Important Legal Information About Your Benefits

SPECIAL ENROLLMENT

Under the Health Insurance Portability and Accountability Act (HIPAA), eligible employees and eligible dependents have the right to enroll for coverage in this Plan outside of Open Enrollment under certain circumstances. Special Enrollment is available in the following three situations.

1. Loss of Eligibility for Other Coverage

   If you declined enrollment for you or your Dependents (including your Spouse) in the Plan, and you signed the Plan's Enrollment Waiver form, you may be able to enroll your Dependents and you in this Plan if you or your Dependents subsequently lose eligibility for that other coverage (or if the employer stops contributing toward your or your Dependents' other coverage). You must request Special Enrollment within 60 days of the loss of eligibility.

   A completed Enrollment Waiver Form must be signed by you and your agencies Director and returned to the Fund office for processing.

2. Marriage, Birth, Adoption or Placement for Adoption

   If you are a participant in the Plan, your Spouse and your new Dependents are permitted to special enroll because of marriage, birth, adoption, or placement for adoption. You must request enrollment within 60 days of marriage and 60 days for birth, adoption, or placement for adoption. See Changes in Family Status below for more on these deadlines.

3. Eligibility for or Loss of State Assistance

   A special enrollment right also arises for you and your dependents who lose coverage under a State Children's Health Insurance Program (CHIP) or Medicaid, or who are eligible to receive premium assistance under those programs. You or your dependents must request enrollment within 60 days of the loss of coverage or the determination of eligibility for premium assistance.

To request a special enrollment or obtain more information, contact the Fund Office at telephone 212-343-1660.

CHANGES IN COVERAGE (Adding or Removing Dependents & Cancelling Coverage)

The Plan follows the IRS rules for the plan that your employer sponsors. Provided that the employer-sponsored plan has adopted these Permitted Election Changes, under these plan rules, You may be permitted to change your coverage elections (including cancellation of coverage or adding dependents) outside of Open Enrollment if you experience any of the following events.

1. Special Enrollment Event

   A plan may permit an employee to revoke an election for coverage under a group health plan during a period of coverage and make a new election that corresponds with the special enrollment rights listed above.

2. Change in Status Event

   Qualifying changes in status include these situations:

   - Events that change Your legal marital status, including: marriage; death of spouse; divorce; legal separation; and annulment.
   - Events that change the number of Your dependents, including: birth; death; adoption; and placement for adoption.
   - Any of the following events that change the employment status of You, Your Spouse, or Your Dependent: termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite; or any other change in employment status with the consequence that You, Your Spouse, or Your Dependent becomes (or ceases to be) eligible under the Plan.

- Events that cause Your Dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstance.
- A change in the place of residence of You, Your Spouse, or Your Dependent.

3. Judgment, Decree, or Order

   If a court has ordered you to cover a spouse or minor children, you must add the spouse and minor children as directed in the court order.

4. Entitlement to Medicare or Medicaid

   If You, Your Spouse, or Your Dependent who is enrolled in this Plan becomes entitled to Medicare or Medicaid, a cafeteria plan may permit the employee to make a prospective election change to cancel or reduce coverage for the same individual under the Plan. In addition, if You, Your Spouse, or Your Dependent who has been entitled to such coverage under Medicare or Medicaid loses eligibility for such coverage, the cafeteria plan may permit You to make a prospective election to commence or increase coverage for the same individual under the Plan.

5. Significant Cost or Coverage Changes

   A change in cost means:

   A significant increase or decrease in your cost for an option offered under the Plan that occurs during the year. Changes that may be made include commencing participation in the Plan for the option with a decrease in cost, or, in the case of an increase in cost, revoking an election for that coverage and, in lieu thereof, either receiving on a prospective basis coverage under another benefit package option providing similar coverage or dropping coverage if no other benefit package option providing similar coverage is available.

