



HEALTH CARE REFORM

What's Happening to My Health Plan?

BlueCross BlueShield of South Carolina *and* BlueChoice HealthPlan of South Carolina



The Patient Protection and Affordable Care Act — health care reform — was signed into law on March 23, 2010. Some parts of this massive law take effect this year, starting with health plan years or benefit periods that begin on or after September 23, 2010.

Typically, health plan coverage is either an individual policy you buy directly from an insurance company or a group policy you get through employment.

Example 1: Your group health coverage started on January 1, 2010. Your next renewal is January 1, 2011. Since your health plan's benefits "start over" on January 1, 2011, that is also when any immediate health care reform changes that apply to your plan will take effect.

Example 2: You have an individual policy. Your next benefit period begins on November 15, 2010. Immediate health care reform changes that apply to your policy will take effect on November 15.



When will health care reform changes affect your health coverage?

The timing depends on whether your plan is a “grandfathered” or “non-grandfathered” plan.

In simplest terms, a plan can only be grandfathered if it was already in effect on the day the health care reform law was enacted: March 23, 2010. A non-grandfathered plan is a plan that didn’t take effect until after March 23, 2010, or has had certain changes made to it.

Example 1: Your group health coverage started on January 1, 2010. It is a grandfathered plan, as long as your employer has not changed it since March 23, 2010.

Example 2: You buy an individual policy on April 1, 2010. It is a non-grandfathered plan.

Please be sure to ask your agent or your group benefits coordinator if you have any questions about your health plan’s grandfathered status.

What's all the fuss about grandfathering versus non-grandfathering?

Only certain parts of the health care reform law apply to grandfathered plans, and some parts of the law apply differently to group plans than to individual plans.

To help sort things out, here is a chart that lists the provisions that take effect this year. The chart shows if they apply to grandfathered or non-grandfathered group or individual plans. This chart is only a summary, and more details about these parts of the law come after the chart. Please be sure to review all of them for a more complete understanding.

PROVISIONS	Individual Policies		Group Plans	
	Grandfathered	Non-grandfathered	Grandfathered	Non-grandfathered
Dependent coverage to age 26	Yes	Yes	Yes	Yes
Pre-existing conditions coverage for under age 19	No	Yes	Yes	Yes
No lifetime maximum limits for essential benefits	Yes	Yes	Yes	Yes
Restricted annual dollar limits for essential benefits	No*	Yes	Yes	Yes
Preventive care services with no cost-sharing	No	Yes	No	Yes
Revised appeals procedures	No	Yes	No	Yes
Out-of-network emergency services	No	Yes	No	Yes
Choice of primary care provider	No	Yes	No	Yes
Access to OB/GYN care without a referral or prior authorization	No	Yes	No	Yes

* Grandfathered individual policies are exempt from the prohibition on annual limits; so the health care reform law does not restrict annual dollar or non-dollar limits for individual grandfathered policies.

More about health care reform changes

Here's a bit more information about the provisions of health care reform that take effect this year. Just remember — whether these things apply to your specific plan or policy all depends on its grandfathered or non-grandfathered status as outlined on the chart on the previous page.



DEPENDENT COVERAGE TO AGE 26

Health plans will extend coverage to dependents up to age 26 (through age 25). The dependents do not have to be students, and they may be married. (IRS rules for determining dependent status do NOT apply.) There will be a special enrollment period, which will last at least 30 days, for dependents who previously were removed from a parent's plan or policy because they had "aged off." Keep in mind that if your health plan did not previously cover dependents, it is not required to do so now. Also, until 2014, a grandfathered group plan does not have to extend coverage to a dependent eligible for coverage through his or her employer.

PRE-EXISTING CONDITIONS COVERAGE FOR UNDER AGE 19

Health plans may not have pre-existing condition limitations for enrollees up to age 19 (through age 18). For individual policies, health plans may offer a special "open enrollment" period.

