

Southwest Ohio Regional Council of Carpenters Health and Welfare Fund

33 Fitch Boulevard
Austintown, Ohio 44515

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PATIENT PROTECTION AND AFFORDABLE CARE ACT

October 25, 2010

IMMEDIATE ATTENTION

Dear Participants:

As you are aware, the Patient Protection and Affordable Care Act (Act) became law on March 23, 2010. Because the Southwest Ohio Regional Council of Carpenters Health and Welfare Plan (Plan) was in existence at the time the law was passed, it is a "grandfathered" plan. Because it is a grandfathered plan, certain provisions of the Act do not apply. However, certain of the Act's other provisions do apply to the Plan. Applicable provisions are explained below.

PROVISIONS OF THE ACT WHICH APPLY TO YOUR PLAN

Even though your Plan is a grandfathered plan, the following provisions of the Act apply beginning January 1, 2011 (but not before that date):

1. **Dependent Coverage Extended (January 1, 2011)**—Children will become eligible for benefits through age 25 – so long as they do not have group health coverage available to them through their employment. That coverage will continue until the first day of the month after their 26th birthday. Children no longer have to live with you or be unmarried, and you no longer have to be financially responsible for their support.

Before this Plan improvement, the Plan only covered unmarried dependent children who lived with the participant until the end of the calendar year in which they attained age 19, unless they were full-time students. In no event were children covered after the end of the calendar year in which the child attained age 23. Beginning January 1, 2011, you are no longer required to show that children are full-time students, reside with you or depend on you for more than one-half of their financial support.

If your children are eligible for coverage, your children can be covered under the Plan **when you enroll them**. Children age 19 or over will also have to provide an **annual verification** of their employment status and state whether group health coverage is available to them through their employment. You must also complete an annual enrollment form listing your child(ren) and providing requested information.

Rules have not been changed for children unable to engage in self-sustaining employment because of a disability. Children disabled before age 19 (or age 23 if a full-time student) may continue to be covered upon proper proof of incapacity. Children disabled thereafter will continue to have coverage until the first day of the month after their 26th birthday.

Similarly, no change is being made in the rule that a grandchild would be covered only if your eligible dependent, who is the parent of the grandchild, is not yet age 18.

If you have a child who is at least 19 years old, but not yet 26, who is not currently covered under the Plan, please complete the attached form and submit it to the Fund Office at the above address in order to apply for coverage. **You must submit the form by December 15, 2010.** Coverage of the child will not begin until all necessary documentation is received. **Coverage will take effective January 1, 2011 and will not be granted retroactively.**

2. **Lifetime Maximums Eliminated (January 1, 2011)**—The Act eliminates most lifetime maximums. This change becomes effective January 1, 2011. Previously, the Plan's lifetime limits included a lifetime limit of \$2,000,000 (\$1,000,000 for Non-PAR providers) for comprehensive medical benefits, and a \$1,000,000 maximum for transplants.

If coverage for you or your dependent ended because you reached the \$1,000,000 or \$2,000,000 lifetime limit, you are eligible to begin having additional claims covered. **Individuals who previously reached the lifetime limit have 30 days from the date of this notice to contact the Fund Office in writing, requesting additional coverage.**

3. **Changes to Calendar Year Maximums (January 1, 2011)**—Beginning January 1, 2011, there will be a Calendar Year maximum of Two Million Dollars (\$2,000,000) under all lines of coverage (combined) per Eligible Person for PAR Benefits, and One Million Dollars (\$1,000,000 for Non-PAR Benefits.) If you use a combination of PAR and Non-PAR providers, Non-PAR benefits will reduce the PAR Calendar Year maximum; however, PAR benefits will not reduce the Non-PAR Calendar Year maximum. The total Calendar Year maximum will not exceed the PAR Provider allowance. Additionally, other Plan restrictions (for example, visit limitations, medical necessity requirements, exclusion for experimental treatments, and \$2,000 limit on fertility services) continue to apply.
4. **Over-the-Counter Products**—Certain over-the-counter drugs and supplies can be reimbursed from any excess dollar bank account you might have. Beginning January 1, 2011, the Plan is not allowed to reimburse you for over the counter products (other than insulin) unless you have a Physician's prescription.

PROVISIONS OF THE ACT WHICH DO NOT APPLY TO YOUR PLAN

You will hear about other provisions in the Act. Some of these are not yet effective. Others do not apply because this Plan is "grandfathered." Provisions which do not apply based on the Plan's grandfathered status include:

- Expanded first-dollar preventive coverages;
- Mandatory coverage of certain clinical trial;
- Expanded out-of-network coverages; and
- Additional claim and review requirements.

Questions regarding which provisions apply and which provisions 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's Trustees, c/o Fund Office, Compensation Programs of Ohio, Inc., 33 Fitch Boulevard, Austintown, Ohio 44515. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/health_reform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans.

Fraternally,
Board of Trustees

CHILD CERTIFICATION FOR HEALTH COVERAGE

Should you desire for your child age 19 or older and younger than age 26 to be covered under the Plan, this form must be completed and signed and returned to the Fund Office, Southwest Ohio Regional Council of Carpenters Health and Welfare Plan, Compensation Programs of Ohio, Inc., 33 Fitch Boulevard, Austintown, Ohio 44515.

Child's Name: _____
Child's Date of Birth: _____
Child's Address: _____

In addition, you must certify that your child is not eligible (does not have the availability to obtain) health coverage through his/her own employer. Please check the appropriate box below:

- I hereby certify that the child shown above is **not employed** as of the date of this certification.
- I hereby certify that the child shown above is employed **but is not eligible** for health coverage through his/her employer:

Name of Child's Employer: _____
Employer's Address: _____

Employer's Human Resource or
Employee Benefits Department Telephone: _____

Authorization To Receive HIPAA Protected Health Information: I authorize the Southwest Ohio Regional Council of Carpenters Health and Welfare Plan, or its duly appointed agent, to contact my employer at any time to verify my employment status and to ascertain whether I am eligible for health insurance coverage through that employer.

_____/_____
Dependent's Signature Date

Notify Fund Office of Other Coverage Eligibility: You and/or your child shown above understand that you must notify the Southwest Ohio Regional Council of Carpenters Health and Welfare Plan as soon as the child becomes eligible (has the availability to secure) health coverage with his/her employer. If the Fund Office is not notified of other coverage/eligibility in a timely manner and claims are paid on the child's behalf, you and your child agree to promptly reimburse the Health Fund for any and all payments made on behalf of the ineligible child. If such reimbursements are not forthcoming, you understand that all future claim payments for the member's claims, and/or any other enrolled dependent's claims, will be offset until full restitution is made. In addition, you understand that legal action may be taken by the Fund against you and/or your ineligible child to recover these ineligible claim payments, and you and your dependent agree to be jointly and severally liable for all such misdirected payments, plus interest and attorney fees, as applicable.

I acknowledge and agree to the foregoing:

_____/_____
Member's Signature Date

Member's Name (Printed)

I acknowledge and agree to the foregoing:

_____/_____
Dependent's Signature Date