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UNITY AND STRENGTH FOR WORKERS
BENEFIT FUNDS

USW HRA FUND
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Dear Participant:

The Board of Trustees of the USW HRA Fund ("Fund") has adopted the following changes to the Health Reimbursement Arrangement ("HRA" or "Plan") provided by the Fund, to comply with the Patient Protection and Affordable Care Act, to provide that all claim reimbursements made for claims submitted on and after March 1, 2013 will be made by electronic payment only, and to provide for an Account Inactivity Fee for inactive accounts with low balances. This letter summarizes the changes.

All page numbers refer to the Summary Plan Description, effective July 1, 2010 ("SPD"), which serves as the plan of benefits for the Fund's HRA. Please keep this document with your SPD, so that you always know the benefits that you are eligible for and the rules that apply.

SUMMARY OF MATERIAL MODIFICATIONS

1. Effective January 1, 2011, the definition of "COBRA Beneficiaries" on page 5 is deleted and replaced with the following:

COBRA Beneficiaries under this Plan are Dependents who are either:

1. your spouse, other than a legally separated or divorced spouse;
2. your children from birth up until, and including, the date of their 26th birthday; or
3. unmarried dependent children who are incapable of self-sustaining employment by reason of mental or physical handicap, who become so incapable on or before the date of their 26th birthday; or

In addition to your biological child, a child includes your stepchild and your adopted child, including a child placed with you for adoption during any waiting period prior to the finalization of the adoption.

2. Effective January 1, 2011, the definition of "Dependent(s)" on pages 5 and 6 is deleted and replaced with the following:

Dependent(s) under this Plan is/are any individuals who are either:

1. your spouse, other than a legally separated or divorced spouse;
2. your children up until, and including, the date of their 26th birthday;
3. unmarried dependent children who are incapable of self-sustaining employment by reason of mental or physical handicap, who become so incapable on or before the date of their 26th birthday;
4. individuals meeting the definition of "dependent" contained in Code Section 105(b); or

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5. a former Dependent who continues to be eligible for coverage under COBRA continuation coverage will be a Dependent until that coverage ends.

In addition to your biological child, a child includes your stepchild and your adopted child, including a child placed with you for adoption during any waiting period prior to the finalization of the adoption. All individuals claiming Dependent status must be listed on the Participant's enrollment form and be properly substantiated to be eligible for coverage under the Plan.

3. Effective January 1, 2011, on page 10, the following is added after the second sentence of the last paragraph of SECTION 1. HOW THIS PLAN WORKS:

Effective for expenses for Over the Counter Drugs (other than insulin) incurred on and after January 1, 2011, the Participant or Dependent, as applicable, must also submit a prescription from a physician or other authorized medical professional to be eligible for reimbursement.

4. Effective January 1, 2011, the subsection "when Dependent Coverage Ceases" on page 13 is deleted and replaced with the following:

When Dependent Coverage Ceases

All coverage for Dependents will cease on the earlier of the following dates:

1. the date a Dependent becomes eligible for coverage under the HRA as an Employee;

2. in the case of Dependent children, the later of

   (a) the day following the date of the 26th birthday of the child, unless the child is disabled as described above; or

   (b) the date the child ceases to meet the definition of "dependent" contained in Code Section 105(b).

3. in the case of a spouse, the later of the date of the Participant's divorce or legal separation from the spouse;

4. in the case of a Dependent who is not a spouse or a child of the Participant, the date the Dependent ceases to meet the definition of "dependent" contained in Code Section 105(b); or

5. the date Participant coverage is terminated. However, if a Dependent loses coverage because a Participant ceases to be an Employee, the Dependent will remain eligible to receive reimbursements, provided that funds remain in the applicable Participant's account and the Dependent is not otherwise ineligible under 1, 2, 3 or 4 above.

5. Effective May 17, 2011, the second paragraph of the subsection "Allocation of Administrative Expenses, Fees, and Investment Income" on page 15 is deleted and replaced with the following:

The Administration Fees, Payment Processing Fees, Denied Claim Processing Fees, and Account Inactivity Fees are determined as indicated below, based on the applicable Program.

6. Effective May 17, 2011, the following language is added after the first sentence of the first paragraph of the subsection "Payment Processing Fees" on page 16:

> Effective for all claims received on and after March 1, 2013, the Fund Office will issue claim reimbursement payments by ACH credit transfer only.

7. Effective May 17, 2011, the following language is added after the subsection "Denied Claim Processing Fees" on page 17:

> Account Inactivity Fees
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> For all Programs, an annual $50.00 Account Inactivity Fee will be applied to a Participant's account if the account balance is less than $100.00 and the account has been inactive for the past two years. The Account Inactivity Fee will be assessed on the last day of each Plan Year in which all of the following requirements are met, determined as of the last day of the Plan Year:
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> 1) The balance of the Participant's account is less than $100.00, as determined before the crediting of any applicable investment income or the deduction of any applicable administrative expenses (other than Administration Fees or Processing Fees) for the Plan Year;
>
> 2) The Participant is not an Active Employee or Non-Covered Employee;
>
> 3) No amounts derived from Contributions or COBRA premiums have been credited to the Participant's account during the current Plan Year or prior Plan Year;
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> 4) No reimbursements for Eligible Medical Expenses have been made from the Participant's account during the current Plan Year or prior Plan Year; and
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> 5) No claims for reimbursement from the Participant's account have been received by the Fund Office during the current Plan Year or prior Plan Year.

8. Effective January 1, 2011, the following language is added at the end of SECTION 4. ACCOUNT INFORMATION on page 17:

> **Overpayments**
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> If a Participant (or his or her Dependent(s)) are overpaid for a claim, the Participant (or his or her Dependent(s)) must return the overpayment. The Fund will have the right to recover any payments made that were based on false or fraudulent information, as well as any payments made in error. Amounts recovered may include interest, costs, and attorney's fees. If repayment is not made, the Fund may deduct the overpayment amount from any future benefits from this Fund that the Participant or his or her Dependent(s) would otherwise receive, or a lawsuit may be initiated to recover the overpayment.

9. Effective January 1, 2011, on page 18, the phrase ", with a prescription from a physician or other authorized medical professional" is inserted after "Over the Counter Drugs" in the list of Eligible Medical Expenses that the Plan will reimburse.

10. Effective January 1, 2011, on page 19, the following is added to the list of expenses that are not covered as Eligible Medical Expenses:

7. effective for expenses incurred on and after January 1, 2011, Over the Counter Drugs (other than insulin), unless prescribed by a physician or other authorized medical professional.

11. Effective January 1, 2011, the following new Section 13 is added to the end of the SPD:

SECTION 13. GRANDFATHER STATUS

The notice below is required by the U.S. Department of Labor:

This group health plan believes this plan or coverage 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 to the USW HRA Fund at 866-408-7155. 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.