October 2013

TO: **All Retiree Participants**
AFL Hotel & Restaurant Workers Health & Welfare Trust Fund

FROM: Board of Trustees

SUBJECT: **Dependent Eligibility, Self-Funded Comprehensive Medical Plan, Medicare Part D Premium Reimbursement**

The Board of Trustees, at their meeting of October 1, 2013, adopted the following changes:

I. Dependent Eligibility

Effective January 1, 2014, dependent coverage is available to all dependents under age 26 regardless of whether they may be eligible for other employer-sponsored health coverage, pursuant to the Patient Protection and Affordable Care Act (the Affordable Care Act).

II. Self-Funded Comprehensive Medical Plan

A. Annual Limit

Effective January 1, 2014, annual limits on essential health benefits are prohibited, pursuant to the Affordable Care Act. Therefore, the annual limit of $2,000,000 per person per calendar year on essential health benefits will be removed.

B. Annual Maximum Copayment

Because this plan no longer has an annual limit on essential health benefits and has an inpatient hospital benefit where the Plan pays 100% of Eligible Charges, the Trustees approved to increase the Maximum Annual Copayment per calendar year, **effective January 1, 2014**, as follows:

Employee Category	Current	Effective January 1, 2014
Retired employees	$2,500 per person, $7,500 per family	$2,800 per person, $8,400 per family

C. Preexisting Condition Exclusion for In Vitro Fertilization

Effective January 1, 2014, preexisting condition exclusions are prohibited, pursuant to the Affordable Care Act. Therefore, the waiting period requirement of 12 consecutive months of coverage under the Plan immediately preceding an in vitro fertilization procedure was removed. Benefits in connection with in vitro fertilization will be covered as follows, provided prior authorization is obtained:

	Participating Provider	Non-Participating Provider
Physician services	90% of E.C.	80% of E.C.
Outpatient DXL	100% of E.C.	80% of E.C.
Prescription drugs	Covered under Drug Plan	Covered under Drug Plan

FOR RETIREES AND SPOUSES OUTSIDE THE STATE OF HAWAII ONLY

III. Medicare Part D Premium Reimbursement

For calendar year 2014, the Trustees approved to continue the Medicare Part D premium reimbursement **up to** $32.34 per month on a quarterly basis.

If your spouse is eligible for Medicare and also enrolls in an approved Medicare Part D Plan, the Trust Fund will reimburse you for your spouse's Medicare Part D premium **up to** $32.34 per month for calendar year 2014, on a quarterly basis.

Reminder: In order for you to receive this reimbursement, you must submit the following documentation to the Trust Fund:

1. A copy or description of the approved Medicare Part D Prescription Drug Plan in which you (or your spouse) are enrolled;
2. Confirmation of your enrollment (or your spouse's enrollment) in the Medicare Part D Prescription Drug Plan;
3. Proof of payment for your Medicare Part D Prescription Drug premium (i.e. receipt from insurance carrier, copy of cancelled check or money order, etc.); and
4. A completed "Application for Out-of-State Medicare Part D Premium Reimbursement" form, which is available upon request from the Trust Fund Office (see attached).

Important Note: If you do not provide all the required documentation, the Trust Fund will not make any reimbursement payment to you.

Should you have any questions on the above changes or need assistance with your coverage, please contact the Trust Fund Office at 523-0199, or for neighbor islands, call toll free at (866) 772-8989.

Disclosure of Grandfathered Status

The Trust Fund believes its group health plans are "grandfathered health plans" 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 plan administrator, Benefit & Risk Management Services, Inc., at 560 North Nimitz Highway, Suite 209, Honolulu, Hawaii 96817-5315 or (808) 523-0199. 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 Web site has a table summarizing which protections do and do not apply to grandfathered health plans.