PLUMBERS & PIPEFITTERS
LOCAL UNION NO. 396

HEALTH & WELFARE FUND

LOCAL UNION NO. 396

of the

UNITED ASSOCIATION OF
PLUMBING AND PIPEFITTING INDUSTRY
OF THE UNITED STATES AND CANADA

33 Fitch Boulevard
Austintown, Ohio 44515
Phone: (330) 270-0453
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Revised: April 1, 2008

PLUMBERS & PIPEFITTERS LOCAL UNION NO. 396
HEALTH AND WELFARE FUND

Board of Trustees

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LOCAL UNION NO. 396 of THE UNITED ASSOCIATION of
PLUMBERS and PIPEFITTING INDUSTRY of
THE UNITED STATES and CANADA

This Plan Administered by
Compensation Programs of Ohio, Inc
33 Fitch Boulevard
Austintown, Ohio 44515

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Important Notice!

It is extremely important that you keep the Fund Office informed of any change in address or desired change in beneficiary. This is your obligation and failure to fulfill this obligation could jeopardize your eligibility or benefits. Tear-out forms are included at the end of the booklet for submission.

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

Also, **you have the responsibility to inform the Fund Office within thirty (30) days of a divorce, legal separation, or a child losing dependent status under the Plan.**

The Employer Identification Number assigned to the Board of Trustees by the Internal Revenue Service is EIN 34-6545105. The Plan Number assigned to this Plan by the Board of Trustees is 501. The electronic payer identification number assigned the Plan is 34654.

Hospital and Medical Benefits are self-funded by the Trust, with a stop loss agreement underwritten by an insurance company.

This booklet is the Plan in effect as of April 1, 2008. From time to time you will receive supplemental bulletins about changes to this Plan. It is your responsibility to review these bulletins.

Introduction

We are pleased to present you with your new benefit booklet containing a summary of the current pertinent provisions of the Plumbers and Pipefitters Local Union No. 396 Health & Welfare Fund.

Your Plan is financed through employer contributions which are made into the Trust Fund, tax exempt to you. Employer contributions are based on an hourly rate and are determined by the provision of the collective bargaining agreements in effect between the local union and participating signatory employers. You may obtain a copy of the collective bargaining agreement by writing to the Plan Administrator, or you may examine the document at the Fund Office.

The Plan is administered by the Board of Trustees consisting of four (4) Trustees from Labor and four (4) Trustees from Management. Under ERISA, the Plan Administrator is the Board of Trustees and this Board has the authority to control and manage the operations and administration of the Plan and is the Agent for service of Legal Process.

The Board of Trustees, as the Administrator of your Plan has authorized the payment of the benefits of the Plan through Compensation Programs of Ohio, Inc., located at 33 Fitch Boulevard, Austintown, Ohio. (Telephone: 330/270-0453 or 1/800-435-2388).

Since the Board of Trustees is the Administrator of the Fund and has the full authority and control of the program, the existing levels of benefits are subject to modification unilaterally by the Trustees from time to time as shall in their sole judgement and discretion be deemed proper for the maximum welfare of the Fund and protection of the assets of the Funds. The Trustees shall also have the sole power to interpret and determine the benefits payable under this Plan at all times and in case there is a controversy, the Board of Trustees' decision in all matters will be final, binding, and conclusive.

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 review the change with the Participants prior to initiating such change.

All benefits under the Plan shall be payable through Participants 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 are provided under the Plan, and no person shall have any claim for benefits against any participating Union, the Association, any Employer or the Trustees.

Only the Board of Trustees has the power to interpret and construe the Plan, determining 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 Participants, participants and their dependents and benefits. 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 its behalf.

This new booklet contains an outline of how you should file claims, benefits provided in the Plan, and in the event an application for benefits is denied, a procedure in which you can file to appeal the denial is included.

This booklet supercedes and replaces any certificate booklet previously issued to you under the Plan. Therefore, we ask that you read this booklet very carefully at this time and submit any questions you may have regarding it to the Administrative Office listed in this booklet. In this manner, any misunderstandings can be resolved at this time.

Sincerely,

THE BOARD OF TRUSTEES

SCHEDULE OF BENEFITS
For All Active and Early Retiree Members and Their Dependents

All Medical Expenses are provided through the Plan's Preferred Provider Organizations (PPO) -- Medical Mutual of Ohio SuperMed Plus network in Ohio, the Devon Network in Pennsylvania and the Multiplan network in all other states.[1] In-Network and Out-Of-Network Benefits are reimbursed based upon PPO contractual obligations and No Benefits are paid for services over UCR.

	In Network	Out of Network
Annual Deductible	$300 single/$600 family	$300 single/$600 family
Co-insurance	20%	30%
Out of Pocket (including deductibles)	$1800 single/$2100 family	$2550 single/$2850 family
Life Time Maximum Amount of Benefits	$1,000,000	
Dependent Age Limit	Age 19 unless a full-time student, then up to age 23	

SUPPLEMENTAL BENEFITS		
Weekly Disability Benefits	Accident - 1st day $250 per week - Maximum 26 weeks	Illness - 8th day
Mental/Nervous disorder	Inpatient - 30 days lifetime maximum	Outpatient - 20 visits annual maximum
Alcohol/substance abuse	Inpatient - $10,000 per calendar year maximum Lifetime maximum benefit – $15,000	Outpatient - $5,000 per calendar year maximum
Death Benefits	$6,000 (Active and Early Retirees only)	
Dental/Vision Benefits[2]	$400 / family / year	

Prescription Drug Benefits		
	Retail	Mail Order
Tier One (generic)	$10 copay	$20 copay
Tier Two (Brand - Preferred)[3]	Greater of $15 or 20% cost of drug	Greater of $30 or 20% cost of drug
Tier Three (Brand - Non Preferred)	Greater of $30 or 40% cost of drug	Greater of $60 or 40% cost of drug
Annual Limit	$25,000 per individual	

[1] Deductible and coinsurance expenses incurred for services by a non-network provider do not apply to the network deductible and coinsurance out-of-pocket limits. Deductible and coinsurance expenses incurred for service by a network provider will also not apply to the non-network deductible and coinsurance out-of-pocket limits.

[2]Not subject to deductibles or co-payments; benefit subject to annual review by Trustees

[3]The Fund has a mandatory generic substitution policy. Members who elect to receive brand medications when a generic is available will be charged the difference between the cost of brand and generic plus the brand co-payment.

Summary of the Current Medicare Supplemental Coverage
Retired Participants and/or Dependents Age 65 and Over 65
and Eligible for Medicare–Parts A & B

All Eligible Retirees and Eligible Dependents Over Age 65 and Eligible Retirees under Age 65 who are Medicare eligible must be enrolled in both parts A and B of Medicare. Medicare will be your primary insurance coverage. The Fund will only pay what Medicare considers a Covered Expense under the Medicare Rules, and then we only pay the balance which Medicare does not pay, subject to the limitations set forth elsewhere in this SPD. The Fund is secondary on all claims. Please submit all medical claims directly to Medicare and any remaining balances to Plumbers & Pipefitters Local Union No. 396 Health & Welfare Fund, 33 Fitch Boulevard, Austintown, Ohio 44515 for payment consideration.

The Medicare Supplemental coverage is provided to Retired Participants and their eligible dependents who are enrolled in Medicare Parts A and B. The Board of Trustees has elected to provide these benefits on a self-funded basis. These benefits are subject to any exclusions and/or restrictions.

Services	Benefits	Medicare Pays	Current Fund Medicare Supplemental Coverage Pays (01/01/08)
MEDICARE (PART A)			
Hospitalization-Semi-private room and board, general nursing and misc. hospital services and supplies	First 60 days 61st to 90th day 91st to 150th day ** Beyond 150 days	All But $1,024* All But $ 256 a day* All but $ 512 a day* Nothing	$1,024 $ 256 $ 512 Nothing
Post-hospital Skilled Nursing Facility Care-You must have been in a hospital for at least 3 days and enter a Medicare approved facility generally within 30 days after hospital discharge	First 20 days Additional 80 days Beyond 100 days	100% of approved amount All but $128 a day* Nothing	Nothing $128 a day* Nothing
Home Health Care - Medically necessary skilled care, home health aide services, medical supplies, etc.	Part-time or intermittent nursing care and other services for as long as you meet criteria for benefits	100% of approved amount; 80% of approved amount for durable medical equipment.	Medicare deductible amount and 20% of remainder of Medicare approved amount.
Hospice Care - Full scope of palliative medical and support services available to the terminally ill.	As long as doctor certifies	All but limited costs for outpatient drugs and inpatient respite care	Nothing
Blood	Blood	All but first 3 pints per calendar year	First 3 pints

Services	Benefits	Medicare Pays	Current Fund Medicare Supplemental Coverage Pays (01/01/08)
MEDICARE (PART B)			
Medical Expenses- Physician's services, inpatient and outpatient medical and surgical and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, etc.	Medicare pays for Medical Services in or out of the hospital	80% of approved amount (after $100 deductible)	20% of approved amount (after $100 deductible on Major Medical ie: office visits, durable medical expenses
	Part B excess charges	Nothing	Nothing
	Part B $135 deductible	Nothing	Approved amt. if basic charge
Clinical Lab Services	Blood tests, etc.	100% of approved amount	Nothing for services
Home Health Care - Medically necessary skilled care, home health aide services, medical supplies, etc.	Part-time or intermittent nursing care and other services for as long as you meet criteria for benefits	100% of approved amount; 80% of approved amount for durable medical equipment	20% of approved amount (after $100 deductible for durable medical equipment)
Outpatient Hospital Treatment - Reasonable and necessary services for the diagnosis or treatment of an illness or injury	Unlimited if medically necessary	80% of approved amount (after $100 deductible)	20% of approved amount
Blood	Blood	80% of approved amount (after $100 deductible and starting with 4th pint)	20% of approved amount
Foreign Hospital and Medical Care - When not covered by Medicare	Medically necessary emergency services during first 60 days of each trip outside of USA	Nothing	Nothing
Life Benefit	$1,500	Nothing	$1,500 (Retired member Only)
Prescription Drugs	Prescription Drugs	Nothing	Retirees are issued a prescription drug card. (See pages 11-12)

* Subject to change under each Medicare adjustment
** 60 reserve days may be used only once.
Note: $100 Major Medical Deductible/ per calendar year (January - December)
*** Prescription drug coverage under the Plan for any retiree, otherwise eligible for benefits, shall terminate if the retiree elects prescription drug coverage under Medicare Part D. The effective date of the termination of the Plan's prescription drug benefits shall be the day before the retiree's Medicare Part D coverage commences.

