Iron Workers District Council of Western New York and Vicinity

Welfare, Pension and Annuity Funds

LOCAL UNIONS
9–NIAGARA FALLS
12–ALBANY
33–ROCHESTER
60–SYRACUSE
440–UTICA

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WELFARE FUND

SUMMARY OF MATERIAL MODIFICATION/REDUCTION
AND
NOTICE TO PARTICIPANTS

(Plan No: 501; EIN 16-0776208)

October 3, 2016

Dear Participant,

The following is a summary of important changes made to your Plan/Summary Plan Description. Please take a moment to carefully read the information below, then keep this communication with your Welfare Fund booklet for future reference.

Prescription Drug Benefits

New Prescription Drug Formulary

Effective August 1, 2016, the Plan will only cover prescription generic and brand name drugs on the Express Scripts National Preferred Formulary, as updated from time to time. The Express Scripts National Preferred Formulary is a list of commonly prescribed medications that can safely and effectively treat most medical conditions while helping to keep costs down. Because non-formulary drugs will not be covered by the plan, if you fill a prescription for a non-formulary drug after July 31, 2016, you will have to pay the entire cost for the prescription. If you were affected by this change, you should already have received a letter from Express Scripts advising you of the change as well as potential alternative, therapeutically equivalent alternatives for you and your physician to consider.

Please note, the National Preferred Formulary is subject to change. To find out whether a medication is on the formulary, call Express Scripts at the number on the back of your identification card or visit Express Scripts online at www.express-scripts.com. In addition, if you attempt to fill a prescription that is not on the National Preferred Formulary, the pharmacist will generally let you know and work with the prescribing physician or health care practitioner to find a comparable drug on the formulary to ensure coverage.

In addition, the cost-sharing amounts of prescription drugs will change on January 1, 2017. The specific changes are described in more detail; however, you will see that the amount of Coinsurance for brand name drugs depends on whether the brand is classified as a *preferred* or *non-preferred* drug on the formulary. As a general rule, generic drugs are the lowest cost

option available under the Plan. When you purchase generic drugs, you will pay a fixed Copayment amount for each prescription. Brand drugs cost more than generic drugs and beginning January 1, 2017, are subject to Coinsurance with mandatory minimums and maximums. In addition, you will pay less for preferred brand drugs than non-preferred brand drugs because the Coinsurance minimums and maximums effective in 2017 are lower for preferred brand drugs.

There may be exceptions for coverage of a non-formulary drug in certain circumstances. Use of drugs that are not on the formulary and thus not covered by the Plan must be approved through Express Scripts' exception process. The requests are evaluated on the basis of medical necessity, the individual's health and safety, and the existence of other comparable alternatives. If you or your physician would like to request an exception, your physician must contact Express Scripts directly because the exception process must be initiated by your physician. If your physician's request is approved through that process, your applicable cost-sharing would depend on whether it is a brand or generic drug. In the case of a brand, your cost would fall under the *non-preferred* brand name drug tier described in the Overview of the Prescription Drug Benefits chart beginning on page 3.

Accredo Specialty Pharmacy

Effective August 1, 2016, Accredo Specialty Pharmacy will be the plan's exclusive supplier of specialty medications. Specialty medications are used to treat a broad array of complex diseases that may require special handling, administration by infusion or injection, or specialized patient support.

Specialty medications obtained from a pharmacy other than Accredo Specialty Pharmacy will not be covered. If you fill a prescription for a specialty drug with a pharmacy other than Accredo, you will have to pay the entire cost for the prescription.

New Cost-Sharing Amounts

Effective January 1, 2017, the cost-sharing amounts for prescription drugs will change. In addition, separate Out-of-Pocket (OOP) Maximums will apply to individuals and families for covered in-network prescription drugs. The OOP Maximum is the most you have to pay for covered in-network prescription drugs in a calendar year and includes Deductibles, Copays, and Coinsurance. After you reach the in-network OOP Maximum, the plan pays 100% of the cost of in network prescription drugs for the remainder of the calendar year.

The OOP Maximum for individuals will apply to everyone, including those enrolled in family coverage. This means that no person can be required to pay more in annual cost- sharing than the individual OOP Maximum, even though a family unit as a whole may be subject to the higher overall OOP Maximum. In addition, please note that the OOP Maximum for in-network health care services (described on page 5) is entirely separate from the OOP Maximum for prescription drugs. A comparison of the changes to the prescription drug plan is provided in the Overview of the Prescription Drug Benefits chart on page 3.