NO LIFETIME DOLLAR LIMITS FOR ESSENTIAL BENEFITS

Health plans will no longer have lifetime dollar maximums for essential benefits. If you lost coverage because you met your lifetime maximum, you may be able to receive benefits again, as long as you are still eligible for coverage.

RESTRICTED ANNUAL DOLLAR LIMITS FOR ESSENTIAL BENEFITS

Until 2014, health plans may place restricted annual dollar limits on essential benefit coverage for each member in addition to annual non-dollar limits on some specific services.

PREVENTIVE CARE SERVICES AT NO COST-SHARING

Certain preventive benefits will be included in non-grandfathered plans at no cost-sharing. This means you do not have to pay any copayment, coinsurance or deductible to receive those services. Cost-sharing may apply to the office visit and other services received during the visit. BlueCross and BlueChoice HealthPlan already cover many preventive services at little or no cost-sharing.

REVISED APPEALS PROCEDURES

Health plans must have processes for both internal appeals and external reviews. BlueCross and BlueChoice HealthPlan already have processes in place, but we will update them to comply with the law as needed for non-grandfathered plans.

OUT-OF-NETWORK EMERGENCY SERVICES

Members may go to out-of-network emergency rooms to get care for emergency conditions. Their health plans must offer benefits (member copayments and coinsurance) at the in-network rate. If your plan has a separate out-of-network deductible or out-of-pocket maximum, your health plan can still apply those amounts to the out-of-network services. The out-of-network provider can then balance bill members — the provider can charge you the difference between your bill and what your health plan will pay. BlueCross and BlueChoice HealthPlan already cover emergency out-of-network services at the in-network rate.

CHOICE OF PRIMARY CARE PROVIDER

If your health plan requires or allows you to select a primary care physician, you can choose any provider in the plan's network. You can also choose a pediatrician for your children. BlueChoice HealthPlan has always allowed its HMO members to choose their own primary care physicians and pediatricians from its network, and BlueCross does not require its members to choose a primary care physician.

ACCESS TO OB/GYN CARE WITHOUT REFERRAL OR PRIOR AUTHORIZATION

Your health plan must allow female members to get care from an obstetrician or gynecologist without a referral or preauthorization. Your health plan may still require you or your doctor to seek preapproval for certain services. BlueCross has always allowed this kind of access, and BlueChoice HealthPlan has always allowed its members access to OB/GYNs for routine care.



But wait ... there's more!

The parts of the health care reform law listed in this brochure are only small pieces of the law – the ones that take effect for plan years (or benefit periods) that begin on or after September 23, 2010.

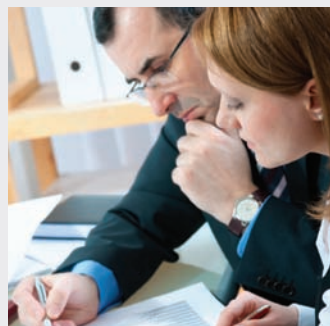
Other parts of the law will take effect beginning in 2011 and on through 2014.

For example, one change that takes effect on January 1, 2011 affects flexible spending accounts (FSAs) and health savings accounts (HSAs).

Starting on January 1, 2011, over-the-counter drugs will no longer be considered eligible expenses for FSA or HSA reimbursement, unless it's insulin or you have a doctor's prescription. This is important to keep in mind when you decide how much to put into these accounts.

Any questions?

Health care reform is bringing many changes to your health care coverage. These changes will be happening over the next several years. If you have an individual policy, please be sure to call your agent to help you understand these changes. If you are a member of a group plan through your employer, ask your benefits coordinator or group administrator. Of course, you can also call the customer service number on the back of your health plan ID card.



Keep in mind that the law is constantly being refined or further defined through rules and regulations. So things may change. One thing won't change, however – BlueCross' ability to adapt to these changes and provide you with the stability and peace of mind you need. That's the value of being a BlueCross or BlueChoice HealthPlan member.

