

2019 Annual Notices

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Introduction

This brochure includes the annual notices that should be distributed to all employees and dependents. This newsletter contains important information so we encourage you to read all sections.

If you have any questions regarding any items contained in this newsletter, please contact your Human Resources office or plan administrator for more information.

We hope you find this information helpful and informative.

Summary of Benefits and Coverage

The Health Care Reform law states that all groups must implement the requirement that health plans and health insurers provide consumers with a Summary of Benefits and Coverage (SBC). The stated purpose of the SBC is to “accurately describe the benefits and coverage under the applicable plan or coverage,” which will allow participants to better compare plan terms and benefits.

In addition, all group health plans will have to distribute a brief standard summary of benefits and must use and distribute a uniform glossary containing definitions for common terms (e.g. “copay”, “deductible”, etc.).

This should be distributed annually, no later than December 1st and within seven days per any employee request. The medical SBC will be created by the insurance carrier and provided to each group for distribution.

In addition, if your group has a stand-alone HRA or FSA that covers expenses beyond excepted benefits, then the plan sponsor, not the insurance carrier, will create and distribute that SBC.



Special Enrollment Rights Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

WHCRA Enrollment Notice



If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). 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.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call your Plan Administrator at the phone number on the back of your carrier ID card.

Patient Protections Disclosure Notice

You do not need prior authorization from the carrier 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 in network 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 your insurance carrier by calling the number on the back of your ID card.

FOR GROUPS WITH HMO PLANS:

The employer's group health plan generally requires or allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your insurance carrier by calling the number on the back of your ID card.

Notice of Availability of Notice of Privacy Practices

Your group health plan (the Plan) is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its regulations to maintain the privacy of your protected health information (PHI) and to provide plan participants with notice of its legal duties and privacy practices with respect to PHI. PHI is any individually identifiable information that is received or maintained by the Plan in electronic, written, or oral form that pertains to your past, present or future mental or physical condition, the provision of health care services for that condition, and the payment for those services.

The Plan is required by law to tell you:

The Plan's uses and disclosures of your PHI;

The Plan's duties with respect to your PHI;

Your right to file a complaint with the Plan and with the Secretary of the U.S. Department of Health and Human Services; and

The person to contact for further information about the Plan's privacy practices.

A copy of the Notice of Privacy Practices is available to all individuals whose PHI will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact your Human Resources office or plan administrator.



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

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your state 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 but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, you may 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 may contact your state Medicaid or CHIP office at **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, you may 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 may contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-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, 2018. You should contact your state for further information on eligibility.

| NEW JERSEY – Medicaid and CHIP |
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| 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 |

| NEW YORK – Medicaid |
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| Website: https://www.health.ny.gov/health_care/medicaid/ |
| Phone: 1-800-541-2831 |

| PENNSYLVANIA – Medicaid |
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| Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm |
| Phone: 1-800-692-7462 |

To see if any more states have added a premium assistance program since January 31, 2018 or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/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

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Notice of Dependent Enrollment Limitations



Newborns: Must be enrolled within **30 days** of birth. If they are not enrolled within this time frame, they are not eligible until the next open enrollment period. If no open enrollment period exists, they are not eligible until a Life Status Event occurs (which may not occur in many instances).

Adoption/Judgments/Decrees/Etc.: Must be enrolled as of effective date listed on legal documentation. Refer to Plan Document on day limitation (i.e. 30 or 60 days to enroll).

Newborns' Act Disclosure

Group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with child-birth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section.

However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

