YOUNGSTOWN AREA ELECTRICAL WELFARE FUND

PLAN BOOKLET FOR ELIGIBLE MEMBERS AND THEIR DEPENDENTS

REVISED NOVEMBER 1, 2003

YOUNGSTOWN AREA ELECTRICAL WELFARE FUND

Board of Trustees

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Edward R. Lyden 4029 Hopkins Road Youngstown, Ohio 44511	Thomas Beil University Electric 419 Belmont Avenue Youngstown, Ohio 44501
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This Plan Administered by
Compensation Programs of Ohio, Inc.
33 Fitch Boulevard
Austintown, Ohio 44515
(330) 270-0453
(800) 435-2388

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Other

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.

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 (30) days of a divorce, legal separation or a child losing dependent status under the Plan.**

The Board of Trustees is the Fund's agent for serving of legal process.

The Fund is identified in U.S. Department of Labor and Internal Revenue Service files by employer identification number 34-0835041 and plan number 501. Records of the fund are kept on the basis of a fiscal year ending December 31.

This booklet is the Plan in effect as of November 1, 2003. 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 Youngstown Area Electrical Welfare Fund. If there is a conflict between the formal Plan document and this summary, the formal Plan will govern.

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 three (3) Trustees from Labor and three (3) 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 44515 (Telephone: 330-270-0453 or 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 beneficiaries of the Fund and protection of the assets of the Fund. 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 can be provided under the Plan, and no person shall have any claim for benefits against any participating Union, the Association, any Employer or the Trustees. The Trustees, the Employers, the Association and the Participating Union shall not be held liable for any benefits or contracts except as provided in the agreement between the Employers and the Participating Union.

Only the Board of Trustees has the power to interpret and construe the Plan, 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 their 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.

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 Eligible Members and Their Dependents

The Schedule of Benefits is a summary of the deductibles, co-payments and other limits when you receive Covered Services from a provider. All Covered Services are subject to the conditions, Exclusions, limitations, terms and provisions of this Certificate including any attachments or riders. This Schedule of Benefits lists the Member's responsibility for Covered Services. Benefits for Covered Services are based on Usual, Customary, and Reasonable charges. When you utilize a non-network provider you are responsible for any balance due between the non-network provider's charge and the Usual, Customary, and Reasonable charges in addition to any co-payments, deductibles, and non-covered charges.

In Network	Out of Network
Deductible: Single $200	$200
Deductible: Family $800	$800
Coinsurance: 20% of $5,000 per person	30% of $5,000 per person
Out of Pocket: $1,200 per person	$1,700 per person

Medical Expense Benefits:

Inpatient hospital services

a) Surgical fees
b) X-ray and lab
c) Outpatient hospital services
d) Anesthesia
e) Physician office services
f) Chiropractic benefits
g) Durable medical equipment
h) Ambulance services
i) Inpatient physician visits and consultations

All Medical Expenses Are Subject to the Usual, Customary, and Reasonable Charges. Also subject to a lifetime maximum of $500,000.

Other Benefits:

Mental/nervous disorder treatment

i)	inpatient	No limitations, subject to annual deductible, co-payments and lifetime maximums
ii)	outpatient	20 visits annual maximum, subject to annual deductible and co-payments

Alcohol/substance abuse benefits (with Trustee approval)

i)	inpatient	$10,000/calendar year maximum, subject to annual deductible and co-payments
ii)	outpatient	$ 5,000/calendar year maximum, subject to annual deductible and co-payments

Lifetime maximum benefit $15,000

TMJ - lifetime maximum benefit $ 400

Weekly Disability Benefits: $300.00 per week - maximum 26 weeks
Payable on 1st day of accident, 8th day illness.

Death Benefit: $5,000 AD&D Benefit: $5,000

Prescription Drug Benefits:

Generic	$5.00 co-payment
Brand Name (no generic available)	20% co-payment
Brand Name (with generic equivalent available)	20% of drug cost plus cost difference between the brand and its generic equivalent.
Lifetime maximum benefit	$250,000

Benefit Period Calendar Year

Dependent Age Limit
Upon the child's attainment of age 19; or age 25 if the child is enrolled as a full-time student in school, college, or university, and primarily supported by the employee.

COVERED SERVICES
Medical Expense Benefits
(For Employees and Dependents)

Benefit

Medical Expense Benefits are as set out below, subject to a cash deductible of $200.00 per person/per year and $800 per family/per year in network and an additional $200 per person/per year and $800 per family/per year deductible out of network. We have contracted to use the SuperMed Plus PPO offered by Medical Mutual of Ohio (MMO) for Ohio Providers, the Devon PPO for Pennsylvania and the Multi-Plan PPO for all remaining states. To verify whether a doctor or hospital participates, Ohio residents may contact Medical Mutual at 1-800-601-9208, Pennsylvania residents may contact Devon at 1-800-431-2273, outside Ohio and Pennsylvania residents may contact MultiPlan at 1-800-672-2140, or visit the Website at www.supermednetwork.com or ask the medical provider.

If Covered Medical Expenses incurred during the last three months of any calendar year are used to satisfy all or part of the deductible amount for that year, they may also be used to satisfy all or part of the deductible amount for the next calendar year.

The daily hospital room and board benefit is the actual charge made by the hospital, if you are confined in semi-private or ward accommodations. If you are confined in a private room, the benefit will equal the hospital's charge for its highest priced semi-private accommodations. For all other covered expenses, which are described below under "Covered Expenses", payment will be made as follows/per person*:

Amount of Covered Expenses	Amount Fund Will Pay In Network	Amount Fund Will Pay Out of Network
First $5,000.00	80%	70%
over $5,000.00	100%	100%

to a maximum of $500,000.00 benefits paid per lifetime

* after deductibles

Covered Expenses

Expenses incurred for any of the following, to the extent, the charge is **reasonable and customary,** will be paid by the fund in accordance with the above Benefit Schedule, (see also What is Not Covered (page 10), Limitations and Exclusions (page 11), and Coordination of Benefits (page 22) of this booklet.)

1. Hospital Confinement
   (a) Board and room charges up to the maximum daily board and room allowance shown above.
   (b) Charges for other services and supplies furnished by the hospital for use during confinement (but not for special nursing services or physician's services).