RULES OF ELIGIBILITY FOR ACTIVE PARTICIPANTS' COVERAGE

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

Initial Eligibility

A Participant shall become eligible to receive benefits on the first day of the month following the month in which employer contributions on his behalf total at least 480 hours, provided the hours have been worked within six consecutive months. Once you meet this requirement, you will also be eligible for benefits the second month following the month in which you accumulated 480 hours.

Newly Organized Participants

In the case of a "newly-organized Participant," the Plan's "Rules of Eligibility for Participants' Coverage" are modified to permit Participants to make self-payments before the normal period of "initial eligibility." A "newly-organized Participant" is a Participant in a collective bargaining unit represented by the Union who has been certified as "newly-organized" by the Union in writing to the Fund. Upon receipt of that notice, the Fund shall notify the newly-organized Participant of the right to obtain coverage by making self-contributions in amounts determined by the Trustees.

The self-contributions will be funded by applying employer contributions made on the Participant's behalf for hours worked in excess of 160 in a month or, if the Participant works 160 hours or less in any month, by the Fund. However, if the Participant works less than 130 hours in any month, the Participant shall pay the difference between the self-contribution premium and the amount of the Employer contributions made on the Participant's behalf in that month.

Coverage includes all Plan benefits except "Loss of Time" benefits. Coverage begins on the Participant's entry into the bargaining unit and may continue for up to nine (9) consecutive months, or until the Participant meets the "initial eligibility" requirements, whichever occurs sooner. Each month's contribution provides one month of coverage.

A Participant's failure to make a timely self-contribution for any month after electing this coverage will result in termination of coverage, with no option to resume this special eligibility. Participants may be considered "newly-organized" only once in their lifetime.

Pre-Existing Conditions Limitation (Newly Organized Participants only)

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

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

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

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

Certificate of Creditable Coverage (For All Participants)

This Plan and an individual's prior plan must supply a participant with certification of coverage at the time coverage ceases. Any participant may also request a certificate, free of

charge, from the Plan Administrator until twenty-four (24) months after the time your coverage ended. For example, you may request a certificate even before the coverage ends. The certification must specify the period of creditable coverage.

If you do not receive a certificate by the time you should have received it or by the time you need it, your first step should be to contact the Plan Administrator of the prior plan responsible for providing the certificate and request one. If any part of your credible coverage was through an insurance company, you can also contact the insurance company for a certificate that reflects that part of your credible coverage as long as you make the request within twenty-four (24) months of your coverage ceasing under the insurance policy.

In any event, if you do not receive a certificate, you may demonstrate to the Plan that you have credible coverage (as well as the time you were in any waiting period) by producing documentation or other evidence of credible coverage (such as pay stubs that reflect the deduction for health insurance, explanation of benefit forms (EOBs) or verification by a doctor or your former health care benefits provider that you had prior health insurance coverage.

Once you obtain a certificate, keep it in case you may later need it. You will need the certificate if you leave your health plan and enroll in a subsequent plan that applies a pre-existing condition exclusion, or if you purchase an individual insurance policy from an insurance company.

Continuation of Eligibility

A Participant will remain eligible to receive benefits provided employer contributions are received with a minimum of 130 hours per calendar month.

Hours of employment will be used to determine eligibility during the second month following the month in which the hours were worked.

Self Contributions

Participants having accumulated less than the minimum required number of hours for continuation of eligibility, may make self-contributions at a rate determined by the Trustees for the number of hours needed to meet the minimum eligibility requirements.

A Participant who is totally unemployed during an eligible accumulation period may continue to maintain his eligibility by paying the premium established by the Board of Trustees for a maximum of 12 consecutive months. Each such payment is subject to review and any changes as the Trustees deem necessary. To be eligible for this benefit, an eligible participant must have worked a minimum of 1200 hours within the immediate preceding 12 month period. A participant who has exhausted the 12 month maximum self-pay allowance will be eligible to participate under COBRA (see page 31).

Participants will be notified of the amount of self-contribution necessary to maintain eligibility. Failure to make a self-contribution by the due date will result in termination. Terminated Participants will have to meet the requirements of Initial Eligibility to become eligible again.

A participant in Plumbers & Pipefitters Local 396 Health and Welfare Fund, who has lost his eligibility for benefits from the fund due to work assignment in the territorial jurisdiction of a sister union, and who has acquired eligibility for benefits provided by the sister local's health & welfare fund may, upon termination of coverage by such fund, regain eligibility in Local Union 396 Welfare Fund beginning with the month in which eligibility in the sister local's welfare fund terminates by paying in advance the amount required by the collective bargaining agreement for a month's coverage; provided, however, that in no event shall any participant be permitted under this rule to regain eligibility while eligible for benefits in a sister union's fund.

Self Employed

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

Sick Credit

An eligible Participant will be credited with two hours per day for a period not to exceed 26 weeks for the purpose of maintaining eligibility while drawing weekly indemnity benefits from this fund or weekly compensation from the Industrial Commission.

Hour Bank

For the purpose of helping Participants maintain eligibility, hours credited to Participants accounts in excess of 160 hours per month during the previous 12 consecutive month period will automatically be applied to reduce the amount of self-contribution required to maintain eligibility.

Reciprocal Agreements

In order to extend to those Participants who are required from time to time to work outside the jurisdiction of this Fund, Reciprocal Agreements have been executed with many of the Welfare Funds in adjacent areas. These Reciprocal Agreements provide for the transfer to this Fund of contributions earned by those Participants who were temporarily working under the jurisdiction of such other Welfare Funds.

Before leaving the jurisdiction area of this Fund, check with the Fund Office to make certain that this Fund has a Reciprocal Agreement in effect with the Welfare Fund in the area where you will be working.

If there is no Reciprocal Agreement in effect, you may be able to regain your coverage by making a self-payment. See Rules of Eligibility; Self Contribution.

Disqualifying Employment

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

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

The participant may appeal this termination of coverage under the Plan's claims appeal procedure. A participant whose coverage has been terminated under these Plan provisions may resume his coverage by once again meeting the Plan's initial eligibility rules, but benefits previously forfeited under these termination provisions will not then be reinstated.

RULES OF ELIGIBILITY FOR DEPENDENT'S COVERAGE

A Participant is eligible for Dependent's coverage on the day he becomes eligible for Participant coverage or on the day he acquires his first eligible dependent, whichever is later.

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

Special Enrollment Rules

If you are eligible for coverage and you acquire a Spouse by marriage or acquire any Dependent Children by birth, adoption or placement for adoption, you may enroll your newly acquired Spouse and/or any Dependent Child no later than thirty-one (31) days after the date of marriage, birth, adoption or placement for adoption. Enrollment forms inserted at the end of this booklet. They can also be obtained from the Fund Office.

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

- Your coverage, your Spouse's coverage, and/or the coverage of any of your other Dependent Child(ren), except with respect to coverage of a newborn or newly adopted Dependent Child, will become effective on the date of the event that created the special enrollment opportunity.
- Coverage of a newborn who is enrolled within thirty-one (31) days after birth will become effective as of the date of the child's birth.
- Coverage of a newly adopted Dependent Child who is enrolled within thirty-one (31) days after birth will become effective as of the date of the child's adoption or placement for adoption, whichever occurs first.

If you do not enroll your Spouse for coverage within thirty-one (31) days of the date on which he or she became eligible for coverage, and if you subsequently acquire a Dependent Child by birth, adoption or placement for adoption, you may enroll your Spouse together with your newly acquired Dependent Child no later than thirty-one (31) days after the date of your newly acquired Dependent Child's birth, or placement for adoption. If you decide to enroll other Dependent Children other than the newly born or adopted child under this provision, your coverage for the other Dependent Children will not commence until all of the proper enrollment forms are completed and claims will not be paid retroactively to the date of their initial eligibility.

If your Spouse and Dependent Child(ren) did not enroll for coverage within the thirty-one (31) days after the date of their initial eligibility because they had other health care coverage under any other health insurance policy or program or employer plan, including COBRA Continuation coverage, individual insurance, Medicare, Medicaid or other public program, and your Spouse and/or Dependent Child(ren) cease to be covered under that other health insurance policy or plan, you may enroll your Spouse and/or Dependent Child(ren) within the thirty-one (31) days after the termination of their coverage under that other health care policy or plan. This applies only if the other coverage terminated because:

- Of loss of eligibility for that other coverage as a result of termination of employment or reduction in the number of hours of employment, or death, divorce or legal separation; or

- Of the termination of employer contributions toward that other coverage; or
- If that other coverage was COBRA Continuation Coverage, the coverage was exhausted.

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

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

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

Termination of Dependent's Coverage

A Participant will cease to be eligible for dependents' coverage on the earlier of the following dates:

1. the date the Participant's coverage for himself terminates;
2. the date the Participant ceases to be in a class of Participants eligible for dependents' coverage;
3. the date dependents' coverage is discontinued;
4. the date the dependent ceases to qualify as a dependent.

Coverage for a Surviving Spouse and/or Surviving Dependent

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

1. Your 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. Your spouse becomes covered by another group program, excluding Medicare, or
3. Your spouse remarries.

Provided your spouse makes application to continue coverage through the Surviving Spouse Program to the Fund Office within sixty (60) days of the Participant's death and pays timely monthly contributions to the Fund Office in the amount and at the time established by the Board of Trustees.

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

RULES OF ELIGIBILITY FOR EARLY RETIRED AND PERMANENTLY DISABLED PARTICIPANTS AND DEPENDENTS

Participants who retire early, i.e., prior to attainment of their 65th birthday, may elect to continue the active Participant program for which they were last eligible exclusively of the weekly indemnity benefit and accidental death and dismemberment benefits until they attain age 65, by paying the required monthly premium. He (She) may also continue the coverage of their spouse by paying the specified additional monthly premium. The monthly premiums are announced from time to time by the Board of Trustees and are always subject to review. The current rates can be obtained upon written request from the Board of Trustees.

Early Retirees must also meet the following criteria:

- you had at least 24 consecutive months of eligible participation in this Welfare Plan immediately before you retired; and
- you are retired from Covered Employment in the trade; and
- you are receiving retirement or Total and Permanent Disability benefits from a qualified pension or corporate retirement plan and/or are receiving disability or retirement benefits under the Social Security Act.

