MAHONING & TRUMBULL

COUNTY BUILDING TRADES

INSURANCE FUND

SUMMARY PLAN DESCRIPTION

THIS BOOKLET REVISED AND AMENDED
April 1, 2005

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INTRODUCTION

This booklet has been prepared to provide you with the information required for you to become familiar with the benefits provided by the Mahoning and Trumbull County Building Trades Insurance Fund, and to familiarize you with the manner in which the benefit claims are administered.

The Insurance Fund is a fund created under the Taft-Hartley Act and is governed by the Employee Retirement Income Security Act, frequently referred to as ERISA. It is funded through employer contributions made on behalf of employee participants of the Fund, and from income earned through investment of Fund assets. The amount of contributions your employer makes to the Fund on your behalf is the amount specified in the collective bargaining agreement under which you work. The Insurance Plan adopted by the Trustees, which is fully described in this booklet, is designed to provide benefits for employees employed under the terms of the collective bargaining agreements negotiated by your local union and your employer. A copy of your collective bargaining agreement may be obtained upon written request to the Plan Administrator.

The Fund is administered by a joint Board of Trustees, half of whom are union appointed trustees, and the other half employer appointed trustees. The names and addresses of each of the current Trustees are as follows:

NAME	TITLE	ADDRESS
Mark Catello Electrician's Local 573	Union Trustee	2430 Parkman Road, NW Warren, Ohio 44485
Terry Conroy Painters Local 476	Union Trustee	8257 Dow Circle West Cleveland, Ohio 44136
Richard Ellis Ironworkers Local 207	Union Trustee	694 Bev Road Youngstown, Ohio 44512
Dennis Hageman Bricklayers Local No. 8	Union Trustee	291 McClurg Road Youngstown, Ohio 44512
William Butch Jack Gibson Construction	Management Trustee	2460 Parkman Road, NW Warren, Ohio 44485
William E. Casey Warren Glass Service, Inc.	Management Trustee	P. O. Box 1028 Warren, Ohio 44484
Joseph T. Joseph Joseph Painting Company	Management Trustee	696 McClurg Road Youngstown, Ohio 44512
Kevin Reilly Builders Association	Management Trustee	P. O. Box 488 Vienna, Ohio 44473

BENEFIT TO YOU OF CHOOSING A NETWORK PROVIDER

The Plan has entered into an arrangement with a preferred provider organization (PPO). When you choose providers that are members of the PPO panel, costs are reduced for you and the Plan.

You may contact the Fund Office or the PPO directly to learn if your providers are in the panel. Copies of Participating provider lists are also available from the Fund Office.

The PPO is:

Medical Mutual of Ohio, Inc.
2060 East Ninth Street
Cleveland, OH 44115-1355
Phone: 1-800-601-9208
Email: www.supermednetwork.com

REASONABLE AND CUSTOMARY CHARGES

The Plan will only consider Reasonable and Customary charges unless using a network provider for which there is a negotiated rate. This generally means the rate for a covered procedure or service charged by the majority of providers within the area where a claim is incurred. Accordingly, you may desire to discuss fees with your providers before services are rendered.

TRUSTEE DECISIONS

The Board of Trustees maintains the sole and exclusive right to determine the eligibility requirements for participation in the Fund. The Trustees maintain the sole and exclusive right to alter, amend or terminate any or all portions of the benefit program provided through the Fund and to determine the cost to be charged for the benefits and coverage provided. No Eligible Person - active, disabled or retired - has any vested rights to benefits, to retiree benefits, or coverages.

PLAN REPRESENTATIONS

Only the Board of Trustees has the authority to interpret and answer questions regarding eligibility for participation in the Fund. However, the Plan Administrator has been given discretion by the Board of Trustees to interpret the Plan document and answer questions regarding Plan benefits. No Union or Employer representative, Trustee, business agent or other individual has the authority to answer questions and/or interpret the provisions or the types of benefits, amount, duration or nature provided by the Plan unless such individual has been given written authority by the Board of Trustees and is acting on its behalf.

CHANGE OF ADDRESS AND STATUS

It is extremely important that you keep the Fund office informed of any change to address or desired change in beneficiary. This is your obligation and failure to fulfill this obligation could jeopardize your eligibility or benefits.

The importance of a current, correct address on file in the Fund Office cannot be overstated. It is the **ONLY** way the Trustees can keep in touch with you regarding plan changes and other developments affecting your interests under the Plan.

Also, you have the responsibility to inform the Fund Office within sixty (60) days of a marriage, divorce, legal separation, birth of a child, or a child losing dependent status under the Plan.

Day to day operation of the Fund is conducted by Compensation Programs of Ohio, Inc., a third-party administrator, to act as the responsible party for maintaining the necessary records and processing claims for benefits filed by participants in the Fund. You may contact them at 1-800-435-2388.

The Plan year of the Fund is the period between October 1 and September 30. The records of the Fund are kept on the basis of a fiscal year ending September 30.

Plan documents and other plan information including a complete list of the employers sponsoring the plan, will be provided by the Trustees if this information is requested in writing. A reasonable charge will be made for furnishing you with copies of the document requested. All plan documents are available for examination at the office address of the Fund at no charge.

The employer identification number of the Fund is 34-0746419. Information that you may require or desire may be secured from the Insurance Fund Office.

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 the Board of Trustees, upon any individual Trustee at the following address: Mahoning & Trumbull County Building Trades Insurance Fund, 33 Fitch Boulevard, Austintown, Ohio 44515, or upon fund counsel, Dennis Haines, Esq., Green Haines Sgambati Co., L.P.A., National City Bank Building, Suite 400, P. O. Box 849, Youngstown, Ohio 44501-0849.

Respectfully,

BOARD OF TRUSTEES

SCHEDULE OF BENEFITS

For All Eligible Employees, Early Retirees, and Their Enrolled Dependents	
This summary provides a brief description of Plan Benefits. These benefits are subject to any exclusions and/or restrictions listed elsewhere in your booklet.	
Benefit Period	Calendar Year (January - December)
Calendar Year Deductible	$300 individual / $600 family
Copayment	80% of first $4,000 of an individual's expenses; 100% thereafter up to the annual and lifetime maximum
Annual out-of-pocket maximum	$1,100 per person
Annual maximum	$300,000 per individual
Lifetime maximum	$1,000,000 per individual

BASIC MEDICAL EXPENSES*

Service		Benefit
Hospital Expense Benefit, Room and Board, and other Hospital Services Outpatient Hospital Services Surgical fees X-ray and Lab Inpatient Doctor visits and Consultations Emergency Room Physicians charges Provider office visits Chiropractic visits Durable medical equipment Ambulance fees		These benefits are payable after satisfying your deductible with the Plan reimbursing 80% of the usual, customary, and reasonable charges up to the first $4,000; thereafter 100% up to the annual and lifetime maximums, unless otherwise noted.

***ALL MEDICAL EXPENSES ARE SUBJECT TO THE USUAL, CUSTOMARY, AND REASONABLE CHARGES**

BASIC MEDICAL EXPENSES (continued)

Mental/Nervous Disorder Treatment*

Inpatient	30 days lifetime	Deductible/co-pays apply (per calendar year)
Outpatient	12 visits per calendar year	Deductible/co-pays apply (per calendar year)
Lifetime Maximum	30 days	

Alcohol/Substance Abuse Treatment*

Inpatient (subject to pre-certification)	$10,000 per calendar year, deductible/co-pays apply (per calendar year)
Outpatient	$ 5,000 per calendar year, deductible/co-pays (per calendar year)
Lifetime Maximum	$15,000

OTHER BENEFITS

Life Insurance/Accidental Death and Dismemberment Benefits (Eligible Employees and Early Retirees Only)

Life Insurance Benefit	$6,500
Accidental Death and Dismemberment	$6,500

Weekly Indemnity Benefits (Eligible Employees Only)
$300 per week, maximum of 26 weeks

***ALL MEDICAL EXPENSES ARE SUBJECT TO THE USUAL, CUSTOMARY, AND REASONABLE CHARGES**

PRESCRIPTION DRUG BENEFITS

(For All Eligible Members, Early Retirees and their Enrolled Dependents)

The Prescription Drug Card Benefit covers charges for drugs prescribed by a physician, dispensed by a pharmacist and not available over the counter without a prescription.

Covered Expenses Include:

Federal Legend Drugs	-	Any medicinal substance which bears the legend: "Caution: Federal Law prohibits dispensing without a prescription."
State Restricted Drugs	-	Any medicinal substance which may be dispensed by prescription only according to state law.
Compounded Medication	-	Any medicinal substance which has at least one ingredient that is a Federal Legend or State Restricted Drug in a therapeutic amount.
Insulin	-	Available by prescription only (include insulin syringes)

A Prescription Administrator has contracted with the Mahoning & Trumbull County Building Trades to provide an efficient and cost effective program that will be easy for you and your dependents to use when you purchase your prescriptions at a Network Pharmacy. Please check with the Fund Office or call the Prescription Drug Administrator (800-361-4542) directly for a participating pharmacy location near you.

The Prescription Drug Card Program requires you to present your Identification Card at the pharmacy each time you have a prescription filled. If you do not use your identification card, you will have to file a claim for payment directly to the Fund Administrator. Your claim may be subject to co-insurance amounts and annual or lifetime maximums. When possible, please check with your pharmacy to determine if a generic equivalent is available which will result in a direct savings to you and the Fund.

The Program works as follows:

% If you choose a generic drug, the co-payment will be $10.00.

% If you choose a single source brand name drug for which there is no existing FDA approved generic equivalent, you will pay 25% of the drug cost

% If you choose or your physician indicates "Dispense As Written" for a brand name drug which has an FDA approved generic equivalent in existence, you will pay 35% of the drug cost.

% the Plan has a maximum thirty-day supply limit for any prescription drug benefits obtained at a retail pharmacy

All expenses are subject to the following:

Calendar Year Annual maximum	$25,000 per person	Lifetime maximum	$100,000 per person

Mail Order Program

The Mail Order Program was designed to allow members to receive large quantities of maintenance medication (e.g. heart medication, blood pressure medication, diabetic medication, etc.). You can obtain a 90 day supply of your prescription with refills permitted as prescribed by the physician. Your co-payment for this 90 day supply is the same as the co-payment for a retail prescription described above.

The Following services, supplies and charges are not covered under this benefit:

1. Contraceptives devices;
2. Therapeutic devices
3. Artificial appliances
4. Disposable insulin syringes which are not prescribed
5. Fees for administering or injecting Prescription Drugs;
6. Charges for more than a 90 day supply of Prescription Drugs;
7. Any refill or Prescription Drug, dispensed after one year from the date of the original Prescription Order;
8. Drugs you can purchase without a Prescription;
9. Prescription Drugs consumed or administered at a location where Prescription Order is issued;
10. Fertility drugs;
11. Nicorette gum and/or other tobacco cessation related medication;
12. Genetically engineered drugs (may be paid upon prior authorization)
13. Male sexual dysfunctional drugs (except a **6**-pill monthly limit for Viagra)
14. Anorexiants (diet pills)
15. Diabetic supplies (e.g., glucometers, lancets, test strips which are covered under the Plan's Basic Medical Expenses)
16. Ostomy products

RULES OF ELIGIBILITY
FOR EMPLOYEES' COVERAGE

The eligibility rules now in effect are shown below. They may be changed from time to time as the Trustees, in their discretion, may deem necessary.

You are eligible for coverage if you are employed under the jurisdiction of one of the union locals participating in the Insurance Fund and if sufficient contributions have been made on your behalf by participating employers.

Initial Eligibility – Active Employees

An employee working under a bargaining agreement shall qualify for initial eligibility following the receipt of 270 hours within a six-month period. Once this amount has been accumulated your eligibility for benefits will begin on the first day of the first month of an eligibility quarter. Once qualified, the employee will have to be credited with the required hours as outlined under the Continuation of Eligibility provisions.

As an example, when contributions are received for an Employee as follows:

October	100 hrs.
November	40 hrs.
December	40 hrs.
January	70 hrs.
February	70 hrs.

This employee will qualify for benefits effective June 1. If the employee meets one of the crediting requirements (e.g. 405 hours during January, February and March) he/she will be eligible for June, July and August.

Effective Eligibility Date

An Employee will be covered on the date he/she became eligible if he/she is available for work on that date; otherwise, you shall not become covered until he/she became available for work.

If a Dependent is confined in a Hospital on the date such Dependent would otherwise become covered or on the date the change in coverage would otherwise become effective, the coverage or change in coverage with respect to that particular Dependent shall be deferred until final discharge from the Hospital. However, for a newborn dependent Child, coverage begins from birth.

Continuation of Eligibility – Active Employees

You will be eligible during	If you are credited with the required hours in the following periods:			
	405 Hours **or** During	810 Hours **or** During	1215 Hours **or** During	1620 Hours During
March April May	October November December	July thru December	April thru December	January thru December
June July August	January February March	October thru March	July thru March	April thru March
September October November	April May June	January thru June	October thru June	July thru June
December January February	July August September	April thru September	January thru September	October thru September

Non-Covered Employment

Any employment or self-employment by a participant in any capacity for or as a non-signatory building or construction contractor anywhere will be deemed to be disqualifying employment that will result in the termination of coverage under the Plan. For this purpose, a non-signatory building or construction contractor is any such contractor who is not signatory to a collective bargaining agreement with a participating union or an affiliated AFL-CIO Building Trades Union. It shall also include any employment for or as a construction or project manager who subcontracts or permits to be subcontracted, directly or indirectly, building trades work to a non-signatory building or construction contractor.

The National Labor Relations Board has determined that union organizers, whether paid or unpaid, are employees protected under the National Labor Relations Act. Accordingly, the employment of such an organizer known as “salt” by a non-signatory contractor will not disqualify such organizer as an employee from participation in the Fund; and, contributions made to the Fund by the Union for such an employee shall be accepted by the Fund.

When the Plan administrator has determined that a participant has engaged in such disqualifying employment, it will promptly so notify the participant. If the participant thereafter engages in *any* disqualifying employment at any time after the 15th day following the date of such notice, the participant’s and his dependent’s coverage under the Plan will be terminated – including forfeiture of all accumulated hour bank credits and any self-payment rights other than COBRA continuation coverage rights. The participant and dependents shall be offered the COBRA continuation coverage rights otherwise available under the Plan for loss of coverage due to a reduction in hours in covered employment.

