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

Dear Participant:

Enclosed is a Notice that updates the version of the new Health Care Law, the Patient Protection and Affordable Care Act (PPACA) that was sent out in March 2012.

Please review this Notice and keep a copy for your records.

Also, included is the Summary of Material Modification (SMM) that has been recently adopted by the Trustees.

Please review and keep this copy for your records.

Very truly yours,

THE FUND OFFICE

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. This Notice updates the version of the Notice that you received in March 2012.

Under the new health care law, the Patient Protection and Affordable Care Act, group health plans generally cannot have annual limits of less than $1,250,000 for the January 1, 2012 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 $1,250,000 for hospitalization, major medical 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 $1,250,000, the Board of Trustees obtained a waiver of these annual limits. As a result, if the Fund did not obtain the waiver, 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.

You should be aware that as a result of obtaining the waiver, there have been no changes or reductions in the current package of health benefits you are receiving. 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

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Notice of Waiver from the PPACA Annual Limit Requirement

Active Plan

The Affordable Care Act prohibits health plans from applying dollar limits below a specific amount on coverage for certain benefits. This year, if a plan applies a dollar limit on the coverage it provides for certain benefits in a year, that limit must be at least $1,250,000.

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, an annual limit of $1,000,000 on major medical benefits and an annual limit of $2,000 on "pediatric" dental benefits, i.e. dental benefits for dependent children age 18 or younger.

This means that your health coverage might not pay for all of the health care expenses you incur. For example, a stay in a hospital costs around $1,853 per day. At this cost, your insurance would only pay 269 days.

Your health plan has requested that the U.S. Department of Health and Human Services waive the requirement to provide coverage for certain key benefits be at least $1,250,000 this year. Your health plan has stated that meeting this minimum dollar limit this year would result in a significant increase in your premiums or a significant decrease in your access to benefits. Based on this representation, the U.S. Department of Health and Human Services has waived the requirement for your plan until December 31, 2013.

If you are concerned about your plan's lower dollar limits on key benefits, you and your family may have other options for health care coverage. 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"), some of which are the result of the health care reform law (the "Patient Protection and Affordable Care Act"). Please keep this document with your SPD.

1. Effective September 1, 2010, Section 2(A) is amended by adding the following paragraph after the second paragraph:

Effective September 1, 2010, Employees must make a weekly contribution to the Fund for coverage. This contribution is made by a pre-tax deduction from your wages through your Employer's cafeteria plan. The Employer is responsible for timely submitting this payment to the Fund on your behalf. However, if you receive Fund coverage for a period during which you are not receiving a paycheck (i.e., while out on disability leave), **you** must send a check to the Fund for employee contributions for that period of coverage. Please discuss with the Fund Office and/or your Employer on how to make sure there are no outstanding employee contributions owed by you during a leave of absence.

2. Effective May 20, 2010, Section 2(A) is amended by adding the following paragraph at the end thereof:

If you were first hired by an Employer on or after May 20, 2010, you will become eligible for benefits as an Eligible Employee on the first day of the month following a 180-day waiting period, as governed by your CBA. For example, with a 180-day period, if you were hired on September 15th, you would first be eligible for benefits on April 1st. **To confirm your eligibility date, call the Fund office.**

However, if you were doing work for an Employer prior to May 20, 2010 that would have been covered by the CBA, but it was prior to the date the Employer commenced participating in this Fund, you will be eligible for benefits as an Eligible Employee once you complete a 90 day waiting period, as governed by your CBA, measured from the date you started working with your Employer.

3. Effective May 20, 2010, Section 2(B) is amended by adding the following paragraph at the end thereof:

New Hire/Non-Grandfathered Group Dependent Eligibility Rules

If you were first hired by an Employer on or after May 20, 2010, the Fund will not provide employer-paid dependent coverage until you have been eligible for coverage as an Eligible Employee for 42 months. Your Dependents will become

eligible for employer-paid dependent coverage on the first of the month following the completion of the 42-month waiting period.

However, once you are eligible for coverage as an Eligible Employee after your 6-month waiting period expires, you can enroll your dependents in Fund coverage by paying for the difference in total cost between single coverage and family coverage with a pre-tax wage deduction from your paycheck. Prior to commencing Fund coverage, the Fund will provide you with a form allowing you to elect Dependent coverage, which you must complete and return within 30 days from the date it is mailed to you. If you do not complete and return this form within 30 days, you will not be allowed to elect coverage for your Dependents until the next Open Enrollment period, occurring October 1st – October 31st of each Plan Year, for coverage effective November 1st.

