HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) CREDITABLE COVERAGE

This federal law was designed to help employees maintain access to health coverage as they change employers or when they leave their employer and seek an individual plan. If you enroll in a new health plan within 63 days of your prior coverage, you will receive credit for time covered under your prior coverage.

An employee covered under a group plan will receive a certificate of creditable coverage issued by the insurance carrier or plan whenever a cancellation of coverage occurs. This certificate acknowledges "credit" for time covered under the health plan. The credit will be applied toward any exclusion period for a pre-existing condition which may be required under some individual and out-of-state plans. The term "pre-existing condition" is a condition for which medical advice, diagnosis, care of treatment was recommended or received within six (6) months of enrolling in a new plan.

You will be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when:

1. You lose coverage under the plan, or
2. You become entitled to elect COBRA continuation coverage, or
3. Your COBRA continuation coverage ceases.

Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Any certificates that you receive should be kept in a safe place. It will be important if you ever seek coverage under a health plan that has an exclusion period for a pre-existing condition.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 (NMHPA)

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean delivery. However, federal law generally does not 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 group health plan does not need to provide the minimum period of coverage for a maternity stay if the mother and health care provider agree to an earlier discharge. A provider is not required to obtain authorization for a length of stay that is not in excess of 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 pre-certification. For information on pre-certification, contact the Claims Administrator.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

The health benefits of most plans must include coverage for the following post-mastectomy services and supplies when provided in a manner determined in consultation between the attending physician and the patient: (1) reconstruction of the breast on which a mastectomy has been performed, (2) surgery and reconstruction of the other breast to produce symmetrical appearance, (3) breast prostheses, and (4) physical complications of all stages of mastectomy, including lymphedemas. Plan participants must be notified, upon enrollment and annually thereafter, of the availability of benefits required due to the WHCRA.

Under the Women's Health and Cancer Rights Act, coverage of mastectomies and breast reconstruction benefits are subject to deductibles, copayments, and coinsurance limitations consistent with those established for other benefits under this Plan.