# NORTHERN NEVADA LABORERS HEALTH & WELFARE TRUST FUND

**445 APPLE STREET * P.O. BOX 11337 * RENO, NV 89510 * P. (775) 826-7200 * F. 775) 824-5080**

**July 2022**

**Dear Participants and Dependents,**

**This Notice includes annual notices the 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.**

## GRANDFATHERED HEALTH PLAN REMINDER

**The Board of Trustees believes that the Northern Nevada Laborers Health & Welfare Trust Fund 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 regimentation 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.

## 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.

## COVID-19 Testing Reminders (During Public Health Emergency Period only)

As a reminder, you previously should have received notices regarding temporary coverage of COVID-19 diagnosis and antibody testing subject to federal guidelines during the public health emergency. Please note during the public health emergency period, at this stage, 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. If the test does not meet federal guidance the Plan is allowed to deny reimbursement of the test or charge you the applicable cost-sharing for the non-covered test. Please also further note, the Plan is not required to cover any employer-return to work testing. Any questions about covered COVID-19 testing please contact the Plan Administrator for more information

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

If you or your children are eligible for Medicaid or the Children's Health Insurance Program ("CHIP") and you are eligible for health coverage from your employer, the State you reside in may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State that provides premium assistance, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **877/KIDS NOW** or ***www.insurekidsnow.gov*** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at *www.askebsa.dol.gov* or by calling toll-free 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, 2019. Contact your State for more information on eligibility –**

| ALABAMA – Medicaid | FLORIDA – Medicaid |
|---|---|
| Website: http://myalhipp.com/<br>Phone: 1-855-692-5447 | Website: http://flmedicaidtplrecovery.com/hipp/<br>Phone: 1-877-357-3268 |
| **ALASKA – Medicaid** | **GEORGIA – Medicaid** |
| The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/<br>Phone: 1-866-251-4861<br>Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx | Website: http://dch.georgia.gov/medicaid<br>- Click on Health Insurance Premium Payment (HIPP)<br>Phone: 404-656-4507 |
| **ARKANSAS – Medicaid** | **INDIANA – Medicaid** |
| Website: http://myarhipp.com/<br>Phone: 1-855-MyARHIPP (855-692-7447) | Healthy Indiana Plan for low-income adults 19-64<br>Website: http://www.in.gov/fssa/hip/<br>Phone: 1-877-438-4479<br>All other Medicaid<br>Website: http://www.indianamedicaid.com<br>Phone 1-800-403-0864 |
| **COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)** | **IOWA – Medicaid** |

| Health First Colorado Website: https://www.healthfirstcolorado.com/<br>Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711<br>CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/<br>State Relay 711 | Website:<br>http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp<br>Phone: 1-888-346-9562 |
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| KANSAS – Medicaid | NEW HAMPSHIRE – Medicaid |
|---|---|
| Website: http://www.kdheks.gov/hcf/<br>Phone: 1-785-296-3512 | Website: https://www.dhhs.nh.gov/ombp/nhhpp/<br>Phone: 603-271-5218<br>Hotline: NH Medicaid Service Center at 1-888-901-4999 |
| **KENTUCKY – Medicaid** | **NEW JERSEY – Medicaid and CHIP** |
| Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570 | Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/<br>Medicaid Phone: 609-631-2392<br>CHIP Website: http://www.njfamilycare.org/index.html<br>CHIP Phone: 1-800-701-0710 |
| **LOUISIANA – Medicaid** | **NEW YORK – Medicaid** |
| Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331<br>Phone: 1-888-695-2447 | Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831 |
| **MAINE – Medicaid** | **NORTH CAROLINA – Medicaid** |
| Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html<br>Phone: 1-800-442-6003<br>TTY: Maine relay 711 | Website: https://dma.ncdhhs.gov/<br>Phone: 919-855-4100 |
| **MASSACHUSETTS – Medicaid and CHIP** | **NORTH DAKOTA – Medicaid** |
| Website: http://www.mass.gov/eohhs/gov/departments/masshe alth/<br>Phone: 1-800-862-4840 | Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/<br>Phone: 1-844-854-4825 |
| **MINNESOTA – Medicaid** | **OKLAHOMA – Medicaid and CHIP** |
| Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp<br>Phone: 1-800-657-3739 | Website: http://www.insureoklahoma.org<br>Phone: 1-888-365-3742 |
| **MISSOURI – Medicaid** | **OREGON – Medicaid** |
| Website: https://www.dss.mo.gov/mhd/participants/pages/hipp. htm<br>Phone: 573-751-2005 | Website: http://healthcare.oregon.gov/Pages/index.aspx<br>http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075 |
| **MONTANA – Medicaid** | **PENNSYLVANIA – Medicaid** |
| Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HI PP<br>Phone: 1-800-694-3084 | Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.ht m<br>Phone: 1-800-692-7462 |
| **NEBRASKA – Medicaid** | **RHODE ISLAND – Medicaid** |
| Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633<br>Lincoln: (402) 473-7000<br>Omaha: (402) 595-1178 | Website: http://www.eohhs.ri.gov/<br>Phone: 855-697-4347 |
| **NEVADA – Medicaid** | **SOUTH CAROLINA – Medicaid** |
| Medicaid Website: https://dhcfp.nv.gov<br>Medicaid Phone: 1-800-992-0900 | Website: https://www.scdhhs.gov<br>Phone: 1-888-549-0820 |

