

Annual Legal Notification

New Dependent Child Eligibility Rules

You can elect medical, dental and/or vision coverage for eligible dependent children up to age 26, whether or not they are students, are married or depend on you for primary financial support. This coverage will be effective January 1, 2011.

You can add your eligible dependent children to these coverages until December 17, 2010, which is 30 days following the start of your enrollment period. If you need to make or change your eligible dependent child elections after December 6, 2010 (the date Open Enrollment ends) or for more information you may contact Kathy Weaver in the Human Resources Department at (215) 453-4636.

2011 Changes to Flexible Spending Accounts (FSAs)

The Health Care Reform Act makes some changes to Health Flexible Spending Accounts (FSAs). An important change takes effect on January 1, 2011. Under the new standard, the cost of an over-the-counter medicine or drug cannot be reimbursed from the account unless a prescription is obtained. The change does not affect insulin, even if purchased without a prescription, or other health care expenses such as medical devices, eye glasses, contact lenses, co-pays and deductibles. The new standard applies only to purchases made on or after Jan. 1, 2011. For detailed information, please review the information under the “My Reimbursement Accounts” folder on the benefits website.

Lifetime Limit No Longer Applies

The lifetime limits on the dollar value of benefits under the AmeriHealth plans no longer apply. Individuals whose coverage ended by reason of reaching a lifetime limit under the AmeriHealth plans are eligible to enroll in the plan. Individuals have until December 17, 2010, which is 30 days from the start of your enrollment period to request enrollment. For more information you may contact Kathy Weaver in the Human Resources Department at (215) 453-4636.

Note: The lifetime maximum for orthodontia, which is covered under the dental plan, will continue to apply.

Patient Protection Disclosure

Aetna QPOS 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, Aetna QPOS 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 the Aetna Customer Service Department at 1-877-402-8742. You will need to provide them Grand View Hospital’s group number which is 268547. For detailed information, please review the “Aetna Medical Disclosure Information” on the benefits website under the “My Medical” folder.

Grandfathered Health Plans

Under the Patient Protection and Affordable Care Act (the Affordable Care Act), Grand View Hospital believes that the AmeriHealth and Aetna QPOS health insurance plans are “grandfathered health plans”. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 215-453-4636. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.]

Newborns’ and Mothers’ Health Protection Act of 1996

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 for a cesarean section. However, Federal law generally does not prohibit the mothers’ 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).

The Women’s Health and Cancer Rights Act of 1998

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 symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to any applicable co-payments, deductibles, and coinsurance in your plan. If you would like more information on WHCRA benefits, call the Human Resources Department at (215) 453-4864.

Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Account (FSA) allows you to lower your taxable income by contributing pre-tax dollars for dependent care expenses.

The Dependent Care FSA can be used to pay for eligible daycare expenses incurred by you or your spouse while working or attending school full-time. Eligible reimbursable expenses are for children up to the age of 13 or for expenses incurred by a disabled (tax dependent) adult that depends on you for care.

A terminated participant has been entitled to reimbursement of claims incurred through the date of termination of participation (but not in excess of the amounts contributed to his or her Dependent Care Account, minus any reimbursements). Now, any one who terminates participation on or after January 1, 2009 shall be entitled to reimbursement of claims incurred through the last day of the Plan Year in which his or her termination of participation occurs (but not in excess of the amounts contributed to his or her Dependent Care Account, minus any reimbursements).

Contributions to the Dependent Care FSA account need to be spent within the calendar year (money contributed that you do not use for expenses incurred in that calendar year is forfeited).

Children's Health Insurance Program (CHIP)

The Children's Health Insurance Program (CHIP) Act was effective on April 1, 2009. This Act provides federal funds to states to subsidize contributions for employer-provided medical coverage for eligible children and families.

Special Enrollment Period

This Act creates new "Special Enrollment Rights" under our Medical Plan for individuals who lose eligibility for Medicaid or CHIP coverage or who become eligible through Medicaid or CHIP for premium assistance in paying contributions under our Medical Plan. The special enrollment period is 60 days within the loss of Medicaid or CHIP coverage or eligibility for premium assistance (not the typical 30 day period that applies in other enrollments such as marriage, birth, loss of other coverage, etc).

The Plan will withhold the total amount of the employees contribution required for enrollment of the employee and the child and the state will then pay the premium assistance subsidy directly to the associate.

Health Care Flexible Spending Account and the Heroes Earnings Assistance and Relief Tax (HEART) Act of 2008

On June 17, 2008 the Heroes Earnings Assistance and Relief Tax (HEART) Act, 2008 was signed into law. Under the HEART Act, military reservists who are called to active duty can receive distributions from unused funds in their Health Care Flexible Spending Account.

A “qualified reservist distribution” can be made from your Health Care Flexible Spending Account without penalties, (any money contributed to a Health Care Flexible Spending Account, which you do not use for expenses incurred in that calendar year is normally forfeited). This new law allows reservists not to forfeit the money under the “use it or lose it rules” that generally apply to Flexible Spending Account plans.

The “qualified reservist distribution” would be the amount you contributed to your Health Care Flexible Spending Account as of the date of your request, minus any premium reimbursements you have received as of the request date.

A qualified reservist is defined as an individual ordered or called to active duty for a period in excess of 179 days or for an indefinite period. The distribution has to be made within the period beginning with the date you are called to active duty and ending on March 31 of the following calendar year.