As described in Section 2(F), there are certain "Qualifying Events", such as getting married and having a child, which would allow you to elect coverage for your Dependents outside of the Open Enrollment period. You must notify the Fund Office and your employer within 30 days of experiencing a "Qualifying Event" and complete any paperwork requested by your employer and/or the Fund Office to establish that this event has occurred. If this is done, you can pay for the cost of Dependent coverage by a pre-tax wage deduction from your paycheck. If you incur a HIPAA Special Enrollment event, as described in Section 2(G), and this event is not a "Qualifying Event" under your employer's cafeteria plan, you can still choose Dependent coverage and pay for the cost on an after-tax basis. For more questions about this process, please contact the Fund Office.

If you were doing work for an Employer prior to May 20, 2010 that would have been covered by the CBA, but it was prior to the date the Employer commenced participating in this Fund, your Dependents are eligible for employer-paid dependent coverage at the same time as you are eligible for coverage, if you had coverage for your Dependents prior to May 20, 2010 under your Employer's prior health plan. If you were only enrolled in single coverage prior to your Employer's participation in this Fund, your Dependents will not be eligible for employer-paid dependent coverage until the 48-month period ends, measured from the date you started coverage as an Eligible Employee under this Fund.

Please note that if you have a child age 19-26 that is eligible for health coverage through the child's employer or the child's spouse's employer, you may still enroll that child in Dependent coverage and keep him or her on coverage until the end of the month in which the child turns 26.

4. Effective January 1, 2011, Section 6 is amended by adding this new subsection (F):

F. Preventive Care Services (for New Hire/Non-Grandfathered Group)

If you were first hired by an Employer on or after May 20, 2010, you are part of the "Non-Grandfathered" or "New Hire" coverage group. This means that, under the new health care reform law, the Fund covers a number of preventive care

services without any cost-sharing for you and your Dependents, such as physical exams, screenings, tests, vaccines, and other preventive services that are on the following recommendation lists after the services have been listed for at least one year prior to the current Plan Year:

- Recommendations of the U.S. Preventive Services Task Force with a rating of A or B
- Recommended Immunizations of the Advisory Committee on Immunization Practices of the CDC
- Preventive care and screenings provided for in the Health Resources and Services Administration comprehensive guidelines.

To the extent a recommended service is provided as part of a regular office visit with your provider, the $15 copay for office visits still will apply. However, you will not be responsible for any copays or coinsurance with respect to any of the preventive services referenced above. **To the extent that you use an out-of-network provider for any preventive care service, you still will be responsible for the difference between the amount that the Fund would have paid an Empire BlueCross/Blue Shield Preferred Provider for this preventive service and the provider's actual charge for the service.**

For example, vaccines to treat HPV (such as Gardisil) are included in the recommended lists. Therefore, if you are in the New Hire group, the 50% cost-sharing requirement on each Gardisil vaccine does not apply, but the $15 co-pay for an office visit will apply if the vaccine is part of a regular office visit. Please note that these recommended lists also include certain age, frequency, setting and other limitations on these preventive services that may affect your ability to receive coverage for the service. If you have questions about whether a particular exam screening, test or vaccine is covered, please contact Empire at 1 (866) 513-2473.

5. Effective January 1, 2011, Section 6(H)(2) and (7) are amended to reflect that the exclusions for preventative examinations and injections do not affect preventive coverage required under Section 6(F) of this SPD.

6. Effective January 1, 2011, Section 9 is amended by adding this new subsection D:

D. COVERED OTC DRUGS FOR NEW HIRE/NON-GRANDFATHERED GROUP

The following Over-the-Counter ("OTC") drugs and vitamins are covered for participants in the Fund's New Hire group if you have a prescription: aspirin, fluoride, folic acid, and iron. There are certain age, gender, and other reasonable medical management limitations on coverage for these OTC drugs and vitamins. For any other questions on this benefit, including how to receive reimbursement for these drugs, please contact Medco at 1 (800) 711-0917.

7. Effective January 1, 2011, Section 9(E)(1) is amended to reflect that the OTC exclusion does not apply to coverage required under Section 9(D) of this SPD.

