Annual Regulatory Disclosures

WOMEN'S PREVENTIVE SERVICES UNDER THE AFFORDABLE CARE ACT

The Affordable Care Act (ACA) requires that a group health plan and a health insurance issuer provide benefits for certain preventive services without cost sharing.

Subject to the terms and conditions of coverage, the following types of services for women may be covered without cost-sharing when using a network provider, beginning Aug. 1, 2012:

- Well-woman visits
- Screening for diabetes during pregnancy
- HPV testing for women at least 30 years of age
- Counseling for sexually transmitted infections
- HIV screening and counseling
- FDA-approved contraception methods, sterilization procedures and counseling
- Breastfeeding support, supplies and counseling
- Interpersonal relations and domestic violence screening and counseling

Contraception: FDA-approved contraception methods, sterilization procedures and counseling will have added coverage to a member's policy for certain contraceptive medicines, devices and procedures. This coverage will be offered without cost-sharing when the services are provided by a network provider. Please note that the coverage of women's contraceptives with no cost-sharing is limited to certain medicines, devices and procedures within the following categories:

- Designated prescription contraception drugs
- Over-the-counter contraceptives for women (foam, sponge, female condoms) when prescribed by a physician
- Designated medical devices such as IUD, diaphragm, cervical cap and contraceptive implants
- Female sterilization procedures

If you have additional questions about this change, please call toll-free 866-446-4353 , Monday through Thursday, 9 a.m. to 5 p.m. CT, and Friday, 9 a.m. to 4:30 p.m. CT. Email your questions anytime to cmproducerservices@bcbstx.com and receive a response no later than the next business day.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

HIPAA Enrollment Rights

Perhaps you have heard of HIPAA – the Health Insurance Portability and Accountability Act – during a visit to your doctor's office. The doctor's staff may have handed you a "HIPAA privacy notice" advising you of protections for your personal health information. But HIPAA covers a lot more than privacy. For many people, health coverage is an important benefit of their jobs. At the time HIPAA was passed, a lot of people were afraid to switch jobs because they might lose the insurance coverage they needed for their families. The following explains how HIPAA's protections make it easier to change employers without losing health coverage for your (and your family's) medical conditions.

HIPAA's umbrella of protection:

- Limits the ability of a new employer plan to exclude coverage for preexisting conditions;
- Provides additional opportunities to enroll in a group health plan if you lose other coverage or experience certain life events;

- Prohibits discrimination against employees and their dependent family members based on any health factors they may have, including prior medical conditions, previous claims experience, and genetic information; and
- Guarantees that certain individuals will have access to, and can renew, individual health insurance policies.

HIPAA Privacy Rights

HIPAA Privacy rights provides for the protection of individually identifiable health information that is transmitted or maintained in any form or medium. The privacy rules affect the day-to-day business operations of all organizations that provide medical care and maintain personal health information.

HIPAA protects an individual's health information and his/her demographic information. This is called "protected health information" or "PHI". Information meets the definition of PHI if, even without the patient's name, if you look at certain information and you can tell who the person is then it is PHI. The PHI can relate to past, present or future physical or mental health of the individual. PHI describes a disease, diagnosis, procedure, prognosis, or condition of the individual and can exist in any medium – files, voice mail, email, fax, or verbal communications.

HIPAA defines information as protected health information if it contains the following information about the patient, the patient's household members, or the patient's employers:

- Names
- Dates relating to a patient , i.e. birthdates, dates of medical treatment, admission and discharge dates, and dates of death
- Telephone numbers, addresses (including city, county, or zip code) fax numbers and other contact information
- Social Security numbers Medical records numbers Photographs
- Finger and voice prints
- Any other unique identifying number
- HIPAA Preexisting Condition Exclusions

Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "preexisting condition exclusions." Pre-existing condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period. In addition, a pre-existing condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee).

HIPAA Preexisting Condition Exclusions-continued

Finally, preexisting condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.
If a plan imposes preexisting condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break. Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break.

