**Office Location:** 4208 W. Partridge Way, Unit 3 • Peoria, IL 61615-2467
**Mailing Address:** P. O. Box 9090 • Peoria, IL 61612-9090
**Toll Free:** 1-866-692-0860 • **Phone:** 309-692-0860 • **Fax:** 309-692-0862

May 2011

Dear Participant:

The **Patient Protection and Affordable Care Act** (the "Affordable Care Act") mandates reforms for group health plans like ours. We must comply with the requirements on the first day of the plan year immediately following September 23, 2010, which is July 1, 2011. In addition, we are making Plan changes to the deductibles and coinsurance amounts.

This letter explains all of these changes.

## Notice of Annual Limit Waiver

**The Affordable Care Act prohibits health plans from applying arbitrary dollar limits for coverage for key benefits. This year, if a plan applies a dollar limit on the coverage it provides for key benefits in a year, that limit must be at least $750,000. Your health insurance coverage, offered by North Central Illinois Laborers Health and Welfare Fund, does not meet the minimum standards required by the Affordable Care Act described above. Instead, it puts an annual limit of $300,000.**

**In order to apply the lower limits described above, your health plan requested a waiver of the requirement that coverage for key benefits be at least $750,000 this year. That waiver was granted by the U.S. Department of Health and Human Services based on your health plan's representation that providing $750,000 in coverage for key benefits this year would result in a significant increase in your premiums or a significant decrease in your access to benefits. This waiver is valid for one year.**

**If the lower limits are a concern, there may be other options for health care coverage available to you and your family members. For more information, go to www.HealthCare.gov.**

**If you have any questions or concerns about this notice, contact the Fund Office at (866) 692-0860. In addition, you can contact the Illinois Department of Insurance about the Illinois Consumer Assistance Program at (877) 527-9431 or DOI.Director@illinois.gov, or go to their**

website at **http://www.insurance.illinois.gov.**

## Changes to Annual and Lifetime Limits

To comply with the Affordable Care Act, the Plan is eliminating lifetime dollar limits on most covered benefits under the medical plans effective July 1, 2011; however, the lifetime dollar limit is being transitioned to an overall annual limit for medical and prescription drug benefits in 2011 of $300,000.

The annual dollar limits on wellness, preventive, well child and well baby care benefits are being eliminated as of July 1, 2011. In addition, the following limits will also be removed:

- Lifetime dollar limits:
  - Durable medical equipment and prosthetic devices (formerly $25,000)
  - Orthodontia for children under the age of 19 (formerly $3,000)
  - Hearing exams will not be subject to the lifetime limit of $5,000; however, devices and repairs are subject to the lifetime limit
- Annual dollar limits:
  - Preventive dental services for children under the age of 19 (formerly $1,500)
  - Orthodontia services for children under the age of 19 (formerly $1,500)
  - Vision exams for children under the age of 19 (formerly $250)

Certain Calendar Year and lifetime limits will continue to apply, as shown in the Summary of Benefits, which is attached.

If you or your dependent reaches a Calendar Year limit for a specific treatment or reaches the overall Calendar Year limit, the Plan will not pay for any such further treatments or services for that individual for the remainder of the Calendar Year. If you or your dependent reaches a lifetime limit for a specific treatment, the Plan will not pay for any further such treatment for the individual's lifetime.

## Changes to Deductibles and Coinsurance

The Trustees regularly review the financial status of the Fund to ensure the Fund can continue to provide you and your family with the health care benefits you need now and in the future. Health care costs continue to rise and, as a result, the Trustees need to make changes to the deductibles and coinsurance effective July 1, 2011, as follows:

- The annual deductibles:
  - Individual: $500 in-network and $1,000 out-of-network;
  - Family: $1,000 in network and $3,000 out-of-network
- Hospital and other services coinsurance:
  - In-Network: the Plan pays 80%; you pay 20%, after deductible
  - Out-of-Network: the Plan pays 60%; you pay 40%, after deductible

You and the Fund save money when you use in-network providers. To find in-network providers in your area, visit the BlueCross BlueShield of Illinois, the Health Alliance, or HFN network websites (see Schedule of Benefits for contact information), or call the number listed on your medical ID card.

## Special Enrollment for Extension of Dependent Coverage to Age 26

One 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 and/or are married. Because of this change, the Plan's definition of dependent is being revised effective July 1, 2011.

If you have a child who is under age 26 (whether married or unmarried), including a child currently receiving continuation coverage under COBRA, you can enroll that child in the Plan as of July 1, 2011. For a full definition, please see the Definition of a Dependent Child following.

**You will receive a Special Enrollment mailing shortly that will include instructions and an enrollment form**

## Definition of Eligible Dependent Child (Effective July 1, 2011)

An Eligible Participant's Child will be eligible for coverage under the Plan, as long as the child meets one of the three categories below.

- A child who has not reached his/her 26th birthday and is the Eligible Participant's:
    - Natural child;
    - Legally adopted child or child placed for adoption;
    - Step-child for whom you have completed the Fund's *Dependent Eligibility Affidavit* form; or
    - Child who is named as an alternate recipient in a child support order, if the Plan determines the support order to be a Qualified Medical Child Support Order (QMCSO).
- An unmarried child for whom you have been appointed legal guardian, as specified in the order appointing guardianship and the child lives with you for more than one-half of the calendar year and receives more than one-half of his or her financial support from you during the calendar year.
- Any unmarried child listed above, at any age, who is permanently and totally disabled due to a medically determinable physical or mental impairment that is expected to result in death or last for a continuous period of 12 months or more if the child:
    - Sustained such disability before the child reached age 26,
    - Is dependent on you for more than 50% of his/her financial support during the calendar year (for the full year for legal guardianship),
    - Resides with you for more than 50% of the calendar year, and
    - Is dependent on you for lifetime care and supervision.

  You must provide proof of incapacity and dependency when requested by the Plan, but not more often than once a year.

## Notice About the Early Retiree Reinsurance Program

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for

maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

If you have received this notice by email, you are responsible for providing a copy of this notice to your family members who are participants in this plan.

## Internal and External Review of Claim Determinations

As you know, the plan provides an extensive internal appeals procedure that allows you and your family the opportunity to request review of claims determinations that you think are not correct. Under the new Affordable Care Act rules, if your internal appeal is denied after July 1, 2011, you will have the right to appeal to an independent reviewer. The rules regarding independent review are currently under development at the Fund Office, and will be available to you in a separate handout after the first of the plan year.

## Rescission of Your Coverage

The Plan may rescind your coverage for fraud or intentional misrepresentation of a material fact after the Plan provides you with notice as required by law. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, meaning that it will be effective back to the time that you should not have been covered by the Plan.

However, this does not include situations involving termination of coverage back to the date of loss of eligibility when there is a delay in administrative recordkeeping between your loss of eligibility and notice to the Plan of that loss, or when you fail to make timely required self-payments for coverage. For any other unintentional mistakes or errors under which you were covered by the Plan when you should not have been covered, the Plan will cancel your coverage prospectively once the mistake is identified.

## In Closing

Please review the Schedule of Benefits that is attached to this letter. If you have any questions about these changes or the Plan in general, please email the Fund Office at ncil@ncil.us or call them at (866) 692-0860.

Sincerely,

The Board of Trustees

*This notice is a Summary of Material Modifications (SMM), within the meaning of Section 104 of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. This notice describes important changes to the Plan. You may find full details in the most recent Summary Plan Description and Plan Document that establish the Plan provisions. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.*