Required Legislative Notices

Affordable Care Act

Did you know that every American is required to have health insurance coverage as of 1/1/2014? Should you choose not to insure yourself, you could be looking at an annual penalty. Open enrollment is now for your company sponsored health plan. Being open enrollment time, it is your one time of year, without a qualified life event, to enroll in the health coverage and avoid paying this penalty. The coverage that is offered through the company is fully compliant per the ACA regulations.

Should you want to explore individual health insurance options outside of your employer group plan(s), the federal exchange has an open enrollment period annually from November 1st to December 15th. You can access the exchange by logging on to www.healthcare.gov if you're interested in researching individual policies today.

Should you waive health coverage during the company's open enrollment period, you will not be eligible to enroll until next year's annual open enrollment period.

Women's Health and Cancer Rights Act Enrollment Notice

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 the Coinsurance applies.

If you would like more information on WHCRA benefits, call your Plan Administrator.

Newborns' and Mothers Health Protection Act Enrollment 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Patient Protection Disclosure

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries:

Aetna generally requires the designation of a primary care provider. 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. Until you make this designation, Coventry/Aetna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Aetna at www.aetna.com or (800) 426-4363.

For plans and issuers that require or allow for the designation of a primary care provider for a child:

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

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider:

You do not need prior authorization from Aetna 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, contact Aetna at www.aetna.com or (800) 426-4363.

HIPAA Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able 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 your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, 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 dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Plan Administrator.

Lifetime Limits Disclosure Notice

The lifetime limit on the dollar value of benefits under your Medical Plan(s) 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. For more information contact you Plan Administrator.

Summary of Benefits and Coverage

Under the law, insurance companies and group health plans will provide consumers with a concise document detailing, in plain language, simple and consistent information about health plan benefits and coverage. This summary of benefits and coverage document will help consumers better understand the coverage they have and, for the first time, allow them to easily compare different coverage options. It will summarize the key features of the plan or coverage, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions.

Coverage Examples

This summary of benefits and coverage will include a new, standardized health plan comparison tool for consumers called "coverage examples," much like the Nutrition Facts label required for packaged foods. The coverage examples would illustrate how a health insurance policy or plan would cover care for common benefits scenarios. Using clear standards and guidelines provided by the Center for Consumer Information and Insurance Oversight (CCIIO), plans and issuers will simulate claims processing for each scenario so consumers can see an illustration of the coverage they get for their premium dollar under a plan. The examples will help consumers see how valuable the health plan will be at times when they may need the coverage.

Uniform Glossary of Terms

Under the Affordable Care Act, consumers will also have a new resource to help them understand some of the most common but confusing jargon used in health insurance. Insurance companies and group health plans will be required to make available upon request a uniform glossary of terms commonly used in health insurance coverage such as "deductible" and "co-payment". To help ensure the document is easily accessible for consumers, the Departments of Health and Human Services (HHS) and Labor will also post the glossary on the new health care reform website, www.HealthCare.gov.

You can access the forms discussed here at **http://www.dol.gov/ebsa/pdf/SBCtemplate.pdf**

The package of materials posted also includes an example of a completed summary of benefits and coverage, uniform glossary, as well as specific technical information for simulating coverage examples for two benefit scenarios: having a baby and managing type 2 diabetes.