<u>Self</u> <u>Contributions</u>

If you have accumulated less than the minimum required number of hours for continuation of eligibility, were unemployed, or working under a state residential agreement for an employer not signatory to the Eastern Ohio, Western Pennsylvania Builders Association collective bargaining agreement, and are not eligible for retired benefits, you may make a self-contribution at the current contribution rate for the number of hours needed to meet the minimum eligibility requirements for the next succeeding benefit period. Self-contributions shall be limited to three (3) consecutive benefit periods for which no hours are reported. After exhausting your self-pay rights, you may be eligible for COBRA benefits (see page 16)

<u>Newly</u> <u>Organized</u> <u>or</u> <u>Apprentices</u>

Plan coverage will be provided to any newly organized employee or apprentice under the following conditions:

A. Employee must notify the Benefit office in writing that he or she is a newly organized employee or apprentice. Employee must include written notification from the Local Union.

B. If notice is provided to the Benefit office on or before the 15th day of a month, the Benefit office will send Employee a notice that Plan coverage will start on the first day of the following month if Employee elects to make a one-time special self-payment.

C. If notice is provided to the Benefit Office after the 15th day of a month, the Benefit Office will send Employee a notice that Plan coverage will start on the first day of the second following month if Employee elects to make a one-time special self-payment.

D. This offer will be available to Employee only once during his or her lifetime. Employee can make the special self-payments for up to a maximum of nine (9) consecutive months.

E. The amount of the special self-payment shall be established by the Trustees upon consultation with the Plan Administrator, and the Employee will be so notified.

F. Employee's first self-payment must be <u>received</u> by the Benefit office no later than the first day of the month for which coverage is to start. Employee can mail the payment or take it in personally, but it must be <u>received</u> by the Benefit Office no later than the due date.

<u>Self</u> <u>Employed</u>

In no event may a self-employed individual make self-contributions to maintain eligibility.

<u>Hour</u> <u>Bank</u>

Reserve hours will be calculated annually at the end of the hours posted for the June 30th work month. Reserve hours will be calculated on the basis that all hours worked in excess of 1,620 hours for the period of July 1 through June 30 will be credited to a reserve hours bank up to a maximum of two hundred fifty (250) per year subject to an overall maximum of 1,620. This 1,620 hours will allow a person to build up to twelve months of coverage. When contributions

are increased under the Collective Bargaining Agreements, an adjustment will be made in your reserve hours to reflect the increased cost of the Plan.

The use of these hours is expressly conditioned upon the Person's Local Union, where at least a majority of these hours have been accumulated, sponsoring a Collective Bargaining Agreement requiring contributions to this Fund.

The Trustees shall also have the discretion to freeze or terminate your reserve hour bank if it is determined that you are performing work in Covered Employment in the craft jurisdiction for an Employer not subject to a collective bargaining agreement. The Reserve hour bank is not a vested benefit and is subject to amendment, reduction or termination.

Sick Credit

An eligible employee will be credited with four hours per day for a period not to exceed 26 weeks for the purpose of maintaining eligibility. This credit is given if you:

ï are receiving Sickness & Accident benefits from this Fund or receiving Workers Compensation benefits; and

ï are seen by a Physician on a regular basis who so states you are Disabled; and

ï make written application to the Fund Office for such credits within six months after the Disability starts.

Credit is given the first day for an injury and beginning the eighth day for an illness. You receive credit until you are no longer receiving Disability or Sickness and Accident Benefits or Workers' Compensation, or until you have received the maximum of 26 weeks, whichever comes first.

There is no limit to the number of separate periods of disability for which benefits are payable. However, successive terms of disability for the same or a related cause and separated by less than two weeks of full-time work will be considered one period of disability.

The Plan may require that you be examined by the Plan's Physicians from time to time.

Family and Medical Leave Act Credits

Contribution Credits of up to 12 weeks in a 12_month period may be available from your Employer for Family and Medical Leave (FMLA). You must have worked 1,250 hours in a 12_month period for an Employer covered by FMLA. Certain other requirements must be met.

Forms for seeking these Credits are available from the Fund Office. The Form must be completed by you and your Employer. FMLA Contribution Credits may be available for:

C The birth of your child and to care for such child.

- C Placement of a child with you for adoption or foster care;
- C To care for your Spouse, Child or parent with a serious health condition; or
- C For your own serious health condition that makes you unable to perform your job.

Please contact the Fund Office for Rules and Regulations governing FMLA Contribution Credits.

Military Service Provision

If you are called up for active duty in the armed services, you are entitled to the protection of the Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA). The Fund will allow you the choice of using your Hour Bank to continue coverage for you and/or your dependents or freezing your Hour Bank until your reinstatement in the Plan. The provisions for reinstatement are based on your application for re-employment and will vary depending on your length of stay in the uniformed services. You need to contact the Fund Office to discuss your options to continue coverage for you and your dependents. In most instances, when you are called to active duty, coverage is provided to you through Tri Care which offers several plans to persons on active duty and, under certain conditions, his/her dependents.

It is extremely important, if you wish to have a continuation of benefits under USERRA, that immediately upon learning of your armed service related absence for any period, you discuss your options with the Fund Office.

Pre-existing Conditions Limitation (Newly Organized Participants only)

If a newly organized Participant has been treated for an injury or illness within six (6) months prior to becoming eligible for benefits under the Plan, then all expenses incurred as a result of such injury or illness will not be considered as eligible expenses until twelve (12) months after the effective date of coverage.

The pre-existing condition exists for twelve months (18 months for late enrollees) after becoming eligible for benefits under the Plan. This period is reduced, however, by counting certain prior coverage toward the exclusion period. Participants with 12 months of coverage with one employer may, therefore, move to a new employer with new coverage without becoming subject to the pre-existing condition exclusion of the new employer.

A Participant is credited for prior coverage under a wide variety of health plans, including group health plans, individual policies, HMOs, Medicare, and various governmental programs. Coverage is not counted toward the exclusion period of the new plan, however, if there has been an intervening break in coverage of 63 days or more. Only coverage after the break may be credited.

No pre-existing condition exclusion may apply to pregnancy-related conditions, newborns or adoptees enrolled during this period.

RULES OF ELIGIBILITY FOR DEPENDENTS' COVERAGE

An employee is eligible for Dependents' coverage on the day he becomes eligible for employee coverage or on the day he acquires his first dependent, whichever is later.

Your eligible Dependents include the following:

(a) The participating member's legal spouse;
(b) The participating member's unmarried children under 19 years of age. Such children include (1) a step-child residing in the member's household; (2) a legally adopted child.
(c) Children after attainment of age 19 but not beyond attainment of age 23, if, in addition to otherwise meeting the definition of dependent children as contained in (b) such dependent is: a full-time student in a recognized course of study or training, not employed on a regular full-time basis, and not otherwise covered under any other employer group insurance or prepayment plan. Also to be eligible for coverage as a dependent under this provision, the child must have been eligible for coverage as a dependent prior to attainment of age 18.
(d) Children after attainment of age 19 while incapable of self-support because of a disabling sickness or injury that commenced prior to age 19 provided such child was eligible for coverage as a dependent prior to attainment of age 19. Such children must otherwise meet the definition of dependent as contained in (b), must legally reside with the member and must be principally supported by the member.
(e) A child (19 years or younger) with whom the participant has had legal custody for two (2) consecutive years or more prior to applying to the Fund for coverage. Additionally, the child must meet the definition of dependency as accepted by the Internal Revenue Service.

To be eligible for dependent coverage, proof may be required that the dependent meets the requirements stated above.

The term dependents does not include a person who is covered under any other group insurance plan or program toward the cost of which an employer contributes or who is covered as a member under this Plan.

Special Enrollment Rights

The Plan does not have a requirement that you specifically enroll in coverage once you become eligible. However, your dependents must be enrolled with the Plan in order to have coverage. If you do not enroll any of the Eligible Dependents upon becoming initially eligible for coverage under this Plan, your Dependents may qualify for the Special Enrollment described in this Section. If you and your Dependents do not meet the Special Enrollment rules, then the Dependent will not become eligible for coverage under this Plan until the date that all of the enrollment forms are completed and claims will not be paid retroactively to the date of their initial eligibility.

If you are eligible for coverage and you acquire a Spouse by marriage or acquire any Dependent Children by birth, adoption or placement for adoption, you may enroll your newly acquired Spouse and/or any Dependent Child no later than sixty (60) days after the date of marriage, birth, adoption or placement for adoption. Enrollment forms can be obtained from the Fund Office.

If the completed written enrollment form is submitted on a timely basis, coverage will be effective as follows:

- Your coverage, your Spouse's coverage, and/or the coverage of any of your other Dependent Child(ren), except with respect to coverage of a newborn or newly adopted Dependent Child, will become effective on the date of the event that created the special enrollment opportunity.
- Coverage of a newborn who is enrolled within sixty (60) days after birth will become effective as of the date of the child's birth.
- Coverage of a newly adopted Dependent Child who is enrolled within sixty (60) days after birth will become effective as of the date of the child's adoption or placement for adoption, whichever occurs first.

If you do not enroll your Spouse for coverage within sixty (60) days of the date on which he or she became eligible for coverage, and if you subsequently acquire a Dependent Child by birth, adoption or placement for adoption, you may enroll your Spouse together with your newly acquired Dependent Child no later than sixty (60) days after the date of your newly acquired Dependent Child's birth, or placement for adoption. If you decide to enroll other Dependent Children other than the newly born or adopted child under this provision, your coverage for the other Dependent Children will not commence until all of the proper enrollment forms are completed and claims will not be paid retroactively to the date of their initial eligibility.

If your Spouse and Dependent Child(ren) did not enroll for coverage within the sixty (60) days after the date of their initial eligibility because they had other health care coverage under any other health insurance policy or program or employer plan, including COBRA Continuation coverage, individual insurance, Medicare, Medicaid or other public program, and your Spouse and/or Dependent Child(ren) cease to be covered under that other health insurance policy or plan, you may enroll your Spouse and/or Dependent Child(ren) within the sixty (60) days after the termination of their coverage under the other health care policy or plan. This applies only if the other coverage terminated because:

- Of loss of eligibility for that other coverage as a result of termination of employment or reduction in the number of hours of employment, or death, divorce or legal separation; or
- Of the termination of employer contributions toward that other coverage; or
- If the other coverage was COBRA Continuation Coverage, the coverage was exhausted.

COBRA Continuation Coverage is exhausted if it ceases for any reason other than either the failure of the individual to pay the applicable COBRA premium on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact in connection with that COBRA Continuation Coverage). Exhaustion of COBRA Continuation Coverage can also occur if the coverage ceases:

- Ç Due to the failure of the employer or other responsible entity to remit premiums in a timely basis;
- Ç When the employer or other responsible entity terminates the health care plan and there is no other COBRA Continuation Coverage available to the individual;
- Ç When the individual no longer resides, lives or works in a service area of an HMO or similar program (whether or not by the choice of the individual) and there is no other COBRA Continuation Coverage available to the individual; or
- Ç Because the 18-month or 36-month period of COBRA Continuation Coverage has expired.

However, you may not avail yourself of this opportunity for Special Enrollment for yourself or any Dependent unless, at the time of Initial or Special Enrollment, you indicated in writing that the reason your Spouse and/or Dependent Child(ren) were not enrolled was because they had coverage under another health insurance policy or plan

TERMINATION OF COVERAGE

Coverage for you and your Eligible Dependents will terminate on the earlier of the following dates (unless you qualify for and elect Continuation of Benefits as described on page 16):

- C The last day of an Eligibility Period if you have insufficient contributions and/or Reserve Hours, and fail to make timely self_payments; or
- C When you begin active duty in the armed forces; or
- C The last day of an Eligibility period in which you die except that your Eligible Dependents will be allowed to remain eligible until any of your accumulated Reserve Hours are exhausted; or
- C The eligibility of an employee will terminate on the date the union which represents him for collective bargaining purposes ceases to participate in the Insurance Fund. Only the disabilities incurred prior to the withdrawal of the union from the Fund will be honored.
- C The date you cease to be available for work under Covered Employment; or
- C The date the Plan terminates.

Dependent coverage may also terminate for your Eligible Dependent if that class of coverage is terminated or on the date that your Dependent:

- C Ceases to be your legal Dependent as provided by the Plan; or
- C Becomes an Eligible Employee under this Plan or another group plan; or

C Begins active duty in the armed forces.

SUSPENSION OF BENEFITS

Your benefits may be suspended if the Trustees determine that you are:

1) performing work in covered employment within the craft jurisdiction and not pursuant to a collective bargaining agreement; or

2) your membership in the Union has been terminated, other than retirement.

REINSTATEMENT

Active Employees who lose coverage will be required to again meet the Plan's Initial Eligibility rules.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA) SUMMARY OF RIGHTS AND OBLIGATIONS REGARDING CONTINUATION OF COVERAGE UNDER THE PLAN

Federal law requires most employers sponsoring group health plans to offer Employees and their families the opportunity to elect a temporary extension of health coverage (called "continuation coverage" or "COBRA coverage") in certain instances where coverage under the group health plan would otherwise end. You do not have to show that you are insurable to elect continuation coverage. However, you will have to pay the entire premium for your continuation coverage.

This summary is intended only to summarize, as best possible, your rights and obligations under the law. The Plan offers no greater COBRA rights than what the COBRA statute requires, and this Notice should be construed accordingly.

Both you (the Participant) and your Spouse should read this summary carefully and keep it with your records.

Qualifying Events

If you are an Active Participant covered by the Plan, you have a right to elect continuation coverage if you lose coverage under the Plan because of any one of the following two "qualifying events":

1. Termination (for reasons other than your gross misconduct) of your employment.
2. Reduction in the hours of your employment.

If you are the Spouse of an Active Participant or Retiree Participant covered by the Plan, you have the right (if you have not waived such right) to elect continuation coverage if you lose coverage under the Plan because of any of the following four "qualifying events":

1. The death of your Spouse.

2. A termination of your Spouse's employment (for reasons other than gross misconduct) or reduction in your Spouse's hours of employment with the Employer.

