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Attorney at Law

**MEMORANDUM
2010-19**

**Health Care Reform: Amending Plan Documents
Action Required**

October 1, 2010

As of September 23, 2010, the Health Care Reform Laws (HCR) impose new obligations under the Employee Retirement Income Security Act (ERISA) disclosure rules, while bringing new disclosure obligations to non-ERISA plans through the Public Health Service Act (PHSA) and the Health Insurance Portability and Accountability Act (HIPAA). Plan Sponsors of both private and public agency plans, whether insured or self-funded, must amend their official plan documents to incorporate the September 23, 2010 benefit changes.

The Short Version

Group health plans must comply with the numerous provisions of the Law (as shown below) for plan years beginning on or after September 23, 2010. Since these provisions are substantive, Plan Sponsors must disclose them in their written plan documents pursuant to ERISA Section 402(a) as well as in summary plan descriptions pursuant to ERISA Section 102(b). Plan Sponsors of public agency plans must also comply with various provisions under PHSA and HIPAA, in addition to various state laws.

Provision	Citation	Effective Date	Applicable to Grandfathered Plans?	
			NO	YES
<u>2010</u>				
Dependent coverage for children under age 26	PHSA § 2714; HCERA § 2301	PYB on or after September 23, 2010	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Patient protections (primary care provider designations, ER services, etc.)	PHSA § 2719A	PYB on or after September 23, 2010	<input checked="" type="checkbox"/>	
Preventive health services	PHSA § 2713	PYB on or after September 23, 2010	<input checked="" type="checkbox"/>	
Preexisting Condition Limitation prohibition for those under age 19	PHSA § 2704; PPACA §§ 1255, 10103	PYB on or after September 23, 2010		<input checked="" type="checkbox"/>
Lifetime limits on essential benefits prohibited	PHSA § 2711	PYB on or after September 23, 2010		<input checked="" type="checkbox"/>



Provision	Citation	Effective Date	Applicable to Grandfathered Plans?	
			NO	YES
Annual limits on essential benefits restricted	PHSA § 2711	PYB on or after September 23, 2010 (<i>full prohibition in 2014</i>)		<input checked="" type="checkbox"/>
Prohibition on rescissions	PHSA § 2712	PYB on or after September 23, 2010		<input checked="" type="checkbox"/>
Nondiscrimination for insured plans	PHSA § 2716	PYB on or after September 23, 2010	<input checked="" type="checkbox"/>	
Appeals process	PHSA § 2719	PYB on or after September 23, 2010	<input checked="" type="checkbox"/>	

For purposes of cafeteria plans with spending accounts, Plan Sponsors must amend their cafeteria plans to remove over-the-counter drug benefits as of January 1, 2011. We will circulate a model amendment for this change shortly.

Grandfathered or NOT!

Based on the proposed Interim Final Rules, a Plan Sponsor may lose or keep grandfathered status on a policy-by-policy basis (e.g. Kaiser plan remains grandfathered, but Anthem Blue Cross policy loses grandfathered status). As a convenience, we have drafted three separate sets of amendments and SMMs to accommodate the possible combinations:

- All plans grandfathered;
- All plans not grandfathered; and,
- Mix of grandfathered and non-grandfathered plans.

Notice Requirements

Plan Sponsors must also provide numerous notices directly to plan participants, on or before the beginning of the first plan year on or after September 23, 2010. The governing agencies have developed [model notices](#) for this purpose in most instances. Please refer to our Update 2010-14 for a discussion of these notices. Since the model notice language is significantly different from the plan provisions in the plan documents, Plan Sponsors must comply with the notice requirements separately. For insured plans, it is our assumption that the policy issuers will assist in compliance with the notice requirements. Plan Sponsors of self-funded group health plans must take full responsibility for meeting the notice requirements.

Existing Wraparound Plan Documents

Plan Sponsors can achieve compliance for the health care component plans incorporated in wraparound plan documents by amending their existing wraparound documents and, as applicable, circulating a summary of material modification. We have attached an Amendment for adoption by Plan Sponsors



whose wraparound documents were prepared by our firm, along with a summary of material modification.

