TRI-COUNTY BUILDING TRADES HEALTH FUND

SUMMARY PLAN DESCRIPTION

Effective: June 1, 2007*

* Unless otherwise noted herein

TRI-COUNTY BUILDING TRADES
HEALTH FUND

CLAIMS PAYORS

AultCare (Canton)
P.O. Box 6910
Canton, Ohio 44706
(330) 363-6360
(800) 344-8858
website: www.aultcare.com

Aultra Administrative Group
4845 Fulton Drive, N.W.
P.O. Box 35276
Canton, Ohio 44735-5276
(330) 493-7278
(800) 325-8424
website: www.aultragroup.com

BOARD OF TRUSTEES

Union Trustees
Jerry Durieux, Chairman
Scott Mazzulli
Dean Tuell

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Roy Rang, Secretary
Scott Winters

PLAN ADMINISTRATOR
BOARD OF TRUSTEES
TRI-COUNTY BUILDING TRADES HEALTH FUND

ADMINISTRATIVE MANAGER / THIRD PARTY ADMINISTRATOR

BeneSys, Inc.
700 Tower Drive
Suite 300
Troy, Michigan 48098-2808
(248) 641-4902
Toll-Free (866) 599-3176
Facsimile (248) 813-9898

FUND COUNSEL

Ronald G. Macala, Esq.
Macala, Gore & Piatt, LLC
4150 Belden Village Street, Suite 602
Canton, Ohio 44718

PLAN YEAR

May 1 – April 30

To all Participants and Beneficiaries:

This Summary Plan Description ("SPD") has been prepared to provide you with details of the coverage through the Tri-County Building Trades Health Fund, how you qualify for benefits and under what circumstances you may not be eligible. This SPD also tells you how to file a claim for benefits and what action you can take if you are denied benefits.

This SPD is a summary. This booklet summarizes the most important features of the Health & Welfare Fund. No general explanation can adequately give you all of the details of your Plan. However, you are advised that this SPD controls should its terms conflict with the Plan.

Only the Board of Trustees of the Fund has the authority to answer questions about eligibility and benefits provided through the Fund, or to interpret the Rules and Regulations. No Union or management representative, individual Trustee, Union business manager or other individual has the authority to answer questions or make decisions concerning the provisions of the Plan unless such individual has been given that authority by the Trustees and is acting on their behalf. The Trustees have delegated the routine day to day administration of the Fund to the Third-Party Administrator, Claims Payor and the Administrative Manager. Any questions regarding benefits or any other matters relating to claims processing should be directed to the appropriate Claims Payor. Any questions regarding eligibility or any other matters related to the Fund should be directed to the Administrative Manager, BeneSys, Inc. 700 Tower Drive, Suite 300, Troy, Michigan 48098-2808.

Please read this booklet carefully so that you will know the benefits to which you and the members of your family are entitled. We suggest you put this booklet in a safe place along with other valuable papers. You will receive benefit updates and other changes to the Plan periodically. You need to insert these notices into this booklet in order to maintain a complete and current list of your benefits and requirements.

When you first become eligible for benefits, you should receive an enrollment package which includes forms for you to complete and return to the Administrative Manager. These enrollment forms are vital to the proper administration of your claims for benefits under this Plan. You must provide the Administrative Manager with an updated Enrollment Form whenever you change your address, acquire a new dependent or lose a dependent through death, divorce or otherwise.

Sincerely,
BOARD OF TRUSTEES

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SCHEDULE OF BENEFITS FOR ACTIVES AND EARLY RETIREES

This Schedule of Benefits provides you and your Eligible Dependents with a summary of the benefits covered under the Tri-County Building Trades Health Fund. Generally, you will have three (3) plan design options from which to choose. These plans include the Full Plan, Standard Plan and Catastrophic Plan design choices. The Standard Plan shall be the default plan design if you do not choose one. Please be advised that your Plan design and optional choices are subject to change. The Amounts listed in the Schedule of Benefits reflect the amount that the Plan covers unless noted otherwise. For a complete description of the benefits covered, review the Explanation of Your Medical Benefits section, beginning at Page 39. Please note that all payments made for medical benefits are based upon Usual, Customary and Reasonable Charges ("UCR") and Medical Necessity.

If a change in benefits is made, the change will generally become effective for death, accidents and illnesses which occur or begin on or after the effective date of the change. For medical treatments, the change will become effective for treatments or services received on or after the effective date of the change, unless the Board of Trustees expressly provides otherwise.

	FULL PLAN		**STANDARD PLAN (DEFAULT PLAN)**		**CATASTROPHIC PLAN**	
MEDICAL BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Lifetime Maximum	$2,000,000	$1,000,000	$2,000,000	$1,000,000	$2,000,000	$1,000,000
Annual Deductibles	$250/person	$500/person	$350/person	$700/person	$1000/person	$2000/person
	$500/family	$1000/family	$600/family	$1200/family	$2000/family	$4000/family
Out-of-Pocket Maximums (Includes deductible)	$250/person	$4500/person	$2400/person	$4800/person	$3000/person	$6000/person
	$500/family	$5000/family	$2700/family	$5400/person	$4000/family	$8000/person
Care in Hospital						
Care-In Hospital (Semi-private room)	100% *	80% UCR **	90% *	70% UCR **	80% *	60% UCR **
Surgery	100% *	80% UCR **	90% *	70% UCR **	80% *	60% UCR **
Anesthesia	100% *	80% UCR **	90% *	70% UCR **	80% *	60% UCR **
Assistant Surgeon	100% *	80% UCR **	90% *	70% UCR **	80% *	60% UCR **
In-Hospital Physician	100% *	80% UCR **	90% *	70% UCR **	80% *	60% UCR **
Diagnostic Lab/X-Ray	100% *	80% UCR **	90% *	70% UCR **	80% *	60% UCR **
Respiratory Therapy	100% *	80% UCR **	90% *	70% UCR **	80% *	60% UCR **
Acute Kidney Dialysis	100% *	80% UCR **	90% *	70% UCR **	80% *	60% UCR **
Maternity Care	100% *	80% UCR **	90% *	70% UCR **	80% *	60% UCR **
Organ Transplant Benefits	100% *	80% UCR **	90% *	70% UCR **	80% *	60% UCR **

	FULL PLAN		STANDARD PLAN (DEFAULT PLAN)		CATASTROPHIC PLAN	
MEDICAL BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Outpatient Care						
Pre-Admission Testing	100% *	80% UCR **	90% *	70% UCR **	80% *	60% UCR **
Surgery (All Related Expenses)	100% *	80% UCR **	90% *	70% UCR **	80% *	60% UCR **
Diagnostic Lab/X-Ray	100% *	80% UCR **	90% *	70% UCR **	80% *	60% UCR **
Emergency Care (within 72 hours of accident/ acute illness/life threatening)	Facility/ Physician 100% After $50.00 Co-Pay. NOTE: Effective January 1, 2008, co-pay increases to $100.00, but co-pay is waived if emergency care is for accidental injury or if admitted. Lab/X-Ray/ Diagnostic Testing 100% *	Facility/ Physician 100% UCR After $50.00 Co-Pay. NOTE: Effective January 1, 2008, co-pay increases to $100.00, but co-pay is waived if emergency care is for accidental injury or if admitted. Lab/X-Ray/ Diagnostic Testing 80% UCR **	Facility/ Physician 100% After $50.00 Co-Pay. NOTE: Effective January 1, 2008, co-pay increases to $100.00, but co-pay is waived if emergency care is for accidental injury or if admitted. Lab/X-Ray/ Diagnostic Testing 90% *	Facility/ Physician 100% UCR After $50.00 Co-Pay. NOTE: Effective January 1, 2008, co-pay increases to $100.00, but co-pay is waived if emergency care is for accidental injury or if admitted. Lab/X-Ray/ Diagnostic Testing 70% UCR **	Facility/ Physician 80% After $50.00 Co-Pay. NOTE: Effective January 1, 2008, co-pay increases to $100.00, but co-pay is waived if emergency care is for accidental injury or if admitted. Lab/X-Ray/ Diagnostic Testing 80% *	Facility/ Physician 80% UCR After $50.00 Co-Pay. NOTE: Effective January 1, 2008, co-pay increases to $100.00, but co-pay is waived if emergency care is for accidental injury or if admitted. Lab/X-Ray/ Diagnostic Testing 60% UCR **
Non-Emergency Care in Emergency Room/Facility	100% *	80% UCR **	90% *	70% UCR **	80% *	60% UCR **
Urgent Care Facility (Effective January 1, 2008)	100% after $20.00 co-pay	80% UCR **	100% after $20.00 co-pay	70% UCR **	100% after $20.00 co-pay	60% UCR **
Occupational/Physical/Speech/ Respiratory Therapies	100% *	80% UCR **	90% *	70% UCR **	80% *	60% UCR **
Acute Kidney Dialysis	100% *	80% UCR **	90% *	70% UCR **	80% *	60% UCR **
Second Surgical Opinion	100% *	80% UCR **	90% *	70% UCR **	80% *	60% UCR **
Sleep Disorders – Evaluation and Treatment (up to $2,500.00 per year)	100% *	80% UCR **	90% *	70% UCR **	80% *	60% UCR **
Diabetes Education	100% *	80% UCR **	90% *	70% UCR **	80% *	60% UCR **
Mental Health						
Inpatient Care/Outpatient Treatment Program (30 days per lifetime)	100% *	80% UCR **	90% *	70% UCR **	80% *	60% UCR **
Outpatient Psychotherapy (up to 25 visits per calendar year)	100% *	80% UCR **	90% *	70% UCR **	80% *	60% UCR **

	FULL PLAN		STANDARD PLAN (DEFAULT PLAN)		CATASTROPHIC PLAN	
MEDICAL BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Alcohol/Substance Abuse[1]						
Inpatient Care/Outpatient Treatment Program	100% *	80% UCR **	90% *	70% UCR **	80% *	60% UCR **
Outpatient Psychotherapy	100% *	80% UCR **	90% *	70% UCR **	80% *	60% UCR **
Physician's Office						
Visits for Illness/Injury	100% After $20 Co-pay	80% UCR **	100% After $20 Co-pay	70% UCR **	100% After $20 Co-pay	60% UCR **
Allergy Testing/Treatment	100% *	80% UCR **	90% *	70% UCR **	80% *	60% UCR **
Occupational/Physical/Speech/ Respiratory Therapies	100% *	80% UCR **	90% *	70% UCR **	80% *	60% UCR **
Surgery (all related expenses)	100% *	80% UCR **	90% *	70% UCR **	80% *	60% UCR **
Diagnostic Lab/X-ray	100% *	80% UCR **	90% *	70% UCR **	80% *	60% UCR **
Diabetes Education	100% *	80% UCR **	90% *	70% UCR **	80% *	60% UCR **
Preventative Care						
Physical Exam/Immunizations/ Prostate/Mammogram/ Gynecological Exam/Pap Test (limited to 1 per calendar year up to $300 combined maximum)	100%	80% UCR **	100%	70% UCR **	100%	60% UCR **
Routine Colonoscopy (1 per calendar year)	100%	80% UCR **	100%	70% UCR **	100%	60% UCR **
Well Child (Birth to age 1 yr., including immunizations)	100%	80% UCR **	100%	70% UCR **	100%	60% UCR **
Affiliates						
Chiropractic Services	100% *	80% UCR **	90% *	70% UCR **	80% *	60% UCR **
Podiatry Services	100% *	80% UCR **	90% *	70% UCR **	80% *	60% UCR **
Other Services						
Skilled Nursing Facility (Pre-Approval Required)	100% *	80% UCR **	90% *	70% UCR **	80% *	60% UCR **
Private Duty Nursing (Pre-Approval Required)	100% *	80% UCR **	90% *	70% UCR **	80% *	60% UCR **
Home Health Care (Pre-Approval Required)	100% *	80% UCR **	90% *	70% UCR **	80% *	60% UCR **
Hospice Care (Pre-Approval Required)	100% *	80% UCR **	90% *	70% UCR **	80% *	60% UCR **
Durable Medical Equipment	100% *	80% UCR **	90% *	70% UCR **	80% *	60% UCR **
Ambulance (up to 2 trips per confinement)	100% *	100% UCR *	90% *	90% UCR *	80% *	80% UCR *
Injectible Medications	100% *	80% UCR **	90% *	70% UCR **	80% *	60% UCR **

[1] Subject to an overall annual maximum of $7,500.00 and an overall lifetime maximum of $15,000.00.

	FULL PLAN		STANDARD PLAN (DEFAULT PLAN)		CATASTROPHIC PLAN	
MEDICAL BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Prescriptions						
Prescriptions	Managed Prescription Drug Program		Managed Prescription Drug Program		80%* - described in Prescription Drug Benefit Section	
Hearing Benefits						
Hearing Benefits (up to $300 per lifetime)	100% *	80% UCR **	90% *	70% UCR **	80% *	60% UCR **
Death Benefit						
Active Participants	$5,000		$5,000		$5,000	
Retirees Under 65	$2,500		$2,500		$2,500	
Accidental Death Benefit						
Active Participants	$5,000		$5,000		$5,000	
Retirees Under 65	No benefit		No benefit		No benefit	
Accidental Dismemberment						
Active Participant (loss of both feet, both hands, one foot, one hand; one hand or foot and loss of sight in one eye or loss of sight in both eyes)	$5,000		$5,000		$5,000	
Active Participant (loss of one hand, one foot or sight in one eye)	$2,500		$2,500		$2,500	
Retirees Under 65	No benefit		No benefit		No benefit	

Full Plan

* An annual deductible of $250 per person/$500 per family is applied first before any medical benefits are paid to **In-Network Providers.** Deductible and coinsurance are subject to an annual maximum of $250 per person/$500 per family. Once you have met this maximum, the Plan begins to pay covered medical expenses at 100%.

** An annual deductible of $500 per person/$1,000 per family is applied first before any medical benefits are paid to **Out-of Network Providers.** Deductible and coinsurance are subject to an annual maximum of $4,500 per person/$5,000 per family. Once you have met this maximum, the Plan begins to pay covered medical expenses at 100% of UCR.

Standard Plan

* An annual deductible of $350 per person/$600 per family is applied first before any medical benefits are paid to **In-Network Providers.** Deductible and coinsurance are subject to an annual maximum of $2,400 per person/$2,700 per family. Once you have met this maximum, the Plan begins to pay covered medical expenses at 100%.

** An annual deductible of $700 per person/$1,200 per family is applied first before any medical benefits are paid to **Out-of Network Providers.** Deductible and coinsurance are subject to an annual maximum of $4,800 per person/$5,400 per family. Once you have met this maximum, the Plan begins to pay covered medical expenses at 100% of UCR.

Catastrophic Plan

* An annual deductible of $1,000 per person/$2,000 per family is applied first before any medical benefits are paid to **In-Network Providers.** Deductible and coinsurance are subject to an annual maximum of $3,000 per person/$4,000 per family. Once you have met this maximum, the Plan begins to pay covered medical expenses at 100%.

** An annual deductible of $2,000 per person/$4,000 per family is applied first before any medical benefits are paid to **Out-of-Network Providers.** Deductible and coinsurance are subject to an annual maximum of $6,000 per person/$8,000 per family. Once you have met this maximum, the Plan begins to pay covered medical expenses at 100% of UCR.

OPTIONAL PACKAGES

	OPTION 1	**OPTION 2**
Dental Benefits	80% up to $900 per Family per Year	80% up to $1,800 per Family per Year
Vision Benefits	80% up to $400 per Family per Year	80% up to $780 per Family per Year
Short Term Disability (Active Participants Only)	$250 per week/up to 26 weeks	$400 per week/up to 26 weeks
Additional Death Benefits	Single: $5,000 Family: $10,000	Single: $10,000 Family: $15,000

SCHEDULE OF BENEFITS FOR MEDICARE PARTICIPANTS

BENEFITS	**MAXIMUM PAYABLE**
For Retired Medicare Participants Only:	
Death Benefit	$2,500
Vision Benefits	80% of $300 per family per calendar year

Benefits Paid in Coordination with Medicare

All Medical Benefits are paid in Coordination with Medicare which is generally based upon what Medicare pays for the following Services and Supplies. In order to review what Medicare pays, please refer to the Medicare website at www.medicare.com.

Important: The Fund shall provide coverage to Medicare enrolled individuals and shall pay such benefits as though the Medicare Participant is properly enrolled in Medicare Parts A & B.

Covered Services	**Benefit Period**	**The Fund Pays**
Hospital expenses benefit semi-private room & board and other hospital services	First 60 days	Deductibles not paid by Medicare up to the Medicare allowable amount.
	61st to 90th day	Deductibles not paid by Medicare up to the Medicare allowable amount.

