

MAY 25, 2011

IMPORTANT INFORMATION ABOUT YOUR HEALTH AND WELFARE BENEFITS

Dear Active and Retired Participants:

As Trustees of the Sheet Metal Workers' Local 73 Welfare Fund (the "Plan"), we value your service and are proud to offer coverage to help meet the health care needs of you and your family. We are committed to keeping you informed and want to make you aware of enhancements to your benefits, effective July 1, 2011. These changes are a result of the Patient Protection and Affordable Care Act (the "Affordable Care Act"), and the Mental Health Parity and Addiction Equity Act of 2008, and are highlighted in this document.

STATEMENT OF GRANDFATHERED STATUS

The Board of Trustees believes that the Plan is a "grandfathered health plan" under the Affordable Care Act, which means that our Plan existed when the health care reform law was signed on March 23, 2010, and that we can preserve certain basic health coverage that was already in effect when the law was passed. However, as with all grandfathered health plans, we must still comply with certain consumer protections in the Affordable Care Act (for example, the elimination of the Plan's lifetime maximum). Consequently, because this Plan is "grandfathered" and not required to adopt other changes required by the Affordable Care Act, this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans.

To find out more about what it means for a health plan to have grandfathered status and what might cause a plan to lose its grandfathered status, you may contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. The website includes a chart summarizing the protections that do and do not apply to grandfathered health plans. You can also contact the Fund Office for more information at 708-449-7373, ext. 3.

ELIMINATION OF PLAN MAXIMUMS

Under the Affordable Care Act, all group health plans must eliminate certain annual dollar limits on essential benefits. In addition, group health plans must eliminate the overall lifetime dollar limit.

Elimination of Annual Maximums

We are eliminating certain annual maximums effective July 1, 2011:

- The Wellness Benefit maximum of \$250 for you and your spouse every two years is eliminated.
- The Infertility Treatment lifetime maximum of \$20,000 for you and your spouse combined is eliminated for the diagnosis and treatment of infertility. The lifetime maximum of \$20,000 will still apply to treatments that promote conception (e.g., in vitro fertilization embryo transfer, artificial insemination, GIFT, ZIFT).
- The Hospice Benefit lifetime maximum of \$10,000 is eliminated. This benefit will now have a 16-day annual limit on inpatient care or an 80-day annual limit on outpatient care. Bereavement Counseling will continue to have a six-visit lifetime limit, but the current \$50 per visit limit is eliminated.
- The Hearing Aid Benefit three-year maximum of \$1,300 is eliminated. The Plan will now pay up to \$650 per hearing aid.
- The Chiropractic Services Benefit annual limit of \$1,250 is eliminated. The Plan will now cover up to 20 visits per year.

- The Vision Benefits maximum of \$225 per person during a consecutive two-year period is eliminated for pediatric preventive care and screening services only. If you or your eligible dependent is under age 19, the Plan will cover reasonable and customary charges for an annual vision exam. The \$225 two-year period maximum will still apply to pediatric lenses and frames, and on all adult vision services (lenses, frames and eye exams).
- The Dental Benefit annual maximum of \$1,500 for Plan A employees and dependents, and the \$900 annual maximum for Retirees, are eliminated for *pediatric services, including preventive care and screenings, only*. As a result, there will be no annual dental maximum for eligible Plan A enrollees under age 19 or retirees' dependents under age 19. The \$1,500 per child lifetime maximum on Plan A orthodontic benefits will remain in effect.

Elimination of Retired Plan Lifetime Maximum

Effective July 1, 2011, the Plan will eliminate the \$600,000 lifetime maximum on the Retired Plan medical coverage to comply with the Affordable Care Act and replace it with a \$750,000 annual maximum.

Special Enrollment Opportunity Due to Elimination of Retired Plan Lifetime Maximum

The Plan is required to provide a special enrollment opportunity that runs at least 30 days. If retiree coverage for you, your spouse, and/or your dependent child(ren) ended under the Plan because you reached the current lifetime maximum, you may re-enroll yourself and/or your dependents in the Plan as of July 1, 2011. To receive Plan coverage, you must request special enrollment to cover you, your spouse, and/or dependent children **no later than June 30, 2011**. *If you request special enrollment by that date, coverage will be effective as of July 1, 2011. Your coverage will begin July 1, 2011 and will not be retroactive to when you originally lost coverage.*

An enrollment form is included with this announcement. Please keep in mind that in order to have coverage effective as of July 1, 2011, you must enroll by **June 30, 2011**. If you are mailing your completed special enrollment form, it must be postmarked by **June 30, 2011**. **The enrollment form should be returned to the Fund Office in the enclosed self addressed envelope.**

EXTENSION OF DEPENDENT COVERAGE TO AGE 26

A 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, reside with you, and/or are married.