   Change in coverage means:

   - The addition of a new benefit option, the elimination of an existing benefit option or a significant change in an existing benefit under the Plan.
   - A change in Your coverage or that of your Spouse, qualified domestic partner or Child through your Spouse, qualified domestic partner or Child's employment, including those changes resulting from your Spouse, qualified domestic partner or Child's election during an annual enrollment period for his or her employer-sponsored plan(s).

6. Additional Permitted Election Changes:

   - You request to cancel coverage because you were in an employment status under which you were reasonably expected to average at least 30 hours of service per week and you have a change in that employment status where you will be reasonably expected to average less than 30 hours of service per week after the change, even if this reduction does not result in you ceasing to be eligible under the Plan
   - You request to cancel coverage because you are eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace or you seek to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period

   For the employment status change you will be required to attest that you and any qualified dependents have enrolled or intend to enroll in another plan that provides minimum essential coverage. The new coverage must be effective on the first day of the month following one full calendar month after the date the original coverage is revoked.

   For the enrollment in a Qualified Health Plan you will be required to attest that you have an enrollment opportunity for a Qualified Health Plan through a Marketplace and that you and any qualified dependents have enrolled or intend to enroll in a Qualified Health Plan for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

CHANGES IN FAMILY STATUS

If you have single coverage at the time the newborn or proposed adopted newborn is born, you must notify the Fund and submit an enrollment form for the newborn within 60 days from the date of birth for coverage. If you do not enroll within 60 days, you may enroll for coverage during the first year after the birth, which will be effective on the date the Fund receives the completed enrollment. If you do not switch coverage and enroll the newborn; the newborn or proposed adopted newborn will not be covered.

If you have family coverage, the newborn child or proposed adopted child will automatically be covered from the date of birth. Please note that you must submit an enrollment form for the newborn or proposed adopted newborn within 60 days of birth. If you submit an enrollment form for the newborn or proposed adopted newborn more than 60 days after the date of birth, any claims received after 60 days will not be processed until the enrollment form is received, with coverage retroactive to the date of birth.

If you have single coverage and you get married and transfer to family coverage within 30 days after the date of marriage, you will receive full continuity of coverage from your individual coverage.

PROOF OF ELIGIBILITY

When applying for Special Enrollment or a Change in Coverage, you are responsible for providing proof of eligibility for such enrollment or coverage changes. For example, if you request to cancel your coverage outside of the Open Enrollment period because you became entitled to Medicare or Medicaid, you must provide proof of your entitlement to Medicare or Medicaid before cancellation can occur. Generally, the documentation listed under the "Documentation Requirements For Dependents" section will satisfy the proof requirements when applicable. For example, marriage or birth certificates will prove you are entitled to add a Spouse or Child. With respect to the above-referenced Additional Permitted Election Changes, you must complete and sign an Attestation Form that must be provided to the Plan. Contact the Plan Administrator for a copy of the Attestation Form, the Enrollment Waiver Form, and any other forms necessary to effectuate a change in your coverage.

PRESCRIPTION DRUG BENEFITS FOR ACTIVES AND DEPENDENTS WHO ARE MEDICARE ELIGIBLE

If you and/or your Dependent(s) are enrolled in either Part A or B of Medicare, you are eligible for Medicare Part D (Medicare's Prescription Drug Plan).

Medicare covers prescription drug benefits under Part D. For Active Participants and/or their Dependents who are Medicare-eligible, this Plan offers "Creditable Coverage." This means that the Plan's prescription drug coverage is expected to pay out, on average, as much or more as the standard Medicare prescription drug benefit will pay. Since this Plan's coverage is as good as Medicare, you do not need to enroll in a Medicare Prescription Drug Plan while you have this Plan's prescription drug coverage. When you lose this coverage, you may enroll in a Medicare Prescription Drug Plan either during a special enrollment period or during Medicare's annual enrollment period (November 15th - December 31st of each year) by calling 1-800-MEDICARE. If you would rather elect Medicare's coverage, you can enroll in the Medicare Part D plan no sooner than 3 months prior to, through 3 months after, your 65th birthday; otherwise, you may incur a premium penalty. For more information about creditable coverage see Plan's Notice of Creditable Coverage that will be mailed to you from the Plan once a year. You may request another copy of this Notice by calling the Fund Office and asking for one.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 (CHIPRA)

