Benefits. You may file a claim for benefits by submitting a written request for benefits to the Plan Administrator. You should contact the Plan Administrator to see if there is an applicable distribution form that must be used. If no specific form is required or available, then your written request for a distribution or a written assertion that your benefits under the Plan have been determined incorrectly, will be considered a claim for benefits.

The claim for benefits must include sufficient evidence to enable the Plan Administrator to determine whether you have met the Plan's definition of disability.

Decisions on the claim will be made within a reasonable period of time appropriate to the

circumstances. “Days” means calendar days. If the Administrator determines the claim is valid, then you will receive a statement describing the amount of benefit, the method or methods of payment, the timing of distributions and other information relevant to the payment of the benefit.

Initial Claims. A claim must be resolved, at the initial level, within 45 days of receipt by the Plan. If, due to matters beyond the control of the Administrator, the Administrator needs additional time to process a claim, the claimant will be notified, within 45 days after the Administrator receives the claim, of those circumstances and of when the Administrator expects to make its decision but not beyond 75 days. If, prior to the end of the extension period, due to matters beyond the control of the Administrator, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to 105 days, provided that the Administrator notifies the claimant of the circumstances requiring the extension and the date as of which the Administrator expects to render a decision. The extension notice will specifically explain the standards on which entitlement to a disability benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed from the claimant to resolve those issues, and the claimant will be afforded at least 45 days within which to provide the specified information.

Adverse Benefit Determinations. If the Plan Administrator determines that all or part of the claim should be denied (an “adverse benefit determination”), it will provide a notice of its decision in written or electronic form explaining the claimant’s appeal rights. An “adverse benefit determination” also includes a rescission, which is a retroactive cancellation or termination of entitlement to disability benefits. The notice will be provided in a culturally and linguistically appropriate manner and will state:

(a) The specific reason or reasons for the adverse determination.

(b) Reference to the specific Plan provisions on which the determination was based.

(c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.

(d) A description of the Plan’s review procedures and the time limits applicable to such procedures. This will include a statement of the claimant’s right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.

(e) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

- the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

- the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant’s adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; or

- a disability determination made by the Social Security Administration regarding the claimant and presented by the claimant to the Plan.

(f) If the adverse benefit determination is based on medical necessity or experimental and/or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(g) Either the specific internal rules, guidelines, protocols, or other similar criteria relied upon to make a determination, or a statement that such rules, guidelines, protocols, or criteria do not exist.

(h) 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 the claim.

Review of Adverse Benefit Determinations. When a claimant receives a notice of an adverse benefit determination, the claimant may request a review of the decision. The request must be in writing and must be filed within 180 days following receipt of the notice. In the case of an adverse benefit determination regarding a rescission of coverage, the claimant must request a review within 90 days of the notice. The claimant or his authorized representative may submit written comments, documents, records, and other information relating to the claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The review shall 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. The review will not afford deference to the initial adverse benefit determination and will be considered by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the initial adverse benefit determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the fiduciary shall consult with a health care professional who was neither involved in or subordinate to the person who made the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

If the Plan considers, relies upon or creates any new or additional evidence during the review of the adverse benefit determination, the Plan will provide such new or additional evidence to the claimant, free of charge, as soon as possible and sufficiently in advance of the time within which a determination on review is required to allow the claimant time to respond.

Before the Plan issues an adverse benefit determination on review that is based on a new or additional rationale, the claimant must be provided a copy of the rationale at no cost to the claimant. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on appeal is required to allow the claimant time to respond.

The claimant will be notified of the determination on review of the claim no later than 45 days after the Plan's receipt of the request for review, unless special circumstances require an extension of time for processing. In such a case, the claimant will be notified, before the end of the initial review period, of the special circumstances requiring the extension and the date a decision is expected. If an extension is provided, the Plan Administrator must notify the claimant of the determination on review no later than 90 days after receipt of the request for review.

Notice of Adverse Benefit Determination on Review. The Plan Administrator shall provide written or electronic notification to the claimant or his authorized representative in a culturally and linguistically appropriate manner. If the initial adverse benefit determination is upheld on review, the notice will include:

(a) The specific reason or reasons for the adverse determination.

(b) Reference to the specific Plan provisions on which the determination was based.

(c) 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 the claim.

(d) A statement of claimant's right to bring a civil action under section 502(a) of ERISA and, if the Plan imposes a contractual limitations period that applies to claimant's right to bring such an action, a statement to that effect which includes the date on which such limitation expires on the claim.

