As an eligible participant in the plan, LERC is required to furnish you with several notices during the year. Please see below for a summary of these notices.

Summary of Benefits and Coverage - Employers must provide a Summary of Benefits and Coverage ("SBC") to all eligible participants at open enrollment, when a material change in benefits is made mid-year or upon initial enrollment. This SBC summarizes the plan's medical and prescription drug benefits and includes comparison information and a glossary of terms.

Women's Health and Cancer Rights Act Notice This notice provides information about special rights available to individuals following a mastectomy. It must be provided upon initial enrollment and annually. (***Attached Below***)

Newborns' and Mothers' Health Protection Act – This notice indicates that plans that offer maternity coverage must pay for at least a 48-hour hospital stay following childbirth (or 96-hour stay for a cesarean section). This notice is often included in the booklet or SPD.

HIPAA Special Enrollment Notices - The Health Insurance Portability and Accountability Act ("HIPAA") requires group health plans to notify eligible participants of their HIPAA special enrollment opportunities when they first enroll in a group health plan and at the annual open enrollment. (***Attached Below***)

HIPAA Notice of Privacy Practices - Your health plan must provide you with a notice (every three years or if there is a significant change in benefits) that tells you how they may use and share your personal health information and how you can exercise your health privacy rights.

Notice of Creditable Coverage - Entities that provide prescription drug coverage to Medicare Part D eligible individuals must notify these individuals whether their drug coverage is creditable or non-creditable to Medicare Part D. This notice must be distributed to all Medicare eligible individuals annually prior to October 15th each year, to new hires and to individuals who become eligible for Medicare during the year.

Plans must also notify CMS on-line by 60 days after the end of the plan year that they distributed the notice as required.

Model Exchange Notice – Employers must provide this to ALL new hires (even those not eligible for benefits) within 14 days of hire. This notice explains that the public exchange is available and under what circumstances an individual might be eligible to participate in the exchange.

COBRA Notices – The plan must provide an initial COBRA notice upon enrollment and a COBRA qualifying event notice when a qualifying event occurs that results in a loss of coverage and COGRA eligibility.

HIPAA Notice of Special Enrollment Rights

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 within “30 days'' or any longer period that applies under the plan after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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. However, you must request enrollment within “30 days'' or any longer period that applies under the plan after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after you or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after you or your dependents' determination of eligibility for such assistance.

WOMEN'S HEALTH AND CANCER RIGHTS ACT
NOTICE TO PARTICIPANTS

As required by federal law, our group health plan continues to provide medical and surgical benefits in connection with a mastectomy as described in this notice and in your plan booklets. Any participant or beneficiary who is receiving benefits in connection with a mastectomy, and who elects breast reconstruction in connection with such mastectomy, shall be entitled to receive coverage for:

1. All stages of reconstruction of the breast on which the mastectomy has been performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance.
3. Prostheses and treatment of physical complications at all stages of mastectomy, including lymphedema (swelling of the hand and arm on the operated side).

These benefits will be provided subject to the same annual deductibles and coinsurance provisions that apply to all other medical and surgical benefits provided through the various health care options under your plan.

If you have any questions about this health provision, please contact

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