2. Medical treatment or surgical procedure by a physician.

3. Private duty nursing service by a registered or licensed nurse if the physician recommends such service, provided the nurse is not a member of the immediate family or household.

4. Local use of ambulance

5. Certain services and supplies:
   (a) anesthetics and oxygen and their administration.

   (b) rental of iron lung, oxygen tent, hospital bed, wheel chair, and similar durable medical equipment designed primarily for use in a hospital for therapeutic purposes. (The fund, at its option, may purchase in lieu of rental).

   (c) Blood and blood plasma, and their administration, to the extent not replaced by donations.

   (d) braces, crutches, and prostheses necessitated by injury or disease occurring while eligible (not including repair and maintenance).

   (e) x-ray examinations and laboratory tests.

   (f) physiotherapy

6. Diagnosis and treatment of nervous and mental conditions by a psychologist, to the extent they would be covered if made by a psychiatrist.

7. Extended Care Facility. Expenses incurred in extended care facilities for the following services and supplies will be covered by the fund:

   (a) Board and room and nursing care (but not private duty nurse or attendant).

   (b) Physical therapy, occupational therapy and speech therapy.

   (c) Medical social service.

   (d) Biologicals, supplies, appliances and equipment ordinarily provided by

the facility for care of patients.

(e) Medical care by an intern or resident-in-training of a hospital and other diagnostic and therapeutic services furnished to extended care facilities patients by a hospital.

(f) Other necessary services generally provided to patients by extended care facilities.

Confinement in an extended care facility must begin before the 65th birthday of the individual confined and must occur by means of direct transfer from a hospital in which the individual was confined for at least three (3) days, and must be for the same condition that caused the hospital confinement.

Maternity
Coverage for inpatient hospital maternity services is treated as any other illness or injury. Hospital, medical and surgical services for a normal pregnancy, complications of pregnancy and miscarriage are covered. If you or your spouse are admitted to the hospital for maternity services, your hospital stay cannot be restricted to less than forty-eight (48) hours (ninety-six hours 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 the expenses incurred due to the pregnancy of a Dependent Child of any Participant.

Drug and Alcoholism Treatment Facilities
Charges for rooms with two or more beds, 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) approved by the Board of Trustees, benefits on account of such treatment will be subject to the following limitations:

Lifetime maximum	$15,000
Inpatient treatment (with Trustees' pre-approval)	
Calendar year maximum	$10,000
Outpatient treatment (with Trustees' pre-approval)	
Calendar year maximum	$ 5,000
Subject to all deductibles and co-insurance amounts	

If you are initially confined in hospital but are then transferred to an Approved Rehabilitation Facility approved by the Board of Trustees, both periods of confinement shall constitute a single confinement.

Services cannot be limited to detoxification but, rather, must include a program of rehabilitation and therapy. Coverage shall be provided only where the eligible person completes the prescribed program of rehabilitation and therapy.

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 approved by the Board of Trustees, benefits on account of such treatment will be subject to the following limitations:

Inpatient treatment	
Calendar year maximum	No limitation
Outpatient treatment	
Calendar year maximum	20 visits
Subject to all deductibles and co-insurance amounts	

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, electroshock 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.

The following services will not be covered: treatment of drug addiction, developmental or perceptual therapy, primal therapy, cathecathon 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.

PRESCRIPTION DRUG BENEFITS
National Prescription Administration
The Prescription Drug Card Benefit covers charges for drugs prescribed by a physician, dispensed by a pharmacist and not available over the counter without a prescription.

Prescriptions	Lifetime maximum	$250,000.00 (Per Person)

Covered Expenses Include:

Federal Legend Drugs	-	Any medicinal substance which bears the legend "Caution: Federal Law prohibits dispensing without a prescription."
State Restricted Drugs	-	Any medicinal substance which may be dispensed by prescription only according to state law.
Compounded Medication	-	Any medicinal substance which has at least one ingredient that a Federal Legend or State Restricted Drug in a therapeutic amount.
Insulin	-	Available by prescription only (include insulin syringes)

A Prescription Administrator has contracted with the Youngstown Area Electrical Welfare Fund to provide an efficient and cost effective program that will be easy for you and your dependents to use when you purchase your prescriptions at a Network Pharmacy. Please check with the Fund Office or call the Prescription Drug Administrator at 800-467-2006 directly for a participating pharmacy location near you.

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 Program Works as follows:

Generic Reimbursement Plan

Your prescription benefit will also include the Generic Reimbursement Plan which will be administered as follows:

- If you choose a generic drug, the co-payment will be $5.00.
- If you choose a single source brand name drug for which there is no existing FDA approved generic equivalent, you will pay 20% of the drug cost
- If you choose or your physician indicates "Dispense As Written" for a brand name drug which has an FDA approved generic equivalent in existence, you will be responsible to pay the cost difference between the brand and its generic equivalent in addition to the 20% of the drug cost.

CFI Program

The CFI Mail Order Program was designed to allow members to receive large quantities of maintenance medication with savings to the member (e.g. heart medication, blood pressure medication, diabetic medication, etc.). To obtain information on how to use the Mail Order Program, call 1-800-467-2006. 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. Contraceptives devices
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 (e.g. CVI mail order)
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)
14. Anorexiants (diet pills)
15. Ostomy products

WHAT IS NOT COVERED

The Fund is able to cover most facilities and types of care. The decision about non-covered care will be made by the Trustees based on medical information supplied by physicians, facilities, or a medical foundation or utilization review committee.

The Fund covers only services and supplies which are medically necessary as determined by the Trustees. The fact that a physician or another provider has furnished, ordered, or approved a service does not, of itself, make that service medically necessary.

Medically necessary services and supplies, as determined by the Trustees, are those which are:

X Consistent with your symptoms, or diagnosis and treatment of your condition.

X Appropriate according to standards of good medical practice, and

X Performed in the least costly setting where services can safely and

appropriately be provided.

The determination of medically necessary will be made by the Trustees based on a review of your medical records. The Fund will not cover any unnecessary services beyond the date that your care was no longer necessary.

X Services and supplies rendered for any of the following are not covered:

Admissions beginning prior to the effective date, or after the cancellation of your coverage.