8. Effective May 1, 2012, your life insurance and accidental death and dismemberment benefits are provided by Lincoln Life and Annuity Company of New York, 8801 Indian Hills Drive, Omaha, NE 68114-4066. The Fund continues to provide $20,000 in life insurance and $10,000 in accidental death and dismemberment benefits for Participants, and $9,000 in life insurance for Eligible Retirees through its new policy with Lincoln. The benefits are governed by the terms of the insurance contract with Lincoln and Lincoln processes these benefits.

9. Effective January 1, 2012, Section 18 is amended by adding this new subsection (D):

D. Additional Initial Claim Procedures for New Hire/Non-Grandfathered Plan

Upon request, the Fund will provide you with the diagnosis codes, treatment codes and their corresponding meaning in connection with any adverse benefit determination made by the Fund. **However, making this request is not a request for an appeal; see Section 18(E) for the procedures on how to appeal an adverse benefit determination.**

If you live in a county in which 10% of more of the population in that county is literate only in a non-English language (as determined by the federal government) you may request to receive any adverse benefit determination or final adverse benefit determination in that non-English language. Please contact the Fund Office for more information.

10. Effective January 1, 2012, Section 18 is amended by adding these new subsections (F) and (G):

F. Additional Appeal Procedures for New Hire/Non-Grandfathered Plan

If, on appeal, the Fund relies upon, considers or prepares new or additional evidence in connection with a claim, this evidence must be provided to you as soon as possible and sufficiently in advance of the date on which you are notified of the Fund's final decision on appeal in order to give you a reasonable opportunity to respond.

If the Fund denies your claim on a basis other than what is originally stated in your initial claim denial, the Fund must provide this basis to you as soon as possible and sufficiently in advance of the date on which the Fund makes a final decision on appeal in order to give you a reasonable opportunity to respond.

G. External Review of Denied Claims for New Hire/Non-Grandfathered Plan

1. Standard External Review. If you receive a final adverse benefit determination based on a medical judgment decision or a rescission of your coverage, you may appeal that determination to an external independent review organization ("IRO"). Claim denials for reasons other than medical judgment or rescission of coverage are not subject to external review.

A request for external review must be filed with the Fund Office within four months after you receive notice of the adverse benefit determination. The Fund will forward the claim onto the applicable IRO for review and the IRO will follow the procedure under the law for reviewing your claim.

Within five business days of receiving your external review request, the IRO will complete a preliminary review of your request to determine whether it is eligible for external review. Within one business day after the preliminary review is complete, the IRO will advise you of the decision. If your claim is eligible for external review, the IRO will commence its review of your claim.

In making its decision, the IRO will review all of the information and documents it timely receives, and will not be bound by any decisions or conclusions reached during the Fund's internal claims and appeals process. In addition, the IRO may consider additional information relating to your claim to the extent the information is available and the IRO considers it to be relevant.

The IRO will provide you with written notice of its external review decision within 45 days after receiving the request for the external review. The IRO's decision notice will contain a general description of the claim and the reason for the external review request, including information sufficient to identify the claim (such as date(s) of service, the health care provider, the claim amount (if applicable)), the reason for the previous denial, and other information required by law.

Upon request, the IRO will make available to you its records relating to your request for external review, unless such disclosure would violate state or federal privacy laws.

Reversal of the Fund's decision. If the Fund receives a final external review decision that reverses the Fund's adverse benefit decision, the Fund immediately will provide coverage or payment of the claim.

2. *Expedited External Review.*

You may request an expedited external review of an urgent care claim denial, or of an appeal denial involving an emergency admission, continued stay or emergency service, if the claimant has not yet been discharged from the facility. You also may request an expedited external review at the same time as an appeal to the Fund's Trustees, if the claimant requires urgent care or is receiving an on-going course of treatment.

Preliminary Review. Immediately upon receiving your request for expedited external review, the IRO will determine whether your request is eligible for standard external review as described above. The Fund immediately will send you a notice of its eligibility determination.

Referral to Independent Review Organization. Upon determining that a request is eligible for external review, the IRO will provide you and the Fund with notice of its decision as soon as possible but no later than 72 hours after it receives the review request.

11. The Fund has updated the Fund's HIPAA Notice of Privacy Practices in Section 21 of the SPD to reflect the HITECH provisions, effective February 17, 2010. If you would like this revised notice, please contact the Fund Office.

12. Effective September 1, 2010, in the subsection entitled "Sources of Contributions" in Section 22 of this SPD, the first sentence is replaced with the following:

"Benefits under the Plan are funded by contributions from employers that are signatories to collective bargaining agreements with the Union and agreements with the Fund, as well as contributions from Employees."