March 2016

TO: **All Eligible Plan Participants**
Hawaii Teamsters Health and Welfare Trust

FROM: Board of Trustees

SUBJECT: **Non-Grandfathered Status for the Medical and Prescription Drug Plans**

This is to notify you that the Board of Trustees have elected to take the Self-Funded Comprehensive Medical Plan, Self-Funded HMO Medical Plan, and the Self-Funded Prescription Drug Plan to "non-grandfathered" status, effective June 1, 2016.

The Affordable Care Act (ACA) requires all non-grandfathered plans to provide certain benefits. The following benefits have been added or improved, as required by the ACA, effective June 1, 2016:

- Preventive Health Care Services
- Out of Network Emergency
- Prescription Drug - Out-of-Pocket
- Claims and Appeals - Independent External Review

Preventive Services

Preventive Healthcare Services covered with no copayment include well childcare visits, certain immunizations, and certain screening services if provided by a Participating Provider.

Out of Network Emergency Services

The plan will pay 90% of Eligible Charges for a physician visit when using an Out of Network Hospital Emergency Room (formerly 80%).

The plan will pay 100% of Eligible Charges for the Emergency Room when using an Out of Network Hospital (formerly 80%).

You will remain responsible for the difference between the actual charge and the Eligible Charge for Out of Network services.

Prescription Drug

1. Maximum Annual Copayment

ACA requires an annual out-of-pocket maximum. The out-of-pocket maximum which has been established by the Trustees is $2,000 for single in any Plan Year and $4,000 for family in any Plan

Year. The out-of-pocket maximum will work no differently than the medical out-of-pocket maximum.

2. Preventive Prescription Benefits

As a result of a non-grandfathered status, ACA requires certain preventive prescription drugs be covered with no copayment.

Claims and Appeals

Effective June 1, 2016, an individual whose appeal was denied **may** qualify to have their appeal reviewed by an independent review organization (IRO).

To be eligible for review by an IRO, you must:

- Meet the applicable eligibility criteria at the time you incurred the medical expense,
- have exhausted your internal appeal rights,
- submit all the necessary information and forms, and
- your claim must be based on retroactive termination of coverage (rescission) or an issue of medical judgment.

All the changes, modifications, or additions will be part of the Summary Plan Description (SPD) and will be available on the fund's website (www.teamsterstrustbenefits.com) on June 1, 2016. Hardcopies of the SPD are available upon request from the Trust Office.

Should you have any questions on the above changes or need assistance with your coverage, please contact the Trust Office at 842-0392, or for neighbor islands, call toll free at (866) 772-8989.