Inpatient hospitalization principally for observation or diagnostic evaluation, physical therapy; or radiotherapy

Services for convalescent or custodial care

Inpatient dental admissions unless as specified necessary to safeguard the patient's health

Care for occupational injury or disease for which any workers' compensation benefits are available

Services for which benefits are available under federal, state or other laws

Services which are not needed to diagnose or treat the patients' illness or condition.

LIMITATIONS AND EXCLUSIONS

The following listed items are specifically excluded from coverage under this plan, and therefore no payments will be made for charges for these services.

1. General health examinations, or eye examinations for astigmatism, myopia or hyperopia.
2. Exams, supplies or fitting/cost of eye glasses or hearing aids, except as a result of any injury covered by the fund.
3. The prevention or correction of teeth irregularities and malocclusion of jaws by wire appliances, braces or other mechanical aids, or any other care, repair, removal, replacement, or treatment of the teeth, or surrounding tissues, except:
   (a) when necessitated by damage to sound natural teeth or surrounding tissues as a result of an injury which occurs while the employee or dependent is insured under this coverage (damage to teeth by chewing is not considered a covered accident), or
   (b) for the excision of impacted unerupted teeth or of a tumor or cyst, or incision and drainage of an abscess or cyst, or
   (c) for any other oral surgical procedure not involving any tooth structure, alveolar process, or gingival tissues.

4. Surgical procedure, treatment or hospital confinement primarily for beautification.
5. Transportation or travel other than local use of ambulance.
6. Injury or disease resulting from war or any act of war, whether declared or undeclared, occurring while insured.
7. No benefits will be payable for expenses incurred in connection with an accidental bodily injury arising out of or in the course of any occupation or employment for wage or profit, or any sickness compensable under any workmen's compensation act of law.
8. The Fund will provide a lifetime maximum benefit payment of up to $400.00 for medical expenses incurred in the treatment of temporomandibular joint (TMJ) syndrome.

Benefits are not provided for services, supplies or charges for the following:

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 the 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 education, 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. For artificial insemination or in-vitro fertilization.
19. For the treatment of sexual problems not caused by organic disease.
20. For reverse sterilization
21. For personal hygiene and convenience items.
22. For hypnosis and acupuncture.
23. For telephone consultations, missed appointments, or failure to complete a claim form.
24. For fraudulent or misrepresented claims.
25. For expenses of care for conditions that State or local law require be treated in a public facility.
26. For topical anesthetics or stand-by anesthesia.
27. For penile implants or any treatment leading to or in connection with penile implants.
28. Evaluation and treatment of sleep disorders.
29. 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 advise of a legally qualified Physician.
30. Charges related to massotherapy.
31. Exercise equipment, health club memberships
32. Air conditioners, purifiers, humidifiers, dehumidifiers, whirlpools, hypoallergenic pillows/mattresses or waterbeds.
33. Milieu therapy
34. Chelation therapy except for arsenic, gold, mercury or lead poisoning.

Additionally, each person covered by Medicare under the Social Security Act shall be considered to have full coverage for all benefits provided under Medicare, including benefits made available on an optional basis. Any person having coverage under Medicare shall not be eligible for any coverage under this plan providing hospital or surgical or medical expenses, except those awarded total and permanent disability by Social Security, commencing with the date Medicare

coverage becomes effective. However, termination of coverage under this plan for hospital, surgical, or medical expenses shall not affect the individual's eligibility for any other benefits under this plan provided he has not retired and remains active at the trade, and shall not affect the eligibility under this plan.

HOW TO FILE A CLAIM FOR BENEFITS AND APPEAL A CLAIM DENIAL

The procedures which you need to follow in order to properly file a claim are constantly changing in order to ensure more efficient and timely processing of your benefits. The changes provided in this new Procedure apply to all claims filed on or after January 1, 2003. You will be provided with any future changes to the procedures in a separate document. Please make sure you review all correspondence about your Fund and keep these additional procedures with your booklet.

How to File Claims for Medical Benefits

When you receive health care services:

- X Show your identification card to the service provider
- X Ask the provider to file a claim for you

If your provider of the medical service is a Participating Provider in the Medical Mutual Network, he/ she will submit all necessary claim information to Medical Mutual on your behalf. Medical Mutual will forward the claims to the Fund's Administrative Office to be reviewed and paid. The Fund's Administrative Office will provide reimbursement from the Fund to the provider directly.

If you do not use a provider who is part of the Medical Mutual Network, you may have to submit a claim for benefits directly to the Fund. If you must submit a claim for health care services received, you should:

- X Obtain an itemized bill from the hospital, doctor, medical facility, dentist or vision facility
- X Obtain a claim form from the Fund's Administrative Office
- X Complete the claim form and attach the itemized bill to the form
- X Send the claim form and bill to the address on the claim form

An itemized bill generally includes all of the following:

- X Participants name and address
- X Patient's name and address
- X Date of Service
- X Type of Service and diagnosis
- X Itemized charges

- Provider's complete name, address and tax identification number

Payment for eligible benefits will be made to the health care provider unless your claim includes a paid receipt. If a receipt is submitted with your claim, payment will be sent to you.

A claim is not filed until it is received by Medical Mutual. The Fund's Administrative Office will process your claim within thirty (30) days of the date it is filed unless special circumstances require additional processing time. If additional information is needed to process your claim, the Fund may request additional information from you or the provider. You and/or your physician will have at least 45 days to submit the additional information.

When certain expenses are not eligible for payment under the Fund, you will be notified by the Fund's Administrative Office that the claim is denied in whole or part with an explanation of the reasons for the denial. This notification which is called a Notice of the Adverse Benefit Determination shall be in writing and will contain the following:

- The specific reasons for the adverse benefit determination;
- The specific reference to the Plan and/or Summary Plan Description provisions on which the adverse benefit determination was based;
- A description of any additional materials or information necessary for you to perfect your claim and an explanation of why such materials or information is necessary;
- The notice of any internal guidelines or protocols used in making the decision, if applicable, and your right to receive a copy;
- A notice of your right to a written explanation of any exclusion which affects your claim; and
- A description of this Fund's Appeals Procedure set forth below.

Prescription claims under NPA Program

You will receive a personalized National Prescription Administrators (NPA) Prescription Benefits Identification Card with eligible dependents listed on the card once you become eligible in this Fund. You must present your Prescription Benefits Identification Card along with your Doctor's prescription to any participating NPA pharmacy.