3. Divorce or legal separation from your Spouse. (Also, if an Employee drops his or her Spouse from coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce will be considered a qualifying event even though the ex-Spouse lost coverage earlier. If the ex-Spouse notifies the Administrative Manager within 60 days of divorce and can establish that the coverage was dropped earlier in anticipation of divorce, then COBRA coverage may be available for the period after the divorce or legal separation.)
4. Your Spouse becomes entitled to Medicare benefits.

In the case of a dependent child of an Active Participant covered by the Plan, he or she has the right to elect continuation coverage if group health coverage under the Plan is lost because of any of the following five "qualifying events":

1. The death of the Active Participant's parent.
2. The termination of the Active Participant parent's employment (for reasons other than gross misconduct) or reduction in the Employee parent's hours of employment with the Employer.
3. Parents' divorce or legal separation.
4. The Active Participant's parent becomes entitled to Medicare benefits.
5. The dependent ceases to be a "dependent child" under the Plan.

<u>Notices and Election</u>[1]

The Plan provides that your Spouse's coverage terminates (thus, is lost) as of the last day of the month in which a divorce or legal separation occurs. A dependent child's coverage terminates the last day of the month in which he or she ceases to be an Eligible Dependent under the Plan (for example, after attainment of a certain age). Under the COBRA statute, you (the Participant) or a family member has the responsibility to notify the Administrative Manager upon a divorce, legal separation, or a child losing dependent status. You or a family member must provide this notice no later than 60 days after the last day of the month of the divorce, legal separation, or a child losing dependent status. If you or a family member fails to provide this notice to the Administrative Manager during this 60 day notice period, any family member who loses coverage will NOT be offered the option to elect continuation coverage. Further, if you or a family member fails to notify the Administrative Manager, and any claims are paid mistakenly for expenses incurred after the last day of the month of the divorce, legal separation, or a child losing dependent status, then you and your qualifying family members will be required to reimburse the Plan for any claims so paid.

If the Administrative Manager is provided timely notice of a divorce, legal separation, or a child's losing dependent status that has caused a loss of coverage, the Administrative Manager will notify the affected family member of the right to elect continuation coverage.

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[1] A complete Cobra Continuation Coverage Election Notice can be found on Pages 24 through 26 of the SPD.

You and/or your qualifying family member will be notified of the right to elect continuation coverage automatically (i.e., without any action required by you or a family member) upon the following events that result in a loss in coverage: the termination of your employment (other than for gross misconduct), reduction in hours, or death, or you becoming entitled to Medicare.

You (the Active Participant or Retired Participant) or your qualifying family member must elect continuation coverage within 60 days after Plan coverage ends, or, if later, 60 days after the Administrative Manager sends you or your family member notice of the right to elect continuation coverage. If you or your qualifying family member does not elect continuation coverage within this 60-day election period, you will lose your right to elect continuation coverage. Your (or your qualifying family member's) election is effective on the day the election is sent to the Administrative Manager. Please Note: No claims will be paid until the COBRA payment is received.

An Active Participant or the Spouse of the covered Active Participant may elect continuation coverage for all qualifying family members. The covered Active Participant, and his or her Spouse and dependent children each have an independent right to elect continuation coverage. Thus a Spouse or dependent child may elect continuation coverage even if the Active Participant does not (or is not deemed to) elect it.

You or your qualifying family member can elect continuation coverage if you or the family member, at the time you or the family member elect continuation coverage, are covered under another employer-sponsored group health plan or are entitled to Medicare.

Type of Coverage; Premium Payments

Ordinarily, you or your qualifying family member will be offered COBRA coverage that is the same coverage that you, he or she had on the day before the qualifying event. Therefore, a person (Active Participant or Retired Participant, Spouse or dependent child) who is not covered under the Plan on the day before the qualifying event is generally not entitled to COBRA coverage except, for example, where there is no coverage because it was eliminated in anticipation of a qualifying event like divorce.

If the coverage for similarly situated employees or their family members is modified, COBRA coverage will be modified the same way.

The premium payments for the "initial premium months" must be paid for you and any qualifying family member by the 45th day after electing continuation coverage. The initial premium months are the months that end on or before the 45th day after the date of the COBRA election. All other premiums are due on the 1st of the month for which the premium is paid, subject to a 30-day grace period. A premium payment is made on the date it is post-marked or actually received; whichever is earlier.

Maximum Coverage Periods

36 Months. If you (or an Eligible Dependent(s)) lose group health coverage because of the Active Participant's death, divorce, legal separation, or the Active Participant becoming entitled to Medicare, or because you lose your status as an Eligible Dependent under the Plan, the maximum coverage period (for your Eligible Dependent(s)) is 36 months from the date of the qualifying event.

18 Months. If you (Active Participant or Eligible Dependent(s)) lose group health coverage because of the Active Participant's termination of employment (other than for gross misconduct) or reduction in hours, the maximum continuation coverage period (for the Active Participant, Spouse and dependent child) is 18 months from the date of termination or reduction in hours. There are three exceptions:

- If an Active Participant or Retired Participant or family member is disabled at any time during the first 60 days of continuation coverage (running from the date of termination of employment or reduction in hours), the continuation coverage period for all qualified beneficiaries under the qualifying event is 29 months from the date of termination or reduction in hours. The Social Security Administration must formally determine under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act that the disability exists and when it began. For the 29-month continuation coverage period to apply, notice of the determination of disability under the Social Security Act must be provided to the Employer or the Administrative Manager both within the 18-month coverage period and within 60 days after the date of the determination.
- If a second qualifying event that gives rise to a 36 month maximum coverage period (for example, the Employee dies or becomes divorced) occurs within an 18-month or 29-month coverage period, the maximum coverage period becomes 36 months from the date of the initial termination or reduction in hours.
- If the qualifying event occurs within 18 months after an individual becomes entitled to Medicare, the maximum coverage period (for the Spouse and dependent child) ends 36 months from the date the individual became entitled to Medicare.

Children Born To, or Placed For Adoption With The Active Participant After The Qualifying Event

If, during the period of continuation coverage, a child is born to, adopted by or placed for adoption with the Active Participant and the Active Participant has elected continuation coverage for himself or herself, the child is considered a qualified beneficiary. The Active Participant or other guardian has the right to elect continuation coverage for the child, provided the child satisfies the otherwise applicable plan eligibility requirements (for example, age). The Active Participant or a family member must notify the Administrative Manager within 30 days of the birth, adoption or placement to enroll the child on COBRA, and COBRA coverage will last as long as it lasts for other family members of the Active Participant. (The 30-day period is the Plan's normal enrollment window for newborn children, adopted children or children placed for adoption). If the Active Participant or family member fails to so notify the Administrative Manager in a timely fashion, the Active Participant will NOT be offered the option to elect COBRA coverage for the child.

Termination of COBRA Before the End of Maximum Coverage Period

Continuation coverage of the Active Participant, Retiree Participant and/or Eligible Dependent(s) will automatically terminate (before the end of the maximum coverage period) when any one of the following six events occurs:

1. The Plan no longer provides group health coverage.
2. The premium for the qualified beneficiary's COBRA coverage is not timely paid.
3. After electing COBRA, you (Active Participant, Retired Participants, Spouse or dependent child) become covered under another group health plan (as an Employee or otherwise) that has no exclusion or limitation with respect to any preexisting condition that you have. If the other plan has applicable exclusions or limitations, your COBRA coverage will terminate after the exclusion or limitation no longer applies (for example, after a 12-month preexisting condition waiting period expires). This rule applies only to the qualified beneficiary who becomes covered by another group health plan. (Note that under Federal law (the Health Insurance Portability and Accountability Act of 1996), an exclusion or limitation of the other group health plan might not apply at all to the qualified beneficiary, depending on the length of his or her creditable health plan coverage prior to enrolling in the other group health plan.)
4. After electing COBRA, you (Active Participants, Retired Participants or Eligible Dependent(s)) become entitled to Medicare benefits. This will apply only to the person who becomes entitled to Medicare.
5. If you (Active Participants, Retired Participants or Eligible Dependent(s)) became entitled to a 29-month maximum coverage period due to disability of a qualified beneficiary, but then there is a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled (however, continuation coverage will not end until the month that begins more than 30 days after the determination).
6. Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to covered Employees or their Spouses or dependent children who have coverage under the Plan for a reason other than the COBRA coverage requirements of Federal law.

<u>Retired Participants</u>

1. <u>Pre-65</u>. If you retire prior to age 65 and have exhausted your Reserve Hours or Dollars Bank, you may elect COBRA coverage to the extent you have not already received retiree coverage from the Fund.
2. <u>65 and older</u>. If you retire at age 65 or older, you shall have the option to receive retiree medical coverage through the Plan or COBRA. However, if you chose retiree medical coverage at retirement then you will cease to be a qualified beneficiary once the COBRA election period has expired and you will not be eligible for any COBRA coverage.

Other Information

If you or a qualifying family member has any questions about COBRA, please contact the Fund's Administrative Manager. If your marital status changes or an Eligible Dependent ceases to be a dependent eligible for coverage under the Plan terms, or your or your Spouse's address changes, you must immediately notify the Administrative Manager.

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

Introduction

You are receiving this Notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your rights to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budge Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Administrative Manager.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed later in this Notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". You, your Spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for such COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the Spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

1. Your Spouse dies;
2. Your Spouse's hours of employment are reduced;
3. Your Spouse's employment ends for any reason other than his or her gross misconduct;
4. Your Spouse becomes entitled to Medicare benefits (under Part A, Part B or both); or
5. You become divorced or legally separated from your Spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than his/her gross misconduct;
4. The parent-employee becomes entitled to Medicare benefits (under Part A, Part B or both);
5. The parents divorced or legally separated from your Spouse; or
6. The child stops being eligible for coverage under the plan as a "dependent child".

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy filed with respect to one or more of the contractors who are signatories to the collective bargaining agreement with the Union and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's Spouse, surviving Spouse, and dependent children will also become qualified beneficiaries if the bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA coverage to qualified beneficiaries only after the Administrative Manager has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the Employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), the employer must notify the Administrative Manager of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and Spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Administrative Manager within sixty (60) days after the qualifying event occurs. You must provide this notice to the Fund's Office of the Administrative Manager.

How Is COBRA Coverage Provided?

Once the Administrative Manager receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their Spouse, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), your divorce or legal separation, or a dependent child's losing

eligibility as a dependent child, COBRA continuation coverage last for up to a total of thirty-six (36) months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than eighteen (18) months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until thirty-six (36) months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight (8) months before the date on which his employment terminates, COBRA continuation coverage for his Spouse and children can last up to thirty-six (36) months after the date of Medicare entitlement, which is equal to twenty-eight (28) months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of eighteen (18) months. There are two ways in which this eighteen (18) month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF EIGHTEEN (18) MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under this Plan is determined by the Social Security Administration to be disabled and you notify the Office of the Administrative Manager in a timely fashion, you and your entire family may be entitled to receive up to an additional eleven (11) months of COBRA continuation coverage, for a total maximum of twenty-nine (29) months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the eighteen (18) month period of continuation coverage.

SECOND QUALIFYING EVENT EXTENSION OF EIGHTEEN (18) MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event while receiving eighteen (18) months of COBRA continuation coverage, the Spouse and dependent children in your family can get up to eighteen (18) additional months of COBRA continuation coverage, for a maximum of thirty-six (36) months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the Spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (Part A, Part B or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the Spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

<u>If You Have Questions</u>

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Office of the Administrative Manager. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed Of Address Changes

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

Plan Contact Information

Additional information about the Plan or COBRA continuation coverage can be obtained, upon request, from the Administrative Manager, Mahoning & Trumbull County Building Trades Insurance Fund, 33 Fitch Boulevard, Austintown, Ohio 44515.

COBRA CONTINUATION COVERAGE ELECTION NOTICE

To be provided to all eligible Participants upon a Qualifying Event

Date: ___________________________

Dear: {Enter Name of Participant, Spouse, Dependent Children, as appropriate}

This Notice contains important information about your right to continue your health care coverage in the Mahoning & Trumbull County Building Trades Insurance Fund. Please read the information contained in this notice very carefully.

This Notice provides important information concerning your rights and what you have to do to continue your health care coverage under the Plan. If you have any questions concerning the information in this Notice or your rights to COBRA coverage, you should contact:

Office of the Administrative Manager
Mahoning & Trumbull County Building Trades Insurance Fund
33 Fitch Blvd.
Austintown, Ohio 44515
Phone: (800) 435-2388

If you do not elect to continue your health care coverage by completing the enclosed "Election Form" and returning it to us, your coverage under the Plan will end on ___________________ due to:

Date

_____ End of Employment
_____ Death of Employee
_____ Enrollment in Medicare
_____ Reduction in Hours of Employment
_____ Divorce or Legal Separation
_____ Loss of Dependent Child Status

Each person "qualified beneficiary") in the category(ies) checked below is entitled to elect COBRA continuation coverage, which will continue group health care coverage under the Plan for up to ______________ months (enter 18 or 36, as appropriate) and check appropriate box or boxes below:

_____ Employee or Former Employee
_____ Spouse or Former Spouse
_____ Dependent Child(ren) covered under the Plan on the day before the event that caused the loss of coverage
_____ Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

If elected, COBRA continuation covera ge will

begin
on ________ and

COBRA continuation coverage will cost $_____________ per month. You do not have to send any payment with the Election Form. Important additional information about payment for COBRA continuation coverage is included in the pages following the Election Form.

COBRA CONTINUATION COVERAGE ELECTION FORM

IMPORTANT – To elect continuation coverage, you MUST complete the enclosed "Election Form" and return it to us. Under federal law, you must have sixty (60) days after the date of this Notice to decide whether you want to elect COBRA continuation coverage under the Plan. Send the completed form to:

Office of the Administrative Manager
Mahoning & Trumbull County Building Trades Insurance Fund
33 Fitch Blvd.
Austintown, Ohio 44515
Phone: (800) 435-2388

You may mail it to the address shown on the Election Form or hand deliver it to the Administrative Manager. The completed Election Form must be post-marked by _____________________ or received by ______________________________________, if submitted by other means. If you do not submit a completed Election Form by this date, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form to the Office of the Administrative Manager before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form.