For more information

"http://www.dol.gov/ebsa.If you have questions about your HIPAA rights, you may contact your state insurance department

or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication

hotline at 1-800-633-4227 (ask for “Protecting Your Health Insurance Coverage”). These publications and other useful information are also available on the Internet at:

MEDICAID AND THE CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP) OFFER FREE OR LOW COST HEATH COVERAGE TO CHILDREN AND FAMILIES

If you are eligible for health coverage from your employer, but are unable to afford the premiums, Illinois has premium assistance programs that can help pay for coverage. Illinois uses funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums. If you or your dependents are already enrolled in Medicaid or CHIP and you live in Illinois, you can contact the Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact the State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer’s health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer’s plan. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

WOMEN’S HEALTH AND CANCER RIGHTS ACT (WHCRA)

If you have had a mastectomy or expect to have one, you may be entitled to special rights under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). Under WHCRA, if your group health plan covers mastectomies, the plan must provide certain reconstructive surgery and other post-mastectomy benefits.

An individual who is 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 lymph edema.

NEWBORNS AND MOTHER’S HEALTH PROTECTION ACT

The Newborns’ and Mothers’ Health Protection Act of 1996 (the Newborns’ Act), signed into law on September 26, 1996, requires plans that offer maternity coverage to pay for at least a 48-hour hospital stay following childbirth (96-hour stay in the case of a cesarean section).

This law was effective for group health plans for plan years beginning on or after January 1, 1998.

The Newborns’ Act and its regulations provide that health plans and insurance issuers may not restrict a mother’s or newborn’s benefits for a hospital length of stay that is connected to childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the attending provider (who may be a physician or nurse midwife) may decide, after consulting with the mother, to discharge the mother or newborn child earlier.

The Newborns’ Act, and its regulations, prohibits incentives (either positive or negative) that could encourage less than the minimum protections under the Act as described above.

A mother cannot be encouraged to accept less than the minimum protections available to her under the Newborns' Act and an attending provider cannot be induced to discharge a mother or newborn earlier than 48 or 96 hours after delivery.

AMERICANS WITH DISABILITIES ACT (ADA)

Individuals with disabilities are protected from discrimination in employment primarily by the Americans with Disabilities Act (ADA) and the Rehabilitation Act. The Department of Labor's Office of Disability Employment Policy (ODEP) provides publications and other technical assistance on the requirements of these laws. However, ODEP does not enforce these laws.

The Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) enforces Section 503 of the Rehabilitation Act, which requires federal contractors and subcontractors with government contracts in excess of $10,000 to take affirmative action to employ and advance in employment qualified individuals with disabilities. Additionally, OFCCP has coordinating authority under Title I of the Americans with Disabilities Act, which prohibits job discrimination by employers against qualified individuals with disabilities. The Equal Employment Opportunity Commission (EEOC) has primary authority for enforcing the employment-related provisions of the ADA, which are found in Title I. Most government contractors are covered by both Section 503 and Title I of the ADA.

OFCCP also enforces the Vietnam Era Veterans' Readjustment Assistance Act (VEVRAA). Some disabled veterans are covered under this law. If a covered disabled veteran believes he or she has been discriminated against by a federal contractor or subcontractor, he or she may file a complaint with OFCCP.

The Department's Civil Rights Center (CRC) enforces the employment-related provisions of Section 504 of the Rehabilitation Act. Section 504 covers organizations and entities that receive federal financial assistance from DOL. CRC also enforces Title II of the ADA as that title applies to the labor- and workforce-related practices of state and local governments and other public entities. Finally, CRC enforces Section 188 of the Workforce Investment Act of 1998 (WIA), which bars disability-based discrimination by programs and activities that are part of the One-Stop employment and training system established by WIA Title I. See the Laws & Regulations subtopic for specific information on these laws.

EMPLOYEE RETIREMENT INCOME SECURITY ACT — ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans.

