



Health and Welfare Fund

6281 Youngstown-Warren Rd., Suite 240
Niles, Ohio 44446
330-652-3475 FAX 330-652-3513
Toll Free 1-800-362-9354
www.ohiocarpenters.com

June 30, 2005

Dear Participant:

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

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget 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 Plan Office, 6281 Youngstown-Warren Road, Suite 240, Niles, Ohio 44446, (800) 362-9354.

OHIO CARPENTERS HEALTH AND WELFARE FUND CONTINUATION COVERAGE RIGHTS UNDER COBRA

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 a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

COBRA continuation coverage will provide you with the same health coverage you and your dependents had prior to your qualifying event. However:

- You will not be eligible to receive life insurance, accidental death and dismemberment coverage, and accident and sickness benefits.
- You are responsible for the payment of the full cost of the continued coverage as determined by the Trustees. The law permits the Plan to charge any person who elects COBRA coverage up to 102% of the full cost of the benefits. If the cost changes, the Plan will revise the premium that you are required to pay, but this change cannot occur more than once every twelve (12) months.

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

- You are no longer eligible due to failure to work the required number of hours, or
- Your employment ends for any reason other than your gross misconduct.

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits; or
- 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:

- The parent-member dies;
 - The parent-member's hours of employment are reduced;
 - The parent-member's employment ends for any reason other than his or her gross misconduct;
 - The parent-member becomes entitled to Medicare benefits;
 - The parents become divorced or legally separated; or
 - The child stops being eligible for coverage under the plan as a "dependent child."
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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 continuation coverage to qualified beneficiaries only after the Plan Office 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, the employer must notify the Plan Office of the qualifying event.

If you terminate your employment or your coverage ends due to a reduction in work hours or your death, the Plan Office will usually receive information from your Employer. **However, in order to ensure that you receive the proper election information, you should contact the Plan Office and advise that you suffered a "qualifying event."**

You Must Provide the Fund Administrator Notice of Some Qualifying Events

In some cases, you must provide the Plan Office with notice of certain qualifying events:

- A divorce from your legal spouse.
- A dependent child's losing eligibility for coverage such as a dependent over 19 who is not a full-time student at an accredited school, college or university, or any dependent over age 24.
- A determination of disability from the Social Security Administration (SSA) that will extend the maximum period of coverage from 19 to 29 months;
- A determination that a qualified beneficiary who qualified for a disability extension is no longer disabled.
- A notice of any second qualifying event that will extend the maximum COBRA coverage period from 18 months to 36 months. Examples of secondary events include a child reaching the limiting age under the plan, a qualified beneficiary becoming entitled to Medicare benefits, divorce of the members and a legal spouse or death of the member.

You have 60 days from the date on which the above qualifying events occur or the date of the Social Security disability award letter to notify the Plan Office. You must provide this notice in writing to:

Fund Administrator
Ohio Carpenters Health and Welfare Fund
6281 Youngstown-Warren Road, Suite 240
Niles, Ohio 44446

How is COBRA Coverage Provided?

Once the Plan Office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries within fourteen (14) days. Under law, you have at least sixty (60) days from the later of the qualifying event date or the date of the COBRA notice to inform the Plan Office that you and/or your dependents want the COBRA continuation coverage. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered members may elect COBRA continuation coverage on behalf of their spouses, 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, your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage last for up to a total of thirty-six (36) months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than eighteen (18) months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until thirty-six (36) months after the date of Medicare entitlement. For example, if a covered employee 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 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Office within sixty (60) days of the disability determination and before the end of the first eighteen (18) months of coverage, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 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 18-month period of continuation coverage.

You must notify the Plan Office of the disability within sixty (60) days of the determination of disability by the Social Security Administration and before the end of the eighteen (18) month continuation period. If the Social Security Administration later determines that you are no longer disabled, you must notify the Plan of that determination within thirty (30) days of the determination. You must send written notice to:

Fund Administrator
Ohio Carpenters Health and Welfare Fund
6281 Youngstown-Warren Road, Suite 240
Niles, Ohio 44446

You may use the attached copy of the COBRA Notice Form for Covered Employees and Qualified Beneficiaries to notify the Plan Office of a disability determination.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 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 member or former member dies, becomes entitled to Medicare benefits (under 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.