(e) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

- the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
- the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; or
- a disability determination made by the Social Security Administration regarding the claimant and presented by the claimant to the Plan.

(f) If the adverse benefit determination is based on medical necessity or experimental and/or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(g) Either the specific internal rules, guidelines, protocols, or other similar criteria relied upon to make the determination, or a statement that such rules, guidelines, protocols, or criteria do

not exist.

Calculation of Time Periods. For purposes of the time periods specified in these procedures, the period of time during which a benefit determination is required to be made begins at the time a claim is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the claim. If a time period is extended because a claimant fails to submit all information necessary for an initial disability claim, the period for making the determination will be tolled from the date the notice requesting the additional information is sent to the claimant until the day the claimant responds. If a time period is extended because a claimant fails to submit all information necessary for an appeal of an adverse benefit determination, the period for making the determination on appeal will be tolled from the date the notice requesting the additional information is sent to the claimant until the day the claimant responds.

Avoiding Conflicts of Interest. For disability claims, the Plan Administrator will ensure that claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of individuals involved in claims decisions. Decisions regarding hiring, compensation, termination, promotion, or similar matters will not be made based on the likelihood that any individual involved in making claims decisions will support the denial of benefits.

Failure of Plan Administrator to Follow Procedures. If the Plan Administrator fails to follow the claims procedures, a claimant will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedy under ERISA section 502(a) on the basis that the Plan Administrator has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

For disability claims, a claimant is deemed to have exhausted the Plan's internal claims and appeals process if the Plan Administrator does not strictly adhere to the applicable requirements of Department of Labor Regulations section 2560.503-1 unless the Plan Administrator's failure to adhere to those requirements is a "de minimis violation" (as defined in the next paragraph). In such cases, if a court rejects the claimant's request for immediate review on the basis that the Plan Administrator met the standards for the de minimis violation exception described above, the claim shall be considered as re-filed on appeal upon the Plan Administrator's receipt of the decision of the court. In such cases, within a reasonable time after the Plan Administrator's receipt of the decision, the Plan shall provide the claimant with notice of the resubmission.

For purposes of this Section, the Plan Administrator's failure to satisfy applicable claim procedure regulations is a "de minimis violation" if (i) the violation does not cause, and is not likely to cause, prejudice or harm to the claimant, (ii) the violation was for good cause or due to matters beyond the control of the Plan Administrator, (iii) the violation occurred in the context of an ongoing, good faith exchange of information between the Plan Administrator and the claimant and (iv) the violation is not part of a pattern or practice of violations by the Plan Administrator. If an issue arises regarding whether this de minimis violation exception applies, a claimant may request a written explanation of the violation from the Plan Administrator, and the Plan Administrator will provide the explanation within 10 days, including a specific description of its reasons, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted.

Failure of Claimant to Follow Procedures. A claimant's compliance with the foregoing provisions is a mandatory prerequisite to the claimant's right to commence any legal action with respect to any claim for benefits under the Plan.

STATUTE OF LIMITATIONS

Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than twelve months after the final review/appeal decision by the Plan Administrator has been rendered (or deemed rendered).

ASSIGNMENT OF BENEFITS

As a general rule, your interest in your Plan account may not be alienated. This means that, except as specifically provided by law, your interest may not be sold, used as collateral for a loan, given away or otherwise transferred. In addition, your creditors may not attach, garnish or otherwise interfere with your account.

There is an exception to this general rule, however. That is, the Plan Administrator must honor a "qualified domestic relations order". A "qualified domestic relations order" is a decree or order issued by a court that obligates you to pay child support or alimony, or otherwise allocates a portion of your assets in the Plan to your spouse, former spouse, child or other dependent. If a qualified domestic relations order ("QDRO") is received, all or a portion of your benefits may be used to satisfy that obligation. The Plan Administrator will determine the validity of any domestic relations order that it receives. You and your beneficiaries can obtain, without charge, a copy of the QDRO Procedures for the Plan from the Plan Administrator.

NO EMPLOYMENT CONTRACT

Nothing contained in the Plan shall be construed as a contract of employment between the Employer and the employee, nor shall anything contained in the Plan give any employee any rights of continued employment with the Employer or limit the right of the Employer to discharge any employee with or without cause.

