

**Supplemental Summary Plan Description Information  
for the Health Plan of  
Alpha Services of Rochester**

**Effective January 1, 2021**

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## **I. Introduction to Alpha Services of Rochester Welfare Benefit Plan**

### **A. Plan Provided**

Alpha Services of Rochester maintains a Welfare Benefit Plan (“Plan”) for the exclusive benefit of eligible employees as well as their spouses and/or dependents. Benefits of the Plan are provided under an insurance contract entered into between Alpha Services of Rochester and EBSO/90 Degrees (or the “Insurance Carrier”).

### **B. Detailed Plan Information**

In addition to this document, the Plan is summarized in more detail in the Master Contract or Insurance Certificate to which this document is related. Such summaries will typically be prepared and/or issued by our insurance carrier. If you have any questions about how to obtain another copy of the Insurance Certificate, please contact the Plan Administrator’s Designee listed in Section II of this document. This document is intended to supplement the Insurance Certificate, and it is recommended that you keep this document attached to the Insurance Certificate at all times.

### **C. Plan Document and Summary Plan Description Requirements**

The Plan to which this document is connected is covered by ERISA (which is a Federal law regulating health and welfare benefits plans). This document is not intended to give you any substantive rights to benefits that are not already provided in the Plan as described in the Insurance Certificate. This document, along with the Insurance Certificate, constitute both a written plan document and Summary Plan Description, as required by the Employee Retirement Income Security Act of 1974 (ERISA), as amended. The above-referenced documents supersede and replace any prior Summary Plan Descriptions.

**Benefits are provided solely pursuant to an insurance contract between the Plan Sponsor and the Insurance Carrier. If the terms of this summary document conflict with the terms of the insurance contract, then the terms of the insurance contract will control, unless superseded by applicable law.**

### **D. Assistance in Non-English Language**

This document, along with the Insurance Certificate, contains a summary in English of your rights and benefits under Alpha Services of Rochester’s Group Health Insurance Plan. If you have difficulty understanding any part of these documents, contact the Plan Administrator’s Designee identified in Section II of this document.

## **II. Plan Information**

### **A. General Plan Information**

#### **1. Plan Sponsor and Address**

Alpha Services of Rochester  
3261 19th Stree NW  
Rochester MN 55901  
507-252-8117

#### **2. Plan Name and Identification Number**

Alpha Services of Rochester Health Benefits Plan  
Employer Federal Tax Identification Number: 41-1992713  
Plan Number: *provide*

#### **3. Type of Plan**

Welfare Benefit Plan providing health insurance.

#### **4. Other Contacts for Benefit/Claim Information**

EBSO - Minimum Essential Coverage plan  
P.O. Box 928  
Findlay, OH, 45839  
866-296-4002

#### **5. Plan Administrator / Plan Fiduciary / Agent for Service of Legal Process**

Alpha Services of Rochester is the Plan Administrator. Alpha Services of Rochester is also the Plan Fiduciary and the agent for the service of legal process on the Plan. Alpha Services of Rochester has designated the following individual to act on behalf of the Plan Administrator:

HR Manager (hereinafter, “the Plan Administrator’s Designee”)  
Alpha Services of Rochester  
3261 19th Stree NW  
Rochester MN 55901  
507-252-8117

The Plan Administrator maintains the Plan’s records, manages the operation of the Plan and interprets the Plan’s provisions. In general, it is the duty of the Plan Administrator to see that the Plan is carried out in accordance with its terms, for the exclusive benefit of the persons entitled to participate in the Plan without discrimination among them. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, and authorizing benefit payments and gathering information necessary for administering the Plan.

The Plan Administrator, usually in conjunction with the Insurance Carrier, has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the plan.

Any interpretation, determination or other action of the Plan Administrator shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes, in its sole discretion and, further, constitutes agreement to the limited standard and scope of review described by this section.

The benefits under the Plan are fully-insured. The Insurance Carrier will generally be responsible for determining both:

- i. Eligibility for coverage (if any) and the amount of benefits payable (if any) under the Plan; and
- ii. The claims procedures to be followed and claims forms to be used by employees and their dependents under the plan. (Detailed claims procedures are contained in the Master Contract or Insurance Certificate to which this Supplement is connected.

If you have any general questions regarding the Plan, your eligibility, or the amount of benefits payable under the Plan, contact the Insurance Carrier. Inquiries may also be directed to the Plan Administrator's Designee identified above.

