BUILDING TRADES HEALTH & WELFARE FUND

REVISED AND RESTATED PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION

Effective May 1, 2012

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I. DEFINITIONS

The words defined in this section will have the following meaning unless the context in which they are used clearly indicates otherwise:

A. **Active Employee** means an Employee who is actually covered by the Fund and who is not retired or totally disabled.

B. **Apprentice Required Contribution** means the amount of money that must be available in the Dollar Bank for individuals in the apprentice program to maintain coverage at the time that quarterly eligibility is determined.

C. **Arbitrary and Capricious** when used with respect to the Board of Trustee's decision to grant or deny payment of a benefit under this Plan means, "having no foundation."

D. **Chiropractor** means an individual who is duly licensed, under the laws of the state in which he or she practices, as a Doctor of Chiropractic (D.C.).

E. **Collective Bargaining Agreement** means a written labor agreement, as amended from time to time, under which an Employer is obligated to make Contributions into this Fund.

F. **Contributions** means payments that Employers are obligated to make to this Fund under the terms of a Collective Bargaining Agreement or under the terms of any other written agreement.

G. **Covered Employee** means an Employee who is actually covered under the Plan and who is currently entitled to receive benefits under the Plan. The term "Covered Employee" does not include an individual who has merely met the eligibility requirements; the individual must be actually covered by the Fund.

H. **Covered Employment** means employment for which an Employer is obligated, under the terms of a Collective Bargaining Agreement, or other writing or agreement, to pay Contributions into the Plan on behalf of Covered Employees.

I. **Dollar Bank** means the mechanism that the Fund uses to track the credit an individual receives for the contribution rate associated with each hour worked under the Fund. At the end of each work quarter, an individual must have enough money in the Dollar Bank to cover the Required Contribution for the associated benefit quarter. If a shortfall exists, the individual must make self-payments to maintain coverage. The Required Contribution and the Apprentice Required Contribution will be reviewed and communicated annually for an effective date of May 1 each year.

J. **Eligible Dependent(s)** means an Eligible Employee's:

1. spouse; and/or
2. child or children up to age twenty six (26). The term child or children includes the

Eligible Employee's natural child, legally adopted child, and stepchild.

K. **Eligible Employee** means an employee who has met the initial qualifications for coverage under the Fund and whose coverage has not been terminated.

L. **Employee** means a person for whom an Employer makes, or is obligated to make, contributions into the Fund under the terms of a Collective Bargaining Agreement between the Employer and the Union.

M. **Hospital** means an institution that provides overnight, in-patient care, has full diagnostic and therapeutic facilities that are under the supervision of a staff of physicians, and that has registered nurses on duty, providing nursing service, twenty-four hours a day. The term Hospital does not include a nursing home, convalescent home, or any other facility that is not primarily engaged in the provision of short-term acute hospital care.

N. **Motor Vehicle** means any vehicle powered by a motor. The term Motor Vehicle does not include boats, lawn mowers, or lawn & garden equipment.

O. **Out-patient Surgery Center** means a facility that exists solely to provide outpatient surgery and treatment, is equipped with functioning operating rooms and recovery areas, and is staffed by physicians and by registered nurses, as well as by other ancillary personnel.

P. **Participant** means an individual who is, or may become eligible to receive a benefit under the Plan, or who's beneficiary is, or may become eligible to receive a benefit under the Plan.

Q. **Participating Pharmacy** means a pharmacy that has entered into a written agreement with the Plan's designated prescription provider to provide prescriptions to Participants.

R. **Physician** means a person who is duly licensed, under the laws of the state in which he or she practices, as a Doctor of Medicine (M.D.) or as a Doctor of Osteopathy (D.O.).

S. **Plan** means the Building Trades Health & Welfare Fund as set forth in this Plan Document/Summary Plan Description, as amended from time to time.

T. **Psychiatrist** means a person who is duly licensed, under the laws of the state in which he or she practices, as a Doctor of Medicine (M.D.) or as a Doctor of Osteopathy, and whose practice is exclusively devoted to the practice of psychiatry.

U. **Psychologist** means a person who has Doctorate degree in Psychology, and who is duly licensed, under the laws of the state in which he or she practices, as a psychologist.

V. **Qualified Medical Child Support Order** means a Court Order that may require a Plan to provide certain coverage to dependent children in the event of their parents' divorce or separation. Contact the Plan Administrator if you have any questions about Qualified

Medical Child Support Orders.

W. **Required Contribution** means the amount of money that must be available in the Dollar Bank to maintain coverage at the time that quarterly eligibility is determined.

X. **Retiree** means a Covered Employee:

1. who has reached age 62, has retired from Covered Employment in the industry covered by the Collective Bargaining Agreement, in the geographic region covered by the Collective Bargaining Agreement; and

2. who has performed at least four thousand five hundred (4,500) hours of Covered Employment after his or her fifty-sixth (56th) birthday, and

3. who has performed at least ten thousand (10,000) hours of Covered Employment since he or she initially became a Covered Employee, and

Y. **Union** means the Central Pennsylvania Regional Council of Carpenters, Local Union Nos. 76 and 214, any successor by combination, consolidation, or merger, or any other Union accepted by the Trustees for participation in the Plan.

II. FUND ADMINISTRATION

A. Introduction

This booklet serves as the Plan Document/Summary Plan Description for the Building Trades Health & Welfare Fund (Fund or Plan). This booklet is written in simple, direct language. This booklet is designed to help you understand the details of the benefits available, the eligibility requirements, and general information about the benefit plans administered by the Fund. We urge you to become familiar with the contents of this booklet so that you and your Eligible Dependents can fully utilize, whenever necessary, the benefits that are available to Participants.

B. How to Obtain a List of Plan Sponsors

You may obtain a list of all of the Employers and Unions who sponsor this Plan by sending a written request to the Plan Administrator. There is a small charge for this service. You may also examine a list of plan sponsors at the Fund Office during normal office hours. There will not be any charge for examining the list there. If you want to know whether a particular Employer or Union is a plan sponsor you can send a written request to the Plan Administrator. If the Employer or Union is a plan sponsor, the Plan Administrator will also provide the sponsor's address. There will not be any charge for this service.

C. Type of Plan

The Building Trades Health & Welfare Fund is an Employee Welfare Benefit Plan. It provides death, disability, hospital, medical, surgical, maternity, major medical, prescription, dental and eye care benefits to its members. Your Plan is a self-funded plan under ERISA; it is not financed or insured through an insurance company or HMO. Your Plan has an Administrative Services Only (ASO) arrangement with Capital BlueCross, Delta Dental, Express Scripts and National Vision Administrators (NVA), which means that said entities provide administrative services to the Building Trades Health & Welfare Plan (such as processing claims), but do not insure the risk of paying benefits to Participants.

