## 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 (WHCRA), provides benefits for mastectomy-related services. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

This coverage is subject to any Plan copayments, annual deductibles, coinsurance and limits that may be applicable and 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.

## Newborn's and Mothers' Health Protection Act Notice Reminder

Under federal law, group health plans, like this Plan, generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician (e.g., Physician, or Health Care Practitioner), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 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 may not, under federal law, require that a Physician or other Health Care Practitioner obtain authorization for prescribing a length of stay of 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. For information on precertification for a length of stay longer than 48 hours for vaginal birth or 96 hours for C-section, contact Empire Blue Cross Blue Shield at the number on your 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 at the Fund Office. The Notice describes how the plan uses and discloses protected health information for hospital, medical, prescription drug, vision, and dental benefits and eligibility and COBRA administration. It also discusses important federal rights that you have with respect to your protected health information.

**Medicare Notice of Creditable Coverage**

If you or your eligible dependents are currently Medicare eligible, or will become Medicare eligible during the next 12 months, you need to be sure that you understand that the prescription drug coverage is creditable (as valuable as Medicare's prescription drug coverage). A copy of the Fund's notice is attached to this document.

**Summary of Benefits and Coverage (SBC)**

The Summary of Benefits and Coverage (SBC) is required by the Affordable Care Act (ACA) to be sent to you every year. It is intended to provide a general description of the health benefits provided by the Plan.

The federal government created the SBC to help people who are shopping for coverage when the health care exchanges opened back in 2014. SBCs are intended to show how different plans cover specific benefits (office visits, diagnostic tests or prescription drugs, for example), and how much coverage they offer for those benefits—what the coinsurance and copayments are for different services. For that reason, we are not allowed to change much of the SBC to make it better fit with your Fund benefits. If you read the SBC or the Glossary and anything seems confusing or does not quite line up with the way the Fund's benefits work, we suggest that you check the SPD and the other benefit materials that you get from the Fund or call the Fund Office.

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

In addition to the above special enrollment rights, contributing employers must provide notice of potential opportunities for premium assistance to all employees who reside in a state that provides premium assistance under Medicaid or CHIP. In order to assist contributing employers with this notification requirement, a copy of the *Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)* notice is included at the end of this document.

**COBRA Continuation Coverage Reminder**

In compliance with a federal law referred to as COBRA Continuation Coverage, this Plan offers participants and their covered dependents (known as qualified beneficiaries) the opportunity to elect temporary continuation of their group health coverage when that coverage would otherwise end because of certain events (called qualifying events). Qualified beneficiaries are entitled to elect COBRA when qualifying events occur, and, as a result of the qualifying event, coverage of that qualified beneficiary ends. Qualified beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

Qualifying events include termination of employment or reduction in hours of work making the participant ineligible for coverage, death of the participant, divorce/legal separation, or a child ceasing to be an eligible dependent child. The maximum period of COBRA coverage is either 18 months (for loss of coverage resulting from termination of employment or reduction in hours of work) or 36 months (for loss of coverage resulting from death of the participant, participant's

entitlement to Medicare, divorce/legal separation, or a child ceasing to be an eligible dependent child), depending on which qualifying event occurred.

In order to elect COBRA coverage after a divorce/legal separation or a child ceasing to be a dependent child under the plan or you, the participant, becomes entitled to Medicare, you and/or a family member must inform the Plan in writing of that event no later than 60 days after that event occurs. That notice should be in writing and should be sent to the Fund Office via first class mail and must include the participant's name, the qualifying event, the date of the event, and the appropriate documentation in support of the qualifying event (such as divorce documents). *If you fail to notify the Fund Office within 60 days of the event, coverage will terminate as of the date of the event and your dependents will have no rights to COBRA.*

***Other Options in Addition to COBRA***

When your coverage terminates, in addition to considering COBRA as a way to continue coverage, there may be other coverage options for you and your family. You may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan) if you request enrollment within 30 days, even if the plan generally does not accept late enrollees.

Additionally, you may want to look for coverage through the Health Care Marketplace (see https://www.healthcare.gov/). In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums for Marketplace coverage, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. However, if you sign up for COBRA continuation coverage, you will only be able to switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." Be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you will have to wait to enroll in Marketplace coverage until the next open enrollment period and could end up without any health coverage in the interim. Once you have exhausted your COBRA continuation coverage and the coverage expires, you will be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

*Keep in mind that if you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage once your election period ends.*

***What if you are Medicare-eligible?*** If you are eligible for Medicare, in general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit https://www.medicare.gov/medicare-and-you.

**Notice of Extension of Certain Deadlines**

In light of the ongoing COVID-19 national emergency, certain deadlines currently imposed by the Plan will be extended to help prevent participants and beneficiaries from losing rights and benefits under the Plan. These extended deadlines relate to HIPAA special enrollment, COBRA and the filing of claims and appeals. In calculating the new deadline, the Plan will disregard the time period between March 1, 2020 and 60 days after the end of the COVID-19 national emergency. This time period is called the Outbreak Period in the examples below.

- ***HIPAA Special Enrollment.*** Participants will get extra time to exercise their special enrollment rights (e.g., enroll a new dependent or a dependent who loses eligibility for other coverage. For example, if this special enrollment event happened on or after March 1, 2020, the new deadline would be 30 days after the end of the Outbreak Period. If the special enrollment event relates to loss of coverage under Medicaid or the Children's Health Insurance Program, the new deadline would be 60 days after the end of the Outbreak Period.

- ***COBRA Continuation Coverage.*** Participants will have additional time to notify the Plan of a qualifying event, submit a COBRA Election Form and make COBRA premium payments. For example, if the usual 60-day clock to submit the Election Form would start ticking on May 15, that clock would not start ticking until the end of the Outbreak Period. These deadline extensions do not extend the maximum period of COBRA coverage. If COBRA is elected and premiums are paid, claims for covered expenses will be paid retroactive to the first date of COBRA coverage, for every month for which premium are paid in full. The Plan will not pay any claims for medical expenses until COBRA is elected and COBRA premiums are paid in full.

- ***Filing Benefits Claims & Appeals.*** Participants will have additional time to file a claim for benefits, submit a request for an internal appeal and request an external appeal. In calculating the new deadlines, the Plan will disregard the days during the Outbreak Period.

If you have questions about this notice or would like more information about the dates that will apply to your rights under the Plan as they relate to special enrollment, COBRA or claims and appeals rights, please contact the Fund Office.