

Trustees

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Nicholas I. Martin
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Matthew Shilvock
John F. Ward
Mark J. Weinstein
Cheryl A. Zane

**AGMA Retirement Plan
AGMA Health Fund**

1430 Broadway, Suite 1203 • New York, NY 10018
Telephone (212) 765-3664 • Fax (212) 956-7599
E-Mail: agmaretirement_health@yahoo.com

Executive Director

Derek J. Davis

**CHANGES TO PLAN B EFFECTIVE SEPTEMBER 1, 2014
IMPORTANT INFORMATION ENCLOSED—PLEASE READ CAREFULLY**

August 4, 2014

Dear Plan B Participants,

As you know from our recent communications, Plan B, as it is currently structured, will not be allowed under the rules of the Affordable Care Act (ACA) effective September 1, 2014.

For the last year, the AGMA Health Fund's Trustees, lawyers, consultants and administrators, have been working together to find a solution that allows the Fund to continue providing meaningful, valuable benefits to our participants—and be in compliance with the law.

We recently sent out a communication discussing some of the options we were considering. The letter mentioned the ways you could continue to use your Plan B account, new Plan B reimbursement rules, and the possibility of a new medical plan.

The Trustees and our advisors continued to discuss the Fund's options and listened to what AGMA members had to say about the proposed changes. **In order to minimize the disruption to you and your families, to allow maximum use of the funds currently in your Plan B accounts for the largest number of participants and to comply with the law, the Trustees have elected to take a *new approach*. Please disregard the information in the last letter.**

Effective August 31, 2014, all current Plan B account balances will be 'frozen.' You may continue to receive reimbursements from your frozen balances, but no new contributions may be added to your balance. More details on the changes are below.

We are changing Plan B so that accounts with contributions received on or before August 31, 2014 will be maintained separately, and no further amounts will be credited to the accounts.

The "frozen" accounts will not be increased due to contributions received on or after September 1, 2014 or as the result of any interest crediting. The frozen accounts will continue to be subject to the current administrative rules, such as the timing of receipts for eligible expenses and the forfeiture provision.

While the accounts will be frozen to new contributions and interest, effective September 1, 2014, **participants may continue to receive reimbursement from their frozen accounts.** The reimbursements will continue to be subject to the current Plan B reimbursement rules with the following *new* exception -- no one may be reimbursed for premiums for individual health insurance policies (including plans purchased through an ACA Marketplace or an individual insurance company) or for member cost-sharing (i.e, copayments, deductibles, coinsurance, etc.) incurred under individual policies.

In other words, claims incurred on or after September 1, 2014 are eligible for reimbursement from frozen accounts subject to the above restriction on individual insurance policies as well as the applicable Plan rules (including the deadline for claims submission). Note that claims incurred before September 1, 2014, but processed for reimbursement on or after September 1, 2014, are also subject to this new exclusion. **If you have a claim for premiums for individual health insurance policies or for member cost-sharing incurred under individual policies, it must be received and processed *BEFORE* September 1, 2014; please submit any such claim immediately.**

We understand that this change will disadvantage some current Plan B participants. We had to make changes to Plan B because of the ACA requirements. *Plan B could not legally continue as it is currently designed.* We reviewed many different options, and the option we chose will benefit the most participants.

On the following pages, we have put together some frequently asked questions and answers about the Plan B changes and the Health Insurance Marketplaces. Members who have a choice between Plan A benefits or Plan B contributions should review the information in Question #6 and #7. We will continue to communicate with you to make this transition as easy as possible.

If you have any questions, we will be posting information to our website, www.agmafunds.org, as it becomes available, or you can call the Fund Office at 212-765-3664 or Administrative Services Only, Inc. at 866-263-1185.

Sincerely,

The Board of Trustees

A handwritten signature in black ink, appearing to read "Derek J. Davis". The signature is fluid and cursive, written over a white background.

By Derek J. Davis
Executive Director

QUESTIONS ABOUT THE PLAN B CHANGES

Q1: What is happening to Plan B and why?