If you are totally and permanently disabled, you are able to continue eligibility under the Disability Retiree Program for you and your dependents through timely self-payments if:

- you were an active, eligible Participant in the Plan for a total of 24 months immediately preceding your disability; and
- you have received your Social Security Disability award.

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

Eligibility for Surviving Spouse

The Surviving Spouse of an Early Retiree and Permanently Disabled Participant Eligible hereunder at death shall terminate at the end of the Eligibility month in which the Retiree had last obtained eligibility. The Surviving Spouse may continue coverage by making required self-payments so long as such coverage is elected within 60 days following the Participant's or Retiree's death.

RULES OF ELIGIBILITY FOR MEDICARE-ENTITLED RETIREES AND ELIGIBLE DEPENDENTS (Age 65)

Eligibility for Normal Retirees

If you are a Normal Retiree, you are able to continue your eligibility through timely self-payments if:

- you had at least 24 consecutive months eligible participation in this Welfare Plan immediately before you retired; and
- you are at least 65 years of age; and
- you are retired from Covered Employment in the trade; and
- you are receiving retirement or Total and Permanent Disability benefits from a qualified pension and/or are receiving disability or retirement benefits under the Social Security Act.

You must notify the Fund Office in writing that you want to maintain your eligibility through the Normal Retirement Program within 31 days of the last month in which you were covered as an active Participant or Early or Disabled Retiree. You will be notified by the Fund Office of the amount due. Self-payments must be made from the date coverage was lost, and will be counted toward any required COBRA continuation coverage. If you fail to make a self-payment, you lose your coverage and it cannot be reinstated.

Coverage for the Normal Retiree's Eligible Dependents may be continued for the same periods, as set forth above, upon timely self-payment.

Eligibility for Surviving Spouse

The Surviving Spouse of a Normal Retiree or Participant Eligible hereunder at death shall terminate at the end of the Eligibility month in which the Retiree had last obtained eligibility. The Surviving Spouse may continue coverage by making required self-payments so long as such coverage is elected within 60 days following the Retiree's death.

EXPLANATION OF MEDICAL BENEFITS

As a participant in this Plan, you and your family are entitled to certain benefits for Hospitalization, Physicians Services, and Other Benefits, as described more specifically below. All of these benefits are subject to the following limitations:

Each calendar year, you must pay the first $300 of covered charges for yourself and the first $600 of covered charges for your family. These amounts are called the "deductible" portion of your coverage. You will be responsible for separate deductibles for in-network and out-of-network providers. Covered expenses incurred during the last three months of a calendar year, which were used to satisfy the deductibles, in full or in part, will be used to reduce the deductible for the following year.

After you have satisfied the deductible portion, for In-Network services the Plan will pay 80% of the next $7,500 in covered charges for you and your dependent and 100% thereafter. For Out-of-Network services the Plan will pay 70% of the next $7,500 for you and your family in covered charges and 100% thereafter.

The Plumbers & Pipefitters Local Union No. 396 Health & Welfare Fund has entered into an agreement with various organizations which are preferred provider organizations (PPO) to obtain discounts from hospitals and physicians. A copy of the PPO Network Directory is available on line at www.supermednetwork.com or by calling the Fund Office at 1-800-435-2388. When you and your Dependents use a Network Provider, the provider is required to charge a discounted rate. The Providers and Physicians which are part of the Network sign contracts with the PPO. These providers and physicians also have the ability to terminate or refuse to sign new contracts. In order to be assured of the current status of your Provider or Physician in the Network, you should contact the PPO directly and inquire. Additionally, please be aware that even though a hospital is contracting with your PPO, each Provider and Physician who works with or in the hospital is not automatically part of the Network. You need to check on each Provider and Physician you use in order to be assured that they are part of the PPO.

MEDICAL EXPENSE BENEFITS

Hospital Expenses

For each day of confinement, you will be paid, subject to the current deductible and co-insurance amounts, the hospital's actual charge for room and board if you are confined in a semi-private or ward accommodations. If you are confined in private room accommodations, you will be paid the hospital's most common rate for semi-private accommodations.

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 is admitted to the hospital for maternity services, your hospital stay cannot be restricted to less than forty-eight (48) hours (ninety-six hours 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.

This Plan does not cover expenses incurred due to the pregnancy of a Dependent Child of any Participant.

Medical Emergency Care Expense Benefit

This benefit covers treatment you or your Eligible Dependents receive in an emergency room of a hospital due to a sudden and acute onset of an accidental injury, ailment, disease, disorder or illness, when services are rendered within seventy-two (72) hours of the incident. The condition is such that in the absence of immediate and ongoing medical attention, it would reasonably result in:

1. Permanently placing you or your Eligible Dependents' health in jeopardy;
2. Serious impairment to bodily functions;
3. Serious and permanent dysfunction of any body organ or part; or
4. Other serious medical consequences.

This benefit is processed as in-network claim regardless of the providers network status.

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.

Sterilization Benefit

The Plan will now provide each eligible participant for himself or herself and spouse a benefit payment subject to a co-payment of fifty percent (50%) of the cost of any sterilization up to a maximum payment of $750.00. Reverse sterilizations are not covered and remain general exclusions under this plan. This coverage is not provided for dependents other than the spouse.

Outpatient Laboratory Diagnostic and X-Ray Services

The following services are covered by the Plan at the level provided in the Summary 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.

Anesthesia Benefit

Anesthesia is administered to allow medical procedures (usually surgery) to be performed without the patient experiencing too much discomfort. This service 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 Summary of Benefits.

Physician and Nursing Charges: Charges for a Physician, Surgeon, or Clinical Psychologist rendering professional services are covered for medically necessary problems.

Chiropractic Benefits: The chiropractic expense benefit covers all services provided or supervised by a chiropractor. The Plan pays 80% of all usual, reasonable, and customary charges. However, any chiropractic treatments are subject to review for medical necessity after twenty-six (26) treatments. Any treatments which are determined to not be medically necessary will not be paid by the Plan.

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

A. It can stand repeated use;
B. It is used to serve a medical purpose rather than being primarily for comfort or convenience;
C. It is not useful to a person in the absence of illness or injury;
D. It is appropriate for home use;
E. It is certified in writing by a physician as being medically necessary;
F. It is related to the patient's physical disorder;
G. The anticipated length of time the equipment will be required for therapeutic use must be certified in writing; AND
H. It is for the exclusive use of the covered person for whom the physician has certified that it is medically necessary.

Immunizations: Immunizations will also be covered based upon physician recommendation as the AAP schedule for immunizations varies based on the latest medical findings or research.

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 the transportation using ground facilities would not have been appropriate due to the life threatening and emergency nature of the accident or illness.

MENTAL AND NERVOUS DISORDERS TREATMENT

If you are admitted as an inpatient for a prescribed course of treatment for mental and/or nervous disorder to a hospital or to an approved Rehabilitative Facility such treatment will be subject to the following limitations:

Inpatient treatment ----------30 day lifetime maximum subject to annual deductible and Plan co-payment

Outpatient treatment

Calendar year maximum-----20 visits annual maximum subject to the annual deductible and co-payment

The following services provided by or under the direct supervision of a physician or a licensed psychologist are covered:

Individual, group, and family psychotherapeutic counseling, electro-shock treatment, psychological testing and psychiatric consultation for treatment of mental disorders.

Individual, group, and family counseling. The attending physician or psychologist must certify the need for treatment after the first three months before additional benefits can be covered.

ALCOHOL AND SUBSTANCE ABUSE TREATMENT

If you are admitted to a drug and alcoholism treatment facilities, charges for rooms with two or more beds, board, general nursing care, and other services, and supplies are covered.

If you are admitted as an inpatient for a prescribed course of treatment for alcoholism or drug abuse dependency to a hospital or to an approved Rehabilitation Facility (including detoxification in an Approved Rehabilitation Facility) such treatment will be subject to the following limitations:

Lifetime maximum----------$15,000
Inpatient treatment
Calendar year maximum----------$10,000, subject to annual deductible and base plan co-payment
Outpatient treatment
Calendar year maximum----------$ 5,000, subject to annual deductible and major medical co-payment

The following services will not be covered: developmental or perceptual therapy, primal therapy, cathectathon therapy, and collaborative therapy.

Ohio law sets certain requirements for a facility or doctor. Be sure to check the status of your doctor or facility before receiving services.

LOSS OF TIME BENEFITS ACTIVE PARTICIPANTS ONLY

Payments will be made at the Weekly Loss of Time rate stated in the Schedule of Benefits when Active Participant is wholly and continuously disabled by an accidental bodily injury occurring off the job, or sickness not connected with employment that prevents him from working at his occupation and which requires the regular care and attendance of a legally qualified physician or surgeon.

Benefits for Active Participants begin with the 1st day of disability due to accidental bodily injury, or the 8th day of disability due to a sickness, and will continue up to the maximum number of weeks stated in the Schedule of Benefits for any one period of disability.

Successive periods of disability due to the same or related causes not separated by return to active employment for a period of two (2) full weeks shall be considered one period of disability.

Note: To receive a weekly loss of time benefit, you must not be receiving wages from any employer or collecting any state workers' compensation or unemployment benefits. You must also be covered under the Plan when you became injured, ill, or unable to work due to pregnancy.

DEATH BENEFITS
Active Participants Only

Upon proof of the death of any Active Participant, the Fund will pay, subject to the provisions of the Plan, the Death Benefits specified in the Schedule of Benefits.

Beneficiary

Each covered Participant shall designate a beneficiary, which designation shall be filed with the Fund. If, at the death of the Active Participant, there be no surviving designated beneficiary as to all or part of the death benefits payable, such death benefits shall be paid, at the option of the Fund, to any one of the following surviving relatives of the Active Participant: spouse, child or children, mother, father, brother or sister, or to the estate of the Active Participant. Payment to any of the above named shall, to the extent thereof, release the Fund from all liability.

The Active Participant may change the beneficiary from time to time by filing a written notice of such change through the Trustees, such change of beneficiary shall relate back and take effect as of the date the Active Participant signed the notice, whether or not the Active Participant is living on the date of the filing, but without prejudice to the Fund on account of any payment made before such notice is filed.