The pharmacist will fill the prescription and charge you the co-payment, which is the amount you pay. The pharmacist will generally ask you to sign the form to indicate that you received the prescription. It is permissible for any of your eligible Dependents to present your identification card with a prescription to the pharmacist and sign for receipt of the prescription. This point of sale purchase of a prescription is not a claim for benefits.

If you elect to have your prescription filled by a pharmacy other than a participating NPA pharmacy, do not use your NPA Prescription Benefits Identification Card. Follow the Claim Reimbursement Procedure described herein to obtain reimbursement of prescription expenses.

You can obtain a NPA Direct Reimbursement form from the Fund's Administrative Office. You are to complete the top portion. Either have the pharmacist complete the remainder of the form or attach an itemized receipt that includes all of the requested information. Pay the charge for the prescription in full to the pharmacy and mail the completed form to NPA's address on the form. Reimbursement will be made directly to you by NPA on the same basis as benefits would have been paid to a participating NPA pharmacy.

If you are not eligible for benefits at the time you contact the NPA pharmacy or in the event that the prescription is not a covered drug under the Fund, you must contact the Fund's Administrative Office for additional information. The Fund's Administrative Office will review your claim for benefits and if the claim is denied in whole or part, provide you with a Notice of the Adverse Benefit Determination in writing which contains the following:

X
The specific reasons for the adverse benefit determination;

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

X A description of any additional materials or information necessary for you to perfect your claim and an explanation of why such materials or information is necessary;

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

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

X A description of this Fund's Appeals Procedure set forth below.

How to file a claim for Weekly Indemnity benefits
Claims should be submitted to the Fund's Administrative Office as soon as possible; do not delay in filing any claims. Claims submitted must be accompanied by any information or proof requested and reasonably required to process such claims. You must obtain a claim form from the Fund's Administrative Office to be completed by you and your treating physician. This documentation should be completed as soon as possible in order to begin receiving your weekly benefits after you complete the waiting period.

The Fund's Administrative Office will make a decision on the claim and notify you

of the decision within 45 days. If the Fund requires an extension of time due to matters beyond its control, you will be notified of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 45 day period. A decision will be made within 30 days of the time the Fund's Administrative Office notifies you of the delay.

If the Fund's Administrative Office needs additional information from you to make its decision, you will be notified as to what information must be submitted. You will have at least 45 days to submit the additional information. Once the Fund's Administrative Office receives the information from you, you will be notified of the decision on the claims within 30 days.

In the event that your claim for benefits is denied in whole or part, the Fund's Administrative Office will provide you with a Notice of the Adverse Benefit Determination in writing which contains the following:

X
The specific reasons for the adverse benefit determination;

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

X A description of any additional materials or information necessary for you to perfect you claim and an explanation of why such materials or information is necessary;

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

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

X A description of this Fund's Appeals Procedure set forth below.

How to file claims for life insurance and accidental Death and Dismemberment benefits

Claims should be submitted to the Fund's Administrative Office as soon as possible; do not delay in filing any claims. Claims for Death, Accidental Death and Accidental Dismemberment benefits will be provided through the Fund's Administrative Office. Claims submitted must be accompanied by any information or proof requested and reasonably required to process such claims. This will generally include a death certificate and documentation to establish the death or dismemberment is the result of an accident.

Generally, the Fund's Administrative Office will notify your beneficiary of the decision on the claim for benefits within 90 days. In the event that the Fund's Administrative Office needs additional time to review the claim for benefits or needs additional information, he/she will be provided with the information on the status prior to the expiration of the initial 90 day period.

When the claim for life insurance benefits falls within the Fund's exclusions, your beneficiary will be notified by the Administrative Office that the claim is denied with an explanation of the reasons for the denial. He/she will receive a Notice of the Adverse Benefit Determination in writing which contains the following:

- X The specific reasons for the adverse benefit determination;
- X The sections of the Plan and/or Summary Plan Description upon which the adverse benefit determination was based;
- X A description of any additional materials or information necessary for him/her to perfect the claim and an explanation of why such materials or information is necessary;
- X The notice of any internal guidelines or protocols used in making the decision, if applicable, and his/her right to receive a copy;
- X A notice of his/her right to a written explanation of any exclusion which affects his/her claim, if applicable; and
- X A description of the Fund's Appeals procedures set forth below.

Proof of Claims
Written proof of claims for payment of Covered Services must be furnished as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form. **All claims must be submitted by you or the Provider no later than 90 days from the date on which the services were incurred.** Failure to furnish the claim within that time will neither invalidate nor reduce any claim if it is shown that it was not reasonably possible to furnish written proof of the claim within that time period and that written proof was provided as soon as reasonably possible. **However, all claims must be filed within one (1) year from the date the claim was incurred and if they are not submitted, they will be denied as untimely.**

No action at law or in equity shall be brought to recover on your claim prior to the exhaustion of the reasonable claims and appeals procedures set forth in this Section. Additionally, no action shall be brought at all unless brought within three (3) years from the expiration of the time which the proof of claim is required.

Physical Examination
The Fund at its own expense shall have the right and opportunity to examine an individual for whom benefits are being claimed under this Fund when and so often as the Trustees may reasonably require while a claim is pending. The Trustees have the right to ask for an autopsy in the case of death, provided this is not forbidden by law.

Review Procedure for claims under the Fund
You or your authorized representative may appeal the decision by the Fund's

Administrative Office to deny any claim for medical, weekly indemnity or life insurance/ accidental death and dismemberment benefits in whole or part. Additionally, any point of service purchase of prescription benefits which is not covered at the pharmacy can be appealed through this Review Procedure. If you are not handling your own claim, then an "authorized representative" must be designated in writing to act on your behalf and the extent of the person's authority must be clearly indicated in the authorization.

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
Youngstown Electrical Welfare Fund
33 Fitch Boulevard
Austintown, Ohio 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:

- X The specific reason for the denial;
- X The sections of the Plan and/or Summary Plan Description upon which the denial was based;
- X A statement advising you of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;

- X A notice of your right to a written explanation of any exclusion which affects your claim, if applicable; and
- X A notice of your right to file a second level appeal to the Benefits Committee of the Board of Trustees.