Read the important information about your rights included in the pages after the Election Form.

I (We) elect to continue our coverage in the Mahoning & Trumbull County Building Trades Insurance Fund (the Plan) as indicated below:

Name Date of Birth Relationship to Employee SSN (or other identifier)

a. ____

Type of Coverage Elected*:____

b. ____

Type of Coverage Elected*:____

c. ____

Type of Coverage Elected*:____

d. ____

Type of Coverage Elected*:____

Signature	Date
Print Name	Relationship to Individual(s) listed above
Print Address	Telephone Number

____

*Type of coverage elected:

1) Participant Only
2) Participant and Spouse
3) Family

IMPORTANT INFORMATION ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS

What Is Continuation Coverage?

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee covered under the group health plan, covered employee's Spouse, and the dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other Participants or Beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights, under the Plan as other Participants or beneficiaries covered under the Plan, including special enrollment rights.

How Long Will Continuation Coverage Last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage may be continued for up to eighteen (18) months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the Plan, coverage may be continued for up to a total of thirty-six (36) months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than eighteen (18) months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until thirty-six (36) months after the date of Medical entitlement. This Notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
- a covered employee becomes entitled to Medicare benefits (under Part A, Part B or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a Participant or Beneficiary not receiving continuation coverage (such as fraud).

How Can You Extend The Length Of Continuation Coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the Administrative Manager of a disability or a second qualifying event in order to extend

the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

An eleven (11) month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration ("SSA") to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Administrative Manager of that fact within 30 days of SSA's determination.

An 18-month extension of coverage will be available to Spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have cause the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Administrative Manager within 60 days after a second qualifying event occurs.

How Can You Elect Continuation Coverage?

To elect continuation coverage, you must complete the Election Form and furnish it according to the direction on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's Spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's Spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and the election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the rights to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within thirty (30) days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How Much Does Continuation Coverage Cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 (or in the case of an extension on continuation coverage due to a disability, 150 percent) percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan Participant or beneficiary who is not receiving continuation coverage. The required payment for continuation coverage for each option is described in this Notice.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp

WHEN AND HOW MUST PAYMENT FOR COBRA CONTINUATION COVERAGE BE MADE?

First payment for COBRA continuation coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage no later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all COBRA continuation coverage rights under the Plan.

You are responsible for making sure that the amount of your payment is correct. You may contact the Office of the Administrative Manager to confirm the correct amount of your first payment.

Your first payment for COBRA continuation coverage should be sent to:

Office of the Administrative Manager

Mahoning & Trumbull County Building Trades Insurance Fund
33 Fitch Blvd.
Austintown, Ohio 44515
Phone: (800) 435-2388

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. The amount due for each coverage period for each qualified beneficiary is shown in this Notice. Under the Plan, these periodic payments for continuation coverage are due on the first day of each month. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that

coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods.

Periodic payments for COBRA continuation coverage should be sent to:

Office of the Administrative Manager

Mahoning & Trumbull County Building Trades Insurance Fund
33 Fitch Blvd.
Austintown, Ohio 44515
Phone: (800) 435-2388

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of its grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA continuation coverage under the Plan.

Can You Elect Other Health Coverage Besides Continuation Coverage?
Yes. You may be able to maintain eligibility through self-contributions, use of any Reserve Hours Bank or Reserve Dollars Bank or use of FMLA, disability or military leave.

For More Information
This Notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available from the Office of the Administrative Manager. If you have any questions concerning the information in this Notice, your rights to coverage, you should contact:

Office of the Administrative Manager
Mahoning & Trumbull County Building Trades Insurance Fund
33 Fitch Blvd.
Austintown, Ohio 44515
Phone: (800) 435-2388

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

ELIGIBILITY FOR EARLY RETIREES AND DEPENDENTS (Under Age 65)
You are able to continue your coverage as an Early Retiree and coverage for your Dependents through timely self_payments if you:

C have had at least 20 quarters of eligible participation in this Welfare Plan out of the 40 quarters immediately before retirement date; and

C have had at least 12 consecutive months eligible participation in this Welfare Plan immediate before retirement date; and

C are receiving a pension from a plan which is sponsored by a local union affiliated with the Fund or early retirement benefits under the Federal Social Security Act; and:

C are retired from Covered Employment in the trade.

You must notify the Fund Office in writing that you want to maintain eligibility through the retiree program within 31 days of the last month in which you are covered as an active Employee.

You will be notified by the Fund Office of the amount due. Self_payments must be made from the date coverage was lost. These self_payments count toward the duration of COBRA continuation coverage. If you fail to make a self_payment, you lose your coverage and it cannot be reinstated.

Coverage for the Early Retiree's Dependents as of the Retiree's effective retirement date may be continued for the same periods, as set forth above, upon timely self_payment. Dependents acquired after the Retiree's effective retirement date will not be eligible for benefits under this Plan.

Retiree benefits have been made available by the Trustees as a privilege, not a right. No person acquires a vested right to such benefits, either before or after their retirement. The Trustees may expand, reduce or cancel coverage for Retirees, change eligibility requirements or the amount of self-payments and otherwise exercise their prudent discretion at any time without legal right or recourse by a Retiree or any other person.

Eligibility for Disabled Retirees and Dependents
If you are Totally and Permanently Disabled, you are able to continue eligibility under the Disability Retiree program for you and your Dependents through timely self_payments if:

C you were an active, Eligible Employee in the Plan for a total of 20 quarters out of the 40 quarters immediately before your Disability; and

C you were an active, Eligible Employee in the Plan for a total of 12 consecutive months immediately before your Disability; and

C you were an Eligible Employee immediately before the date that the Total and Permanent Disability was incurred; and

C you have received your Social Security disability award; and

C you are retired from Covered Employment in the trade.

The Disabled Employee must notify the Fund Office in writing that he wants to maintain his eligibility through self_payments within 31 days of the last month in which he was covered as an active employee or retires. He will be notified by the Fund Office of the amount due. If he fails to make a timely self_payment, he loses his eligibility and it cannot be reinstated. Self_payments must be made from the date coverage was lost, and will be counted toward any required COBRA continuation coverage.

Coverage will terminate if your self_payments are late, your Disability ends and you are able to return to active employment, or you become eligible for the Normal Retiree Program.

Coverage for the Disabled Employee's Dependents as of the effective date of disability may be continued for the same periods, as set forth above, upon timely self_payment. Dependents acquired after the Disabled Employee's effective disability date will not be eligible for benefits under this Plan.

Disabled Employee benefits have been made available by the Trustees as a privilege, not a right. No person acquires a vested right to such benefits, either before or after the Employee becomes disabled. The Trustees may expand, reduce or cancel coverage for Disabled Employees, change eligibility requirements or the amount of self_payments and otherwise exercise their prudent discretion at any time without legal right or recourse by a Disabled Employee or any other person.

ELIGIBILITY FOR NORMAL RETIRED EMPLOYEES (at or after age 65)

1. This coverage is limited to employees of the construction industry who:
   - A. Have retired from active employment of any kind or are receiving Social Security retirement benefits; and
   - B. Are not eligible for benefits as an active employee; and
   - C. Have accumulated 6,000 hours of credit as an active employee, or the basis of credited hours paid by contributing employers and self-payments; and
   - D. Representatives for collective bargaining purposes is affiliated with this Insurance Fund at the time of the employee's retirement, and in accordance with the Rules of Eligibility has maintained his eligibility.

You must notify the Fund Office in writing that you want to maintain your eligibility through the Normal Retiree Program within 31 days of the last month in which you were covered as an active employee or Early or Disabled Retiree. You will be notified by the Fund Office of the amount due. Self_payments must be made from the date coverage was lost, and will be counted

toward any required COBRA continuation coverage. If you fail to make a self_payment, you lose your coverage and it cannot be reinstated.

Coverage for the Normal Retiree's Dependents as of the Retiree's effective retirement date may be continued for the same periods, as set forth above, upon timely self_payment. Dependents acquired after the Retiree's effective retirement date will not be eligible for benefits under this Plan.

Retiree benefits have been made available by the Trustees as a privilege, not a right. No person acquires a vested right to such benefits, either before or after their retirement. The Trustees may expand, reduce or cancel coverage for Retirees, change eligibility requirements or the amount of self-payments and otherwise exercise their prudent discretion at any time without legal right or recourse by a Retiree or any other person.

Eligibility for Surviving Spouses and Eligible Dependents at Date of Death
The Surviving Spouse of an Early Retiree, Disabled Retiree, Normal Retiree or Employee Eligible hereunder at death shall terminate at the end of the Eligibility month in which the Retiree had last obtained eligibility. The Surviving Spouse may continue coverage by making required self_payments so long as such coverage is elected within 60 days following the Employee's or Retiree's death.

If the surviving spouse fails to join the surviving spouse program within 60 days after the death of the Eligible Retired Employee or Eligible Employee, or if the surviving spouse, upon joining the program, fails to make the contributions required by the Trustees, eligibility for participation shall terminate and the surviving spouse shall not be able to be reinstated to the surviving spouse program in the future.

Coverage for Surviving Spouses would also cease on the earliest of the following:

C The date they no longer meet the definition of a Dependent; or

C The date they become covered by another group plan (excluding Medicare); or

C The date the Spouse remarries; or

C The date the Spouse dies.

Coverage for dependents of the deceased Eligible Employee or Retiree upon death may be continued for the same periods, as set forth above, upon timely self_payment.

Surviving spouse benefits have been made available by the Trustees as a privilege, not a right. No surviving spouse or dependent acquires a vested right to benefits, either before or after the Employee's death. The Board of Trustees may expand, reduce or cancel coverage for surviving spouses and/or dependents, change eligibility requirements and/or the self_pay rate and otherwise exercise its discretion at any time without legal right to recourse by a surviving spouse, dependent or any other person.

Information Regarding Eligibility

Any questions concerning your eligibility should be directed to the Fund Office, 33 Fitch Boulevard, Austintown, Ohio 44515 or by calling telephone number (800) 435_2388 or (330) 270-0453.

BASIC MEDICAL EXPENSES

HOSPITAL EXPENSE BENEFITS

(For Eligible Employees, Early Retirees and Eligible Enrolled Dependents)

BENEFITS PROVIDED IN ACCREDITED HOSPITALS

When you are admitted for treatment as an inpatient to an accredited hospital, benefits will be provided for semi-private room accommodations and all other services provided by the hospital for the diagnosis and treatment for your condition including treatment in an intensive care unit, blood and blood plasma and ambulance service. You will be responsible for an additional co-payment in the amount of $300 for inpatient services received at a hospital that is not a provider in the Plan's PPO.

If you occupy a private room in an accredited hospital, you will be entitled to all of the above described benefits, but you will be required to pay the hospital the excess, if any, of its regular charge for the private room over the hospital's most common charge for semi-private rooms.

The following requirements must be met for covered hospital benefit consideration:

(a) Maintains permanent and full-time facilities for ten or more resident patients.
(b) Has a licensed physician or surgeon in regular attendance.
(c) Continuously provides 24-hour-a-day nursing service by registered nurses.
(d) Is primarily engaged in providing diagnostic and therapeutic facilities for medical and surgical care for injured and sick persons on a basis other than as rest home, nursing home, convalescent home, a place for the aged, a place for alcoholics, or a place for drug addicts.

BENEFITS PROVIDED IN OTHER HOSPITALS

If you are admitted to a non-accredited hospital, you will be entitled for covered hospital services in accordance with the following schedule:

(a) up to $25.00 for the first day of hospitalization, and

(b) up to $10.00 per day for each additional day of hospitalization, for the remaining number of days for which you are eligible under this program, as set out below.

MATERNITY BENEFITS

The benefits provided under the Program are only available to a female employee or a member's spouse for hospital confinement in a pregnancy case.

INPATIENT HOSPITALIZATION - DENTAL CASES

The hospital benefits provided under the Insurance Fund are available if you are admitted to a hospital (a) for extraction of boney impacted teeth, or (b) for extraction of teeth other than impacted teeth or for other dental processes provided hospitalization is certified by a licensed

physician or a doctor of dental surgery as being necessary to safeguard the health of the person confined.

OUTPATIENT TREATMENT - SURGICAL CASES
The hospital benefits provided under the Plan are available if you receive surgical treatment for medically necessary procedures in the outpatient department of an accredited hospital.

OUTPATIENT TREATMENT - RADIATION THERAPY
If you receive radiation treatments in the outpatient department of a covered hospital, such treatments are covered to the extent that they are provided as a hospital service.

OUTPATIENT LABORATORY SERVICE
Benefits are available for out patient laboratory services.

INPATIENT ADMISSIONS AND OUTPATIENT VISITS FOR DIAGNOSTIC STUDY
Hospital benefits are provided for inpatient admissions for diagnostic study when the study is directed toward the diagnosis of a definite condition of illness or injury.

Hospital benefits are also available for the following diagnostic services performed in the outpatient department of a covered hospital which provides such services, when directed toward the diagnosis of a definite condition of illness or injury:

> X-ray examinations with films, metabolism testing, radioactive isotope studies, and cardiographic and encephalographic examinations, but excluding work-up procedures performed in the outpatient department when the patient is to be admitted as an inpatient unless provided for under the section titled BENEFITS PROVIDED IN ACCREDITED HOSPITAL on Page 25.

Hospital benefits are not provided for the following services:

> Audiometric testing; eye refractions, examinations for the fitting of eyeglasses or hearing aids; dental examinations; premarital examinations; research studies, screening; or routine physical examinations or check-ups.

SURGICAL BENEFITS

Benefits are provided for surgical services consisting of operative and cutting procedures (including the usual post-operative care) for the treatment of illnesses, fractures or dislocations, which are performed in or out of a hospital by a licensed physician and, in the case of reduction of fractures or dislocations of the jaw, which are performed either by a licensed physician or by a doctor of dental surgery. If you are an inpatient in a covered hospital benefits will also be provided for the services of a licensed physician, who actively assists the operating surgeon in the performance of such surgical services when the condition of the patient and the type of surgical services requires such assistance and when the hospital does not employ interns, residents, or house staff.