Extended Coverage

If an Active Participant before attaining age 60 becomes totally disabled from bodily injury or disease so as to be wholly prevented from performing any work or engaging in any occupation for remuneration or profit, and if he dies within one year after termination of the earned benefit period, and while remaining continuously so disabled, the Fund will pay the amount of the Active Participant's benefits as determined by the Schedule of Benefits.

If an Active Participant has become totally disabled and then, not later than one year after furnishes written proof satisfactory to the Fund that such total disability has continued, his coverage for benefits will be extended during continuance of such total disability.

Total and permanent disability will be acknowledged and recognized to exist if the Active Participant has suffered the entire and irrecoverable loss of both eyes, severance of both hands, above the wrist and one foot above the ankle.

If an Active Participant has furnished proof of total disability, but becomes able to again perform some work or to engage in some occupation for remuneration or profit, or if he refuses to be examined as required or fails to furnish proof of total disability within the time required, all coverage on the Active Participant shall terminate immediately.

The Fund shall have the right at any time during total disability to require proof of existence and continuance of such disability, and to make examination of the Active Participant, by a Fund appointed examiner, but not more than once a year after the benefit coverage has been extended for two years.

Notice of Claims

No payment shall be made on account of the death of any Active Participant under this provision, unless written notice of death is received by the Fund within 12 months after the date of death.

Accidental Death and Dismemberment Benefits

Active Participants Only

When a bodily injury caused solely by an accident occurring while benefit coverage is in force shall directly and independently of all other causes result in any of the following losses within

ninety days after the accident, the Fund will pay for the loss based on the Principal Sum stated in the Schedule of Benefits in addition to any other benefits amounts as follows:

The Principal Sum for Loss of Life

The Principal Sum for Loss of:

(1) both hands; (2) both feet; (3) both eyes; (4) any two such members.

One-half the Principal Sum for Loss of:

(1) one hand; (2) one foot; (3) one eye.

"Loss" as used in this section with reference to hand or foot means complete severance through or above the wrist or ankle joint and with reference to eye means the irrecoverable loss of the entire sight of the eye.

If more than one specific loss results from one accident, the amount provided for the greatest loss sustained will be paid.

These benefits are payable whether injury is on or off the job.

Payments will be made directly to the Covered Participant if living, otherwise to his beneficiary. The Covered Participant may change the beneficiary at any time by completing the proper form.

PRESCRIPTION DRUG BENEFITS

Envision Rx Options

A Prescription Administrator has contracted with the Plumbers & Pipefitters to provide an efficient and cost-effective program that will be easy for participants and dependents to use when purchasing prescriptions at a Network Pharmacy. A listing of the major participating pharmacies may be obtained from the Fund Office or contact the Help Desk at 1-800-361-4542 to determine if a pharmacy participates.

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

The Plan utilizes a formulary which can help your physician prescribe medications to resolve medical needs while limiting the financial impact to both the participant and the Plan. The formulary recommends that physicians prescribe proven and effective, but often less-expensive alternatives, whenever practical. Envision Rx Options determines where drugs fall on their formulary based on many factors, but mainly the determinations are made on safety and efficacy of the medications.

The formulary divides drugs into three categories or "tiers." "Tier One" drugs include most generic drugs. "Tier Two" drugs include preferred brand name drugs. Tier Two medications are the preferred medications for physicians to prescribe. "Tier Three" drugs are considered "non-preferred" drugs and will typically result in a higher copay.

The copay structure is based on which tier the medication falls into. For Tier One drugs the copay will be $10 at retail and $20 at mail order, for Tier Two drugs the copay will be the maximum of $15 or 20% at retail and the maximum of $30 or 20% at mail order, and Tier Three Drugs will be the maximum of $30 or 40% at retail and the maximum of $60 or 40% at mail order. In addition, members who elect to receive brand medications when a generic equivalent is available will be charged the difference between the cost of the generic and the brand drug in addition to the brand co-payment. For a complete formulary list please log into www.envisionrx.com or contact the Envision help desk at 1-800-361-4542.

All participants who use maintenance medication are encouraged to use the mail order program. The savings will benefit both participant and the Fund since co-payments for a 90-day supply is the same as a retail prescription.

The formulary no longer covers the brand products Aciphex, Prevacid, Nexium and Protonix **unless** you have previously tried and failed Prilosec OTC or Omeprazole as a prescription benefit. You must have been on Prilosec OTC or Omeprazole by your physician writing a prescription for it and have had that prescription processed at your pharmacy by using your pharmacy prescription card. If you have tried and failed Prilosec OTC or Omeprazole, and you require one of these drugs, you will then pay the applicable tier copay for the branded drugs if your prescription history with Envision shows that you have utilized Prilosec OTC or Omeprazole as a prescription benefit in the past. You will need to have your doctor write a prescription specifically for Prilosec OTC and present this prescription to your pharmacist so you may obtain supplies through your Envision/Rx Options pharmacy plan for a $5.00 copay. You are not required to change medications but if you continue to use Nexium, Aciphex, Prevacid or Protonix without first utilizing Prilosec OTC or Omeprazole you will be required to pay 100% of the cost of these drugs.

Mail Order Program

The Mail Order Program was designed to allow members to receive large quantities of maintenance medication (e.g. heart medication, blood pressure medication, diabetic medication, etc.). You can obtain a 90 day supply of your prescription with refills permitted as prescribed by the physician.

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

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

GENERAL EXCLUSIONS

All Medical Expenses Are Subject to the Usual, Customary, and Reasonable Charge

Benefits are not provided for services, supplies or charges:

1. Which are not prescribed by or under the direction of a Physician or Professional Provider.
2. Which are not performed within the scope of the Provider's license.
3. Received from other than a Provider.
4. Which are Experimental/Investigative.
5. Which are not Medically Necessary, as determined by **the Plan.**
6. To the extent governmental units or their agencies provide benefits.
7. For an injury, ailment, condition, disease, disorder or illness that occurs as a result of any act of war, or during the commission of a felony by the Covered Participant.
8. For which you have no legal obligation to pay in the absence of this or like coverage.
9. 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.
10. Received from a member of your Immediate Family.
11. Which are received in a military facility for a military service related injury, ailment, condition, disease, disorder or illness.
12. For Surgery and other services only to improve appearance but not to restore body function or correct deformity which was caused by disease, trauma, birth defects, growth defects or prior therapeutic processes.
13. Primarily for educational, vocational or training purposes.
14. For the treatment of obesity, including dietary supplements, vitamins and any care which is primarily dieting or exercise for weight loss.
15. For marital counseling
16. For transsexual surgery or any treatment leading to or in connection with transsexual surgery.
17. For birth control devices.
18. Any charges relating to infertility.
19. For the treatment of sexual problems not caused by organic disease.
20. For reverse sterilization.
21. For or related to the treatment of temporal mandibular joint syndrome with intraoral prosthetic devices or by any other method to alter vertical dimension; for the treatment of temporal mandibular joint dysfunction not caused by documented organic disease or physical trauma.
22. For personal hygiene and convenience items.
23. For hypnosis and acupuncture.
24. For telephone consultations, missed appointments or completion of a claim form.
25. For fraudulent or misrepresented claims.
26. For expenses of care for conditions that State or local law require be treated in a public facility.
27. For topical anesthetics or stand-by anesthesia.
28. For penile implants or any treatment leading to or in connection with penile implants for a condition not caused by a physiological disorder.
29. Evaluation and treatment of sleep disorders centers (unless determined to be medically necessary which will then be limited to one treatment per year).
30. Any loss sustained or contracted as a result of an Eligible Participant or Eligible Dependent being under the influence of any narcotic or other drug or as a consequence of the use thereof, unless administered upon the advice of a legally qualified Physician.

31. Charges related to massotherapy.
32. Exercise equipment.
33. Air conditioners, purifiers, humidifiers, dehumidifiers, whirlpools, hypo-allergenic pillows/mattresses or waterbeds.
34. Milieu therapy.
35. Chelation therapy.
36. Loss caused by (a) accidental bodily injury which arises out of or occurs in the course of any occupation or employment for wage or profit, or (b) sickness for which the Covered Participant is entitled to benefits under any Workman's Compensation or Occupational Disease Law, unless specifically provided for in the Schedule of Benefits.
37. Care rendered within any facility of, or provided by, the United States Veterans' Administration.
38. Loss caused by war or any act of war (declared or undeclared) or military or naval service of any country.
39. Expenses for or in connection with hearing aids
40. Expenses for or in connection with cosmetic surgery, except cosmetic surgery which is not primarily for beautification but is performed to correct or improve a bodily function or congenital malformation, or as provided for under the Women's Health and Cancer Rights Act (see page 17).
41. Expenses for travel or transportation except ambulance charges as specified under the Major Medical Expenses Benefit.
42. Charges for services furnished by an institution which is primarily a rest home, a home for the aged, a nursing home, a convalescent home, or any institution of like character providing custodial care.
43. Treatment on or to the teeth; treatment of gingival tissues (gums) others than for tumors; physician's services for extraction of teeth; non-surgical treatment of dental abscesses.
44. Charges for services of a dentist except for the treatment necessary to alleviate the damage to sound natural teeth or to extract broken and injured teeth, as a result of an accidental bodily injury including the replacement of such teeth in whole or in part.
45. Charges for services of a dentist except for the surgical removal of impacted (whole or partially) wisdom teeth including anesthesia.
46. Charges for dental X-rays, except when performed in connection with an accidental bodily injury.
47. Routine physical examinations. Elective procedures and well person care except for elective sterilization for participant or spouse co-pay of 50% to a maximum of $750.00.
48. Medical treatment received in connection with a pregnancy by dependent children.
49. Any expenses when a participant is not eligible for benefits.

Limitations on Covered Expenses -
Benefits are not payable:
1. For any charges for room and board which are in excess of the hospital's most common rate for semi-private accommodations.
2. For any charges made by a special care facility which are in excess of $25.00 for any one day or $1,000 in a calendar year.
3. For any cosmetic surgery, unless the result of an accident or as provided for under the Women's Health and Cancer Rights Act.
4. For eyeglasses, and examinations for prescription for fitting of eyeglasses (subject to the Schedule of Benefits as reviewed annually by the Trustees).

5. Charges for services of a dentist except for the treatment necessary to alleviate the damage to sound natural teeth or to extract broken or injured teeth, as a result of an accidental bodily injury including the replacement of such teeth in whole or in part. The services must commence within one (1) year of injury.

