DIVISION 1181 A.T.U. – NEW YORK WELFARE FUND
101-49 Woodhaven Boulevard, Ozone Park, N.Y. 11416
(718) 845-5800

Dear Participant:

Attached is a Notice that we are required to send to you by federal law. Under the new health care law, the Patient Protection and Affordable Care Act, group health plans generally cannot have annual limits of less than $750,000 for the January 1, 2011 Plan Year for certain "essential" benefits. Plans can seek a waiver of annual limits for "essential" benefits from the Department of Health and Human Services if complying with the new annual limit would result in a significant decrease in employee access to benefits or a significant increase in employee payments.

Because the Active Plan currently has an annual limit on "essential" benefits below $750,000 for hospitalization and "pediatric" dental benefits, and the Fund's benefit consultant projected that the Fund's cost of benefits would increase significantly if it were required to increase the annual limit for these benefits to $750,000, the Board of Trustees obtained a waiver of these annual limits. As a result, if the Fund did not obtain the waiver for the plan year beginning January 1, 2011, the Trustees would have had to consider decreasing benefits or increasing participant cost sharing, such as increases in deductibles, co-payments and co-insurance. Because the Trustees did not want to have to consider decreasing benefits or increasing the out of pocket costs you pay for your health insurance, they decided that the best alternative was to apply to HHS for the waiver. Please note that all other annual limits in the Plan are considered to be "non-essential" benefits and there have been no changes to any other annual limits.

<u>You should be aware that as a result of obtaining the waiver, there will be no reductions in the current package of health benefits you are receiving</u>. The Board of Trustees is proud of the affordable health benefits that they have been able to provide over many years.

Please contact the Fund Office at 718-845-5800 with any questions you may have.

Very truly yours,

Robert D'Ulisse, Fund Director
On behalf of the Board of Trustees

DIVISION 1181 A.T.U. – NEW YORK WELFARE FUND
101-49 WOODHAVEN BOULEVARD, OZONE PARK, N.Y. 11416
(718) 845-5800

Notice of Waiver from the PPACA Annual Limit Requirement

Active Plan

The Affordable Care Act prohibits health plans from applying arbitrary dollar limits for coverage for key benefits. This year, if a plan applies a dollar limit on the coverage it provides for key benefits in a year, that limit must be at least $750,000.

Your health insurance coverage, offered by Division 1181 A.T.U. – New York Welfare Fund, does not meet the minimum standards required by the Affordable Care Act described above. Instead, it puts an annual limit of $500,000 on hospitalization benefits, and an annual limit of $2,000 on "pediatric" dental benefits, i.e. dental benefits for dependent children age 18 or younger.

In order to apply the lower limits described above, your health plan requested a waiver of the requirement that coverage for key benefits be at least $750,000 this year. That waiver was granted by the U.S. Department of Health and Human Services based on your health plan's representation that providing $750,000 in coverage for key benefits this year would result in a significant increase in your premiums or a significant decrease in your access to benefits. This waiver is valid for one year.

If the lower limits are a concern, there may be other options for health care coverage available to you and your family members. For more information, go to: www.HealthCare.gov.

If you have any questions or concerns about this notice, contact the Fund Office at (718) 845-5800.

In addition, if you live in New York, you can contact the New York Department of Insurance's Consumer Services Bureau at 1-800-342-3736. If you live in New Jersey you can contact the New Jersey Department of Banking and Insurance at 1-800-446-7467.

DIVISION 1181 A.T.U. - NEW YORK WELFARE FUND
SUMMARY OF MATERIAL MODIFICATIONS

The Board of Trustees of the Division 1181 A.T.U. - New York Welfare Fund is pleased to announce the following benefit improvements to the Division 1181 A.T.U. - New York Welfare Fund's Plan of benefits ("Plan") as a result of the health care reform law referred to as the Patient Protection and Affordable Health Care Act. In addition, the following SMM clarifies the scope of benefits provided under the Plan as described in your Summary Plan Description ("SPD"). Please keep this document with your SPD.

1. The definition of "Allowable Charge" in Section 1 of the SPD is amended by deleting the current definition and replacing it with the following:

> ***Allowable Charge*** means the lowest of: (1) the amount listed in the Fund's Schedule of Allowances for a given procedure; (2) the usual charge by the health care provider for the same or similar service or supply; (3) the charge that the Fund would pay under an agreement with a preferred provider organization to provide services to Covered Persons; or (4) the health care provider's actual charge (except for in-network hospital claims).

2. We are pleased to advise that the Fund has expanded dependent child coverage for most categories of children until the end of the month in which a dependent child reaches age 26. Therefore, effective January 1, 2011, the definition of "Dependent" in Section 1(A) is deleted in its entirety and replaced with the following:

> A. **In General**. Dependent means the following: (1) your legal spouse (including a same-sex spouse) if such spouse is not legally separated from you, (2) your biological or adopted child, a child placed with you for adoption, your stepchild, or a child over whom you have guardianship rights from birth to the end of the month in which they become age 26, or (3) your foster child from birth to the end of the calendar year in which they become age 19. For a foster child, the child must be unmarried, be dependent upon you for support and maintenance and live with you in a regular parent-child relationship. These conditions do not apply to other dependent children. To enroll, official copies of birth certificates, adoption papers, or guardianship papers must be submitted to the Fund Office. Dependent also includes someone who is provided coverage under this Plan pursuant to a Qualified Medical Child Support Order ("QMCSO").
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> If a child age 19-26 is excluded from coverage due to being eligible for health coverage through the child's employer or the child's spouse's employment (see subsection B below), the child can still qualify as a Dependent provided that he or she satisfies the student coverage requirements set forth in subsection C or disabled child coverage under subsection D.
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> **B. Exclusion for Children age 19-26 ("Adult Child").** If your Adult Child is eligible for health coverage through the child's employer or the child's spouse's employer, he or she will not be entitled to Dependent coverage under this Plan after the end of the calendar year in which the adult child attains age 19, unless he or she

otherwise is entitled under the student coverage rules in subsection C below or disabled child coverage under subsection D.

