333 West Vine Street
Suite 500
Lexington, KY 40507
877.423.5246
www.aflciotpa.org

To: All Active Employees Eligible for Coverage

From: Plan Administrator
AFL-CIO Health & Welfare Plan

Date: May 27, 2016

Re: Plan Open Enrollment Period

Important!

If you want to continue your current coverage under the Plan, or if you are not covered under the Plan and do not wish to be covered, you do not need to take any action.

Open Enrollment Begins June 1

The AFL-CIO Health & Welfare Plan (Plan) will hold an open enrollment period from June 1, 2016 through June 30, 2016, with new coverage or coverage changes effective July 1, 2016. Open enrollment provides an opportunity for an active employee and/or his or her spouse, dependents or children who are eligible for the Plan, but not currently covered by the Plan, to apply for coverage. **If you are already enrolled in coverage under the Plan and are not interested in making any changes to your coverage or enrolling any eligible spouse, child or dependent who is not already covered, you do not need to do anything. Your current coverage in the Plan will continue.**

Similarly, if you are not covered by the Plan and are not interested in enrolling, no action is needed.

Changing Your Current Coverage

If you would like to make a change to your coverage or apply to enroll yourself or your spouse, child or dependent in the Plan, you must complete the applicable enrollment forms. In this case, please contact us toll free at 1-877-423-5246. You will be provided with the appropriate forms for your coverage change request and the process will be coordinated with your employer.

Summary of Benefits and Coverage (SBC)

For your reference, a copy of the Summary of Benefits and Coverage (SBC) for the coverage that you are eligible for under the Plan is attached to this notice and is also available on the Plan website (www.aflciotpa.com). The SBC is a summary of your benefits and coverage provided in standardized format in accordance with ACA requirements. Please also continue to refer to the Plan's Summary Plan Description (SPD) for more specific information about the Plan.

If You Have Questions

This memo will also be posted on the Plan's website (www.aflciotpa.org), where all applicable election and change forms are also posted.

If you have any questions regarding the open enrollment period or your eligibility for coverage under the Plan, please feel free to call us toll free at 1-877-423-5246.

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The plan described in the enclosed Summary of Benefits and Coverage (SBC) is a "grandfathered health plan" under the ACA. As permitted by the ACA, 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 ACA 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 ACA, 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, UMR, 333 West Vine Street, Suite 500, Lexington, KY 40507 or 1-888-999-7741. 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.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at welcometouhc.com or by calling 1-800-996-0592.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$0** Individual / **$0** Family Non-Network: **$50** Individual / **$150** Family per calendar year. Copays, prescription drugs, and services listed below as "No Charge" do not apply to the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Network: **Unlimited** Individual / **Unlimited** Family Non-Network: **$1,050** Individual / **$3,150** Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	**Premium**, prescription drugs, copays, balance-billed charges, health care this plan doesn't cover, and penalties for failure to obtain pre-notification for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see myuhc.com or call **1-800-996-0592.**	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If a non-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5 copay per visit	20% coinsurance after deductible	If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply.
	Specialist visit	$5 copay per visit	20% coinsurance after deductible	If you receive services in addition to office visit, additional copays, deductibles, or coinsurance may apply.
	Other practitioner office visit	$5 copay per visit	20% coinsurance after deductible	Manipulative (chiropractic) services only and are limited to 100 visits per calendar year.
	Preventive care / screening / immunization	No Charge	No Charge	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% coinsurance after deductible	None
	Imaging (CT / PET scans, MRIs)	No Charge	20% coinsurance after deductible	Pre- notification is required non-network or benefit reduces to 50% of eligible expenses.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at myuhc.com	Tier 1 – Your Lowest-Cost Option	Retail: $1 copay Mail-Order: $0 copay	Retail: $1 copay Mail Order: Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 34 day supply Mail-Order: Up to a 102 day supply Certain drugs may have a pre-notification requirement or may result in a higher cost. If you use a non-network pharmacy (including a mail order pharmacy), you are responsible for any amount over the allowed amount. Tier 1 contraceptives covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered.
	Tier 2 – Your Midrange-Cost Option	Retail: $15 copay Mail-Order: $15 copay	Retail: $15 copay Mail Order: Not Covered	
	Tier 3 – Your Highest-Cost Option	Retail: $15 copay Mail Order: $15 copay	Retail: $15 copay Mail Order: Not Covered	
	Tier 4 – Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	No Charge	Pre-notification is required non-network or benefit reduces to 50% of eligible expenses.
	Physician / surgeon fees	No Charge	No Charge	None
If you need immediate medical attention	Emergency room services	No Charge	No Charge	None
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	$5 copay per visit	20% coinsurance after deductible	If you receive services in addition to urgent care, additional copays, deductibles, or coinsurance may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% coinsurance after deductible	Pre-notification is required non-network or benefit reduces to 50% of eligible expenses.
	Physician / surgeon fees	No Charge	20% coinsurance after deductible	None

