# Notification of rights under the Affordable Care Act

## Non-Grandfathered Group Health Plan Notice

Your employer believes the Group Health Plan (GHP) provided to employees is a "non-grandfathered health Plan" under the Patient Protection and Affordable Care Act (the PPACA). Non-Group Grandfathered Health Plans must comply with certain consumer protections in the PPACA.

You are receiving this notice and all other Notices required of a Non-Grandfathered Health Plan.

### Lifetime Limits on Essential Health Benefits

Under the Patient Protection and Affordable Care Act (PPACA) of March 23, 2010, the lifetime limit on the dollar value of benefits under the Group Health Plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the Plan are eligible to enroll in the Plan. Individuals have 30 days from the date of this notice to request enrollment in the Plan. If the plan previously had lifetime limits this provision is not applicable to you as an employee.

The term "Essential Health Benefits" means essential health benefits under Section 1302(b) of the PPACA and applicable regulations.

Section 1302(b) of the PPACA defines essential health benefits to "include at least the following general categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care."

Please refer to your Benefits Summary for the Plan maximum, if any applicable to non-essential benefits.

### Notice of Annual Limits on Essential Health Benefits

Under the Patient Protection and Affordable Care Act of March 23, 2010 (PPACA), following are the new **maximum** annual Plan limit amounts for Essential Health Benefits.

Effective for any Group Health Plans beginning on or after September 23, 2010, but before September 23, 2011, the minimum annual Plan limit for Essential Health Benefits **can be no lower than** $750,000. This minimum will be adjusted annually until Plan Years beginning 2014, at which time there can be no maximum annual limit for Essential Health Benefits.

Only essential benefits can be counted towards annual limits; meaning that benefits that are provided that are considered to be 'non-essential benefits' do not count towards the annual Plan maximums.

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laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care."

Please refer to your Benefits Summary for the Plan maximum, if any.

# Non-Grandfathered Health Plan Notice of Opportunity to Enroll in Group Health Plan Due to the extension of Dependent Coverage to Age 26

Under the Patient Protection and Affordable Care Act of March 23, 2010 (PPACA), individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the group health Plan or health insurance coverage even if the dependent child is eligible for health coverage under another health Plan. Individuals may request enrollment for such children for 30 days from the date of this notice. Enrollment will be effective retroactively to first day of the Plan Year beginning after September 23, 2010.

## Notice of No Pre-Existing Condition Exclusions for Children Under Age 19

Under the Patient Protection and Affordable Care Act (PPACA) of March 23, 2010, protections apply with respect to enrollees children under age 19 for Plan Years beginning on or after September 23, 2010. A dependent child under age 19 cannot be denied benefits based on a preexisting condition. In order for an individual seeking enrollment to receive the same protection that applies in the case of such an enrollee, the individual similarly cannot be denied enrollment or specific benefits based on a preexisting condition.

Thus, for Plan Years beginning on or after September 23, 2010, PHS Act Section 2704 protects individuals under age 19 with a preexisting condition from being denied coverage under a Plan or health insurance coverage (through denial of enrollment or denial of specific benefits) based on the preexisting condition

## Patient Protection Prohibition on Rescissions Notice

Under the Patient Protection and Affordable Care Act (PPACA) of March 23, 2010, for Plan Years beginning on or after September 23, 2010, a group health Plan, or a health insurance issuer offering group or individual health insurance coverage, must not rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact. Under the new standard for rescissions, Plans and issuers cannot rescind coverage unless an individual was involved in fraud or made an intentional misrepresentation of material fact. These provisions generally provide that a health insurance issuer in the group and individual markets cannot cancel, or fail to renew, coverage for an individual or a group for any reason other than those enumerated in the statute (that is, nonpayment of premiums; fraud or intentional misrepresentation of material fact; withdrawal of a product or withdrawal of an issuer from the market; movement of an individual or an employer outside the service area; or, for bona fide association coverage, cessation of association membership).

These interim final regulations clarify that, to the extent that an omission constitutes fraud, that omission would permit the plan or issuer to rescind coverage under this section. For purposes of these interim final regulations, a rescission is a cancellation or discontinuance of coverage that has retroactive effect. For example, a cancellation that treats a policy as void from the time of the individual's or group's enrollment is a rescission. As another example, a cancellation that voids benefits paid up to a year before the cancellation is also a rescission for this purpose.

A cancellation or discontinuance of coverage with only a prospective effect is not a rescission, and neither is a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. Coverage may not be cancelled unless prior notice is provided. These interim final regulations provide that a group health Plan, or health insurance issuer offering group health insurance coverage, must provide at least 30 calendar days advance notice to an individual before coverage may be rescinded. Even though prior notice must be provided in the case of a rescission, applicable law may permit the rescission to void coverage retroactively.

# Appeals Process Notice

Under the Patient Protection and Affordable Care Act (PPACA) of March 23, 2010, allows consumers in new health plans access to internal and external appeals processes that are clearly defined, impartial, and designed to ensure that, when health care is needed and covered, consumers get it. Section 2719 of the PHS Act generally requires that group health plans and health insurance issuers that are not grandfathered health plans have an effective internal claims and appeals process. The statutory language provides further that plans, and issuers in the group market, shall provide an internal claims and appeals process that initially incorporates the procedures of 29 CFR 2560.503-1 (the 2000 DOL claims procedure regulation) and shall update such procedures in accordance with any standards established by the Secretary of Labor for such plans and issuers.