Covered Services	Benefit Period	The Fund Pays
	91st to 150 days	Deductibles not paid by Medicare up to the Medicare allowable amount.
Home Health Care	Part-time or intermittent nursing care and other services for as long as you meet criteria for benefits.	The deductible amount which is required by Medicare and 20% of the remainder of the Medicare approved amount.
Hospice Care Participants with certain medical conditions will receive pain and symptom relief, and supportive services for the management of terminal illness.	Full scope of palliative medical and support services are covered as long as the doctor certifies need.	Benefits payable if you meet the requirements under this Plan.
Skilled nursing facility (limit of 100 days) Semiprivate room, meals, skilled nursing and rehabilitative services and other services and supplies.	First 20 days	No benefits paid
	Additional 80 days	Deductibles not paid by Medicare up to the Medicare allowable amount.
	Over 100 days	No benefits paid
Blood	From a hospital or skilled nursing facility during covered stay.	The first three pints.
Medical Expense, Physician's services, inpatient and out-patient medical and surgical services and supplies, physical, occupational and speech therapy, diagnostic tests and durable medical equipment.	Medicare pays for medical services in or out of hospital.	20% of approved charges.
	Part B excess charges	No benefit paid
	Part B deductible	Part B deductible
Outpatient Routine Pap Smear, Mammogram, (one per year)	All female Medicare beneficiaries Mammogram limited to Medicare Eligible females age 40 and over	20% of approved charges
Clinical Laboratory.	Blood tests, urinalysis, etc.	No benefits paid
Outpatient Hospital Treatment	Services for diagnosis or treatment of an illness or injury	20% of approved charged.
Home Health Care	For people without Part A coverage	20% of approved durable medical equipment
Diabetes Monitoring	Includes coverage for glucose monitors, test strips, lancets, and diabetes education	20% of approved charges after Part B deductible

Blood	As an outpatient or as part of Part B covered service	First three (3) pints after Part B deductible
Prostate Cancer Screening (one per year)		20% of approved charges after Part B deductible
Colorectal Cancer Screening	All Medicare Participants age 50 and older	No benefits paid for Fecal Occult Blood Test, 20% paid on all other approved charges after Part B deductible.
Vaccinations		20% of Hepatitis B shot after deductible
Foreign Hospital and Medical Care	Medically necessary emergency services during the first 60 days of each trip outside of the United States.	80% (after first $250 each calendar year) up to a lifetime maximum of $50,000

These general categories of coverage are created by Medicare. You will be notified of the exact coverage and Medicare deductibles due for all covered services upon enrollment in Medicare Part A and Part B coverage. In the event that any of the Medicare deductibles or Coinsurance payment requirements is changed, you will be notified by Medicare directly. For more information on how the Tri-County Building Trades Health Fund pays in coordination with Medicare please contact the Administrative Manager.

RULES OF ELIGIBILITY FOR ACTIVE HOURLY PARTICIPANTS

A. Initial Eligibility

You shall become initially eligible to participate in this Fund if, during any consecutive twelve (12) month period, you accumulate greater than the amount of one (1) month cost for coverage under the Standard Plan design or any other plan design cost (if more expensive) which you may choose.

After you have met the initial eligibility requirement as set forth above, you will be eligible for benefits on the third month following the month which, based upon contributions received by the Administrative Manager, you accumulate the required contributions.

However, you may be immediately eligible if you choose to make self-payments equal to the monthly cost of your plan design choice.

B. Special Rules for Flat Rate

An employer that performs primary residential or production work may elect to participate in the flat-rate program established by the Trustees.

The flat-rate program shall require a participating employer to make a single, pre-established, premium payment to the Fund on behalf of all of its eligible employees. This premium shall be paid by each employer on or before a date, each month, designated by the Trustees.

The flat-rate premium shall be set, and may be amended as necessary, by the Trustees. Any change in the amount of the flat-rate premium will be communicated to employers by the Trustees at least thirty (30) days prior to the effective date of the change in premium amount.

After you have met the initial eligibility requirements, as set forth above, you will be eligible for benefits on the 1st day of the month if contributions are received by the Plan Administrative Manager prior to the 20th day of that month; or the first day of the following month if contributions are received by the Plan Administrative Manager on or after the 20th day of that month.

Example: An Employer hires an employee participant January 14th. The Employer shall pay the flat rate monthly premium beginning with the month of January. The employee participant is covered under this Plan beginning January 1st. An Employer hires an employee participant January 19th. The Employer shall pay the flat rate monthly premium beginning with the month of February. The employee participant is covered under this Plan beginning February 1st.

For flat rate Participants, upon layoff, the Employer shall continue monthly Premiums for two (2) months from the month in which the layoff occurs where the Participant continues to be laid off.

Example: A participant works at least one (1) day in January and is laid off in January. The Employer shall provide a monthly premium for January. The same participant continued to be laid off in February. The Employer shall provide a monthly premium for February. The same participant continued to be laid off in March. The Employer shall provide a monthly premium for March. The same participant continued to be laid off in April. No monthly premium is due for April.

However, “flat rate” Active Participants are not eligible to accumulate Reserve Dollars. Such Participant may be entitled to continue coverage through continuation coverage as described on Page 28 of this Booklet.

The Trustees shall have full and exclusive authority to determine the participation rules, benefit schedules, coverages, limitations and exclusions for the flat-rate program.

If an employee is terminated from the flat-rate program, the employer shall be responsible for the monthly premium for the remainder of the month of termination and for the next two consecutive months.

An employer that elects to terminate its participation in the flat-rate program shall be responsible for the premiums for its employees for the remainder of the month in which termination occurs, and for the next two consecutive months.

C. Continuation of Eligibility

Once you have met the initial eligibility rules, you will remain eligible for coverage for each month in which your hourly contributions equal or exceed the monthly cost of your plan design choice. Contributions will be used to determine eligibility during the third month following the month in which the contributions were made.

D. Accumulation Of Reserve Hours/Dollars

Participants in this Fund, with the exception of employees participating under an agreement requiring a monthly premium, are eligible to accumulate a Reserve Dollars Bank.

Effective January 1, 2005, a Reserve Dollars Bank was established for each eligible Participant. Individual Participants shall accrue their Reserve Dollars Bank each month in the following manner: Each Participant shall have added to his/her Reserve Dollars Bank, the difference between the total amount of contributions made on his/her behalf for the month and the monthly cost of his/her plan design choice or the Standard Plan if no Plan design choice was selected. Once created, this Reserve Dollars Bank shall accumulate a balance, but may not be utilized by Participants for continuation of eligibility for benefits until January 1, 2006, or later at the future discretion of the Board of Trustees.

Effective January 1, 2006, or later at the future discretion of the Board of Trustees, the accumulated Reserve Dollars Bank for each individual Participant may be utilized for eligibility only. Effective January 1, 2006, or the later date, each Participant shall also have added to his/her Reserve Dollars Bank an amount equal to such Participant's Reserve Dollars Bank multiplied by the hourly contribution rate in effect at the time such hours were earned.

The individual Participant's Reserve Dollars Bank shall not constitute a vested benefit under federal or state law and shall not be transferable or payable to you or any other person or entity.

1. General Provisions

Effective September 1, 2006, Participants who are eligible to accumulate a Reserve Dollars Bank shall be permitted to receive reimbursement for certain health-related expenses through the Reserve Dollars Bank. **The Reserve Dollars Bank may only be utilized if your Reserve Dollars Bank balance is at least $10,000.00, and the amount available to be utilized is only the balance above $10,000.00.**

This Reserve Dollar Bank shall not create or constitute a vested benefit.

When a Participant, or his/her Eligible Dependent(s) has unreimbursed medical expenses and an existing balance over $10,000.00 in his/her individual Reserve Dollars Bank, the Participant may submit, on a form provided by the Fund office, proof of such expenses for reimbursement from their individual Reserve Dollars Bank. Reimbursement checks shall be issued to Participants on a quarterly basis.

Medical expenses will be reimbursed only to the extent that reimbursement for such medical expenses is not available to the Participant by this Fund or under any health insurance policy or plan provided through any employer of the Participant and/or his/her spouse. Such expenses must be paid for by you or your Eligible Dependent(s) and proof of such payment must be submitted to the Plan along with the appropriate form requesting reimbursement.

Claims for reimbursements shall be filed no later than one (1) year following the end of the Calendar Year in which the services were rendered.

2. Reimbursable Expenses or Items

To the extent you have at least $10,000.00 in your reserve dollars bank and you utilized all or some of the balance in your Reserve Dollars Bank over that $10,000.00, reimbursement shall be made for the following expenses:

a. Deductibles, co-payments and expenses in excess of benefit maximums applied to covered medical expenses under the Plan or other qualified plan for which you or your Eligible Dependent spouse receive medical benefits;

b. Unreimbursed cost of prescription medicines (prescribed by a doctor) and insulin, including co-pays;

c. Unreimbursed dental, orthodontic or periodontal expenses, except for bleaching or bonding, if solely for cosmetic reasons;

d. Unreimbursed expenses for special items (i.e. artificial limbs or teeth, eyeglasses, contact lenses, hearing aids, crutches, wheelchair, etc.);

e. Unreimbursed expenses incurred by an organ donor including, but not limited to, airplane fare and ambulance costs;

f. Unreimbursed expenses for physical therapy, chiropractic services or massage therapy (pursuant to recommendation of a doctor or physician);

g. Unreimbursed expenses for optometrists' fees, eye exams, eyeglasses, contact lenses, saline solution, and lens insurance;

h. Unreimbursed expenses for dermatology;

i. Unreimbursed expenses for routine physicals;

j. Unreimbursed expenses for vaccinations or well baby care;

k. Unreimbursed expenses for weight loss program if prescribed by doctor or physician for treatment of hypertension, obesity, and stress directly related to excessive weight;

l. Unreimbursed expenses for equipment or improvements to the Employee's home needed for specific medical care needs if prescribed by a doctor or physician;

m. Unreimbursed expenses for costs and care of guide dogs and other animals aiding the blind, deaf and disabled;

n. Unreimbursed expenses for hearing aids (and batteries) and telephones (for hearing impaired);

o. Unreimbursed expenses for treatment at a drug or alcohol center (includes meal, lodging provided by the center and mileage for transportation);

p. Unreimbursed expenses for special school or home for mentally, physically or learning disabled persons and language training and remedial reading coursed for children with dyslexia when prescribed by a doctor or physician;

q. Unreimbursed expenses for invalid care, nursing home care or a portion of any lump-sum advance payment for lifetime care in retirement home, to the extent allocable to medical care; and

r. Any other medical expenses identified in Internal Revenue Code ("Code") Section 213 and/or any regulations adopted thereunder by the Internal Revenue Service ("IRS"), if approved by the Board of Trustees.

3. Expenses or Items Not Subject to Reimbursement

The following items shall not be subject to reimbursement:

a. Expenses for which you or your Eligible Dependent claimed or will claim a medical expense deduction on your tax return;

b. Expenses incurred before you became initially eligible for medical benefits under the Plan, unless permitted by Code Section 213;

c. Except as otherwise provided herein, expenses incurred after termination of employment and eligibility, unless permitted by Code Section 213;

d. Expenses for general health (even if following doctor's advice) such as:

1. Health club dues, unless prescribed by a doctor for a specific health condition;

2. Household help (even if recommended by a doctor);

3. Social activities, such as dancing or swimming lessons;

4. Trip for general health improvement;

5. Resort Hotel;

6. Vacation expenses;

7. Swimming lessons; and

8. Dancing lessons.

e. Cosmetic surgery, as defined by Section 213 of the Internal Revenue Code ("Code") or other medical procedures for purely cosmetic reasons;

f. Organic food, unless required for specific medical ailment or condition;

g. Life insurance or income protection policies or policies providing payment for loss life, limb, sight, etc.

h. Nursing services for a healthy baby, diaper services or babysitting expenses;

i. Medical insurance included in a car insurance policy covering all persons injured in or by the Participant's car;

j. Maternity clothes;

k. Any self treatment;

l. Toothpaste, toiletries, cosmetics and bottled or distilled water;

m. Medical services in a U.S. Government Hospital or medical services provided at no cost through any public program;

n. Expenses for CB radio;

o. Expenses for chauffeur;

p. Expenses for Church of Scientology "auditing" or "processing";

q. Expenses for religious deprogramming;

r. Expenses for domestic partner's health expenses unless a dependent for IRS purposes;

s. Ear piercing or tattoo removal;

t. Funeral expenses;

u. Expenses for hair transplants;

v. House remodeling, except as otherwise provided for herein;

w. Child care expenses;

x. Insurance premiums, except as provided for otherwise herein;

y. Marijuana and other illegal narcotics;

z. Illegal medical operations;

aa. Dust-elimination system, accept as otherwise provided for herein housekeeping, lawn care and vacuum cleaning;

bb. Television and television equipment, except for closed-caption decoder for deaf person to display audio portion of program (i.e. subtitles);

cc. Medical expenses for which reimbursement is available under another plan or program; and

dd. Any other medical expenses excluded by Section 213 of the Code, any regulations adopted thereunder by the IRS or via applicable court decisions.

4. Duration of Use of the Reserve Dollars Bank

Any monies deposited in a Participant's Reserve Dollars Bank may only be utilized for medical reimbursement so long as the Participant is actively employed (or available for such employment) pursuant to a collective bargaining agreement and/or Assent of Participation requiring any contributions to the Tri-County Building Trades Health Fund and for a period of time not to exceed the date such Participant reaches his or her Medicare eligible age.

5. Survivor or Other Eligible Dependent Use of Reserve Dollars Bank

In the event of a Participant's death, his or her individual Reserve Dollars Bank, until the date the Participant would have reached his or her Medicare eligible age, can be used by his or her Spouse and his or her Eligible Dependent(s), or if unmarried or widowed, for his or her other Eligible Dependent(s). This individual Bank may only be used for reimbursement purposes, as set forth above, and shall not be paid directly to the surviving Spouse or other Eligible Dependent(s) other than for reimbursement for eligible expenses or payment of monthly premiums for medical coverage. However, once the Bank reaches a balance of less than $10,000.00, it shall only be utilized by his surviving Spouse or other Dependent(s) for monthly premiums for medical coverage. Furthermore, no reimbursement or payment of premiums shall be made to the surviving Spouse or other Eligible Dependent(s) after the date the Participant would have reached his or her Medicare eligible age.

6. Administrative Fees

The Health Fund may assess an administrative fee against a Participant's individual Reserve Dollars Bank of a surviving Spouse or other Eligible Dependent(s) for the administrative costs of processing such reimbursement claims.

7. Forfeiture of Bank

If the Participant resigns as a member of the Union, takes a "withdrawal card", or fails to obtain reinstatement to the Union within thirty (30) days of suspension by the Union, the Participant's Bank will be wholly forfeited to the Fund.

E. Continuing Coverage by Making Self-Payments

You will only be eligible to make a self-payment to continue your coverage if you are actively seeking work through a Participating Union and are laid off, unemployed, or on strike.

To be actively seeking work, you must:

1. Maintain membership through the Local Union and register your availability to work at least every thirty (30) days with your Participating Union, or

2. Be available for work referred to by your Participating Union within the trade to a job which is identified as lasting at least one (1) week.

All self-payments received become property of the Fund as of the day received. Self-payment for hours in a work month which are then received as a result of a late payment by a Contributing Employer or reciprocity agreement, may be refunded in their entirety as determined by the Trustees.

You can continue your eligibility for up to eighteen (18) months provided you meet the requirements to make self-payments under this Section. However, once you have reached the end of your eighteen (18) months, you may be eligible to continue your coverage under the COBRA Continuation Coverage offered by the Fund. For more information on this coverage, please see Pages 30 of this Booklet.

F. Partial Self-Payments

If you are credited with less than the required contribution amount to continue eligibility, you may make a self-payment for the difference between monthly cost of the Plan design choice selected by you, or the Standard Plan if no Plan design option was selected by you. You can make this partial self-payment for any month in which you have some hours reported to the Fund, and it is not subject to the eighteen (18) month maximum on self-payments as described below.

G. Limitation On Full Self-Payments

If you meet the above criteria, you are eligible to make full self-payments for up to eighteen (18) months.

H. Special Continuation of Coverage for Disabled Participants

If you are disabled, so as to prevent you from performing any type of gainful employment, you will be able to continue your eligibility during the disability for a period of eighteen (18) months by making self-payments to the Fund. If it is determined that you are still unable to resume work in Covered Employment after

the first eighteen (18) months of your disability, you may be able to further continue your self-payments for an additional period of twenty-four (24) months.

If you suffer from a disabling condition which prohibits you from performing any work which is covered under a collective bargaining agreement, but you are able to perform other gainful employment, you will be entitled to maintain eligibility while you are seeking other employment or are being retrained to perform other employment. You may continue to make self-payments under this provision for up to twenty-four (24) months. You may be asked to provide periodic proof of your continuing disability from performing work in Covered Employment, and/or proof that you are seeking other employment or are being retrained for other employment, during this extended self payment period. If you become eligible to participate in Medicare due to your disability or age while making self-payments, you will be given the opportunity to participate in the Retiree Program which is outlined on Pages 24 of this booklet.

Once you have exhausted the maximum time period that you are eligible to continue your coverage through making your self-payments, you may be eligible to continue your coverage under the COBRA Continuation Coverage offered by the Fund. For more information on this coverage, please see Page 28 of this Booklet.

I. Reinstatement of Eligibility

If you fail to maintain your eligibility by meeting the hourly requirements and fail to make self-payments as allowed by the Fund, you will not become eligible in this Fund until you complete the Initial Eligibility Requirements of this section.

J. Continuation of Eligibility under the Family and Medical Leave Act (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) requires your employer to provide you with up to twelve (12) weeks of unpaid leave during any twelve (12) month period for specified family and medical reasons, if you are eligible. During this 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 twelve (12) months and for at least 1,250 hours during the twelve (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 20 or more work weeks during the current or preceding calendar year.)

Further, effective January 28, 2008, Participants with members in the Armed Services are entitled to FMLA leave under the following circumstances:

1) When leave is needed so that the Participant can care for an injured or ill family member in the Armed Services; and

2) When such leave is required due to "any qualifying exigency" related to a family member's service or call to duty.

The Participant must be a spouse, parent, child or nearest blood relative of the member in the Armed Services. A Participant who is eligible for FMLA leave under this provision will be granted up to twenty-six (26) weeks of leave in a single twelve (12) month period.

During 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 receive continued eligibility.

A covered employer must grant an eligible Participant up to a total of twelve (12) work weeks of unpaid leave during any twelve (12) month period (26 weeks for Participants with members in the armed services as provided above) for one or more of the following reasons:

1. For the birth or placement of a child for adoption or foster care;

2. To care for an immediate family member (Spouse, child or parent) with a serious health condition;

3. To take medical leave when the Participant is unable to work because of a serious health condition; or

4. For Participants with members in the armed services, the reasons provided above.

Upon return from FMLA leave, a Participant must be restored to his or her original job or to an equivalent job. In addition, a 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.