D. How the Plan is Administered

The Board of Trustees administers the Plan. The Board of Trustees has the sole power, authority, and right to determine all eligibility and benefits under the Plan, and to interpret, amend, modify or terminate the Plan. The following people are members of the Board of Trustees:

Employer Representatives	Union Representatives
Thomas B. George	Michael W. Platt
Terrence McDonough	Richard Musko

William Brightbill	John Gadomski
Jim Novinger	Gary Ford
Joline Sobeck	

The Board has delegated some of its responsibilities to the Plan Administrator, who carries out the Fund's day-to-day administrative duties. Diana L. Schaeffer is the current Plan Administrator. The Plan Administrator can be reached at the following address and telephone number:

Plan Administrator
Building Trades Health & Welfare Fund
1718 Heilmandale Road – Suite 400
Lebanon, PA 17046
Telephone: (717) 273-3800
Toll Free: 1-800-493-4390

E. Agent for Service of Legal Process

Legal papers and process issued by a court can be served on the Plan Administrator or on any member of the Board of Trustees. All of these people can be served at the address listed above.

F. End of "Plan Year"

The Fund operates on a fiscal year that begins on May 1 and ends on April 30.

G. Plan Number

The Employer Identification Number ("EIN") is 23-1700500. The Plan Number for the Plan is 501.

H. Collective Bargaining Agreements that Relate to the Fund

The Fund is maintained under the terms of Collective Bargaining Agreements. These are on file at the Fund Office; you can examine them at the Fund Office during normal business hours. You can, by making a request according to procedures established by the Plan Administrator, examine these Collective Bargaining Agreements at the Unions' Offices or at certain Employers' Offices. You can also obtain a copy of any of these Collective Bargaining Agreements, for a small charge, by sending a written request to the Plan Administrator.

I. Who Provides the Money to Operate the Fund

The Fund operates on Contributions that are paid by members of the employer associations who have Collective Bargaining Agreements with the Unions that sponsor the Plan, and Contributions by those covered under COBRA.

J. How the Fund Accumulates its Capital

Employer Contributions are placed in an investment portfolio that is managed by Morgan Stanley Smith Barney. Payments by those covered under COBRA are paid directly to the Fund and are also placed into interest-bearing accounts or investments.

III. ELIGIBILITY FOR COVERAGE

A. Requirements for General Eligibility

Any Employee who works under the jurisdiction of the Central Pennsylvania Regional Council of Carpenters, under the jurisdiction of any Local Union that has been accepted for participation in the Plan, or under the jurisdiction of a Local Union with which this Union has a reciprocal agreement, and who works for Employers who are required to make Contributions to this Fund, may become a member of this Fund. To actually become covered under the Fund, individuals must satisfy the coverage requirements that are discussed below. Employers are required to contribute to the Fund, on behalf of their Employees, on a cents-per-hour basis. This means that your initial coverage, and your continued coverage, depends upon the number of hours that you work and earn Contributions into the Fund. The following rules and requirements govern Fund coverage.

B. Requirements for Initial and Continued Coverage Under the Plan

1. New Members – Benefit Coverage

As a new member, you will not be eligible for coverage until you have accumulated the Required Contribution in your Dollar Bank within six (6) consecutive months. Upon accumulation of the Dollar Bank during a particular work quarter, you will then be eligible for coverage effective for the corresponding eligibility quarter.

COVERAGE SCHEDULE	
WORK QUARTERS	**ELIGIBILITY QUARTERS**
May, June, & July	October, November, & December
August, September, & October	January, February, & March
November, December, & January	April, May, & June
February, March, & April	July, August, & September

2. Dollar Bank Participation

You begin to accumulate a Dollar Bank with the first hour of Covered Employment. For each hour worked in Covered Employment, you will receive an amount in your Dollar Bank equal to the current contribution rate for the Fund. You may accumulate up to a maximum of $8,000 in your Dollar Bank.

3. Ongoing Eligibility

a. Covered Eligibility – At the end of each work quarter, you will receive coverage from the Fund if you have accumulated an amount in your Dollar Bank of at least the Required Contribution amount.

b. Shortfall in Dollar Bank – If you do not have a sufficient Dollar Bank balance at the end of a work quarter to maintain ongoing eligibility, you

will be allowed to self-pay to maintain coverage. The self-payment will be an amount equal to the shortfall amount of your Dollar Bank. If you do not choose to make self-payments to maintain coverage, you will be offered COBRA.

c. Eligibility to Make Self-Payments – You will be eligible to make self-payments described in the "Shortfall in Dollar Bank" section, above, only if a balance exists in your Dollar Bank, either through covered service in the work quarters, or a carryover Dollar Bank balance from the prior period.

d. Carry-Over/Forfeiture of Dollar Bank – If you have a balance in your Dollar Bank that does not meet the eligibility for coverage requirement, and you do not choose to make self-payments to maintain coverage, any existing Dollar Bank balance will be carried over for a period of twelve (12) consecutive months from the date of the last hour of credited service you worked. The Dollar Bank carryover amount will be forfeited at the close of the twelve (12) month period, if you have incurred a termination of coverage of a period of twelve (12) consecutive months.

4. Apprentice Eligibility

Quarterly eligibility for participants in the apprentice program will be adjusted to reflect a loss of potential hours of service in the amount of 40 hours for each quarter (due to educational participation requirements). At the end of each work quarter, each individual in the apprentice program will receive coverage from the Fund if they have accumulated an amount in their Dollar Bank of at least the Apprentice Required Contribution amount. The Apprentice Required Contribution will only be applicable for a maximum of four (4) years, after which the Required Contribution amount will apply.

5. Termination of Coverage

A Covered Employee's coverage will be terminated if any of the following events occur:

a. you accept employment, within the industry, from an employer who has not signed a Collective Bargaining Agreement with the Union; or

c. you do not have a sufficient Dollar Bank balance at the end of a work quarter to maintain ongoing eligibility and you choose not to make self-payments to maintain coverage; or

d. the date you enter full time service in the armed forces; or

e. the date the benefit programs are terminated by the Board of Trustees.

6. Reinstatement of Coverage

For all individuals who terminate coverage, you will need to satisfy the new member requirement, as described above, in order for coverage to be reinstated.

7. Continued Coverage While in Uniformed Service

If an Eligible Employee performs service in the Uniformed Services of the United States, federal law provides certain rights to continued coverage under this Plan. An Eligible Employee may choose to continue coverage for a period of 24 months or their period of military service (whichever is shorter).

The term "Uniformed Services" means the Army, Navy, Air Force, Marines, Coast Guard, Reserves, Army and Air National Guards, the commissioned corps of the Public Health Service, and any other persons designated by the President in time of war or national emergency.

If an Employee (and his or her Eligible Dependents) is eligible for benefits as of the date of entry into the Uniformed Services, and the Employee's absence is due to a Uniformed Service leave of 31 days or less, coverage will be continued at no cost to the Employee. The Employee will be credited with hours necessary to keep coverage in effect as if the Employee had worked in Covered Employment with the Contributing Employer during the period of service. If an Eligible Employee (and his or her Eligible Dependents) is eligible for benefits as of the date of entry into the Uniformed Services, and the Employee's absence is due to a uniformed services leave of 31 days or more, the Employee or Eligible Dependents may elect to continue coverage by: (1) using the balance in their Dollar Bank, or (2) self-payment under the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). An Employee electing to continue coverage need not use the balance in their Dollar Bank and may always pay the required premium and preserve the Dollar Bank, but if he/she chooses to use his/her Dollar Bank to pay USERRA premiums, the portion of the Dollar Bank that is used will not be re-credited to the Employee upon reinstatement.