Stand Alone Health Plans

To amend stand alone self-funded health plans, a Plan Sponsor may use our model general wraparound plan documents subject to their review by the Sponsor's legal counsel. For insured plans, plan issuers will amend their own policies, as issued to their policyholders.

Model Plan Amendments

To assist Plan Sponsors, we have prepared the following amendments for review by their own counsel and incorporation into plan documents and summary plan descriptions (see links below):

Plan Status	Amendment and Summary Material Modification
1. Documents produced elsewhere and the plan believes all its health plans components are grandfathered	Grandfathered Amendment and SMM
2. Documents produced elsewhere and the plan believes all its health plans components are <u>NOT</u> grandfathered	Non-grandfathered Amendment and SMM
3. Documents produced elsewhere and the plan believes some of its health plans components are grandfathered and some are not grandfathered	Mixed Amendment and SMM

Please feel free to contact us with any questions.

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(PLAN NAME) _____

AMENDMENT NO. _____

Effective Date: _____ *[enter first day of the Plan Year beginning on or after September 23, 2010]*

As of the Effective Date, (Plan Name) _____ is hereby amended to achieve compliance with the Patient Protection and Affordable Care Act (PPACA) and related statutes, as follows:

1. SECTION 1, ESTABLISHMENT AND PURPOSE, is hereby amended to include:

1.6 Patient Protection and Affordable Care Act (PPACA)

Effective as of the first day of the new Plan Year beginning on or after September 23, 2010, the «EMPLOYER_SHORT_NAME» health care plans shall become subject to certain provisions of the Patient Protection and Affordable Care Act (PPACA). This Plan has been written to comply with the relevant provisions of PPACA.

2. The Plan Document is hereby amended to include the following new Section 4:

SECTION 4 – PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA)

4.1 Effective Date

The following provisions in this Section 4 shall take effect as of the first day of the Plan Year beginning on or after September 23, 2010 unless otherwise stated.

4.2 Coverage for Dependents Up to Age 26

Group health plans must make dependent coverage to adult children until they turn age 26. For plan years beginning before January 1, 2014, the mandate applies only if an adult child is not eligible to enroll in some other eligible employer-sponsored group health plan. For plan years beginning on or after January 1, 2014, the mandate to provide coverage for adult children through age 26 will apply to all group health plans, even if the adult child is eligible for coverage under some other employer-sponsored group health plan. Adult children shall include those who are a child of the participant, whether or not they:

- Married or not married;
- Live at home;
- Are a dependent on the employee's tax return; or,
- Are a student.

For Plan Years beginning prior to January 1, 2014, for grandfathered plans only, this mandate applies only if the individual is not eligible to be enrolled in other employer-sponsored group health coverage.

4.3 Lifetime Limit Special Enrollment

As of the first day of Plan Year on or after September 23, 2010, the lifetime limit on the dollar value of benefits under the 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 notice to request enrollment.

4.4 Elimination or Restriction of Annual Limits on Essential Benefits

Annual dollar limits on Essential Health Benefits shall be no less than:

- For plan years beginning on or after September 23, 2010, a minimum annual limit of \$750,000;
- For plan years beginning on or after September 23, 2011, a minimum annual limit of \$1.25 million; and,
- For plan years beginning on or after September 23, 2012 (but before January 1, 2014), a minimum annual limit of \$2 million.

4.5 Essential Health Benefits

The law generally defines Essential Health Benefits to include the following coverage:

- 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, including chronic disease management
- Pediatric services, including oral and vision care

4.6 Prohibition on Preexisting Condition Exclusions (PCEs) for Children under Age 19

Effective as of Plan Years beginning on or after September 23, 2010, group health plans are prohibited from imposing any PCEs on individuals enrolled in the plan who are under 19 years of age (this includes both employees who may themselves be under 19 years of age and their dependents under age 19).

4.7 Prohibition on Rescissions

The health care component plans in this Plan shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this Section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Such plan or coverage may not be cancelled except with prior notice to the enrollee, and only as permitted under Section 2702(c) or Section 2742(b) of PPACA.

