AGMA Health Fund
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November 15, 2017

AGMA HEALTH FUND PLAN A OPEN ENROLLMENT AND OTHER IMPORTANT ANNUAL REMINDERS

Dear Participant:

As you may be aware, the AGMA Health Fund (the "Fund") allows you to make certain changes to your Health Plan enrollment once a year during the Fund's annual Open Enrollment Period. We are writing you this letter to let you know that the Open Enrollment Period for the Fund is beginning on Wednesday, November 15, 2017 and will end on Friday, December 15, 2017. We also take this opportunity to provide you and your family with important annual reminders.

I. Open Enrollment Begins on November 15, 2017

If you wish to make any of the four changes listed below, they will become effective as of January 1, 2018; however, you must provide formal, written notification that is received by the AGMA Health Fund Office by **December 15, 2017**. In addition to notifying the AGMA Health Fund of these changes, you are responsible for notifying the Human Resources Office or the appropriate staff member at the Company that employs you.

Changes to your Health Plan can be any one of the following:

1. Adding Family Coverage (at an additional cost of $1,383 per month)
2. Adding Domestic Partner Coverage – an application form must be completed prior to adding a Domestic Partner (at an additional cost of $1,383 per month); same-sex spouses are treated as spouses and not domestic partners
3. Changing to AGMA Health Fund Plan B from AGMA Health Fund Plan A (Only available if this option is included as an option in the Collective Bargaining Agreement between your Company and AGMA; in addition, participants must contact the Fund Office to complete a form and provide proof of other eligible group coverage) **
4. Changing to AGMA Health Fund Plan A from AGMA Health Fund Plan B (Only available if this option is included as an option in the Collective Bargaining Agreement between your Company and AGMA) **

** Switching between Plan A and Plan B: The contributions for work in November and December will be directed to the Plan you elect for January 1, so that coverage under your new option can begin on January 1. For example, if you elect to move from Plan B to Plan A, contributions for your work in November and December will be paid to Plan A so that you will qualify for Plan A on January 1. This would mean that your last Plan B contribution will be for October work, due in Mid-November. Similarly, if you elect to move from Plan A to Plan B (and timely submit the necessary proof of other group health coverage), contributions for work in November and December will be paid to Plan B and should be available to you by January 1; your Plan A coverage will end December 31.

Self-Pay **Dental** Coverage: During Open Enrollment, you can also join the **self-pay Dental Coverage**, effective January 1, 2018. This plan, available from Aetna Dental, costs $22.62 per month for individual coverage and $64.80 per month for family coverage which is payable directly through the Fund Office and in advance of the coverage month.

Self-Pay **Vision** Coverage: In addition to the option to self-pay for Dental Coverage, the Trustees are pleased to continue to offer the opportunity to join the **self-pay Vision Coverage**, effective January 1, 2018. This plan, which is provided by Aetna Vision Preferred, costs $4.84 for individual coverage and $12.34 per month for family coverage which is payable directly through the Fund Office and in advance of the coverage month. You may elect vision coverage only at Open Enrollment. Please see our website (www.agmafunds.org/faq_dentalvision.html) for additional information on the available benefits of this option.

If you wish to make one of these enrollment changes, your written notice must be received by the AGMA Health Fund Office at the above address by December 15, 2017. Otherwise, no changes will be allowed until the Fund's next annual Open Enrollment Period a year from now, except in the circumstances described in the Special Enrollment section in Part III of this letter.

II. Important Benefit Updates

Updated Summary of Benefits & Coverage: Enclosed with this mailing is a letter detailing the changes in certain plan benefits; that letter includes the updated Summary of Benefits & Coverage (SBC) for your plan effective January 1, 2018. This information is also available online at our website www.agmafunds.org.

Precertification: Under the terms of our contract with Aetna, certain in-network services require precertification before you can begin to receive treatment. Please remember that it is the responsibility of the in-network provider to process all precertification requests. If an in-network provider fails to precertify a service, the member is held harmless. Generally, a member is not aware that a precertification request was submitted by the provider. However, it is a member's responsibility to precertify all out-of-network services.

Coverage for Dependents: In response to a number of questions that have been directed to the Fund Office, we would like to remind you of the dates of coverage for your dependents. If you have coverage that includes your dependent children, they may continue on your medical coverage until the end of the month in which they turn age 26. If you are paying for either the vision or dental coverage, your dependent child can continue on this coverage until the end of the month in which they turn age 19 (or age 23 if they are enrolled in school).

