Northwest Ironworkers Trust Funds

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Administered by
Welfare & Pension Administration Service, Inc.

June 10, 2015

To: All Eligible Plan Participants and Beneficiaries
Northwest Ironworkers Health and Security Fund

Re: Plan Changes Effective July 1, 2015

This is a summary of material modification describing changes to your health plan adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your 2009 Edition of the Summary Plan Description Booklet.

The Trustees adopted the following changes to the Northwest Ironworkers Health and Security Plan ("Plan"). Unless otherwise stated, the changes are effective for services received on and after July 1, 2015. This notice does not describe benefits or changes under the Kaiser HMO option or the Alaska Shop Employees Health Plan.

Coverage of Preventive Care

The Plan has been amended to cover recommended preventive care services required by the Affordable Care Act. The covered preventive services include well baby and well child care visits at specified intervals; immunizations for infants, children, adolescents, and adults as recommended by the Federal Centers for Disease Control and Prevention; and colorectal cancer screening at specified intervals for adults age 50 to 75.

Additional preventive care and screenings will be covered for women as required by the Affordable Care Act, and as supported by applicable guidelines, including: well-women visits; mammograms; and cervical cancer screenings. However, coverage for pregnancy of a dependent daughter is limited to those routine prenatal services listed under the Women's Preventive Care Act.

Contraceptives and contraceptive devices for dependent children are covered as required by the Affordable Care Act.

Covered preventive care now also includes a limited number of over-the-counter pharmaceuticals when prescribed by your physician. Please check with EnvisionRx (the Pharmacy Benefit Manager) at (800) 361-4542 for limitations that may apply on the following over-the-counter medications:

- aspirin (325 mg and 81 mg) for cardiovascular disease for men and women
- folic acid (0.4 mg and 0.8 mg) supplements for women
- smoking cessation drugs and products

This is only a summary of the recommended preventive care required by the Affordable Care Act. If you have questions about specific services, including whether the services are recommended preventive services under the Affordable Care Act, you may contact the Administration Office or review the list of recommended preventive services at:

http:/www.healthcare.gov/preventive-care-benefits/

Benefits Payable for Covered Preventive Care

The Plan will provide benefits for covered preventive care, identified above, without cost-sharing, ***when services are provided by a network preferred provider organization ("PPO")***. This means the deductible, coinsurance, and co-pays will not be applied.

Some pharmaceuticals, including some over-the-counter medications, are also included in the preventive care benefit when prescribed by a physician, and will be covered without cost-sharing when purchased through the Plan's Pharmacy Benefit Manager.

Preventive services that are received from a *non*-PPO provider will be subject to the deductible and coinsurance. In addition, a *non*-PPO provider may bill you for the difference between the billed amount and the Usual, Customary and Reasonable charge allowed by the Plan.

Coinsurance Maximum / Out-of-Pocket Maximum

Effective July 1, 2015, the annual PPO coinsurance maximum for medical benefits is being replaced with an out-of-pocket maximum. The new out-of-pocket maximum is $4,250 per person / $8,500 per family, and will now include the deductible ($250 per person / $500 per family), as well as the PPO coinsurance and copays.

The *non*-PPO coinsurance maximum remains unchanged at $8,000 per person, after the $250 annual deductible is met.

In addition, an out-of-pocket maximum limit for covered medications on the formulary prescription drug list will be established at $2,350 per person / $4,700 per family. There is no out-of-pocket limit for non-formulary prescriptions.

Hospice Services

The current $10,000 lifetime maximum limit for Hospice Services has been eliminated.

Emergency Services Received in a Hospital Emergency Department

The Plan has been amended to provide benefits for emergency services to treat an "Emergency Medical Condition" in the emergency department of a hospital without regard to whether the provider is a PPO provider. This means that if emergency services for treatment of an Emergency Medical Condition are received from a non-PPO provider, the PPO coinsurance rate will be applied. However, a non-PPO provider may still bill you for the difference between the billed amount and the Usual, Customary and Reasonable charge allowed by the Plan.

An "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to place the health of the individual or unborn child in serious jeopardy, to expose the individual to serious impairment of bodily functions, or result in serious dysfunction of any organ or body part.

Coverage for Costs Associated with Certain Clinical Trials

The Plan does not provide benefits for services and supplies which are Experimental and/or Investigational. However, the Plan has been amended to provide that routine patient costs for items and services furnished in connection with an approved clinical trial will not be considered Experimental or Investigational if the item or service would otherwise be a Covered Expense for an Eligible Individual who is *not* enrolled in the clinical trial. An approved clinical trial is a phase I, II, III, or IV clinical trial that is conducted in relation

to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The Eligible Individual must be eligible to participate in the approved clinical trial according to the trial protocol. The following are not covered:

- The actual clinical trial or the investigational team;
- Items and services solely for data collection that are not directly used in the clinical management of the patient; or
- Services that are clearly inconsistent with widely accepted and established standards of care for a particular condition.

The Plan will investigate claims that might be considered Experimental or Investigational. The Plan may consult with medical professionals to determine whether the treatment is excluded as Experimental or Investigational, or whether it is covered as part of an approved clinical trial.

All clinical trials must be preauthorized by the Preauthorization/Utilization Management Organization.

Coverage of Bariatric (Weight Loss) Surgery

The Plan has been amended to cover medically necessary bariatric surgery for treatment of morbid obesity in adults who satisfy specific plan criteria. These criteria include, but are not limited to:

- A body mass index (BMI) greater than 40 kg/m, *OR* a BMI greater than 35 kg/m with certain co-morbidities;
- Physician supervised weight reduction program which includes:
    - A program of a least six consecutive months' duration within the two year period prior to surgery being considered;
    - Evidence of active participation in a program documented in the medical records.
- A psychological evaluation by a licensed mental health provider to establish emotional stability and the ability to comply with post-surgical limitations.