| SOUTH DAKOTA - Medicaid | WASHINGTON – Medicaid |
|---|---|
| Website: http://dss.sd.gov<br>Phone: 1-888-828-0059 | Website: http://www.hca.wa.gov/free-or-low-cost- health-care/program-administration/premium-payment- program<br>Phone: 1-800-562-3022 ext. 15473 |
| **TEXAS – Medicaid** | **WEST VIRGINIA – Medicaid** |
| Website: http://gethipptexas.com/<br>Phone: 1-800-440-0493 | Website: http://mywvhipp.com/<br>Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |
| **UTAH – Medicaid and CHIP** | **WISCONSIN – Medicaid and CHIP** |
| Medicaid Website: https://medicaid.utah.gov/<br>CHIP Website: http://health.utah.gov/chip<br>Phone: 1-877-543-7669 | Website:<br>https://www.dhs.wisconsin.gov/publications/p1/p10095.p df<br>Phone: 1-800-362-3002 |
| **VERMONT– Medicaid** | **WYOMING – Medicaid** |
| Website: http://www.greenmountaincare.org/<br>Phone: 1-800-250-8427 | Website: https://wyequalitycare.acs-inc.com/<br>Phone: 307-777-7531 |
| **VIRGINIA – Medicaid and CHIP** | |
| Medicaid Website:<br>http://www.coverva.org/programs_premium_assistance.cfm<br>Medicaid Phone: 1-800-432-5924<br>CHIP Website:<br>http://www.coverva.org/programs_premium_assistance.cfm<br>CHIP Phone: 1-855-242-8282 | |

**To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:**

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (327

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. The SBC provides a summary of what the Plan covers and what it costs. You also have the right to request and receive within seven (7) business days a SBC for the Plan. 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.

## MINIMUM ESSENTIAL COVERAGE

The Affordable Care Act establishes a minimum value standard of benefits for health plans. The minimum value standard is 60% (actuarial value) and eligible employer-sponsored plans (such as this Plan) are considered minimum essential coverage. (**Note:** Beginning in 2019, the individual penalty for failing to have adequate health coverage has been reduced to zero. This means there will no longer be a penalty assessed against individuals for failing to have health coverage. However, we believe there is little if any impact on you given that you have adequate coverage under this Plan.) **As such, the Board of Trustees believes this Plan provides minimum essential coverage and meets the minimum value standard for the benefits it provides.**

## RESCISSION OF COVERAGE RESTRICTIONS

Under the Affordable Care Act, the Plan and Insurers cannot retroactively cancel or terminate your coverage, except in cases of fraud, intentional misrepresentation of material fact, or failure to timely pay premiums. However, a retroactive cancellation of coverage is not considered a rescission if (1) it only has prospective effect, (2) is initiated by the covered individual, (3) due to delay in administrative record-keeping, (4) attributed to a failure to timely pay required premiums or contributions toward the cost of coverage, or (5) termination of coverage retroactive to the divorce, if the Plan does not cover former spouses. Plans and Insurers that rescind coverage must give affected individuals at least 30 days advance notice.

## 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 $85,000 for individuals or above $170,000 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 2019 will be based on your adjusted gross income on your 2017 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.

## HIPAA SPECIAL ENROLLMENT RIGHTS

Under Federal Law, if you declined enrollment for yourself and/or your dependents because of having other sufficient group health coverage, you may be able to enroll yourself and/or your dependents in this Plan, if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 30 days after you or your dependents' other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement of adoption, you may be able to enroll yourself and your dependents within 30 days after the birth, adoption, placement for adoption, or marriage provided you complete and submit an Enrollment Form along with any other Plan required documentation (ex. marriage certificate, birth certificate, adoption papers) to the Trust Fund Office. To request special enrollment information, please contact the Plan Administrator 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.

## MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA)

The Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") is a federal law that prevents large group health plans and health insurers that provide mental health or substance abuse benefits from imposing less favorable benefit limitations, including financial requirements (e.g., deductibles, copayments, coinsurance and out of pocket limitations), treatment limitations (e.g., number of visits or days of coverage), and non-quantitative treatment limitations (e.g., preauthorization requirement, exclusion based on medical necessity) on those benefits than on medical and surgical benefits offered. As such, the limitations applicable to mental health or substance abuse benefits can be no more restrictive than the predominant limitations applied to substantially all medical and surgical benefits.

Pursuant to the Final MHPAEA rules, the Plan or Health Insurer will provide any current participants or potential participants (including dependents), upon request, the criteria for medical necessity determinations with respect to mental health/substance abuse benefits and the reason for any denial of reimbursement or payment for services with respect to mental health/substance abuse benefits.

It is the intention of the Board of Trustees that the Plan's benefits be provided in compliance with the requirements of MHPAEA and lawful regulations issued thereunder. For more information on MHPAEA, please visit the Department of Labor website at *www.dol.gov/ebsa.*