A premium for continuation coverage under USERRA will be in an amount established by the Trust. Such premium shall be payable in monthly installments. the maximum length of USERRA Continuation Coverage is the lesser of:

a. 24 months beginning on the day that the Uniformed Services leave commences; or

b. a period ending on the day after the Eligible Employee fails to return to employment within the time allowed by USERRA.

If non-service related health care expenses are incurred by the Employee or Dependents during a period of Uniformed Services leave, and those expenses are submitted to the Plan and benefits are paid by the Plan, the employee will be deemed to have chosen continued coverage for the month(s) beginning when the Employee entered Uniformed Service leave through the last month in which those health care expenses were incurred. In this case, available dollars will be deducted from the Employee's Dollar Bank to provide eligibility to the extent possible.

If an Employee was eligible for benefits on the date of entry into the Uniformed Services, upon completion of service the Employee notifies the Employer of his or her intent to return to employment, and full payment of all required premiums, the Employee's eligibility will pick up as it was the day before the Employee entered into the Uniformed Services.

The Plan pays no benefits for conditions incurred or aggravated during the performance of duties in the Uniformed Services.

If there is any conflict between these provisions and USERRA, the minimum requirements of USERRA govern.

C. If You Were Covered as an Eligible Dependent on the Date that You Became an Employee

If you were covered as an Eligible Dependent on the date that you became an Employee you may be entitled to medical and benefit coverage as a Covered Employee or an Eligible Dependent depending upon whether you are age 26 or younger. If you are covered as a Covered Employee you will be eligible for coverage when you have accumulated the Required Contribution in your Dollar Bank. Your coverage will begin with the eligibility quarter corresponding to the work quarter in which you met the eligibility requirement, as outlined in the "New Member – Benefit Coverage" section of this Plan.

D. Life Status Changes That Affect Eligibility

The following life status changes may affect your eligibility under the Plan. This section also describes the documents you will need to provide to the Plan to verify your change in life status:

Member marries: Provide a copy of the Marriage Certificate to the Fund Office.

Member becomes a stepparent: Provide a copy of the Birth Certificate to the Fund Office as well as the most recent income tax return listing the child as a dependent.

Member has a newborn child: Provide a copy of the child's Birth Certificate within thirty (30) days after the child's birth, and the child's Social Security number as soon as it is available.

Member adopts a child: Provide a copy of the final adoption papers to the Fund Office as soon as available.

Member divorces: Notify the Fund Office as soon as the divorce has been filed and provide a copy of the divorce decree as soon as the divorce is finalized.

Member's spouse loses coverage under another benefit plan: Provide Fund Office with a copy of the termination notice.

Member or Dependent is deceased: Provide a copy of the Death Certificate to the Fund Office.

Member's employment status changes (example Retiree turns 65): Provide the Fund Office with a copy of Medicare Card showing the member is eligible for Parts A and B.

If the member experiences any life status changes he or she must send the appropriate documentation to the Fund Office within thirty (30) days in order to implement the changes. If you fail to provide the required documentation, changes will not be implemented until the first day of the month following the date that the documentation is provided.

E. COBRA Coverage

A Federal law – the Consolidate Omnibus Budget Reconciliation Act – (commonly known as "COBRA") requires organizations that sponsor health care plans to offer temporary extension of coverage to Employees and their Eligible Dependents in certain situations. The chart below shows the Qualifying Events that may entitle you (or your dependent) to COBRA coverage, and the length of time coverage may continue.

Qualifying Event	**Who May Continue**	**How Long**
Your employment stops for any reason other than gross misconduct	You and your dependents	18 months (up to 29 months if you or a qualified beneficiary is disabled at the time employment stops or within 60 days of beginning COBRA Coverage)* If you are on duty in the uniformed services for more than 31 days, your spouse and dependents may continue coverage for up to 18 months
	Dependent spouse/children	Up to 36 months if you are enrolled in Medicare**
Divorce/legal separation and you stop coverage for your spouse or children	Ex-spouse or legally separate spouse and/or your dependent children	36 months
Dependent child no longer eligible	Dependent children	36 months
You enroll in Medicare and drop Fund plan	Dependent spouse/children	36 months
You die	Dependent spouse/children	36 months

*If the disabled person (under the Social Security definition) entitled to the extension has non-disabled family members who are entitled to COBRA coverage, the non-disabled members may continue coverage for up to 29 months as well.

**If you enroll in Medicare before you terminate or before you lose full-time status, your dependents may continue coverage up to the later of 36 months from the date you enroll in Medicare, or 18 months from the date of your termination or reduction in hours. For example, if you enroll in Medicare on January 1, and terminate employment on February 1, your spouse and children may continue coverage for up to 36 months, counting from January 1.

F. Rate of Contribution for COBRA Coverage

The Board of Trustees sets the amount that is charged for COBRA coverage. Under Federal law the Fund may charge as much as 102% of the Fund's cost for providing coverage to a similarly situated beneficiary. The rate of payment cannot be increased more than once in any twelve-month (12) period. Individuals must pay the rate that is in effect when each payment is due.

G. Notice of Your Right to COBRA Coverage

The Plan Administrator will mail a notice to those members who are eligible for COBRA coverage. If you are a Covered Employee, the Plan Administrator will mail the required notice to you on or before the tenth (10th) day of the month prior to the month in which you will lose your coverage. If, for example, an employee will lose eligibility for coverage in June, the Plan Administrator will mail the notice by May 10th. If you are a covered beneficiary and you experience a divorce, legal separation, or loss of your status as a dependent child, you must notify the Plan Administrator within sixty (60) days of the date of your divorce, legal separation, or loss of status as a dependent. If you do not do so, you may lose your right to continue coverage. The Plan Administrator must notify you of your right to continue coverage within fourteen (14) days of the date that he or she receives notice of a termination of employment, reduction in hours, death, divorce, legal separation, loss of status as a dependent, or your application, and approval for Medicare. You have sixty (60) days from the later of the coverage loss date or the date the COBRA election notice is provided to you to elect to continue that coverage.

H. Termination of COBRA Coverage

Your COBRA coverage will be terminated if any of the following events occur:

a. the Employer stops providing any group health plan; or

b. you fail to make timely payment of any premiums that are due. Monthly payments are timely if they are made within thirty (30) days of the due date. The first payment is timely if it is made within forty-five (45) days of the date that you elect to become a self-pay member under COBRA, or

c. you become covered under any other group health plan (as an employee or as a dependent) that does not exclude or limit coverage for pre-existing illnesses; or

d. you apply for and are granted Medicare coverage.

IV. PLAN BENEFITS FOR COVERED EMPLOYEES AND DEPENDENTS

A. Introduction

Unless a benefit is specifically included in the Plan, it is not an included benefit. Please note that the Fund does not always provide the same benefit to Eligible Dependents that it provides to Covered Employees. The following subsections will describe the benefits provided by the Plan. You must read the following subsections and booklets provided by Capital BlueCross, Delta Dental, Express Scripts or other prescription provider, and NVA carefully to determine whether you or your dependents are eligible for particular benefits. The Fund provides Benefits in the following categories.

