Administrative Offices

U.A. Local No. 467 Trust Funds

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U.A. LOCAL 467 HEALTH, WELFARE AND VACATION PLAN

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DATE: **November 2020**

TO: **PARTICIPANTS & DEPENDENTS**

RE: **ANNUAL NOTICES**

This Notice is being provided because certain annual notices the U.A. LOCAL 467 HEALTH, WELFARE AND VACATION PLAN is required to provide you under the Patient Protection and Affordable Care Act ("ACA") and other Federal Laws. Moreover, some items in this Notice are provided for your information and as a reminder (not required by any specific law). No action is necessary on your part. This is for informational purposes only. You may also review your Blue Cross or Kaiser Evidence of Coverage booklets for coverage and detail information.

ACA GRANDFATHERED HEALTH PLAN REMINDER

The Board of Trustees believes that the Plan is a "Grandfathered health plan" under the Affordable Care Act. A Grandfathered health plan can preserve certain basic health coverage that was already in effect when that Act was enacted. Being a grandfathered health plan means that your Plan is not required to include certain consumer protections of the Act that apply to other plans, for example, requiring the provision of preventive health services without any cost sharing. Grandfathered health plans must comply, however, with certain other consumer protections in the Act, such as the elimination of annual and lifetime limits on the Plan's essential health benefits. (For a definition of what constitutes as Essential Health Benefits, please visit *www.healthcare.gov/glossary/essential-health-benefits*.)

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Office at 408-288-4455 or 1-800-541-8059. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor (DOL) at 1–866–444–3272 or *www.dol.gov/ebsa/healthreform*. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Under a federal law known as the Women's Health and Cancer Rights Act of 1998, group health plans, insurers (such as Blue Cross), and HMOs (such as Kaiser) that provide medical and surgical benefits for a mastectomy must provide benefits for reconstructive surgery, in consultation with the attending physician and patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed, including coverage for nipple and areola reconstruction, and re-pigmentation to restore the physical appearance of the breast;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis, and
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

This coverage is subject to the Plan's deductibles, coinsurance, and co-payment provisions (consistent with those established for other benefits under the Plan). If you have any questions about whether your Plan covers mastectomies or reconstructive surgery, you may contact the Plan at 1-408-288-4440. If you are enrolled in the Kaiser HMO option, you may contact Kaiser directly at 1-800-464-4000 or if you are enrolled in the Blue Cross PPO option, you can contact Blue Cross directly at 1-855-256-9404.

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Under Federal Law, Group health plans, Insurers (such as Blue Cross), and HMOs (such as Kaiser) generally may not, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following natural birth delivery (vaginal delivery) or less than 96 hours following a cesarean section. However, federal law generally does prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

The Plan and Insurers may not set level of benefits or out-of-pocket costs so that any portion of the 48-hour (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 provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as set forth above). However, to use certain providers or facilities, or to reduce your out-of-pocket costs you may be required to obtain precertification. Call the Plan Office at 1-408-288-4440 for more information.

AVAILABILITY OF THE PLAN'S HIPAA NOTICE OF PRIVACY PRACTICES

The Plan's Notice of Privacy Practice describes the ways that the Plan uses and discloses your medical information, your rights, the Plan's legal responsibility regarding your medical information, and how you can get access to your health information. **Under federal law, you have the right to request a copy of the Plan's Privacy Notice at any time.** The Notice is also provided to you at least once every three years or when there is a material change to the Notice. For a copy, please contact the Plan office at 1-408-288-4440.

INDIVIDUAL MANDATE (STATE LAW REQUIREMENT) & MINIMUM ESSENTIAL COVERAGE

Beginning in 2019, the federal individual tax penalty for failing to have adequate health coverage under the ACA has been reduced to zero under the Tax Cut and Jobs Act of 2017. (This means you will no longer be required to meet the federal mandate for 2020.) Please keep in mind that although the federal individual tax penalty no longer applies, California has its own State Individual Health Insurance Mandate that requires California residents to have qualifying health coverage or pay a fee with your state taxes beginning with the 2020 Plan year unless an exception applies. The Affordable Care Act establishes a minimum value standard of benefits for a health plan such as this Plan. The minimum value standard is 60% (actuarial value) and Grandfathered Health Plans (such as this Plan) are considered minimum essential coverage. **The Health and Welfare Plan provides minimum essential coverage and meets the minimum value standard for the benefits it provides**. **Therefore, no action is necessary for the California mandate purposes as you have adequate coverage through the Plan.**

ACA AVAILABILITY OF SUMMARY OF BENEFITS & COVERAGE (SBC)

Under the Affordable Care Act, Group health plans and Insurers (such as Kaiser and Blue Cross) are responsible for providing a Summary of Benefits and Coverage, also known as an SBC, to eligible Participants and their dependents as well as to new Participants and their dependents upon enrollment. The SBC provides a summary of what the Plan covers and what it costs and allows you to compare the Plan's benefit options (currently Blue Cross PPO option and Kaiser HMO option) offered to you and your dependents. You also have the right to request and receive within seven (7) business days an SBC for the Plan. If you want a copy of the Plan's SBC for its Blue Cross PPO medical option or Kaiser HMO medical option and/or more details about your coverage and costs, please contact the Plan Office at 1-408-288-4440.

OUT OF STATE RETIREES UNDER 65 PARTICIPATE IN BLUE CROSS PREFERRED PROVIDER OPTION

Out-of-state retirees of the U.A. Local 467 Health and Welfare Plan who are under age 65 are permitted to participate in the Blue Cross Preferred Provider Option in the same manner as in-state Participants have such right. As a result, the Plan does not provide direct reimbursement to retirees for obtaining their own coverage outside the Plan.