The following are currently in force or extended as noted. Participants should contact the health insurer or plan for guidance pertaining to claims appeal. Certain procedures are currently in effect and certain have been granted delayed enforcement by the HHS (Health and Human Services), the DOL (Department of Labor) and the Treasury (the Departments)

1. The scope of adverse benefit determinations eligible for internal claims and appeals includes a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time). **Currently in force for all plans.**

2. Notwithstanding the rule in the 2000 DOL claims procedure regulation that provides for notification in the case of urgent care claims not later than 72 hours after the receipt of the claim, a plan or issuer must notify a claimant of a benefit determination (whether adverse or not) with respect to a claim involving urgent care as soon as possible, taking into account the medical exigencies, but not later than 24 hours after the receipt of the claim by the plan or issuer. **Extended until first day of plan year effective on or after January 1, 2012.**

3. Clarifications with respect to full and fair review, such that plans and issuers are clearly required to provide the claimant (free of charge) with new or additional evidence considered, relied upon, or generated by the plan or issuer in connection with the claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the claimant to respond to such new evidence or rationale. **Currently in force for all plans.**

4. Clarifications regarding conflicts of interest, such that decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to an individual, such as a claims adjudicator or medical expert, must not be based upon the likelihood that the individual will support the denial of benefits. **Currently in force for all plans.**

5. Notices must be provided in a culturally and linguistically appropriate manner, as required by the statute, and as set forth in paragraph (e) of the 2010 interim final regulations. **Extended until first day of plan year effective on or after January 1, 2012.**

6. Notices to claimants must provide additional content. Specifically:

a. *****Any notice of adverse benefit determination or final internal adverse benefit determination must include information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable), **the **<u>diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning</u>. * Effective date is the first day of the first plan year beginning on or after July 1, 2011**

**** Extended until first day of plan year effective on or after January 1, 2012.**

b. The plan or issuer must ensure that the reason or reasons for an adverse benefit determination or final internal adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the plan's or issuer's standard, if any, that was used in denying the claim. In the case of a final internal adverse benefit determination, this description must also include a discussion of the decision. **Effective date is the first day of the first plan year beginning on or after July 1, 2011.**

c. The plan or issuer must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal. **Effective date is the first day of the first plan year beginning on or after July 1, 2011.**

d. The plan or issuer must disclose the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793. **Effective date is the first day of the first plan year beginning on or after July 1, 2011.**

7. If a plan or issuer fails to strictly adhere to all the requirements of the 2010 interim final regulations, the claimant is deemed to have exhausted the plan's or issuer's internal claims and appeals process, regardless of whether the plan or issuer asserts that it has substantially complied, and the claimant may initiate any available external review process or remedies available under ERISA or under State law. **Extended until first day of plan year effective on or after January 1, 2012.**

**Resources to help you:** For questions about your appeal rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA, refer to your Health Plan Certificate of Coverage or Evidence of Coverage, Your Employer Plan Administrator or Contact the State Insurance Commissioner.

# Coverage of Preventive Services Notice

Under the Patient Protection and Affordable Care Act (PPACA) of March 23, 2010, requires that certain preventive services must be covered with no cost-sharing to the enrolled Participants. For new health policies and non-grandfathered policies beginning on or after September 23, 2010, preventive services that have strong scientific evidence of their health benefits must be covered and Plans can no longer charge a patient a co-payment, co-insurance or deductible for these services when they are delivered by a network provider.

**Covering High-Value Preventive Services Including New Services for Women and Children**
Plans covered by these rules must offer coverage of a comprehensive range of preventive services that are recommended by physicians and other experts without imposing any cost- sharing requirements. Specifically, these recommendations include:

- **Evidence-based preventive services:** The U.S. Preventive Services Task Force, an independent panel of scientific experts, ranks preventive services based on the strength of the scientific evidence documenting their benefits. Preventive services with a "grade" of A or B, like breast and colon cancer screenings, screening for vitamin deficiencies during pregnancy, screenings for diabetes, high cholesterol and high blood pressure, and tobacco cessation counseling will be covered under these rules.
- **Routine vaccines:** Health Plans will cover a set of standard vaccines recommended by the Advisory Committee on Immunization Practices ranging from routine childhood immunizations to periodic tetanus shots for adults.
- **Prevention for children:** Health Plans will cover preventive care for children recommended under the *Bright Futures* guidelines, developed by the Health Resources and Services Administration with the American Academy of Pediatrics. These guidelines provide pediatricians and other health care professionals with recommendations on the services they should provide to children from birth to age 21 to keep them healthy and improve their chances of becoming healthy adults. The types of services that will be covered include regular pediatrician visits, vision and hearing screening, developmental assessments, immunizations, and screening and counseling to address obesity and help children maintain a healthy weight.
- **Prevention for women:** Health Plans will cover preventive care provided to women under both the Task Force recommendations and new guidelines being developed by doctors, nurses, and scientists, which are expected to be issued by August 1, 2011.

# Patient Protection Disclosure Notice- Provider Designation for Non-Grandfathered Plans

Under the Patient Protection and Affordable Care Act (PPACA) of March 23, 2010, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Group Health Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating health care professionals who specialize in obstetrics or gynecology refer to your provider network materials.