Benefits are also provided for operative and cutting procedures for the treatment of diseases and injuries of the jaw or for the extraction of impacted teeth and if the surgical services is performed by a licensed physician or a doctor of dental surgery.

Surgical services which would be covered if performed by a licensed physician shall also be covered when performed by a duly licensed podiatrist acting within the scope of his license.

An internal penile prosthesis will be considered medically necessary for the treatment of erectile dysfunction for individuals 18 years of age or older who met the following medically appropriateness criteria:

ï paraplegia or quadriplegia

ï pelvic trauma with urinary system injury

ï Peyronie’s disease

ï history of radiation therapy to the pelvis

ï history of radical pelvic or perineal surgery (such as cystectomy, prostatectomy, partial penectomy, abdominal-perineal resection, anterior exenteration or total pelvic exenteration)

ï For coverage of other organic diagnoses, documentation must indicate all other forms of therapy have failed and impotence has existed for over one year.

ï The use of an internal penile prosthesis is considered not medically necessary for the treatment of psychogenic erectile dysfunction.

ï The prosthesis used must have FDA approval.

This coverage is subject to the Plan’s annual deductibles and co-insurance provisions.

PHYSICIANS' SERVICES BENEFITS
FOR SURGERY, OBSTETRICS, IN-HOSPITAL MEDICAL CARE,
ANESTHESIA, RADIATION THERAPY AND
DIAGNOSTIC EXAMINATIONS
(For Members, Early Retirees, and Eligible Enrolled Dependents)

Payment for providers that are not part of the PPO are based on the usual, customary, and reasonable fee. This means that, subject to certain deductibles and co-payments specified in the Schedule of Benefits, the Fund pays the charge of the physician for a covered service, but not more than the prevailing fee for such service as determined by the Fund.

In determining what constitutes the usual, customary and reasonable fee, the Fund will take into consideration the following:

)a(The usual fee which the individual physician most frequently charges to the majority of his patients for a similar service or medical procedure.
)b(The fees which fall within the customary range of fees charged in a locality by most physicians of similar training and experience for the performance of a similar service or medical procedure.
)c(Unusual circumstances or medical complications requiring additional time, skill, and experience in connection with a particular service or medical procedure.

These provisions are designed to recognize that there will be differences in physicians' charges because of such factors as the prevailing fees or charges in the geographical locality, skill of the physician, and complexity of the service performed.

The Fund makes the determination as to the prevailing fee. If you become obligated to a physician for a charge in excess of the prevailing fee as determined by the Fund, the Fund will not pay such excess.

Benefits will be not provided under for the following: X-ray examinations in connection with care of teeth, research studies, screening, routine physical examinations or check-ups, premarital examinations, routine procedures provided on admission to a hospital, fluoroscopy without films, or any examination not necessary to diagnosis of an illness or injury.

OBSTETRICAL BENEFITS
Benefits are provided for obstetrical services, including necessary prenatal and postnatal care, furnished to a female employee or a member's spouse either in or out of a hospital by the licensed physician in charge of the case.

ANESTHESIA SERVICES
Benefits are provided for the administration of anesthetics, except local infiltration anesthetic, provided either in or out of a hospital in surgical, obstetrical cases, or medically necessary dental cases when administered and billed by a licensed physician, other than the operating surgeon or

his assistant, who is not an employee of, not compensated by, a hospital, laboratory, or other institution.

RADIATION THERAPY BENEFITS

Benefits are provided for treatment by X-ray, radium, external radiation or radioactive isotopes (including the cost of materials unless supplied by a hospital), provided either in or out of a hospital, when performed and billed by the licensed physician in charge of the case.

When your condition requires radiation therapy services in conjunction with medical, surgical or obstetrical services payment will be made for such radiation therapy services in addition to the payment for such other types of services if the physician performing the radiation therapy services is not the same physician who performs the medical, surgical or obstetrical services.

DIAGNOSTIC X-RAY SERVICES

Benefits are provided as specified below for a diagnostic X-ray examination, either in or out of a hospital, which is required in the diagnosis of any condition of illness or injury, which is customarily billed by the physician who made such examination, and which is:

(a)Ordered by a licensed physician or a doctor of dental surgery who is engaged in general or special practice other than radiology, and when so ordered, is made by a licensed physician (excluding a doctor of dental surgery or the doctor ordering such X-ray) who limits his practice to radiology;
(b)Made by a licensed physician (excluding a doctor or dental surgery) qualified to undertake radiological examinations within the confines of a single specialty; or
(c)Made by a licensed physician in an emergency or emergency traumatic case.

MENTAL HEALTH - INPATIENT SERVICES

If you or your dependents are receiving treatment of psychiatric related conditions on an Inpatient basis, the Plan will pay for covered charges up to the annual maximum up to a lifetime maximum amount.

The following services are payable for treatment Psychiatric Treatment - Nervous/Mental Disorders:

ï Individual psychotherapy
ï Group psychotherapy
ï Electroshock therapy and related anesthesia in a hospital or psychiatric hospital.
ï Psychological testing, limited to one battery of covered person per calendar year.

All charges applied to the Mental Health Service Benefit will subject to completion of the program(s) and/or treatment(s) prescribed by a licensed physician or psychologist.

MENTAL HEALTH - OUTPATIENT SERVICES

The Fund will pay for all Covered Charges incurred on an outpatient basis up to the calendar year maximum as a result of a nervous and/or mental disorder which are in excess of the deductible provided that the maximum amount payable for professional psychiatric treatment under the clinical supervision of a licensed Physician or a licensed Psychologist, whether performed in an office, Hospital or a community mental health facility approved by the Commission on Accreditation of Hospitals or Certified by the Department of Mental Health and Mental Retardation, shall not exceed the Annual Maximum amount set forth in the Schedule of Benefits.

All charges applied to the Mental Health Service Benefit will be subject to completion of the program(s) or treatment(s) as prescribed by a licensed physician, psychiatrist, or psychologist.

SUBSTANCE ABUSE SERVICES - INPATIENT/OUTPATIENT

This benefit covers treatment of drug abuse and alcoholism related conditions, if you or your dependents are being treated as an Inpatient/Outpatient in a network facility:

Inpatient - $10,000 maximum calendar year
Outpatient - $5,000 maximum calendar year
Lifetime Maximum of $15,000

(Subject to annual deductibles and co-payments)

Services not covered under this benefit include:

- Treatment not prescribed and supervised by a physician, psychiatrist, or licensed psychologist
- Legal services, recreational, vocational, financial, or educational counseling, except as part of a chemical dependency treatment program
- Detoxification or drug withdrawal programs not rendered by a hospital or as part of a maintenance program
- Personal comfort items
- Marriage or family counseling.

DEATH BENEFIT

(Eligible Employees and Early Retirees)

In event of your death, $6,500 is payable in a lump sum to the beneficiary you select.

If you become permanently and totally disabled prior to your 65th birthday, this benefit may be continued without further cost to you until you become eligible for the normal retirement benefits, provided you submit satisfactory evidence of such disability.

Please notify the Insurance Fund office immediately if you wish to change your beneficiary.

ACCIDENTAL DEATH
OR
DISMEMBERMENT BENEFIT

(Eligible Employees and Early Retirees)

Six thousand five hundred dollars ($6,500) is payable to your beneficiary in the event of accidental death. If you lose both hands, both feet, sight of both eyes, one hand or one foot and sight of one eye, or one hand and one foot, within 90 days after and as a result of an accident, you will receive a $6,500 dismemberment benefit.

One half the amount of the dismemberment benefit is payable to you for loss of one hand, one foot, or sight of one eye within 90 days after and as a result of an accident.

Loss as used in the above clauses with reference to hand or foot means complete severance through or above the wrist or ankle joint, and with reference to eye means the irrevocable loss of the entire sight thereof. Benefits will not be paid for more than one of the above losses (the greatest) sustained as the result of any one accident.

WEEKLY INDEMNITY

(Eligible Employees Only)

The Weekly Indemnity Benefit is $300.00 and is payable if you are unable to work because of an accident occurring off the job, or a sickness not connected with employment. You must be under the continuing care of a licensed medical doctor.

Benefits begin the first day of disability if due to an accident, and 8th day of disability if due to illness. Maximum number of weeks per disability is 26.

There is no limit to the number of separate periods of disability for which benefits are payable. However, successive terms of disability for the same or a related cause and separated by less than two weeks of full-time work will be considered one period of disability.

Participants drawing this benefit are also given four hours per day for each day he draws this benefit for his credited hours account. The purpose of this additional benefit is to make it less costly for the temporarily disabled member to maintain eligibility. Similarly, a member is also credited four hours per day for each day he draws benefits from the State as the result of an industrial disability. In order to gain this credit, be sure to notify the Fund when you have been awarded Worker's Compensation benefits.

Participants whose domicile is not in the jurisdiction of a participating union, or whose usual representative for collective bargaining purposes is not a participating union, shall not be eligible for weekly indemnity benefits for disabilities commencing after the employee has terminated employment with a contributing employer.

BENEFITS FOR MOTHERS AND NEWBORNS

This child birth benefit is for any hospital length of stay in connection with childbirth for the mother or newborn child, following a normal vaginal delivery, to a minimum of 48 hours. This benefit is for any hospital length stay in connection with childbirth for the mother or newborn child, following a cesarean section, to a minimum of 96 hours. This, however, does not prohibit the Mother's or newborn's attending provider after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable.)

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The Women's Health and Cancer Rights Act of 1998 provides you with certain medical benefits in connection with a mastectomy. If you elect breast reconstruction, coverage will be provided, in a manner, determined in consultation with the attending physician and the patient, for:

C Reconstruction of the breast on which the mastectomy was performed;

C Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

C Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

ROUTINE PREVENTATIVE CARE BENEFIT

The Plan will pay charges for:

% One routine Papanicolaou test (pap smear) per calendar year and any office visit incidental to such test;
% Routine mammograms and any office visit incidental to such test;
% Well Care Child Care as follows:

< Birth to 1 Year - Coverage for History and Physical examination, development assessment, anticipatory guidance and laboratory services and immunizations at birth, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months/1 year. Intervals are based on the current Recommendations for Preventative Pediatric Health Care of the American Academy of Pediatrics.
Immunizations will be covered based on physician recommendation as the AAP schedule for immunizations varies based on the latest medical findings or research.
< 1 Year to Age 9 - Benefits will be provided for a History and Physical examination development assessment, anticipatory guidance and laboratory services and immunizations at 15 months, 18 months, 24 months, 3 years, 4 years, 5 years, 6 years, and 8 years.
Immunizations will be covered based on physician recommendation as the AAP schedule for immunizations varies based on the latest medical findings or research.

% Vasectomies
% Surgical sterilization

CONVALESCENT NURSING HOME CARE

Expenses incurred for convalescent nursing home care as described in this paragraph are also included in the term Covered Medical Expenses. They include ward or semi-private rate charges (for private room, the charges up to the home's most common semi-private room rate) for room, board, and services provided by professional and practical nursing personnel, excluding custodial and personal type care, for nor more than 365 days for the same or related cause or causes, subject to the following:

(a) Confinement must in a convalescent nursing home which qualifies as an Extended Care Facility under Medicare or is otherwise approved by the Fund. A home will be approved by the Fund if it is accredited as an Extended Care Facility or a Nursing Care Facility by the Joint Commission on Accreditation of Hospitals. (Before you or your dependent enter a nursing home, you should, if possible, inquire of the Fund as to whether such home meets the above requirements).

(b) Nursing home care will be covered only if confinement immediately follows prior inpatient hospitalization involving surgery, or if not involving surgery, immediately follows an inpatient hospitalization of at least three days, and is ordered by a physician as necessary for convalescence from an illness or injury, or treatment of a terminal condition or a long term disability, where nursing home facilities are required and the care required is not principally custodial.

USUAL, CUSTOMARY AND REASONABLE CHARGE

The Usual, Customary and Reasonable (UCR) maximum is the highest allowable expense that your Plan will cover for a given treatment or procedure.

When your claim is filed, the charge for each treatment will be compared with charges for the same treatment made by other health providers. The maximum amount allowed for a covered service is based on the following criteria:

The UCR will never exceed the actual amount billed by the physician or professional provider for a given service.

The UCR may be limited to the customary charge based on the distribution of charges billed by all physicians and/or other professional providers for a given service within a given specialty and geographic area.

The UCR must also be reasonable with respect to customary charges for services of comparable complexity and difficulty.

DATE EXPENSES ARE INCURRED

Covered Medical Expenses are considered to have been incurred on the date when the applicable medical services, supplies, or treatments are rendered.

EXCLUSIONS AND LIMITATIONS

Benefits are not provided for services, supplies or charges:

1) Which are not prescribed by or under the direction of a Physician or Professional Provider
2) Which are not performed within the scope of the Provider's license
3) Which are Experimental/Investigative
4) Which are not Medically Necessary, as determined by the Plan
5) To the extent governmental units or their agencies provide benefits
6) For an injury, ailment, condition, disease, disorder or illness that occurs as a result of any act of war, or during the commission of a felony by the Covered Participant
7) For which you have no legal obligation to pay in the absence of this or like coverage
8) Received from a member of your Immediate Family
9) Which are received in a military facility for a military service related injury, ailment, condition, disease, disorder or illness
10) Primarily for education, vocational or training purposes
11) Exogenous obesity: The following criteria must be met in order for Gastric Restrictive Surgery to be considered medically necessary:
    a) Documented five (5) year history of morbid obesity (body mass index (BMI) over 40 kg/m^2) or a BMI greater than 35 and a clinically serious condition such as coronary heart disease, type 2 diabetes mellitus, obstructive sleep apnea, or hypertension; and
    b) The Participant or Dependent must be treated in a surgical program with experience in obesity surgery and includes a multi-disciplinary preoperative and postoperative approach; and
    c) The Participant or Dependent must participate in a six-month treatment plan within the year preceding surgery which includes a multi-disciplinary non-surgical program including a low or very low calorie diet, increased physical activity, and behavior reinforcement under the direction of the physician who refers the patient for such surgery; and
    d) Documented failure of non-surgical methods of weight reduction; and
    e) Absence of significant pyschopathology that can limit an individual's understanding of the procedure or ability to comply with medical/surgical recommendations; and
    f) Documentation that the Participant or Dependent has received counseling post-operatively regarding cosmetic difficulties and that the patient has agreed to post-operative treatment plans; and
    g) Participant or Dependent must be at least eighteen (18) years of age.