**6. Plan Year: January 1 – December 31.**

**7. Eligibility**

The following employees are eligible to participate in the plan:

Employees of Alpha Services of Rochester who are regularly scheduled to work, or who average, 30 hours per week. If an employee elects coverage, the following individuals may also be eligible for coverage:

- Spouses
- Dependent to age 26

You must affirmatively enroll to receive benefits under this Plan. Eligible employees must complete an application form (available from the Plan Administrator's Designee) to enroll themselves and/or eligible spouses and dependents. New employees must generally enroll within a certain time period after being hired, as described in the Insurance Certificate. Thereafter, enrollment is generally limited to

the annual open enrollment period unless the employee qualifies for Special Enrollment under the Plan.

#### **8. Waiting Period & Effective Date of Coverage**

Upon meeting the eligibility requirements set forth in the previous section, eligible employees will be permitted to enroll in the Plan after the completion of the following waiting period: First of the month following 60 days of employment. The date Plan coverage goes into effect will be the date on which employees successfully complete the waiting period.

#### **9. Amendment to, Loss of, or Termination of Benefits**

Alpha Services of Rochester reserves the right to amend or terminate the Plan and any employee contribution amounts at any time without the consent of any participant or beneficiary. Likewise, the costs of premiums for benefits may be increased at our discretion, or the discretion of any insurance companies or third-party administrators with whom we have contracted.

Your coverage under this Plan will terminate if:

- A. You no longer meet the eligibility requirements of the Plan (subject to your right to Continuation of Benefits),
- B. You cease to make required employee contributions, or
- C. The Plan terminates.

More detailed information regarding the reasons you or your dependents could lose your eligibility for benefits under the Plan can be found in the Insurance Certificate. The Plan (and any subsequent amendments) may be amended or terminated by a written instrument signed by the individual authorized above to act on behalf of the Plan Administrator or other designee.

#### **10. No Contract of Employment**

The Plan is not a contract of employment and does not create any right to employment, nor does it interfere with your right or our right to end the employment relationship at any time.

#### **11. Termination of Benefits**

Unless the Insurance Certificate states otherwise, your participation in the Plan (and that of your eligible family members) will terminate on the last day of the month in which you experience a “qualifying event” (such as termination or reduction of work hours; please see the COBRA section of this document or the Insurance Certificate for examples of additional “qualifying events”). Additional causes for the termination of coverage include, but may not be limited to, the failure to pay your share of an applicable premium, the reduction of your work hours below any required hourly threshold, and the submission by you of any false claims. For additional details regarding the timelines and circumstances of benefits termination please refer to the Insurance Certificate.

## **12. Funding Medium**

The Plan is fully insured. Benefits are provided under a group insurance contract entered into between Alpha Services of Rochester and the Insurance Carrier. Claims for benefits are sent to the Insurance Carrier.

The cost of this Plan is paid with contributions shared by Alpha Services of Rochester and the employee. These contributions are paid to the Insurance Carrier in accordance with the certificate of insurance.

## **13. Loss or Recovery of Benefits**

The Plan may recover overpaid benefits and erroneously paid benefits through its right to subrogation and reimbursement. These Plan rights are described in the Insurance Certificate.

## **14. Filing a Claim and Claim Denial**

For purposes of determining the amount of, and entitlement to, benefits under the Plan, the insurer or HMO is a fiduciary under the Plan, and has the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance or HMO contract.

To obtain benefits under the Plan, you must follow the claims procedures under the applicable insurance or HMO contract, which may require you to complete, sign, and submit a written claim on a specified form. Contact the Plan Administrator's Designee for any such forms.

The Insurance Carrier or HMO will decide your claim in accordance with its reasonable claims procedures, as required by ERISA and the PHSA. The Insurance Carrier or HMO has the right to secure independent medical advice, and to require such other evidence as it deems necessary in order to decide your claim. If the Insurance Carrier or HMO denies your claim, in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the Insurance Carrier or HMO for a review of the denied claim. The Insurance Carrier or HMO will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA and the PHSA. If you fail to appeal on in a timely fashion, you may lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which is generally a prerequisite to bringing legal action).

For more detailed information regarding claims processing, denials, and appeals, please see the Insurance Certificate.



## **B. Government Required Notices**

### **1. ERISA Rights**

#### **Your ERISA Rights:**

As a participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

#### *Receive Information About Your Plan and Benefits*

Examine, without charge, at the Plan Administrator's Designee's office and at other specified locations, such as worksites and union halls (if applicable), all documents governing the plan, including insurance contracts and collective bargaining agreements (if applicable), and a copy of the latest annual Form 5500 report (if any), filed by the Plan.

Obtain, upon written request to the Plan Administrator's Designee, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements (if applicable), and copies of the latest annual Form 5500 report (if applicable) and updated summary plan description. The Plan Administrator's Designee may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report if a 5500 is filed. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if applicable.

#### *Continue Group Health Plan Coverage*

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA and/or state continuation coverage rights.

