HAWAII TEAMSTERS HEALTH & WELFARE TRUST FUND

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HEALTH & WELFARE ● PENSION ● LEGAL ● TRAINING

TO: **All Eligible Participants**
Hawaii Teamsters Health and Welfare Trust Fund

FROM: Board of Trustees

SUBJECT: **Annual Important Reminders**

I. Women's Health and Cancer Rights Act of 1998 (WHCRA)

Under federal law, group health plans, insurers, and HMO's that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery, effective for the first plan year beginning on or after October 21, 1998. In the case of a participant or beneficiary who is receiving benefits under the plan in connection with a mastectomy and who elects breast reconstructive, federal law requires coverage in a manner determined in consultation with the attending physician and the patient for:

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

This coverage is subject to a plan's annual deductable and coinsurance provisions. These provisions are generally described in the Plan's Summary Plan Description ("SPD").

If you have any questions about whether your plan covers mastectomies or reconstructive surgery, please contact your Plan Administrator at (808) 523-0199 or (866) 772-8989 if you are calling from the neighbor islands.

II. Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)

Group health plans and health insurance issuers offering group health insurance coverage 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 caesarean delivery. 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, health plans and insurance issuers may not, under Federal law, require that a provider obtain authorization from the health plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

III. Genetic Information Nondiscrimination Act of 2008 (GINA)

Effective September 1, 2010, the following provisions apply to the Hawaii Teamsters Health and Welfare Trust Fund. Under GINA, group health plans and health insurance issuers generally may no;

- Adjust premium or contribution amounts for the covered group on the basis of genetic information;
- Request or require an individual or a family member to undergo a genetic test;
- Request, require, or purchase genetic information for underwriting purposes;
- Request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment or coverage under the plan. However, a doctor or health care professional who is providing health care services to you may request that you undergo a genetic test, which you voluntarily agree to, for treatment of a health condition. Then, the group health plan and health insurance issuer may obtain and use the results of a genetic test to make a determination regarding payment for medically necessary health care services, provided only the minimum amount of information necessary is requested.

In addition, group health plans may request, but not require, a participant or beneficiary to undergo a genetic test for research purposes if certain conditions are met, including that:

- The request is made in writing;
- The research complies with Federal and State laws;
- The plan clearly indicates to the participant or beneficiary that compliance with the request is voluntary; and
- The plan indicates that noncompliance will have no effect on eligibility or benefits.

IV. Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

Effective September 1, 2010, the Self-Funded Comprehensive Medical Plans implemented benefit changes in accordance with the Mental Health Parity and Addiction Equity Act of 2008, a Federal law that requires parity with respect to financial requirements and treatment limitations between mental health or substance abuse disorder benefits and medical/surgical benefits.