B. Dental Benefits

Your dental benefit coverage is provided through an ASO arrangement with Delta Dental. At the time you were enrolled in the Dental Plan you were given a plan booklet and other information provided by Delta Dental. The booklet and information that was provided to you describes the benefits and coverage available under the dental program. You should refer to that booklet and information for a description of any benefits provided, limitations on any benefits, deductibles, co-payments, maximums, procedures you must follow, and any other information related to your dental coverage. If you have any questions regarding your coverage for specific benefits or claims, you must first contact Delta Dental at the telephone numbers or addresses listed in the dental program booklet. If you are unable to obtain an answer to your question from Delta Dental, you may contact the Fund Office for assistance.

C. Death Benefits

Death Benefits are provided directly by the Plan, and include the following benefits:

1. Covered Employee. $15,000.00

2. Spouse of a Covered Employee . . . . . $ 1,000.00

3. Covered Retiree. . . . . $ 2,000.00[1]

D. Disability (Loss of Time) Benefits

1. Occupational Accident or Illness

This benefit is available only to Covered Employees, and is not available to a

[1] Retirees who were covered under the Local Union No. 645 Health and Welfare Fund should refer to the Notice of Benefits mailed to them on 2/13/07.

spouse or beneficiary. If you are a Covered Employee who is totally disabled as the result of an occupational accident or illness, you will receive four hundred dollars ($400.00) (minus withholding) for the first week that you are totally disabled unless you are paid for the first week of disability under a state Workers' Compensation or Occupational Disease law.

2. Non-occupational Accident or Illness

This benefit is available only to Covered Employees who have a balance in their Dollar Bank at the time the disability began, and is not available to a spouse, beneficiary, or retiree. If you are a Covered Employee and are totally disabled as the result of a non-occupational accident or illness, that is not an excluded claim under the Plan, you will receive four hundred dollars ($400.00) per week (minus withholding), for up to twenty-six (26) weeks, for each period of total disability within a one (1) year period. The one (1) year period begins on the date you receive your first disability payment from the Plan. If you suffer another disability after the one (1) year period, you may receive up to an additional twenty-six (26) weeks of disability payments, however you may not receive more than fifty-two (52) weeks of disability payments within a three (3) year period.

In the case of disability due to accident, benefits are payable from the first day of disability. In the case of disability due to illness, benefits become payable on the eighth day of total disability; however, if the total disability resulting from illness continues for at least three weeks, benefits for the first week of disability shall be paid.

3. Exclusions

If you are in COBRA status, you are not eligible to receive disability benefits. If, however, you began to receive disability benefits prior to going into COBRA status, you will be able to continue to receive disability benefits while you are in COBRA status.

Note: Life insurance and disability benefits, if applicable, are not subject to COBRA continuation provisions.

E. Medical Benefits

1. All Participants Except Closed-Group Retirees

Your medical benefit coverage is administered by BlueCross. The Plan offers a PPO with three tiers of benefits, the High Option Plan, the Standard Option Plan and the Low Option Plan. At the time you were enrolled in the Plan you were enrolled in the PPO and were given a plan booklet and other information provided by the program in which you were enrolled which described the three options. The booklet that was provided to you describes the benefits and coverage

available under the PPO. You should refer to that booklet and information for a description of any benefits provided, deductibles, co-payments, maximums, limitations on benefits, procedures you must follow, and any other information related to your medical coverage. If you are a participant who was covered under the plan in the prior benefit year, once a year during the open enrollment period you will have the option to select one of the three tiers of benefits. If you do not make a selection you will be enrolled in the same option that you were enrolled in the previous year. If you are a new member, your benefit package will be limited to the Low Option Plan until the next open enrollment at which point you will be able to select from any of the three tiers of benefits. If you have any questions regarding your coverage for specific benefits or claims, you must first contact BlueCross at the telephone numbers or addresses listed in the booklet for your program. If you are unable to obtain an answer to your question from BlueCross, you may contact the Fund Office for assistance.

2. Closed-Group Retirees

Your benefits are provided directly by the Plan. Generally, if Medicare covers a service or charge, it will also be covered by the Plan, subject to the Plan's coordination of benefit provisions. There may be some exceptions, deductibles, or limitations to coverage for specific services or charges even if Medicare covers the service or charge. If you have any question about your coverage, or whether a particular service or charge is covered by the Plan you should contact the Fund Office for specific information.

F. Prescription Benefits

Your prescription benefit coverage is currently provided through an ASO arrangement with Express Scripts. At the time you were enrolled in the Prescription Plan you were given a plan booklet and other information provided by Express Scripts. The booklet and information that was provided to you describes the benefits and coverage available under the prescription program. You should refer to that booklet and information for a description of any benefits provided, deductibles, co-payments, maximums, limitations on any benefits, procedures you must follow, and any other information related to your prescription coverage. If you have any questions regarding your coverage for specific benefits or claims, you must first contact Express Scripts or the current prescription provider at the telephone numbers or addresses listed in the prescription program booklet. If you are unable to obtain an answer to your question from Express Scripts or the current prescription provider, you may contact the Fund Office for assistance.

G. Vision Benefits

Your vision benefit coverage is provided through an ASO arrangement with National Vision Administrators, Inc. (NVA). At the time you were enrolled in the Vision Plan you were given a plan booklet and other information provided by NVA. The booklet and information that was provided to you describes the benefits and coverage available under the vision program. You should refer to that booklet and information for a description of any benefits provided,

deductibles, co-payments, maximums, limitations on any benefits, procedures you must follow, and any other information related to your vision coverage. If you have any questions regarding your coverage for specific benefits or claims, you must first contact NVA at the telephone numbers or addresses listed in the vision program booklet. If you are unable to obtain an answer to your question from NVA, you may contact the Fund Office for assistance.

V. COORDINATION OF BENEFITS

This section describes what happens when you have another insurance, or are eligible for another program, which covers an illness or injury that is also covered by this Fund.

A. "Another Plan or Program"

When this section of your booklet uses the words "plan" or "program" these words mean programs, policies, or organizations that provide medical, surgical, hospitalization, disability, or major medical benefits, and include coverage:

1. under a law or under a governmental program such as Medicare, Workers' Compensation, or an Occupational Disease program;

2. under a group insurance plan or other type of coverage for a group of individuals, including student coverage obtained through an educational institution; or

3. under an individual insurance policy that pays medical, hospitalization, surgical, major medical, or disability benefits, regardless of whether this policy is purchased by the Participant, by another employer, or by another individual.

B. Plan Benefits Will Be Coordinated

Benefits under this Fund will be coordinated with the benefits provided by other plans or programs, so that the total amount of the benefit will not be more than the amount that would be provided by whichever plan or program would pay the largest benefit for that particular item.