A1: One of the major changes under ACA is that reimbursement plans like Plan B cannot be offered to anyone who is not offered and enrolled in a “group health plan.” A group health plan is generally a plan offered by an employer or a union. An individual insurance policy obtained through the Marketplace or directly from an insurer is **NOT** a group health plan. *Medicare is not considered a group health plan.*

Effective August 31, 2014, all Plan B accounts will be ‘frozen’ to new contributions going forward. Plan B accounts with contributions received on or before August 31, 2014 will be maintained separately, but no further amounts will be credited to the accounts. The “frozen” accounts will **not** be increased due to contributions received on or after September 1, 2014 or as the result of any interest crediting.

The frozen accounts will continue to be subject to the current administrative rules, such as the timing of receipts for eligible expenses and the forfeiture provision.

Q2: What will happen to the funds in my Plan B account? Will I still be able to use them for reimbursement?

A2: While the accounts will be frozen to new contributions and interest, effective August 31, 2014, **participants may continue to receive reimbursement from their frozen accounts.**

The reimbursements will continue to be subject to the current Plan B reimbursement rules with the following *new* exception--no one may be reimbursed for premiums for individual health insurance policies (including plans purchased through an ACA Marketplace) or for member cost-sharing (i.e, copayments, deductibles, coinsurance, etc.) incurred under individual policies.

In other words, claims incurred on or after September 1, 2014 are eligible for reimbursement from frozen accounts subject to the above restriction on individual insurance policies as well as the applicable Plan rules (including the deadline for claims submission).

Note that claims incurred before September 1 but processed for reimbursement on or after September 1 are also subject to this new exclusion. **If you have a claim for premiums for individual health insurance policies or for member cost-sharing incurred under individual policies, you need to submit it immediately so that it is received and processed **BEFORE** September 1, 2014.**

Q3: Can I use my frozen balance to be reimbursed for Medicare or a Medicare supplemental plan premiums?

A3: Yes, you can be reimbursed for your Medicare or Medicare supplemental plan premiums from your frozen balance. (As of September 1, special rules apply to those redirecting contributions from Plan A to Plan B with respect to Medicare, see Q6 and Q7).

Q4: I have always submitted dental and optical expenses for reimbursement. Will I still be able to claim these expenses after September 1?

A4: Yes, limited dental and optical expenses are considered “excepted benefits” under the ACA (i.e, those types of expenses are not subject to the same restrictions); you will still be able to submit these expenses for reimbursement today and after September 1.

Q5: How do I find out my Plan B account balance?

A5: You can find your current Plan B balance by logging in at www.asonet.com, or by calling Administrative Services Only, Inc. toll-free at 866-263-1185.

Q6: Under my AGMA contract, my employer offers me a choice between having Plan A coverage or directing my Plan A contributions to Plan B. How do the changes affect me?

A6: If you are in this situation, your benefits will stay largely the same as they are now. But your eligibility to direct contributions to Plan B will change, as explained below.

Your current Plan B account will be frozen to new contributions and interest crediting, the same as for other Plan B participants. You will continue to be eligible to use your Plan B account funds for eligible reimbursements. The changes in what is defined as an expense that is eligible for reimbursement will apply as well.

Contributions received after September 1, 2014 will go into a *new*, separate Plan B account for you. You will be eligible to continue claiming reimbursements against this new Plan B account as long as you are eligible for Plan A coverage. This is true, even if you elect to receive Plan B contributions instead, providing that you can prove you have coverage through a group health plan elsewhere (see next question).

Claims will be paid out of your frozen Plan B account first until it is exhausted, and then claims will be paid from your new Plan B account.

If you have funds in your new Plan B account but become ineligible for Plan A coverage, you will not be eligible to claim a reimbursement from your new Plan B account until you are again eligible for Plan A coverage. This is because one of the requirements of the law is that you need to be eligible for the Fund’s Plan A coverage for your health reimbursement account (Plan B) to be accessible to you. You will be able to continue to obtain reimbursement for claims from any balance in your old, frozen Plan B account.