[Instructions only (delete this highlighted text in final Amendment: If the plan contains a cafeteria plan component, add the following section 4.8 and renumber the following provisions accordingly)]

4.8 Elimination of Over-the-Counter Drug Purchases

For purposes of the cafeteria plan component, over-the-counter drug purchases are reimbursable only with a doctor's prescription (except insulin) if they are incurred after December 31, 2010.

[Instructions only (delete this highlighted text in final Amendment: The following are variable provisions applicable only to plans with non-grandfathered health plan components. Renumber accordingly.)]

4.8 Patient Protections

Effective for plan years beginning on or after September 23, 2010.

- **Emergency Services.** If a group health plan provides benefits for emergency services, the plan:
 - May not require preauthorization, including for emergency services provided out-of-network;
 - Must provide coverage regardless of whether the provider is in- or out-of-network;
 - May not impose any administrative requirement or coverage limitation that is more restrictive than would be imposed on in-network emergency services; and
 - Any co-payment amount or co-insurance rate cannot be higher for out-of-network services than for co-payment amounts and co-insurance rates imposed on in-network services. Benefits provided for out-of-network emergency must be provided in an amount equal to the greatest of the following three amounts:
 - the median of the amount negotiated with in-network providers for emergency services without regard to co-payments and co-insurance (if no per-service amount is negotiated, such as under a capitation or other similar payment, this amount is disregarded)
 - the amount the plan generally pays for out-of-network services, such as usual, customary and reasonable amount, but without regard to in-network co-payments or co-insurance and without reduction for the plan's usual cost-sharing generally applicable to out-of-network services
 - the amount that would be paid under Medicare Parts A and B, without regard to co-payments and co-insurance.
- **Primary Care Provider Designation.** If this Plan requires or allows Participants to designate primary care providers, or if the Plan automatically designates a primary care provider for a Participant, then the Participant has the right to designate any primary care provider who participates in the Plan's network and who is available to accept the Participant or Participant's family members. For children, the Participant may designate a pediatrician as the primary care provider.
- **Access to Obstetrical or Gynecological Care.** A Participant shall not need prior authorization from the 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 the Plan's network who specializes in obstetrics or gynecology.
- **Access to Pediatric Care.** If the Plan requires or provides for the designation of a participating primary care provider for a dependent child, the Plan shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if such provider participates in the network of the Plan or issuer.

4.9 Preventive Care

Effective for plan years beginning on or after September 23, 2010, group health plans subject to the preventive services coverage mandate must provide coverage for all of the following preventive services without imposing any co-payments, co-insurance, deductibles, or other cost-sharing requirements:

- Evidence-based items or services with an A or B rating recommended by the United States Preventive Services Task Force;
- Immunizations for routine use in children, adolescents, or adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents; and,
- Other evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women.

4.10 Non-discrimination Testing

Effective for Plan Years beginning on or after September 23, 2010, insured group health plans are required to satisfy the nondiscrimination rules of IRC Code §105(h)(2). These rules prohibit discrimination in favor of Highly Compensated Individuals (HCIs). For this purpose, the term “group health plan” does not include certain benefits such as plans providing limited-scope dental or vision benefits under a separate insurance policy or where coverage is elected by participants separately from the medical coverage. Therefore, the nondiscrimination rule will not apply to insured plans that provide these “excepted” benefits.

4.11 Claims Appeal Process

In addition to the claims appeals procedures described in Section 5 of this Plan, a group health plan shall implement an effective appeals process for appeals of coverage determinations and claims, under which the Plan or issuer shall, at a minimum:

- Have in effect an internal claims appeal process;
- Provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman to assist such enrollees with the appeals processes; and
- Allow enrollees to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.

A group health plan shall also:

- Comply with the applicable State external review process for such plans and issuers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans; or,
- Implement an effective external review process that meets minimum standards established by the Secretary through guidance and that is similar to the process as applicable to the internal claims process:
 - if the applicable State has not established an external review process that meets the requirements as applicable to the internal claims process; or
 - if the plan is a self-insured plan that is not subject to State insurance regulation (including a State law that establishes an external review process as applicable to the internal claims process).