PARTICIPANT WITH 25 BENEFIT CREDITS WHO BECOMES DISABLED PRIOR TO AGE 65

If a Participant incurs a permanent disability prior to reaching retirement age under the U.A. Local 467 Defined Benefit Pension Plan, he or she will be eligible for the Medicare Retiree Plan if he or she has at least 25 Benefit Credits under the U.A. Local 467 Defined Benefit Pension Plan and has not worked for a non-signatory employer.

COVERAGE OF PREGNANCIES FOR DEPENDENT DAUGHTERS

The Board of Trustees provides coverage for pregnancy and maternity care expenses, including related conditions, similar to what is already being for spouses, to eligible dependent daughters through age 25 (coverage is lost at the end of the month in which the daughter turns age 26 although COBRA would be available to purchase at that time).

NOTICE OF NONDISCRIMINATION

Discrimination is Against the Law

The Plan is required to provide you with this Notice of Nondiscrimination about your rights under the law. The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of their race, color, national origin, age, disability, or sex. For example, the law requires that women be treated equally with men in the health care they receive and prohibits the denial of health coverage based on pregnancy, gender identity and sex stereotyping. The Plan covers transgender services for Participants and dependents that are determined to be medically necessary by a licensed physician.

- Provides free aids and services to people with disabilities to communicate effectively with the Plan, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need any of the above services, please contact the Trust Fund Office at (408) 288-4400.

Your Right to File Grievance & Appeal with the Plan's Civil Rights Coordinator

If you believe that the Plan has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, or sex, you can file a written grievance (including an appeal) in person or by mail, fax, or email with the Plan's Civil Rights Coordinator at the contact below. If you have questions on the Plan's grievance procedures or need help filing a grievance, please contact the Plan's Civil Rights Coordinator, Sandy Stephenson.

6800 Santa Teresa Boulevard, Suite 100, San Jose CA 95119
Telephone: (408) 288-4400, Fax: (408) 288-4439

You can also file a grievance with Kaiser Permanente or Blue Cross. For information about Kaiser or Blue Cross's grievance procedures please refer to your Kaiser or Blue Cross Evidence of Coverage booklet.

Your Right to File Complaint with the U.S. Department of HHS

You also may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201
Telephone: 1-800-868-1019, 800-537-7697 (TDD)
Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*

For information about the Nondiscrimination rules, *www.hhs.gov/civil-rights/for-individuals/section-1557*.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM

If you or your children are eligible for Medicaid or the Children's Health Insurance Program ("CHIP") and you are eligible for health coverage from your employer, the State you reside in 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. **NOTE: If you live in California, California is no longer a state that provides premium assistance to help pay for Medicaid or CHIP coverage. However, the Medi-Cal Program will continue to provide health, dental, and vision benefits to California's low income uninsured children. Information is available at *www.coveredca.com/medi-cal/*.**

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State that provides premium assistance, you can 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 can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or ***www.insurekidsnow.gov*** to find out how to apply. If you qualify, you can 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 do not live in California, to find out if the State you reside in provides assistance in paying your employer health plan premiums or for more information on eligibility, you may contact either:

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

ONE YEAR TO FILE A LAWSUIT

To encourage the quick resolution of benefit disputes, the Plan provides that if an appeal has been denied or there has been a different form of adverse action taken, a Participant, Beneficiary or any other person or entity has one year from the date of such denied appeal or adverse action to file a lawsuit against the Plan, an individual Trustee, the Board of Trustees and/or any other person or entity involved with the denied appeal or adverse action. If you fail to do so, no lawsuit is permitted. This one-

year limitation period covers any and all claims for benefits referenced in this Plan. Thus, Participants and beneficiaries (and others) are encouraged to file timely appeals and to review and analyze their options sooner rather than later.

MEDICARE COORDINATION--YOU AND/ OR YOUR SPOUSE ARE REQUIRED TO ENROLL

Medicare is our country's federal health insurance program for people who worked at least ten years in Medicare-covered employment who are age 65 or older, for people under age 65 with certain disabilities, and for people of any age who have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). If you are receiving Social Security Disability Income (SSDI) benefits, you generally become eligible for Medicare coverage 24 months after your SSDI benefits begin.

Under the Medicare program, the hospital insurance portion is called Medicare Part A, and the medical insurance portion, such as for the cost of physicians, is called Medicare Part B. Medicare Part A is financed by payroll taxes, and, if you are eligible to receive such benefits based on your own or your spouse's employment, you do not pay a premium. Medicare Part B is partly financed by monthly premiums paid by individuals enrolled for Part B coverage. Most working people are entitled to Medicare Part A when they reach age 65 because either they or a spouse paid Medicare taxes while working.

The Plan coordinates benefits with Medicare as if you are covered under both Medicare Part A (hospital benefits) and Part B (medical benefits). **This means you and/or your dependent spouse must enroll in both Medicare Part A and Part B as soon as you and/or your spouse are eligible for Medicare. To be eligible for Retiree benefits under the Plan, you and/or your spouse are required to formally enroll in both Medicare Parts A and B and pay the required premium as soon as you and/or your spouse are entitled to coverage. If you do not enroll in Medicare (Part A and Part B), the Plan will not make up for the portion of expenses that Medicare would have paid and you will be required to pay an additional Retiree Health and Welfare Premium in addition to the rate currently paid, until the Medicare coverage goes into effect**.

For enrollment and eligibility information, you should call Social Security at (800) 772-1213. You can also find Medicare information on the Internet at www.medicare.gov.

Please contact this office if you have any questions about the above notices.