

4th DISTRICT IBEW HEALTH FUND

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September 30, 2010

The Patient Protection and Affordable Care Act of 2010 requires plans to extend coverage to children aged nineteen (19) to twenty-six (26), except for children who are eligible to enroll in an employer-sponsored group health plan by virtue of their employment or, if married, by virtue of their spouse's employment.* This provision is applicable to the 4th District IBEW Health Fund as of October 1, 2010. The purpose of this notice is to advise of this change in the Plan and to provide the opportunity for you to reenroll your adult child(ren) whose coverage was terminated under the rules previously in effect.

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended after age 18, but before attainment of age 26, are now eligible to enroll in the 4th District IBEW Health Fund. Individuals may request enrollment for such children for 30 days from the date of this notice. Enrollment will be effective October 1, 2010. For more information contact the Fund Office at the address or telephone number shown above.

The special enrollment form to request enrollment of a child age 19 but less than age 26 is on the reverse of this notice. The form requests information concerning the child's or child's spouse's employment, if applicable, to permit the Fund Office to contact the employer regarding the availability of group health plan coverage to the child.

*The Trustees have adopted a revised dependent definition to allow continued coverage for student dependents who are entitled to group health coverage by virtue of their employment and would, therefore, not otherwise be covered by the Plan. If your student dependent is employed and is entitled to group health coverage as a result, you should contact the Fund Office for student enrollment information.

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 in 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 plan administrator at the address or telephone number shown above.

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.

4TH DISTRICT IBEW HEALTH FUND
DEPENDENT CHILD ENROLLMENT FORM (AGES 19 through 25)

Participant's Name _____ SSN _____

Participant's Address _____

Dependent's Name _____ SSN _____

Dependent's Address (if different) _____

Is Dependent Employed? _____ If Yes, Name of Employer _____

Address of Dependent's Employer (if employed) _____

Telephone Number of Dependent's Employer (if employed) _____

Is Dependent Married? _____ If So, Name of Dependent's Spouse _____

Is Dependent's Spouse Employed? _____ If So, Name of Employer _____

Address of Dependent's Spouse's Employer (if employed) _____

Telephone Number of Dependent's Spouse's Employer (if employed) _____

I hereby attest that insurance coverage is not available to this Dependent through either his/her direct employer or through his/her spouse's employer. You have our permission to contact the employer(s) listed above, if applicable, for verification of insurance availability. I understand that if this information changes, it is our responsibility to notify the Fund Office immediately.

Participant's Signature _____ Date _____

Dependent's Signature _____ Date: _____