U.A. LOCAL 350 HEALTH, WELFARE & VACATION AND RETIREMENT TRUST FUND

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August 2021

ANNUAL NOTICE

Dear Participants and Dependents,

This Notice includes annual notices the U.A. Local 350 Health, Welfare and Vacation Plan ("Plan") is required to provide you under the Affordable Care Act and other Federal Laws. It also includes other reminders. This is for informational purposes only. No action is necessary. If you have any questions, please contact the Trust Fund Office at (775) 826-7200.

GRANDFATHERED HEALTH PLAN REMINDER

The Board of Trustees believes that the U.A. Local 350 Health, Welfare and Vacation Plan is a "grandfathered health plan" under the Affordable Care Act ("ACA"). As permitted by the ACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that ACA was enacted. Being a grandfathered health plan means that your Plan is not required to include certain consumer protections of the ACA that apply to other plans (known as a Non-Grandfathered plan), 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 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 (775) 826-7200. 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

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, in consultation with the attending physician and patient, including:

- all stages of reconstruction of the breast on which the mastectomy was performed (including coverage for nipple and areola reconstruction and repigmentation to restore the physical appearance of the breast),
- reconstruction and surgery to achieve symmetry between the breasts,
- prostheses, and treatment of physical complications resulting from all stages of the mastectomy, including lymphedema (swelling that sometimes happens after treatment for breast cancer).

This coverage may be subject to the Plan's deductibles, coinsurance, and/or co-payment provisions (consistent with those established for other benefits under the Plan). **If you have any questions, please call the Plan administrator at 775-826-7200.**

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Under Federal law, Group Health Plans and Insurers, may not generally restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. 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 newborn earlier than 48 hours (or 96 hours). 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 and Insurers cannot require that a physician or health care provider obtain authorization for prescribing a length of stay 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. **Call the Plan Administrator at 775-826-7200 for more information.**

COVID-19 Testing & Vaccination Reminders

As a reminder, you previously should have received notices regarding temporary coverage of COVID-19 diagnosis and antibody testing, including vaccinations during the public health emergency. Please note during the public health emergency period, the Plan will cover at no cost-sharing to you only those COVID-19 tests (including antibody tests) that are approved, cleared or authorized by the FDA (or the FDA has authorized the test for emergency use) and a healthcare provider (licensed under applicable law) has determined there is a medical necessity for the test and orders the administration of such test for you and/or your eligible dependent. The Plan will also cover COVID-19 vaccinations at no cost-sharing whether received in-network and out-of-network and without prior authorization at a doctor's office, medical facilities, governmental health facilities, including participating pharmacies through Optum Rx. Please note under federal law, providers are prohibiting form seeking reimbursement from you for the vaccine including the costs for administering the vaccine. **Any questions about COVID-19 vaccinations and/or testing please contact the Plan Administrator for more information.**

HIPAA PRIVACY NOTICE REMINDER

This Notice is to remind you that, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Plan will only use or disclose your individual health information, known as protected health information, in accordance with the Plan's Notice of Privacy Practices. **You may obtain a copy of the Plan's Notice of Privacy Practices at any time by calling the Plan Administrator at 775-826-7200, to request that a copy be mailed to you.** Within a reasonable period of time of your request, the Plan administrator's office will mail you a copy of the Notice. The Notice is also automatically provided to you at least once every three years or when there is a material change to the Notice.

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, 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, 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, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't 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, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-

	program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 E-mail: hipp@dhcs.ca.gov	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**MONTANA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710

Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

Contact your State for more information on eligibility –To see if any other states have added a premium assistance program since JAN. 31, 2021, or for more information on special enrollment rights, 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

AVAILABILITY OF SUMMARY OF BENEFITS & COVERAGE ("SBC")

Under the Affordable Care Act, Group health plans are responsible for providing a Summary of Benefits Coverage, also known as an SBC, to eligible new Participants and their dependents. for providing a Summary of Benefits Coverage, also known as an SBC, to eligible Participants and their dependents. The SBC is intended to provide an easy-to-read summary of what the Plan covers, what it costs, common benefit scenarios and definitions for frequently used terms. You also have the right to request and receive within seven (7) business days, an electronic or printed copies of current SBCs for the Plan's self-funded benefits at no cost to you. **If you want a copy of the Plan's SBC and/or more details about your coverage and costs, please contact the Plan Administrator at (775) 826-7200.**

MEDICARE COORDINATION FOR RETIREES WHO ARE ELIGIBLE FOR MEDICARE– You 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 it 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.

If you are retired, the Plan coordinates benefits with Medicare as if you are covered under both Medicare Part A and Part B. This means you and/or your spouse must enroll in both Medicare Part A and Part B, as soon as you and/or your spouse are eligible for Medicare. If you and/or your spouse 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 failure to do so will resort in late enrollment penalties.

Medicare's prescription drug plan (**Medicare Part D**) is available to Medicare beneficiaries and is part of your coverage if you are enrolled in the Plan. If you earn a higher income (above $87,000 for individuals or above $174,000 for married couples), Federal Law requires that you pay an additional premium for your Medicare Part D coverage to the Social Security Administration. This additional premium is called the Income-Related Monthly Adjustment Amount (also known as "IRMAA"). The premium is based on your modified adjusted gross income as reported on your IRS tax return from two years ago (thus, the fee in 2020 will be based on your adjusted gross income on your 2018 tax return). If you must pay a higher premium, Medicare will send you a letter with your premium amounts and the reason for their determination.

For more information on Medicare, please call Medicare at 800/MEDICARE (800/633-4227) or visit *www.medicare.gov*. TTY users should call 877/486-2048. If you have any questions, please contact the Plan Office at (775) 826-7200.

Option to Decline Dental and/or Vision Coverage

In accordance with Health Reform regulations, you have the option to decline/waive the Plan's dental and vision coverage and keep coverage under the Plan's medical and mental health benefits. If you do nothing, you will continue to have dental and vision health coverage through the Plan. To decline/waive coverage complete the portion of the Plan's enrollment form related to declining/waiving dental and/or vision coverage. Enrollment forms are available from the Trust Fund Office. Note that there is no additional compensation to you or you eligible dependent(s), if you choose to decline/waive dental and/or vision coverage. **Please contact the Plan Administrator at (775) 826-7200 for more information.**

Notice of Availability of Schedule of Allowances

As a reminder, the **Plan's Schedule of Allowances** Applicable to Non-Contract Providers is available to you and your eligible dependents from the Trust Fund Office. The Schedule of Allowances is the maximum amount allowed under the Plan for certain services for which you and/or your dependents receive from providers who are not contracted with the Plan. **Please contact the Plan Administrator at (775) 826-7200 for more information.**