



## ANNUAL NOTICE

# WOMAN'S HEALTH and CANCER RIGHT'S ACT of 1998

The Omnibus Budget Bill amended ERISA by adding a new section that requires group health plans providing medical and surgical benefits with respect to a mastectomy to cover certain reconstructive and related services following the mastectomy.

This NOTICE shall serve to comply with the terms of the Act requiring each plan participant to receive notification when initially enrolled in the Plan, and each year thereafter.

Your Plan will cover the following in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance;
- Coverage for breast prostheses;
- Complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and patient.

Deductibles and co-payments may apply to these services. Refer to your Plan Document for specific benefit information.

## **“Q & A: Recent Changes in Health Care Law”**

### **REVISED SUPPLEMENT**

On April 1, 1997, the Department of Labor published a pamphlet, “Questions and Answers: Recent Changes in Health Care Law.” This pamphlet provided answers to the questions most often asked by participants and plan sponsors about these laws.

This supplement contains questions and answers on the Women’s Health and Cancer Rights Act of 1998 (Women’s Health Act). The Women’s Health Act was signed into law on October 21, 1998. The law includes important new protections for breast cancer patients who elect breast reconstruction concerning a mastectomy.

This supplement is available through the Employee Benefits Security Administration.

This publication may not address your specific health care questions and is not intended to be relied upon as the official position of the Department of Labor. If you have additional questions, please contact:

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# **The Women's Health and Cancer Rights Act of 1998: Questions and Answers**

The Women's Health and Cancer Rights Act (Women's Health Act) was signed into law on October 21, 1998. The law includes important protections for breast cancer patients who elect breast reconstruction concerning a mastectomy. The Women's Health Act amended the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Service Act (PHS Act) and is administered by the Departments of Labor and Centers for Medicare and Medicaid Services (CMS).

The following information is intended to provide general guidance on frequently asked questions about the Women's Health Act provisions that amend ERISA.

## **I've been diagnosed with breast cancer and plan to have a mastectomy. How will the Women's Health Act affect my benefits?**

Under the Women's Health Act, group health plans, insurance companies and health maintenance organizations (HMOs) offering mastectomy coverage must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. Coverage includes 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.

## **Will the Women's Health Act require all group health plans, insurance companies, and HMOs to provide reconstructive surgery benefits?**

All group health plans, and their insurance companies or HMOs, that provide coverage for medical and surgical benefits with respect to a mastectomy are subject to the requirements of the Women's Health Act.

## **Under the Women's Health Act, may group health plans, insurance companies, or HMOs impose deductibles or coinsurance requirements for reconstructive surgery concerning a mastectomy?**

Yes, but only if the deductibles and coinsurance are consistent with those established for other benefits under the plan or coverage.

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### **When do these requirements take effect?**

The reconstructive surgery requirements apply to group health plans for plan years beginning on or after October 21, 1998. To find out when your plan year begins, check your Summary Plan Description (SPD) or contact your plan administrator.

These requirements also apply to individual health insurance policies offered, sold, issued, renewed, in effect, or operated on or after October 21, 1998. These requirements were placed in the PHS Act within the jurisdiction of the Department of Health and Human Services.

### **My State requires the coverage for breast reconstruction that is required by the Women's Health Act and also requires minimum hospital stays in connection with a mastectomy that is not required by the Women's Health Act. If I have a mastectomy and breast reconstruction, am I also entitled to the minimum hospital stay?**

It depends. The federal Women's Health Act permits State law protections to apply to certain health coverage. State law protections apply if the State law is in effect on October 21, 1998 (date of enactment of the Women's Health Act) and the State law requires at least the coverage for reconstructive breast surgery that is required by the federal Women's Health Act.

If State law meets these requirements, and then it applies to coverage provided by an insurance company or HMO ("insured" coverage). If you obtained your coverage through your employer and your coverage is "insured," you would be entitled to the minimum hospital stay required by State law. If you obtained your coverage through your employer but your coverage is not provided by an insurance company or HMO (that is, your employer "self-insures" your coverage), then State law does not apply. In that case, only the federal Women's Health Act applies and it does not require minimum hospital stays. To find out if your group health coverage is "insured" or "self-insured," check your Summary Plan Description (SPD) or contact your plan administrator.

If you obtained your coverage under a private individual health insurance policy (not through your employer), check with your State Insurance Commissioner's office to learn if State law applies.

### **Notice Requirements under the Women's Health Act**

The Women's Health Act also requires that group health plans, insurance companies, and HMOs provide two notices regarding the coverage required by the Women's Health Act. The following information is intended to provide general guidance on frequently asked questions about these notice requirements under the provisions of the Women's Health Act that amend ERISA.

**Are all group health plans, and their insurance companies and HMOs, required to satisfy the notice requirements under the Women's Health Act?**

All group health plans, and their insurance companies or HMOs, that offer coverage for medical and surgical benefits with respect to a mastectomy are subject to the notice requirements under the Women's Health Act.

**What are the notice requirements under the Women's Health Act?**

There are two separate notices required under the Women's Health Act. The first notice is a one-time requirement under which group health plans, and their insurance companies or HMOs, must furnish a written description of the benefits that the Women's Health Act requires. The second notice must also describe the benefits required under the Women's Health Act but it must be provided upon enrollment in the plan and it must be furnished annually thereafter to participants and beneficiaries.

**How must these notices be delivered to participants and beneficiaries?**

These notices must be delivered in accordance with the Department of Labor's disclosure regulations applicable to furnishing summary plan descriptions. (29 CFR § 2520.104b-1). For example, the notices may be provided by first class mail or any other means of delivery prescribed in the regulation. It is the view of the Department that a separate notice would be required to be furnished to a group health plan beneficiary where the last known address of the beneficiary is different than the last known address of the covered participant.

**Does a group health plan that already provided the coverage required by the Women's Health Act have to send out the initial one-time notice?**

A group health plan that, prior to the date of enactment (October 21, 1998), already provided the coverage required by the Women's Health Act (and continues to provide such coverage) will have satisfied the initial one-time notice requirement if the information required to be provided in the initial notice was previously furnished to participants and beneficiaries in accordance with the Department's regulations on disclosure of information to participants and beneficiaries.

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### **What information must be included in the Women's Health Act notices?**

The Notices must describe the benefits that the Women's Health Act requires the group health plan, and its insurance companies or HMOs, to cover. The Notice must indicate that, in the case of a participant or beneficiary who is receiving benefits under the plan in connection with a mastectomy and who elects breast reconstruction, the coverage will be provided 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.

The notice must also describe any deductibles and coinsurance limitations applicable to such coverage. Under the Women's Health Act, coverage of breast reconstruction benefits may be subject only to deductibles and coinsurance limitations consistent with those established for other benefits under the plan or coverage.