GENERAL PROVISIONS

In the event that it shall be found that any Covered Participant to whom a benefit is payable is unable to care for his affairs because of illness or accident, any payment due (unless prior claim therefor shall have been made by a dully qualified guardian or other legal representative) may be paid to the spouse, children, parents, brothers and sisters, nephews and nieces or other person deemed by the Trustees to have incurred expense for such Covered Participant otherwise entitled to such payment. Any such payment shall be a payment for the account of the Covered Participant and shall be a complete discharge of any liability of the Plan and Fund thereof.

The Fund, through its physician, shall have the right and opportunity to examine the person whose injury or sickness is the basis of claim when and so often as it may reasonably require during pendency of claim hereunder.

If any time limitation of the Plan with respect to giving notice filing proof of loss or commencing an action at law or in equity is less than that permitted by the law of the state in which the Covered Person resides at the time the Plan is in effect such limitation is hereby extended to agree with the minimum period permitted by such law.

Consent of the Covered Participant's beneficiary, if any, shall not be requisite to any change of beneficiary or to any other changes in the Plan.

The Covered Persons shall have the sole right to select their own physician, surgeon and hospital and a physician-patient relationship shall be maintained.

Women's Health and Cancer Rights of 1998

Under federal law, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. This covers reconstruction of the breast on which the mastectomy was performed, surgery on the other breast to produce a symmetrical appearance, and prosthesis and physical complications of all stages of mastectomy, including lymphedemas, as a result of consultation with a physician.

Under this Plan, these federally mandated benefits are covered. Please review the Surgical Services Section (base plan benefits) of this summary plan description for applicable plan provisions that affect the amount of the benefit and your financial responsibility for these services. This coverage is subject to the Plan's annual deductible and coinsurance provisions.

Common Accident and Multiple Birth

If A Participant and one or more of his dependents, or if two or more of A Participant's dependents receive injuries in the same accident and, as a result of those injuries, incur covered expenses during the same calendar year in which the accident occurs, only one Deductible Amount will be deducted from the total covered expenses incurred for those individuals during the remainder of that calender year.

If A Participant acquires two or more children as a result of a multiple birth and if, during the same calendar year in which the birth occurs, the Participant incurs covered expenses for those children as a result of premature birth, abnormal congenital condition, or sickness commencing or injury received not more than 30 days after birth, only one Deductible Amount will be deducted from the total covered expenses incurred for those children during that calendar year.

In no event will the provisions of the preceding two paragraphs be applied if, as a result, a lesser amount should become payable than would otherwise have become payable.

Coordination of Benefits (COB)

All benefit provisions of the plan are subject to this provision. Quite frequently, because husband and wife are working, members of a family are covered under more than one (1) group plan of Participant benefits. Thus, in some instances, benefits are received under two (2) group plans in a total amount greater than the Medical Expense actually incurred.

To avoid duplication of benefits for Allowable Expenses, the benefits paid under the Group Plan shall be reduced so that the total benefits under all plans shall not exceed the Allowable Expense incurred during any calendar year.

"Allowable Expenses" means any necessary, reasonable and customary item of expense for medical care or treatment covered under at least one (1) of such plans covering the individual for whom a claim is made.

The group health benefits will be coordinated with any other plan providing benefits or services for Allowable Expenses. If another Plan, covering an individual insured under this Group Plan, does not have a coordination of benefits payable for Allowable Expenses under the other plan will be paid in full before any benefits are paid under this Group Plan.

Where both group plans contain a coordination of benefits provision, our Plan will pay first(1st) or second(2nd) based on the following rules:

1. A plan covering a person as A Participant will pay benefits first(1st). A plan covering a person as a dependent will pay second(2nd).

2. If a dependent child is covered by both parents' plans, the benefits of the plan which covers the child of the parent whose date of birth, excluding year of birth, occurs earlier in a calendar year will be determined first(1st). The benefits of the plan which covers the child of parent whose date of birth, excluding year of birth, occurs later in a calendar year will be determined second(2nd).

If this plan is coordinating with a plan which contains the gender-based rule and, as a result, the plans do not agree on the order of benefits, the gender-based rule will determine the order.

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

(a) The Plan of the parent with custody pays first(1st).The Plan of the parent without custody pays second(2nd).

(b) If the parent with custody has remarried, the order is:

(i) The plan of the parent with custody;

(ii) The plan of the step-parent;

(iii) The plan of the parent without custody.

If there is a court decree which states that one(1) of the parents is responsible for the child's health care expenses, the plan of that parent will pay first(1st). That order will supercede any order given in (a) or (b).

4. If a person is covered under more than one(1) plan, the plan he or she was covered under longer pays first(1st). The exceptions to the rule is:

A group plan that covers a person other than as a laid-off or retired Participant, or dependent of such person, will determine the benefits that are paid first(1st). A group plan that covers a person as a laid-off or retired Participant, or dependent of such person, will determine the benefits that are paid second(2nd).

Subrogation and Recoupment

This Plan will use its right of Subrogation and Recoupment if you or your Dependent are paid benefits under this Plan for expenses due to injuries or illnesses which arise out of the acts or omissions of any person or entity or which arise under any no-fault coverage (for the purpose of this provision, collectively referred to as "Other Coverage"). The term "Covered Person" as used

hereinafter shall include the employee, participant, or any eligible dependent as defined elsewhere in the Plan.

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

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

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

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

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

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

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

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

1. How the injury or illness occurred.
2. The identity of any potentially responsible third parties, including their insurer, adjuster, and claim numbers.
3. Accident reports.
4. An assignment of your beneficial interest in any monetary recovery as a result of such injury or illness, to the extent of the Plan's subrogated interest.

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

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

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

The Plan may recover mistaken payments in any other lawful manner, as well.

CLAIMS SETTLEMENT/APPEALS PROCEDURE

REVIEW PROCEDURE FOR MEDICAL, DENTAL, VISION, PRESCRIPTION, LOSS OF TIME, DEATH AND ACCIDENTAL DEATH AND DISMEMBERMENT CLAIMS

You or your authorized representative may appeal the decision by the Fund's Administrative Office to deny any claim for medical, dental, vision, loss of time, death or accidental death and dismemberment benefits in whole or part. 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. Additionally, any point of service purchase of prescription benefits which is not covered at the pharmacy can be appealed through this Review Procedure.

FILING OF CLAIMS

- Claims must be filed within one year from the date of service.
- Secure a claim form from the Administrative Office.
- Fill out your portion of the claim form.
- Have your doctor complete his part of the form.
- Mail the completed claim form, together with all itemized bills, including hospital bills to the Administrative Office.
- Mail any further bills or statements for medical or hospital services to the Administrative Office as soon as you receive them.
- You may have your benefits assigned to the hospital or to the doctor. If you elect this method of payment, your claim benefits will be paid directly to the hospital or your doctor.

First Level Review

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

Administrative Manager
Plumbers and Pipefitters Local Union No. 396 Health and Welfare Fund
33 Fitch Blvd
Austintown, OH 44515

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

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

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

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

- The specific reason for the denial;

- The sections 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.

The decision of the Administrative Manager is final and binding unless it is appealed to the Benefits Committee under the procedures provided below for Second Level Reviews.

Second Level Review

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

Benefits Committee
Plumbers and Pipefitters Local Union No. 396 Health and Welfare Fund
33 Fitch Blvd
Austintown, OH 44515

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

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

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

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

- The specific reason for the denial;
- The sections 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;
- A notice of your right to file a voluntary appeal to the Board of Trustees as outlined below; 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.

Voluntary Appeal to the Board of Trustees

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

The Appeal should be addressed as follows:

Board of Trustees
Plumbers and Pipefitters Local Union No. 396 Health and Welfare Fund
33 Fitch Blvd
Austintown, OH 44515

The Board of Trustees will review the appeal at their next regularly scheduled 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;

1. 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;
2. The Fund requires that the voluntary level of appeal is available only after the Claimant has pursued the required appeal(s);
3. You, upon request, shall be provided sufficient information relating to the voluntary level of appeal to enable you to make an informed decision about whether to submit a benefit dispute to this procedure including:
   - A statement that using this procedure will have no effect on your right to receive other benefits under this Fund;
   - A statement that you have the right to have a personal representative with regard to your claim;
   - A notice of any circumstances which may impair the impartiality of the Board of Trustees;
5. The Fund will not impose any fees or costs on you as part of this voluntary appeal process.

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

- The specific reason for the denial;
- The sections of the Plan and/or Summary Plan Description upon which the denial was based;
- 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).

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

Introduction

This notice contains important information about your rights to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

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

What is COBRA Continuation Coverage?

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

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

(1) Yours 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 or her gross misconduct;

(4) The parent-employee becomes entitled to Medicare benefits (under Part A, Part B or both);

(5) The parents divorced or legally separated from your spouse; or

(6) The child stops being eligible for coverage under the plan as a "dependent child".

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

When is COBRA coverage available?

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

You Must Give Notice of Some Qualifying Events

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

How is COBRA coverage provided?

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

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

Disability Extension of Eighteen (18) Month Period of Continuation Coverage

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

Second Qualifying Event Extension of Eighteen (18) Month Period of Continuation Coverage

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

If You Have Questions

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

COBRA CONTINUATION COVERAGE ELECTION NOTICE
To be provided to all eligible Participants upon a Qualifying Event

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

This Notice contains important information about your right to continue your health care coverage in the Plumbers and Pipefitters Local Union No. 396 Health and Welfare Fund. Please read the information contained in this notice very carefully.

This Notice provides important information concerning your rights and what you have to do to continue your health care coverage under the Plan. If you have any questions concerning the information in this Notice or your rights to COBRA coverage, you should contact the Office of the Administrative Manager, Compensation Programs of Ohio, Inc., 33 Fitch Boulevard, Austintown, Ohio 44515; (800) 435-2388.

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

- ☐ End of Employment
- ☐ Death of Employee

- ☐ Enrollment in Medicare
- ☐ Reduction in Hours of Employment
- ☐ Divorce or Legal Separation
- ☐ Loss of Dependent Child Status

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

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

If elected, COBRA continuation coverage will begin on _____date_____ and can last until _____date_____

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

COBRA CONTINUATION COVERAGE ELECTION FORM

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

Office of the Administrative Manager
Plumbers & Pipefitters Local Union No. 396 Health & Welfare Fund
c/o Compensation Programs of Ohio, Inc.
33 Fitch Boulevard
Austintown, Ohio 44515
Phone: (800) 435-2388

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

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

I (We) elect to continue our coverage in the Plumbers & Pipefitters Local Union No. 396 Health & Welfare Fund (the Plan) as indicated below:

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

a. _____

Type of Coverage Elected*: _____

b. _____

Type of Coverage Elected*: _____

c. _____

Type of Coverage Elected*: _____

d. _____

Type of Coverage Elected*: _____

_____

Signature Date

_____

Print Name Relationship to Individual(s) listed above

_____

Print Address Telephone Number

*Type of coverage elected:

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

IMPORTANT INFORMATION ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS

What is continuation coverage?