    Any Gastric Restrictive Surgery must be pre-certified and coordinated with The Fund Office. However, Gastric Banding is not covered under this Plan as an Eligible Expense. If it is determined you meet these criteria, the Plan will pay for the Gastric Restrictive Surgery and all related expenses (including post-operative treatment) up to a lifetime maximum of $25,000 subject to an 80/20 co-payment. This lifetime maximum will not be subject to any of the Plan's other out-of-pocket maximums.
12) For family and marital counseling

13) Services of more than one Physician rendering treatment for the same condition
14) Sex-change operations, gender dysphoria, penile and breast implant, infertility, artificial insemination, invitro fertilization, gamete intrafallopian transfer (GIFT), and services of a surrogate mother
15) For birth control
16) For reverse sterilization
17) For or related to the treatment of temporal mandibular joint syndrome with intraoral prosthetic devices or by any other method to alter vertical dimension; for the treatment of temporal mandibular joint dysfunction
18) Personal hygiene and convenience items (such as, but not limited to, air conditioners, humidifiers, hot tubs, whirlpools, sunbeds, waterbeds, physical fitness equipment or like items), weight control programs, transportation vehicles or home improvements, health club or country club memberships even though a Physician may prescribe them
19) For hypnosis, acupuncture, or any related expense
20) For telephone consultations, missed appointments or completion of a claim form
21) For fraudulent or misrepresented claims
22) For expenses of care for conditions that State or local law require be treated in a public facility
23) For topical anesthetics or stand-by anesthesia
24) Evaluation and treatment of sleep disorders (unless determined to be medically necessary which will then be limited to one study per year)
25) Any loss sustained or contracted as a result of an Eligible Participant or Eligible Dependent being under the influence of any narcotic or other drug or as a consequence of the use thereof, unless administered upon the advice of a legally qualified Physician
26) Charges related to massotherapy
27) Milieu therapy
28) Chelation therapy
29) Loss caused by (a) accidental bodily injury which arises out of or occurs in the course of any occupation or employment for wage or profit, or (b) sickness for which the Covered Participant is entitled to benefits under any Workman's Compensation or Occupational Disease Law, unless specifically provided for in the Schedule of Benefits
30) Loss caused by war or any act of war (declared or undeclared) or military or naval service of any country
31) Expenses for or in connection with hearing aids
32) Expenses for or in connection with cosmetic surgery, except cosmetic surgery which is not primarily for beautification but is performed to correct or improve a bodily function or congenital malformation, or to restore facial appearance following an accident, or as provided for under the Women's Health and Cancer Rights Act (see page 32)
33) Expenses for travel or transportation except ambulance charges to the closest facility where appropriate service can be obtained
34) Charges for services furnished by an institution which is primarily a rest home, a home for the aged, a nursing home, a convalescent home, or any institution of like character providing custodial care

35) Treatment on or for treatment of gingival tissues (gums) other than for tumors, physician's services for extraction of teeth; non-surgical treatment of dental abscesses
36) Charges for services of a dentist except for the treatment necessary to alleviate the damage to sound natural teeth or to extract broken or injured teeth, as a result of an accidental bodily injury including the replacement of such teeth in whole or in part, occurred while insured hereunder within one year of injury
37) Charges for services of a dentist except for the surgical removal of impacted (whole or partially) wisdom teeth including anesthesia
38) Charges for dental x-rays, except when performed in connection with an accidental bodily injury
39) Routine physical examinations, elective procedures (except elective sterilization and well person care)
40) Medical treatment received in connection with a pregnancy by dependent children
41) Any expenses when participant is not eligible for benefits
42) Hospice care
43) Eye refractions, eyeglasses or their fitting
44) Eyeglasses, contact lenses (except for one pair of eyeglasses or contact lenses and examinations for the prescription or fitting thereof following a cataract operation), dentures, hearing aids or other devices or their fitting and related services
45) Maintenance Therapy
46) Charges for keratotomies or keratoplasties
47) No benefits are payable for services or supplies related to the treatment for abuse of nicotine from tobacco and other sources
48) Air ambulance costs, where no life-threatening medical emergency is established or to the extent costs exceed $3,000
49) Surgery performed for the removal of excess fat of skin after weight loss or pregnancy unless Medically Necessary
50) Over-the-counter drugs or vitamins
51) Immunizations (after age 9 years)
52) An injury for which you are reimbursed or entitled to be reimbursed by an third party for which such third party is liable
53) Food supplements or augmentation
54) Corrective shoes, arch supports and foot care only to improve comfort or appearance such as subluxation (except capsular or bone surgery)
55) Court-ordered services
56) Services of any practitioner who is not legally licensed to practice medicine and surgery, except to the extent specifically provided in the "Physician Services Benefits" or as required by law
57) Treatment of corns, bunions (except capsular or bone surgery therefore), callouses, nails of the feet except surgery for ingrown nails, flat feet, fallen arches, chronic foot strain, or systematic complaints of the feet
58) Expenses for which payment or reimbursement is received by or for the account of the individual as a result of a legal action or settlement
59) Occupational therapy, physical therapy, and speech therapy when covered therapy does not restore or no further improvement can be expected
60) Cost of social workers, education and job retraining, learning disabilities and attention deficit disorders

61) Any injury sustained while engaged in any conduct which was in violation of any federal, state or local criminal statute (felony), and regardless of whether charged, indicted or convicted.

62) Services, supplies and treatment before you become eligible or after your eligibility terminates

63) Charges in excess of those which are Reasonable and Customary (see definition at page 33)

64) Primarily for education, vocational or training purposes, learning disabilities, and attention deficit disorders

NORMAL RETIRED AND PERMANENTLY DISABLED EMPLOYEE PROGRAMS

Upon retirement at or after age 65, a covered employee who was eligible for benefits under the active program may elect to continue his coverage under the retired employee program as set forth in the benefit schedule by paying the required monthly payment. He may also continue the coverage of his spouse by paying the specified additional monthly payment. The monthly payments are announced from time to time by the Board of Trustees and are always subject to review. The current rates can be obtained upon written request from the Board of Trustees.

Employees who qualify for extended life insurance coverage under the waiver-of-contribution coverage provided to employees who become totally disabled while eligible for benefits under the active employee program may elect to continue the active program exclusive of the weekly indemnity benefits and accidental death and dismemberment benefits by making the required monthly payment. The monthly payments are announced from time to time by the Board of Trustees and are always subject to review. The current rates can be obtained upon written request from the Board of Trustees. Upon attainment of age 65, coverage would then be provided pursuant to the terms of the retired employee program.

The schedule of Benefits listed below is for the Retired Medicare Employee and his dependents.

	BENEFIT	EMPLOYEE	DEPENDENT
1.	Life Insurance	$1,500	None
2.	Accidental Death	$1,500	None
3.	First Hospital Confinement	$ 52	$ 52
4.	Hospital Confinements between 61 and 90 days (Daily Rate)	$ 13	$ 13
5.	Out-patient hospital charges for emergencies due to accident	$ 20	$ 20
6.	Up to the first $50.00 of Surgery plus 20% of co-insurance on the balance using a $300.00 surgery schedule as a basis for determining the benefit payable.		
7.	Retirees' insured dependents under the age of 65 can be covered under the Early Retired Employees Program.		
8.	The retired Employee, for his own protection, should enroll himself and his dependent for Medicare and the Supplemental Medical Insurance when they are eligible for these coverages.		

MEDICARE

Any member or dependent who has attained age 65 will be considered to be covered by Part A (Hospital Insurance Benefits) and Part B (Supplemental Medical Insurance Benefits) of Health Insurance for the Aged, Title XVII of the Social Security Act (Medicare) as of the first day of the month in which the 65th birthday of such employee or dependent occurs, regardless of whether or not enrollment for such Medicare benefits has been made, and the following shall apply to such employee or dependent:

a) To the extent that the benefits of the Program are provided under Medicare Part A and Part B, they shall not be provided under the Program.

It is most important that any member of dependent who is approaching age 65 enroll for Medicare, by going to the nearest Social Security office during the three month period before his 65th birthday, and thus avoid a serious gap in this protection against medical expenses.

FILING A CLAIM FORM

How to File Claims for Medical Benefits

The procedures which you need to follow in order to properly file a claim are constantly changing in order to ensure more efficient and timely processing of your benefits. You will be provided with any future changes to the procedures in a separate document.

When you receive health care services:

- C Show your identification card to the service provider
- C Ask the provider to file a claim for you

If your provider of the medical service is a Participating Provider in the Medical Mutual Network, he/ she will submit all necessary claim information to Medical Mutual on your behalf. Medical Mutual will forward the claims to the Fund's Administrative Office to be reviewed and paid. The Fund's Administrative Office will provide reimbursement from the Fund to the provider directly.

If you do not use a provider who is part of the Medical Mutual Network, you may have to submit a claim for benefits directly to the Fund. If you must submit a claim for health care services received, you should:

- C Obtain an itemized bill from the hospital, doctor, medical facility, dentist or vision facility
- C Obtain a claim form from the Fund's Administrative Office
- C Complete the claim form and attach the itemized bill to the form
- C Send the claim form and bill to the address on the claim form
- C An itemized bill generally includes all of the following:
- C Participants name and address
- C Patient's name and address
- C Date of Service
- C Type of Service and diagnosis
- C Itemized charges
- C Provider's complete name, address and tax identification number

Payment for eligible benefits will be made to the health care provider unless your claim includes a paid receipt. If a receipt is submitted with your claim, payment will be sent to you.

A claim is not filed until it is received by Medical Mutual. The Fund's Administrative Office will process your claim within thirty (30) days of the date it is filed unless special circumstances require additional processing time. If additional information is needed to process your claim, the Fund may request additional information from you or the provider. You and/or your physician will have at least 45 days to submit the additional information.

When certain expenses are not eligible for payment under the Fund, you will be notified by the Fund's Administrative Office that the claim is denied in whole or part with an explanation of the reasons for the denial. This notification which is called a Notice of the Adverse Benefit Determination shall be in writing and will contain the following:

- C The specific reasons for the adverse benefit determination;
- C The specific reference to the Plan and/or Summary Plan Description provisions on which the adverse benefit determination was based;
- C A description of any additional materials or information necessary for you to perfect your claim and an explanation of why such materials or information is necessary;
- C The notice of any internal guidelines or protocols used in making the decision, if applicable, and your right to receive a copy;
- C A notice of your right to a written explanation of any exclusion which affects your claim; and
- C A description of this Fund's Appeals Procedure set forth below.

Claims under Prescription Program

You will receive a personalized Prescription Benefits Identification Card once you become eligible in this Fund. You must present your Prescription Benefits Identification Card along with your Doctor's prescription to any participating pharmacy.

The pharmacist will fill the prescription and charge you the co-payment, which is the amount you pay. The pharmacist will generally ask you to sign the form to indicate that you received the prescription. It is permissible for any of your eligible Dependents to present your identification card with a prescription to the pharmacist and sign for receipt of the prescription. This point of sale purchase of a prescription is not a claim for benefits. If you do not receive your prescription at the retail pharmacy due to a denial of coverage, you need to contact the Administrative Office to make a claim for benefit coverage.

If you elect to have your prescription filled by a pharmacy other than a participating pharmacy, do not use your Prescription Benefits Identification Card. Follow the Claim Reimbursement Procedure described herein to obtain reimbursement of prescription expenses.

You can obtain a Direct Reimbursement form from the Fund's Administrative Office. You are to complete the top portion. Either have the pharmacist complete the remainder of the form or attach an itemized receipt that includes all of the requested information. Pay the charge for the prescription in full to the pharmacy and mail the completed form to Rx Option's address on the form. Reimbursement will be made directly to you by on the same basis as benefits would have been paid to a participating pharmacy.

If you are not eligible for benefits at the time you contact the pharmacy or in the event that the prescription is not a covered drug under the Fund, you must contact the Fund's Administrative Office for additional information. The Fund's Administrative Office will review your claim for benefits and if the claim is denied in whole or part, provide you with a Notice of the Adverse Benefit Determination in writing which contains the following:

- C The specific reasons for the adverse benefit determination;
- C The specific reference to the Plan and/or Summary Plan Description provision on which the adverse benefit determination was based;
- C A description of any additional materials or information necessary for you to perfect your claim and an explanation of why such materials or information is necessary;
- C The notice of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;
- C A notice of your right to a written explanation of any exclusion which affects your claim, if applicable; and
- C A description of this Fund's Appeals Procedure set forth below.

How to file a claim for Weekly Indemnity benefits

Claims should be submitted to the Fund's Administrative Office as soon as possible; do not delay in filing any claims. Claims submitted must be accompanied by any information or proof requested and reasonably required to process such claims. You must obtain a claim form from the Fund's Administrative Office to be completed by you and your treating physician. This documentation should be completed as soon as possible in order to begin receiving your weekly benefits after you complete the waiting period.

The Fund's Administrative Office will make a decision on the claim and notify you of the decision within 45 days. If the Fund requires an extension of time due to matters beyond its control, you will be notified of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 45 day period. A decision will be made within 30 days of the time the Fund's Administrative Office notifies you of the delay.

If the Fund's Administrative Office needs additional information from you to make its decision, you will be notified as to what information must be submitted. You will have at least 45 days to submit the additional information. Once the Fund's Administrative Office receives the information from you, you will be notified of the decision on the claims within 30 days.

In the event that your claim for benefits is denied in whole or part, the Fund's Administrative Office will provide you with a Notice of the Adverse Benefit Determination in writing which contains the following:

- C The specific reasons for the adverse benefit determination;
- C The specific reference to the Plan and/or Summary Plan Description provision on which the adverse benefit determination was based;
- C A description of any additional materials or information necessary for you to perfect you claim and an explanation of why such materials or information is necessary;
- C The notice of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;

- C A notice of your right to a written explanation of any exclusion which affects your claim, if applicable; and
- C A description of this Fund's Appeals Procedure set forth below.

