MEMORANDUM

TO: All Active and Non-Medicare Retired Participants and/or their Dependents

FROM: Board of Trustees

RE: Plan Design Changes effective January 1, 2006

DATE: November 29, 2005

Each year, the Board of Trustees examines the current and projected costs of the Fund's Health Insurance Program. The Trustees' goal is to continue to provide comprehensive health care coverage for both active and retired members while ensuring the strength of the Fund for today and many years in the future.

As you know, the cost of medical care is skyrocketing everywhere. Over the past few years, benefits paid under the Plan have likewise increased at an alarming rate. Medical care increases have placed a tremendous strain on the Fund's current assets and reserves.

The equation for maintaining the Plan on a sound financial basis is relatively simple in that Annual Plan Income (including contributions, self-payments, and investment earnings) must equal or exceed the amounts being paid for benefits and administration of the Plan. When this equation gets out of balance, action must be taken by either increasing monthly charges to all participants or reducing benefits payable or a combination of both.

As you are aware, the Fund began using the SuperMed Classic Preferred Provider Organization (PPO) June 1, 2002. When that change was made, each participant was subject to an additional charge for using hospitals outside the PPO. Effective for services incurred on and after January 1, 2006, the Plan will require separate deductibles and co-insurance for all medical providers (hospitals and doctors) based upon whether the provider participates in the Medical Mutual of Ohio SuperMed Plus network for Ohio and MultiPlan network for all other states.

Enclosed is Medical Mutual's SuperMed Plus Network directory for Northeast Ohio. To verify whether a doctor or hospital participates, you may use the directory as a reference, however we urge you to contact Medical Mutual at 1-800-601-9208, visit the Website at www.supermednetwork.com, or ask the medical provider since the listing of providers continuously changes.

The following table reflects how benefits will be processed for all services (both hospital and physicians) after January 1, 2006.

IN NETWORK/OUT OF NETWORK DIFFERENTIAL					
Current Plan			**New Plan Effective January 1, 2006**		
			In Network		Out of Network
Deductible: Single	$300		Deductible: Single	$30	$300
Deductible: Family	$600		Deductible: Family	$60	$600
Coinsurance: 20% of $4,000 per individual			Coinsurance: 20% of $4,000 per individual		30% of $4,000 per individual

The out-of-network schedule will not be used for emergency medical care. Those charges will be treated as if they were provided at an In-network Facility. You will be receiving a new set of identification cards the week of December 19th.

The Trustees feel that these changes, plus the increase in the hourly contribution rate, will maintain the Plan on a sound financial basis and continue to provide you and your family with comprehensive coverage.

As always, if you should have any additional questions, please contact the Fund Office.

Sincerely,

BOARD OF TRUSTEES