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

Continuation coverage is the same coverage that the Plan gives to other Participants or Beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary

who elects continuation coverage will have the same rights, under the Plan as other participants or beneficiaries covered under the Plan, including special enrollment rights.

How long will continuation coverage last?

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

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

(1) any required premium is not paid in full

(2) a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,

(3) a covered employee becomes entitled to Medicare benefits (under Part A, Part B or both) after electing continuation coverage, or

(4) the employer ceases to provide any group health plan for its employees.

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

How can you extend the length of continuation coverage?

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

Disability

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

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B or both), or a dependent child's

ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Office of the Administrative Manager within 60 days after a second qualifying event occurs.

How can you elect continuation coverage?

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

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

How much does continuation coverage cost?

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

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

When and how must payment for COBRA continuation coverage be made?

First payment for COBRA continuation coverage

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

you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all COBRA continuation coverage rights under the Plan.

You are responsible for making sure that the amount of your payment is correct. You may contact the Office of the Administrative Manager to confirm the correct amount of your first payment. Your first payment for COBRA continuation coverage should be sent to:

Office of The Administrative Manager
Plumbers & Pipefitters Local Union No. 396 Health & Welfare Fund
c/o Compensation Programs of Ohio, Inc.
33 Fitch Boulevard
Austintown, Ohio 44515
Phone: (800) 435-2388

Periodic payments for COBRA continuation coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. The amount due for each coverage period for each qualified beneficiary is shown in this Notice. Under the Plan, these periodic payments for continuation coverage are due on the first day of each month. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods.

Periodic payments for COBRA continuation coverage should be sent to:

Office of the Administrative Manager
Plumbers & Pipefitters Local Union No. 396 Health & Welfare Fund
c/o Compensation Programs of Ohio, Inc.
33 Fitch Boulevard
Austintown, Ohio 44515
Phone: (800) 435-2388

Grace periods for periodic payments

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.

For more information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your

Summary Plan Description or from the Office of the Administrative Manager. If you have any questions concerning the information in this Notice, your rights to coverage, or if you want a copy of your Summary Plan Description, you should contact the Office of the Administrative Manager; Plumbers & Pipefitters Local Union No. 396 Health & Welfare Fund, c/o Compensation Programs of Ohio, Inc., 33 Fitch Boulevard, Austintown, Ohio 44515, (800) 435-2388.

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

Notification and Filings

In the event your coverage is scheduled to be terminated due to failure to work the required number of hours in covered employment, you will be notified as to your right to make a direct payment to continue your Group Health Benefits. **In all other cases, you or a family member are responsible for giving notice to the Plan administrator of any divorce, legal separation, or change in a dependent child's status (attainment of maximum age, change in student classification, etc.) which results in a loss of Group Health Coverage.**

FAMILY AND MEDICAL LEAVE ACT OF 1993

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

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

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

A covered employer must grant an eligible participant up to a total of 12 work weeks of unpaid leave during any 12-month period for on or more of the following reasons:

- ☐ For the birth or placement of a child for adoption or foster care;
- ☐ To care for an immediate family member (spouse, child or parent) with a serious health condition; or
- ☐ To take medical leave when the participant is unable to work because of a serious health condition; or
- ☐ Certain active military duty exigencies.

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

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 Participant earned or was entitled to before using FMLA leave.

Please contact the Fund office if you have any questions regarding your options under the FMLA.

Repayment of Contributions to Employer

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

COVERAGE DURING AND SUBSEQUENT TO SERVICE IN THE UNIFORMED SERVICES

Uniformed Service: "Uniformed Service" means the Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

Service in the Uniformed Services: "Service in the Uniformed Services" means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any duty, and a period for which a person is absent from employment for the purpose of performing funeral honors duty as authorized by Section 12503 of Title 10 or Section 15 of Title 32.

Any eligible employee who becomes absent from his position fo employment by reason of service in the uniformed services shall be entitled to elect continuing coverage for himself and his dependents. This right to elect coverage exists even if the eligible employee will also be covered under a military health plan.

In order to be entitled to continuing coverage, the eligible employee must give advance written or verbal notice of uniformed service to his employer and the Fund Office. This notice will only be excused if the giving of such notice is precluded by military necessity, or if under the circumstances giving notice is deemed otherwise impossible or unreasonable.

Any eligible employee who elects continuing coverage may be required to pay for said coverage as follows:

(a) In the case of an eligible employee who performs service in the uniformed services for less than 31 days, such eligible employee may not be required to pay more than the normal employee contribution rate;

(b) In the case of an eligible employee who performs service in the uniformed services for more than 30 days, such eligible employee may be required to pay not more than 102 percent of the full premium under the Plan.

In the event the eligible employee has a reserve of bank hours, he may use the bank hours in order to cover monthly premiums until all bank hours are exhausted. Thereafter, the eligible employee will be responsible for paying premiums as outlined above. If the eligible employee does not elect continuing coverage, the individual's hour bank shall be frozen until such time as he returns from uniformed services and re-enters employment.

Additionally, if an employer so chooses, it may voluntarily pay the full premium for coverage under the Plan for service members and their families.

The maximum period of coverage available under this election shall be the lesser of:

(a) 24 months from the date on which the eligible employee's absence begins; or

(b) the day after the date on which the eligible employee fails to apply for or return for a position of employment, as set forth below.

Upon the completion of service in the uniformed services, the eligible employee shall notify the Fund Office and his employer of the intent to apply for or return to a position of employment as follows:

(a) In the case of an eligible employee whose period of service in the uniformed services was less than 31 days, by reporting to the employer:

(1) not later than the beginning of the first full regularly scheduled work period on the first full calendar day following the completion of the period of service and the expiration of eight hours after a period allowing for the safe transportation of the eligible employee from the place of that service to the eligible employee's residence; or

(2) as soon as possible after the expiration of the eight-hour period referred to in clause (1), if reporting within the period referred to in such clause is impossible or unreasonable through no fault of the eligible employee.

(b) In the case of an eligible employee who is absent from a position of employment for a period of any length for the purposes of an examination to determine the eligible employee's fitness to perform service in the uniformed services, by reporting in the manner and time referred to in subparagraph (a) above.

(c) In the case of an eligible employee whose period of service in the uniformed services was for more than 30 days but less than 181 days, by submitting an application for re-employment with the employer not later than 14 days after the completion of the period of service or if submitting such application within such period is impossible or unreasonable through no fault of the eligible employee, the next first full calendar day when submission of such application becomes possible.

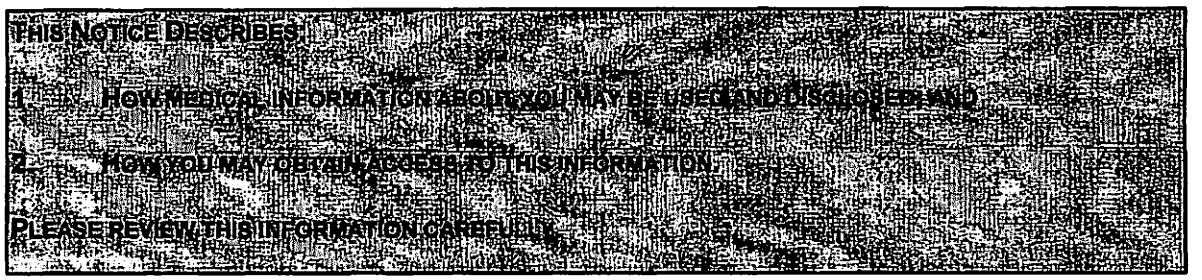
(d) In the case of an eligible employee whose period of service in the uniformed services was for more than 180 days, by submitting an application for re-employment with the employer not later than 90 days after the completion of the period of service.

An eligible employee who is hospitalized for, or convalescing from, an illness or injury incurred in, or aggravated during, the performance of service in the uniformed services shall, at the end of the period that is necessary for the eligible employee to recover from such illness or injury, report to his employer (in the case of person described in subparagraph (a) or (b) above) or submit an application for re-employment with such employer (in the case of a person described in subparagraph (c) or (d) above). Except as provided below, such period of recovery may not exceed two years.

Such two year period shall be extended by the minimum time period to accommodate the circumstances beyond such eligible employee's control which make reporting within the periods specified above impossible or unreasonable.

Upon an eligible employee's honorable discharge and return from the uniformed service, the eligible employee shall have the right to immediate reinstatement of coverage under the Plan upon re-employment without being subjected to any exclusion or waiting period, provided the eligible employee fulfills the notice requirements outlined above. However, coverage will not be afforded for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. In addition to the required notice, the eligible employee shall also supply the Fund Office with copies of his discharge papers showing the date of his induction or enlistment in uniformed service and the date of his discharge. Failure on the part of the eligible employee to file such documentation with the Fund Office and/or provide the above notice may be deemed an indication that the eligible employee does not wish to restore his eligibility status under the Plan.

Notice of Privacy Practices



Section 1: Purpose of This Notice and Effective Date

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

This Notice is required by law. The Plumbers and Pipefitters Local Union No. 396 Health and Welfare Fund (the "Fund") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

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

2 Your rights to privacy with respect to your PHI,

3 The Fund's duties with respect to your PHI,

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

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

Section 2: Your Protected Health Information

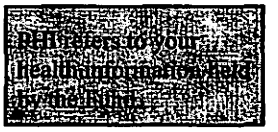
Protected Health Information (PHI) Defined

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

When the Fund May Disclose Your PHI

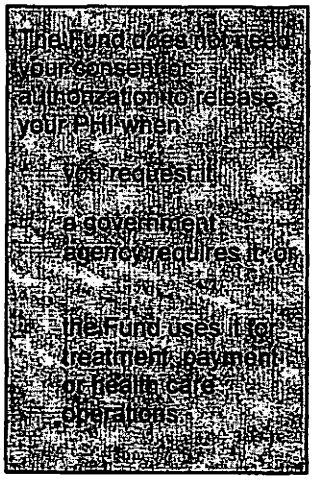
The Fund Sponsor has amended its Fund Documents to protect your PHI as required by federal law. Under the law, the Fund may disclose your PHI without your consent or authorization in the following cases:

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



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

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



- Treatment,
- Payment, or
- Health care operations.