C. Primary and Secondary Plans

If you, or your dependents, are covered by more than one program or plan, and if both plans cover a particular charge, then the primary plan will pay first. If the primary plan does not cover the entire charge, then the secondary plan may pay the difference between what has already been paid, and what the secondary plan would have paid for that charge if you did not have a primary plan. The following examples illustrate some of the situations in which the secondary plan would, or would not pay benefits.

If you were charged $700.00 for a service and your primary plan would pay $600.00 for that service, but your secondary plan would pay $700.00 for the same service, then your primary plan would pay $600.00 and your secondary plan would pay $100.00.

If you were charged $700.00 for a service and your primary plan would pay $700.00 for that service, but your secondary plan would pay $600.00 for the same service, then your primary plan would pay $700.00 and your secondary plan would not pay anything.

If you were charged $700.00 for a service and your primary plan and secondary plan would both pay $600.00 for that service, then your primary plan would pay $600.00 and your secondary plan would not pay anything.

The following rules determine which plan is primary and which plan is secondary:

1. government programs, including Workers' Compensation, and Occupational Disease programs will be primary, unless Federal law, or State law which is applicable to the Plan, dictates that the program in question is secondary;

2. a plan that does not have a coordination-of-benefits provision is always primary;

3. if an individual is a self-pay member under COBRA coverage, is working elsewhere, and is covered under his or her other employment, then the Fund is secondary;

4. if all the plans that cover the person who is receiving the service or benefit have coordinating provisions, then:

    a. the plan that covers the patient directly, rather than covering the patient as a spouse or as a dependent, is the primary plan and all other plans are secondary;

    b. if a child is covered by both parents' plans, then the "Birthday Rule" applies, the primary plan is the plan held by the parent whose birth month is earlier. If, for example, the child is covered under both parents' plans and the father's birthday falls in November while the mother's birthday falls in June, then the mother’s plan is primary.

    c. if the child's parents are separated or divorced, and there is no Court Order specifying who will provide medical coverage for the child, then:

        i) the plan of the parent who has primary custody of the child shall be primary;

        ii) the plan of the spouse of the parent with primary custody of the child shall be primary; or

        iii) if neither the custodial parent, nor the custodial parent's spouse has coverage, then the Plan will be primary.

        iv) if neither (i), (ii), nor (iii) apply then the plan that has covered the patient for the longest uninterrupted period of time is the primary plan.

D. The Fund Will Not Coordinate Benefits With Certain Plans

The Fund will not coordinate benefits with direct-pay policies purchased or paid for by a Fund Participant, or another person, and which reimburse the Participant for wage loss or which pay a fixed dollar amount directly to the Participant for each day of hospitalization.

VI. SUBROGATION

A. Subrogation Explained

Subrogation is a legal principle that allows the Fund to recover money that it has paid for medical benefits when another person may have been responsible for your injuries. The Fund is not liable, under the terms of the Plan, for injuries or illness for which another person may be responsible or liable. Ordinarily the Fund will not pay those benefits because they are excluded claims under the terms of the Plan. If the Plan Administrator denies your claim, because it is an excluded claim, you may appeal the denial and request that the Fund pay those claims. The Fund will, however, require you to sign a subrogation agreement before it considers your request. A subrogation agreement is a legal and binding document which states that if you recover any amount from another individual, or insurer, the Fund will be reimbursed for the total amounts it has paid on your behalf, and also states that any attorney's fees that you incur to recover money from another person or insurer will not be deducted from the amounts to be reimbursed to the Fund. Any attorneys' fees will be your responsibility and will be deducted from your portion of your recovery. The Fund is not required to accept every request to pay otherwise excluded claims simply because you sign a subrogation agreement. Each case is reviewed individually and the Board of Trustees reviews the information and decides whether or not to accept the subrogation agreement and pay the claims. In reviewing a request to pay such a claim, the Trustees consider a number of factors in reaching their decision, as required by their duties under ERISA, including the amount of the charges, and the likelihood that you will win your case and the Fund will be reimbursed, the length of time it is likely to take before the Fund is reimbursed, and whether the Fund has sufficient excess assets available to pay a claim it would not otherwise be obligated to pay. Before the Board makes a decision to accept a subrogation agreement you may be required to provide documentation to the Board to demonstrate that you are taking legal action against the person or his insurer who may be responsible for payment of your claims. You may also be required to sign a release so that the Fund can obtain information from, or communicate with your attorney.

Some examples of subrogation are:

You are injured at work, and your employer denies your workers' compensation claim. You contact an attorney and file a Claim Petition with Workers' Compensation. Your bills, however, are not being paid. This would be an excluded claim under the Fund, and the Fund would deny payment of those bills.

You could then request that the Fund make payment and offer to sign a subrogation agreement. The Board would then consider all the facts and circumstances of your Workers' Compensation claim before deciding, and would need to contact your attorney to be sure that he or she protects the Fund's interest in the Workers' Compensation proceeding. Likewise, if you were injured in a store when a display rack fell over onto you, you would be entitled to sue the store for your injuries, and your injuries would be an excluded claim under the terms of the Plan. You could request that the Plan pay your medical bills if you agreed to sign the subrogation agreement. The Board of Trustees would consider the same factors described above in deciding whether to accept your subrogation agreement and make payment for your charges.

B. Your Responsibilities

If it is possible that another individual or organization should be the one to pay for your, or your dependent's, medical care then you, or your dependent, will be required to assign your rights of recovery, for the amount that the Fund has paid, to the Fund. You must do this by signing, and delivering, an Accident Form and/or an Assignment Form to the Plan Administrator. You cannot do anything that would injure the Fund's assignment or its right to recover what it has paid. The Fund is entitled to recover the amount that it has paid for services that were provided to you or to your dependent when those services should have been paid by someone else.

VII. RECIPROCAL AGREEMENTS

A. Work in Another Geographic Area May Be Credited

When an employee who is an Eligible Employee under this Fund works in a geographic area covered by another plan that has signed a Reciprocal Agreement with this Fund, then the Eligible Employee will continue to receive credit toward his or her eligibility with this Fund, regardless of any difference between the contribution rates that are in effect under each Fund.

B. Employees Qualified under this Fund May Not Receive Benefits from Another Fund

An employee who initially qualified under the rules of this Fund will make claims to and receive benefits from only this Fund, even though the employee might otherwise meet the eligibility requirements of one or more other Funds that have signed Reciprocal Agreements with this Fund.

C. Employees Qualified under Another Fund May Not Receive Benefits from this Fund

An employee who is initially qualified to receive benefits under another Fund that has signed a Reciprocal Agreement with this Fund may not make claims or receive benefits under this Fund, even though the employee might otherwise be eligible for benefits under this Fund.

D. Employees Who Work in Another Fund's Jurisdiction must Notify the Plan Administrator

Employees who are covered by this Fund, and who work in another Fund's jurisdiction must, if the other Fund has signed a Reciprocal Agreement with this Fund, notify the Plan Administrator of the location and dates of their employment under the other Fund's jurisdiction.

VIII. RETIREES

Individuals who meet the Plan's definition of "Retiree" and who were Covered Employees under the Plan, and who had a balance in their Dollar Bank on the date of retirement from Covered Employment are eligible to participate in the Plan. Please Note that a Retiree spouse may receive coverage under the Plan if, and only if the Participant spouse elects and continues coverage under the Plan.