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
Youngstown Electrical Welfare Fund
33 Fitch Boulevard
Austintown, Ohio 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:

X
The specific reason for the denial;

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

your claim, if applicable; and

X 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
Youngstown Electrical Welfare Fund
33 Fitch Boulevard
Austintown, Ohio 44515

The Board of Trustees will review the appeal at their next scheduled quarterly 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:

1. The Fund will not assert a failure to exhaust administrative remedies;
2. 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;
3. The Fund requires that the voluntary level of appeal is available only after the Claimant has pursued the required appeal(s);
4. 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.

6. 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).

COORDINATION OF BENEFITS
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 employee 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 payable 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 provision, 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 an employee will pay benefits first (1st) . A plan covering a person as a dependent will pay second (2^{nd}).

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 the parent whose date of birth, excluding year of birth, occurs later in a calendar year, will be determined second (2nd).

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

   a) The plan of the parent with custody pays first (1st).

   b) The plan of the parent without custody pays second (2nd).

   If the parent with custody has remarried, the order is:

   a) the plan of the parent with custody;

   b) the plan of the step parent;

   c) 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 supersede 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 exception to this rule is:

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

SUBROGATION

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 for which someone else may be obligated to pay you for any reason.

Subrogation means that this Plan can recoup from the person who caused the injury, or that person's insurance company, the benefits paid on your behalf for that injury, including, but not limited to, claims compensable under state workers' compensation laws, medical malpractice or tortious conduct by a third party. Recoupment means that this Plan can recoup from you or any insurance policy, including but not limited to, a fault or no-fault automobile insurance policy, under-insured/uninsured automobile insurance policy, or other casualty or liability insurance policy, the amount of benefits paid by this Plan that should have been paid by another plan or insurance policy in accordance with the coordination of benefits rules in this Plan.

Your claims and benefit payments will normally continue to be paid in the same way as they always have been. However, you or your dependent will have certain

responsibilities to this Plan. When you or your dependent submit a claim for injuries, the Fund Office will have you complete forms requesting information as to how the injuries occurred and the identity of any potentially responsible third parties; the disclosure of any applicable insurance coverage; and requesting acknowledgment of this Plan's subrogation and recoupment provision by you and your attorney. At the request of the Fund Office, you must also sign any other documents and do whatever else is reasonably necessary to secure the Plan's right of subrogation and recoupment, including written acknowledgment of a lien in favor of this Plan that may be delivered in any way to the person whose act caused the injuries, his agent or his insurance company or any other insurance company, or that may be filed with a court having jurisdiction in the matter.

In consideration of this Plan's advancing your expenses, which may be the responsibility of the tortfeasor, or other insurer, including but not limited to, a fault or no-fault automobile insurer, under-insured/uninsured insurer, or other casualty or liability insurer, you, the tortfeasor and your respective agents and representatives agree to acknowledge and abide by the subrogation lien and reimburse this Plan directly to the extent of any benefits paid. You must not do anything to impair or negate this right of subrogation and recoupment, and if any of your acts or omissions compromise this right of subrogation and recoupment, this Plan will seek reimbursement of all appropriate benefits paid directly to you and/or your eligible dependents and/or will offset benefits otherwise payable to you under this Plan. Claim processing **may be suspended** until the Fund Office receives adequate information and completed forms.

The eligible Participant, Eligible Retired Participant and the Eligible Dependent ("Eligible Person") shall reimburse the Fund for any benefits paid out of any monies recovered from the third party as the result of judgment, settlement or otherwise.

To the extent of the aforesaid payments made or to be made by the Fund to the Eligible Person, any money that may be recovered by the Eligible Person as a result of such payments by the Fund, or otherwise, from any third-party with respect to the matter giving rise to the above-referenced loss, whether by judgment, settlement or otherwise, together with such costs as are allowed by law, shall be repaid to the Fund by the Eligible Person. The Fund, however, shall not be obligated to share, set-off or reimburse any portion of the Eligible Person's attorney fees and/or costs and expenses associated with any lawsuit, judgment or settlement which preceded such recovery by the Eligible Person. Moreover, the Fund may seek reimbursement from the Eligible Person for any amounts paid by the Fund to the Eligible Person and/or on behalf of the Eligible Person, regardless of whether the Eligible Person has received full reimbursement or been made whole for any or all losses claimed by the Eligible Person.

RULES OF ELIGIBILITY FOR EMPLOYEES' 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.

You are eligible for coverage if you are employed under the jurisdiction of the union and if sufficient contributions have been made on your behalf by participating employers.

Initial Eligibility
You become eligible for coverage under the plan on the first day of the month following the month in which 142 hours of contributions have been made to the fund on your behalf. The coverage of an employee who is not able and available for work on the date his coverage would otherwise become effective shall not become effective until the date he is able and available for work.

Pre-existing Condition Rule
The Board of Trustees, in order to protect your Group Medical Fund, adopted a pre-existing condition rule that will, under certain circumstances, limit the benefits paid to members and/or their dependents who have become eligible in the Group Medical Fund on or after May 1, 1989.

A pre-existing condition is an illness, injury, or medical condition which exists on the effective date of coverage and for which the member or dependent has received medical treatment or advice within six (6) months prior to becoming eligible for benefits under the Plan. To that end, the trustees have amended the benefit provisions of the Group Medical Plan to include the following provision:

No payment will be made for services related to a pre-existing condition for a period of twelve (12) months after the effective date of coverage. If you receive services, no payment will be made for twelve (12) months after the effective date. This period is reduced, however, by counting certain prior coverage toward the Exclusion period. Participants with twelve (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, HMO's 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, newborn or adoptees enrolled during the period.

Hour Bank
When contributions are received for hours in excess of the minimum number of hours required to maintain your eligibility in the fund (presently 142 hours), the excess hours will be credited to your hour bank account.

In periods of unemployment, your hour bank hours will be used by the fund to maintain your eligibility for coverage under the plan, subject to the limitation set forth below under "Self-Contributions."

Self-Contributions
If you have accumulated less than the minimum required number of hours of contributions for continuation of eligibility (presently 142 hours), you may make a self-contribution at the current contribution rate for the number of hours needed to meet the eligibility minimum requirements. Self-contributions may only be used to maintain eligibility for a period of eighteen months.