Q7: I am eligible for Plan A coverage, but have elected to have my contributions directed to a Plan B account instead. Will I be able to continue this approach?

A7: Yes, but you will be required to provide the Fund Office with proof of your eligible alternative coverage through a group health plan *or you will not be permitted to opt out and will instead be registered for Plan A coverage*. Alternate group health plan coverage must be of minimum value to be considered eligible; Medicare is not considered a group health plan. The Fund will provide you with more information about how this will work. If you have opted out of Plan A coverage, we'll be contacting you directly to discuss how the changes will impact you and what your options will be.

Q8: Why are changes being made to my collective bargaining agreement?

A8: AGMA (the Union, *not* the AGMA Health Fund) has started to negotiate with employers to amend all of its contracts so that there will be no further contributions going solely to Plan B. In the new collective bargaining agreements, AGMA may propose to have contributions that were directed to Plan B instead directed to the AGMA Retirement Plan, which is a separate Trust in which members receive individual accounts based upon contributions. Any change (such as this one) to AGMA's contract with the employer is subject to collective bargaining and agreement between the management and the union.

QUESTIONS ABOUT HEALTH CARE REFORM MARKETPLACES

Q9: What is the Health Insurance Marketplace?

A9: The Health Insurance Marketplaces were created by the Affordable Care Act (ACA). (When the law was first passed, they were called "Exchanges.") The Marketplaces are a new way to find health coverage for those who need it. You can compare your options and costs based on what's available in your state.

There was an initial enrollment period for health insurance coverage through the Marketplaces that ended on March 31, 2014. The next enrollment period begins on November 15, 2014, for coverage effective January 1, 2015. You can only purchase a Marketplace plan outside of the enrollment period if you qualify for a special enrollment. You can qualify for a special enrollment if you experience a life event, including a change in family status (for example, marriage or birth of a child) or loss of other job-based health coverage.

It is important to remember that the insurance sold through the public Marketplaces is not meant to replace employment-based plans, such as the AGMA Health Fund Plan A. It is designed to offer coverage opportunities for people who might not currently have health insurance.

Q10: What is the Individual Mandate?

A10: One of the changes required by the Affordable Care Act (ACA) is the “individual mandate,” which requires that just about everyone have a minimum level of coverage. If you don’t, you may have to pay a penalty. Your health insurance coverage can come:

- From your (or your spouse’s) employment, including AGMA Health Fund coverage,
- Through a policy you buy on your own, including those offered through the Health Insurance Marketplace, or
- Through a government-sponsored program like Medicare or Medicaid.

Basically, if you have medical coverage, you should not have to pay a penalty.

There are exceptions, however. Examples of health plans that don’t meet minimum essential coverage include plans that only cover vision or dental care, plans that only offer coverage for a single condition (such as cancer), or plans that only offer discounts on medical services. If your only coverage is a plan like one of these, you may have to pay a penalty.

Q11: Does my AGMA Health Fund coverage meet the Individual Mandate? Will I have to pay a penalty?

A11: IF YOU HAVE THE FUND’S COVERAGE, your coverage meets the individual mandate standard and you will not have to pay a penalty.

IF YOU DO NOT HAVE THE FUND’S COVERAGE and you do not have other coverage through another employer or through your spouse’s employment, for example, you may have to pay a penalty. You may want to look at the coverage options being offered through the Health Insurance Marketplace.

Q12: Can I buy a Marketplace plan?

A12: Yes. Just about anyone* can purchase a medical plan through a Marketplace. However, if you are eligible for AGMA Health Fund Plan A coverage or have a frozen Plan B balance, you will have to pay the full cost of the Marketplace plan’s monthly premiums. Because you are an eligible participant in a group health plan, you are not eligible for a premium assistance tax credit.

*To be eligible to purchase health coverage through the Marketplace, you:

- must live in the United States,
- must be a U.S. citizen or national (or be lawfully present), and
- cannot be currently incarcerated.

Q13: Should I try to find coverage through my state's Marketplace?

A13: Just because you can buy a Marketplace plan does not mean you should. There are different answers depending on your eligibility for AGMA Health Fund coverage.

