CALIFORNIA FIELD IRONWORKERS TRUST FUNDS

Pension Trust • Welfare Plan • Vacation Trust
Apprenticeship Training & Journeyman
Retraining Fund • Annuity Trust

Date: **July 2011**

To: All Active Employees and their Dependents, including COBRA beneficiaries, of the California Ironworkers Field Welfare Plan

From: The Board of Trustees of the California Ironworkers Field Welfare Plan

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This Summary of Material Modifications (SMM) will advise you of certain changes that have been made to the California Ironworkers Field Welfare Plan to comply with the new health care reform law (Affordable Care Act). These changes take effect June 1, 2011. **This information is VERY IMPORTANT to you and your dependents**. Please take the time to read it carefully and keep it with your copy of the Summary Plan Description. Capitalized terms in this SMM have the same meaning as in your Summary Plan Description.

Except where specifically stated otherwise, the changes described in this SMM are applicable to the Fee-For-Service Medical Plans for Active Participants (including participants covered under the Special Z Contract and the A-Rodman Contract). A few changes will apply to participants enrolled in the HMO plans for Active Employees, and one change is applicable to participants enrolled in the Fee-for-Service Dental Plan.

The changes described in this SMM are not applicable to the plan for Retired Participants.

The HMO plans for active Employees will also be making changes to comply with the Affordable Care Act. HMO Enrollees will receive a separate notice describing the changes being made to their HMO plan.

DEPENDENT COVERAGE FOR CHILDREN UP TO AGE 26 EFFECTIVE JUNE 1, 2011

(Not Applicable To Participants Covered Under The A-Rodman Contract)

Effective June 1, 2011, your eligible Dependent Children will be covered under the Plan up to the end of the calendar month in which the child attains age 26, regardless of the child's residence, student status, marital status, or financial dependency. Children who can be covered up to age 26 include:

- Your natural children (including children born out of wedlock if you are shown to be the parent by birth certificate or appropriate judicial decree);
- Your legally adopted children and children placed with you for adoption;
- Your stepchildren;
- A child for whom you have been named the legal guardian by a Court;
- A child that the Plan is required to cover for benefits under a Qualified Medical Child Support Order (QMSCO).

As before, eligibility may be continued past age 26 for an unmarried Dependent child who is physically or mentally handicapped and who chiefly depends on the Employee for support and maintenance. Proof of incapacity must be provided, and the disabling condition must have been present before the child reached the age of 21.

The Retiree Plan is not subject to the requirements of the new health care reform law. Therefore, eligible Children covered under the Retiree Plan will not have coverage up to age 26. The Retiree Plan will retain the same eligibility rules for coverage of Children that were in place in May, 2011.

LIFETIME MAXIMUM CONVERTED TO ANNUAL MAXIMUM EFFECTIVE JUNE 1, 2011

As of June 1, 2011 the Fee-For-Service Plan's Maximum Lifetime Benefit of $5,000,000 ($1,000,000 for participants covered under the Special Z Contract) will be eliminated. The Fund will implement a new Annual Maximum of $5,000,000 ($1,000,000 for participants covered under the Special Z Contract).

Under the new rule, the Plan will pay your Covered Charges up to the Plan's Annual Maximum each calendar year.

CHANGES TO CERTAIN BENEFIT LIMITATIONS EFFECTIVE JUNE 1, 2011

Dollar limits for certain benefits are being replaced or eliminated. The chart below shows the dollar limitation in place before June 1, 2011, and the change that is being made to that limitation, effective June 1, 2011. The chart does not show the Plan's payment amounts or percentages for the services listed.

The changes described in this Section are to the Fee-For-Service Medical Plan and the Fee-For-Service Dental Plan. The only benefit changes that may affect enrollees in the HMO plans are the changes to Substance Abuse benefits and Dental Services under the Fee-For-Service Plan.

Service	Old Benefit Limitation	New Benefit Limitation as of June 1, 2011
Substance Abuse (Active Employees only, no dependent coverage. HMO Enrollees may also receive these services)	Detoxification is limited to a maximum of one episode per calendar year, up to a maximum of $4,000 per calendar year, and a coverage limit of 2 episodes per lifetime.	The dollar limits will be eliminated. The Fund will allow a lifetime maximum of 4 detoxification episodes.
Mental Health	$25,000 lifetime limit	The dollar limit will be eliminated. The Fund will allow the following: • A maximum of 30 inpatient days per calendar year, and a lifetime maximum of 60 inpatient days; • A maximum of 30 outpatient visits per calendar year.
Outpatient Therapy (Physical and Respiratory)	$2,000 maximum per calendar year, with additional treatment available if care is for an accident or occurs as a result of major surgery, stroke or heart attack.	The dollar limit will be eliminated. The Fund will allow a maximum of 20 combined visits per calendar year.
Speech and Occupational Therapy combined	$2,000 maximum per calendar year	The dollar limit will be eliminated. The Fund will allow a maximum of 20 visits per calendar year.
Dental services under the Fee-For-Service Dental Plan (not including orthodontic services)	$3,000 maximum per calendar year	The $3,000 maximum will be removed for pediatric dental services (up to age 18). The $3,000 annual maximum will continue to apply to adults age 18 and over.
Hearing Exam	$100 maximum per calendar year	The dollar limit will be eliminated. The Fund will allow one hearing exam per calendar year. The hearing exam will be covered at 100% of the contract rate if you use a Contract Provider and 100% of the Allowable Charge if you use a Non-Contracting Provider.