[End of variable non-grandfathered provisions sections]

4.12 Continuing Effect of This Section 4

The provisions of PPACA described in this Section 4 shall continue in effect, for the health care component plans contained herein, as modified by further legislation and regulatory guidance.

3. SECTION 5, CLAIMS AND APPEALS PROCEDURES, has been modified to include this additional clause to the first sentence of this Section:

In so far as these procedures are consistent with Section 4 of this Plan, the procedures outlined below must be followed by Covered Persons ("claimants") to obtain payment of benefits under this Plan.

4. Original Sections 4 through 6 have been renumbered accordingly.

All other Plan provisions remain unchanged so long as they are consistent with this Amendment.

In Witness Whereof, the undersigned authorized Representative of (Employer Full Name) hereby adopts this Amendment to the (Plan Name) on this (day) of (month), 201 .

Signature: _____

Printed Name: _____

Title: _____

SUMMARY OF MATERIAL MODIFICATION

To: Participants

From: _____

Re: Amendment to (Plan Name) _____

Effective (Effective Date) _____ *[enter first day of the Plan Year beginning on or after September 23, 2010]*, the (Employer Full Name) _____

has amended its group health plan to achieve compliance with the Patient Protection and Affordable Care Act (PPACA) as follows:

The Summary Plan Description is hereby amended to include the following new provisions:

PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA)

Effective Date

The following provisions in this Section 4 shall take effect as of the first day of the Plan Year beginning on or after September 23, 2010 unless otherwise stated.

Coverage for Dependents Up to Age 26

Group health plans must make dependent coverage to adult children until they turn age 26. For plan years beginning before January 1, 2014, the mandate applies only if an adult child is not eligible to enroll in some other eligible employer-sponsored group health plan. For plan years beginning on or after January 1, 2014, the mandate to provide coverage for adult children through age 26 will apply to all group health plans, even if the adult child is eligible for coverage under some other employer-sponsored group health plan. Adult children shall include those who are a child of the participant, whether or not they:

- Married or not married;
- Live at home;
- Are a dependent on the employee's tax return; or,
- Are a student.

For Plan Years beginning prior to January 1, 2014, for grandfathered plans only, this mandate applies only if the individual is not eligible to be enrolled in other employer-sponsored group health coverage.

Lifetime Limit Special Enrollment

As of the first day of Plan Year on or after September 23, 2010, the lifetime limit on the dollar value of benefits under the 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 notice to request enrollment.

Elimination or Restriction of Annual Limits on Essential Benefits

Annual dollar limits on Essential Health Benefits shall be no less than:

- For plan years beginning on or after September 23, 2010, a minimum annual limit of \$750,000;
- For plan years beginning on or after September 23, 2011, a minimum annual limit of \$1.25 million; and,
- For plan years beginning on or after September 23, 2012 (but before January 1, 2014), a minimum annual limit of \$2 million.

Essential Health Benefits

The law generally defines Essential Health Benefits to include the following coverage:

- 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, including chronic disease management
- Pediatric services, including oral and vision care

Prohibition on Preexisting Condition Exclusions (PCEs) for Children under Age 19

Effective as of Plan Years beginning on or after September 23, 2010, group health plans are prohibited from imposing any PCEs on individuals enrolled in the plan who are under 19 years of age (this includes both employees who may themselves be under 19 years of age and their dependents under age 19).

Prohibition on Rescissions

The health care component plans in this Plan shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this Section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Such plan or coverage may not be cancelled except with prior notice to the enrollee, and only as permitted under Section 2702(c) or Section 2742(b) of PPACA.

[Instructions only (delete this highlighted text in final SMM: if the plan contains a cafeteria plan component, add the following section)]

Elimination of Over-the-Counter Drug Purchases

For purposes of the cafeteria plan component, over-the-counter drug purchases are reimbursable only with a doctor's prescription (except insulin) if they are incurred after December 31, 2010.