A. Retirees Who Retired on or After January 1, 1998 and Who Are Under Age Sixty Five (65)

Effective January 1, 1998, eligible Retirees are permitted to purchase coverage under the Plan, including medical insurance, dental, vision, and prescription coverage. The Board of Trustees has the discretion and authority to determine the monthly premium rate that will be charged for Retiree coverage, and to alter that rate from time to time. If a retiree fails to make the required monthly payment within thirty (30) days of its due date, coverage under the Plan will terminate and will not be reinstated.

B. Retirees Who Retired on or After January 1, 1998 and Who Are Age Sixty Five (65) or Older

Effective January 1, 1998, Retirees and spouses who are 65 years old, or older, and who have Medicare Part A and Part B may purchase coverage under the Plan which includes medical supplemental insurance that coordinates with Medicare coverage, vision, dental, and prescription benefits. The Board of Trustees has the discretion and authority to determine the monthly premium rate that will be charged for Retiree coverage, and to alter that rate from time to time. If a retiree fails to make the required monthly payment within thirty (30) days of its due date, coverage under the Plan will terminate and will not be reinstated.

C. Retirees Who Retired Before January 1, 1998 and Who Are Age Sixty Five (65) or Older (Closed-Group Retirees)

Retirees who retired before January 1, 1998, and who were covered under the Plan, or who retired under another Plan that merged with this Plan between January 1, 1998 and January 1, 2001, and who have remained covered under the Plan then in effect, are covered under the self-funded portion of the Plan. Retirees who are covered under this portion of the Plan must have Medicare Part A and Part B and the Plan coordinates with the Retiree's Medicare coverage to provide supplemental coverage, as well as vision, dental, and prescription benefits. Please note that not all Retirees will receive prescription benefits in that certain Retirees are eligible for “basic only” coverage. The Board of Trustees has the discretion and authority to determine the monthly premium rate that will be charged for Retiree coverage, and to alter that rate from time to time. If a retiree fails to make the required monthly payment within thirty (30) days of its due date, coverage under the Plan will terminate and will not be reinstated.

D. For Retirees Who have a Spouse that is Older and Eligible for Medicare at the Time of Retirement

Spouses of Retirees who are older and eligible for Medicare will need to have both Medicare Part A and Part B in place prior to the termination of the Dollar Bank.

IX. EXCLUDED CLAIMS

A. The Fund Will Not Pay for Certain Claims

Unless applicable state or federal law otherwise mandates coverage, the Fund will not pay benefits if your claim involves:

1. illness or injury that is caused by, or related to, employment (these claims are covered by Workers' Compensation); or

2. illness or injury for which a governmental agency will provide services without charge to the recipient of the services; or

3. illness or injury that is caused by, or related to, participation in the commission of a felony, or misdemeanor, under the laws of the Commonwealth of Pennsylvania or the United States or an act that is against public policy; or

4. illness or injury that is caused by, or related to, the illicit use of any narcotic, opiate, hallucinogen, marijuana, or any other Controlled Substance as that term is defined in the Pennsylvania Drug and Alcohol Abuse Control Act, or

5. illness or injury that is caused by, or related to, participation in any sporting or athletic event for pay, or for which a prize worth more than fifty (50) dollars may be awarded. This includes participation in automobile races and any other motor vehicle races; or

6. illness or injury that is caused by, or results from another person's actions, or failure to act, for which you may have the right to take legal action and recover money for the treatment of your injuries. If, for example, you were injured because of someone else's negligence you would have the right to sue the person and recover damages for your injury and for medical treatment; or

7. medical bills of over $10,000.00 resulting from an accident or injury involving any type of all-terrain vehicle (ATV), recreational vehicle (RV), boat, motorcycle, or snowmobile.

X. CLAIMS FOR BENEFITS

A. Claims for Medical Benefits

1. All Participants', except closed-group Retirees, medical benefits are provided through BlueCross's PPO Plan. Any claims for medical benefits must be submitted to the PPO Plan. When you were enrolled, you were provided with a booklet prepared by the Insurance Provider that described the Insurer's plan, its requirements, rules, benefits, exclusions, coverage, claims procedures, and appeal procedures. You must refer to that booklet to determine your benefits, coverage, and the rules and procedures applicable to you.

2. Closed-Group Retirees Supplemental benefits are provided to Closed-Group Retirees through the Self-funded portion of the Plan. Generally, if Medicare covers a particular charge or service, the Plan also covers that charge or service subject to the Plan's coordination of benefits provisions. If you have a question about whether a particular charge or service is covered under the Plan you may contact the Fund Office for information. To make a valid claim for medical benefits you must follow these rules:

    a. you must submit your claim for benefits within one hundred eighty (180) days;

    b. for medical, hospital, or surgical benefits the one hundred eighty (180) day claim period begins when you, or your dependent, receive(s) the treatment for which you are submitting the claim;

    c. you must submit the bills, for which you are seeking payment, along with your claim form;

    d. you must submit a Medicare Payment Statement with your Claim form;

    e. you must provide any medical or hospital reports that Plan Administrator or the Board asks you to provide.

B. Claims for Disability (Loss of Time) Benefits

Disability (Loss of Time) benefits are paid directly by the Plan, and all claims must be submitted to the Fund Office. To make a valid claim for disability benefits you must follow these rules:

1. you must submit your claim for benefits within one hundred eighty (180) days;

2. the one hundred eighty (180) day claim period begins when your disability

begins;

3. you must submit, with your claim form, a statement from your doctor which says that you are totally disabled, and which describes the cause of your disability;

4. you must provide any additional information, documents, or records that the Board, or the Plan Administrator, requests.

C. Claims for Death Benefits

Death benefits are paid directly by the Plan, and all claims must be submitted to the Fund Office. To make a valid claim for Death Benefits you must follow these rules:

1. you must submit your claim for benefits within one hundred eighty (180) days;

2. the one hundred eighty (180) day claim period begins on the date of death;

3. a death certificate must be submitted with the claim form;

4. the applicant for death benefits must provide any additional information, documents, or records that the Board or the Plan Administrator, requests.

D. Health Care Claims (includes health, dental, and vision):

1. *Urgent Health Care Claim* (Claims for conditions that could jeopardize life, health, or ability to regain maximum function, or would subject you to severe pain)

Steps to Take	
Step 1:	The Plan has **72 hours** after receiving your initial claim to approve or deny the claim.
Step 2:	If denied, you have **180 days** after receiving notice of the claim to appeal the Plan's decision.
Step 3:	The Plan has **72 hours** after receiving your appeal to notify you of its appeal decision.

If your claim is incomplete or improper.

Steps to Take	
Step 1:	The Plan has **24 hours** after receiving your initial claim to notify you that your claim is improper or incomplete.
Step 2:	You have **48 hours** after receiving notice from the Plan to correct or complete your claim.

Step 3:	The Plan has **48 hours** to notify you if your claim is approved or denied. The Plan must do so within the earlier of 48 hours of: 1. Receiving you completed claim, or 2. Your deadline to complete the claim.
Step 4:	If denied, you have **180 days** after receiving notice of the denied to appeal the Plan's decision.

