UNITED STEELWORKERS
USW
UNITY AND STRENGTH FOR WORKERS
BENEFIT FUNDS

USW HRA FUND
Maria F. Wieck, CPA, CEBS
Administrative Officer
Trevor K. England, JD, CPA
Financial Officer

December 8, 2010

Re: Important Changes under the USW HRA Fund

Dear Participant:

This letter includes important information about your health reimbursement arrangement ("HRA") pursuant to the Patient Protection and Affordable Health Care Act (commonly referred to as Health Care Reform).

Effective January 1, 2011, the Plan will allow your qualified children to participate in the Plan for health care services provided until their 26th birthday. This includes children who are currently enrolled in COBRA under the Plan, and children who were previously denied coverage (or were not eligible to enroll in coverage), because the availability of dependent coverage for children ended before the attainment of age 26. A qualified child is your biological child, adopted child, child placed with you for adoption or step-child. Qualified children are eligible to participate in the Plan regardless of whether they are married, financially dependent upon you or reside with you.

If you have a qualified child that you wish to cover under the Plan, you may enroll them in coverage effective January 1, 2011 by completing the enclosed Special Enrollment Form for Adult Children Age 19-26 and returning it to the Fund Office along with a copy of your child's birth certificate and any other documentation proving their age and relationship to you **no later than January 30, 2011**. Once the proper documentation is received by the Fund Office, coverage will commence retroactive to January 1, 2011.

If your enrollment information is received after January 30, 2011, coverage will commence on the day the Fund office receives your properly completed enrollment documents and will be prospective only.

This group health plan 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 USW HRA Fund at 866-408-7158. 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.

Sincerely,

The Board of Trustees

USW HRA Fund
3320 Perimeter Hill Drive
Nashville, TN 37211-4123
866-408-7158

SPECIAL ENROLLMENT FORM FOR ELIGIBLE ADULT CHILDREN AGE 19-26

A. Employee Information:			
Last Name		First Name	Middle Initial (MI)
Mailing Address			Social Security Number
City		State	Zip Code
Gender ☐ F ☐ M	Date of Birth: (Month/Day/Year)	Home Phone Number	Cell Phone Number
B. First Adult Child You Wish to Enroll: Child's relationship to you: ☐ Natural ☐ Adopted Child ☐ Child placed with you for adoption ☐ Stepchild			
Last Name		First Name	Middle Initial (MI)
Gender ☐ F ☐ M	Date of Birth: (Month/Day/Year)	Social Security Number	
C. Second Adult Child You Wish to Enroll: Child's relationship to you: ☐ Natural ☐ Adopted Child ☐ Child placed with you for adoption ☐ Stepchild			
Last Name		First Name	
Gender ☐ F ☐ M		Date of Birth: (Month/Day/Year)	
Last Name		First Name	
Gender ☐ F ☐ M		Date of Birth: (Month/Day/Year)	

Employee Statement: I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge. I understand that if I conceal information, provide false information, or otherwise mislead the Plan, my child's eligibility for Plan coverage will be terminated retroactively and I will be liable for any claims that were paid erroneously based on the false or misleading information.

Signature_____ Date_____

Adult Child's Statement: I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge. I understand that if I conceal information, provide false information, or otherwise mislead the Plan, my eligibility for Plan coverage will be terminated retroactively and I and my parent will be liable for any claims that were paid erroneously based on the false or misleading information.

Signature_____ Date_____