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

Induction into the Armed Forces
The Trustees wish to provide notice to you that if you are called up for active duty in the armed services, you are entitled to the protection of the Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA). The Fund will allow you the choice of using your Hour Bank to continue coverage for you and/or your dependents or freezing your Hour Bank until your reinstatement in the Plan. The provisions for reinstatement are based on your application for re-employment and will vary depending on your length of stay in the uniformed services. You need to contact the Fund Office to discuss your options to continue coverage for you and your dependents. In most instances, when you are called to active duty, coverage is provided to you through Tri Care which offers several plans to persons on active duty and, under certain conditions, his/her dependents.

It is extremely important, if you wish to have a continuation of benefits under USERRA, that immediately upon learning of your armed service related absence for any period, you discuss your options with the Fund Office.

Suspension of Eligibility
If you are eligible for coverage under this plan, but also qualify for benefits under another Welfare plan in another Local Union's jurisdiction, and there is no reciprocity in effect between this plan and the other plan, you may elect to suspend participation under this plan.

You must make written notice by certified mail of your desire to suspend benefits under this plan. The Board of Trustees will consider your application and advise you of the terms and conditions of your suspended benefits.

Frozen Hour Bank
The Trustees have amended the rules and will allow a participating member to freeze his hour bank when that member finds it to his advantage to do so (i.e., when his spouse’s insurance will cover him and he is in a self-payment situation with the Welfare

Fund). The freezing of a participant's hour bank will be allowed once per calendar year. His hour bank will remain frozen until employer contributions are reported to the Welfare Fund on his behalf. At that time, the member's hour bank account will become unfrozen. Remember, to freeze his hour bank account, a member must do so in writing. A certified letter must be signed and mailed to the Fund requesting that his hour bank be frozen.

Reciprocity Agreements
Payment of benefits to employees covered by reciprocity agreements shall be governed by the terms of such agreements.

Early Retired and Permanently Disabled Employee Programs
Employees who retire early, i.e., prior to attainment of their 65th birthday, may elect to continue the active employee program for which they were last eligible exclusive of the weekly indemnity benefit and accidental death and dismemberment benefits until they attain the age 65, by paying the required monthly payment, at which time coverage would be provided pursuant to the terms of the program for retired employees age 65 and over. The monthly payments 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 Fund Office.

Employees who qualify for extended life insurance coverage under the waiver of contribution coverage provided to employees who become totally disabled while eligible for benefits under the active employee program may elect to continue the active employee program exclusive of the weekly indemnity benefits and accidental death and dismemberment benefits by making the required monthly payment. The monthly payments 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 Fund Office. Coverage will terminate at age 65.

Normal Retirement Program
Upon retirement at or after age 65, a covered employee who is eligible for benefits under the active program will have those benefits terminated. The Board of Trustees provide a quarterly reimbursement of $15.30 toward the cost of the retiree's Medicare Part B premiums. A normal retiree may continue coverage for his qualified dependents who are under the age of 65 and not otherwise eligible for Medicare benefits by paying a specified additional monthly premium. The monthly payments are announced from time to time by the Board of Trustees and are always subject to review. The current rate can be obtained upon written request from the Fund Office.

Rules of Eligibility for Dependents' Coverage
An employee is eligible for Dependents' coverage on the day he becomes eligible for employee coverage, or on the day he acquires his first dependent, whichever is later.

However, the effective date of coverage will be postponed for any dependent who is confined as a bed patient in any institution providing medical or nursing care, or

confined at home or elsewhere, so as to be unable to carry on any substantial part of the regular and customary activities of a person of the same age and sex in good health, on the date benefits for that dependent would have become effective. Coverage for a dependent in this circumstance will become effective upon the expiration of 30 days following the date the dependent ceases to be so confined.

In no event will the provisions of the preceding paragraph apply to any dependent child born while the employee is eligible for dependents' coverage.

Termination of Dependents' Coverage
An employee will cease to be eligible for dependents' coverage on the earliest of the following dates:

- X the date the employee's coverage for himself terminates;
- X the date the employee ceases to be in a class of employees eligible for dependents' coverage;
- X the date dependents' coverage is discontinued;
- X the date your dependent commences active duty in the armed forces of any country or state or international organization or becomes a member of any civilian force auxiliary to military force;
- X the date the dependent ceases to qualify as a dependent;

A spouse's eligibility will be continued for a period of twenty-four months following the death of the active eligible employee.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)
The Consolidate Omnibus Budget Reconciliation Act requires that the Trustees offer those eligible Participants and dependents, whose Health Benefits are scheduled to be terminated, the opportunity of continuing their Group Health Benefits through a series of monthly direct payments for a limited period of time. The following paragraphs are intended to explain and summarize your rights and those of your dependents under this new law.

Rights to Self Payment
Member: If you are an active member whose benefits are scheduled to be terminated due to having failed to work the required number of hours, you have the right to continue your Group Health Benefits through a series of monthly direct payments for a period of up to eighteen(18) months, starting with the date your regular eligibility under the plan was scheduled to be terminated due to failure to work the required number of hours.

Dependents: Your spouse (husband or wife) also has the right to continue his or her Group Health benefits on a direct payment basis under any of the following circumstances:

- X Upon your Death (providing you were eligible at time of death).

- X Upon your termination from the Plan due to failure to work the required number of hours.
- X Upon divorce or legal separation from you.
- X When you become eligible for Medicare and your regular Group Health Benefits are terminated.

Your dependent children (as described in the Plan) may also continue their Group Health Benefits on a direct payment basis under any of the following circumstances:

- X Upon your death (providing you and such dependent child were covered for benefits at the time of your death).
- X Upon termination of your employment (providing your child was covered at the time of such termination).
- X Upon your divorce or legal separation
- X Upon the date your eligibility (and that of your dependent child) due to becoming eligible for Medicare
- X The date your dependent child ceases to be dependent(due to age, change in student status, etc.).

You your spouse, or your dependent child (where applicable) will have the option to continue Group Health Benefits for the period shown below.