2. *Pre-Service Health Claim* (Group health claims where treatment must be pre-certified before it is performed)

Steps to Take	
Step 1:	The Plan has **15 days** after receiving your initial claim to notify you if your claim is approved or denied.
Step 2:	You have **180 days** after receiving notice of the claim denial to appeal the Plan's decision.
Step 3:	The Plan has **30 days** after receiving your appeal to notify you of the appeal decision.

If you claim is incomplete or improper:

Steps to Take	
Step 1:	The Plan has **5 days** after receiving your initial claim to notify you that your claim is an improper claim.
Step 2.	The Plan has **15 days** after receiving your claim to notify you of its decision to approve or deny the claim. If the plan needs more information and provides an extension notice during the initial 15-day period, the Plan has **30 days** after receiving the claim to notify you of its decision.
Step 3:	You have **45 days** after receiving the extension notice to provide additional information or complete the claim.
Step 4:	If your claim is denied, you have **180 days** after receiving the claim denial to appeal the Plan's decision.
Step 5:	The Plan has **30 days** after receiving your appeal to notify you of the appeal decision.

3. *Post-Service Health Claim* (Group health claims where you request reimbursement after treatment has been performed.)

Steps to Take	
Step 1:	The Plan has **30 days** after receiving your initial claim to notify you if your claim is denied.
Step 2:	If your claim is denied, you have **180 days** after receiving notice of the claim denial to appeal the Plan's decision.
Step 3:	The Plan has **60 days** after receiving your appeal to notify you of the appeal decision.

If the Plan needs further information or an extension:

Steps to Take	
Step 1:	The Plan has **30 days** after receiving the initial claim to notify you if your claim is denied. If the Plan needs more information and provides an extension notice during the initial 30-day period, the Plan has **45 days** after receiving the claim to notify you if your claim is denied.
Step 2:	You have **45 days** after receiving the extension notice to provide additional information or complete your claim.
Step 3:	If you claim is denied, you have **180 days** after receiving the claim denial to appeal the Plan's decision.
Step 4:	The Plan has **60 days** after receiving your appeal to notify you of the appeal decision.

E. Disability Claims

(Long Term or Short Term Leave as a result of illness or injury)

Steps to Take	
Step 1:	The Plan has **45 days** after receiving the initial claim to notify you if your claim is denied. If the Plan needs more information and provides an extension notice during the initial 45-day period, the Plan has **30 days** after receiving the claim to notify you if your claim is denied. If the Plan determines a decision cannot be rendered in the initial 30-day extension period, the Plan may extend the determination period for another **30 days**.

Step 2:	If the Plan notifies you that additional information is needed to make a determination on your claim, you will have **45 days,** from your notice that additional information is necessary, to supply such information.
Step 3:	If your claim is denied, you have **180 days** after receiving notice of the denial to appeal the Plan's decision.
Step 4:	The Plan has 45 days after receiving your appeal to notify you of the appeal decision. If the Plan determines a decision cannot be rendered in the initial 45-day extension period, the Plan may extend the determination period for another **45 days**.

XI. RIGHTS TO APPEAL A DENIAL OF BENEFITS

A. Appeal to the Board of Trustees

Any Participant or Beneficiary who applies for benefits under the Plan, and whose application for benefits is denied, or who believes that he or she did not receive the full amount of benefits to which he or she is entitled, shall have the right to request that the Board of Trustees review his or her application for benefits, provided that the Participant or Beneficiary submits a written, signed statement of appeal giving the reasons why he or she is appealing. The written statement of appeal must be filed with the Plan Administrator within one hundred eighty (180) days of the date that the Plan Administrator issues a Notice of Denial to the Participant or Beneficiary. If the Participant or Beneficiary wishes to have a hearing, the statement of appeal must specifically request a hearing. The Board of Trustees shall hold a hearing within sixty (60) days of the date that the statement of appeal is received by the Plan Administrator, or if a hearing was not requested, will act on the appeal within sixty (60) days of receipt of the statement of appeal. The Board of Trustees shall issue a written decision within sixty (60) days of the date of the hearing, or if a hearing was not requested, within sixty (60) days of its decision. If the Board of Trustees denies the appeal, its written decision shall specify the reasons why the appeal was denied.

B. Review by an Arbitrator

The Participant or Beneficiary may, if the Board of Trustees denies all or part of his or her appeal, request that an independent arbitrator review the Board's decision. The Arbitrator may decide only whether the Board's actions in denying the claim were Arbitrary and Capricious. To obtain review by an arbitrator the Participant or Beneficiary must submit a written request to the Plan Administrator stating that he or she is requesting arbitration of the Board's decision. The written request for arbitration must be submitted within one hundred and eighty (180) days of the date that the Board of Trustees issued its decision. The arbitrator will be selected by the American Arbitration Association according to its rules and procedures. The arbitrator may impose the cost of the arbitration on both parties, or may impose the entire cost of arbitration on one of the parties. The Plan shall require that the arbitrator schedule a hearing within ninety (90) days of the date that arbitration was requested, and shall require that the arbitrator issue a decision within ninety (90) days of the date of the hearing.

C. Consequences of Failure to File an Appeal

If the Participant or Beneficiary fails to file an appeal of the Plan Administrator's, or Board of Trustees' decision, as the case may be, the last un-appealed decision shall be final and binding.

XII. ERRORS IN PAYMENTS AND FRAUD

The Board of Trustees, on behalf of the Plan, specifically retains the right to recover all monies paid in error to or on behalf of any Participant or Beneficiary, from the Participant or Beneficiary, or from the person or business to which payment was made. When the Plan Administrator discovers a payment "made in error" the Plan Administrator will notify the Participant, Beneficiary, or recipient of payment, indicating the circumstances and amount of payment, together with a request for reimbursement. If the Participant, Beneficiary, or recipient refuses to reimburse the payment, the Board may, at its discretion, bring legal action to recover the payment, or may deduct the amount of payment from any future benefit payments that the Participant or Beneficiary may become entitled to under the Plan. The Board also reserves the right, at its discretion, to deduct the amount of the payment from the Participant's hour bank.

Any person who submits, or attempts to submit false, misleading, or incomplete information, or who in any way attempts to defraud the Fund, or to seek payments or benefits to which he or she is not entitled may be prosecuted in any manner the Board deems advisable.

XIII. CERTIFICATE OF HEALTH COVERAGE

As required by law, this Plan complies with the applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA). HIPAA provisions apply to group health Plans only, not all benefit Plans offered under this Plan.

A. Continuity of Coverage

HIPAA requires that your group health Plan reduce or eliminate the exclusionary period of coverage for pre-existing conditions under your group health Plans (not long term disability Plans), if you have creditable coverage from another Plan. Typically you should be provided with a certificate of creditable coverage, free of charge, from your group health Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, or if you request it up to 24 months after losing coverage. Typically, without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion of 12 months (18 months for late enrollees) after your enrollment date in your coverage.