If you return to work within twelve (12) weeks (or 26 weeks as provided above), you will not lose health care coverage. If you do not return to work within twelve (12) weeks (0r 26 weeks as provided above), you may then qualify to continue coverage under COBRA. You may be able to self-pay for COBRA coverage for up to 18 additional months. See Page 28 for information on COBRA Continuation Coverage.

If you take a leave under the FMLA and you fail to return to your Employer for any reason after such absence, your employer has the right to collect all contributions made on your behalf during such leave of absence under the FMLA.

Please contact the Administrative Manager if you have any questions regarding your options under the FMLA

K. Termination of Active Participant's Coverage

In addition to the termination provisions stated above, an Active Participant's coverage under any benefit provision shall terminate upon any of the following:

1. Termination of the Plan, or

2. The Active Participant ceases to be eligible for participation in the Plan, or

3. Plan modification to terminate coverage in the Active Participant's classification, or

4. Plan modification to terminate a specific type of coverage under the Plan, or

5. On the date the Active Participant fails to make a required self-payment or COBRA payment, or

6. On the date the Active Participant enters the Armed Forces on full-time active duty, or

7. On the date an Active Participant materially misrepresents information provided to the Plan and/or appropriate Claims Payor (or other insurance provider) or commits fraud or forgery, or

8. The Active Participant allows a non-covered or ineligible person to use his/her benefit card to obtain or attempt to obtain benefits from this Plan, or

9. The Active Participant's Employer ceases to be a signatory to a collective bargaining agreement with the Sheet Metal Workers Local Union No. 33.

RULES OF ELIGIBILITY FOR DEPENDENTS

A. Eligibility Rules for Dependents

Your Eligible Dependents are any of the following individuals who are not Participants:

1. Your legal Spouse;

2. Each of your children who is under age nineteen (19) and unmarried; as well as, an adopted child, a dependent child placed within the Participant's home prior to and in anticipation of adoption provided proper notice and documentation is provided to the Administrative Manager demonstrating the pending adoption, or a stepchild who resides in your household and is dependent upon you for principal support;

3. Each of your children who is unmarried and over age nineteen (19) and under age TWENTY THREE (23) **ONLY IF** ENROLLED AS A FULL-TIME STUDENT IN AN ACCREDITED SCHOOL, COLLEGE, OR UNIVERSITY WITH THE INTENT OF OBTAINING A DEGREE and is dependent upon you for principal support. (The Board of Trustees has the right and opportunity to require proof of a child's status as a student and the right to verify any information submitted as evidence);

4. Each of your unmarried children who is incapable of self-sustaining employment because of mental or physical disability, and who became incapable before age nineteen (19) and while eligible for benefits under this Plan.

Extension of this coverage is subject to the Claims Payor receiving written proof of the incapacity not later than thirty-one (31) days after attainment of age nineteen (19). When filing a claim for a mentally disabled or permanently physically disabled child over 19, you must include a physician's statement (on letterhead stationery) which details the severity of your child's mental disability or permanent physical disability. Additional information may be requested but proof of continued incapacity will not be required more than once each year.

Please Note:
If your Eligible Dependent has the opportunity to enroll in his or her employer's health care plan, and the contribution[2] that the Eligible Dependent would have to pay amounts to less than Two Hundred Dollars ($200.00) per month, the Eligible Dependent must enroll in his or her health care plan and that plan, subject to the "Coordination of Benefits" criteria on Page 73, will be the primary insurer for the Eligible Dependent. If the Eligible Dependent fails to obtain his/her employer's health care plan, health care coverage for that Eligible Dependent will terminate under this Plan.

B. Definition of Child

The word "child" or “children” includes the following:

1. Your natural born child.

2. Your Legally adopted child, including a child being placed for adoption, whether or not the adoption has become final.

3. Your Stepchild residing in your household, solely supported by you as evidenced by your federal income tax returns.

4. A child of a Participant who is recognized under a Qualified Medical Child Support Order as having the right to enrollment for the group health plan, even though the child does not reside with the Participant or live within the service area of the health insurance carrier.

5. The word "child" also includes a relative of a Participant or Spouse for whom the Participant or Spouse has legal custody. (Please see QMCSO Section, Page 21).

Proof that the child is an Eligible Dependent may be established by one or more of the following documents:

1. Child's birth certificate;

2. Child's baptismal certificate;

3. Court order or record or other legally recognized proof of dependent status;

4. Participant Tax Returns to establish dependent status.

[2] Not including co-pays, deductibles, or any other out-of-pocket costs.

C. Continued Eligibility for Dependents

Dependent coverage is contingent on your maintaining eligibility. Additionally, an Eligible Dependent will only be eligible during the time they meet the definition of Eligible Dependent provided above. Upon the death of a Participant, the Eligible Dependent is entitled to continue coverage in the Plan until the end of the time period for which the Participant’s coverage was earned or paid as of the date of death.

At the expiration of the earned coverage for the Participant, the Eligible Dependents of the deceased Participant may, upon written application, arrange

with the Administrative Manager to make payments to provide continuing coverage under the Surviving Spouse Eligible Dependent Programs described later. Additionally, an Eligible Dependent of a deceased Participant may be eligible for continuation of benefits under COBRA. See Page 28 of this booklet for additional information. This COBRA coverage also applies to an Eligible Dependent who terminates coverage under the Plan due to the failure to meet the definition of Eligible Dependent as stated previously.

D. Termination Of Eligible Dependent Coverage

Eligible Dependent coverage will automatically terminate upon the occurrence of the earliest of the following events:

1. Termination of Active Participant's coverage, or

2. The date the dependent ceases to be an Eligible Dependent, except that if the individual is an "eligible dependent" under Section A(3) above (enrolled as a full-time student), the last day of the month in which that individual reaches age twenty-three (23); or

3. The date of termination of Eligible Dependent benefits under the Plan, or

4. The date the Plan is discontinued, or

5. The date the Eligible Dependent enters the Armed Forces on full-time active duty, or

6. On the last day of the month after the date of any final decree of divorce, annulment or dissolution of the marriage (for Spouse of an Active Participant), or

7. The date an Eligible Dependent materially misrepresents information provided to the Plan or the Claims Payor (or other insurance provider) or commits fraud or forgery, or

8. The Eligible Dependent allows a non-covered or ineligible person to use his or her benefit card to obtain or attempt to obtain benefits from this Plan.

E. Coverage for a Surviving Eligible Dependent

Upon the death of a Participant, his legal Spouse will be eligible to participate in this Plan under the Surviving Eligible Dependent Program until:

1. The Spouse becomes eligible to participate in a group hospitalization program offered by his/her employer that provides substantially the same benefits as this Plan;

2. The Spouse becomes covered by another group program, excluding Medicare; or

3. The Spouse remarries.

Such coverage will only be available in the Standard Plan design form but such Surviving Eligible Dependents will be permitted to enroll in the Option 1 additional coverage package. The surviving Spouse must make application to continue coverage through the Surviving Eligible Dependent Program to the Administrative Manager within sixty (60) days of the Participant's death and pay timely monthly contributions to the Administrative Manager in the amount and at the time established by the Board of Trustees.

If you are a Participant upon your death, your Eligible Dependents will also be eligible to participate in the Plan under the Surviving Eligible Dependent Program until he/she fails to meet the definition of Eligible Dependent. Additionally, the Eligible Dependent must make application to continue coverage through the Surviving Eligible Dependent Program to the Administrative Manager within sixty (60) days of the Participant's death and pay timely monthly contributions to the Administrative Manager in the amount and at the time established by the Board of Trustees.

F. Termination of Surviving Eligible Dependent Coverage

Dependent coverage will automatically terminate upon the occurrence of the earliest of the following events:

1. The date the Surviving Eligible Dependent ceases to be eligible;

2. The date of termination of Surviving Eligible Dependent benefits under the Plan;

3. The date the Plan is discontinued;

4. The date the Surviving Eligible Dependent enters the Armed Forces on full-time active duty;

5. The date a Surviving Eligible Dependent materially misrepresents information provided to the Plan or Claims Payor (or other insurance provider) or commits fraud or forgery, or

6. The Surviving Eligible Dependent allows a non-covered or ineligible person to use his/her benefit card to obtain or attempt to obtain benefits from this Plan, or

7. The Local Union of the Surviving Eligible Dependent's Deceased Spouse or parent withdraws its participation in the Plan.

G. Qualified Medical Child Support Orders

ERISA requires the Plan's Administrative Manager to honor court orders or administrative court directives (i.e., medical child support decrees) to provide medical plan coverage to children and/or other "alternate recipients" and to begin such coverage while you are working.

These orders must meet the Qualified Medical Child Support Orders (QMCSO) rules, which require that certain federal standards be satisfied. The Plan's Administrative Manager will deny medical plan coverage under any judgment, decree or order as a "Qualified Medical Child Support Order" unless it satisfies all of the requirements set forth below. Assuming such Order meets these federal requirements, the Plan's Administrative Manager will follow the terms of the Order if this Plan is the proper party to the legal proceeding from which the Order has been issued.

The Plan's Administrative Manager will follow court orders or administrative court orders that meet all of the following requirements:

1. The Order relates to the provision of medical child support order.

2. The Order creates or recognizes the existence of an alternate recipient's right to medical coverage under the participant's medical benefits.

3. The Order specifies the social security number, name, birth date, and last known mailing address of the participant and each alternate recipient covered by the Order.

4. The Order specifies the type and period of medical coverage and requires that such coverage be paid by the participant in accordance with the medical plan and federal law.

5. The Order specifically names the Tri-County Building Trades Health Fund as the Plan to which the Order applies.

6. The Order does not require this plan to provide any type of medical coverage, benefit(s), or form of coverage or option(s) not otherwise provided under this plan.

Upon request to the Administrative Manager, you will be provided with a copy of the Plan's Procedures for Processing Medical Child Support Orders.

ELIGIBILITY FOR RETIREE OR DISABILITY PROGRAM

A. Eligibility For Retiree Program

If you retire from employment while being covered in this Plan, you may continue your eligibility by making contributions for retiree benefits directly to the Fund. The amount of contributions you will be required to pay will be determined by the Board of Trustees from time-to-time based on the cost of the benefits.

In order to participate in the Retiree Program, you must meet the following requirements:

1. You must have been awarded a pension through a qualified retirement program acceptable by the Board of Trustees or receive social security retirement benefits from the Social Security Administration.

2. You must have been an Active Participant in the Tri-County Building Trades Health Fund 1) for a total of ten (10) years out of the last fifteen (15) years immediately proceeding the date on which you retire; or 2) for a total of seven (7) out of the last fifteen (15) years immediately preceding the date on which you retire and also been an Active Participant for at least twenty-four (24) consecutive months preceding your retirement.

3. You must elect to continue and make the first required self-contribution for Retiree Program coverage no later than thirty (30) days following the date your coverage as an Active Participant terminates. Failure to make the first contribution payment within the time specified will make you ineligible to participate in the Retiree Program.

4. You must notify the Administrative Manager within thirty (30) days of the effective date of your retirement. If you fail to notify the Administrative Manager within thirty (30) days of the effective date of your retirement, you will be ineligible to participate in the Plan and will not be entitled to any benefits from the Plan. The Fund reserves the right to recapture any benefit payments improperly made to you or your dependents.

For a retiree over sixty-five (65), whose spouse is not Medicare eligible, to continue covering your spouse under the aforementioned program, the retiree must choose the early retiree family plan. For a retiree over sixty-five (65), whose spouse is not Medicare eligible, if you choose to discontinue coverage for your spouse, you would choose the single post-65 Medicare plan.

For a retiree under sixty-five (65), whose spouse is over sixty-five (65) and Medicare eligible, the retiree may choose either single early retiree rate and the Medicare eligible rate for the retiree’s spouse or choose the family early retiree rate.

A surviving spouse may continue on the Plan. However, the surviving spouse will no longer be eligible if said surviving spouse remarries or has the opportunity to enroll in his or her Employer's health care plan, and the out-of-pocket maximum amount that the eligible dependent would have to pay amounts to less than Two Hundred Dollars ($200.00) per month (excluding co-pays, deductibles, or any other out-of-pocket costs) (as the surviving spouse must enroll in his or her health coverage and that Plan will be the primary insurance for the Eligible Dependent). If the Eligible Dependent fails to obtain his or her Employer's health care plan, health care coverage to that Eligible Dependent will terminate under this Plan.

B. Eligibility For Disability Program

If you are disabled and have maintained continuous eligibility through self-payment during your disability, and you have been an Active Participant for a period of five (5) Plan Years out of the previous seven (7) Plan Years before your disability date, upon receipt of a disability award from the Social Security Administration and/or receipt of disability benefits from the National Sheet Metal Pension Plan or the Sheet Metal Local Union No. 33 Pension Plan, you shall be eligible to participate in benefits available to Retired Participants providing the necessary contributions, as required by the Trustees, are received within 31 days following your eligibility for Medicare and you submit verification of such Medicare eligibility to the Trustees. You will continue thereafter to be eligible to participate in the benefits available for Retired Participants provided you continue to be eligible for Medicare and pay the necessary contributions as required by the Trustees.

A retiree who is disabled under this Plan will remain on the single or family coverage depending on the retiree's election of single or family coverage.

C. Eligibility For Dependents In Retiree or Disability Program

Dependent coverage is contingent on your maintaining eligibility. Additionally, a dependent will only be eligible during the time they meet the definition of Eligible Dependent. Upon the death of the Retired or Disabled Participant, the Eligible Dependent may be eligible to continue coverage under the Surviving Eligible Dependent Program as discussed below.

If your Eligible Dependent is also eligible for Medicare, you can make payments to include your Dependent for coverage under the Plan of Benefits for Retirees who are Medicare Eligible. However, if your Eligible Dependent is not eligible for Medicare, the benefits for that Eligible Dependent (other than Short-Term Disability, Death, Accidental Death and Dismemberment) will be provided under the Standard Plan until your Eligible Dependent reaches Medicare age or ceases to meet the definition of Eligible Dependent.

Eligible Dependent**,** as used in this section, is defined on Pages 17-18 under the Rules of Eligibility for Dependents.

D. Special Continuation For a Retiree's or Disability Retiree's Surviving Eligible Dependents

Upon the death of a Retired Participant, his legal Spouse and Eligible Dependents will be eligible to participate in this Plan under the Surviving Eligible Dependent Program until:

1. The surviving Spouse becomes eligible to participate in a group hospitalization program offered by his or her employer that provides substantially the same benefits as this Plan, or

2. The Surviving Eligible Dependent becomes covered by another group program, excluding Medicare, or

3. The surviving Spouse remarries; or

4. Provided your Spouse and/or dependents make application to continue coverage through the Surviving Eligible Dependent Program and pays timely monthly contributions to the Administrative Manager in the amount and at the time established by the Board of Trustees, or

5. The dependent fails to meet the definition of Eligible Dependent provided above, or

6. The Local Union of the Surviving Eligible Dependent's Deceased Spouse or parent withdraws its participation in the Plan.

In the event that coverage is terminated in this Plan for your Surviving Eligible Dependents, they may be able to continue coverage under the COBRA Continuation Rules as provided in this SPD.

E. Retiree or Disability Self-Payments

You are required to remit payment to the Administrative Manager monthly in order to continue your coverage in this Plan of Benefits for you and for your Eligible Dependents. Your self-payment must be received by the Administrative Manager by the due date reflected on the billing notice. In the event that the self-payment is not received for your coverage by the due date, you will be considered delinquent.

Under the Retiree or Disability Program, your coverage and your Eligible Dependents will be terminated immediately for the failure to remit the payment in a timely manner. You will not be eligible for reinstatement in the future without resuming work as an Active Participant and fulfilling the initial eligibility rules of the Fund.

Under some circumstances, you and/or your Eligible Dependents may have the ability to continue your coverage under COBRA Continuation Rules as provided in this SPD.

F. Re-Employment of Retired Participants

If you return to work for a Contributing Employer and contributions are received on your behalf, the hours worked will be credited towards payment of your Retiree premiums.

G. Termination of Retiree or Disability Program Eligibility

A Retired or Disabled Participant's coverage will automatically terminate upon the occurrence of the earliest of the following events:

1. Termination of the Plan, or

2. Plan modification to terminate coverage in the Retired Participant or Disabled Participant classification, or

3. Plan modification to terminate a specific type of coverage under the Plan, or

4. The date the Retired Participant or Disabled Participant ceases to be eligible for participation (as a Retired or Disabled Participant) in the Plan, or

5. On the date the Retired Participant or Disabled Participant fails to make a required self-payment, or

6. On the date the Retired Participant or Disabled Participant enters the Armed Forces on full-time active duty, or

7. The date a Retired Participant or Disabled Participant materially misrepresents information provided to the Plan or the Claims Payor (or other insurance provider) or commits fraud or forgery, or

8. The Retired Participant or Disabled Participant allows a non-covered or ineligible person to use his or her benefit card to obtain or attempt to obtain benefits from this Plan, or

The Retired Participant's Local Union withdraws its participation in the Plan.

Your Eligible Dependents will also lose coverage on the same date that you lose coverage due to one of the above listed reasons. Under certain circumstances, you and/or your Eligible Dependent may have the ability to continue coverage under the COBRA Continuation Rules provided in this booklet.