OVERVIEW OF THE PRESCRIPTION DRUG BENEFITS

	Current		Effective January 1, 2017	
	Retail (Greater of a 30-day supply or 100 units)	**Mail (90-day supply)**	**Retail (Greater of a 30-day supply or 100 units)**	**Mail (90-day supply)**
	NON-SPECIALTY PRESCRIPTION DRUGS			
Generic	$10 Copay	$20 Copay	$10 Copay	$20 Copay
Brand *Preferred*	$20 Copay	$40 Copay	20% Coinsurance ($20 Min/$40 Max)	20% Coinsurance ($50 Min/$100 Max)
Brand *Non-preferred*			20% Coinsurance ($40 Min/$80 Max)	20% Coinsurance ($100 Min/$200 Max)
	SPECIALTY PRESCRIPTION DRUGS			
Generic	$10 Copay	$20 Copay	Not covered	20% Coinsurance ($300 Max per prescription)
Brand *Preferred*	$20 Copay	$40 Copay	Not covered	20% Coinsurance ($300 Max per prescription)
Brand *Non-preferred*			Not covered	20% Coinsurance ($400 Max per prescription)
Out-of-Pocket Maximum*				
Per Individual	Not applicable		$4,150	
Per Family	Not Applicable		$8,300	

*The OOP Maximums listed in the Overview of the Prescription Drug Benefits chart above are for prescription drugs only. Separate OOP Maximums also apply to the medical plan beginning January 1, 2017.

Medical Plan Benefits

New Deductible Amounts

Effective January 1, 2017, separate Deductibles will apply for in-network and out-of-network services. A Deductible is the amount you owe for covered health care services in a calendar

year before the plan begins to pay. Lower Deductibles apply to in-network services as compared to out-of-network services. A comparison of the changes to the Deductible amounts is provided in the Overview of the Medical Benefits chart beginning on page 5.

New Hospital Copayment (Copay)

Effective January 1, 2017, a Copay will apply to each Hospital admission. A Copay is a fixed dollar amount you pay for a covered health care service. You will pay a smaller Copay amount for an in-network Hospital admission as compared to out-of-network Hospital admissions. The specific Copay amounts for in and out-of-network Hospital admissions are provided in the Overview of the Medical Benefits chart on page 5.

Please note, when you are admitted to an out-of-network Hospital as an inpatient, you will have to pay Coinsurance for health care services furnished to you during your stay.

New Coinsurance Levels

Effective January 1, 2017, the Coinsurance levels you pay for health care services and medical supplies will change. Coinsurance is your share of the costs of a covered health care service, calculated as a percentage of the Allowed Amount for the service. When you pay Coinsurance for a covered health care service, the plan will pay the rest of the Allowed Amount for the service. You will pay less Coinsurance (and the plan will pay more of the Allowed Amount) for in-network services as compared to out-of-network services. Generally, any applicable Deductible must be met before Coinsurance is applied. A comparison of the changes to the Coinsurance amounts is provided in the Overview of Changes to Medical Benefits chart on page 5.

New Out-of-Pocket (OOP) Maximums

Effective January 1, 2017, separate OOP Maximums will apply to individuals and families for covered in-network health care services. The OOP Maximum is the most you have to pay for covered in-network health care services in a calendar year and includes Deductibles, Copays, and Coinsurance. After you reach the in-network OOP Maximum, the plan pays 100% of the costs of services for the remainder of the calendar year for in-network services. There will no longer be a limit on out-of-pocket costs for out-of-network services.

The OOP Maximum for individuals will apply to everyone, including those enrolled in family coverage. This means that no person can be required to pay more in annual cost- sharing than the individual OOP Maximum, even though a family unit as a whole may be subject to the higher overall OOP Maximum. In addition, please note that the OOP Maximum for prescription drugs (described on page 3) is entirely separate from the OOP Maximum for in-network health care services. A comparison of the changes to the OOP Maximums is provided in the Overview of the Medical Benefits chart on page 5.

OVERVIEW OF CHANGES TO MEDICAL BENEFITS

	Current		Effective January 1, 2017	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible				
Per Individual	$200	$200	$400	$800
Per Family	$400	$400	$800	$1,600
Hospital Admission Copay	$0		$100	$200
Coinsurance				
Hospital, Specialized Health Care Facilities and Home Health Care	None	10%	None	30%
Office Visits, Urgent Care Outpatient Rehabilitation Services and Durable Medical Equipment	20%	30%	20%	40%
Inpatient Health Care Practitioner Visits and Surgeons' Fees	4%	14%	20%	40%
Diagnostic Tests and Imaging	4%	14%	20%	40%
Out-of-Pocket Maximum*				
Per individual	$2,500	$2,500	$3,000	No limit
Per family	Not applicable	Not applicable	$6,000	No limit
OOP Maximum includes Deductibles?	No		Yes	

*The OOP Maximums listed in the Overview of the Medical Benefits chart above are for covered health care services and medical supplies only. Separate OOP Maximums also apply to the prescription drug plan beginning January 1, 2017.