Revised Definition of Dependent Children

As a result of this extension, the Plan's definition of a Dependent Child is changing. Effective July 1, 2011, an eligible Dependent Child (whether a student, married or unmarried) will include your:

- Children under age 26 who are your natural children, adopted children, children placed with you for adoption, stepchildren, and foster children placed with you by an authorized agency or by court order, judgment or decree;
- Children for whom you or your covered spouse are required to provide medical coverage under a Qualified Medical Child Support Order (QMCSO);
- Unmarried children who have reached age 26, became physically or mentally disabled prior to age 19, have the same principal residence as you for more than one-half of the calendar year, and are dependent on you for more than one-half of their support for the calendar year. To be eligible, your Child must be unable to engage in the normal activities of a person of like gender and age in good health due to disability or handicap. You must consult the Fund Office within 31 days before Plan benefits might otherwise terminate to apply for continued coverage for your disabled Dependent Child.

An unmarried disabled child who has reached age 26, but does not reside with you, will be a Dependent Child under the Plan if:

- The Child's parents are divorced or legally separated under a decree of divorce or separate maintenance, are separated under a written separation agreement, or live apart at all times during the last six months of the calendar year;
- The Child's parents provide over one-half of the Child's support during the calendar year; and
- The Child is in the custody of one or both of his or her parents for more than one-half of the calendar year and is not the qualifying child of any other person during the calendar year.

Children's coverage will terminate on the date they reach age 26 unless they qualify for extended coverage as physically or mentally disabled.

Special Enrollment Opportunity for Children

If you have a child who is under age 26 regardless of whether the child is a student, resides with you, is married/unmarried, or currently receiving continuation coverage under COBRA, that child has a right to coverage under the Plan as of July 1, 2011. This special enrollment opportunity applies to:

- Children whose coverage under the Plan has already ended, and
- Children who were previously denied coverage under the Plan;

You must furnish the Trustees with any requested documentation relating to your dependents. Required documentation proving dependent relationship may include one or more of the following:

- Birth Certificate or adoption papers—for your children, it must list you and/or your spouse as a parent;
- Qualified Medical Child Support Order (QMCSO); and
- Social Security Number.

Note: If your dependent was previously covered under the Plan, you are not required to provide documentation. If you submit the enrollment form by June 30, 2011, your child's coverage will begin July 1, 2011 and will not be retroactive to when he/she originally lost coverage.

To enroll your child(ren), please see the special enrollment form enclosed with this announcement. ***For coverage to be effective July 1, 2011, you must request special enrollment on behalf of your child(ren) no later than June 30, 2011.*** You must submit your completed form to the Fund Office at the address shown at the top of the enrollment form by **June 30, 2011**. If you are mailing your completed special enrollment form, it must be postmarked by **June 30, 2011**.

ELIMINATION OF PRE-EXISTING CONDITION LIMITATION ON PLAN C NON-BARGAINED ENROLLEES UNDER AGE 19

The Affordable Care Act requires all group health plans with a pre-existing condition limitation to eliminate this exclusion for enrollees under age 19. The change becomes effective for the Plan on July 1, 2011. With this change, the Plan will no longer exclude benefits or deny coverage for Plan C non-bargained enrollees under age 19 because of a pre-existing condition, even if the individual received medical advice, diagnosis, care, or treatment before July 1, 2011.

ADDITIONAL BENEFIT PLAN CHANGES

Behavioral Health and Substance Abuse Changes

Coverage under the Plan's Mental Health and Substance Abuse Benefits is changing so that such benefits will be treated in the same manner as other medical benefits. The following changes will be effective July 1, 2011:

- **No Annual or Lifetime Maximums for Inpatient Days.** The annual maximum of 30 days per calendar year for inpatient mental health no longer applies. In addition, the \$15,000 calendar year maximum and \$30,000 lifetime maximum on substance abuse treatment no longer apply.