SPECIAL ENROLLMENT RIGHTS

An Active Participant (or Eligible Dependent of such Active Participant) who is eligible but not enrolled for coverage under the Plan may enroll for coverage under the terms of the Plan, by notifying the Fund office in writing, should the individual lose other coverage if each of the following conditions are met:

1. The Active Participant or Eligible Dependent was covered under a group health plan or had health insurance at the time coverage was previously offered to the Active Participant or Eligible Dependent;

2. The Active Participant or Eligible Dependent stated in writing at such time that coverage under a group health plan or health insurance was the reason for declining enrollment and provided a copy of such written statement to the Fund's Administrative Manager;

3. The Active Participant or Eligible Dependent's coverage:

    a. was under a COBRA continuation provision and the coverage under such provision was exhausted; or

    b. was not under such COBRA provisions and either the coverage was terminated as a result of loss of eligibility for coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or employer contributions towards such coverage was terminated; and

    c. The Active Participant or Eligible Dependent requests such enrollment in writing not later than sixty (60) days after the dates of exhaustion of coverage or termination of coverage or employer contributions. Even if the Active Participant and/or Eligible Dependent notifies the Fund Office within sixty (60) days, the Active Participant and/or Eligible Dependent should refer to Coordination of Benefits.

Notwithstanding the foregoing, an Active Participant and/or Eligible Dependent shall have the right to special enrollment in the Plan after marriage, birth, adoption or placement for adoption. If any of the preceding events occur, the Active Participant and/or Eligible Dependent must request special enrollment within writing in sixty (60) days of the event that triggered special enrollment. If the request is granted, coverage shall be effective the date of the event.

If you fail to notify the Fund within the time period of sixty (60) days stated above, you may still apply for special enrollment; however, the Eligible Dependent will not be eligible for benefits until the first of the month following the month in which you notify the Fund office in writing. In addition, there shall be no retroactive

coverage and all of the pre-existing exclusions shall apply if the Fund is not notified within the sixty (60) day time period stated above.

To request special enrollment or to obtain more information, contact the Plan's Administrative Manager, BeneSys, Inc., at P.O. Box 368, Troy, Michigan 48099-0368, (248) 641-4902 or (866) 599-3176.

TERMINATION OF COVERAGE

Special Continuation Rules for Participants who Enter Military Service

Eligibility for benefits ceases on the date you enter full time service in the Armed Forces. The
Plan will reinstate your benefits without a waiting period or initial eligibility period or other exclusion upon your reemployment with any Contributing Employer under this Plan.

The Plan will provide you with the ability to retain coverage during the time you are in qualified military service. If you are in qualified military service for less than thirty-one (31) days, the cost of continuing your coverage will be the responsibility of the Plan, provided, you meet the conditions for reemployment. During this qualified military service of less than thirty-one (31) days, your bank hours will not be used in order to maintain your eligibility.

If you are in qualified military service for more than thirty-one (31) days, the cost of providing continuation of coverage will be your responsibility. The Plan will credit your Reserve Dollars Bank before billing you a monthly continuation coverage premium. You will be entitled to make the self-payments for a maximum period of twenty-four (24) months.

Your coverage will be reinstated upon your reemployment with any Contributing Employer under this Plan if you apply for reemployment within fourteen (14) days after your honorable discharge, if you serve between thirty-one (31) and one hundred eighty-one (181) days in qualified military service. If your service exceeds one hundred eighty-one (181) days, you must apply for reemployment within ninety (90) days after your honorable discharge. Additionally, you must be re-employed with a Contributing Employer in this Plan.

You must give the Administrative Manager notice of your qualified military service as soon as you know that you are leaving Covered Employment to join the Armed Services and must provide the Administrative Manager with notice that you were previously an Eligible Participant with the Plan as soon as you return to work with a Contributing Employer under the Plan.

Questions regarding your entitlement to this leave and to the continuation benefits should be referred to the Plan's Administrative Manager.

Certification of Coverage upon Termination

If your coverage under this Plan terminates, your new health care coverage may have exclusions and waiting periods. At the time your coverage ends under this Plan, you will receive a Certificate of Creditable Coverage to present to your new health care plan. This Certificate will provide your new Plan with information on your coverage under this Plan. A pre-existing condition is a condition for which you incurred medical expenses, received medical treatment, used prescription drugs or were advised by a physician or other professional provider to receive treatment prior to your effective date of initial eligibility. A pre-existing condition does not apply to pregnancy, pregnancy-related conditions or any condition related to genetic information. Additionally, a pre-existing condition exclusion does not apply to newborn children or children who have been continuously covered by a group health plan within thirty (30) days of the birth or adoption.

For Example: You were treated for a heart condition under this Plan for two (2) years and terminated coverage. Your new health care provider imposed a twelve (12) month pre-existing condition exclusion which denies coverage for any condition that you were treated for in the twelve (12) months prior to joining the new health plan. Since you were treated for this heart condition for over twelve (12) months, this Plan will issue a Certificate of Creditable Coverage which states the time period that your were covered under this Plan and that treatment for this heart condition was covered. Once you present this Certificate to your new health coverage provider, they are required under the federal law to cover you for your treatment related to the heart condition from the first day of coverage once you have otherwise satisfied your deductibles, etc.

This coverage period that you are covered under this Plan is referred to as “Creditable Coverage”. The pre-existing condition period required by another plan will be reduced by this Creditable Coverage period. However, a period of creditable coverage is not counted if there is a break in coverage of sixty-three (63) days or more between the end of the Creditable Coverage under this Plan and the enrollment in the new coverage. This Credit also applies to your Eligible Dependents.

If you need a Certificate, you can contact the Claims Payor up to twenty-four (24) months after losing coverage for an additional copy.

COBRA COVERAGE - 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.

A. Introduction

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.

B. What is COBRA 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 of beneficiaries covered under the Plan, including special enrollment rights.

If you are a Participant, 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.

C. <u>When is COBRA Coverage Available?</u>

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.

D. 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.

E. 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 termination of employment (other than for gross misconduct) or reduction of the employee's hours of employment, the maximum continuation coverage period for the Participant, Spouse, and Dependent child is eighteen (18) months from the date of termination or reduction in hours. However, there are four (4) 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 form the date the individual became entitled to Medicare.

- If you meet the conditions set forth in the "Special Continuation Rules for Participants Who Enter Military Service" (Page 29 of your Summary Plan Description and Plan Documents which was issued in April 2005) you will be offered COBRA coverage for twenty-four (24) months rather than the normal period of eighteen (18) months.

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.

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.

IMPORTANT INFORMATION ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS

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:

BeneSys, Inc.
P.O. Box 368
Troy, Michigan 48099-0368
(248) 641-4902
(866) 599-3176

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 the appropriate Plan's Administrative Manager at:

BeneSys, Inc.
P.O. Box 368
Troy, Michigan 48099-0368
(248) 641-4902
(866) 599-3176

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.

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:

BeneSys, Inc.
P.O. Box 368
Troy, Michigan 48099-0368
(248) 641-4902
(866) 599-3176

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.)

DEATH BENEFIT

If an Active Participant or Retiree dies from any cause as covered by the Certificate of Coverage from Lincoln Financial Insurance Company, Death Benefit will be paid to the person's named Beneficiary. For information about this death benefit, refer to your Certificate of Coverage from Lincoln Financial Insurance Company.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT (For Active Participants Only)

If you have an accident while you are eligible for benefits under the Fund, and the accident causes loss of life, dismemberment or blindness, the amount of the Accidental Death and Dismemberment Benefit shown in the Schedule of Benefits will be paid to you or your Beneficiary. This benefit is paid only for Active Participants. For information about this benefit, refer to your Certificate of Coverage from Lincoln Financial Insurance Company.

PAYMENT RESPONSIBILITY FOR MEDICAL BENEFITS

The Tri-County Building Trades Health Fund pays benefits for you and your Eligible Dependents based upon the Schedule of Benefits provided in the front of this SPD. However, these payments are subject to various deductibles, coinsurance and other limitations described in this section, as well as, in the Schedule of Benefits.

A. Deductible

This is the amount of covered medical expenses that you pay each Calendar Year before benefits are payable from the Plan. Family deductible may be satisfied through any combination of individual deductibles. Single and Family deductible requirements are listed in the Schedule of Benefits. The deductible amounts you pay to In-Network and Out-of-Network Providers are not integrated. Therefore, deductibles paid to In-Network Providers will not apply to the deductibles required for Out-of-Network Providers.

B. Deductible Carry-Over

In the event that your deductible is not satisfied in a calendar year, any covered charges applied toward the deductible in the last ninety (90) days of the calendar year may be carried over to the following calendar year and combined with any subsequent covered charges to satisfy the deductible for that following calendar year.

C. Coinsurance Limit

Under the Comprehensive Plan of Benefits, each calendar year you and your Eligible Dependents are responsible for the coinsurance amount up to the Out-of-Pocket Maximum set forth in the Schedule of Benefits.

D. Out-of-Pocket Maximum

The Plan provides a maximum amount of covered expenses that any one person covered under the Plan will have to pay each calendar year under the Plan.

The Out-of-Pocket expense limit applies to covered benefits and eligible charges of In-Network and Out-of-Network Providers which, due to deductible and Coinsurance provisions of your Plan, have not been fully paid by the Plan. These unpaid expenses are your responsibility until the annual Coinsurance expense limit is reached. Once the annual limit has been reached, your Plan will pay covered medical expenses at 100% to In-Network Providers and 100% of UCR charges to Out-of-Network Providers. The out-of-pocket amounts you pay to In-Network and Out-of-Network Providers are integrated. Therefore, Out-of-Pocket expenses paid to In-Network Providers will apply to the Out-of-Pocket expenses required for Out-of-Network Providers.

Please refer to the Schedule of Benefits for deductible and Coinsurance requirements and the list of expenses that do not apply to Out-of-Pocket maximums.

E. Lifetime Maximum

There is an overall lifetime maximum expense benefit for you and for each Eligible Dependent, as shown in the Schedule of Benefits. Whenever benefits are paid they are charged against the individual's overall lifetime maximum.

F. Usual, Customary and Reasonable Charges

This term is commonly called UCR. It is comparable to the fee usually charged for the same or similar service rendered by other Providers in the same geographical area whose training, education and professional standing is equivalent to that of the Provider making the charge.

G. For In-Network Providers and Physicians

Charges for medical services that are established between the Claims Payor and the service provider. The Fund pays these charges at the established rate, so an In-Network doctor or hospital will not bill you for any charges that are above the UCR.

H. For Out-of-Network Providers and Physicians

Charges above UCR will normally not be covered by the Plan. However, since the physician does not have a contract with your Claims Payor, you may be responsible for the charges exceeding UCR.

For example, if an Out-of-Network provider charges a fee of $125.00 for a procedure and the Usual, Reasonable and Customary charge for this procedure in the same area is $100.00, then you will be responsible for payment of the $25.00 to the provider directly, subject to any deductible(s). However, if you went to an In-Network provider, the $100.00 would be paid by the Fund and the provider would waive payment of the remaining $25.00 due to the contract they have with your Claims Payor.

With regard to Out-of-Network Hospitals, many of these hospitals still have negotiated payment terms and methods with your Claims Payor in order to establish payment that will be accepted based upon the medical service you receive, so UCR does not technically apply to inpatient hospital facility charges.

If you are a patient in an In-Network hospital and receive ancillary services from an Out-of-Network provider (such as radiologist, anesthesiologist and pathologist), payment shall be based on the billed charges rather than UCR.

ENROLLMENT

Your Plan utilizes a Preferred Provider Organization (PPO) through your Claims Payor which provides financial incentives to use the providers within the network associated with that Claims Payor. Your network will be determined by the county and/or state of your residence. The specific network will be listed on your identification card. If you have any questions about which network you are in, please contact your Claims Payor. When you and your Eligible Dependents use the “In-Network” Providers and Physicians, the Fund may receive a discount or another form of cost reduction which is reflected in the co-insurance paid by the Participants. You and your Eligible Dependents will also receive the maximum Plan benefits when you utilize In-Network Providers and Physicians. However, when you utilize Out-of-Network Providers and Physicians, you will be subject to co-insurance payments and charges above the UCR costs.

The Open Enrollment Period will be from November 1 through November 30 of each Calendar Year. You will receive information from the Administrative Manager which allows you to select a type of health coverage. You must return your executed Enrollment Form to the Administrative Manager by November 30th or your benefit plan

level will remain the same for the next Plan Year. If you timely return such form your new Plan design or optional benefit choice(s) shall become effective for services provided on or after January 1st. Note: Enrollment into an optional benefit package, referred to on Page 55, cannot be revoked until the next open enrollment period.

With the exception of Participants of certain employers whose collective bargaining agreement may dictate which plan they are enrolled in (i.e. the Standard Plan), you are provided an opportunity to choose one of the plan design options available (i.e. Full Plan, Standard Plan or Catastrophic Plan). However, each Plan Year, the Plan offers an Open Enrollment period which allows you and your Eligible Dependents to switch medical benefit plan levels. (See your Schedule of Benefits for more details).

If you fail to enroll in a different benefit plan level during the Open Enrollment Period, you will remain in your current benefit plan level.

You may obtain information about your providers and physicians by accessing your Network on their website or by contacting them directly. These providers and physicians have the ability to terminate or refuse to sign new contracts with the Network. In order to be assured of the current status of your Provider or Physician in the Network, you should contact your network. Additionally, please be aware that even though a hospital is contracting with your network, each Provider and Physician who works with or in the hospital is not automatically part of the Network. Your ID will contain information on how to obtain a list of network providers and/or physicians. You need to check on each Provider and Physician you use in order to be assured that they are part of your Network.

EXPLANATION OF MEDICAL BENEFITS

The Tri-County Building Trades Health Fund has entered into an agreement with various organizations which are preferred provider organizations (PPO) to obtain discounts from hospitals and physicians. When you and your Eligible Dependents use an In-Network Provider, the provider is required to charge a discounted rate for certain services based upon contracts it has with the PPO. Accordingly, this reduces the co-insurance amount that is charged to you and your Eligible Dependents, as well as, provides an overall cost saving to the Fund. When you or your Eligible Dependents use the services of any provider, you should present your Identification Card issued by the Fund. This enables the provider to determine that you are a member of a group that uses the PPO. This will assist the Fund in ensuring that the proper discounts are provided, and thus, lower your co-insurance.

Additionally, in order to ensure that all Participants receive quality oriented cost effective care, the Claims Payor has the authority to implement a utilization management program. This program will be designated to assist the hospital and provider community in developing treatment protocols that manage your care in the most appropriate medical setting.

The Fund covers hospital and Medical benefits for you and your Eligible Dependents. You and your Eligible Dependents will be required to pay your deductible and any co-insurance amount as stated in the Schedule of Benefits prior to any payment by the Fund.

All services and supplies must be medically necessary in order to be covered services or supplies under this Plan of Benefits.

A. Inpatient Hospital Benefits

These benefits are subject to the limitations and any exclusions as set forth in the Schedule of Benefits. If you are hospitalized because of an illness, injury or pregnancy, the Hospital Expense Benefit covers the hospital bill for your room and board and for miscellaneous expenses related to treatment you receive while you are an inpatient in the hospital. This benefit also covers the charges for miscellaneous expenses related to surgery you have on an outpatient basis.

1. Room and board in a semi-private room, an intensive care unit, coronary care unit, burn unit or isolation room, if medically required. If no rate for a semi-private room is available at the hospital where you are confined the Fund will pay a rate based on the average charge for a semi-private room in the surrounding area.

Note: If you choose to stay in a private room you must pay the difference between the private and the semi-private room rate. If you are put into a private room because you are contagious to other patients, the private room rate will be paid.

B. Hospital Outpatient Benefits

Hospital outpatient benefits are payable for the cost of outpatient services and the medical care and treatment received in an outpatient department of the Hospital. These outpatient hospital charges are paid up to the limit shown in the Schedule of Benefits.

C. Maternity Services

Coverage for inpatient hospital maternity services is treated as any other illness or injury. Hospital, medical and surgical services for a normal pregnancy, complications of pregnancy and miscarriage are covered. If you or your Spouse are admitted to the hospital for maternity services, your hospital stay cannot be restricted to less than forty-eight (48) hours, ninety-six hours (96) for cesarean section in accordance with the legislation passed by the Newborn and Mothers Health Protection Act of 1996, provided, however, if both the physician and mother consent, the stay can be shortened.

D. Accident Or Medical Emergency Care Expense Benefit

Your Plan provides coverage for treatment rendered within the time limitation specified in the Schedule of Benefits for an Accident or Medical Emergency. These are defined as follows:

- **Accident:** An Accident is an unforeseen injury to the body caused by unexpected, sometimes violent means.

- **Medical Emergency:** A Medical Emergency is the sudden onset of an acute condition with symptoms which appear life-threatening or disabling and require immediate medical attention and/or surgical care to prevent serious physical impairment or loss of life.

The interpretation of diagnostic tests and the treatment of a Medical Emergency are covered which include heart attacks, strokes, loss of consciousness or respiration, convulsions and other acute conditions which the Plan determines to be Medical Emergencies.

If you have an Emergency Medical Condition, go to the nearest hospital or dial 911 for Emergency Services. An Emergency Medical Condition is any medical condition that is severe enough to cause a prudent layperson with an average knowledge of health and medicine to believe that the absence of immediate medical attention could result in any of the following:

1. Placing the health of an individual or, with respect to a pregnant woman, the health of the woman of her unborn child, in serious jeopardy.

2. Serious impairment to bodily functions.

3. Serious dysfunction of any bodily organ or part.

Emergency Services will be covered according to your benefits chart no matter when or where you receive them. If you go to an Out-of-Network facility, payment may be limited to UCR.

If Emergency Facilities are used and it is determined by the Plan that the situation was neither an Accident nor an Emergency Medical Condition, Covered Services will be paid at the level of coverage stated in the Schedule of Benefits under Non-Emergency Care.

