IMPORTANT NOTICE FROM WRC SENIOR SERVICES REGARDING THE WRC SENIOR SERVICES HEALTH AND WELFARE PLAN FOR PLAN YEAR JULY 1, 2018

The Employee Retirement Income Security Act (ERISA), Department of Labor (DOL), Department of Health and Human Services (HHS) and Internal Revenue Service (IRS) require plan administrators to provide certain information related to their health and welfare benefit plans to plan participants in writing. To satisfy this requirement, please see the attached consolidated notifications. These notices explain your rights and obligations in relation to the health and welfare plan provided by WRC Senior Services. Please read the attached notices carefully and retain a copy for your records. *Please note this is not a legal document and should not be construed as legal advice.*

The following is a summary of notices included in this packet:

- ✓ Health Care Reform Notices
  - Lifetime Maximum Notice
  - FSA/HSA/HRA OTC Restrictions
  - Information on Rescissions
  - Information on Nondiscrimination 105(h) Rules
- ✓ Medicare Part D Notice (separate attachment)
- ✓ Women's Health and Cancer Rights Act (WHCRA) Notice
- ✓ The Newborns' and Mothers' Health Protections Act (NMHPA) Notice
- ✓ Mental Health Parity Act (MHPA)
- ✓ Health Information Technology for Economic and Clinical Health Act (HITECH)
- ✓ Genetic Information Nondiscrimination Act (GINA)
- ✓ HIPAA Special Enrollment Rights Notice
- ✓ Children's Health Insurance Program Reauthorization Act (CHIPRA) Notice (separate attachment)
- ✓ Uniformed Services Employment and Reemployment Rights Act (USERRA) Notice
- ✓ COBRA

If you have any questions regarding any of these notices, please contact:

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HEALTH CARE REFORM NOTICES

On March 23, 2010, President Obama implemented significant changes in health care. The following notices are required to be provided to you as part of this legislation. Please review the provisions below and contact the plan administrator with any questions.

LIFETIME MAXIMUM NOTICE

The lifetime limit on the dollar value of benefits under Highmark BlueCross BlueShield PPO no longer applies.

FLEXIBLE SPENDING ACCOUNT, HEALTH CARE SPENDING ACCOUNTS, HEALTH SAVINGS ACCOUNTS AND HEALTH REIMBURSEMENT ACCOUNTS

Effective January 1, 2011, over-the-counter medication and drugs (except insulin) may only be reimbursed through the FSA, HSA and/or HRA with a prescription.

INFORMATION ON RESCISSIONS

The Affordable Care Act, which was signed into law in March 2010, prohibits the rescission of health plan coverage except for fraud or intentional misrepresentation of a material fact. A rescission of a person's health plan coverage means that we would treat that person as never having had the coverage. The prohibition on rescissions applies to group health plans, including grandfathered plans, effective for plan years beginning on or after September 23, 2010.

In June 2010, the Interim Final Regulations (IFRs) on rescissions were issued. These regulations provide that a rescission includes any retroactive terminations or retroactive cancellations of coverage except to the extent that the termination or cancellation is due to the failure to timely pay premiums. Rescissions are prohibited except in the case of fraud or intentional misrepresentation of a material fact. **For example, if an employee is enrolled in the plan and makes the required contributions, then the employee's coverage may not be rescinded if it is later discovered that the employee was mistakenly enrolled and was not eligible to participate. If a mistake was made, and there was no fraud or intentional misrepresentation of a material fact, then the employee's coverage may be cancelled prospectively but not retroactively.**

Should a member's coverage be rescinded, then the member must be provided 30 days advance written notice of the rescission. The notice must also include the member's appeal rights as required by law and as provided in the member's plan benefit documents. Please be aware that if you rescind a member's coverage, you must provide the proper notice to the member.

The IFRs on rescission can be found at the following Internet link: http://edocket.access.gpo.gov/2010/2010-15278.htm; with a clarifying FAQ on rescissions at http://www.dol.gov/ebsa/faqs/faq-aca2.html.

INFORMATION ON NON-DISCRIMINATION 105(H) RULES

The Affordable Care Act also extended the Section 105(h) rules of the Internal Revenue Code to non-grandfathered fully insured group health plans. Section 105(h) prohibits employers from discriminating in favor of highly compensated individuals (HCIs) relative to other employees in eligibility and benefits under a group health plan.

The Affordable Care Act stated that the 105(h) rules would apply to non-grandfathered fully insured group health plans on their first plan year on or after September 23, 2010. On December 22, 2010, however, the IRS (with the support of the Departments of Labor and HHS) announced that compliance with the rules will not be required of insured plans until guidance is provided regarding their application. Until that time, sanctions for failure to comply with the rules will not apply. Furthermore, the agencies expect that when such guidance is issued, its effective date will be delayed until plan years beginning a certain time after issuance.

Under 105(h), HCIs generally consist of officers and owners and individuals in the top quartile of employees (when ranked according to compensation). Certain types of non-grandfathered plans, such as class/carve-out plans (that only cover a class of employees that consist primarily of HCIs or cover such class at a higher benefit level than another class that does not include HCIs), are either prohibited or suspect under 105(h). Insured plan sponsors that violate the 105(h) rules are subject to a $100 per day per failure penalty. This penalty would likely apply to each non-HCI who is impermissibly excluded under the plan.