ERISA requires plans to provide participants with plan information including important information about plan features and funding; provides fiduciary responsibilities for those who manage and control plan assets; requires plans to establish a grievance and appeals process for participants to get benefits from their plans; and gives participants the right to sue for benefits and breaches of fiduciary duty.

There have been a number of amendments to ERISA, expanding the protections available to health benefit plan participants and beneficiaries. One important amendment, the Consolidated Omnibus Budget Reconciliation Act (COBRA), provides some workers and their families with the right to continue their health coverage for a limited time after certain events, such as the loss of a job. Another amendment to ERISA is the Health Insurance Portability and Accountability Act (HIPAA) which provides important new protections for working Americans and their families who have preexisting medical conditions or might otherwise suffer discrimination in health coverage based on factors that relate to an individual's health. Other important amendments include the Newborns' and Mothers' Health Protection Act, the Mental Health Parity Act, and the Women's Health and Cancer Rights Act.

In general, ERISA does not cover group health plans established or maintained by governmental entities, churches for their employees, or plans which are maintained solely to comply with applicable workers compensation, unemployment, or disability laws. ERISA also does not cover plans maintained outside the United States primarily for the benefit of nonresident aliens or unfunded excess benefit plans.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act (FMLA) provides certain employees with up to 12 weeks of unpaid, job- protected leave per year. It also requires that their group health benefits be maintained during the leave.

FMLA is designed to help employees balance their work and family responsibilities by allowing them to take reasonable unpaid leave for certain family and medical reasons. It also seeks to accommodate the legitimate interests of employers and promote equal employment opportunity for men and women.

FMLA applies to all public agencies, all public and private elementary and secondary schools, and companies with 50 or more employees. These employers must provide an eligible employee with up to 12 weeks of unpaid leave each year for any of the following reasons:

- for the birth and care of the newborn child of an employee;
- for placement with the employee of a child for adoption or foster care;
- to care for an immediate family member (spouse, child, or parent) with a serious health condition;
- or to take medical leave when the employee is unable to work because of a serious health condition.

Employees are eligible for leave if they have worked for their employer at least 12 months, at least 1,250 hours over the past 12 months, and work at a location where the company employs 50 or more employees within 75 miles. Whether an employee has worked the minimum 1,250 hours of service is determined according to FLSA principles for determining compensable hours or work.

Time taken off work due to pregnancy complications can be counted against the 12 weeks of family and medical leave.

A final rule effective on January 16, 2009, updates the FMLA regulations to implement new military family leave entitlements enacted under the National Defense Authorization Act for FY 2008.

Special rules apply to employees of local education agencies. The Department of Labor administers FMLA; however, the Office of Personnel Management (OPM) administers FMLA for most federal employees.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

The purpose of USERRA (the Uniformed Services Employment and Reemployment Rights Act) is to protect those who voluntarily or involuntarily leave civilian employment to serve in the military reserves. USERRA applies to states, local governments, and private employers, including religious organizations and multiemployer plans.

While the law was passed in 1994, these are the first set of final regulations to interpret USERRA. The regulations also require employers to provide employees with notice of their rights and employer obligations under the law.

While USERRA generally guarantees a reservist's right to reemployment after completing military service, it also covers the health care and retirement rights and obligations pertaining to reservists.

Health Coverage Highlights

- If employees leave a job for military service, those employees may continue existing employer-based health coverage for themselves and their dependents for up to 24 months while in the military.
- If the employee serves for less than 31 days, the employer must charge no more than the regular employee contribution; for longer periods, the employer may charge 102% of the full premium, similar to COBRA.
- If an employee doesn’t elect to continue coverage during military service, he has the right to be reinstated in the employer’s health plan upon reemployment, generally without any waiting periods or exclusions except for service-connected illnesses or injuries.
- If an employee does not give advance notice of service, generally 30 days, and does not elect continuation of coverage, the plan administrator may cancel the employee’s coverage. However, under certain circumstances, the administrator

must reinstate the employee's health coverage retroactively upon election to continue coverage and after the employee pays all unpaid amounts due. The plan cannot impose administrative fees.
- Health plan administrators may adopt reasonable rules allowing cancellation of coverage if the employee's payment is not timely.

