U.A. LOCAL 350 HEALTH & WELFARE PLAN

445 APPLE STREET * P.O. BOX 11337 * RENO, NV 89510 * P. (775) 826-7200 F. 775) 824-5080

June 2017

Dear Members,

This Notice includes annual notices the Plan is required to provide you under the Affordable Care Act and other Federal Laws. It also includes other reminders. This is for informational purposes only. No action is necessary.

Grandfathered Health Plan Reminder

The Board of Trustees believes that the U.A. Local 350 Health and Welfare Plan is a "grandfathered health plan" under the Affordable Care Act ("ACA"). As permitted by the ACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that ACA was enacted. Being a grandfathered health plan means that your Plan is not required to include certain consumer protections of the ACA that apply to other plans (known as a Non-Grandfathered plan), for example, requiring the provision of preventive health services without any cost sharing. Grandfathered health plans must comply, however, with certain other consumer protections in the Act, such as the elimination of annual and lifetime limits on the Plan's essential health benefits. (For a definition of what constitutes as Essential Health Benefits, please visit *www.healthcare.gov/glossary/essential-health-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 Trust Fund Office at (775) 826-7200. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor (DOL) 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.

Women's Health and Cancer Rights Act

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction of the breast on which the mastectomy was performed, reconstruction and surgery to achieve symmetry between the breasts, prostheses, and treatment of physical complications resulting from all stages of the mastectomy, including lymphedema (swelling that sometimes happens after treatment for breast cancer). This coverage may be subject to the Plan's deductibles, coinsurance, and co-payment provisions (consistent with those established for other benefits under the Plan). If you have any questions, please call the Plan administrator at 775-826-7200.

Newborns and Mothers Health Protection Act

Under Federal law, Group Health Plans and Insurers, may not generally restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours). The Plan and Insurers may not set level of benefits or out-of-pocket costs so that any portion of the 48-hour (96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the Plan and Insurers cannot require that a physician or health care provider obtain authorization for prescribing a length of stay up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs you may be required to obtain precertification. Call the Plan administrator at 775-826-7200 for more information.

HIPAA Privacy Notice Reminder

This Notice is to remind you that, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Plan will only use or disclose your individual health information, known as protected health information, in accordance with the Plan's Notice of Privacy Practices. You may obtain a copy of the Plan's Notice of Privacy Practices at any time by calling the Plan Administrator at 775-826-7200, to request that a copy be mailed to you. Within a reasonable period of time of your request, the Plan administrator's office will mail you a copy of the Notice. The Notice is also automatically provided to you at least once every three years or when there is a material change to the Notice.

Calendar Year Deductible Reminder

The Plan's Calendar Year deductibles are $250 per individual and $750 per family. Three individual deductibles met in full by three family members during a calendar year will satisfy the family deductible maximum for that particular calendar year. The Deductible is the amount of covered expenses you and/or your family must pay during each calendar year before certain major medical benefits are payable by the Plan. However, there are certain services that are covered before you meet your deductible, such as certain preventive care, outpatient lab procedures and prescription drugs. For more details on coverage, please contact the Trust Fund Office. **NOTE:** Please further be advised, the calendar year deductible is not waived when there is dual coverage and the Plan is secondary.

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or the Children's Health Insurance Program ("CHIP") and you are eligible for health coverage from your employer, the State you reside in may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State that provides premium assistance, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **877/KIDS NOW** or ***www.insurekidsnow.gov*** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at *www.askebsa.dol.gov* or by calling toll-free 866/444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**

Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website:http://www.dhs.pa.gov/provider/medicalassistance/ healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

AVAILABILITY OF SUMMARY OF BENEFITS & COVERAGE

Under the Affordable Care Act, Group health plans are responsible for providing a Summary of Benefits & Coverage, also known as an SBC, to eligible Participants and their dependents. The SBC provides a summary of what the Plan covers and what it costs. You also have the right to request and receive within 7 business days a SBC for the Plan. If you want a copy of the Plan's SBC and/or more details about your coverage and costs, please contact the Plan at (775) 826-7200.

INDIVIDUAL MANDATE & MINIMUM ESSENTIAL COVERAGE

The Affordable Care Act establishes a minimum value standard of benefits for health plans and requires you and your dependents to have health coverage that qualifies as minimum essential coverage. Subject to certain exceptions, failure to have minimum essential health coverage will subject you to an IRS penalty. The minimum value standard is 60% (actuarial value) and eligible employer-sponsored plans (such as this Plan) are considered minimum essential coverage. **As such, if you are covered under this Plan you meet the individual mandate, since the Board of Trustees believes this Plan provides minimum essential coverage and meets the minimum value standard for the benefits it provides.**

Beginning in March 2016 and annually thereafter, the Plan will be required to send you a statement (known as Form 1095-B) about the coverage you and/or your dependents are enrolled in. This information is intended to help you meet your individual mandate requirement and to assist you in reporting your health coverage when you file your income tax return. The Plan is also required to file this Form with the IRS. At the time of this mailing, you should have already received this form.