E. Inpatient Mental Health Services

This benefit covers treatment of psychiatric related conditions. If you or your Eligible Dependents are being treated as an Inpatient in a psychiatric facility, the Plan will pay the Usual, Customary and Reasonable (UCR) charges up to a thirty

(30) day lifetime maximum. The following services are payable for treatment for Inpatient Psychiatric Treatment Nervous/Mental Disorders:

1. Individual psychotherapy.

2. Group psychotherapy.

3. Electroshock therapy and related anesthesia only if given in a hospital or psychiatric hospital.

4. Psychological testing, limited to one battery of tests per covered person per calendar year.

Note: If you choose to stay in a private room, you must pay the difference between the private and semi-private room rate.

F. Inpatient And Outpatient Alcohol and Substance Abuse Treatment

The Plan will cover detoxification and rehabilitation services on an inpatient treatment basis for drug abuse or alcoholism. In order to receive the payment for the benefit, the program must be completed in its entirety. Services not provided under this benefit include:

1. Treatment not prescribed and performed by a physician or licensed psychologist.

2. Legal services, recreational, vocational, financial or educational counseling, except as part of a chemical dependency treatment program.

3. Detoxification or drug withdrawal programs not rendered by a Hospital or as part of a maintenance program.

4. Personal comfort items.

5. Marriage or family counseling except as part of a psychiatric treatment program.

G. Organ Transplant Benefit

The Fund will cover all expenses related to the transplantation of an organ, including patient screening, organ procurement and transportation, surgery for the patient and a live human donor, follow-up care in the home or a hospital and immunosuppressant drugs, if the following conditions are met:

1. The transplantation is not considered experimental or investigational by the American Medical Association; and

2. The patient is admitted to a transplant center program in a Comprehensive center approved either by the Federal government or the appropriate state agency of the state in which the center is located.

The provision of this Fund regarding coordination of benefits shall be applicable to the payment of expenses for organ transplantation under this Section.

In order to ensure that you receive the proper payment, please contact the Claims Payor prior to entering an Organ Transplant Program.

H. Surgical Expense Benefit

The Surgical Expense Benefit covers the physician's bill for surgery performed in a hospital, qualified outpatient surgical facility or a physician's office up to the Usual, Customary and Reasonable charges for such surgery in the area in which the services are provided. The surgery, must be the result of illness, injury or pregnancy.

I. Multiple Surgical Procedures

When one or more surgical procedure is performed during one operation, the main procedure will be paid at one hundred percent (100%) of the benefit and the subsequent procedures (up to four (4) additional unless more are approved by the UM Department of AultCare) will be paid at fifty percent (50%) of the benefit.

Successive operations shall be considered to have been performed during one period of disability unless between operations you have returned to full-time employment for sixty (60) consecutive days, or in the case of an Eligible Dependent, such operation is due to entirely unrelated causes.

J. Anesthesia Benefit

Anesthesia is covered by the Fund when rendered in connection with a covered service. The kind of anesthesia selected depends on the type of service performed and by the instructions of the physician or surgeon performing the procedure. Anesthesia may be administered only by a physician or a certified registered nurse anesthetist. This benefit is paid according to the level provided in the Schedule of Benefits.

K. Oral Surgery

Oral Surgery includes charges of a dentist or dental surgeon for repair or damage to the jaw and sound natural teeth which occurs as the direct result of an accident.

Charges of a dental surgeon for the following oral surgical procedures are covered:

- Operative and cutting procedures provided for the treatment of diseases and injuries of the mandible and maxilla.

- Surgical removal of impacted wisdom teeth, whether partially or completely covered by bone or soft tissue.

- Dental root resection (apicoectomy).

- Excision of tumors and cysts.

- Alveolectomy.

- Gingivectomy.

L. Reconstructive Surgery

Reconstructive surgery shall be payable as other surgeries only when the surgery is for the correction of conditions resulting from accidental injuries, and is completed in a manner determined with the attending physician, unless it is determined to be cosmetic. However, effective for services rendered on or after November 1, 1998, the following medical and surgical benefits will be covered for you and your Eligible Dependents who elect breast reconstruction in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;

- Surgery and reconstruction of the other breast to produce symmetrical appearance, and

- Coverage for prosthesis and physical complications of all stages of the mastectomy, including lymphedemas;

M. Services Excluded From Coverage Under Surgical Benefits

1. Surgical and all related procedures which are performed for cosmetic reasons are not covered unless as a result of an accidental injury. Examples of cosmetic surgery include, but are not limited to:

    - Surgery for Obesity, including gastric by-pass, gastric stapling, intestinal bypass, lipectomy, suction lipectomy, or any other surgical procedure which is simply to remove fat tissue.

    - Reduction Mammoplasty - (breast reduction surgery).

- Augmentation Mammoplasty - (breast enlargement surgery), unless part of reconstruction following breast surgery due to a mastectomy, as noted previously.

- Rhinoplasty - (plastic surgery on the nose) unless the result of an accident or chronic nasal obstruction.

- Otoplasty - (plastic- surgery on ears).

- Blepharoplast - (repair of drooping eyelids) unless the droop restricts field of vision as verified by an ophthalmologist.

- Rhytidectomy - (face lift).

- Dyschromia - (tattoo removal).

- Panniculectomy – (sometimes called "tummy-tuck").

- Genioplasty - (chin augmentation).

2. Any balance over the UCR allowance established by the Plan.

3. Charges for care, treatment, services and supplies which are not uniformly and professionally endorsed by the general medical community as standard medical care, including care, treatment, services and supplies which are experimental in nature.

4. Reversal of elective sterilization procedures.

5. Personal comfort items, such as hair appointments, magazines, telephone or television service in your room.

6. All taxes and surcharges.

N. Inpatient and Outpatient Laboratory Diagnostic and X-Ray Services

The following services are covered by the Plan at the level provided in the Schedule of Benefits on an inpatient or outpatient basis:

- Radiology, ultrasound and nuclear medicine

- Laboratory and pathology services, when provided to an Inpatient of a hospital or facility other provider

- EKG, EEG and other electronic diagnostic medical procedures

The Outpatient Diagnostic x-ray and Laboratory Expense Benefit covers charges for x-ray and/or Laboratory work done at your physician's request, on an outpatient basis, because of illness, injury or pregnancy.

Exclusions for this benefit include routine dental x-rays and laboratory work.

O. Mammogram Services

This Plan will provide coverage for Mammogram services as medically necessary at the level provided in the Schedule of Benefits.

P. Colonoscopy Services

This Plan will provide coverage for colonoscopy services as medically necessary at the level provided in the Schedule of Benefits, subject to the American Cancer Society Guidelines.

Q. Prostate Specific Antigen Tests

The Plan will provide coverage for Prostate Specific Antigen (PSA) Tests as medically necessary at the level provided in the Schedule of Benefits.

R. Ambulance Benefits

The Fund will pay the Usual, Customary and Reasonable (UCR) covered charges for professional licensed ambulance service under this benefit. A maximum of two (2) trips per confinement will be provided.

The Ambulance Service Benefit covers transportation charges for professional licensed ambulance service that is needed only for medical treatment. In addition, the Usual, Customary and Reasonable charges for air ambulance will also be covered, provided **all** of the following conditions are met:

- The transportation is by a vehicle designed and equipped and used only to transport the sick and injured.

- The transportation is from the scene of an accident or medical emergency to a hospital or between hospitals.

- The trip is to the closest facility that can give the appropriate services for the condition.

- Certification by an attending physician must be received indicating that transportation using ground facilities would not have been appropriate due to the life threatening and emergency nature of the accident or illness.

S. Skilled Nursing and Extended Care Services

The same benefits available to an Inpatient of a Hospital are available to an Inpatient of a Skilled Nursing facility. Such services must be skilled care and authorized and provided pursuant to your Physician's Plan of treatment. Your Physician must certify initially and every two (2) weeks that you are receiving Skilled Care and not merely Custodial Care.

No benefits are payable for the following:

- Once a patient can no longer significantly improve from treatment for the current condition as determined by the Plan.
- For custodial care, rest care or care for someone's convenience.
- For treatment of mental illness, drug abuse or alcoholism.

T. Physician and Nursing Charges

Charges for a Physician, Surgeon, or Clinical Psychologist rendering professional services are covered for medically necessary procedures.

NURSING SERVICES – The Plan covers the services of a graduate registered nurse, provided the nurse is not a member of your family. Additionally, the Plan provides coverage for a Private Duty Nurse, which is a registered, licensed vocational or licensed practical nurse, when the services are ordered by the physician and are medically necessary.

U. Special Services

BLOOD/BLOOD PLASMA - Blood, blood plasma not replaced or donated, administration of blood and blood plasma, oxygen, its administration and the cost to rent, up to the purchase price, equipment for its administration.

V. Allergy Testing and Treatments

The Plan will provide coverage for allergy testing and treatment as medically necessary at the level provided in the Schedule of Benefits.

W. Home Health Care

Charges for home health care services and supplies are covered only for care and treatment of an injury or sickness where Hospital or Skilled Nursing Facility treatment of an injury would otherwise be required. The Home Health Care Services must be provided under a Home Health Care Plan created and monitored by your Physician.

The following are Covered Services when you receive them from a Hospital or Home Health Care Agency:

- Professional service of a registered or licensed practical nurse; treatment by physical means, occupational therapy or speech therapy; medical and surgical supplies;

- Prescription drugs;

- Oxygen and its administration;

- Medical social services, such as the counseling of patients; and

- Home health aide visits when you are also receiving covered nursing or therapy services.

The Plan does not pay home health care benefits for any services or supplies not specifically listed in this Home Health Care Services section. Examples are:

- Dietitian services;

- Homemaker, housekeeping services;

- Food or home delivered meals; and

- Custodial care, rest care or care for someone's convenience.

X. Hospice Care

A Plan Participant who is eligible for regular Plan benefits will be eligible for hospice care benefits if the Participant is certified by a physician to have a life expectancy of six (6) months or less. The eligible person must submit an election statement to the Benefit Trust Office choosing hospice care in lieu of all other Plan benefits. When hospice care benefits are elected, all other Plan benefits are waived except for the service of the patient's attending physician provided that physician is not employed or compensated by the hospice. However, expenses for any illness or injury which is related to the terminal illness will be covered under regular Plan benefits. An election of hospice care may be revoked at any time to resume regular Plan benefits.

Hospice services covered under this benefit include all reasonable and necessary services for the care or management of the terminal illness as well as related conditions, including physician services, nursing services, inpatient care, home health and homemaker services, physical and occupational therapy, medical supplies, drugs and counseling services.

The Plan will pay for the following services, up to the amount of the allowance permitted for hospice care by the federal Medicare law in the geographic area in which the hospice is located:

- Continuous home care when at least eight hours of daily care is required during crisis periods in which the patient elects not to be hospitalized.

- Routine home care.

- General inpatient care when continuous care is provided in the hospital or similar facility and when less intensive care is not provided.

- Respite inpatient care, up to a maximum of five consecutive days, when short term inpatient care is required in a hospital, nursing home or free-standing hospice facility in order to relieve the family from home care duties. Benefits for respite inpatient care shall be paid only when the patient does not require intensive care and when general inpatient benefits are not payable.

- Physician's services, except when the physician renders to the patient outside the scope of normal supervisory activities, or when the expenses are those of the patient's attending physician. Such expenses shall be covered under the applicable limits of the Plan.

The maximum benefits payable per individual for hospice services shall be the maximum allowance under the federal Medicare law for the geographic area in which the hospice is located. To the extent that services are provided or expenses incurred by the patient which are not part of the hospice program, such services and expenses shall be considered covered charges under the applicable plan of benefits to which the Participant was entitled at the time he elected to waive those benefits to become eligible for hospice benefits.

Y. Therapy Services

The Plan provides coverage for services which promote recovery from illness or injury. However, the treatment must be performed by a licensed therapist, including a licensed physiotherapist acting within the scope of his license.

PHYSICAL THERAPY – Treatments to relieve pain, restore maximum function and to prevent disability following disease, injury or loss of a body part. Such services include physical treatments, hydrotherapy, heat or similar modalities, physical agents, biomechanical and neurophysiologic principles.

INPATIENT OR OUTPATIENT SPEECH AND OCCUPATIONAL THERAPY – The Plan pays for this coverage at the levels provided in the Schedule of Benefits in the event that the therapy is necessary due to a

medical condition and it is expected to produce significant improvement in the level of functioning.

RESPIRATORY THERAPY – Introduction of dry or moist gases into the lungs for treatment purposes and must be provided and billed by a Hospital.

RADIATION THERAPY – The treatment of disease by x-ray, radium or radioactive isotopes.

CHEMOTHERAPY – The treatment of malignant disease by chemical or biological antineoplactic agents.

DIALYSIS TREATMENTS – The treatment by dialysis methods of an acute or chronic kidney ailment, including chronic ambulatory peritoneal dialysis, which may include the supportive use of an artificial kidney machine.

OUTPATIENT CARDIAC REHABILITATION SERVICES – Payment is provided for Outpatient cardiac rehabilitation services which are Medically Necessary as the result of a cardiac event. It must be expected that the therapy will result in a significant improvement in the level of cardiac functioning.

Z. Chiropractic Benefits

The chiropractic expense benefit covers all services provided or supervised by a chiropractor. However, any chiropractic treatments are subject to review for medical necessity after twenty-six (26) visits. Any treatments which are determined to not be medically necessary will not be paid by the Plan.

AA. Outpatient Mental Health Care Services

To qualify as a covered medical expense, the service must be provided for the diagnosis, evaluation or treatment of mental illness. Benefits are generally not payable for the treatment of a mental deficiency or mental retardation once the condition is diagnosed.

The Plan will pay for all Covered Charges incurred on an outpatient basis 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 Outpatient Mental Health Service Benefit will be subject to completion of the program(s) or treatment(s) as prescribed by a licensed physician or psychologist.

BB. Durable Medical Equipment

Reimbursement will be made at the usual, customary and reasonable cost under the Plan for the purchase of durable medical equipment which meets all of the following criteria:

1. It can stand repeated use;

2. It is used to serve a medical purpose rather than being primarily for comfort or convenience;
3. It is not useful to a person in the absence of illness or injury;

4. It is appropriate for home use;

5. It is certified in writing by a physician as being medically necessary;

6. It is related to the patient's physical disorder;

7. The anticipated length of time the equipment will be required for therapeutic use must be certified in writing; and

8. It is for the exclusive use of the covered person for whom the physician has certified that is medically necessary.

This benefit payment is also limited to the purchase price.

CC. Prosthetic Appliances

The Plan will cover the purchase, fitting, adjustments, repairs and replacements of prosthetic devises which are artificial substitutes and necessary supplies that:

1. Replace all or a part of a missing body organ and its adjoining tissue.

2. Replace all or part of the function of a permanently useless or malfunctioning body organ.

Excluded from coverage under this benefit are the following:

- Dental appliances.

- Replacement of cataract lenses unless needed because of a lens prescription change.

- Elastic bandages.

- Garter belts or similar devises.

- Orthopedic shoes which are not attached to braces or which are not otherwise deemed medically necessary.

DD. Injectible Medications

Injectible medications (and corresponding hypodermic needles and/or syringes for such medications) are covered by the Fund's medical benefits, as it is not covered by the Fund's prescription program.

EE. Accidental Dental Services

The Fund will cover dental services rendered by a physician or dentist for the treatment of an injury to the jaw or to natural teeth, including the initial replacement of these teeth and any necessary dental x-rays resulting from an accident. This Accidental Dental benefit is payable under the Schedule of Benefits subject to the deductible.

FF. Routine Care Services

ROUTINE GYNECOLOGICAL/ PAP EXAM SERVICES – The Plan will provide coverage for each covered person as medically necessary at the level provided in the Schedule of Benefits.

MAMMOGRAM SERVICES - This Plan will provide coverage for Mammogram services as medically necessary at the level provided in the Schedule of Benefits.

PROSTATE SPECIFIC ANTIGEN TESTS - The Plan will provide coverage for Prostate Specific Antigen (PSA) Tests as medically necessary at the level provided in the Schedule of Benefits.

ROUTINE ADULT PHYSICAL – The Plan will cover routine adult physical exams once per calendar year at the level provided in the Schedule of Benefits.

IMMUNIZATIONS – The Plan will cover routine adult immunizations at the level provided in the Schedule of Benefits.

GG. Well Child Care

1. Birth to Age One (1)

Coverage for a history and physical examination, development assessment, anticipatory guidance and laboratory services and immunizations at birth and at proper intervals up to one (1) year, will be

covered for each of your Eligible Dependents. Additionally, the proper intervals are based upon the current Recommendations for Preventative Pediatric Health Care of the American Academy of Pediatrics (AAP).

2. After Age One (1)

Benefits will be provided for a History and Physical examination, development assessment, anticipatory guidance and laboratory services and immunizations at the level provided in the Schedule of Benefits. Immunizations will also be covered based upon physician recommendation as the AAP schedule for immunizations varies based on the latest medical findings or research.=

3. Exclusions From Well Child Care

The Plan does not cover:

a. Services which are covered to any extent under any other benefit sections of the Plan.

b. Services which are for diagnosis or treatment of a suspected or identified injury or disease.

c. Services not performed by a physician under his/her direct supervision during a single visit.

d. Medicine, drugs, appliances, equipment or supplies.

e. Dental exams.

HH. Diabetes Educational Benefit

Where a physician diagnoses a Participant and/or Dependent with diabetes and the physician orders diabetes education, the Plan will pay for said education at the standard in-network and out-of-network rates, after satisfaction of the in-network and out-of-network deductibles, up to a limit of one (1) class per lifetime.

II. Hearing Benefits

The Hearing Benefits paid under this Fund include all charges relating to hearing exams, hearing correction devices (hearing aids), including the purchase, repair, maintenance, batteries, etc. Payment for these services is subject to the lifetime maximum amount per eligible individual, as specified in the Schedule of Benefits.

