ABATEMENT WORKERS NATIONAL

HEALTH AND WELFARE FUND

P. O. BOX 1349
Troy, MI 48099-1349
(248) 641-4907 or (800) 772-0459

Notice of COBRA Continuation Coverage Rights

Introduction

You are receiving this notice because you have recently become covered under the Abatement Workers National Health and Welfare Fund ("the Fund"). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description or get a copy of the Plan Document from the Fund Office.

The Plan administrator is BeneSys (the "Fund Office") located at 700 Tower Drive, Suite 300, Troy, MI 48098. You can call the office at 248-641-4907. The Plan administrator is responsible for administering COBRA continuation coverage.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross misconduct.

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

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes enrolled in Medicare (Part A, Part B or both); or
5. You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the plan as a "dependent child."

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events.

For other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You may send written notice of the event to: Abatement Workers National Health and Welfare Fund, PO Box 1349, Troy, MI 48099-1349, or you can report a qualifying event by calling the Fund Office at 248-641-4907 and speaking to a representative in the eligibility department. You will be required to

send a full copy of your divorce decree or documentation of your legal separation to the Fund Office at: PO Box 1349, Troy, MI 48099-1349.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying event.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both) your divorce or legal separation, or dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage last for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension Of 18-Month Period Of Continuation Coverage

If you or anyone in your family covered under the plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent along with a copy of the Social Security Administration's determination to the Abatement Workers National Health and Welfare Fund, PO Box 1349, Troy, MI 48099-1349.

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to: Abatement Workers National Health and Welfare Fund, PO Box 1349, Troy, MI 48099-1349, or you can report a qualifying event by calling the Fund

Office at 248-641-4907 and speaking to a representative in the eligibility department. You will be required to send a full copy of your divorce decree or documentation of your legal separation, or Medicare Card to the Fund Office at: PO Box 1349, Troy, MI 48099-1349.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the Fund Office by calling 248-641-4907. Written correspondence should be sent to: Abatement Workers National Health and Welfare Fund PO Box 1349, Troy, MI 48099-1349. You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA offices are available through EBSA's website at **www.dol.gov/ebsa**.

Keep Your Plan Informed of Address Changes

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

Enrollment Form--Must Be Completed

(See reverse side for instructions as to information requested in Items 1-8 below and for mailing instructions.)

1. Qualified Beneficiary's Name (Last, First, Middle Initial)

2. Qualified Beneficiary's Social Security Number

3.Employee's Social Security Number(If Qualified Beneficiary is Other Than Terminated Employee)

4.Qualified Beneficiary's Birth date

5. Qualified Beneficiary's Address (Street, City, State, Zip Code)

6. Phone Number

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7. I request continuation of the following coverage: ____

Coverage is for: ____Self & Spouse ____Self, Spouse & Child/Children

____Self & Child/Children ____Child Only

____Spouse & Child/Children ____Self Only ____Spouse Only

If you or any of you dependents are covered under another Group Health Plan, please indicate Type of Coverage, Health Plan Sponsor and Family Members Covered.

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8. Dependent Qualified Beneficiaries, (If Applicable)

Name (First, Middle Initial, Last)	Relationship	Social Security Number	Birth date	Student ?* (Y or N)	

*List the first name of the dependent(s) and the school(s) being attended:

_____

_____

Qualified Beneficiary's Signature: _____Election Date: _____

Qualified Beneficiary's Instructions For Completion of Enrollment Form

A covered employee or spouse may make an election for any other qualified beneficiary.

Item No. 1. Please complete your name: (Last, First & Middle Initial).

Item No. 2. Fill in your Social Security Number

Item No. 3. Fill in the Social Security Number of the employee who originally held the coverage under the group. This should be completed for all qualified beneficiaries other than the terminated employee.

Item No. 4. Your Birth date.

Item No. 5. Complete your full address.

Item No. 6. Fill in a phone number where you can be contacted.

Item No. 7. Enrollment coverages will be the same for all family members unless a separate Election Form is furnished (make copies for extras).

Item No. 8. List family members for whom you are electing continuation coverage.

* The Name, Relationship, Social Security Number and Birth date of all such dependents should be listed. These dependents must have been previously covered under the Plan.
* Indicate "Y" or "N" to indicate if the dependent(s) is a full time student. If so, list the dependent(s) and name of school(s) being attended.

The cost for Continued Group Health Coverage is: $801.00 (Cost is a per month charge)

THE ABOVE RATE **DOES NOT** INCLUDE WELFARE PLAN BENEFITS THAT ARE NOT DIRECTLY RELATED TO HEALTH CARE SUCH AS LIFE INSURANCE OR LONG OR SHORT TERM DISABILITY.

You must return this form or contact this office within 60 days of the date it was sent to you in order to qualify for coverage.
Sign and date the form, and send along with a check for the coverage period to date. Payment for coverage, from the termination date to the current date, must be received within 45 days of electing COBRA.

ABATEMENT WORKERS NATIONAL
FRINGE BENEFIT FUNDS
PO Box 1349
Troy, MI 48099-1349