RECISSION OF COVERAGE RESTRICTIONS

Under the Affordable Care Act, the Plan and Insurers cannot retroactively cancel or terminate your coverage, except in cases of fraud, intentional misrepresentation of material fact, or failure to timely pay premiums. However, a retroactive cancellation of coverage is not considered a rescission if (1) it only has prospective effect, (2) is initiated by the covered individual, (3) due to delay in administrative record-keeping, (4) attributed to a failure to timely pay required premiums or contributions toward the cost of coverage, or (5) termination of coverage retroactive to the divorce, if the Plan does not cover former spouses. Plans and Insurers that rescind coverage must give affected individuals at least 30 days advance notice.

MEDICARE COORDINATION For Retirees Who Are Eligible for Medicare – You are Required to Enroll

Medicare is our country's federal health insurance program for people who worked at least ten years in Medicare-covered employment who are age 65 or older, for people under age 65 with certain disabilities, and for people of any age who have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). If you are receiving Social Security Disability Income ("SSDI") benefits, you generally become eligible for Medicare coverage 24 months after your SSDI benefits begin.

Under the Medicare program, the hospital insurance portion is called Medicare Part A, and the medical insurance portion, such as for the cost of physicians, is called Medicare Part B. Medicare Part A is financed by payroll taxes, and, if you are eligible to receive it based on your own or your spouse's employment, you do not pay a premium. Medicare Part B is partly financed by monthly premiums paid by individuals enrolled for Part B coverage. Most working people are entitled to Medicare Part A when they reach age 65 because either they or a spouse paid Medicare taxes while working.

If you are retired, the Plan coordinates benefits with Medicare as if you are covered under both Medicare Part A (hospital benefits) and Part B (medical benefits). This means you and/or your spouse must enroll in **both Medicare Part A and Part B**, as soon as you and/or your spouse are eligible for Medicare. If you and/or your spouse do not enroll in Medicare (Part A and Part B), the Plan will not make up for the portion of expenses that Medicare would have paid and failure to do so will resort in late enrollment penalties.

Medicare's prescription drug plan (**Medicare Part D**) is available to Medicare beneficiaries and is part of your coverage if you are enrolled in the Plan. If you earn a higher income (above $85,000 for individuals or above $170,000 for married couples), Federal Law requires that you pay an additional premium for your Medicare Part D coverage to the Social Security Administration. This additional premium is called the Income-Related Monthly Adjustment Amount (also known as "IRMAA"). The premium is based on your modified adjusted gross income as reported on your IRS tax return from two years ago (thus, the fee in 2016 will be based on your adjusted gross income on your 2014 tax return). If you must pay a higher premium, Medicare will send you a letter with your premium amounts and the reason for their determination.

For more information on Medicare, please call Medicare at 800/MEDICARE (800/633-4227) or visit *www.medicare.gov*. TTY users should call 877/486-2048. If you have any questions, please contact the Plan Office at (775) 826-7200.

Special Enrollment Rights

Under Federal Law, if you declined enrollment for yourself and/or your dependents because of having other sufficient group health coverage, you may be able to enroll yourself and/or your dependents in this Plan, if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 30 days after you or your dependents' other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement of adoption, you may be able to enroll yourself and your dependents within 30 days after the birth, adoption, placement for adoption, or marriage provided you complete and submit an Enrollment Form along with any other Plan required documentation (ex. marriage certificate, birth certificate, adoption papers) to the Trust Fund Office. To request special enrollment information, please contact the Plan Administrator at (775) 826-7200.

IMPORTANT REMINDER to provide Plan with Taxpayer Identification Number (TIN) OR Social Security Number (SSN) of Each Enrollee

Employers and Plans are required by law to collect the Taxpayer identification number (TIN) or Social Security Number (SSN) of each Plan Participant and Dependent. Employers and the Plan are required to provide that number on reports (known as the Forms 1094-B, 1095-B, 1094-C, and 1095-C) that will be provided to the IRS each year. Employers and Plans are required to make at least three attempts to gather missing TINs/SSNs.

If a dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN: http://www.socialsecurity.gov/online/ss-5.pdf. Applying for a social security number is FREE.

If you have not yet provided the social security number (or other TIN) for each of your dependents that you have enrolled in the Plan, please contact the Plan Administrator at (775) 826-7200.

Option to Decline Dental and/or Vision Coverage

In accordance with Health Reform regulations, you have the option to decline/waive the Plan's dental and vision coverage. To decline/waive coverage complete the portion of the Plan's enrollment form related to declining/waiving dental and/or vision coverage. Enrollment forms are available from the Trust Fund Office. Note that there is no additional compensation to you if you choose to decline/waive dental and/or vision coverage. Please contact the Plan Administrator at (775) 826-7200 for more information.

Notice of Availability of Schedule of Allowances

As a reminder, the Plan's Schedule of Allowances Applicable to Non-Contract Providers is available to you from the Trust Fund Office. The Schedule of Allowances is the maximum amount allowed under the Plan for certain services for which you and/or your dependents receive from providers who are not contracted with the Plan. Please contact the Plan Administrator at (775) 826-7200 for more information.