

IMPORTANT CHANGES

Due to Health Care Reform and Other Legislation



IRON WORKERS'
Tri-State Welfare Fund

NOVEMBER 2010

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Benefit Changes for 2011

The **Patient Protection and Affordable Care Act** (the “Affordable Care Act”) mandates reforms for group health plans like ours. We must comply with the requirements on the first day of the plan year immediately following September 23, 2010, which is January 1, 2011. In addition, all group health plans are also required to modify their benefit plans based on the **Mental Health Parity and Addiction Equity Act of 2008** (MHPAEA). Therefore, as of January 1, 2011, we are also making changes to the Plan in accordance with the required regulations under MHPAEA.

This brochure explains all of the changes.

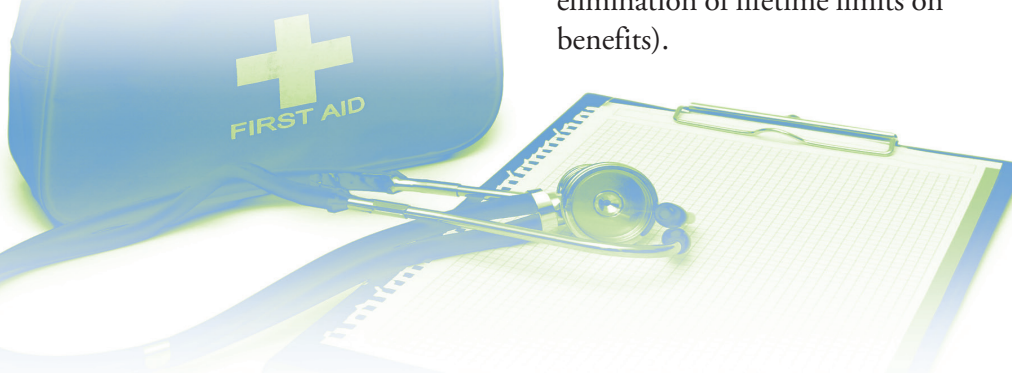


Statement of Grandfathered Status

The Trustees believe that this Plan is a “grandfathered health plan” under the Affordable Care Act, which permits us to preserve certain basic health coverage already in effect before the law was passed. Being a grandfathered health plan means that our Plan:

- May not include certain consumer protections in the Affordable Care Act that apply to other plans; but
- Must comply with certain consumer protections in the Affordable Care Act that do apply to other plans (for example, the elimination of lifetime limits on benefits).

If you have questions about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status, you can call the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) at 1-800-444-3272 or visit its website, www.dol.gov/ebsa/healthreform. You may also request a written explanation from the Fund Office by email to tristate@abpa-tpa.com or by sending a request in writing.



Extension of Dependent Coverage to Age 26

One significant change required by the Affordable Care Act is the extension of dependent coverage to children up to age 26, regardless of whether they are students and/or are married. Because of this change, the Plan's definition of dependent is being revised effective January 1, 2011. For a full definition, please see definition on page 3.

Note that if your child has access to health care coverage through his or her employer, your child **will not** be covered under this Plan. In addition, there is no age limit for a disabled child who sustained the disability prior to age 26.



SPECIAL enrollment

Special Enrollment for Children up to Age 26

If you have a child who is under age 26 (whether married or unmarried), including a child currently receiving continuation coverage under COBRA, you can enroll that child in the Plan as of January 1, 2011. This special enrollment opportunity applies to:

- Children whose coverage under the Plan has already ended;
- Children who were previously denied coverage under the Plan; and
- Children who were not previously eligible to enroll in the Plan because their eligibility for dependent coverage under the prior Plan provisions ended before they reached age 26.

See the box **Definition of Dependent Child** on page 3. If your child qualifies under this definition, you may enroll your child for coverage. To enroll your child, complete the enclosed Special Enrollment Form and mail it to the address shown on the form. The extended open enrollment period continues until January 15, 2011. To enroll your child for coverage effective January 1, 2011, you must mail the completed enrollment form by January 15, 2011 (postmarked). ***If you miss this deadline, your dependent's claims will be delayed until you complete and submit an enrollment form.***

Notice of Special Enrollment Rights (HIPAA)

If you decline Plan enrollment for your dependent because he or she has other health insurance or group health plan coverage and the other coverage ends, you may enroll your dependent in the Plan if you request enrollment within 30 days after your dependent's other coverage ends. Your dependent must meet the definition of a dependent child to be eligible for coverage.



