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LOCAL 36 BENEFIT FUNDS
2319 CHOUTEAU AVE., SUITE 300 · ST. LOUIS, MO 63103 · www.smw36benefits.org
Tel: (314) 652-8175 Toll-Free: (800) 741-9411 Fax: (314) 652-0338

October 14, 2019

The Woman's Health and Cancer Rights Act of 1998 requires Welfare Funds that provide coverage for mastectomies to also provide coverage for related reconstructive surgery and to provide notice of this coverage on an annual basis.

The SMART Local 36 Welfare Fund provides coverage in conformity with this Act as follows:

A participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, is also covered for

(1) all stages of reconstruction of the breast on which the mastectomy has been performed;

(2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) prostheses and physical complications of mastectomy, including lymphedemas (fluid retention and swelling related to the lymph nodes);

in a manner determined in consultation with the attending physician and the patient.

Coverage is subject to any deductibles, co-payments, pre-certification, pre-authorization, or other requirements that apply under the plan for similar types of coverage.

This is an annual notification of benefits that are currently in place. If you have any questions concerning this coverage you may contact the Fund office.

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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).