EXPLANATION OF MEDICAL BENEFITS FOR MEDICARE PARTICIPANTS

A. Medicare

Medicare is a two-part program. The first part is officially called "Hospital Insurance Benefits for the Aged and Disabled" and is commonly referred to as Part A of Medicare. The second part is officially called "Supplementary Medicare Insurance Benefits for the Aged and Disabled" and is commonly referred to as Part B of Medicare. Part A of Medicare primarily covers hospital benefits, although other benefits are also provided. Part B of Medicare primarily covers physician's services, although it does cover a number of other items and services. Typically, a person becomes eligible for Medicare upon reaching age 65. Under certain circumstances, a person may become eligible for Medicare before reaching age 65 if the person is a disabled worker, dependent widow/widower, or has chronic end-stage renal disease (ESRD). You should be aware that even if you do not choose to retire and do not begin receiving Social Security monthly payments at age 65, you are eligible to apply for both Parts A and Parts B of Medicare.

Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income Benefits is also entitled to Medicare coverage after a waiting period.

If you or your Spouse are covered by this Plan and become totally disabled and entitled to Medicare because of disability, the Plan pays first and Medicare pays second.

If you or your Spouse become entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for a limited period of time, starting the earlier of:

1. The month in which Medicare ESRD coverage begins; or

2. The first month in which the individual receives a kidney transplant.

3. Then, after the 30th month Medicare pays first and this Plan pays second.

You must provide satisfactory evidence of Medicare coverage to the Administrative Manager in order to obtain the reimbursement. The rate of the reimbursement will be the standard Medicare rate then in effect. Penalty premiums imposed by Medicare for late enrollment will not be reimbursed.

Important: The Fund does not provide any coverage to Medicare eligible individuals who do not enroll in Medicare Part A and Part B.

B. Medicare Premium

Most people do not have to pay any premium for the Hospital benefits offered under Medicare Part A. There is, however, a premium charged for the Part B, medical coverage. The Part B program helps pay for doctors, outpatient hospital care and other medical services that are medically necessary. These two options, Medicare Part A and Part B are available everywhere in the United States. You may go to any doctor, specialist or hospital that accepts Medicare.

Once you are approaching age 65, you will be notified of your entitlement to Medicare Part A. However, you are responsible for enrolling in Medicare Part B within a seven-month enrollment period, i.e. three months prior to your 65th birthday and four months after. If you fail to enroll in Part B during this seven month enrollment period, you will not be eligible to enroll again until Medicare's open enrollment period. Medicare will assess a penalty for late enrollment equal to a 10% increase in the premium if you delay your enrollment over 12 months. If you are still working in covered employment when you reach age 65, you do not have to enroll in Medicare Part B. As long as you remain covered by the Fund, this enrollment can be deferred without incurring the penalty until you actually stop working, so you may wait to apply for Part B until you retire.

C. Effect of Medicare

Since you are eligible for Medicare, the Tri-County Building Trades Health Fund will pay for your medical benefits in coordination with Medicare. You will be responsible for submitting your medical claims to Medicare first. After Medicare Part A and Part B pay the maximum benefit under Medicare, this Fund will pay the remaining allowable charges. In the event that the medical expenses you incur are not covered by Medicare Part A and/or Part B, this Fund will not pay the charges either. This Fund only pays as a supplement to the Medicare program. Additionally, any charges that are excluded by this Fund will be excluded even in the event that they are allowed charges under Medicare.

The way your benefits under the Fund and under Medicare are paid (or are coordinated) is different depending on whether you are an active or a retired employee eligible for Medicare.

The Plan will pay its benefits before Medicare only for:

1. An Active Participant who is age 65 or older;

2. An Active Participant's dependent Spouse who is age 65 or older;

3. The first thirty (30) months of treatment in the case of any covered person entitled to Medicare solely on the basis of end-stage renal disease;

4. Any person covered under the benefit program for Active Participants who is less than 65 years of age and who is receiving Medicare benefits because of disability.

When any of these situations are not present, the Plan will pay its benefits secondary after Medicare has paid its benefits as primary.

PRESCRIPTION DRUG BENEFIT

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.

The Fund uses a Prescription Drug administrator who processes and pays all prescription drug charges. This administrator operates to provide an efficient and cost effective program that is easy for you and your Eligible Dependents to use when you purchase your prescriptions from any pharmacy. Your Identification Card contains both medical and prescription information. You need to present this card to the pharmacy with your prescription and pay the co-insurance in order to receive your prescription.

In some instances, you may be required to have pre-authorization or to submit additional information prior to the payment being made by the Plan. When this occurs, contact the Prescription Drug administrator at the number listed on your Identification Card or the Claims Payor for more information. In the event that you are required to pay the full cost of the prescription drug which is covered by this Plan, you need to submit a claim form to your Claims Payor to receive reimbursement.

A. Prescription Drug Coverage

The Plan provides different levels of coverage depending upon the types of drugs being prescribed and whether you use a pharmacy which is part of the Prescription Drug Network utilized by this Fund.

The types of coverage for prescription drugs (for the Full Plan and Standard Plan) are divided into three (3) categories for purposes of both retail and mail order. These categories are as follows:

1. Generic;
2. Brand Preferred;
3. Brand Non-Preferred.

If you choose a brand name drug when a generic drug is available, you are responsible for paying the higher co-payment as outlined in the Schedule of Benefits, plus the difference in price between the generic and the brand drug.

Participants in the Catastrophic Plan will receive a discount card for Participating Pharmacies with a 100% co-payment at participating pharmacies. After you have met your deductible you shall be reimbursed at your co-insurance amount.

A separate notice regarding the Managed Prescription Drug Program and the corresponding benefits was previously provided to you by the Fund.

The following types of prescription drugs will be covered under the Prescription Drug Benefit for the Fund.

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.

B. Excluded From The Prescription Drug Plan

The Fund will not pay for the following charges under the Prescription Drug program:

1. Prescription Drugs if the Pharmacy charge or the prescription charge is less than the amount of the Deductible;

2. Therapeutic devices;

3. Artificial appliances;

4. Injectible medications;

5. Hypodermic needles, syringes, or comparable medical supplies, devices or appliances;

6. Over the counter medication or medical supplies other than diabetic supplies;

7. Fees for administering or injecting Prescription Drugs;

8. Charges for more than a 90-day supply of Prescription Drugs;

9. Any refill of a Prescription Drug, dispensed after one (1) year from the date of the original Prescription Order;

10. Drugs you can purchase without a Prescription;

11. Prescription Drugs consumed or administered at the location where the Prescription Order is issued;

12. Experimental, investigation or unproven drugs;

13. Durable medical equipment;

14. Drugs for cosmetic purposes only;

15. Weight loss medications;

16. Replacement prescriptions (lost, stolen or broken);

17. Smoking cessation products;

18. Contraceptive devices;

19. Infertility medications;

20. Vitamins;

21. Allergy sera; and

22. Vaccines, immunizing agents or biological sera

OPTIONAL BENEFIT PACKAGES

Note: You must purchase a complete package of optional benefits. You cannot choose dental, vision, short-term disability benefits or additional life insurance individually.

A. Dental Benefit

This benefit covers you and your Eligible Dependents. However, Retired Participants will only remain eligible for dental benefits until age 65. In order to be covered, the dental services must be performed by a licensed Dentist. The Plan reserves the right to question and have any charges professionally reviewed to see if it is covered under terms provided in this SPD. The Plan will provide coverage for Dental Benefits in the amount specified in the Schedule of Benefits.

1. Exclusions For Dental Benefits. The following services and charges are excluded from coverage under the Dental Benefit for this Plan:

   a. Which are not performed within the scope of the Provider's license.

   b. For services not recommended or prescribed by a dentist and/or oral surgeon while acting within the scope of their license as being necessary for the treatment of an illness or injury.

   c. Incurred while coverage is not in force.

d. Rendered prior to the effective date of coverage or subsequent to the termination of coverage.

e. For charges which exceed the annual maximum benefit provisions established pursuant to or under the Plan.

f. Charges due to an occupational accident where benefits are payable under Workers' Compensation laws or other similar laws, or due to injury arising out of or in the course of any employment for wage or profit.

g. Failure to keep scheduled appointments or charges for completion of claim forms.

h. Charges for the replacement of lost, missing or stolen dental/orthodontic appliances.

Please note that certain charges are covered under your hospitalization and medical benefit. Charges for the removal of boney impacted teeth as well as approved oral surgery, as provided on Page 41 of the SPD, are covered under the Comprehensive Plan of Benefits. Additionally, dental services which are related to an accidental injury to the mouth or face are usually covered under Accidental Dental Services, as provided on Page 49 of this SPD.

B. Vision Benefit

The Vision Benefit covers eye examinations, lenses, frames, contact lenses and service for lenses and frames for you and your Eligible Dependents.

This benefit covers you and your Eligible Dependents under the Vision Benefit for charges up to a maximum per calendar year as provided in the Schedule of Benefits.

1. Lasik Surgery Guidelines

Refractive surgery, defined as any surgical procedures performed solely to change the eye's prescription, will be considered an elective, non-covered procedure unless medically necessary. This includes but is not limited to LASIK (Laser Assisted in Situ Keratomilcusis), PRK (Photo Refractive Keratectomy), RK (Radial Keratotomy); AK (Astingmatic Keratotomy), LK (Lamellar Keratoplasty), INTACS, and non-cataract lens implementation. Refractive surgery may be considered medically necessary in the following circumstances:

a. Anisometropia - A difference in the prescription between the two eyes of $\geq$ 2 diopters in any meridian, which produces significant visual distortion in spectacles.

b. High Myopia - Near sightedness of ≥ 10 diopters of spherical equivalent.

c. High hyperopia - Far sightedness of ≥ 10 diopters of spherical equivalent.

d. Irregular astigmatism - Corneal irregularity producing significant visual disturbances with spectacles.

All of these conditions must first be attempted to be corrected by contact lens wear. If contact lens wear is deemed impossible due to some medical reasons, such as moderate to severe dry eyes, recurrent contact lens-related infections, anatomical disfiguration, or manual dexterity issues, the refractive surgery will be approved as medically necessary. This approval is subject to review of records dating five years prior to request.

C. Short-Term Disability

1. Eligibility to Receive Weekly Disability Benefits

This Fund provides Weekly Disability Benefits for Active Participants. These Weekly Disability payments will be paid to you in the amount stated in the Schedule of Benefits for a maximum of twenty-six (26) weeks, if you are disabled and cannot work. These benefits are not intended to replace all of your lost wages, but to help you through a difficult time.

To receive a Weekly Disability Benefit, you must be disabled as a result of a non-work related injury or illness, not receiving wages from any employer and you must be under a physician's care. You must be actively employed and covered when you become injured, ill or unable to work due to pregnancy. Only the Active Participant is eligible to receive this Weekly Disability Benefits. There are no Weekly Disability Benefits for your legal Spouse or dependents.

Weekly Disability Benefits are payable from the **first** day of disability due to an accident or the **eighth** day of disability due to sickness unless you are confined in a hospital. The Weekly Disability Benefit will be paid on the first day you are confined in the hospital. These Benefit payments will continue up to the maximum of twenty-six (26) weeks during any one period of disability.

2. Termination of Weekly Disability Benefit Payments

If you are ill, injured or pregnant, your Weekly Disability Benefits stop when your physician states you can return to work or after twenty-six (26) weeks of benefits have been paid. The Fund reserves the right to request a status report from the physician, in connection with a claim for disability.

Two or more periods of disability are considered as one unless between periods of disability you have returned to active work or normal employment for sixty (60) consecutive days or unless your second disability is not related to your first disability.

3. Partial Weeks of Disability

You will be paid at the daily rate of one-seventh of the full Weekly Benefit Amount as provided in the Schedule of Benefits.

4. Continuation of Coverage During Periods of Disability

If you are unable to work due to a disability and you are unable to return to work when your employer is no longer obligated to make contributions to the Fund on your behalf, you may be able to continue coverage in this Fund. You will receive partial credit toward payment of your eligibility for medical benefits while you are receiving your Weekly Benefit. You are required to make any additional payments required to continue your coverage. Additional coverage may be allowed under the Self-Payment program outlined in the Rules of Eligibility Section of this Booklet.

When that coverage ends, you may choose to receive extended continuation of benefits under your COBRA Continuation Coverage rights. Please see Page 28 for further information.

D. Additional Life Insurance

The amount of additional life insurance will be dependent on the level and choice of options picked up. For more details, see your Certificate of Coverage from Lincoln Financial Insurance Company.

WORKERS' COMPENSATION BENEFITS

This Plan pays benefits for illnesses and injuries that are not work-related. The benefits provided by the Plan which include but are not limited to Weekly Disability Benefit payments and hospitalization and medical coverage does not replace Workers Compensation Benefits. If you are entitled to payment for your medical claims or lost wages from Workers' Compensation, this Fund will not pay those claims.

Workers Compensation is a state fund to which your employer contributes and which pays for work-related injuries or illnesses. It is to your advantage to know what kind of protection Workers' Compensation provides you. State Workers Compensation laws vary from state to state. You should know about the law in your state. To find out, call your State Bureau of Workers Compensation (each state has one) or a local office. It is their job to see that your claim is handled quickly and efficiently. The most important thing to remember is to act immediately! Often there are time limits on how long you can take to file a claim. If you miss the time limit, you may not be able to file at all.

Here are some suggestions to help you get the benefits that belong to you:

1. Let your employer know when you are injured or think that you are ill because of conditions on the job.

2. Get in touch with your Administrative Manager. They can help you contact the right offices and people.

3. Contact your state Workers Compensation office or a local office to get your claim started.

NOTE:
If a claim is denied under this Section and you are appealing a ruling by the Compensation Commission, you may receive benefits under a Subrogation Agreement. If you believe that you qualify for such an Agreement, please review the provisions on Subrogation at Page 73 of this SPD and contact the Administrative Manager. Such requests are reviewed on an individual basis.

GENERAL EXCLUSIONS

The Plan does not provide benefits for services, supplies or charges:

1. Which are not prescribed by or performed 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. Received from other than a Provider.

4. For experimental services including, but not limited to procedures, or substances which have not been recognized as accepted standards of medical practice (Federal Drug Administration, American Medical Association).

5. Which are not Medically Necessary, as determined by the Plan.

6. For services not recommended or prescribed by a physician, dentist or optometrist while acting within the scope of their license as being necessary for the treatment of an illness or injury.

7. For amounts you must pay as a Deductible or Copayment.

8. 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 Active Participant.

9. For accidental bodily injuries arising out of or in the course of the employment of the eligible person or sickness covered by Workers' Compensation law or similar legislation.

10. Furnished by or for the United States Government or any agency thereof, except to the extent required by federal law.

11. For loss incurred while engaged in military service for any country.

12. For which you have no legal obligation to pay in the absence of this or like coverage.

13. That exceed those which are considered Usual, Customary and Reasonable.

14. Incurred during confinement in a Hospital owned or operated by a state, province or political subdivision, unless there is an unconditional requirement to pay these charges.

15. Incurred to the extent that benefits are payable therefore by any plan which this Plan replaces.

16. For which benefits are available under federal, state or other laws (except where payment under the Plan is mandated).

17. Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group.

18. Services performed by a person who ordinarily resides in the Participant's home or is a relative (defined under the Plan to mean the Spouse of the Participant, or the parent, child, brother or sister of the Participant or the Participant's Spouse).
19. Incurred before your Effective Date or for Hospital or Skilled Nursing Facility services received during an Inpatient stay that began before your Effective Date.

20. Incurred after you stopped being a covered Participant or Eligible Dependent except as otherwise specified herein.

21. For the following: Physical examinations or services solely required by an insurance company to obtain insurance Physical examinations or services solely required by a governmental agency such as the FAA, DOT, etc. Physical examinations or services solely required by an employer in order to begin or to continue working, premarital examinations and/or school sports physicals.

22. For which payment was made or would have been made under Medicare Parts A or B. This applies when you are eligible for Medicare even if you did not apply for or claim Medicare benefits. This does not apply, however, if in accordance with federal law, this coverage is primary and Medicare is the secondary payer of your health care expenses.

23. Which are received in a military facility for a military service related injury, ailment, condition, disease, disorder or illness.

24. For surgery and other services only to improve appearance but not to restore a body function or correct deformity which was caused by disease, trauma, birth defects, growth defects or prior therapeutic processes, except as otherwise provided in this SPD.

25. For elevators, inclines, chair lifts, air conditioners, air purifiers, home improvements and transportation expenses.

26. For services primarily for educational, occupational, vocational rehabilitation or training purposes.

27. Rendered or billed for by a school or halfway house or a member of its staff.

28. For corrective shoes, arch supports and orthotics.

29. For the treatment of obesity, including nutritional counseling, dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss.

30. For marital or family counseling or training services.

31. For homemaking services, such as housekeeping, meal preparation of serving as a companion.

32. For cosmetic surgery**,** except for the repair of accidental injuries or for the reconstruction of the breast on which a mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance and prostheses required due to such mastectomy, including lymphedemas.

33. Relating to infertility studies or charges relating to the restoration or enhancement of fertility or the ability to conceive by artificial means, including but not limited to in-vitro fertilization or embryo transfer.

34. For surrogate pregnancies.

35. Relating to sexual dysfunctions, unless caused by organic diseases, including but not limited to impotency.

36. Related to sex transformations, including any treatment leading to or in connection with transsexual surgery.

37. For or related to the treatment of temporal mandibular joint syndrome with intraoral prosthetic devices or by any other method to alter vertical dimension.