Person	**Reason for Termination**	**Period**
Participant	Failure to Work the Required Number of hours in covered employment	18 months
Spouse	Death of the Participant	36 months
	Divorce or Legal Separation	36 months
	Participant becomes eligible for Medicare	36 months
Dependent-Child	No longer qualifies as a dependent child under the Group Plan	36 months

The Group Health coverage will cease immediately in the event the;

- X Self Payments are not received when due.
- X The date you or any of your dependents become covered under another Group Health Plan (including Medicare).
- X The date a divorced spouse remarries and becomes covered under another Group Health Plan.

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. I**n 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:

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

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.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Plan has been amended as a result of the Women's Health and Cancer Rights Act. This federal legislation requires that, as a result of consultation with a physician, the plan cover reconstruction of the breast on which the mastectomy was performed, surgery on the other breast to produce a symmetrical appearance and prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas. This coverage is subject to the Plan's annual deductibles and co-insurance provisions and was effective January 1, 1999.

DEATH BENEFIT

(Employees Only)

Benefit

In the event of your death, $5,000 will be paid to the beneficiary named by you.

Continuation of Death Benefit Coverage If Disabled

If, because of total disability which continues for nine months or more, you should terminate your employment before age 60, your death benefit will remain in force without payment for a period of twelve months, and thereafter as long as you are continuously totally disabled. All such continuations must be approved by the Board of Trustees of the Fund and are subject to yearly proof of continuance of your disability.

Change of Beneficiary

You may change your beneficiary at any time by making written request to the Welfare Fund on the form prescribed by the Trustees. The change will take effect as of the date you sign the request.

ACCIDENTAL DEATH AND DISMEMBERMENT

(Employees Only) Benefit

If you suffer any of the losses shown below as a result of bodily injuries caused directly and exclusively by accident, the following benefits, based upon a full benefit of $5,000.00 will be payable:

The full benefit of $5,000.00 will be paid for loss of (1) life, (2) two hands, or (3) two feet, or (4) sight of two eyes, or (5) on hand and one foot, or (6) one hand and sight of one eye, or (7) one foot and sight of one eye;

One-half benefit, or $2,500.00 will be paid for loss of (1) one hand or one foot, or (2) sight of one eye.

Loss of hands or feet means loss by severance at or above the wrist or ankle joints. Loss of sight means total and irrecoverable loss of the entire sight.

The total amount payable for all losses suffered in any one accident may not exceed the maximum $5,000.00 benefit. Sufficient proof of losses must be presented to the Trustees within ninety (90) days after the date of injury.

Payment for loss of life will be made to the beneficiary you have designated. Payment for any other losses will be made to you.

Losses not covered
No benefits are payable for loss resulting from:

(a) disease, or bodily or mental infirmity, or medical or surgical treatment thereof; or

(b) ptomaines, or bacterial infections, except infection introduced through a visible wound accidentally sustained; or

(c) suicide while sane or insane, or intentionally self-inflicted injuries; or

(d) war or any act of war, whether declared or undeclared; or the commission of or attempt to commit a felony.

Change of Beneficiary
You may change your beneficiary at any time by making written request to the Welfare Fund on the form prescribed by the Trustees. The change will take effect as of the date you sign the request.

ACCIDENT AND SICKNESS
WEEKLY DISABILITY BENEFITS
(Employees Only)

Benefit
Weekly disability income is payable if you are wholly disabled and are unable to work because of an accident occurring off the job, or a sickness not connected with employment. The maximum amount of weekly disability income is $300.00 per week. However, in no event will the amount of weekly benefit payment exceed 66-2/3% of your regular weekly earnings, exclusive of overtime pay.

Benefits begin with the **1st day of disability due to an accidental bodily injury, or the 8th day of disability due to a sickness,** and no benefits will be paid for any day prior to the 15th day. The maximum number of weeks payable for each disability is twenty six (26) weeks.

Limitations
No benefits will be payable:

1. For any period during which the employee is not under the care of a licensed medical

doctor;

2. For any accidental bodily injury arising out of or in the course of any occupation or employment for wage or profit, or any sickness compensable under any workmen's compensation act or law.

Successive Periods of Disability

Successive periods of disability due to the same or related causes will be considered one period of disability unless they are separated by a two week period during which the employee is not absent from active full time work. Successive periods of disability due to entirely unrelated causes will be considered one period of disability unless they are separated by complete recovery and return to active full time work.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

A Qualified Medical Child Support Order (QMCSO) is a judgement, decree or order made pursuant to a state relations law (including community property law) setting forth provisions regarding the support for a child of a Participant (alternative recipient) and which:

1. Creates or recognizes the existence of an Alternative Recipient's right to, or assigns to an Alternative Recipient the right to receive benefits for which a Participant or beneficiary is eligible under this Plan; and

2. Specifies (i) the name and last known mailing address (if any) of the participant and each Alternative Recipient covered by the Order, and (ii) a reasonable description of the type of coverage to be provided by the Plan or the manner in which the coverage is to be determined; and

3. Does not require the Plan to:

(i) provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of any law relating to medical child support as describe in Section 1908 of the Social Security Act.

Upon receipt of any judgement, decree of order (including approval of a property settlement agreement) relating to the provision of payment by the Plan to an Alternative Recipient pursuant to a state domestic relations law, the Board shall promptly notify the affected Participant and any Alternative Recipient of the receipt of such judgement, decree or order and shall notify the affected Participant and any Alternative Recipient of the Board's procedures for determining whether or not the judgement, decree or order is a Qualified Medical Child Support Order.

The Board shall adhere to the following procedures for determining the status of a judgement, decree or order as a QMCSO, and for administering plan benefits in accordance with QMCSO:

1. Upon receipt of any judgement, decree, or order (including approval of property settlement agreement) relating to the provision of payment by the Plan to an Alternative

Recipient pursuant to a state domestic relations law, the Board shall promptly notify the affected Participant and any Alternative Recipient of such receipt. This notification shall include a description of these procedures for determining the status of a judgement, decree or order as a QMSCO, and for administering plan benefits.

2. An Alternative Recipient may designate a representative for receipt of communications from the Board.

3. The Board shall determine whether the received judgement, decree or order is a QMSCO as defined in ERISA, Section 609 (a) and paragraph A, above, and shall notify the affected Participant and any Alternative Recipient or their representative(s) of this determination within a reasonable time. This notification shall include an explanation of the Board's determination.