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

When the Disclosure of Your PHI Requires Your Written Authorization

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

Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment.

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

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

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

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

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

1. ***When required by law.***

2. ***Public health purposes.*** To an authorized public health authority if required by law or for public health and safety purposes. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease of condition, if authorized by law.

3. ***Domestic violence or abuse situations.*** When authorized by law to report information about abuse, neglect or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Fund will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm.

4. ***Health Oversight activities.*** To a health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

5. ***Legal proceedings.*** When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request that is accompanied by a court order.

6. ***Law enforcement health purposes.*** When required for law enforcement purposes (for example, to report certain types of wounds).

7. ***Law enforcement emergency purposes.*** For law enforcement purposes including:

   a. identifying or locating a suspect, fugitive, material witness or missing person, and

   b. disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances.

8. ***Determining cause of death or organ donation.*** When required to be given to a coroner or medical examiner to identify a deceased person, determine a cause of death or other authorized duties. We may also disclose PHI for cadaveric organ, eye or tissue donation purposes.

9. ***Funeral purposes.*** When required to be given to funeral directors to carry out their duties with respect to the decedent.

10. ***Health or safety threats.*** When, consistent with applicable law and standards of ethical conduct, the Fund in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

11. ***Workers' compensation programs***. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

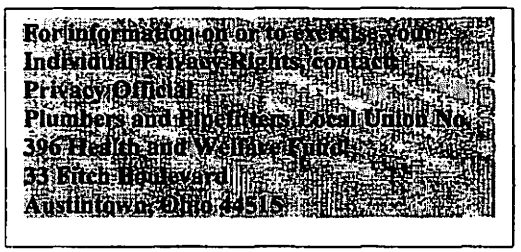
Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke your authorization. The right to revoke the authorization can be limited if the covered entity has taken action in reliance of your authorization or if the authorization was obtained as a condition of obtaining insurance.

Other Uses or Disclosures

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

The Fund may disclose protected health information to the sponsor of the Fund for reviewing your appeal of a benefit claims or for other reasons regarding the administration of this Fund. The "Fund Sponsor" of this Plan is the Plumbers and Pipefitters Local Union No. 396 Health and Welfare Fund Board of Trustees.

Section 3: Your Individual Privacy Rights



You May Request Restrictions on PHI Uses and Disclosures

You may request the Fund to:

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

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

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

You have the Right to Receive Confidential Communications

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

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

You May Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Fund maintains the PHI.

The Fund must provide the requested information within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Fund is unable to comply with the deadline. If unable to comply with the above deadline, the Fund will provide you in writing an explanation and a revised date of receipt.

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

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

Designated Record Set: includes your medical records and billing records that are maintained in paper form or electronically by or for a covered health care provider. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health Fund or other information used in whole or in part by or for the covered entity to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you is not included.

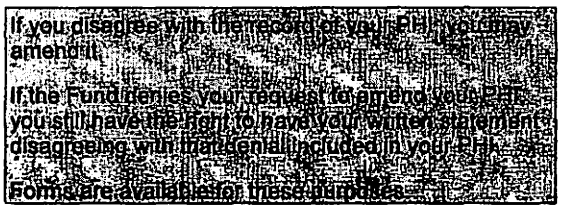
You Have the Right to Amend Your PHI

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

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

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

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



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

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

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

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

Your Personal Representative

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

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

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

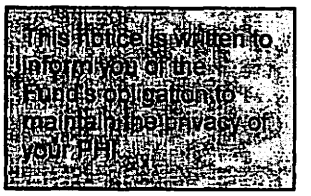
You or your spouse may elect not to have one another as your Personal Representative. You or your spouse must fill out an Opt-out of Personal Representation Form and submit the Form to the Privacy Official. Your covered dependent children also have the right to submit an Opt-out Form if they do not wish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

Section 4: The Fund's Duties

Maintaining Your Privacy

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

This notice is effective beginning on April 14, 2003 and the Fund is required to comply with the terms of this notice. However, the Fund reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Fund prior to that date. If a privacy practice is changed, a revised version of this notice will be



provided to you and to all past and present participants and beneficiaries for whom the Fund still maintains PHI. This revised notice will be mailed to the covered participant and dependents.

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

- The uses or disclosures of PHI,
- Your individual rights,
- The duties of the Fund, or
- Other privacy practices stated in this notice.

Disclosing Only the Minimum Necessary Protected Health Information

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

> The Fund must limit its uses and disclosures of PHI or requests for PHI to the ***minimum necessary*** amount to accomplish its purposes.

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

- Disclosures to or requests by a health care provider for treatment,
- Uses or disclosures made to you,
- Disclosures made to the Secretary of the U.S. Department of Health and Human Services pursuant to its enforcement activities under HIPAA,
- Uses or disclosures required by law, and
- Uses or disclosures required for the Fund's compliance with the HIPAA privacy regulations.

> You have the right to file a complaint if you feel your privacy rights have been violated.
>
> The Fund may not retaliate against you for filing a complaint.

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

- Does not identify you, and
- With respect to which there is no reasonable basis to believe that the information can be used to identify you.

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

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

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

You may also file a complaint with:
Secretary of the U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, D.C. 20201

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

Section 6: If You Need More Information

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

Section 7: Conclusion

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

BENEFIT PLAN IN REVIEW

How are Remittance Reports Processed?

Reports and payments are mailed directly to the Fund's Office. All monies received are deposited in the Trust Fund bank account. Hours listed in the reports and the amounts paid are credited to each Participant's personal account by the Fund Office and provide the basis for determining benefits.

Who Audits Fund Office Records?

The books and accounts of the Fund are audited yearly by a firm of independent certified public accountants. A copy of the latest financial report will be furnished to anyone upon request.

Who Is Responsible For Monies Paid?

The Trustees, who serve without pay, are responsible for the management of all business affairs of the Fund, including the receipt and disbursement of all money.

Half of these Trustees are elected by the Union and half are appointed by the Employers. These Trustees, in turn, delegate the day-to-day work to an Administrator who has an office force to accomplish the work.

All contributions except for necessary expenses and reserves goes toward helping member. No salary or commission of any kind is paid to any trustee, employer representative or to any union official or union agent.

How Are Cash Funds Protected?

All monies received are deposited in banks in the name of the Welfare Trust Fund. No withdrawals or disbursements can be made except by authorization of the Board of Trustees upon signature of at least two designated Trustees. The Trustees, the Administrator and all the office Participants are covered by fidelity bond insurance.

How Do I Become Eligible For Benefits?

To become eligible for benefits, you must complete a Participant Identification Record on which you will list accurate data about yourself and your dependents. You can get this card from the Welfare Office. Eligibility is based on required contributions received in your behalf during a Work Period as provided for in the Rules of Eligibility. These contributions will make you eligible, in the subsequent benefit period, for the applicable plan of benefits.

How Long Will My Eligibility Continue?

As long as you meet the eligibility requirements as provided in the Rules of Eligibility and sufficient contributions are received in your behalf during a Work Period, you will receive benefits in a subsequent Benefit Period.

What If My Hours Are Insufficient for Benefits?

If you are not eligible because sufficient contributions have not been received by the Fund in your behalf, you may become eligible by making a self-payment as provided for in the Rules of Eligibility.

How Can I Be Sure I Have Sufficient Contributions?

We suggest that you keep a record of the hours you worked as shown on your pay stubs. In this way you can easily tell if you have enough contributions before the eligibility period closes.

Will I Be Covered During Disability?

The Fund will credit you, if you are an eligible Participant with 2 hours of credit for each day you are unable to work because of an occupational injury for which you are receiving Workmen's Compensation or weekly loss of time benefits from this Fund. This credit will be given without any cost to you or to your Employer for a period not greater than 26 weeks upon receipt by the Fund Office of written proof of disability signed by your doctor. Any additional credits needed to continue your eligibility must be paid by you.

Who Determines Benefits?

When the Fund started in 1963, the Trustees setup a table of benefits based upon estimated income and estimated benefit payment. Since that time, the Trustees have periodically reviewed the actual income ant the actual benefit payment experience, and as a result of their studies the Schedule of Benefits has been revised from time to time.

One of the principal responsibilities of the Board of Trustees is to provide the best benefit schedule in keeping with the income while maintaining overall security in the financial strength of the Fund.

What Benefits Are Provided?

For the active Participant, his dependent wife and children, the Welfare Plan pays hospitalization, medical and surgical benefits. In addition, the Participant is covered by Loss of Time weekly benefits which are payable if the Participant is unable to work because of non-occupational illness or injury; during such time the Participant must be under the regular care of a physician.

No maternity benefits are provided to dependent children.
Death Benefits are also provided for the Covered Participant.

Who Are My Dependents?

Members of your immediate family are your dependents. This means your wife and your unmarried children under 19 years of age, provided, however, should any unmarried children be in attendance full time at a college or university or in a trade or training school beyond the high school level, then such child shall be considered a "member of the family" while in attendance in such school, but there shall be no coverage for such child beyond age 23. The term children includes step-children, foster children and legally adopted children.

How Are Benefits Collected?

If you or your dependents are hospitalized or otherwise entitled to benefits, you should obtain a claim form by phoning or writing to the Plumbers& Pipefitters Local Union No. 396 Health & Welfare Fund, 33 Fitch Blvd., Austintown, OH 44515 phone: (330) 270-0456 or 1-800-435-2388.

Whether you phone or write, always state your full name, address, social security number, and the name of your last Employer. This permits quick and positive identification of your welfare account.

When the claim form is sent to you, it must be presented to your doctor who will complete the medical section; certain other questions must be answered by you and your Employer.

The form is then returned to the Plumbers & Pipefitters Welfare Fund Office along with your bills for hospitalization, surgery and ambulance service. Payment is made directly to you unless as assignment has been made to the hospital or doctor.

Your claim can be handled by mail; you do not have to take time off to visit the Fund Office.

Can Fund Pay Hospital or Doctor Direct?

By giving the hospital an assignment of your hospital benefits, the Fund will then make payment directly to the hospital. Of course, if any of the charges exceed the maximum payable under the Benefit Schedule, you will be required to make up the difference. Direct payment can also be made to the doctor by giving him a similar assignment.