PREVENTIVE CARE SERVICES – FEE-FOR-SERVICE PLAN
EFFECTIVE JUNE 1, 2011

Effective June 1, 2011, the Plan will cover 100% of the contract rate for Preventive Care Services provided by a Contract Provider (there will be no deductible, copay and/or coinsurance for these services).

Preventive Care Services from a Non-Contracting Provider will be subject to the Deductible applied to Non-Contracting Providers and will be paid by the Plan at the reduced Coinsurance percentage applicable to Non-Contracting Providers.

In the coming months, the Fund will publish additional information describing the Preventive Care Services covered under this new rule, including the limitations applicable to such benefits. In the meantime, contact the Fund Office if you have any questions.

Preventive Care Services covered under the Plan may include many of the services provided by your Physician at a routine annual physical exam (or by a pediatrician during a routine well-baby or well-child visit). For example, depending on your age, the following services may be covered as Preventive Care Services:

- Blood pressure, diabetes, and cholesterol tests
- certain cancer screenings, including mammograms and colonoscopies
- Limited counseling concerning such topics as quitting smoking, losing weight, eating healthfully, treating depression and reducing alcohol use
- Routine vaccinations against diseases such as measles, polio or meningitis
- Flu and pneumonia shots
- Counseling, screening, and vaccines to ensure healthy pregnancies
- Regular well-baby and well-child visits, from birth to age 18

As a general rule, Preventive Care Services will be covered only if they are administered in accordance with guidelines, including frequency limits, issued by the Fund and only if required to be covered by the Affordable Care Act or under the terms of the Plan.

NO RETROACTIVE CANCELLATION OF COVERAGE
EFFECTIVE JUNE 1, 2011

In accordance with the requirements in the Affordable Care Act, effective June 1, 2011, the Plan will not retroactively cancel coverage except as allowed by law (for example, when COBRA premiums are not timely paid, or in cases of fraud or intentional misrepresentation of material fact).

HOSPITAL EMERGENCY ROOM SERVICES
EFFECTIVE JUNE 1, 2011

When you seek treatment at a hospital emergency room because of an Emergency Medical Condition, the Plan will cover Emergency Services as shown in the chart below. The chart below does not show coverage provided for treatment of conditions that are not Emergency Medical Conditions.

Emergency Services Provided in a Hospital Emergency Room		
Plan Option	**Contract Provider**	**Non-Contracting Provider**
Active Fee-For-Service Plan	90% of Contract Rate; Deductible Applies	90% of Allowable Charges; Deductible Applies

Special Z Contract	80% of Contract Rate; Deductible Applies	80% of Allowable Charges; Deductible Applies
Special A-Rodman Contract	90% of Contract Rate after a $100 copayment; Deductible Applies	90% of Allowable Charges after a $100 copayment; Deductible Applies

Here are some additional rules applicable to coverage provided for Emergency Services:

- As always, you do not have to obtain prior authorization before seeking emergency room treatment for an Emergency Medical Condition, though you or your family must call the Plan's UR Provider (Blue Cross or First Health) the next working day after admission to the hospital.

- If you obtain Emergency Services from a Non-Contract Provider, the Plan generally pays a percentage of the Allowable Charges. The Plan does not pay a percentage of actual charges. If the provider charges exceed the Plan's Allowable Charge, you will be responsible for the difference between the actual billed charges and the amount paid by the Plan.

- The Allowable Charge for Emergency Services provided by a Non-Contracting Provider will not be less than what is required by law.

- Amounts paid by the Participant for Emergency Services, whether rendered by a Contract Provider or a Non-Contracting Provider, will count towards the Plan's out-of-pocket maximum (except amounts that exceed the Allowable Charge).

The term "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: placing the health of the person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

The term "Emergency Services" means a medical screening examination and medical treatment necessary to evaluate and stabilize an individual with an Emergency Medical Condition (in other words, to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the person from the facility). Emergency Services must be rendered in a hospital emergency room.

INTERNAL AND EXTERNAL REVIEW OF COVERAGE DETERMINATIONS EFFECTIVE JUNE 1, 2011

As you know, the Fund 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, or if you have otherwise exhausted the Plan's internal claims and appeals procedures, you will have the right to appeal some types of claims to an independent reviewer under the Plan's external review process. In some limited cases, you can request an external review following an adverse claim determination, without having to file an internal appeal. The rules regarding external independent review are currently under development at the Fund Office, and will be available to you at a later date.

This SMM modifies your Summary Plan Description (SPD). Please keep this important notice with your SPD for easy reference to all Plan provisions. Should you have any questions, please contact the Trust Fund Office.

Receipt of this notice does not constitute a determination of your eligibility. If you wish to verify eligibility, or if you have any questions regarding the Plan changes, please contact the Trust Fund Office.

In accordance with ERISA reporting requirements this document serves as your Summary of Material Modifications to the Plan.

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