How to file claims for life insurance and Accidental Death and Dismemberment benefits

Claims should be submitted to the Fund's Administrative Office as soon as possible; do not delay in filing any claims. Claims for Death, Accidental Death and Accidental Dismemberment benefits will be provided through the Fund's Administrative Office. Claims submitted must be accompanied by any information or proof requested and reasonably required to process such claims. This will generally include a death certificate and documentation to establish the death or dismemberment is the result of an accident.

Generally, the Fund's Administrative Office will notify your beneficiary of the decision on the claim for benefits within 90 days. In the event that the Fund's Administrative Office needs additional time to review the claim for benefits or needs additional information, he/she will be provided with the information on the status prior to the expiration of the initial 90 day period.

When the claim for life insurance benefits falls within the Fund's exclusions, your beneficiary will be notified by the Administrative Office that the claim is denied with an explanation of the reasons for the denial. He/ she will receive a Notice of the Adverse Benefit Determination in writing which contains the following:

- C The specific reasons for the adverse benefit determination;
- C The sections of the Plan and/or Summary Plan Description upon which the adverse benefit determination was based;
- C A description of any additional materials or information necessary for him/her to perfect the claim and an explanation of why such materials or information is necessary;
- C The notice of any internal guidelines or protocols used in making the decision, if applicable, and his/her right to receive a copy;
- C A notice of his/her right to a written explanation of any exclusion which affects his/her claim, if applicable; and
- C A description of the Fund's Appeals procedures set forth below.

Proof of Claims

Written proof of claims for payment of Covered Services must be furnished as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form. **All claims must be submitted by you or the Provider no later than 90 days from the date on which the services were incurred.** Failure to furnish the claim within that time will neither invalidate nor reduce any claim if it is shown that it was not reasonably possible to furnish written proof of the claim within that time period and that written proof was provided as soon as reasonably possible. **However, all claims must be filed within one (1) year from the date the claim was incurred and if they are not submitted, they will be denied as untimely.**

No action at law or in equity shall be brought to recover on your claim prior to the exhaustion of the reasonable claims and appeals procedures set forth in this Section. Additionally, no action shall be brought at all unless brought within three (3) years from the expiration of the time which the proof of claim is required.

Physical Examination
The Fund at its own expense shall have the right and opportunity to examine an individual for whom benefits are being claimed under this Fund when and so often as the Trustees may reasonably require while a claim is pending. The Trustees have the right to ask for an autopsy in the case of death, provided this is not forbidden by law.

COORDINATION OF BENEFITS

ORDER OF BENEFIT DETERMINATION

A Policy covering a person as an employee will pay benefits first. A policy covering a person as a dependent will pay second.

If a dependent child is covered by both parents' policies, the benefits of the policy which covers the child of the parent whose date of birth, excluding year of birth, occurs earlier in a calendar year will be determined first. The benefits of the policy which covers the child of the parent whose date of birth, excluding year of birth, occurs later in a calendar year, will be determined second.

When the parents are divorced or separated, the order is:

C The policy of the parent with custody pays first.
The policy of the parent without custody pays second.
C If the parent with custody has remarried, the order is:
1. The policy of the parent with custody
2. The policy of the step-parent
3. The policy of the parent without custody.

If there is a court decree which states that one of the parents is responsible for the child's health care expenses, the policy of that parent will pay first. That order will supersede any order given in a) or b).

If a person is covered under more than one policy the policy he or she was covered under longer pays first. The exception to this rule is:

> A group policy that covers a person other than as a laid-off or retired employee, or dependent of such person, will determine the benefits that are paid first. A group policy that covers a person as a laid-off or retired employee, or dependent of such person will determine the benefits that are paid first. A group policy that covers a person as a laid-off or retired employee, or dependent of such person, will determine the benefits that are paid second.

SUBROGATION

The Mahoning & Trumbull County Building Trades Insurance Fund will take advantage of its right to subrogation if you or your dependent is paid benefits by the Plan due to any injury or illness which arises out of the acts or omissions of any person or entity or which arise under any no-fault coverage (for the purpose of this provision, collectively referred to as "Other Coverage").

The term Covered Person as used hereinafter shall include the employee, participant, or any eligible dependent as defined elsewhere in the Plan.

Subrogation. In the event of any payment under the Plan, the Plan shall, to the extent of such payment, be subrogated to all the rights of recovery of a Covered Person which arise out of the acts or omissions of any person or entity or which arise under any no-fault coverage (for the purpose of this provisions, collectively referred to as "Other Coverage"). The Plan is subrogated to all rights of recovery of a Covered Person regardless of whether the Covered Person obtains a full or partial recovery from such person, entity or Other Coverage. The Plan's subrogation interest shall take priority over any and all rights of recovery held by a Covered Person against such person, entity, or Other Coverage arising out of the event which triggered the Plan's payment of Medical Benefits. The Plan's subrogation interest shall apply regardless of whether the Covered Person has incurred fees or costs in order to obtain a recovery from any person, entity, or Other Coverage. The "make-whole" rule shall not apply.

In the event the Plan has a subrogated interest or right of recovery, no Covered Person shall release any party, person, corporation, entity, insurance company, insurance policies, or funds that may be liable or obligated to the Covered Person for the acts or omissions of any person or entity without the written approval of the Plan.

In the event a Covered Person pursues a claim against any person, entity, or Other Coverage, the covered Person agrees to include the Plan's subrogated interest and rights of recovery in that claim, and if there is a failure to do so, the Plan shall be legally presumed to be included in such claim. In the event a Covered Person does not pursue a claim against any person, entity, or Other Coverage, the Plan shall have the right to pursue, sue, compromise, or settle any such claims in the Covered Person's name and to execute any and all documents necessary to pursue said claim in the Covered Person's name.

Reimbursement. Each Covered Person hereby agrees to reimburse the Plan, for any Medical Benefits paid by the Plan, out of any money recovered from any person, entity, or Other Coverage as the result of judgment, settlement, or otherwise, regardless of how the money is classified. The Plan has the right to be reimbursed in an amount equal to the amount of Medical Benefits paid hereunder, regardless of whether the Covered Person obtains a full or partial recovery from such person, entity or Other Coverage. The Plan shall be reimbursed on a first priority basis, regardless of whether or not the Covered Person has been or will be made whole and regardless of whether the Covered Person has incurred fees or costs in order to obtain a recovery from any person, entity, or Other Coverage.

The "make-whole" rule shall not apply.

In the event a Covered Person settles, recovers, or is reimbursed by any person, entity, or Other Coverage, the Covered Person shall hold any such money in trust for the benefit of the Plan. If a Covered Person fails to reimburse the Plan in accordance with this provision, the Covered Person shall be liable to the Plan for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person. Each Covered Person also agrees to execute and deliver all necessary instruments, to furnish such information and assistance, and to take any action the Plan Administrator may require to facilitate enforcement of its rights under this Plan.

The Plan will not pay or be responsible for, without the written consent of the Board of Trustees, any fees or costs associated with a Covered Person pursuing a claim against a third party or any other coverage. The Plan's subrogation interest and the Plan's reimbursement interest shall not be subject to offset for any fees or costs associated with a Covered Person pursuing a claim against a third party or any other coverage.

For purposes of this provision, the term "Covered Person" includes anyone acting for, or on behalf of, a Covered Person when the Covered Person is referred to as taking an action.

You are also advised that when you or your eligible Dependents submit a claim to this Plan for injury or illness, you will be required to complete and execute a form requesting the following information:

1. How the injury or illness occurred.

2. The identity of any potentially responsible third parties, including their insurer, adjusters, and claim numbers.

3. Accident reports.

4. An assignment of your beneficial interest in any monetary recovery as a result of such injury or illness, to the extent of the Plan's subrogated interest.

You may also be required to sign other documents and do whatever is reasonably necessary to secure this Plan's Right of Subrogation. The Plan is entitled to full reimbursement prior to any other disbursement of any recovery, including fees and/or expenses.

You or your eligible Dependent shall not do anything to impair or negate this Plan's Right of Subrogation. If you or your eligible Dependent(s) perform any act or fail to act, and such should compromise the Plan's Right of Subrogation in full, this Plan will immediately seek reimbursement of all benefit amounts paid in that regard either by legal action or otherwise.

Furthermore, the Plan shall have the right to offset any future benefit payments to either you or your eligible Dependent(s) in the amount of any outstanding lien.

If the Plan should provide benefits to you or your eligible Dependent(s) and, for whatever reason, such payment is not required under the terms of this Plan, the Plan shall have the right to offset any future benefit payments to either you or your eligible Dependent(s), in the

amount of any mistaken payment. The Plan may recover mistaken payments in any other lawful manner as well.

FAMILY AND MEDICAL LEAVE ACT OF 1993

A new federal law, THE FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA) was enacted on February 5, 1993. FMLA is generally effective on February 5, 1994. Generally FMLA requires your Employer to provide you with up to 12 weeks of unpaid leave during any 12-month period for specified family and medical reasons, if you are eligible. During the period, your Employer must provide health coverage for you on the same terms and conditions that you would receive if you continued to work.

To be eligible for leave under FMLA, you must work for the same contributing Employer for at least 12 months and for at least 1,250 hours during the 12-month period before the leave begins. Generally, your Employer is obligated to provide Family and Medical leave only if your employer employs 50 or more employees each working day during each of 20 or more work weeks during the current or preceding calendar year.

During the FMLA leave, your Employer must make contributions to the Fund on your behalf so that your health coverage will be continued. Federal law requires that you received continued eligibility

A covered Employer must grant an eligible Participant up to a total of 12 workweeks of unpaid leave during any 12-month period for one or more of the following reasons:

* For the birth or placement of a child for adoption or foster care;
* To care for an immediate family member (spouse, child or parent) with a serious health condition; or
* To take medical leave when the Active Participant is unable to work because of a serious health condition.

Arrangements will need to be made for Active Participants to pay their share of health insurance premiums while on leave.

Upon return from FMLA leave, an Active Participant must be restored to his or her original job or to an equivalent job. In addition, an Active Participant's use of FMLA leave cannot result in the loss of any employment benefit that the employee earned or was entitled to before using FMLA leave.

REPAYMENT OF CONTRIBUTIONS TO EMPLOYER

If you take a leave under the FMLA and you fail to return to your Employer for any reason after such absence, under the Act your behalf during such leave of absence. Thus, to insure your continuing coverage under this Plan and to prevent possible repayment of all contributions to your Employer, you should return to work at the end of your leave of absence under the FMLA.

APPEAL PROCEDURES

<u>REVIEW PROCEDURE FOR CLAIMS UNDER THE FUND</u>

You or your authorized representative may appeal the decision by the Fund's Administrative Office to deny any claim for medical, weekly indemnity or life insurance/ accidental death and dismemberment benefits in whole or part. Additionally, any point of service purchase of prescription benefits which is not covered at the pharmacy can be appealed through this Review Procedure. If you are not handling your own claim, then an "authorized representative" must be designated in writing to act on your behalf and the extent of the person's authority must be clearly indicated in the authorization.

<u>First Level Review</u>

You may file a written notice of appeal to the Administrative Manager for the Board of Trustees at any time within 180 days after the mailing of the Notice of Adverse Benefit Determination. The written notice only needs to state your name, address, social security number, phone number, and the fact that you are appealing from the decision of the Fund's Administrative Office, giving the date of the Notice.

The Appeal should be addressed as follows:

Administrative Manager
Mahoning & Trumbull County Building Trades Insurance Fund
33 Fitch Boulevard
Austintown, Ohio 44515

During the appeals process, you will also be afforded access to all relevant information related to your claim for benefits and its denial and may submit written issues and comments pertinent to the appeal. Additionally, you or your representative may submit additional information prior to any determination on your appeal.

If an appeal requires medical judgment, the Administrative Manager shall consult an appropriate health professional and will disclose the identity of such individual to you upon request.

The Administrative Manager will consider your appeal of a claim for payment of services which you already obtained, called a "post-service claim", as soon as possible after receipt of your request. You will be notified of the decision of the Administrative Manager within thirty (30) days of the date the request for a First Level review is received.

In the event that the denial is upheld, you will receive a written Notice which includes the following information:

C The specific reason for the denial;

C The sections of the Plan and/or Summary Plan Description upon which the denial was based;

C A statement advising you of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;

- C A notice of your right to a written explanation of any exclusion which affects your claim, if applicable; and
- C A notice of your right to file a second level appeal to the Benefits Committee of the Board of Trustees.

Second Level Review

You may file a written notice of appeal to the Benefits Committee for the Board of Trustees at any time within sixty (60) days after the mailing of the Notice of Denial of the First Level Review. The written notice only needs to state your name, address, phone number, social security number and the fact that you are appealing from the decision of the Fund's Administrative Manager, giving the date of the Notice. The Appeal should be addressed as follows:

Benefits Committee
Mahoning & Trumbull County Building Trades Insurance Fund
33 Fitch Boulevard
Austintown, Ohio 44515

During the appeals process, you will also be afforded access to all relevant information related to your claim for benefits and its denial and may submit written issues and comments pertinent to the appeal. Additionally, you or your representative may submit additional information prior to any determination on your appeal.

If an appeal requires medical judgment, the Benefits Committee shall consult an appropriate health professional and will disclose the identity of such individual to you upon request.

The Benefits Committee will consider your appeal of a claim for payment of services which you already obtained, called a "post-service claim", as soon as possible after receipt of your request. You will be notified of the decision of the Benefits Committee within thirty (30) days of the date the request for a Second Level review is received.

In the event that the denial is upheld, you will receive a written Notice which includes the following information:

The specific reason for the denial;

- C The sections of the Plan and/or Summary Plan Description upon which the denial was based;
- C A statement advising you of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;
- C A notice of your right to a written explanation of any exclusion which affects your claim, if applicable; and
- C A notice of your right to file a lawsuit under ERISA Section 502(a).

The decision of the Benefits Committee for the Board of Trustees is final and binding.

Voluntary Appeal to the Board of Trustees

Once you have filed your appeal through the two levels of review, you have the right to file a lawsuit in federal court. However, prior to instituting federal court action, you can file a voluntary appeal to the full Board of Trustees. You must file the Notice of Voluntary Appeal to the Board of Trustees within sixty (60) days of the mailing Notice of Final Decision by the Benefits Committee.

