# Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of 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 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 your plan administrator by calling the Customer Service number on the back of your ID card.

# Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean 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 her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator by calling the Customer Service number on the back of your ID card.

# HIPAA Notice of Special Enrollment Rights

If you decline enrollment in NCSD's health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in a NCSD health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 30 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in NCSD's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 30 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment rights, you may add the dependent to your current coverage or change to another health plan.

# Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for NCSD describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting NCSD Business Services.

# Medicare Secondary Payer (MSP) Notice

Medicare Secondary Payer {MSP) regulations is a term used when Medicare does not have primary payment responsibilities. This term applies to all active district employees and their dependents currently enrolled in a district active medical plan in addition to being covered under Medicare. It does not apply to retirees enrolled in district Retiree coverage.

If you are an active employee or employee's dependent enrolled in a district plan as well as Medicare, please be advised that the district's coverage is primary. This simply means the district coverage must pay first and then Medicare will pick up any eligible balances. It is your responsibility to inform your providers that you are enrolled in both plans and the employee active plan is primary.

When you, your spouse, or your dependents receive health care services, be sure to tell our doctor or other providers about any changes in your insurance. If you elect Kaiser, please make sure you use the Kaiser Facilities and Providers as Kaiser requires. If you and/or your dependents seek services from providers outside of the Kaiser network, you will be held responsible for any and all charges that would have otherwise been processed by Kaiser on a primary basis.