IRON WORKERS DISTRICT COUNCIL OF WESTERN NEW YORK AND VICINITY WELFARE FUND

SUMMARY OF MATERIAL MODIFICATIONS
AND
NOTICE TO PARTICIPANTS

(Plan No: 501; I.D. 16-0776208)

June 2011

Dear Participant,

The following is a summary of important changes made to your Plan/Summary Plan Description. Please keep this with your Welfare Fund booklet.

On July 1, 2011, several changes will take effect as a result of the Patient Protection and Affordable Care Act of 2010 (the "Affordable Care Act"). Please take a moment to carefully read the information below.

A. Coverage for Dependent Children up to Age 26

The Plan's definition of Dependent Child is amended in accordance with the Affordable Care Act. Effective July 1, 2011, the Fund will extend coverage to participants' eligible children up to the end of the month in which the child attains age 26. Eligible children include a child, whether married or unmarried, under the age of 26 who is a participant's natural child, legally adopted child, child placed for adoption, and any children as required by a Qualified Medical Child Support Order. Coverage is available regardless of student status, financial dependency on the participant, or any other factor other than the relationship between the child and the participant.

However, until June 30, 2014, in order to receive such coverage under the Fund, adult children who are over age 18 and not yet age 26 cannot have access to health insurance coverage through their own employer or their spouse's employer. This means that if your adult child has health insurance coverage available through his or her own employer or a spouse's employer – even if it requires your child to pay all or any portion of the cost of the coverage, and even if your child has not enrolled in the employer's plan – your child will not be eligible for extended coverage under this Fund. Please note, in addition, that if your adult child is married, this Fund will not provide coverage to the child's spouse or children.

As long as you (the Participant) remain eligible under the Fund, coverage for your eligible children will generally be provided until the last day of the month in which your eligible child attains age 26.

The provisions for "Extension of Coverage for Handicapped Children" and "Qualified Medical Child Support Order or National Medical Support Order" have not changed.

B. Elimination of Lifetime Benefit Maximum on Major Medical Benefits

Effective July 1, 2011, the $750,000 maximum lifetime benefit for all covered medical expenses combined under the Iron Workers District Council of Western New York and Vicinity Welfare Fund no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information, contact the Plan Administrator at (585) 424-3510 or toll free at (800) 288-0782.

C. Establishment of a $750,000 Annual Benefit Maximum on Major Medical Benefits through June 30, 2012

Effective for the Plan Year beginning July 1, 2011, the Annual Maximum Medical Expense Benefit will be $750,000 per year whether such illness or injury is related to physical health or mental health.

Major Medical Expense Benefits for each of your eligible dependents will be provided to them on the same basis as your own, as described above.

D. Removal of Dollar Limit Maximums of Certain Essential Benefits

The dollar maximums on the following benefits have been eliminated effective July 1, 2011. Any amounts included for these benefits will accumulate toward the Plan's annual Maximum Benefit of $750,000 (except as otherwise noted) for the Plan Year beginning July 1, 2011. Benefits will continue to be payable according to the amount prescribed by the reasonable and customary charge as determined by the schedule adopted by the Trustees.

Hospital/Medical Benefits

- The $10,000 annual dollar maximum for Durable Medical Equipment (DME) no longer applies. Please see page 30 of the Summary Plan Description (SPD) for more information about this benefit.

- The $5,000 per injury or illness dollar maximum on outpatient rehabilitative services and the $40,000 per injury or illness dollar maximum on inpatient and outpatient rehabilitative services no longer applies. Please see page 41 of the Summary Plan Description for more information about this benefit.

- The $600 reimbursement maximum (for eligible dependent children between the ages of birth and 12 months) and the $100 per visit reimbursement maximum (for eligible dependent children between the ages of 13 months and 6 years) for exams, testing and immunizations under a Well-Child visit no longer applies. Please note that there remains a maximum of twelve (12) Well Child visits for eligible dependent children between the ages of birth and 6 years. Please see page 43 of the Summary Plan Description (SPD) for more information about this benefit.

- The $100 per visit reimbursement maximum for eligible children between the ages of 7 and 19 years for exams, testing and immunizations under a Well Child visit no longer applies. Please note that there remains a maximum of three (3) Well Child visits for eligible dependent children between the ages of 7 years and 19 years. Please see page 43 of the Summary Plan Description (SPD) for more information about this benefit.

Dental Benefits (excluding orthodontia benefits for children)

The $1,500 annual dollar maximum per individual has been eliminated effective July 1, 2011 for your covered eligible children under the age of 19.

Please note that the lifetime maximum benefit of $2,050 for orthodontia treatment for dependent children still applies.

Please note that the $1,500 annual dollar maximum per individual for covered dental benefits per eligible covered employee, spouse, and dependent(s) ages 19 and above still applies.

Please see pages 49-55 of the Summary Plan Description (SPD) for more information about covered Dental Benefits.

Optical Benefits

Effective July 1, 2011, for children under the age of 19, the $200 maximum reimbursement for an eye examination, prescription glasses or contact lenses, eyeglass frames and/or optical repairs no longer applies for optical care. Please note that optical/vision benefits are limited to once every 24 months, and are subject to reasonable and customary amounts. Please see page 38 of the Summary Plan Description (SPD) for more information about this benefit.

E. Important Notice Regarding Termination of Healthcare Coverage for Cause, Including Fraud or Intentional Misrepresentation

As always, the Fund reserves the right to terminate coverage for you and/or your dependent(s) if you and/or your dependent(s) are otherwise determined to be ineligible for coverage. Pursuant to the Affordable Care Act, the coverage will not be rescinded retroactively (as opposed to prospectively) except in certain circumstances, such as where you or your covered dependent(s) commits fraud or intentional misrepresentation (for example, in enrollment materials, a claim, or appeal for benefits or in response to a question from the Fund administrator or its delegates). In such cases of fraud or intentional misrepresentation, your coverage may be rescinded retroactively upon thirty (30) days' notice. Failure to inform the Fund Office that you or your dependent is covered under another group health plan or knowingly providing false information to obtain coverage for an ineligible dependent are examples of actions that constitute fraud or intentional misrepresentation. Coverage may also be eliminated retroactively (without notice) in cases in which it would not be considered rescission under the Affordable Care Act, such as failure to pay a required premium or contribution toward the cost of coverage.

F. Grandfathered Status under the Affordable Care Act

The Iron Workers District Council of Western New York and Vicinity Welfare Fund believes this is a "grandfathered health plan" under the Patient Protection and Affordable Care Act of 2010 ("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.

As a grandfathered plan, your plan may not include certain consumer protections of the Affordable Care Act that apply to non-grandfathered plans: for example, the requirement for the provision of preventive health services without any cost sharing would not apply to a grandfathered plan. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on 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 Ms. Suzanne Ranelli, the Administrative Manager, at (585) 424-3510 or at (800) 288-0782. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (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.

As always, if you have any questions regarding these benefit modifications, please contact the Fund Office at (585) 424-3510.

Sincerely,

The Board of Trustees