38. For hypnosis and/or acupuncture, unless medically necessary and prescribed by a physician.

39. For telephone consultations, missed appointments, completion of a claim, or insurance forms or medical reports.

40. For expenses for care of conditions that state or local law require be treated in a public facility.

41. For topical anesthetics or stand-by anesthesia.

42. For penile implants or any treatment leading to or in connection with penile implants.

43. For any loss sustained or contracted as a result of an eligible Participant or Eligible Dependent being under the influence of alcohol, any narcotic or other drug or as a consequence of the use thereof, unless administered upon the advice of a legally qualified Physician.

44. For treatment of an accident or illness that occurred while committing a felony.

45. For legal abortions which are not medically necessary either as a life-sustaining measure for the mother or to end a pregnancy which is the result of a criminal act.

46. Related to massotherapy.

47. For exercise equipment and other equipment such as air conditioners, purifiers, humidifiers, dehumidifiers, whirlpools, hypoallergenic pillows/mattresses or waterbeds.

48. For personal services and supplies (including telephone rentals, hygiene, convenience items, etc.).

49. For custodial care and/or housekeeping.

50. For non-prescription items, including over-the-counter drugs or supplies, vitamins, nutritional supplements and other non-prescription items, except where specifically included herein.

51. For services which are related to learning disabilities or behavior problems including, but not limited to, Attention Deficit Disorder.

52. For Milieu therapy.

53. For Chelation therapy.

54. For the services of blood donors.

55. Which are not specified as covered services or which are specifically excluded in the text of this document.

56. For travel time and travel related expenses of a provider, even though prescribed by a physician.

57. For a private duty nurse when the covered person is hospital confined. A private duty nurse means a nurse who is not an employee of the hospital in which the covered person is confined.

58. Incurred while coverage is not in force.

59. To the extent that payment under this plan is prohibited by law to which you or your family member is subject at the time expenses are incurred.

60. Furnished during periods when the patient is temporarily absent from the hospital.

61. For nutritional supplement.

62. Care and treatment of an injury or sickness that results from engaging in a hazardous hobby for award, reward or profit. A hobby is hazardous if it is an unusual activity which is characterized by a constant threat of danger or risk of bodily harm. Care and treatment of an injury or sickness that results from engaging in motorcycle use for transportation, water and snow skiing will be considered eligible expenses.

63. Travel or flight in or descent from any type of aircraft, if you are a student pilot or member of the crew, or if you are a passenger on:

    a) Any civilian aircraft **not** having a current and valid worthiness certificate, or piloted by a person who does hold a valid and current certificate of competency or a rate authorizing him to pilot such aircraft; or

    b) Any type aircraft operated by a military authority of the United States, or by any duly constituted governmental authority of any other country recognized by the United States government while in the course of any training maneuvers of any Armed Forces.

65. Incurred for protective items used by the provider.

66. Which are determined to be as a result of a pre-existing condition, as defined and stated elsewhere in this SPD except in certain cases where prior coverage may eliminate such exclusions.

67. Rendered prior to the effective date of coverage or subsequent to the termination of coverage.

68. For charges which exceed the annual or lifetime maximum benefit provisions established under the Plan.

69. For replacement of artificial limbs and eyes.

CLAIMS AND APPEALS PROCEDURES

A. How to File a Claim for Benefits Through the Claims Payor (Medical, Prescription, Dental, Vision, Short-Term Disability, Death, Accidental Death and Dismemberment).

In the case that you and your Eligible Dependents use Providers who participate in your Network, the provider will submit a claim for you directly to your Claims Payor for payment.

However, if you use a Non-Participating or Out-of-Network provider or physician, it is your responsibility to submit the claim form to your Claims Payor for payment. Generally, you may have to file a claim under the following circumstances:

- When services are provided in hospitals or other health care institutions, which do not contract with your Claims Payor.
- When outpatient services are provided by hospitals outside of the geographic area served by your Plan.
- When a provider has charged you for a service that you believe should be submitted to your Claims Payor.
- When you believe that the provider's claim submitted to your Claims Payor was inaccurate.

If you must submit a claim for hospital services received, you should:

- Obtain an itemized bill from the hospital, doctor or other service provider.
- Obtain a claim form from your Claims Payor or the Administrative Manager.
- Complete the claim form and attach the itemized bill to the form.
- Send the claim form and bill to the address on the claim form

All claims for payment must include the following information:

- Name and Social Security Number of the Participant.

- Name and address of the provider of service (doctor, hospital, etc.).
- Patient's Name and relationship to the Participant.
- Date of Service (s).
- Diagnosis Codes.
- Type of Service(s).
- Amount Charged for each Service.

Submit original itemized bills and make copies of these bills for your own records. Once submitted, itemized bills cannot be returned. When submitting an itemized bill, all information must be on the provider's pre-printed letterhead or stationery. Please remember: Canceled checks, cash register receipts or personal itemizations are not acceptable as itemized bills.

Payment for these Non-Participating or Out-of-Network Providers will be made to you directly once you have met your deductibles, co-payment and co-insurance obligations. It is your responsibility to provide this payment to your provider.

A claim is not filed until it is received by your Claims Payor. They 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, your Claims Payor may request additional information from you or the provider. You and/or your provider 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 Claims Payor 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 Adverse Benefit Determination in the form of an Explanation of Benefits (EOB) which shall be in writing and will contain the following:

- The specific reasons for the adverse benefit determination;
- The specific reference to the Plan and/or Summary Plan Description provisions on which the adverse benefit determination was based;
- 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;
- The notice of any internal guidelines or protocols used in making the decision, if applicable, and your right to receive a copy;

- A notice of your right to a written explanation of any exclusion which affects your claim; and

- A description of your Claims Payor 's Appeals Procedure set forth below.

B. How to File a Benefit Claim for Medicare Eligible Participants.

If you are covered by Medicare while a Participant under this Fund, be sure to show your provider your Medicare and Fund Identification cards. The necessary information to file with your secondary insurance is the Fund's Identification Card. Be sure to ask the provider if they will file your secondary insurance or if you will be responsible to file yourself. Never assume that the provider will submit your claim to the Claims Payor on your behalf. It is not the responsibility of the provider to submit for you although many of them do so as a courtesy and to insure that they receive their payments.

All claims must be submitted to Medicare first. When Medicare has processed the claim, you and your doctor will receive a Medicare Explanation of Benefits (EOB).

If the provider will be submitting your claim to the Claims Payor for secondary payment by Medicare, they must send three (3) things to the address on the Fund's Identification card:

1. A copy of the itemized bill.

2. Something indicating that they have your signature on file to assign payment directly to the provider.

3. A copy of the Medicare Explanation of Benefits.

If the provider submits all of the above, the payment from the Fund will be made directly to them. THE CLAIMS PAYOR WILL NOT PROCESS ANY CLAIM THAT IS NOT ACCOMPANIED BY A MEDICARE EOB.

If the provider will not submit to your secondary insurance, you have the option of submitting the claims yourself or sending the Medicare EOB's to the Claims Payor. When submitting the claim yourself, you need to contact the Claims Payor or Fund Office for a claim form and send it along with the Medicare EOB to the Claims Payor.

You must submit originals of all itemized bills and the Medicare EOB. You should make copies of the itemized bills and Medicare EOB for your own records. Once your claim is received, the itemized bills and Medicare EOB cannot be returned.

To avoid delay in handling your claim, be sure your answers to any questions are complete and correct. This claim form must be accompanied by itemized bills showing:

1. Person or organization providing the service or supply,

2. Type of service or supply,

3. Date of service or supply,

4. Amount charged, and

5. Name of patient.

A claim is not filed until it is received by the Claims Payor. The Administrative Manager will process your post service 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 Claims Payor may request additional information from you or the provider. You and/or your provider will have at least forty-five (45) days to submit the additional information.

When certain expenses are not eligible for payment under the Fund, you will be notified by the Claims Payor 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 Adverse Benefit Determination in the form of an Explanation of Benefits (EOB) which shall be in writing and will contain the following:

- The specific reasons for the adverse benefit determination;

- The specific reference to the Plan and/or Summary Plan Description provisions on which the adverse benefit determination was based;

- 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;

- The notice of any internal guidelines or protocols used in making the decision, if applicable, and your right to receive a copy;

- A notice of your right to a written explanation of any exclusion which affects your claim; and

- A description of the Fund's Appeals Procedure set forth below.

C. 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 no 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 period in which the proof of claim is required.

D. 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.

E. Review procedure for Claims Under The Fund

You or your authorized representative may appeal the decision by the Claims Payor to deny any claim for medical, dental, vision, weekly disability 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 for which you receive a denial from the Claim's Payor 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.

F. First Level Review for benefits provided through the Claims Payor

You may file a written notice of appeal to the Claims Payor at any time within one hundred eighty (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 Claim's Payor, giving the date of the Notice. The Appeal should be addressed as follows:

AultCare **Aultra Administrative Group**

Attn: Grievance and Appeals Department
P.O. Box 6029
Canton, Ohio 44706

Attn: Grievance and Appeals Department
P.O. Box 35276
Canton, Ohio 44735-5276

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, your Claims Payor shall consult an appropriate health professional and will disclose the identity of such individual to you upon request.

Tri-County Building Trades Health Fund 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 our request. You will be notified of the decision of the Claims Payor 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:

- The specific reason(s) for the denial;
- The section(s) of the Plan and/or Summary Plan Description upon which the denial was based;
- A statement advising you an any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim, if applicable; and
- A notice of our right to file a Second Level Appeal to the Benefits Committee of the Board of Trustees.

G. First Level Review For All Claims Other than Notice of Adverse Benefit Determination

You may file a written notice of appeal to the Administrative Manager for the Board of Trustees at any time within one hundred eighty (180) days after you receive notification that your non-Adverse Benefit Determination claim has been denied. 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
Tri-County Building Trades Health Fund
P.O. Box 368
Troy, Michigan 48099-0368
(248) 641-4902
(866) 599-3176

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 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;
- The seconds of the Plan and/or Summary Plan Description upon which the denial was based;
- A statement advising you of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim, if applicable; and
- A notice of your right to file a second level appeal to the Benefits Committee of the Board of Trustees.

H. 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 either the Claims Payor or the Administrative Manager, giving the date of the notice. The Appeal should be addressed as follows:

For benefits provided through Claims Payor,
address and file notice with your Claims Payor for review with the Benefits Committee at:

AultCare
Attn: Grievance and Appeals Department
P.O. Box 6029
Canton, Ohio 44706

Aultra Administrative Group
Attn: Grievance and Appeals Department
P.O. Box 35276
Canton, Ohio 44735-5276

For claims other than Notice of Adverse Benefit Determination,
address and file notice with the Benefits Committee at:

Benefits Committee
Tri-County Building Trades Health Fund
P.O. Box 368
Troy, Michigan 48099-0368
(248) 641-4902
(866) 599-3176

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 our 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(s) for the denial;
- The section(s) of the Plan and/or Summary Plan Description upon which the denial was based;
- A statement advising you of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim, if applicable; and
- 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.

I. 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 of the notice of a final decision by the Benefits Committee.

The appeal should be addressed as follows:

Board of Trustees
Tri-County Building Trades Health Fund
P.O. Box 368
Troy, Michigan 48099-0368
(248) 641-4902
(866) 599-3176

The Board of Trustees will review the appeal at their next scheduled regular 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,

- The Fund will not assert a failure to exhaust administrative remedies;

- 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;

- The Fund requires that the voluntary level of appeal is available only after the Claimant has pursued the required appeal(s);

- 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;

- The Fund will not impose any fees or costs on you as part of this voluntary appeal process.

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

- The specific reason(s) for the denial;

- The section(s) of the Plan and/or Summary Plan Description upon which the denial was based;

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

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

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

COORDINATION OF BENEFITS

If you have coverage under more than one group plan, this Plan will coordinate with your other plan. Coordination of Benefits provides complete payment of your allowable

expenses while preventing duplicate payment for the same service. The objective is to make sure the combined payments of all health care plans are no more than your actual bills.

Coordination of Benefits does not apply to your Death Benefit, nor does it apply when you or your Eligible Dependents have individual health policies. Coordination of Benefits does take place when you and your Eligible Dependents are covered by this Plan and another plan that provides group health and welfare benefits. This is especially common when both you and your Spouse work, with each of you covered as a dependent under the other person's group health insurance plan.

Primary responsibility, when there is coverage under more than one group plan, is decided by these general rules.

1. If you have another group plan that does not coordinate benefits, that group plan will always be primary.

2. The plan which covers you as an Active Participant has primary responsibility before the plan covering you as a dependent.

A. Coordination of Benefits for a Dependent Child

Eligibility for an Eligible Dependent child's coverage will be determined by the "Birthday Rule". This means that when a child is covered under group health plans for both parents, the plan of the parent whose birth date (month and day only) occurs earlier in the calendar year, will pay first. The other plan will coordinate to pay second.

For example, You and your Spouse are both covered by different plans. Your birth date is January 15th, while your Spouse's birth date is March 30th. Under the birthday rule, your plan will pay benefits as primary for the children, and your Spouse's plan will pay second.

When the parents of the Eligible Dependent child are divorced or separated, if a court decrees exists which specified that a certain parent is responsible for the children's health care expenses, his or her plan of coverage pays first.

If no court decree specifies that a certain parent is responsible for the child's health care expenses, then:

- The plan of the parent with custody pays first;

- The plan of the Spouse of the parent with custody (i.e. the stepparent) pays second;

- The plan of the parent without custody pays third; and
- The plan of the Spouse of the parent without custody pays last.

If a court decree gives joint-custody and does not mention health care coverage, then this Fund will follow the Birthday Rule to determine the child's primary benefit coverage.

B. Coordination with Coverage of a Spouse

If the Eligible Dependent Spouse of a Plan Participant fails to accept a plan offered by his/her employer and that plan would have been the primary payor for the Spouse, or for the children under the Birthday Rule, this Fund will not pay any claims on behalf of the Spouse or dependent children.

C. Other Considerations

If you and your Spouse are both Active Participants in the Fund as employees of a contributing employer and both are eligible for health benefits under this Plan, such Participant(s) shall be subject to only one (1) deductible.

NOTE

Please be sure to include Coordination of Benefit information when completing any forms for services received or initially, when you complete your Enrollment Forms. This will include the name of your legal Spouse's employer and the identification of any other group insurance plan. Incomplete information will only delay the processing of your claim.

Additionally, it is important to complete an updated Enrollment Form at any time that you or your Eligible Dependent's information changes.

You can contact the Administrative Manager to obtain a new Enrollment Form at any time.

SUBROGATION

The Plan shall be entitled to subrogation and reimbursement if you or your Dependent (claimant) are paid benefits under the Plan for claims due to injuries or illness for which a third-party may be obligated to pay you for any person.

Right to Subrogate
The Plan is subrogated to any and all rights of recovery and causes of action that the claimant may have against any third party, whether by suit, settlement, or otherwise, that may be liable for a claimant's injury or illness for which the Plan has paid or is obligated to pay benefits on the claimant's behalf.

Rights to Reimbursement With Source of Funds Specifically Identified
The Plan shall also be entitled, to the extent of payments made or to be made on account of the claim, to the proceeds of any settlement, judgment, or payment from any source liable for making a payment relating to the claimant's injury, illness, or condition.

A source includes, but is not limited to, a responsible party and/or responsible party's insurer (or self-funded protection), no-fault protection, personal injury protection, medical payments coverage, financial responsibility, uninsured or underinsured insurance coverage, an employer under the provisions of a workers' compensation law, an individual policy of insurance maintained by a claimant, and organization, corporation, or government agency.

Rejection of Make-Whole Doctrine
Such subrogation and reimbursement rights shall apply on a priority, first dollar basis to any recovery, whether by suit, settlement, or otherwise, whether there is a partial or full recovery and regardless of whether the amounts are characterized or described as medical expenses or as amounts other than for medical expenses. **This provision is intended to and does reject and superseded any "make-whole" rule/doctrine, which rule/doctrine might otherwise require that you be "made whole" before the Plan may be entitled to assert its subrogation right.**

Equitable Lien by Agreement
Once the Plan makes or is obligated to make payments on behalf of a claimant, the Plan is granted, and the claimant consents to, an equitable lien by agreement or a constructive trust on the proceeds of any payment, settlement, or judgment received by the claimant or dependant from any source to the extent of payments made or to be made by the Plan on the claimant's behalf.

Claimant Must Set Aside Funds
The claimant shall hold in trust for the Plan's benefit that portion of the total recovery from any source that is due for payments made or to be made. The claimant shall reimburse the Plan immediately upon recovery. The claimant shall immediately notify the Plan if he or she is involved in or suffers an accident or injury for which a third party may be liable. The claimant shall again notify the Plan if he or she pursues a claim to recover damages or other relief relating to an injury or illness for which the Plan may make payments on the claimant's behalf. The claimant shall do nothing to impair, release, discharge or prejudice the Plan's rights to subrogation and/or reimbursement. The claimant shall assist and cooperate with representatives the Plan designates. The claimant shall do everything necessary to enable the Plan to enforce its subrogation and reimbursement. The claimant shall immediately notify the Plan upon receiving a judgment, settlement offer or compromise offer and shall not settle or compromise any claims without the Plan's consent.

First-Dollar Recovery
The Plan's subrogation and reimbursement rights shall apply on a priority first-dollar basis to any recovery whether by suit, settlement, or otherwise regardless of whether a claimant is made whole.

Disavowal of "Common-Fund" Doctrine
The Plan's subrogation and reimbursement rights apply to any recovery by the claimant without regard to legal fees and expenses of the claimant. The claimant shall be solely responsible for paying all legal fees and expenses in connection with any recovery for

the underlying injury, sickness, accident or condition, and the Plan's recovery shall not be reduced by such legal fees or expenses.

The Plan specifically disavows any claims that a claimant or dependant may make under any federal or state common law defense including, but not limited to, the make-whole doctrine and/or the common-fund doctrine.