If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	$5 copay per visit	20% coinsurance after deductible	None
	Mental / Behavioral health inpatient services	No Charge	20% coinsurance after deductible	Pre-notification is required non-network or benefit reduces to 50% of eligible expenses.
	Substance use disorder outpatient services	$5 copay per visit	20% coinsurance after deductible	None
	Substance use disorder inpatient services	No Charge	20% coinsurance after deductible	Pre-notification is required non-network or benefit reduces to 50% of eligible expenses.
If you are pregnant	Prenatal and postnatal care	$5 copay initial visit	20% coinsurance after deductible	Additional copays, deductibles, or coinsurance may apply depending on services rendered.
	Delivery and all inpatient services	No Charge	20% coinsurance after deductible	Inpatient pre-notification may apply.
If you need help recovering or have other special health needs	Home health care	No Charge	20% coinsurance after deductible	Limited to 40 visits per calendar year. Pre-notification is required non-network or benefit reduces to 50% of eligible expenses.
	Rehabilitation services	$5 copay per outpatient visit	20% coinsurance after deductible	Limited to 100 outpatient visits per type of therapy, per calendar year. Inpatient Rehabilitation services are combined with inpatient skilled nursing care and limited to 60 days per calendar year.
	Habilitative services	$5 copay per outpatient visit	20% coinsurance after deductible	Except for Habilitation Services provided in early intervention and school services, Habilitative Services for children 0-21.
	Skilled nursing care	No Charge	20% coinsurance after deductible	Limited to 60 days per calendar year (combined with inpatient rehabilitation). Pre-notification is required non-network or benefit reduces to 50% of eligible expenses.
	Durable medical equipment	No Charge	20% coinsurance after deductible	Pre-notification is required non-network for DME over $1,000 or benefit reduces to 50% of eligible expenses.
	Hospice service	No Charge	20% coinsurance after deductible	Inpatient pre-notification is required non-network or benefit reduces to 50% of eligible expenses.

If your child needs dental or eye care	Eye exam	$5 copay per outpatient visit	20% coinsurance after deductible	General eye exams are covered. Vision exams, including refraction, are limited to once every other calendar year from a network provider.
	Glasses	Not Covered	Not Covered	Covered under vision plan.
	Dental check-up	Not Covered	Not Covered	Covered under dental plan.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult/Child)
- Glasses (Adult/Child)
- Infertility treatment
- Long-term care
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Dental under dental plan
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult/Child)
- Vision under vision plan

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-996-0592. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Member Service number listed on the back of your ID card or myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform or District of Columbia Department of Insurance, Securities, and Banking at 1-202-727-8000 or disr.washingtondc.gov/disr/site/default.asp.

Additionally, a consumer assistance program may help you file your appeal. Contact DC Office of the Health Care Ombudsman and Bill of Rights at 1-877-685-6391 or healthreform.dc.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-996-0592.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-996-0592.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-996-0592.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-996-0592.

--------------------------*To see examples of how this plan might cover costs for a sample medical situation, see the next page.* --------------------------

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,340
- **Patient pays** $200

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$0
Coinsurance	$0
Limits or exclusions	$200
Total	**$200**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $5,060
- **Patient pays** $340

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$300
Coinsurance	$0
Limits or exclusions	$40
Total	**$340**

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.