

Dear Participant:

The Patient Protection and Affordable Care Act of 2010 requires plans to extend coverage to children through age twenty-five (25), except for children who are eligible to enroll in an employer-sponsored group health plan by virtue of their employment or, if married, by virtue of their spouse's employment. This provision is applicable to the Pipe Trades Industry Health and Welfare Plan as of July 1, 2011. The purpose of this notice is to advise of this change in the Plan and to provide the opportunity for you to reenroll your eligible adult child(ren) whose coverage was terminated under the rules previously in effect.

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended after age 18, but before attainment of age 26, are now eligible to enroll in the Pipe Trades Industry Health and Welfare Plan. Individuals may request enrollment for such children for 30 days from the date of this notice. Enrollment will be effective July 1, 2011. If you do not enroll said children because they have employer sponsored coverage available through their or their spouse's employer and the child later loses the employer sponsored plan coverage, you have 30 days to request enrollment of that child in this plan. If you fail to enroll an eligible child now, later enrollment will be effective on the date the application is received. For more information contact the Plan Office at the address or telephone number shown above.

Enclosed is a special enrollment form to request enrollment of a child age 21 or older but less than age 26. The form requests information concerning the child's or child's spouse's employment, if applicable, to permit the Plan Office to contact the employer regarding the availability of group health plan coverage to the child.

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits in benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at the address or telephone number shown below. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

If you have any questions regarding these changes, please contact the Plan Office at 1-800-837-5678 or 1-812-877-2581.

Sincerely yours,
Board of Trustees

**PIPE TRADES INDUSTRY HEALTH AND WELFARE FUND
DEPENDENT CHILD ENROLLMENT FORM (AGES 21 through 25)**

To Be Completed for Enrollment for those Dependents who do not have other health care coverage available via their employment or their spouse's employment.

Participant's Name _____ SSN _____

Participant's Address _____

Telephone # _____ Email Address _____

Dependent's Name _____ SSN _____

Dependent's Birth date _____

Dependent's Address (if different) _____

Is Dependent Employed? _____ If Yes, Name of Employer _____

Address of Dependent's Employer (If employed) _____

Telephone Number of Dependent's Employer (if employed) _____

Is Dependent Married? _____ If So, Name of Dependent's Spouse _____

Is Dependent's Spouse Employed? _____ If So, Name of Employer _____

Address of Dependent's Spouse's Employer (If employed) _____

Telephone Number of Dependent's Spouse's Employer (if employed) _____

I hereby attest that health care coverage is not available to this Dependent through either his/her direct employer or through his/her spouse's employer. The Fund Office has our permission to contact the employer(s) listed above, if applicable, for verification of health care coverage availability. I understand that if this information changes, it is our responsibility to notify the Fund Office immediately.

Participant's Signature _____ Date _____

Dependent's Signature _____ Date: _____