B. Special Enrollment Rights

HIPAA also requires a group health Plan to provide special mid-year enrollment opportunities to certain Employees and/or their Dependents in two circumstances:

- loss of other coverage, or
- acquisition of a new Dependent.

A Participant enrollment under these special enrollment rules is not a late enrollee and thus would not be subject to the late enrollment penalties prescribed by HIPAA.

If you are covered under another group health Plan and involuntarily lose that coverage (due to expiration of COBRA or loss of eligibility under the other group Plan), you or your Dependents may enter the Plan under the special mid-year enrollment rights. You must request enrollment in writing within 30 days after the loss of other coverage or the Employer's cessation of contributions for such other coverage. Coverage will begin on the first day of the month after the Plan receives the enrollment form.

If you as an Employee acquire a new Dependent, by marriage, birth, adoption, or placement for adoption, you have a right to enroll yourself and the new Dependent in the group health Plan. You must request enrollment in writing within 30 days of the marriage, birth, adoption, or placement for adoption. Coverage will become effective retroactive to the date of marriage, birth, adoption, or placement for adoption.

XIV. NOTICE OF RIGHT TO CERTIFICATE OF HEALTH COVERAGE

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which medical coverage can be excluded for pre-existing medical conditions. Under the law, a pre-existing condition exclusion may not be imposed for more than 12 months (18 months for a late enrollee). This period is reduced by any prior health coverage.

HIPAA requires that prior health coverage count towards satisfying the pre-existing limit. In short, this makes your prior health coverage "portable" because it is credited toward any pre-existing condition exclusion. Prior health coverage will count toward the pre-existing condition limitation as long as you have not had a break in coverage between the old plan and the new plan of 63 or more days.

HIPAA provides that you and your covered Dependents are entitled to a certificate from your prior employer or claims administrator to show evidence of prior health coverage.

Upon request, you have the right to receive a certificate of prior Health and Welfare Fund medical Plan coverage since July 1, 1996.

The fund administrator will automatically provide a certificate of prior coverage to you if you lose the Building Trades Health & Welfare Plan coverage on or after June 1, 1997. For Dependents who lose coverage, the fund administrator will provide certificates of prior coverage on or after June 1, 1998, to the extent records are available.

Coverage under the Building Trades Health & Welfare Plan is not subject to any Preexisting Condition limitations.

If you terminate coverage under the Building Trades Health & Welfare Plan, check with the plan under which you become covered to see if your new plan excludes pre-existing conditions and if you need to provide a certificate of previous coverage.

XV. PRIVACY OF MEDICAL INFORMATION

A. The Plan Protects the Privacy of Personal Health Information

The Plan complies with the requirements of ERISA in protecting the privacy of your personal health information from disclosure. The Plan also requires that individuals who provide services to the Plan, such as the Plan's attorneys or accountants who may become aware of your personal health information, for example if you appeal a denial of a benefit, to protect the privacy of your personal health information. Other than transmitting information to the Insurance Provider or to your physicians, hospitals, laboratories, or other medical service providers, as necessary to process your claim or appeal, or determine payment of your claim, the Plan requires written authorization from you before it will disclose any of your personal health information. For example, you may wish to have the Plan disclose your personal health information to your attorney because you were injured on the job. Before the Plan will disclose that information, you must sign a written authorization allowing the Plan to provide that information to your attorney. If you have authorized the disclosure of personal health information, you have the right to revoke that authorization, and as soon as the Plan receives your written revocation of authorization it will refuse to disclose any additional information to the person you had authorized to receive information.

B. You Have the Right to Access, Inspect, and Copy Your Personal Health Information

You may do so by contacting the Plan offices, during normal business hours to arrange for a convenient appointment time to review your personal health information.

C. You Have the Right to Amend Your Personal Health Information

If you discover that personal health information contained in the Plan's records is not accurate, you have the right to submit a written amendment of your personal health information to the Plan Administrator for inclusion in the Plan's records of your personal health information.

D. You Have the Right to Receive Notification If Your Unsecured Protected Health Information Has Been Breached.

If a breach of your Protected Health Information has occurred you have the right receive notification of that breach. Notice is also required to be provided to the US Department of Health and Human Services and in the case of a mass breach involving more than 500 individuals notice will be provided to a prominent media outlet.

XVI. WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The federal Women's Health and Cancer Rights Act of 1998 requires coverage of treatment related to mastectomy. If you are eligible for mastectomy benefits under your health coverage and you elect breast reconstruction in connection with such mastectomy, you are also covered for the following:

1. Reconstruction of the breast on which mastectomy has been performed;
2. Surgery and reconstruction on the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications of all states of mastectomy, including Iymphademas.

Coverage for reconstructive breast surgery may not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the coverage definition of "Medically Necessary." Benefits will be provided on the same basis as for any other Illness or injury under your Plan. Coverage is subject to applicable Deductibles, co-payments and Coinsurance payment.

XVII. NEWBORNS' AND MOTHERS' PROTECTIONS (THE NEWBORNS ACT)

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

XVIII. FAMILY MEDICAL LEAVE ACT (FMLA)

A. Compliance

When required by law, our benefit program will comply with the Family and Medical Leave Act (FMLA) requiring continuation rights for health expense coverage assuming the Employer/Plan Sponsor meets certain criteria during the preceding calendar year. If the Employer/Plan Sponsor is subject to the law and you are covered under health benefit Plans, you may be able to continue the coverage under our benefit Plan for a certain period of time.

B. Benefits

To the extent required under the FMLA, and the regulations thereunder, an Employee on leave of absence under the FMLA may choose to continue coverage under the Plan by making the applicable contributions, on an after-tax basis, in accordance with procedures established by the Administrator that are consistent with the FMLA. In addition, to the extent required under and in accordance with the FMLA, and the regulations thereunder, any Employer contributions made under the terms of the Plan shall continue to be made on behalf of an Employee on an FMLA leave.

XIX. MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2012. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	**COLORADO** – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ALASKA – Medicaid	
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	
ARIZONA – CHIP	**FLORIDA** – Medicaid
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268
	GEORGIA – Medicaid
	Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150

IDAHO – Medicaid and CHIP	**MONTANA** – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9948	Website: http://dhhs.ne.gov/medicaid/Pages/med_kidsconx.aspx Phone: 1-877-255-3092
IOWA – Medicaid	**NEVADA** – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: www.dhhs.nh.gov/ombp/index.htm Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/OIAS/public-assistance/index.html Phone: 1-800-572-3839	
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK –** Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA** – Medicaid and CHIP
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA** – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP	**UTAH** – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid and CHIP	**VERMONT**– Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-877-314-5678	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
RHODE ISLAND – Medicaid	**WASHINGTON** – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	**WISCONSIN** – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any more States have added a premium assistance program since January 31, 2012, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

OMB Control Number 1210-0137 (expires 09/30/2013)

XX. STATEMENT OF YOUR RIGHTS UNDER ERISA

As a participant in the Building Trades Health & Welfare 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 Fund Office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

B. Continue Group Health Plan Coverage

Continue health coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer 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 if you request it 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 the operation of the employee benefits plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or

any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

D. Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the 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 Federal Court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suite in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

E. Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.