#### *Prudent Actions by Plan Fiduciaries*

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union (if applicable), or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

#### *Enforce Your Rights*

If your claim for a Plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual Form 5500 report (if any) from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

#### *Assistance with Your Questions*

If you have any questions about your plan, you should contact the Plan Administrator's Designee. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA), 200 Constitution Avenue N.W., Washington, D.C. 20210, call the EBSA toll-free number: 1-866-444-EBSA, or visit their website: [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

## **2. COBRA Rights**

### **Introduction**

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under certain component parts of the Plan (such as health and dental insurance). The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under applicable component parts of the Plan when you would otherwise lose your group health coverage. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the component parts of the Plan and under federal law, you should either review the certificates of insurance,

plan documents, or other governing documents for each component part of the Plan, or contact the Plan Administrator's Designee.

**You may have other options available to you when you lose group health coverage.** For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

### **What is COBRA Continuation Coverage**

COBRA continuation coverage is offered when coverage under a component part of the Plan would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage due to the occurrence of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under a component part of the Plan because either one of the following qualifying events happens:

- (1) Your hours of employment are reduced, or
- (2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you may become a qualified beneficiary if you will lose your coverage under a component part of the Plan because any of the following qualifying events happens:

- (1) Your spouse dies;
- (2) Your spouse's hours of employment are reduced;
- (3) Your spouse's employment ends for any reason other than his or her gross misconduct;
- (4) Your spouse becomes entitled to Medicare (Part A, Part B, or both); or
- (5) You become divorced or legally separated from your spouse.
  - a. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

Your dependent children may become qualified beneficiaries if they will lose coverage under a component part of the Plan because any of the following qualifying events happens:

- (1) The parent-employee dies;
- (2) The parent-employee's hours of employment are reduced;
- (3) The parent-employee's employment ends for any reason other than his or her gross misconduct,
- (4) The parent-employee becomes entitled to Medicare (Part A, Part B, or both);
- (5) The parents become divorced or legally separated; or
- (6) The child stops being eligible for coverage under the plan as a "dependent child."

Under special rules that apply if an employee does not return to work at the end of an FMLA leave, some individuals may be entitled to elect COBRA even if they lost coverage under a component part of the Plan during the leave. Contact the Plan Administrator's Designee for more information about these special rules.

If retiree benefits are offered through a component part of the Plan, the employer's filing for bankruptcy under Title 11 of the United States Code can also be a qualifying event. If a proceeding in bankruptcy is filed by the employer sponsoring the Plan, and that bankruptcy results in the loss of coverage of any retired employee covered under a component part of the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

### **When is COBRA Coverage Available?**

COBRA continuation coverage will be offered to qualified beneficiaries only after the Plan Administrator's Designee has been notified that a qualifying event has occurred. The Plan Administrator's Designee must be notified by the employer of the following qualifying events:

- (1) The end of employment or reduction of hours of employment;
- (2) Death of employee; or
- (3) Employee becoming entitled to Medicare benefits (under Part A, Part B or both)

### **You Must Give Notice of Some Qualifying Events**

**For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator's Designee. The Plan requires you to notify the Plan Administrator's Designee within 60 days after the qualifying event occurs. You must send this notice to the Plan Administrator's Designee, who may be contacted as outlined in paragraph II.A.5., above. The**

**notice must be in writing, indicating the participant affected. If the qualifying event is a divorce, a copy of the divorce decree must be provided.**

### **How is COBRA Coverage Provided?**

COBRA continuation coverage is a temporary continuation of coverage. Once the Plan Administrator's Designee receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that coverage would otherwise have been lost.

If the qualifying event is termination of employment or the reduction of work hours, COBRA continuation coverage will be available for up to 18 months. However, there are a number of scenarios under which employees and/or their dependents may be able to continue COBRA coverage for longer than 18 months.

When the qualifying event is the death of the employee, entitlement of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

When the qualifying event is a reduction in work hours due to military leave of more than 30 days, continuation coverage may be available under USERRA for up to 24 months.