Change in Network and Claims Administration from MultiPlan to Excellus Blue Cross Blue Shield

Beginning January 1, 2017, the Fund has contracted with Excellus Blue Cross Blue Shield to use its PPO network of medical providers as well as the expansive Nationwide BlueCard PPO network. The discounts offered through the Excellus networks are more substantial than those offered through the MultiPlan networks. This change means that in most instances, both the Fund's and your costs for medical services will be lower than they would have been had the Fund stayed with MultiPlan.

Many of the providers that participants currently use already participate in the Excellus or BlueCard PPO networks, meaning that for most, there is no reason to change your doctor or

hospital that you currently use. However, it is highly recommended that you contact your medical providers to ensure that they participate in the Excellus PPO or BlueCard PPO network before visiting them in 2017. **You can also search for your provider by going to www.excellusbcbs.com and clicking on the "Members" tab and look for the provider search function.** Using providers that participate in the network will save you money on your claims. In addition, special cost-sharing limits and plan features such as out-of-pocket maximums and free preventive health care only apply when you visit an in-network provider.

With the change in network to Excellus, the Fund is also relinquishing the administration and adjudication of claims to Excellus. This means that Excellus will be administering your plan of benefits beginning January 1, 2017. In addition, your Explanation of Benefits will be produced and sent by Excellus, so please recognize that mail you may receive from Excellus is likely important Fund-related information. If you have problems or questions about your medical claims or benefits that are incurred on or after January 1, 2017, you should reach out directly to Excellus at the phone number provided on your member ID card that will be mailed to you in December. You should continue to use your current ID card for services rendered prior to January 1, 2017. In certain instances, the Fund Office will still be available to assist in resolving issues you may experience.

The Fund Office is currently working diligently with Excellus to make this transition as smooth as possible for you and your dependents. In the near future, the Fund will send you more detailed and comprehensive benefit information and correspondence describing the specifics of the changes to the network and claims administrative process including, but not limited to, who to contact to find an in-network doctor, prior authorizations, questions or problems concerning your claims or benefits, and questions about grievances or appeals.

Loss of Grandfathered Health Plan Status

As a result of the changes to the prescription drug and medical benefits described in this notice, the Plan will lose its grandfathered health plan status effective January 1, 2017. This means that the Plan will have to make benefit improvements to comply with certain requirements of the Affordable Care Act (ACA) that are only applicable to non-grandfathered health plans. You will be notified of the specific improvements the plan is making at a later time. The following are examples of the types of improvements you can expect:

- **Preventive items and services.** The ACA requires that non-grandfathered health plans provide a variety of preventive services without cost sharing when provided by an in-network provider.

- **Emergency room care/Emergency services.** Non-grandfathered health plans must cover emergency services without requiring prior authorization and without regard to the network status of the hospital or health care professionals involved in providing the emergency care. Additionally, non-grandfathered health plans must not impose any administrative or coverage limitations on out-of-network emergency services that are more restrictive than those that apply when emergency services are furnished in-network.

- **Internal claims and appeals and external review.** The ACA requires non-grandfathered health plans to revise their internal appeals processes and to adopt a new external appeals procedure.

- **Provider nondiscrimination.** Non-grandfathered health plans may not discriminate with respect to coverage or participation under the plan against health care providers who are acting within the scope of their license or certification under state law.

- **Clinical trials.** The ACA requires that routine costs of clinical trials related to cancer or other life-threatening illnesses be covered if the trial meets specific statutory requirements.

Please keep this letter with your Welfare Fund Summary Plan Description booklet. It is important to retain this information until a new Summary Plan Description booklet is issued to you.

If you have any questions regarding these benefit modifications, contact the Fund Office at 1-800-288-0782.

Sincerely,

The Board of Trustees

The Iron Workers District Council of Western New York and Vicinity believes this plan is a "grandfathered health plan" 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, 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 the plan administrator at 1-800-288-0782. 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. This website has a table summarizing which protections do and do not apply to grandfathered health plans.