YOUR RIGHTS UNDER ERISA

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

Receive Information About Your Plan and Benefits. You can examine, free of charge, at the Plan Administrator's office and at other locations, such as worksites and union halls, all of the Plan documents, 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.

You can obtain copies of all Plan documents (including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated

Summary Plan Description) by writing to the Plan Administrator. You may have to pay a reasonable charge to cover the cost of photocopying.

You can receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

You can obtain a statement telling you whether you have a right to receive a benefit at normal retirement age. If you have such a right, the statement will tell you what your benefits would be at retirement age if you stop working now. If you do not now have a right to a benefit, the statement will tell you how many more years you have to work in order to have a right to a benefit. This statement must be requested in writing and is not required to be given more than once a year. The Plan must provide the statement free of charge.

Prudent Actions by Plan Fiduciaries. In addition to creating rights for Plan participants, ERISA imposes duties upon the people who operate the Plan. These people are called fiduciaries and have a duty to act prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including the 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 under a Plan or exercising your rights under ERISA.

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

Under ERISA, there are steps you can take to enforce the preceding rights. For instance, if you make a written request for materials from the Plan and do not receive them within 30 days, you may file suit in Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations 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 the Plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue,

N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PLAN GUARANTEES

Because this Plan is a type of retirement plan called a "defined contribution plan", Plan benefits are not insured by the Pension Benefit Guaranty Corporation under the Plan insurance provisions of the Employee Retirement Income Security Act of 1974.

ADDITIONAL INFORMATION

ADMINISTRATION

The official Plan name is the I.A.T.S.E. Local No. 6 Profit Sharing Plan.

The Plan Sponsor is:

Joint Board of Trustees of the I.A.T.S.E. Local No. 6 Profit Sharing Plan
6405 Metcalf Ave., Ste. 200
Overland Park, KS 66202

The Plan Administrator is the Joint Board of Trustees. Plan Administrator correspondence should be mailed to:

Joint Board of Trustees of the I.A.T.S.E. Local No. 6 Profit Sharing Plan
6405 Metcalf Ave., Ste. 200
Overland Park, KS 66202
Telephone No.: (800) 542-4482

The Plan Trustee is the Joint Board of Trustees, comprised of Mr. Todd Moore, Mr. Kevin Whalen, Ms. Margaret Bailey, and Mr. Mark Bernstein.

Trustee correspondence should be mailed to:

Joint Board of Trustees of the I.A.T.S.E. Local No. 6 Profit Sharing Plan
6405 Metcalf Ave., Ste. 200
Overland Park, KS 66202
Telephone No.: (800) 542-4482

TRUST IRS IDENTIFICATION NUMBER, PLAN NUMBER, TYPE OF PLAN AND EFFECTIVE DATE

Employer Identification Number: 43-0497330

Plan Number: 002

Type of Plan:	Defined Contribution Plan
Effective Date:	The Plan was initially effective on January 1, 1998. This Summary Plan Description describes the Plan's provisions as of September 2020.

AGENT FOR SERVICE OF LEGAL PROCESS

The Plan Administrator

PLAN YEAR

The fiscal year of the Plan for purposes of administration and recordkeeping is the period beginning each January 1 and ending each December 31 during which this Plan is in effect.

FUNDING MEDIUM

Plan benefits are provided through the medium of a trust.

FRAUDULENT CLAIMS OR INFORMATION

If any participant or beneficiary provides false or fraudulent information or documents to the Plan Sponsor, the Employer, and/or the Plan Administrator, any application or claim for benefits may be denied. The Plan Administrator has the right to recover any benefit payment made on the basis of the false or fraudulent information or documents.

ERRORS IN ACCOUNTS

If, due to an error, a Plan account or distribution from the Plan is more or less than it should have been if the error had not occurred, the Plan Administrator will correct the error by adjusting the Plan account or distribution to the extent practicable. Any such correction shall be final and binding on all participants and beneficiaries.

DISCRETION TO INTERPRET THE PLAN AND RESOLVE DISPUTES

The Plan Administrator has complete discretion to interpret and apply all terms of the Plan, the Trust, and this Summary Plan Description. The Plan Administrator also has complete discretion to make any findings of fact needed to administer the Plan and make decisions on benefit claims. Any dispute about eligibility for benefits under the Plan, the form of benefit payment, the amount of benefits, any right to payments from the Plan, or any other matter involving the Plan will be resolved by the Plan Administrator or by a person designated by the Plan Administrator and will be final and binding on all persons.