### **Disability Extension of 18-month Period of Continuation Coverage**

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator's Designee in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability must be determined to have started at some time before the 60<sup>th</sup> day of COBRA continuation coverage, and must last at least until the end of the 18-month period of continuation coverage. In order to receive this extension, you must provide the Plan Administrator's Designee with a copy of the determination by the Social Security

Administration within 60 days of the date of the determination by the Social Security Administration, the date of the qualifying event, or the date that coverage would otherwise be lost under a component part of the Plan as a result of the qualifying event, whichever is later, but in no event later than the end of the original 18 month period of continuation coverage. **Notice must be provided to the Plan Administrator's Designee, who may be contacted as outlined in paragraph II.A.5., above.**

### **Second Qualifying Event Extension of 18-month Period of Continuation Coverage**

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator's Designee. This extension may be available to the spouse and any dependent children receiving COBRA continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under a component part of the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. **In all of these cases, you must make sure that the Plan Administrator's Designee is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator's Designee, who may be contacted as outlined in paragraph II.A.5., above.**

### **State Law**

Individual states may have COBRA or health care continuation laws that cover fully-insured health plans and permit coverage to continue in a similar manner to COBRA. Some states may provide for a greater continuation benefit, others less. In some cases, self-funded plans incorporate the terms of their state's continuation laws. When state law and COBRA are both applicable, the qualified beneficiary is entitled to receive the most liberal benefit.

### **Are there other coverage options besides COBRA Continuation Coverage?**

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

### **If You Have Questions**

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about

your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit [www.dol.gov/ebsa](http://www.dol.gov/ebsa) (addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov).

### **Keep Your Plan Informed of Address Changes**

In order to protect your family's rights, you should keep the Plan Administrator's Designee informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator's Designee. If you have any questions about your COBRA rights, contact the Plan Administrator's Designee.

## **3. HIPAA Notice**

### **Your HIPAA Rights:**

The Health Insurance Portability and Accountability Act (HIPAA) provides for a special enrollment right if you, or a spouse and dependent, lose coverage elsewhere or obtain a new dependent through marriage, birth or adoption. The requirements for the special enrollment right are detailed below.

### **Loss of Coverage:**

If you decline enrollment for yourself and your dependents (including your spouse) because of other health insurance coverage, and that coverage terminates due to certain qualifying reasons, you may be entitled to a special enrollment period in the Plan. The qualifying reasons leading to a special enrollment right for loss of coverage are:

- Exhaustion of COBRA or state law continuation rights;
- Loss of eligibility for other coverage due to legal separation, divorce, death, termination of employment or reduction in hours; or
- Because employer contributions for the other coverage cease.

Should one of the above noted events occur, you must notify the Plan within 30 days to take advantage of this special enrollment right. You must inform the Plan Administrator's Designee in writing at the time you decline coverage that you are declining coverage because of other health insurance coverage in order to be eligible for this special enrollment period.

### **Marriage, Birth or Adoption:**

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself, your spouse, and your newly acquired dependents, provided that enrollment is requested within 30 days after the marriage, birth, adoption, or placement for adoption.

**Loss of Medicaid or State Child Health Plan (CHIP) Coverage:**

If you and/or your dependents were covered under a Medicaid plan or State Child Health Plan (CHIP) and that coverage is being terminated due to a loss of eligibility, you may be able to enroll yourself and your dependents on the health plan, provided you request enrollment within 60 days after the date that termination of such coverage occurred, and that you meet certain other important conditions described in the insurance certificate. Coverage under this plan will be effective on the date the other coverage ended.

**Eligibility for Premium Subsidy Assistance under Medicaid or State Child Health Plan (CHIP):**

If you and/or your dependents are determined to be eligible under a state's Medicaid plan or State Child Health Plan (CHIP) for a premium subsidy assistance, you may be able to enroll yourself and your dependents on the health plan, provided you request enrollment within 60 days of the determination of eligibility for premium subsidy assistance for you or your dependents, and that you meet certain other important conditions as described in the Master Contract or Insurance Certificate.

**4. Qualified Medical Child Support Orders**

This plan will comply with Qualified Medical Child Support Orders (QMCSO) as required by ERISA. A QMCSO is a court order typically issued as part of a divorce or a state child support order that requires health plan coverage for the child of a plan participant.

The procedures to comply with a QMCSO are available to employees. Contact the Plan Administrator's Designee for the QMCSO procedures.

**5. Women's Health and Cancer Rights Act**

The Women's Health and Cancer Rights Act (WHCRA) requires that all group health plans that provide coverage for mastectomies also provide coverage for breast reconstructive surgery in connection with that mastectomy.

All participants and beneficiaries who receive benefits under the group health plan with respect to a mastectomy and elect breast reconstruction surgery in connection with that mastectomy are entitled to coverage for that reconstruction in a manner determined in consultation with the attending physician and the patient. Such coverage includes:

- 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 at all stages 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 the Plan Administrator's Designee.

#### **6. Rights Under Newborns and Mothers Health Protection Act**

Under the Newborns and Mothers Health Protection Act (NMHPA), group health plans 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 a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of the above periods. 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 (or 96 hours as applicable).

Also, under federal law, plans and insurers 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, a plan or issuer may not, under federal law, require that a physician or other health care provider 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, contact the Plan Administrator's Designee