Definition of Eligible Dependent Child

(Effective January 1, 2011)

An “Eligible Child” under the Plan is any one of the following individuals:

- Anyone who has not reached his/her 26th birthday, does not have access to health care coverage through his or her employer, and is the employee’s:
 - » Natural child;
 - » Adopted child or child placed for adoption;
 - » Foster child;
 - » Child who is named as an alternate recipient in a child support order, if the Plan determines the support order to be a Qualified Medical Child Support Order (QMCSO);
 - » Step-child who was born to the spouse or who was legally adopted by the spouse before the marriage of the employee and that spouse;
- Any child listed above, at any age, who is permanently and totally disabled and incapable of self-sustaining employment by reason of a medically determined physical or mental impairment that is expected to last for a continuous period of 12 or more months or result in death, and if:
 - » Such incapacity began before the child reached age 26,
 - » The child is dependent on the employee for at least 50% of his/her financial support and maintenance in each calendar year,
 - » The child maintains a principal residence with the employee during each calendar year, and
 - » The employee provides proof of such incapacity for the child when the Trustees request such proof.



Mental Health and Substance Abuse Benefit Changes

The Plan is eliminating the lifetime maximums on alcohol, chemical and drug dependency treatment beginning January 1, 2011. Mental health and substance abuse services continue to be covered at 80% for in-network providers and 60% for out-of-network providers, after you meet the annual deductible.

Changes to Annual and Lifetime Limits

The Plan is eliminating annual and lifetime limits on most covered benefits under the Comprehensive Medical Plan effective January 1, 2011; however, for 2011, the lifetime limit is being transitioned to an annual limit of \$1 million per participant. The Plan will continue to cover services at 80% for in-network providers and 60% for out-of-network providers, after you meet the annual deductible.

The annual limits on well child and well adult benefits are being eliminated.

Certain calendar year and lifetime limits will continue to apply, as shown in the Summary of Comprehensive Medical Benefits on page 4.

If you have dental and vision benefits, the calendar year maximums will no longer apply to children under the age of 19 for preventive services.



Special Enrollment for Individuals Who Reached the Lifetime Limit

If you or any of your dependents have lost coverage because you reached the Plan’s current \$1 million lifetime limit, you can re-enroll yourself or your dependent in the Plan as of January 1, 2011, as long as you or your dependent continues to meet the eligibility requirements of the Plan.

The Trustees are providing an extended special enrollment period until January 15, 2011. To re-enroll, you must complete and mail the enclosed special enrollment form **no later than January 15, 2011 (postmarked)**. *If you complete and send the special enrollment form by January 15, 2011, coverage will be effective on January 1, 2011. If you miss this deadline, payment of claims may be delayed.*

To determine if your dependent child is eligible, see the **Definition of Dependent Child** box above.

Schedule of Comprehensive Medical Benefits*

Effective January 1, 2011

- Active Plan of Benefits for Employees and Dependents
- Retiree Plan of Benefits for Eligible Retirees, Disabled Employees, their Dependents, Widows, and Dependents of Deceased Employees
- Plan of Benefits for Dependents of Medicare-Eligible Retirees Who Are Not Eligible for Medicare

Comprehensive Medical Benefits (For All)

	Prior to January 1, 2011	On and After January 1, 2011
Annual Deductible		
Individual	\$300	\$300
Family	\$600	\$600
Other Deductibles		
Emergency room copayment, waived if admitted	\$50	\$50
For Hospitalization (without obtaining pre-approval)	\$200	\$200
Annual Out-of-Pocket Limits		
Individual	\$5,000	\$5,000
Family	\$10,000	\$10,000
The annual out-of-pocket limits only apply to in-network charges. Out-of-network charges are not applied toward the out-of-pocket limits.		
Plan Covers...		
In-network charges	80%	80%
Out-of-network Allowable Charges	60%	60%
Calendar Year Maximums (per person)		
Well child examinations and immunizations (no deductible)	Up to \$500 the first year of life and \$300 each subsequent year	NO LIMIT
Well adult examinations and immunizations (no deductible)	\$1,000	NO LIMIT
Home health care visits	100	100
Days of treatment in a skilled nursing care facility	120	120
All covered expenses	Lifetime \$1,000,000	Annual \$1,000,000
Lifetime Maximums (per person)		
In-patient alcohol, chemical & drug dependency treatment	\$30,000	NO LIMIT
Out-patient alcohol, chemical & drug dependency treatment	\$10,000	NO LIMIT
Treatment of infertility or promotion of pregnancy (per family)	\$25,000	NO LIMIT
Diabetes education	\$500	\$500
Bereavement Services	\$500	\$500
All covered services	\$1,000,000	UNLIMITED

*NOTE: highlighted rows indicate a change in benefits.

More Information

If you have questions about your benefits or these changes, please contact the Fund Office at 1-866-463-9418.

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This notice is a Summary of Material Modifications (SMM), within the meaning of Section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. This notice describes important changes to the Iron Workers' Tri-State Welfare Fund. You may find full details in the most recent Summary Plan Description and Plan Document that establish the Plan provisions. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.