Under the amended grandfather rules, the following fully insured plans are not grandfathered and may be impacted by the 105(h) rules:

- an insured plan sold with a new coverage effective date after March 23 and before November 15, 2010; or
- an insured plan that was grandfathered on March 23, 2010, and subsequently lost its grandfather status due to changes in the plan.

If these non-grandfathered plans are class/carve-out plans as described above, they may face compliance issues under the 105(h) rules, depending on how the future guidance takes shape.

Customers that have a fully insured non-grandfathered class/carve-out plan, or have questions about the application of the 105(h) rules to their plan, should review the matter with their tax or legal counsel. Customers concerned that their plans may be considered discriminatory under 105(h) may contact their broker.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) ENROLLMENT NOTICE

Your Rights After a Mastectomy

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. Therefore, the deductible and coinsurance you will be subject depends on which health plan you choose.

WHCRA ANNUAL NOTICE

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 including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?

Call your Human Resources Department for more information.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA) NOTICE

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).

Plans may be subject to State law requirements, please refer to the Plan Summary Plan Document for details describing any applicable State law.

MENTAL HEALTH PARITY ACT (MHPA)

The Mental Health Parity Act (MHPA) provides for parity in the application of annual and lifetime dollar limits on mental health benefits with annual and lifetime dollar limits on medical/surgical benefits.

HEALTH INFORMATION TECHNOLOGY FOR ECONOMIC AND CLINICAL HEALTH ACT (HITECH)

The Health Information Technology for Economic and Clinical Health Act (HITECH Act) was signed into law on February 17, 2009 as part of the American Recovery and Reinvestment Act of 2009 (ARRA), an economic stimulus bill.

The HITECH Act requires entities covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to report data breaches affecting 500 or more individuals to HHS and the media, in addition to notifying the affected individuals.

Following a breach of unsecured protected health information covered entities must provide notification of the breach to affected individuals, the Secretary, and, in certain circumstances, to the media. In addition, business associates must notify covered entities that a breach has occurred.

GENETIC INFORMATION NON-DISCRIMINATION ACT (GINA)

The Genetic Information Nondiscrimination Act of 2008 enacted May 21, 2008, GINA), is designed to prohibit the use of genetic information in health insurance and employment. The Act prohibits group health plans and health insurers from denying coverage to a healthy individual or charging that person higher premiums based solely on a genetic predisposition to developing a disease in the future. The legislation also bars employers from using individuals' genetic information when making

hiring, firing, job placement, or promotion decisions.

HIPAA SPECIAL ENROLLMENT RIGHTS

This notice is being provided so that you understand your right to apply for group health insurance coverage outside of WRC Senior Services' open enrollment period. You should read this notice regardless of whether or not you are currently covered under the WRC Senior Services Group Health Plan. The Health Insurance Portability and Accountability Act (HIPAA) requires that employees be allowed to enroll themselves and/or their dependent(s) in an employer's Group Health Plan under certain circumstances, described below, provided that the employee notified the employer within 30 days of the occurrence of any following events:

- Loss of health coverage under another employer plan (including exhaustion of COBRA coverage);
- Acquiring a spouse through marriage; or
- Acquiring a dependent child through birth, adoption, placement for adoption or foster care placement.

To request special enrollment or obtain more information, please contact your Human Resources Department.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA) NOTICE

Effective April 1, 2009, the Children's Health Insurance Program Reauthorization Act of 2009 creates two new special enrollment rights for employees and/or their dependents. In addition to the special enrollment rights set forth above, all group health plans must also permit eligible employees and their dependent(s) to enroll in an employer plan if the employee requests enrollment under the group health plan within 60 days of the occurrence of following events:

- Loss of coverage under Medicaid or a state child health plan: If you or your dependent(s) lose coverage under Medicaid or a state child health plan, you may request to enroll yourself and/or your dependent(s) in our group health plan not later than 60 days after the date coverage ends under Medicaid or the state child health plan.
- Gaining eligibility for coverage under Medicaid or a state child health plan: If you and/or your dependent(s) become eligible for financial assistance from Medicaid or a state child health plan, you may request to enroll yourself and/or your dependent(s) under our group health plan, provided that your request is made not later than 60 days after the date that Medicaid or the state child health plan determines that you and/ or your dependent(s) are eligible for such financial assistance. If you and/or your dependent(s) are currently enrolled in our group health plan, you have the option of terminating your and/or your dependent's (s') enrollment in our group health plan and enroll in Medicaid or a state child health plan.

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, 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 **1-877-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, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. Please note that once you terminate your enrollment in our group health plan, your dependent's (s') enrollment will be also terminated.

Failure to notify your Human Resources Department of your loss or gain of eligibility for coverage under Medicaid or a state child health plan within 60 days will prevent you from enrolling in our plans and/or making any changes to your coverage elections until our next open enrollment period.

To request special enrollment or obtain more information, please contact your Human Resources Department.

If you live in one of the States listed on page 7-10, you may be eligible for assistance paying your employer health plan premiums.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA) NOTICE

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA).

Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted.

If you do not elect to continue to participate in the Plan during an absence for military duty that is more than 31 days, you and your covered family members will have the opportunity to elect COBRA Continuation Coverage only under the medical insurance policy for the 24-month period (18-month period if you elected coverage prior to December 10, 2004) that begins on the first day of your leave of absence. You must pay the premiums for Continuation Coverage with after-tax funds, subject to the rules that are set out in that plan.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events.

Qualified individuals may be required to pay the entire premium for coverage up to 102 percent of the cost to the plan.