- **No Annual or Lifetime Maximum for Outpatient Visits.** The annual maximum of 45 visits per calendar year for outpatient mental health no longer applies. In addition, the \$15,000 calendar year maximum and \$30,000 lifetime maximum on substance abuse treatment no longer apply.
- **Coinsurance on Outpatient Visits Changing.** The current 50% coinsurance on outpatient visits will change to match the medical coinsurance.
 - **In-Network:** The Plan will pay 80% of hospital outpatient visits, and 85% of In-Network physician visits.
 - **Out-of-Network:** The Plan will pay 70% of all outpatient visits.
- **In-Network Out-of-Pocket Maximum.** Any mental health and substance abuse In-Network out-of-pocket expenses will now apply toward satisfying the Plan's out-of-pocket maximum. Once you reach the Plan's out-of-pocket maximum, the Plan will cover 100% of eligible expenses.

A FINAL NOTE

Please take some time to review this announcement. If you are married, share this information with your spouse. Contact the Fund Office at 1-708-449-7373, ext. 3 if you have any questions about the benefits described in this notice.

For more information about the Affordable Care Act, you may also contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Sincerely,

Board of Trustees
Sheet Metal Workers' Local 73 Welfare Fund

This announcement, which serves as a Summary of Material Modifications, contains only highlights of recent changes to the Sheet Metal Workers' Local 73 Welfare Fund. Full details are contained in the documents that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the document language will govern. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.

RETURN THIS FORM TO FUND OFFICE
IN THE ENCLOSED SELF ADDRESSED ENVELOPE!!

Sheet Metal Workers' Local 73 Welfare Fund

4530 Roosevelt Road, Hillside, Illinois 60162~Phone: 708-449-7373~Fax 708-449-7458~www.sm73funds.org

**SPECIAL ENROLLMENT OPPORTUNITY
 FOR DEPENDENT CHILDREN UNDER AGE 26 OR
 INDIVIDUALS WHO LOST COVERAGE DUE TO REACHING RETIRED PLAN'S LIFETIME LIMIT**

The Patient Protection and Affordable Care Act extends dependent coverage to children up to age 26 or to individuals who lost Plan coverage due to reaching the Retired Plan's lifetime maximum. If you or your dependents are now eligible for Plan coverage, you have a special enrollment opportunity to enroll yourself or your eligible dependent child in the Plan.

For coverage to be effective July 1, 2011, you must send this completed form and any required documentation to the Fund Office at the address above by June 30, 2011 (dropped off, postmarked or faxed).

Participant Information

Participant Full Name: _____ Participant SSN: _____
 Address: _____ City: _____ State: ____ Zip Code: _____
 Home Phone #: _____ Date of Birth: _____ Marital Status: Single Married Divorced Widowed

Dependent Information

Provide all information for eligible dependents to be covered under the Plan.

| Dependent's Full Name (First, MI, Last) | Relationship | Gender | | Social Security Number | Date of Birth (mm/dd/yyyy) | Currently Insured? | | If Yes, please specify Policyholder: DE = Dependent's Employer, DSE = Dependent's Spouse's Employer or O = Other - please specify |
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If dependent's address is different from Participant, provide information below:

Address: _____ City: _____ State: ____ Zip Code: _____

Dependent Documentation/Proof

You must also enclose a CERTIFIED STATE OR COUNTY duplicate of the birth certificate to add a child. A certified duplicate is a copy acquired from the state or county in which the birth occurred. Hospital and church records are not acceptable. All information must be completed and provided or your dependents will not be enrolled under your group health care coverage. **If your dependent was previously covered under the Plan, you ARE NOT required to provide your birth certificate.**

Participant Authorization

I understand that the information on this form will be used to determine eligibility for coverage for my dependent(s) under the Sheet Metal Workers' Local 73 Welfare Fund effective July 1, 2011. I hereby certify that the information on this form, to the best of my knowledge and belief, is true, correct, and complete. I also understand that willingly falsifying any of the information on this form is considered to be fraud and may be cause for termination of coverage and may also be subject to penalties.

Participant Name (print): _____

Participant Signature: _____ Date: _____

Dependent's Signature: _____ Date: _____