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) permits you and your dependent(s) who are eligible, but not enrolled, for coverage through the Fund, to enroll outside of the Fund's normal enrollment period under the following circumstances:

- If your coverage or your dependent's coverage under Medicaid or the Children's Health Insurance Plan ("CHIP") terminates as a result of loss of eligibility for either program. If this circumstance occurs, you must request coverage from the Fund within sixty (60) days after the termination of Medicaid or CHIP coverage.
- If you or your dependent(s) become eligible for a Medicaid or CHIP premium assistance subsidy. If this circumstance occurs, you must request coverage from the Fund within sixty (60) days after eligibility for the Medicaid or CHIP subsidy was determined.

Please contact the Fund Office at (212) 343-1660 for more information.

MENTAL HEALTH PARITY

The Mental Health Parity Act (MHPA), signed into law on September 26, 1996, requires that annual or lifetime dollar limits on mental health benefits be no lower than any such dollar limits for medical and surgical benefits offered by a group health plan or health insurance issuer offering coverage in connection with a group health plan.

The law:

- Generally requires parity of mental health benefits with medical/surgical benefits with respect to the application of aggregate lifetime and annual dollar limits under a group health plan
- Provides that plan sponsors retain discretion regarding the extent and scope of mental health benefits offered to workers and their families (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity).

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) supplements prior provisions under the MHPA. Under the MHPAEA, group health plans and health insurance issuers are required to:

- Ensure that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA)

The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) affects the amount of time you and your newborn child are covered for a hospital stay following childbirth. This law applies both to the mother and the newborn covered by this Plan. In general, this plan may NOT restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section.

If you deliver in the hospital, the 48-hour (or 96-hour) period starts at the time of delivery. If you deliver outside the hospital and you are later admitted to the hospital in connection with childbirth, the period begins at the time of the admission.

Although the NMHPA prohibits this Plan from restricting the length of a hospital stay in connection with childbirth, this Plan does not have to cover the full 48 or 96 hours in all cases. If an attending provider, after speaking with you, determines that either you or your child can be discharged before the 48-hour (or 96-hour) period, this Plan does not have to continue covering the stay for whichever one of you is ready for discharge. An attending provider is an individual, licensed under State law, who is directly responsible for providing maternity or pediatric care to you or your newborn child. In addition to physicians, an individual such as a nurse midwife, physician assistant, or nurse practitioner may be an attending provider. This Plan, Hospital, insurance company, or HMO would NOT be an attending provider.

The Plan benefits relating to this Act are found in the benefits section of this SPD. Your health coverage provided by this Fund complies with NMHPA standards.

STATEMENT OF PRIVACY PRACTICES

This section describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

The Trustees and the Fund office have always made the protection of your personal information a very important priority. We want you to have a clear understanding of how we use and safeguard your information.

This section describes how the Welfare Fund may use and disclose your Protected Health Information ("PHI"), defined below, in order to carry out treatment, payment and health care operations and for other purposes permitted or required by law. It also describes your rights to access and control your PHI.

Federal legislation known as the Health Insurance Portability and Accountability Act ("HIPAA") requires the Fund to establish a formal policy and procedures for maintaining the privacy of your PHI.

This section is effective beginning in April 2003, and the Welfare Fund is required to comply with its terms. However, the Welfare Fund reserves the right to change its privacy practices and this section and to apply the changes to any PHI received or maintained by the Welfare Fund prior to that date. If a privacy practice is materially changed, a revised version of this section will be provided to Employees via first class mail, and to all other persons upon request. Any revised version of this section will be distributed within 60 days of the effective date of any material change to the Welfare Fund's policies.