You must notify the Plan Office within sixty (60) days after the second qualifying event occurs. You must send this notice to:

Fund Administrator
Ohio Carpenters Health and Welfare Fund
6281 Youngstown-Warren Road, Suite 240
Niles, Ohio 44446

You may use the attached copy of the COBRA Notice Form for Covered Employees and Qualified Beneficiaries to notify the Plan Office of these events.

Changes to COBRA Coverage

If you have a newborn child, adopt a child or have a child placed with you for adoption (for whom you are financially responsible) while you are on COBRA coverage, you may add the child to your coverage. You must notify the Fund Administrator, in writing, of the birth or placement in order to have the child added to your coverage. These children born, adopted or placed for adoption have the same COBRA rights as the spouse and dependents who were covered by the Plan before the event that triggered COBRA coverage and their continued coverage depends on timely uninterrupted payment of premiums on their behalf.

Termination of COBRA Coverage

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

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

If your or your dependents' COBRA coverage ends, you will be provided with a Certificate of Creditable Coverage, which is certification of your length of coverage under the Ohio Carpenters Health and Welfare plan. This may help reduce or eliminate any pre-existing limitations under any new medical plan under which you subsequently become covered.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. Additional information on COBRA benefits is available in the Summary Plan Description (SPD) or by contacting the Fund Administrator.

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

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

Fund Administrator
Ohio Carpenters Health and Welfare Fund
6281 Youngstown-Warren Road, Suite 240
Niles, Ohio 44446
(330) 652-3475
(330) 652-3513 Fax
(800) 362-9354 Toll Free

COBRA NOTICE FORM FOR COVERED EMPLOYEES AND QUALIFIED BENEFICIARIES

From: _____
(Enter your name)

Address: _____
(Enter your address)

To: Ohio Carpenters Health and Welfare Fund
6281 Youngstown-Warren Road, Suite 240
Niles, Ohio 44446

Date: _____

Re: COBRA Notice to Ohio Carpenters Health and Welfare Fund

Dear Plan Office Manager:

This letter is to inform you of the following event(s) **[Check the event(s) that apply and include and/or attach the requested information]:**

My spouse and I have/will become divorced or legally separated.

Date of divorce or legal separation: _____

Names of covered employees (participant) and all qualified beneficiaries (spouse and other dependents):

Attach a copy of the decree of divorce or legal separation.

My child will/has ceased to be covered under the Plan as a dependent child of a participant.

Date child has/will no longer be considered a dependent _____

Name of child: _____

Reason why child is no longer a dependent: _____

(e.g., no longer a student, over age 19 or 25, if your dependent is a full-time student)

DETACH HERE

I myself and/or my dependents, who are currently receiving COBRA, have a second qualifying event due to an employee's death, entitlement to Medicare, divorce or legal separation or child losing dependent status.

State the qualifying event that applies: _____

Date of the Second Qualifying Event: _____

Attach a certified copy of the death certificate or a copy of the decree of divorce or legal separation.

I myself and/or my dependent have been determined to be disabled by the Social Security Administration.

Name of the Disabled person: _____

Date of the Social Security determination: _____

Attach a copy of the determination letter from the Social Security Administration.

I myself and/or my dependent have been determined to be no longer disabled by the Social Security Administration.

Name of the Disabled person: _____

Date of the Social Security determination: _____

Attach a copy of the determination letter from the Social Security Administration.

If you have any questions about this Notice Form, please contact me or [my representative _____ (enter the name of your representative, if you have named one to act on your behalf)] at the following telephone number _____

My current address, and that of my dependents, is:

Sincerely,

(Signature of Covered Employee or Qualified Beneficiary who is completing this Notice)

(Print Name of Covered Employee or Qualified Beneficiary who is completing this Notice)