Teladoc: Effective September 1, 2015, Aetna introduced the services of Teladoc®, which is a provider of phone and online video physician consulting. Members now have nationwide access, except in Idaho and Arkansas, to physicians that can treat them for common medical issues without a visit to a brick and mortar office. These doctors will be able to treat common medical conditions such as cold and flu symptoms, bronchitis, allergies, sinus problems, respiratory infections and ear infections, just to name a few. They can also recommend treatment and prescribe medication, when appropriate. The availability of this service is expected to reduce unnecessary visits to the ER and/or urgent care centers. The member pays the PCP office copayment for this service. This service is available 24/7/365 and you can initiate a call by going online to Teladoc.com/Aetna or by calling 1-855-Teladoc (835-2362). Please call Aetna at 866-658-2455 if you have any questions about this or any benefit.

Request for Social Security Numbers: Beginning in 2015, Aetna may contact you asking for a social security number for you and/or one of your dependents. Aetna must collect this information in order to complete a required form that will maintain their compliance with the Affordable Care Act. You may also provide this information online at Aetna.com or by calling the number on the back of your Aetna ID card.

III. Important Annual Reminders

Special Enrollment

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your

dependents' other coverage). However, you must request enrollment in writing within 31 days after your or your dependents' other coverage ends.

In addition, if you have a new dependent as a result of marriage, entering into a domestic partnership, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, registration of the domestic partnership, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact Derek Davis, Executive Director the Fund Office at (212) 765-3664.

Annual Notice of Women's Health and Cancer Rights Act (WHCRA)

Your group health plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). For more information, call the Fund Office at (212) 765-3664.

This coverage is subject to any plan copayments, annual deductibles, and coinsurance provisions that may be applicable, consistent with those established for other benefits under the plan. These provisions are described in the Plan's Summary Plan Description (SPD).

If you have any questions about whether your plan covers mastectomies or reconstructive surgery, please contact the Fund Office or you may also call Aetna at the toll-free Member Services number on your Aetna ID card.

Availability of a HIPAA Privacy Notice for Your Group Health Plan

If you would like to see (or obtain a copy of) the plan's HIPAA Notice of Privacy Practices, please contact the Privacy Officer located at 1430 Broadway, Suite 1203, New York, NY 10018, visit www.agmaretirement-health.org or call the Fund Office. The Notice describes how the plan uses and discloses protected health information for the offices of the AGMA Health Fund (the "Fund") and other business associates of the Fund. It also discusses important federal rights that you have with respect to your protected health information. This Notice does not apply to the insured hospital, medical, prescription drug and dental benefits provided through a contract with Aetna. You should have received a HIPAA Privacy Notice directly from Aetna outlining its privacy practices. You may request a copy of Aetna's HIPAA Privacy Notice that pertains to the insured hospital, medical, prescription drug, vision and dental benefits by contacting Aetna directly at the toll-free Member Services number on your Aetna ID card.

IV. Notice of Certain Rights Under the Affordable Care Act

Designation of Primary Care Provider

Aetna does not require the selection or designation of a primary care provider (PCP). You have the ability to visit any network or non-network health care provider (including a Pediatrician for a child); however, your out-of-pocket costs may be higher if you use a non-network provider.

Direct Access to Obstetrical and Gynecological Care

You do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Aetna at the telephone number listed on your Aetna ID card.

V. Electronic Communications

The Fund Office is aware that many participants prefer to receive communications electronically and are willing to forego printed copies of certain documents to improve the delivery of these items and to help reduce operating costs.

If you wish to sign up for electronic copies, please complete and return the enclosed **Consent to Electronic Disclosure** (members who are receiving this material electronically will not receive another copy of this form). If you have already submitted this form, there is no need to re-submit it unless your information has changed. You also have the ability to rescind this option by informing us in writing.

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If you have any questions, please contact the Fund Office by phone at 212-765-3664 or e-mail the general Fund Office mailbox at info@agmafunds.org or at agmaretirement_health@yahoo.com.

Sincerely,

Derek J. Davis
Executive Director
For the Board of Trustees
AGMA Health Fund

Encs: Consent to Electronic Disclosure (printed copy only)