PROTECTED HEALTH INFORMATION

The term "Protected Health Information" includes all individually identifiable health information related to an individual's past, present or future physical or mental health condition or to payment for health care. PHI includes information maintained by the Welfare Fund in oral, written, or electronic form.

USES AND DISCLOSURES OF HEALTH INFORMATION

Disclosure of Your PHI Generally Requires Your Written Authorization.

Except as provided in this section, any use and disclosure of PHI will be made only with your written authorization. Once you give the Fund authorization to release your PHI, the Fund cannot guarantee that the person or organization to whom the information is provided will not disclose such information. You may revoke your authorization at any time in writing, except if the Fund has already acted based on your authorization.

There are circumstances in which the Welfare Fund will disclose your PHI in the absence of a written authorization. Under the law, the Welfare Fund may disclose your PHI without your authorization or without giving you the opportunity to agree or object, in the following cases:

- At your request. If you request it, the Welfare Fund is required to give you access to certain of your PHI in order to allow you to inspect and/or copy it. Your right to this information is detailed later in this section.
- For treatment, payment or health care operations. The Welfare Fund and its business associates may use PHI in order to carry out treatment, payment or health care operations.
- "Treatment" is defined as the provision, coordination, or management of health care and related services. For example, the Welfare Fund may disclose PHI to providers to provide information about alternative treatments.
- "Payment" includes but is not limited to actions to make coverage determinations and payment for services and items you receive. For example, the Welfare Fund may disclose to a doctor whether you are eligible for coverage or the amount that the Welfare Fund will reimburse a provider for certain services. If the Welfare Fund contracts with third parties to help us with payment operations, such as a physician who reviews medical claims, we will also disclose information to them. These third parties are known as "business associates."
- "Health care operations" are the operations of the Welfare Fund relating to such things as underwriting and quality assessment and other insurance activities relating to creating or renewing insurance contracts. They also include auditing functions, including fraud compliance programs, business planning and development, business management and general administrative activities. For example, the Welfare Fund may use PHI to audit the accuracy of its claims processing functions.
- Disclosure to Trustees. The Welfare Fund may also disclose PHI to the Trustees as Plan sponsor, for plan administrative functions. For example, the Welfare Fund may disclose information to the Trustees to allow them to decide an appeal or review a subrogation claim.
- In addition, the Welfare Fund may disclose "summary health information" to the Trustees for obtaining premium bids or modifying, amending or terminating the Welfare Fund's group health plan. Summary information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor such as the Trustees has provided health benefits under a group health plan. Identifying information will be deleted from summary health information, in accordance with federal privacy rules.
- Disclosure to Family and Friends. The Welfare Fund may release PHI to friends or family members that you have identified who are involved in caring for you or involved in paying for your care unless you notify the Welfare Fund's Privacy Officer in writing (contact information below) that you object. The Welfare Fund will disclose only PHI that is directly relevant to that person's involvement. In an emergency or if you become incapacitated, the Welfare Fund may also disclose your PHI to other family members, relatives or close friends under certain circumstances as permitted in the Welfare Fund's procedures, unless you have previously notified the Welfare Fund's Privacy Officer in writing that you do not want your information shared under those circumstances.
- If you want the Welfare Fund to disclose routinely your PHI to specific persons then you must complete an authorization form designating that person as authorized to receive your PHI. Authorization forms are available from the Privacy Officer at the Welfare Fund office.
- Additional Disclosures. In addition to the above permitted uses and disclosures, the Welfare Fund may also use and disclose your PHI under the following unique circumstances:

- When required by applicable law.
- As required by HHS. Disclosure of your PHI may be required by the U.S. Department of Health and Human Services to investigate the Welfare Fund's compliance with the privacy regulations.
- For public health purposes. Disclosure of your PHI to an authorized public health authority may be necessary if required by law or for public health and safety purposes. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
- In the event of domestic violence or abuse. Your PHI may be disclosed when authorized by law to report information about abuse, neglect or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect, or domestic violence. In such case, the Welfare Fund will promptly inform you that such a disclosure has been or will be made unless so informing you would cause a risk of serious harm.
- Health oversight activities. Your PHI may be disclosed to a health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against health care providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to the Department of Labor).
- Legal proceedings. Your PHI may be disclosed when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or court ordered discovery request. In the case of subpoenas and discovery requests which are not court ordered, the Welfare Fund will disclose your PHI only if certain conditions are met.
- Law enforcement purposes. Your PHI may be disclosed for certain law enforcement purposes, such as identification or location of a suspect, fugitive, material witness or missing person, and reporting a crime.
- To a coroner, medical examiner, or funeral director related to information about a deceased individual.
- For organ, eye, or tissue donation purposes.
- Research. Your PHI may be disclosed for research, subject to certain conditions.
- Health or safety threats. Your PHI may be disclosed when, consistent with applicable law and standards of ethical conduct, the Welfare Fund in good faith believes the use or disclosure of PHI is necessary to prevent a serious and imminent threat to the health or safety of a person or the public. Under these circumstances, the Welfare Fund will limit the disclosure to a person reasonably able to prevent or lessen the threat, including the target of the threat.
- Government Functions. Your PHI may be disclosed in connection with certain government functions, such as military service or national security.
- Correctional/Law Enforcement. Your PHI may be disclosed to correctional institutions or law enforcement officials if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary for the institution to provide you with health care; to protect your health and safety or the health and safety of others; or for the safety and security of the correctional institution.
- Business Associates. The Welfare Fund may disclose your PHI to business associates of the Fund that perform functions or services on the Fund's behalf. The business associates are under contract with the Fund to protect your PHI and are not allowed to use such information other than as specified in the contract.
- Data breach notifications. The Fund may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your PHI.
- Workers' Compensation Programs. Your PHI may be disclosed to the extent necessary to comply with Workers' Compensation or other similar programs established by law.

- Marketing. The Fund will not disclose PHI to any other company for their use in marketing their products to you and will not sell your PHI, unless the Fund first obtains your written authorization.
- Genetic Information. The Fund will not use or disclose your genetic information that falls under the definition of PHI for underwriting purposes.

BREACH NOTIFICATION

In the event that the Fund discloses PHI and such disclosure is not permitted by this policy or the HIPAA Privacy Rule, the Fund is required to notify you of the breach unless certain exceptions apply. The disclosure of "secured" PHI (i.e., PHI that is encrypted) is not subject to this requirement.

YOUR INDIVIDUAL PRIVACY RIGHTS

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," defined below, for as long as the Welfare Fund (Fund) maintains the PHI. You or your personal representative will be required to request access to the PHI in your designated record set in writing. A reasonable fee for copying may be charged. Requests for access to PHI should be made to the Fund's Privacy Officer.

The Fund must provide the requested information within 30 days. A single 30-day extension is allowed if the Fund is unable to comply with the deadline.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights and a description of how you may complain to the Welfare and HHS.

A "designated record set" includes your medical or billing records that are maintained by the Fund. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by the Fund or other information used in whole or in part by or for the Fund to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you is not included.

The Fund is also required to provide you with access to electronically stored PHI (electronic PHI) maintained in a designated record set in the electronic form and format you request, if it is readily producible and, if not, in the form and format agreed to by you and the Fund. Additionally, you may request in writing that the Fund transmit your electronic PHI directly to another person designated by you. The Fund must provide the requested electronic PHI in the same manner and time frame as it is required to provide all other PHI.

If you feel that any PHI kept by the Fund is incorrect or incomplete, you may request that the Fund amend it subject to certain exceptions. PHI is not subject to amendment if it was not created by the Fund, is not part of the designated record set you are permitted to inspect and copy, or if it is not kept by the Fund. The Fund has 60 days after receiving your request to act on it. The Fund is allowed a single 30-day extension if the Fund is unable to comply with the 60-day deadline. If the Fund denied your request in whole or part, the Fund must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of that PHI. You should make your request to amend PHI to the Fund's Privacy Officer, in writing, at the address below.