All hospitals have such assignment forms which they will furnish upon request.

Will Fund Pay All Surgeon's Bills?

All claims for benefits are subject to the determination that the charges are customary and reasonable for the services rendered and for which benefits are being paid.

It is a good idea to discuss the surgical fee with your surgeon before you undergo treatment. an understanding on your part as to what the treatment involves, as well as an understanding by the doctor of your finances, may avoid trouble. If you are not satisfied with this reply, you can file a protest with the Medical Society in your area. (The procedure can be learned by contacting the Medical Society.)

Will My Other Policies Affect Benefits?

You may have as many individual policies as you may choose. Such individual policies, whether for hospitalization, accidents, life, etc., in no way affect your benefits under the Plumbers & Pipefitters Welfare Fund. However, if you or your dependents are covered by another group benefit plan, the Coordination of Benefits provisions described in this booklet would apply.

What Is Meant By Coordination of Benefits?

Coordination of Benefits is the practice by which two group benefit plans "share" the coverage on members of the same family who are covered by separate group benefit plans. The plan in which the claimant is covered as A Participant is Usually the primary plan and pays first.

Do I Need Help In Collecting Benefits?

The Fund Office is set up to see that you are paid all the benefits to which you may be entitled. In case of death claim, the Fund Office, upon notification, will send the proper forms to your beneficiary and help with filing without cost to the claimant.

What Benefits Are Paid For Work Injuries?

While you are at work, you are covered by Workmen's Compensation Insurance. This insurance is carried by your Employer as required by State Law, and it pays direct benefits to an injured Participant. Because you are protected under such a policy, the Welfare Fund does not pay for occupational injuries.

However, if an active Participant dies because of injuries on or off the job, the Welfare Fund Benefit Plan provides for the payment of death and accident benefits. Also, it pays specific amount if A Participant loses a hand, foot, or an eye, or two such bodily members, either on or off the job. Such payments are independent of any amount that would be payable under Workmen's Compensation laws.

A word of advise regarding occupational injuries. If you believe any condition is due to any injury in the course of your employment, you should insist upon payments due you under Workmen's Compensation laws. If you don't, you may permanently deny yourself future benefits if later you should become disabled or hospitalized.

What Are My Unemployment Benefits?

If you are not disabled by illness or injury, you are entitled to apply to the Ohio Bureau of Employment Services for unemployment compensation. But regardless of the circumstances you

cannot collect unemployment benefits from the State and disability benefits for the same period. To do so makes you liable to criminal prosecution by the State.

Will I Be Protected If I Work Outside Fund Area?

Reciprocity Agreements have been adopted by the Trustees for this Fund. Where the agreements are in effect, they provide for the transfer of contributions of remittances to the Welfare Fund where the Participant is a member.

What Is Meant By The Term "Earned Benefit Period?"

An earned Benefit Period is that period following a Work Period for which you have established coverage for benefits by hours worked.

What If I Retire Before The Expiration of An Earned Benefit Period?

If you retire before the expiration of an Earned Benefit Period when you have established eligibility by hours worked, you will be entitled to all benefits, including loss of time.

What If I Make A Self-Payment to Establish Eligibility And Then Retire Before The Expiration of My Earned Benefit Period?

If you retire before the expiration of the Benefit Period for which self-payment was made, you will continue to receive all benefits until the expiration of the Earned Benefit Period.

Are Retirees Entitled to Any Benefits Under The Fund?

Eligible retirees who are age 65 and over may be entitled to hospital and medical/surgical benefits as listed in the pages describing a Medicare Supplement with prescription coverage. The Eligible Retired Participant has a Death Benefit of $1,500.

DEFINITION OF TERMS

The following terms shall have the meanings set forth below, unless the context of the Trust Agreement clearly requires otherwise.

"Contributions'" shall mean the regular payment which the Employer has agreed to contribute to the Fund on behalf of his Participants.

"Dentist" shall mean a Doctor of Dentistry who is legally qualified to practice dentistry in accordance with all applicable laws.

"Earned Benefit Period" shall mean that period for which an Active Participant is eligible to receive benefits under the Plan by virtue of having the required amount of contributions paid by his Employer who is required to contribute to the Fund by the provisions of a labor agreement negotiated with the Union.

"Eligible Participant" (also referred to as "Covered Participant") shall mean a Participant who is at the time eligible for benefits as provided in the Rules of Eligibility.

"Employer" shall mean any Employer who is a member of the Youngstown Chapter of P.H.C.C., Inc. of Eastern Ohio and Western Pennsylvania, or any other Association or group of Employers or any individual Employer who has duly executed a collective bargaining agreement with the Union requiring periodic payments to the Fund in the form of remittances or contributions on behalf of its Participants, or any Employer not a party to such a collective bargaining agreement who satisfies the requirements for participation as established by the Trustees and agrees to be bound by the Trust Agreement.

"Hospital" shall mean any institution which meets all of the following requirements:

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

"Hospital Expense" Benefit provides reimbursement for expenses you've incurred as a result of being confined in a covered hospital.

"Medical Necessity or Medically Necessary" means the service or supply is:

- ➢ Consistent with the symptom or diagnosis and treatment of the covered individual's illness or injury;
- ➢ Appropriate with regard to standards of good medical practice;
- ➢ Not solely for the covered individual's convenience or that of his Physician or the facility at which the covered individual receives treatment; and
- ➢ Performed in the least costly setting where services can be safely appropriately provided (e.g., rendered to the covered individual as an inpatient only when the services cannot be safely provided as an outpatient).

Evidence to help decide whether services or supplies were Medically Necessary may be required from the providers of the service before benefits are provided.

"Member of the Family" (also referred to as "covered Dependent") shall include the spouse of an eligible Participant and any unmarried children under nineteen (19) years of age who are not regularly employed and who live in the household of an eligible Participant, provided, however, should any unmarried children be in full time attendance at a college or university or in a trade or training school beyond the high school level, then such child shall be considered a "member of the family" (or "covered dependent") while in attendance in such school but there shall be no coverage for such child upon attainment of age twenty-three (23).Also, if an unmarried dependent child is incapable of self-sustaining employment because of mental retardation or physical handicap, and (1) became incapable while he was a dependent child as defined herein, (2) is chiefly dependent upon the Eligible Participant for support and maintenance, and (3) if the Eligible Participant furnishes due proof of such incapacity, then such dependent's eligibility for benefits shall be continued for as long as Participant remains eligible and such dependent remains in such condition.

"Participant" shall mean an individual who is employed by an Employer and is represented for collective bargaining purposes by the Union.

"Physician or Surgeon" shall mean a licensed physician or surgeon who is legally qualified to practice medicine in accordance with all applicable laws.

"Reasonable and Customary Charges" (also referred to as UCR) shall mean -- the highest allowable expenses that the Plan will accept for a given treatment or procedure. The terms means charges for services and supplies essential to the care of the individual which do not exceed the usual charges for those services and supplies by health providers in that area. The amount the Plan will pay will be based on the amount for a service or supply customarily charged by the majority of health providers in that geographic area. If the charge is more than the customary charge determined by the Plan, the Eligible Person will have to pay the difference.

"Trust" and "Fund" shall mean the trust estate, as it is from time to time constituted, including investments, the income from any such investments, contributions, and any other properties received or held by the Trustees for the purposes of the Trust Agreement.

"Trustees" shall mean the Trustees designated in accordance with Article 1, Section 7 of the Restated Agreement and Declaration of Trust of Plumbers and Pipefitters Local Union 396 Health and Welfare Fund.

STATEMENT OF YOUR RIGHTS UNDER ERISA

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

This federal law establishes certain minimum standards for the operation of employee benefit plans, including the Plumbers and Pipefitters Local Union No. 396 Health and Welfare Plan. The Trustees of your Plan, in consultation with their professional advisors, have reviewed these standards carefully and have taken steps necessary to assure full compliance with ERISA.

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

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

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

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

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

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

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

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

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

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

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

(C) No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a heath and welfare benefit to which you may be entitled, or exercising your rights under ERISA.

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

(E) Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in Federal court. In such a case, the court may require the Plan Administrative Manager to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrative Manager. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's monies, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The Court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

(F) If you have any questions about your Plan, you should contact the Plan Administrative Manager or the Board of Trustees. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Trustees, you should contact the nearest area office of the U.S. Labor-Management Services Administration, Department of Labor or the Pension and Welfare Benefits Administration, whose offices are located at:

U.S. Department of Labor
Employee Benefits Security Administration
1730 K Street, Suite 556
Washington, DC 20006
Tel: (202) 254-7013

Or

U.S. Department of Labor
Employee Benefits Security Administration
1885 Dixie Highway, Suite 210
Ft. Wright, Kentucky 41011-2664
Tel: (606) 578-4680

Or

Division of Technical Assistance and Inquiries
Employee Benefit Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Plumbers and Pipefitters Local Union #396 Health and Welfare Fund

33 Fitch Blvd
Austintown, Ohio 44515

Telephone: 1-800-435-2388
330-270-0453

Enrollment/Change of Address form

If this form is to change current information, mark type of change below:

Add dependents_____ Change address _____ Delete Dependents_____

Change Beneficiary _____

Please complete and return this form to assure enrollment or that your changes are processed. If additional documentation or information is needed, you will be notified:

Local Number: _____

Member Name: _____

Social Security: _____

Address: _____

_____

Phone Number: _____

Date of Birth: _____

Sex: _____

Marital Status: _____

Spouse Name: _____

Date of Marriage: _____

Social Security No. _____

Date of Birth: _____

Sex: _____

Dependent Name: _____

Relationship to Member: _____

Date of Birth: _____

Sex: _____

Social Security: _____

OVER

Dependent Name: _____

Relationship to Member: _____

Date of Birth: _____

Sex: _____

Social Security: _____

Dependent Name: _____

Relationship to Member: _____

Date of Birth: _____

Sex: _____

Social Security: _____

Dependent Name: _____

Relationship to Member: _____

Date of Birth: _____

Sex: _____

Social Security: _____

Are any family members covered by another group health plan? ___Yes _____No

DEATH BENEFIT INFORMATION

Name _____SSN#:_____

Relationship:_____

Address: _____

_____

Intentionally withholding or falsifying information requested on the form may result in loss of coverage for you and your dependents.

Member Signature: _____ Date:_____