4. The Board shall further comply with any future requirement imposed by the Department of Labor or the Internal Revenue Service (executed in accordance with their rule making powers) in its administration of matters involving QMSCO's.

STATEMENT OF RIGHTS UNDER THE EMPLOYEE RETIREMENT SECURITY ACT OF 1974 (ERISA)

As a participant in the Youngstown Area Electrical Welfare Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Participants shall be entitled to:

Receive Information about your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified 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.

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

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

Continue Group Health Plan Coverage

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

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits 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 suite in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions
If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200

Constitution Avenue, N.W., Washington, DC 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.

DEFINITIONS

Active Service

An employee will be considered in active service with an employer on a day which is one of the employer's scheduled work days, if he is performing in the customary manner all of the regular duties of his employment with the employer on a full-time basis on that day, either at one of the employer's business establishments or at some location to which the employer's business requires him to travel. An employee will be considered in active service on a day which is not one of the employer's scheduled work days only if he was performing in the customary manner all of the regular duties of his employment on the next preceding scheduled work day.

Dependent

The term dependent means:

The lawful spouse of an employee

Any unmarried child of the employee who is:

less than 19 years of age;

19 years but under 25 years of age, enrolled as a full-time student in a school, college or university and primarily supported by the employee;

is 19 years of age or over and mentally or physically incapable of earning a living, provided the child became so incapable prior to the attainment of age 19. The Trustees have the right to require proof of incapacity when claim is first made for benefits after attainment of age 19 by a dependent child and also, at any time, to require proof of the continuation of such incapacity.

The term child will include a child born of the employee, a child legally adopted by the employee, or a stepchild of the employee living with the employee in a normal parent-child relationship.

No one may be a dependent who is eligible for coverage as an employee and no one may be a dependent of more than one employee. Additionally, to be eligible for dependent coverage, proof may be required that the dependent meets the requirements stated above.

It is important that you give prompt written notice on the prescribed form of any change in your family status, such as marriage or divorce, birth of a child, marriage of any of your dependent children.

Employee

The term employee means an employee employed under the jurisdiction of the union by an employer making contributions to the Welfare Fund in accordance with the terms of a collective bargaining agreement.

Hospital
The term hospital means (1) an institution constituted, licensed and operated in accordance with the laws pertaining to hospitals, which maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of injury and sickness, and which provides such treatment for compensation, by or under the supervision of physicians on an inpatient basis with continuous 24-hour nursing service by registered graduate nurses, or (2) an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, and is accredited as a hospital by the Joint Commission on the Accreditation of Hospitals.

The term hospital will not include a hotel, rest home, nursing home, convalescent home, place for custodial care, home for the aged, or a place primarily devoted to the treatment of drug addicts or alcoholics.

Hospital Confinement
A person shall be considered to be confined in a hospital under the following conditions:

1. The individual remains in the hospital for 18 consecutive hours or longer, or

2. a board and room charge is made, or

3 . The individual enters the hospital before midnight of the day following the day of an injury requiring emergency care, or

4. The individual enters the hospital for a surgical procedure.

Surgical Procedure
The term surgical procedure means only the following: (a) a cutting operation; (b) suturing of a wound; (c) treatment of a fracture; (d) reduction of a dislocation; (e) radiotherapy (excluding radioactive isotope therapy) if used in lieu of a cutting operation for removal of a tumor; (f) electrocauterization; (g) diagnostic and therapeutic endoscopic procedures; (h) injection treatment of hemorrhoids and varicose veins.

Reasonable and Customary Charges
Charges made for medical services or supplies essential to the care of the individual will be considered reasonable and customary if they are the amount normally charged by the provider for similar services and supplies and do not exceed the amount ordinarily charged by most providers of comparable services and supplies in the locality where the services or supplies are received. In determining whether charges are reasonable and customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances which required additional time, skill or experience.

Physician
The term physician means an individual who is operating within the scope of his license and is licensed to prescribe and administer drugs or to perform surgery.

Medicare
The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

Extended Care Facility
The term Extended Care Facility means an institution, or a distinct part of an institution, which:

(a) provides for inpatients (i) 24-hour nursing care and related services for patients who require medical or nursing care, or (ii) service for the rehabilitation of injured or sick persons;

(b) has policies developed with the advice of, and subject to review by, professional personnel to cover nursing care and related services;

(c) has a physician, a registered professional nurse, or a medical staff responsible for the execution of such policies;

(d) requires that every patient be under the care of a physician and makes a physician available to furnish medical care in case of an emergency;

(e) maintains clinical records on all patients, and has appropriate methods for dispensing drugs and biologicals;

(f) has at least one registered professional nurse employed full time;

(g) provides for periodic reviews by a group of physicians to examine into the need for admissions, adequacy of care, duration of stay and medical necessity of continuing confinement of patients;

(h) is licensed pursuant to law, or is approved by appropriate authority as qualifying for licensing.

The term Extended Care Facility does not include a place which is primarily for custodial care.

Total Disability

An employee will be considered totally disabled during any period when, as a result of injury or sickness, is completely unable to perform the duties of their occupation and is not performing any other work or engaging in any other occupation or employment for wage or profit. A dependent will be considered totally disabled during any period when, as a result of injury or sickness, they are unable to engage in normal activities of a person of the same age and sex.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES:

1. HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED; AND
2. HOW YOU MAY OBTAIN ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS INFORMATION CAREFULLY.

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 Youngstown Area Electrical 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.

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.

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 Fund is the Youngstown Electrical Welfare Fund Board of Trustees.

Section 3: Your Individual Privacy Rights
For information on or to exercise your Individual Privacy Rights, contact:

Privacy Official
Youngstown Area Electrical Welfare Fund
33 Fitch Boulevard
Austintown, Ohio 44515

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.

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.

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.

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.

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.

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.

If you disagree with the record of your PHI, you may amend it.

If the Fund denies your request to amend your PHI, you still have the right to have your written statement disagreeing with that denial included in your PHI.

Forms are available for these purposes.

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 designate a personal representative by completing a form that is available from the Fund Office.

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

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

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.

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.

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.

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.

This notice is written to inform you of the Fund's obligation to maintain the privacy of your PHI.