BUILDING SERVICE 32BJ HEALTH FUND
and the
PATIENT PROTECTION AND AFFORDABLE CARE ACT

The Building Service 32BJ Health Fund (Health Fund) offers several self-insured plans of benefits for full-time workers, and all of those plans are minimum essential coverage (MEC). These Plans include the Metropolitan, Suburban, Tri-State, and Basic Plans (Plans). All Plans are intended to comply with the Patient Protection and Affordable Care Act (ACA). The Health Fund also offers plans in the Washington, DC area that are fully-insured by Kaiser.

Eligibility

Subject to the terms of collective bargaining agreements (CBAs), all of the Plans offer coverage to full-time employees after a waiting period that complies with the ACA. If the contribution rate agreed to in the CBA covers family coverage, dependent children are covered through at least the last day of the month in which they attain age 26. Some CBAs require a contribution rate that only provides for employee-only coverage. In those cases, the Health Fund will not provide dependent coverage. The Health Fund only will offer coverage to dependents when the CBA provides for such coverage. Please note, however, that an employer may not be considered to have offered coverage to its full-time employees for the purpose of the employer shared responsibility requirements (commonly called "the employer mandate") if dependent children are not also offered coverage. If you are not certain whether your CBA provides family coverage, please contact Employer Services.

Your collective bargaining agreement (and not the Plan):

- establishes the definition of full-time employee for purposes of employer contributions/eligibility,
- determines whether coverage is employee-only or family, and
- determines the employee contribution (if any) for employee-only or family coverage.

It is your responsibility to determine whether you satisfy the requirements under the ACA regarding offers of coverage to full-time employees.

Benefits: Minimum Value and Affordability

All of the Plans are minimum essential coverage and provide a comprehensive package of benefits and services that are described in the applicable summary plan description and Summary of Benefits and Coverage. All of the Plans have been certified by the Health Fund's actuary as exceeding the minimum value requirement under the ACA.

If there are no employee contributions for employee-only coverage, as is true in nearly all CBAs, the affordability requirement under the ACA is satisfied. If there are employee contributions for employee-only coverage, you will need to review the amount of such contributions to determine whether the affordability requirement is satisfied.

Reporting

The Health Fund completes minimum essential coverage reporting under Internal Revenue Code Section 6055, which applies to plans and insurers, early each calendar year for coverage for the prior calendar year. The Health Fund issues Forms 1095-B to all participants to whom the Health Fund provides coverage during the calendar year. It does this for all Plans except those in the Washington, DC area that are fully insured by Kaiser. Kaiser does minimum essential coverage reporting for those plans.

You are responsible for reporting under Internal Revenue Code Section 6056, which applies to employers, if you are an applicable large employer (ALE) and for providing Forms 1095-C to your full-time employees. Upon written request, and to the extent permitted under HIPAA privacy rules, the Health Fund will provide information to you about your employees who have coverage under the Health Fund each calendar year. You are responsible for determining which of your employees were full-time as defined by the ACA, and for completing and distributing the 1095-C forms to your employees. The Health Fund will not prepare, file, or distribute any Forms 1095-C or 1094-C on behalf of any large contributing employer.

Fees

The Health Fund pays the Transitional Reinsurance Fee plus the Health Fund's required contribution to the Patient-Centered Outcomes Research Institute (PCORI).

Excise Tax on High Cost Employer-Sponsored Health Coverage

Starting in 2020, employer-sponsored health coverage that exceeds a government set dollar threshold is subject to an excise tax equal to 40 percent of the amount in excess of the dollar threshold. The excise tax on high cost employer-sponsored health coverage (commonly called the "Cadillac Tax") was originally set to take effect in 2018, but was delayed by two years to 2020. When this excise tax takes effect, it will be paid when the total cost of employer-sponsored health coverage exceeds a certain threshold. All of the Plans have been reviewed by the Health Fund's actuary and are not expected to trigger the tax anytime through 2020.

Questions

If you have questions about this notice, please call the Health Fund's Compliance Department at (212) 539-2778. If you have questions about the coverage provided under your collective bargaining agreement, please contact Employer Services at 212-388-3354 or by email at employerrelations@32bjfunds.com.