- **If you are eligible for AGMA Health Fund Plan A medical coverage or have a frozen Plan B balance**, you are not eligible for a premium assistance tax credit. If you are enrolled in Plan A coverage, you do not need to shop for Marketplace insurance.
- **If you are not eligible for or have lost AGMA Health Fund Plan A medical coverage and you do not have coverage from another source** (e.g., through your spouse's employer), you may want to explore the coverage options in your state's Health Insurance Marketplace and you may be eligible for a premium assistance tax credit if you purchase a plan through the Marketplace. (You will not be eligible for the tax credit for any month that you have a frozen Plan B balance unless you waive that balance). Visit the federal government's website www.healthcare.gov for more information about your options. If you regain eligibility for Plan A coverage, you can re-enroll in Plan A (and drop your Marketplace plan). Be sure to keep the Marketplace informed of any change in your eligibility for Fund coverage, especially if you are receiving a premium assistance tax credit. If you have recently lost your eligibility for Plan A coverage, you have the option of electing COBRA Continuation Coverage.
- **If you are on COBRA Continuation Coverage or choose COBRA Continuation Coverage**, you pay the full share of your monthly medical coverage premium plus a 2% administrative fee. COBRA payments are eligible expenses for Plan B reimbursement from an available frozen balance. You may want to explore the coverage options in your state's Health Insurance Marketplace as an alternative to COBRA Continuation Coverage. You may be able to find a medical plan that meets your needs and is cheaper than what you are currently paying.

You may also be eligible for a premium assistance tax credit if you purchase a plan through the Marketplace instead of COBRA Continuation Coverage. Losing Fund coverage eligibility or exhausting COBRA eligibility are qualifying events for special enrollment in the Marketplace, but discontinuing COBRA coverage is not. Visit the federal government's website www.healthcare.gov for more information about your options. If you regain eligibility for Fund coverage, you can re-enroll in the Fund. Be sure to keep the Marketplace informed of any change in your eligibility for Fund coverage, especially if you are receiving a premium assistance tax credit.

Q14: If I have Marketplace coverage, am I eligible for the premium assistance tax credit that is offered?

A14: There are certain income restrictions that will determine if you qualify for the premium assistance tax credit. However, **if you have any available balance in a frozen Plan B account, you are not eligible to receive the premium assistance tax credit in any month in which you maintain that balance.** You may forgo the premium assistance tax credit for each month you do have an available balance or you can contact the Fund Office to permanently forfeit your balance, which would then make you eligible for the premium assistance tax credit.

Q15: If I have Marketplace coverage, can I submit those premiums or expenses to Plan B for reimbursement?

A15: Not after August 31. After that date, Plan B cannot reimburse premium or related healthcare expenses for individual plans. Coverage through the Marketplace is through an individual insurance plan and those expenses cannot be reimbursed after August 31.

NEED MORE INFORMATION?

As always, if you have questions about health coverage provided by the AGMA Health Fund or other options if you are no longer eligible for coverage from the Health Fund, you can:

- **Call the AGMA Health Fund:** (212) 765-3664
- **Visit the Fund's website:** www.agmafunds.org
- **Call Administrative Services Only, Inc.:** (866) 263-1185

The Health Fund's staff also may be able to assist you with questions about the Health Insurance Marketplace and the requirements of the Affordable Care Act.

You can also visit the federal government's website dedicated to Marketplace information, www.healthcare.gov, or you can contact an ACA Navigator. ACA Navigators are trained to help consumers learn about their health plan options and to assist with enrollment. The ACA Navigators' website address is <http://acanavigators.com/>.

The information describing the Affordable Care Act and the Marketplaces contained in this document was compiled from available resources that we believe to be accurate and reliable. Although we have made every effort to ensure that this material is correct as of the date of publication, this information may be affected by changes in laws and regulations or the interpretation of such laws and regulations. This notice is designed to provide a general overview, and should not be treated as legal, tax, or financial guidance for individual situations. Please thoroughly examine the current laws and regulations or contact an appropriate qualified professional before relying on the contents of this notice.