To receive coverage, the Adult Child and the Participant will be required to complete a notarized form attesting that the child is not eligible for coverage through the child's employer or the child's spouses' employer. Failure to complete this form upon request from the Fund Office will result in your Adult Child being ineligible for Dependent coverage under this Plan.

C. **Student Coverage.** Your foster child (or any other child otherwise ineligible for coverage due to subsection B) who is a full-time student enrolled for at least 12 credits per semester (9 credits per trimester) in an accredited school may be a Dependent under the Plan until the end of the calendar year in which they become age 23. Letters from the school confirming full-time enrollment must be submitted to the Fund Office for each semester to maintain coverage of such children as Dependents. Contact the Fund Office for information regarding whether your child's school is an accredited school.

If a Dependent child, who is enrolled in student coverage under this paragraph, is on a medically necessary leave of absence from an accredited school because of a serious injury or illness, coverage under this Plan will be extended, free of charge, during the leave of absence until the earlier of (i) the one-year anniversary of the date on which the leave of absence began, or (ii) the date on which the Dependent child's coverage under the Plan would otherwise terminate. To be eligible for this extended coverage, the Participant must provide the Plan with written certification from the Dependent child's treating physician that the leave of absence from school is medically necessary and is as a result of a serious illness or injury. The extended coverage commences on the date such certification is received by the Fund, but will be retroactive to the date on which the leave of absence began. Extended coverage under this paragraph will run concurrently with coverage under COBRA. This means that if the Dependent child receives one-year of extended coverage under this paragraph and, after the expiration of this one-year period, the Dependent child is not otherwise eligible for Plan coverage in accordance with the above paragraphs, the child can only elect to continue coverage under COBRA for up to an additional 24 months, not 36 months.

D. **Dependents with Disabilities**. Any Dependent child, regardless of age, who is incapable of self-sustaining employment by reason of mental or physical disability, may be a Dependent under the Plan, provided such child suffered the incapacity prior to reaching age 19 and is dependent upon you for support and maintenance. In such circumstances, you must submit a comprehensive medical report including date of onset and expected duration of the disability to the Fund Office. From time to time, additional medical certification of continued disability may be required by the Fund to maintain coverage of such children as Dependents. Any dependent qualifying for coverage under this paragraph will not be subject to the employment exclusion set forth in subsection B above.

3. Effective January 1, 2011, Section 2(E) is amended to provide that if you elect to waive coverage under the Fund pursuant to the collective bargaining agreement between your employer and the Union, and you later elect coverage from the Fund, no pre-existing condition exclusion will be imposed on any Participant or Dependent who is under age 19.

4. Effective January 1, 2011, Section 6(B) is amended by replacing the $1,000,000 lifetime limit on major medical benefits with a $1,000,000 annual limit on major medical benefits.

5. Effective January 1, 2011, the following language is added to your SPD:

> The Fund reserves the right to retroactively rescind or cancel your coverage under the Plan if you or any of your Dependents engage in fraud and/or intentional misrepresentation of a material fact, or if you or your Employer fails to timely pay premiums or contributions to the Fund. Failure to follow the terms of the Plan, such as failing to notify the Fund of a change in dependent status, accepting benefits in excess of what is covered under the Plan or after you or your Dependent are no longer eligible for coverage, will be considered fraud and/or intentional misrepresentation. You are treated as having knowledge of all the eligibility terms of this Plan. In the event that the Fund has made benefits to you on your behalf in error as a result of any of the above events, you are required to reimburse the Fund for all benefits overpaid, pursuant to Section 20 of this SPD.

6. Section 4 of the SPD is amended by adding this paragraph at the end thereof:

> For any mental health benefits provided under this Plan, any processes, strategies, evidentiary standards, or other factors used to determine any nonquantitative treatment limitation (such as a medical necessity determination) as applied to mental health benefits will be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards or other factors used to determine any nonquantitative treatment limitation for medical/surgical benefits, except when recognized clinically appropriate standards of care permit a difference.

7. Section 6(D) is amended to clarify that the Plan covers one gynecological wellness visit each year for female Participants and Dependents.

8. Section 6(D)(6) is amended to clarify that the Plan covers up to a maximum of 36 physical therapy visits per calendar year.

9. Section 6(D)(8) is amended to clarify that air ambulances are covered. However, if the Fund determines that the conditions for requiring an air ambulance transport have not been met, but the Participant's condition did require transportation via a land ambulance, reimbursement for an air ambulance will be limited to the amount the Fund would have paid for a land ambulance.

10. Section 6(D)(9) is amended to clarify that if a Participant receives treatment to repair sound and natural teeth resulting from an accident or injury, he or she must complete the treatment within 12 months of the accident or injury for the service to be covered.

11. Section 6(F) is amended to clarify that prosthetic wigs and toupees are covered in and out of network, subject to a $350 maximum every three years.

Notice of Grandfathered Status

The Division 1181 A.T.U. – New York Welfare Fund believes that both its Active and Retiree Plans are "grandfathered health plans" 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, effective January 1, 2011, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits of essential 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 as set forth 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.

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