The Appeal should be addressed as follows:

Board of Trustees
Mahoning & Trumbull County Building Trades Insurance Fund
33 Fitch Boulevard
Austintown, Ohio 44515

The Board of Trustees will review the appeal at their next scheduled quarterly meeting. In the event that the Trustees are unable to address your appeal at their next scheduled meeting, you will be notified that the decision will be delayed and the date of the following meeting at which your appeal will be reviewed. You will receive notice of the decision of the Board of Trustees as soon as possible after the decision is made.

In the event that you file a voluntary appeal with the Board of Trustees:

1. The Fund will not assert a failure to exhaust administrative remedies;
2. The Fund agrees that any Statute of Limitations applicable to pursuing the claim in court will be tolled during the period of the voluntary appeal process;
3. The Fund requires that the voluntary level of appeal is available only after the Claimant has pursued the required appeal(s);
4. You, upon request, shall be provided sufficient information relating to the voluntary level of appeal to enable you to make an informed decision about whether to submit a benefit dispute to this procedure including:
    - A statement that using this procedure will have no effect on your right to receive other benefits under this Fund;
    - A statement that you have the right to have a personal representative with regard to your claim;
    - A notice of any circumstances which may impair the impartiality of the Board of Trustees;
5. The Fund will not impose any fees or costs on you as part of this voluntary appeal process.
6. In the event the denial is upheld, you will receive a written notice which includes the following information:
    - The specific reason for the denial;
    - The sections of the Plan and/or Summary Plan Description upon which the denial was based;

C A statement advising you of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;

C A notice of your right to a written explanation of any exclusion which affects your claim, if applicable; and

C A notice of your right to file a lawsuit under ERISA Section 502(a).

NOTICE OF PRIVACY PRACTICES

THIS SECTION DESCRIBES:

1. HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED; AND
2. HOW YOU MAY OBTAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS INFORMATION CAREFULLY.

Section 1: Purpose of This Notice and Effective Date

Effective date. The effective date of this Notice is April 14, 2003.

This Notice is required by law. The Mahoning and Trumbull County Building Trades Insurance Fund (the "Fund") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

A. The Fund's uses and disclosures of Protected Health Information (PHI),

B. Your rights to privacy with respect to your PHI,

C. The Fund's duties with respect to your PHI,

D. Your right to file a complaint with the Fund and with the Secretary of the U.S. Department of Health and Human Services, and

E. The person or office you should contact for further information about the Fund's privacy practices.

Section 2: Your Protected Health Information

Protected Health Information (PHI) Defined

The term "Protected Health Information" (PHI) includes all information related to your past or present health condition that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Fund in oral, written, electronic or any other form.

When the Fund May Disclose Your PHI (PHI refers to your health information held by the Fund.)

The Fund Sponsor has amended its Fund Documents to protect your PHI as required by federal law. Under the law, the Fund may disclose your PHI without your consent or authorization in the following cases:

C **At your request.** If you request it, the Fund is required to give you access to certain PHI in order to allow you to inspect it and/or copy it.

C ***As required by an agency of the government****.* The Secretary of the Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Fund's compliance with the privacy regulations.

C ***For treatment, payment or health care operations.*** The Fund and its business associates will use PHI without your consent, authorization or opportunity to agree or object in order to carry out:

% Treatment,

% Payment, or

% Health care operations.

Definitions of Treatment, Payment or Health Care Operations	
Treatment is health care.	Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. ***For example***: The Fund may disclose to a treating physical therapist the name of your treating physician so that the physical therapist may ask for your x-rays from the treating physician.
Payment is paying claims for health care and related activities.	Payment includes but is not limited to making coverage determinations and payment. These actions include billing, claims management, subrogation, Fund reimbursement, reviews for medical necessity and appropriateness of care, utilization review and preauthorization. ***For example:*** The Fund tells your doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Fund.
HealthCare Operations keep the Fund operating soundly.	Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business funding and development, business management and general administrative activities. ***For example:*** The Fund uses information about your medical claims to project future benefit costs or to audit the accuracy of claims processing functions.

When the Disclosure of Your PHI Requires Your Written Authorization

The Fund must generally obtain your written authorization before it will use or disclose psychotherapy notes about you from your psychotherapist. However, the Fund may use and disclose such notes when needed to defend itself against litigation filed by you.

Use or Disclosure of Your PHI That Requires You be Given an Opportunity to Agree or Disagree Before the Use or Release

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed under federal law if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care, and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Use or Disclosure of Your PHI for Which Consent, Authorization or Opportunity to Object Is Not Required

The Fund is allowed under federal law to use and disclose your PHI without your consent, authorization or request under the following circumstances:

1. ***When required by law.***
2. ***Public health purposes.*** To an authorized public health authority if required by law or for public health and safety purposes. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease of condition, if authorized by law.
3. ***Domestic violence or abuse situations.*** When authorized by law to report information about abuse, neglect or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Fund will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm.
4. ***Health Oversight activities.*** To a health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
5. ***Legal proceedings.*** When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request that is accompanied by a court order.
6. ***Law enforcement health purposes.*** When required for law enforcement purposes (for example, to report certain types of wounds).

7. ***Law enforcement emergency purposes.*** For law enforcement purposes including:
    1. identifying or locating a suspect, fugitive, material witness or missing person, and
    2. disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances.
8. ***Determining cause of death or organ donation.*** When required to be given to a coroner or medical examiner to identify a deceased person, determine a cause of death or other authorized duties. We may also disclose PHI for cadaveric organ, eye or tissue donation purposes.
9. ***Funeral purposes.*** When required to be given to funeral directors to carry out their duties with respect to the decedent.
10. ***Health or safety threats.*** When, consistent with applicable law and standards of ethical conduct, the Fund in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
11. ***Workers' compensation programs.*** When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke your authorization.

Other Uses or Disclosures

The Fund may contact you to provide you information about treatment alternatives or other health-related benefits and services that may be of interest to you.

The Fund may disclose protected health information to the sponsor of the Fund for reviewing your appeal of a benefit claims or for other reasons regarding the administration of this Fund. The "Fund Sponsor" of this Fund is the Mahoning and Trumbull County Building Trades Fund Board of Trustees.

Section 3: Your Individual Privacy Rights

You May Request Restrictions on PHI Uses and Disclosures

You may request the Fund to:

1. Restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations, or

2. Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

The Fund, however, is not required to agree to your request if the Fund Administrator or Privacy Official determines it to be unreasonable.

In addition, the Fund will accommodate an individual's reasonable request to receive communications of PHI by alternative means or at alternative locations where the request includes a statement that disclosure could endanger the individual.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

You May Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Fund maintains the PHI. "*Designated Record Set*" includes your medical records and billing records that are maintained in paper form or electronically by or for a covered health care provider. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health Fund or other information used in whole or in part by or for the covered entity to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you is not included.

The Fund must provide the requested information within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Fund is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights and a description of how you may complain to Fund and the Secretary of the U.S. Department of Health and Human Services.

You Have the Right to Amend Your PHI

You have the right to request that the Fund amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set subject to certain exceptions. See the Fund's Right to Amend Policy for a list of exceptions.

The Fund has 60 days after receiving your request to act on it. The Fund is allowed a single 30-day extension if the Fund is unable to comply with the 60-day deadline. If the Fund denied your request in whole or part, the Fund must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of that PHI.

You or your personal representative will be required to complete a form to request amendment of the PHI.

You Have the Right to Receive an Accounting of the Fund's PHI Disclosures

At your request, the Fund will also provide you with an accounting of disclosures by the Fund of your PHI. This accounting period starts as of April 14, 2003 and allows you to request an accounting for up to six years of disclosures after that date. The maximum period of time you can request is six years. Please contact the Fund Office for a complete listing of the contents of an accounting. You should request a copy of the Fund's Accounting for Disclosure Policy.

The Fund has 60 days to provide the accounting. The Fund is allowed an additional 30 days if the Fund gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Fund will charge a reasonable, cost-based fee for each subsequent accounting.

You Have the Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice, contact the Privacy Official at the address provided at the beginning of this Section 3.

Your Personal Representative

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority will be a completed, signed and approved Appointment of Personal Representative form. You may obtain this form by calling the Fund Office.

The Fund retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

The Fund will recognize certain individuals as personal representatives without you having to complete an Appointment of Personal Representative form. For example, the Fund will automatically consider spouse's covered under the Fund as the Personal Representatives for each other. Additionally, the Fund will consider a covered parent, guardian, or other person acting *in loco parentis* as the Personal Representative of any dependent covered by the Fund unless applicable law requires otherwise. A parent may act on an individual's behalf, including requesting access to their PHI. Covered Dependents, including your spouse may, however, request that the Fund restrict information that goes to family members as described above at the beginning of Section 3 of this Notice. Additionally, the Fund will automatically consider any person designated under a Power of Attorney which is on file with the Fund as a Personal Representative.

You or your spouse may elect not to have one another as your Personal Representative. You or your spouse must fill out an Opt-out of Personal Representation Form and submit the Form to the Privacy Official. Your covered dependent children also have the right to submit an Opt-out Form if they do not wish to have one or both of their parents as their deemed Personal Representative. All requests are reviewed by the Privacy Official who may deny the requests, especially those based upon State law restrictions.

Section 4: The Fund's Duties

Maintaining Your Privacy

The Fund is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with notice of its legal duties and privacy practices.

This notice is effective beginning on April 14, 2003 and the Fund is required to comply with the terms of this notice. However, the Fund reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Fund prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to you and to all past and present participants and beneficiaries for whom the Fund still maintains PHI. This revised notice will be mailed to the covered participant and dependents.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to:

(a) The uses or disclosures of PHI,

(b) Your individual rights,

(c) The duties of the Fund, or

(d) Other privacy practices stated in this notice.

Disclosing Only the Minimum Necessary Protected Health Information

When using or disclosing PHI or when requesting PHI from another covered entity, the Fund will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

C Disclosures to or requests by a health care provider for treatment,

C Uses or disclosures made to you,

C Disclosures made to the Secretary of the U.S. Department of Health and Human Services pursuant to its enforcement activities under HIPAA,

C Uses or disclosures required by law, and

C Uses or disclosures required for the Fund's compliance with the HIPAA privacy regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that:

C Does not identify you, and

C With respect to which there is no reasonable basis to believe that the information can be used to identify you.

In addition, the Fund may use or disclose "summary health information" to the Fund Sponsor for obtaining premium bids or modifying, amending or terminating the group health Fund. Summary information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a Fund Sponsor has provided health benefits under a group health Fund. Identifying information will be deleted from summary health information, in accordance with HIPAA.

Section 5: Your Right to File a Complaint with the Fund or the HHS Secretary

If you believe that your privacy rights have been violated, you may file a complaint with the Fund Privacy Official at the address provided in Section 3.

You may also file a complaint with:

Secretary of the U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, D.C. 20201

The Fund will not retaliate against you for filing a complaint.

Section 6: If You Need More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Privacy Official at the address provided in Section 3:

Section 7: Conclusion

PHI use and disclosure by the Fund is regulated by the federal Health Insurance Portability and Accountability Act, known as HIPAA. You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede this notice if there is any discrepancy between the information in this notice and the regulations.

This notice is written to inform you of the Fund's obligation to maintain the privacy of your PHI.

STATEMENT OF RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

ERISA stands for the Employee Retirement Income Security Act which was signed into law in 1974.

This federal law establishes certain minimum standards for the operation of employee benefit plans, including the Canton Electrical Welfare Plan. The Trustees of your Plan, in consultation with their professional advisors, have reviewed these standards carefully and have taken steps necessary to assure full compliance with ERISA.

ERISA requires that Plan Participants and beneficiaries be provided with certain information about their benefits, how they may qualify for benefits and the procedures to follow when filing a claim for benefits. This information has already been presented in the preceding pages of this Summary Plan Description.

ERISA also requires that Participants and beneficiaries be furnished with certain information about the operation of the Plan and about their rights under the Plan.

READ THIS SECTION CAREFULLY. Only by doing so can you be sure that you have the information you need to protect your rights and your best interests under this Plan.

(A) ERISA provides that all Plan Participants shall be entitled to:

(1) Examine, without charge, at the Fund Office and at other specific locations such as worksites and Union halls, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the public disclosure room of the Pension and Welfare Benefit Administration.

(2) Obtain, upon written request to the Administrative Manager or Board of Trustees, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements and a copy of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrative Manager may make a reasonable charge for the copies.

(3) Receive 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.

(4) Obtain a complete list of employers sponsoring the Plan upon written request to the Administrative Manager which list is available for examination by Participants and Beneficiaries.

(5) In addition, Participants and Beneficiaries may obtain from the Administrative Manager, upon written request, information as to whether a particular employer or employee organization is a sponsor to the Plan and if the employer or employee organization is a plan sponsor, the sponsor's address.

The people who operate your Plan, called "fiduciaries" of the Plan have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries.

(B) In addition to creating right for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan.

(C) 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 pension benefit to which you may be entitled, or exercising your rights under ERISA.

(D) If you have a claim for a welfare benefit denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. The Plan's Claim Procedures are furnished automatically without charge as a separate document. If you have a claim for benefits which is denied, in whole or in part, you may file suit in a state or federal court after you exhaust your appeal rights.

(E) Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in Federal Court. In such a case, the court may require the Plan Administrative Manager 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 Administrative Manager. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the Plan's monies, 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.

(F) If you have any questions about your Plan, you should contact the Plan Administrative Manager or the Board of Trustees. If you have any questions about this statement or about your rights under ERISA, or if you need assistance

in obtaining documents from the Trustees, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor or the Pension and Welfare Benefits Administration, whose offices are located at:

U.S. Department of Labor
Employee Benefits Security Administration
1730 K Street, Suite 556
Washington, DC 20006
Tel: (202) 254-7013
Or
U.S. Department of Labor
Employee Benefit Security Administration
1885 Dixie Highway, Suite 210
Ft. Wright, Kentucky 41011-2664

Tel: (606) 578-4680 Or
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 Pension and Welfare Benefits Administration.