

To Plan Participants:

There are several important notifications related to your benefit plans. We are required to provide the notifications on an annual basis. If you want a copy of the notification, or have any questions regarding this information, please contact Christine Hart, Benefits Coordinator, NFTA, Human Resources Department, (716) 855-7652.

Summary of Benefits and Coverage (SBC)

Special Enrollment Rights

Women's Health and Cancer Rights Act Enrollment Notice

Newborns' and Mothers' Health Protection Act of 1996

Children’s Health Insurance Program (CHIP)

**Notice about Special Enrollment Rights**

**Highmark Blue Cross Blue Shield of WNY Health Plan**

A federal law called HIPAA requires that we notify you about an important provision in the Group Health Plan (Plan). This provision is your right to enroll in the Plan under its “special enrollment provision”.

**Special Enrollment Provision**

**Loss of Other Coverage (Excluding Medicaid or a State Children’s Health Insurance Program).** If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be eligible to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). However, you must request enrollment within 30 days after you or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

**Loss of Coverage for Medicaid or a State Children’s Health Insurance Program.** If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children’s health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents’ coverage ends under Medicaid or a state children’s health insurance program.

**New Dependent by Marriage, Birth, Adoption, or Placement for Adoption.** If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

**Eligibility for Medicaid or a State Children’s Health Insurance Program.** If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children’s health insurance program with respect to coverage under this Plan, you may be able to enroll yourself and your dependents under this Plan. However, you must request enrollment within 60 days after you or your dependents’ determination of eligibility for such assistance.

**Women’s Health & Cancer Right Act of 1998**

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.

**The Newborns and Mother’s Health Protection Act of 1996**

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with the 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).

To request special enrollment or to obtain more information about the Plan’s special enrollment provisions, contact Christine Hart, NFTA, Human Resources Department at 716-855-7652.