Boilermakers Lodge No. 154 Welfare Fund
Administered by Wilson-McShane Corporation
3001 Metro Drive - Suite 500
Bloomington, MN 55425

Phone: (412) 800-7010

BOILERMAKERS LODGE NO. 154 WELFARE FUND
MEDICAL REIMBURSEMENT BENEFIT PROGRAM
MAJOR MEDICAL COVERAGE ATTESTATION FORM

* PLEASE RETURN TO THE FUND OFFICE *
* FAILURE TO RETURN FORM BY MARCH 1, 2025 WILL RESULT IN AN ACCOUNT FREEZE *

Due to restrictions placed on health reimbursement arrangements ("HRAs") by the Patient Protection and Affordable Care Act ("PPACA"), the Boilermakers Lodge No. 154 Welfare Fund ("Fund") must confirm that all participants for whom employer contributions are being made to the Fund on their behalf are enrolled in major medical coverage that meets certain standards under PPACA **on an annual basis**.

If you receive major medical coverage through another plan provided by your employer, you should have been provided with a notice and a Summary of Benefits and Coverage that contains an explanation as to whether that coverage meets the minimum value standard under PPACA. If you receive major medical coverage through your spouse's employer or another source, the plan sponsor of that health plan should have provided you with this information. If you do not know whether the primary health plan in which you are enrolled meets the minimum value standard under PPACA, please contact that plan for more information. If you are not enrolled in major medical coverage at all, please indicate that as well.

Name: _____ Employer: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Birth Date: _____

Please select the statement below that applies to you:

1. ___ I am enrolled in a health plan through the Boilermakers National Health & Welfare Fund based on contributions made by my employer.
2. ___ I am enrolled in health plan provided by my employer other than the Boilermakers National Health & Welfare Fund.
3. ___ I am enrolled in a health plan that is not provided by my employer.
4. ___ I am not enrolled in any other health plan except the Boilermakers Lodge No. 154 Welfare Fund Medical Reimbursement Benefit Program.

If you selected 1, please sign the Attestation below:

I have read the statements above and I attest to the following:

- I am enrolled in the Boilermakers National Health & Welfare Fund based on contributions made by my employer.

Participant's Signature: _____ Date: _____

If you selected 2 or 3 please select the statement below that applies to you:

A. ____ The health plan I am enrolled in meets the minimum value standard.
B. ____ The health plan I am enrolled in does not meet the minimum value standard.

If you selected A, please sign the Attestation below:

I have read the statements above and I attest to the following:

- I am enrolled in a group health plan that meets the minimum value standard of the Patient Protection and Affordable Care Act.
- I understand that I must promptly inform the Fund if and when I am no longer enrolled in a group health plan that

Participant's Signature: _____ Date: _____

If you selected B, please provide the date that you began being enrolled in the health plan that does not meet the minimum value standard and sign below.

I am a participant in the Boilermakers Lodge No. 154 Welfare Fund. I am enrolled in a health plan that does not meet the minimum value standard from the date of _____.

Participant's Signature: _____ Date: _____

Please contact the Fund Office at (412) 800-7010 with any questions.

Return this form to the Fund Office:

Boilermakers Lodge No. 154 Welfare Fund
Attn: Claims Department
3001 Metro Drive, Suite 500
Bloomington, MN 55425