All bariatric surgery must be preauthorized by the Preauthorization/Utilization Management Organization.

Outpatient Dialysis Treatment Benefits for ESRD

If you or your eligible dependents are diagnosed with end-stage renal disease ("ESRD") you may be eligible for Medicare coverage by nature of the diagnosis. You are not obligated by the Plan to apply for and enroll in Medicare Part A and/or Part B if you have ESRD. However, enrolling in Medicare when eligible may offer some protection from balance billing by the provider of ESRD services. Balance billing means the difference between the billed amount and the amount allowed by the Plan and/or Medicare.

Benefits for outpatient kidney dialysis for treatment of ESRD have been amended. Benefits are now provided by the Plan as follows:

- If you or your eligible dependents are not yet eligible to enroll in Medicare, benefits are provided for dialysis according to the Schedule of Medical Benefits in the Summary Plan Description Booklet (SPD).
- If you or your eligible dependents are enrolled in, or are eligible to enroll in Medicare, and Medicare becomes or is eligible to become the secondary payer for ESRD services and supplies
- (regardless of whether you are actually enrolled in Medicare), benefits for kidney dialysis are provided at 150% of the current Medicare allowed amount.
- If Medicare becomes primary payer for ESRD services, the Plan pays secondary to Medicare and coordinates benefits up to 100% of the then current Medicare allowed amount for kidney dialysis.

Notwithstanding the above, the Plan may, at its sole discretion, agree to a contractual arrangement for payment with a provider of ESRD services. The contract may allow for a different payment for ESRD services than listed above or in the SPD, but in no circumstances will a contractual arrangement allow for a payment less than the payments listed above.

In order to ensure the correct coordination of claim payments between the Plan and Medicare, you are required to provide the Administration Office with the effective date of Medicare coverage.

Claim Appeal Procedures

Appeal Procedures
The Claim Appeal Procedures are described in the Summary Plan Description Booklet. Generally, a claimant who believes he did not receive the full amount of benefits to which he is entitled, has the right to appeal to the Board of Trustees, provided a written request for appeal is submitted within 180 days after receipt of notification of an adverse decision. A properly submitted appeal will be presented to the Trustees for review.

Amendment Effective July 1, 2015
A claimant who remains dissatisfied with the Trustees' decision on appeal, may bring a civil action under ERISA § 502(a). Effective for appeals reviewed by the Trustees on and after July 1, 2015, the Plan has been amended to allow a claimant to request external review by an Independent Review Organization ("IRO") as an alternative to filing a civil action. ***External review is only available if the claim on appeal involves medical judgment or the retroactive rescission of health coverage.*** There is no external review for non-healthcare claims, such as weekly disability, accidental death and dismemberment, or life insurance.

A request for external review must be filed with the Administration Office within four months from the claimant's receipt of the Trustees' decision on appeal. Requests for external review may be mailed to the following address:

Attn: Appeals
WPAS, Inc.
PO Box 34203
Seattle, WA 98124-1203

Failure to file a request for external review within the four-month period will end the claimant's ability to seek external review.

Preliminary Review of External Review Request
Within five business days of receipt of a request for external review, the Plan will complete a preliminary review of the request. The preliminary review will be expedited if the request satisfies the requirements for an urgent care claim. Within one business day after completion of this review, the Plan will notify the claimant of its decision. If the request is not eligible for external review, the Plan will notify the claimant. If the request for external review is incomplete, the Plan will identify what is needed and the claimant will have the longer of 48 hours or the remaining portion of the four-month external review request period to provide the information. If the external review request is complete and eligible for external review, the Plan will refer the matter to an IRO.

Review by Independent Review Organization
If a properly filed request for external review is received, the Plan will provide the IRO with the required documentation in the time required by applicable federal regulations. The IRO will provide a response to the claimant within 45 days after it has received the request to review.

The Plan's existing Claim and Appeal Procedures provide for an expedited review of an urgent care claim. If an urgent care claim is submitted to an IRO, a decision will be made within 72 hours.

If the IRO directs that benefits be paid, benefits will be provided under the Plan in accordance with the decision. If the decision continues to be adverse, the claimant has the right to bring a civil action under ERISA § 502(a). A claimant must exhaust the Plan's Claim and Appeal Procedures prior to filing a civil action. Any civil action seeking to overturn a denial or other decision of the Trustees must be brought within three years of the Trustees' issuance of a written decision on appeal. A failure to file a civil action within the three-year period will bar the right to further review of the appeal.

Non-Grandfathered Status Under Affordable Care Act

Effective July 1, 2015, the Plan is no longer considered "grandfathered" under the Affordable Care Act.

This notice does not describe any changes to the Alaska Shop Employees Health Plan, which continues to be grandfathered under the Affordable Care Act.

Summary of Benefits and Coverage (SBC)

In accordance with the Affordable Care Act, the Trust is required to provide a SBC to all participants and beneficiaries. The enclosed SBC is for the Plan option in which you are currently enrolled. *Please note: The SBC furnished to the participant will be considered provided to dependents unless the Plan has been advised of a different address for dependents.*

A **Uniform Glossary of Terms** has also been published by the government. This document is intended to describe terms commonly used in health insurance coverage, such as "deductible" and "copayment." You can view the Glossary at www.dol.gov/ebsa/healthreform or you can call the Administration Office at the number below.

If you have any questions regarding the information contained in this notice, please contact the Administration Office at (206) 441-7226 or (866) 986-1515, option 1.

Board of Trustees
Northwest Ironworkers Health and Security Fund

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