At your request, the Fund will also provide you with a list of certain disclosures by the Fund of your PHI made after April 14, 2003. This accounting is not required to include disclosures related to treatment, payment for treatment, or health care operations, or disclosures made to you or authorized by you in writing. The Fund has 60 days to provide the accounting. The Fund is allowed an additional 30 days if the Fund gives you a written statement of the reasons for the delay and the date by which the accounting will be provided. The first accounting you request in a 12-month period will be provided free of charge. If you request more than one accounting within a 12-month period, the Fund will charge a reasonable cost- based fee for each subsequent accounting. You or your

personal representative must submit your request for restrictions on uses and disclosures of your PHI in writing to the Fund's Privacy Officer at the address below.

You may request that the Fund restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations. In addition, you may restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

The Fund is not required to agree to your request. You or your personal representative must submit your request for restrictions on uses and disclosures of your PHI in writing to the Fund's Privacy Officer at the address below.

You may also request to receive communications of PHI confidentially by alternative means or solely at an alternative location (for example, mailing information somewhere other than your home address) if it is feasible and reasonable. Make such requests to the attention of the Fund's Privacy Officer at the address below. Please note that the Plan must grant this request only if the individual states he or she would be in danger. You or your personal representative may request confidential communications of your PHI orally or in writing. However, requests to modify or cancel a previous confidential communication request must be made in writing.

You may exercise your rights through a personal representative. Except as provided below in connection with parents of un-emancipated minor children, your personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you. The Fund retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

The Fund will recognize certain individuals as personal representatives without completion of an Appointment of Personal Representative form. For example, the Fund will consider a parent or guardian as the personal representative of an unemancipated minor unless applicable state law requires otherwise. Unemancipated minors may, however, request that the Fund restrict information that goes to family members if permitted by applicable state laws. Other documentation that may substitute for this form would include other official legal documentation that demonstrates that under relevant state law the representative is authorized to make health care decisions for you (for example, appointment as a legal guardian, or a health care power of attorney).

THE WELFARE FUND'S DUTIES

The Welfare Fund is required by law to maintain the privacy of your PHI and to provide you with this notice of its legal duties and privacy practices.

If you believe that your privacy rights have been violated, you may file a complaint with the Welfare Fund in care of the Privacy Officer at the following address:

Randy S. Paul, Privacy Officer
District Council 1707, Local 95 Head Start Employees Welfare Fund
420 West 45th Street, 3rd Floor
New York, NY 10036

You may also file a complaint with:

Secretary of the U.S. Department of Health & Human Services
Hubert H. Humphrey Building
200 Independence Ave. S.W.
Washington, D.C. 20201

The Welfare Fund will not retaliate against you for filing a complaint.

If you have any questions regarding this section or the subjects addressed in it, you may contact the Privacy Officer at the Welfare Fund office.

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act of 1998 (WHCRA) requires group health plans and insurance companies that provide coverage for mastectomies to provide certain mastectomy-related benefits or services to plan participants and beneficiaries. The Plan provides the benefits required under the WHCRA, and makes these benefits available to eligible Participants.

Under the WHCRA, a group health plan Participant who is receiving benefits in connection with a mastectomy, and who elects breast reconstruction in connection with the mastectomy is entitled to coverage for the following:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of mastectomy, including lymph edema.

Coverage for these benefits or services will be provided in a manner determined in consultation with the participant's or beneficiary's attending Physician.

If you are a participant in the Plan, and are currently receiving, or in the future receive benefits under the Plan in connection with a mastectomy, you are entitled to coverage for the benefits and services described above in the event that you elect breast reconstruction. Your eligible Dependents are also entitled to coverage for these benefits or services on the same terms. Coverage for the mastectomy-related services or benefits required under the WHCRA will be subject to the same deductibles and co-insurance or co-payment provisions that apply with respect to other medical or surgical benefits provided under the Plan.

If you have any questions about the WHCRA, please contact the Fund Office.