Cooperation
The Plan Administrator may require the claimant to complete and/or execute certain documentation to assist the Plan in the enforcement of its subrogation rights including, but not limited to, a subrogation and reimbursement questionnaire and a repayment agreement. **The completion and/or execution of any documents requested by the Plan Administrator shall be a condition to receiving payment for a claim. Further, the Plan shall have the right to suspend all benefit payments due to a claimant, the employee of whom a claimant is a dependent, and/or any other dependent of such an employee if the claimant fails to complete and/or execute such documentation.**

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 claimant's pursuit of 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 claimant's pursuit of a claim against a third-party or any other coverage.

IMPORTANT INFORMATION ABOUT THE FUND

This booklet describes the health and welfare benefits available to you and your beneficiaries under the Plan, known as the Tri-County Building Trades Health Fund.

The Board of Trustees is responsible for the operation of the Plan and acts as Plan Administrator . It is responsible for reporting Plan information to government agencies and disclosing the same information to Plan Participants and beneficiaries. The Board consists of equal representation by the Employers and the Unions who have entered into collective bargaining agreements which are related to the Plan.

You can contact the Board of Trustees at the address and telephone number below:

Board of Trustees
Tri-County Building Trades Health Fund
P.O. Box 368
Troy, Michigan 48099-0368
(248) 641-4902
(866) 599-3176
Facsimile: (248) 918-9898

The Trustees of the Plan are as follows:

Union Trustees	Management Trustees

Jerry Durieux, Chairman Sheet Metal Workers Local 33 1890 Venture Circle, S.E. Massillon, Ohio 44646	Dan Derreberry 7179 Virginia Road Atwater, Ohio 44201
Scott Mazzulli Sheet Metal Workers Local 33 106 South Fourth Street Martins Ferry, Ohio 43935	Roy Rang, Secretary PBC Inc. 495 Wolf Ledges Parkway Akron, Ohio 44311
Dean Tuell Sheet Metal Workers Local 33 4601 A Camden Avenue Parkersburg, WV 26101-7325	Scott Winters H.E. Neumann Co. 2100 Middlecreek Road Triadelphia, WV 26059

The following person has been designated as the agent for legal process:

Ronald G. Macala, Esq.
Macala, Gore & Piatt, LLC
4150 Belden Village Street, N.W., Suite 602
P.O. Box 35186
Canton, Ohio 44735
Telephone: (330) 493-1570
Facsimile: (330) 493-7042

Service of legal process may also be made upon the Board of Trustees or any individual Trustee.

The Plan Sponsor: The Board of Trustees, Tri-County Building Trades Health Fund. Additionally, upon written request, the Administrative Manager will provide you with information as to whether a particular employer is contributing to the Fund on behalf of Participants working under a collective bargaining agreement.

Plan Number: The Plan number assigned to the Trust is 501. The Employer Identification Number assigned by the Internal Revenue Service is 34-0751987.

Plan Year: The Plan year is the Fund's fiscal year which is the period of May 1 through April 30. The records of the Fund are kept on the basis of the Fund's fiscal year, however benefits are paid on the basis of a calendar year.

Collective Bargaining Agreements: The Plan is maintained pursuant to various Collective Bargaining Agreements with the Participating Unions. The Participating Union

is currently the Sheet Metal Workers Local Union No. 33. Your Collective Bargaining Agreement is the contract between your Employer and your union, which requires your Employer to contribute to the Fund for you. The amount of the employer contributions is determined by the provisions in the Agreement. You may obtain a copy of the Collective Bargaining Agreements under which the plan is maintained by writing the Administrative Manager or your Union. Additionally, you can review a copy of the Collective Bargaining Agreement at the Administrative Manager or your Union hall.

The Tri-County Building Trades Health Fund is maintained for the purposes of providing hospitalization, medical, surgical, death, dismemberment, weekly disability and other related benefits.

- The Medical benefits are self-insured by the Tri-County Building Trades Health Fund and administered by BeneSys, Inc., P.O. Box 368, Troy, Michigan 48099-0368.

- The Vision and Dental benefits are self-insured by the Tri-County Building Trades Health Fund and administered by BeneSys, Inc., P.O. Box 368, Troy, Michigan 48099-0368.

- The Prescription Drug Benefits are self-insured by the Tri-County Building Trades Health Fund and are administered by BeneSys, Inc., P.O. Box 368, Troy, Michigan 48099-0368. The pharmacy network is managed by AultCare, 2600 Sixth Street, Canton, Ohio 44708.

- Death and Accidental Death and Dismemberment benefits are fully-insured and administered by Lincoln Financial Insurance Company Insurance Company, 8801 Indian Hills Drive, Omaha, Nebraska 68114-4066.

- Weekly Disability Benefits are self-insured by the Tri-County Building Trades Health Fund and administered by BeneSys, Inc., P.O. Box 368, Troy, Michigan 48099-0368.

- Medicare Benefit Claims are fully-insured and administered by the Primetime Health Plan, P.O. Box 6905, Canton, Ohio 44706.

- Eligibility for benefits, including, but not limited to COBRA, shall be determined and administered by BeneSys, Inc., P.O. Box 368, Troy, Michigan 48099-0368.

- Reinsurance coverage is provided to the Fund by McKinley Life Insurance Company.

IMPORTANT

Benefits offered by the Tri-County Building Trades Health Fund are not guaranteed to the Participants, retirees and/or dependents covered by the Fund.

The Trustees of the Fund reserve the full, absolute and discretionary right to amend, modify, suspend, withdraw, discontinue, or terminate the Fund in whole or part at any time for any or all of the Participants. Although the Trustees hope to maintain the present level of benefits and to improve upon them, if possible, a primary concern of the Trustees is to protect the financial soundness of the Fund at all times. To do so may require Plan changes from time to time. Therefore, any benefits and/or persons covered by the Plan are not guaranteed.

If the Plan ends, money in the Fund to the extent possible, would be used in the following order according to the priority required by any applicable law and the provisions stated in this Plan Document, to:

- pay reasonable administrative expenses
- provide benefits and premium payments to Participants; and
- pay any other expenses that are deemed to be in the interest of the Plan.

No Funds can be returned to any employer.

Changes in the Plan may also be required in order to preserve the Fund's tax exempt status under the Internal Revenue Service rules and regulations. These rules and regulations may change and as a result, the Trustees may find it necessary to change the Plan provisions so that the Trust does not lose its tax exempt status. In the event of a change that would result in the reduction of any benefit provided by the Plan, the Trustees will endeavor to provide notice of the change to the Participants prior to initiating such change.

All benefits under the Plan shall be payable through Employees or agents of the Trustees acting under their authority. Benefits as authorized under the Plan are not vested and will be paid as long as the Fund can operate on a sound financial basis. No benefits shall be payable except those which can be provided under the Plan, and no person shall have any claim for benefits against any participating Union, the Association, any Employer or the Trustees. The Trustees, the Employers and the Participating Unions shall not be held liable for any benefits or contracts except as provided in the agreement between the Employers and the Participating Union.

Only the Board of Trustees has the power to interpret and construe the Plan, determine all questions of eligibility and status under the Plan and determine all questions arising in the administration of the Plan, including the power to determine the rights or eligibility of employees, Participants and their dependents and beneficiaries. This includes the authority and right to make findings of fact relating to these decisions.

No union or management representative, individual trustee, business agent or other individual has the authority to answer questions or make decisions concerning the provisions of the Health and Welfare Fund unless such individual has been given the authority by the Board of Trustees and is acting on their behalf.

USES AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use and disclosure of Protected Health Information (PHI): The privacy regulations govern the use and/or disclosure of protected health information ("PHI"). "Protected

health information" means individually identifiable health information that is transmitted or maintained by electronic media or is transmitted or maintained in any other form or medium. "Individually identifiable health" information is health information that either actually identifies an individual or creates a reasonable basis to believe that the information would identify an individual. The Plan will use protected health information to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations.

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

- Determination of eligibility, coverage, and cost sharing amounts (e.g. cost of a benefit, plan maximums, and co-payments as determined for an individual's claim)
- Coordination of benefits
- Adjudication of health benefit claims (including appeals and other payment disputes)
- Subrogation of health benefit claims
- Establishing employee contributions
- Risk adjusting amounts due based on enrollee health status and demographic characteristics
- Billing, collection activities and related health care data processing
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to Participant (and their authorized representatives') inquiries about payments
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance), if necessary in the future
- Medical necessity reviews, or reviews of appropriateness of care or justification of charges
- Utilization review, including precertification, preauthorization, concurrent review and retrospective review
- Reimbursement to the plan

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

- Quality Assessment

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

- Rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities.

- Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance).

- Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs.

- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies.

- Business management and general administrative activities of the entity, including, but not limited to:

    - Management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification;
    - Customer service, including the provision of data analyses for policyholders, plan sponsors, or other customers.
    - Resolution of internal grievances. Filing of governmental forms, including Form 5500 and other activities necessary to ensure compliance with applicable federal laws, including ERISA and the Internal Revenue Code. “Treatment” includes, but is not limited to, 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.

The Plan will use and disclose PHI as required by law and as permitted by authorization of the Participant or Beneficiary.

For purposes of this section the Board of Trustees for the Tri-County Building Trades Health Fund is the Plan Sponsor. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the plan documents have been amended to incorporate the following provisions:

With respect to PHI, the Plan Sponsor agrees to:

1. Not use or further disclose the information other than as permitted or required by the plan document or as required by law;

2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

3. Not use or disclose the information for employment-related actions and decisions unless authorized by the individual;

4. Not use or disclose the information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual;

5. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

6. Make PHI available to the individual in accordance with the access requirements of HIPAA;

7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

8. Make available the information required to provide an accounting of disclosures;

9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health plan available to the Secretary of HHS for the purposes of determining compliance by the group health plan with HIPAA;

10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI.

- The Fund's Administrative Manager;
- Staff designated by the Fund's Administrative Manager; and
- Board of Trustees of the Tri-County Building Trades Health Fund.

The persons described in this section B may only have access to and use and disclose PHI for plan administration functions that are performed on behalf of the Fund. If the persons described in section B do not comply with this Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

STATEMENT OF ERISA RIGHTS

Statement of Rights Under the Employee Retirement Income Security Act of 1974 (ERISA)

As a Participant in the Tri-County Building Trades Health Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan Participants shall be entitled to:

A. Receive Information about Your Plan and Benefits.

Examine, without charge, at the Administrative Manager's office and at other specified locations (such as worksites at which at least fifty (50) individuals are employed and union halls) all documents governing the plan, including insurance contracts, collective bargaining agreements, and copies of all such documents filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain copies of all Plan Documents and plan information, including insurance contracts, collective bargaining agreements, and documents filed with the Department of Labor, upon written request to the Administrative Manager. The Administrative Manager may make a reasonable charge for the copies.

Obtain a complete list of the employers contributing to the Plan, upon written request to the Administrative Manager, which is available for examination by Participants and Beneficiaries at a reasonable copying charge. In addition, Participants and Beneficiaries may receive from the Administrative Manager, upon written request, information as to whether a particular employer or employee organization contributes to the Plan and, if the employer or employee organization is a contributor, that entity's address.

Receive a summary of the Plan's annual financial report (Form 5500). The Administrative Manager is required by law to furnish each Participant with a copy of this summary annual report.

B. Continue Group Health Plan Coverage

Continue health care coverage for yourself or your Eligible Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Eligible Dependents may have to pay for such coverage. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage when your COBRA continuation coverage ceases, if you request it before losing coverage or up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

C. Prudent Actions By Plan Fiduciaries

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

D. Enforce Your Rights

If you claim for a welfare benefit is denied or ignore, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the 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 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrative Manger to provide the materials and pay you up to $110 a day until you receive the materials unless the materials were not sent because of reasons beyond the control of the Plan 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 medical child support order, you may file suit in Federal court. If this should happen that the plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance form 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.

E. ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about this Statement or about your rights under ERISA, you should contact the nearest Employee Benefits Security Administration offices, located as follows:

U.S. Department of Labor
Employee Benefits Security Administration
1885 Dixie Highway - Ste. 210
Ft. Wright, KY 41011-2664
Phone: (859) 578-4680, or toll-free at (866) 444-3272

Or

U.S. Department of Labor
Employee Benefits Security Administration
1730 K Street - Ste. 556
Washington, D.C. 20006
Phone: (202) 254-7013

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.

PLAN DEFINITIONS

Here are some definition of terms used in this booklet, as they apply to your Plan.

Active Participant- A person covered under a Collective Bargaining Agreement or assent of participation who is employed by an Employer who must make contributions to the Fund. Also, a person employed by a Local Union or a person employed by the Fund, provided the person has met the eligibility requirements set forth in this Plan.

Appeal Process- If you are unhappy with the handling of your claim, there is a multi-step claim appeal process which is outlined on Page 63-71 of the Summary Plan Description. The appeal process allows you to have a separate review of your claim.

Beneficiary – A person who is designated by the Participant to receive a Death Benefit payable under this Plan, provided however, that no Death Benefit can be paid directly to a minor.

Benefit Period - The period of time during which you receive Covered Services as listed in the Schedule of Benefits. Additionally, for purposes of Medicare eligible Participants,

Benefit Period is defined by Medicare. Medicare measures your benefit period on the use of the hospital or skilled nursing facility. A benefit period begins the day you go to the hospital or skilled nursing facility and ends at the time you have not received services from this hospital or skilled nursing facility for a period of sixty (60) days in a row. There is no limit of the number of benefit periods you can have, however, each new benefit period requires the payment of a new deductible.

Charge **-** The amount of money expected in payment of services or supplies provided for an injury, illness or condition under treatment. The term, Usual, Customary and Reasonable Charge (UCR), further defines Charge to mean the normal monetary amount due for services or supplies provided in that geographic area by most providers.

Collective Bargaining Agreement – The successive collective bargaining agreements between your Employer and a Participating Union which provide for contributions into the Trust Fund, as well as, any extensions or renewals of the agreement or any new agreements entered into between the parties which provide for such contributions.

Contributing Employer or Employer – An Employer who has a Collective Bargaining Agreement with a Participating Union and who meets the Trustees' requirements for participation under this Fund. The Participating Union shall be considered as the Employer of the Employees of the Union for whom the Union contributes to the Trust Fund.

Covered Employment – Employment for which a Contributing Employer is required to make Contributions on behalf of an Employee under the terms of a Collective Bargaining Agreement with one of the Participating Unions.

Covered Expense – Any necessary and reasonable Hospital, Medical, Surgical or Prescription Drug expense, part or all of which is included under this Plan of benefits for a Participant or Eligible Dependent for whom the claim is made.

Custodial Care – Care which does not require constant supervision of skilled medical personnel to assist the patient in meeting his/her activities of daily living; such care can be taught to and administered by a lay person. Custodial care includes but is not limited to:

- Administration of medication which can be self-administered or administered by a lay person with training, or
- Help in walking, bathing, dressing, feeding or the preparation of special diets.

Eligible Dependent – A person who meets the eligibility requirements under the Eligibility Rules for Dependents under this Plan which generally includes the Spouse and children of a Participant.

Employee – Any employee represented by the Union and working for an Employer, in covered employment, under a Collective Bargaining Agreement as defined in this Document with respect to whose employment a Contributing Employer is required to

make contributions into the Trust Fund; and any officer or other employees of the Union for whom the Union contributes to the Trust Fund under the terms of a Participation and Assent Agreement approved by the Trustees.

The term "employee" does not include self-employed persons, sole proprietorships or partners of a business organization which is a Contributing Employer.

Fund or Trust Fund – The Tri-County Building Trades Health Fund and the entire assets which include all money received in the form of employer contributions, together with all contracts, (including dividends, interest, refunds and other sums payable to the Trustees on such contracts), all investments made and held by the Trustees, all income, increments, earnings and profits and any property or funds received and held by the Trustees by reason of their acceptance of the Amended and Restated Agreement and Declaration of Trust.

Hospital – Any institution which is an approved and accredited hospital recognized as such by the American Hospital Association, which operates for the caring and treating of sick and injured persons with surgical and diagnostic facilities and having twenty-four (24) hours nursing service.

Incurred – A charge will be considered incurred on the date a covered person receives the service or supply for which the charge is made.

Medical Necessity – A service or supply that is required to diagnose or treat an injury, ailment, condition, disease, disorder or illness and which the Plan has determined is:

- Appropriate with regard to the standards of good medical practice;
- Not primarily for the convenience of you or a provider;
- The most appropriate supply or level of service which can be safely provided to you. When applied to the care of an Inpatient, this means that your medical symptoms or condition require that the services cannot be safely or adequately provided to you as an Outpatient.

Medicare Deductible - The amount you must pay for health care before Medicare begins to pay. There is a deductible for each benefit period as determined by Medicare for Part A and on an annual calendar year basis for Part B. These deductible amounts are set by Medicare and can be changed each year.

Participant – An Employee who has satisfied the Rules of Eligibility requirements of the Plan as set forth on Pages 8-17 of this Booklet.

Participating Union or Union – Sheet Metal Workers' Local Union 33, the Sheet Metal Workers' Local Pension Plan, and the Sheet Metal Workers' Local Union 33 Joint Apprenticeship and Training Fund.

Plan – Your Health and Welfare benefits offered by the Board of Trustees for the Tri-County Building Trades Health Fund. This booklet is a summary of the provisions of the Plan of Benefits or a "SPD."

Retired Participant – A person no longer employed and receiving retirement benefits from a qualified pension plan acceptable to the Trustees who has been an Active Participant during the period of ten (10) years out of the previous fifteen (15) Plan years prior to the date of his retirement, who has provided the necessary contributions as required by the Trustees.

Utilization Review – The evaluation and promotion of efficient use of professional medical care services, procedures and facilities.