Retirement Highlights

- On reemployment, the employee is treated as not having a break in service for purposes of participation, vesting and benefit accrual.
- The employee may take from one to 90 days to report back to work. This period also counts as continuous service.
- With some exceptions, an employee recuperating from a service-related illness or injury may take up to two years from the date he or she completed service to apply for reemployment. This period counts also counts as continuous service.
- With a defined contribution plan, once the employee returns to work, the employer must allocate the amount of its make-up contribution for the employee, generally within 90 days of reemployment. The employer must also grant make-up contributions by the employee and elective deferrals in the same way that it allocates amounts for other employees.
- With a defined benefit plan, the employee's accrued benefit will be increased for the period of service after she is reemployed and after repaying any distributions from the plan. The employee must be allowed to repay the amount, plus interest, after reemployment. The repayment period must be equal to three times the individual's immediate past period of uniformed services, not to exceed five years.
- If a benefit is based on compensation, the rule for calculating this amount during a period of service is the same rate of pay that the employee would have received if he or she were not in the military. However, if compensation is based on commissions, then the average rate of compensation during the 12 -month period prior to the period of uniformed service applies. If an individual was employed for less than 12 months, then the average rate of compensation derives from this shorter period.

MICHELLE'S LAW

Group health insurance plans with plan years beginning on or after October 9, 2009 are subject to a federal law, commonly known as Michelle's Law, which protects the health insurance coverage of dependent college students who need to take medically necessary leave from school. This is an important issue for employers because, although the Congressional Budget Office assumes fewer than 1% of college students take a medical leave of absence, when the situation does arise, having a child in college with a serious illness or injury can have a devastating impact on employee productivity.

Michelle Morse was a college student in New Hampshire. She was diagnosed with colon cancer and advised to take a leave of absence from school because of the strenuous treatment the cancer required. Under law existing at the time, Michelle's leave would have terminated her coverage as a dependent under her parent's plan, and the only way to preserve it was through payment of a COBRA premium. The premium for Michelle would have been $550 per month. Michelle could not afford the COBRA premium, so she stayed in school with a full-time course load and passed away on November 10, 2005.

Since then, New Hampshire and at least 10 other States have enacted laws to protect students who need to take medical leave from college. In October 2008, President George W. Bush signed H.R. 2581, which amended the Employee Retirement Income Security Act ("ERISA") and made Michelle's Law a federal law.

Michelle's Law is effective for plan years beginning on or after October 9, 2009. Thus, for most health insurance plans that observe a calendar year anniversary date, this law will affect those plans beginning January 1, 2010. However, fully insured plans and self-funded non-ERISA plans may already be required to comply with state versions of the law. California's law went into effect January 1, 2009.

Under the new law, the group health insurance plan may not terminate an eligible college student's health insurance coverage because the student takes a medically necessary leave of absence. Such "absence" may also include the student changing his

or her status to part-time as a result of the illness or injury. The leave of absence must be medically necessary, must commence while the student is suffering from a serious illness or injury, and the leave of absence must otherwise cause the child to lose medical coverage under the health insurance plan.

In order to be eligible, the student must have been a student at a post-secondary educational institution prior to the commencement of the leave. The student will be eligible for medical coverage for one year. Medical coverage will end after one year or the date the coverage would otherwise have terminated under the health insurance plan. Similar to COBRA, the student is eligible to continue the same benefits as if he or she had not taken a leave of absence. Also, if the plan is modified during the leave, the new plan applies to the student on the leave.

The group health insurance plan may require a written certification by the student's physician certifying the child is suffering from a serious illness or injury and that a leave of absence is medically necessary.