[Instructions only (delete this highlighted text in final SMM: the following are variable provisions applicable only to plans with non-grandfathered health plan components.)]

Patient Protections

Effective for plan years beginning on or after September 23, 2010.

- **Emergency Services.** If a group health plan provides benefits for emergency services, the plan:
 - May not require preauthorization, including for emergency services provided out-of-network;
 - Must provide coverage regardless of whether the provider is in- or out-of-network;
 - May not impose any administrative requirement or coverage limitation that is more restrictive than would be imposed on in-network emergency services; and
 - Any co-payment amount or co-insurance rate cannot be higher for out-of-network services than for co-payment amounts and co-insurance rates imposed on in-network services. Benefits provided for out-of-network emergency must be provided in an amount equal to the greatest of the following three amounts:
 - the median of the amount negotiated with in-network providers for emergency services without regard to co-payments and co-insurance (if no per-service amount is negotiated, such as under a capitation or other similar payment, this amount is disregarded)
 - the amount the plan generally pays for out-of-network services, such as usual, customary and reasonable amount, but without regard to in-network co-payments or co-insurance and without reduction for the plan's usual cost-sharing generally applicable to out-of-network services
 - the amount that would be paid under Medicare Parts A and B, without regard to co-payments and co-insurance.
- **Primary Care Provider Designation.** If this Plan requires or allows Participants to designate primary care providers, or if the Plan automatically designates a primary care provider for a Participant, then the Participant has the right to designate any primary care provider who participates in the Plan's network and who is available to accept the Participant or Participant's family members. For children, the Participant may designate a pediatrician as the primary care provider.
- **Access to Obstetrical or Gynecological Care.** A Participant shall not need prior authorization from the 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 the Plan's network who specializes in obstetrics or gynecology.
- **Access to Pediatric Care.** If the Plan requires or provides for the designation of a participating primary care provider for a dependent child, the Plan shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if such provider participates in the network of the Plan or issuer.

Preventive Care

Effective for plan years beginning on or after September 23, 2010, group health plans subject to the preventive services coverage mandate must provide coverage for all of the following preventive services without imposing any co-payments, co-insurance, deductibles, or other cost-sharing requirements:

- Evidence-based items or services with an A or B rating recommended by the United States Preventive Services Task Force;
- Immunizations for routine use in children, adolescents, or adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents; and,

- Other evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women.

Non-discrimination Testing

Effective for Plan Years beginning on or after September 23, 2010, insured group health plans are required to satisfy the nondiscrimination rules of IRC Code §105(h)(2). These rules prohibit discrimination in favor of Highly Compensated Individuals (HCIs). For this purpose, the term “group health plan” does not include certain benefits such as plans providing limited-scope dental or vision benefits under a separate insurance policy or where coverage is elected by participants separately from the medical coverage. Therefore, the nondiscrimination rule will not apply to insured plans that provide these “excepted” benefits.

Claims Appeal Process

In addition to the claims appeals procedures described in Section 5 of this Plan, a group health plan shall implement an effective appeals process for appeals of coverage determinations and claims, under which the Plan or issuer shall, at a minimum:

- Have in effect an internal claims appeal process;
- Provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman to assist such enrollees with the appeals processes; and
- Allow enrollees to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.

A group health plan shall also:

- Comply with the applicable State external review process for such plans and issuers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans; or,
- Implement an effective external review process that meets minimum standards established by the Secretary through guidance and that is similar to the process as applicable to the internal claims process:
 - if the applicable State has not established an external review process that meets the requirements as applicable to the internal claims process; or
 - if the plan is a self-insured plan that is not subject to State insurance regulation (including a State law that establishes an external review process as applicable to the internal claims process).

[End of variable nongrandfathered provisions sections]

1. Claims and Appeals Procedures, has been modified to include this additional clause to the first sentence of this Section:

In so far as these procedures are consistent with this Plan, the procedures outlined below must be followed by Covered Persons (“claimants”) to obtain payment of benefits under this Plan.

All other Plan provisions remain unchanged so long as they are consistent with this modification.

Please keep this Summary of Material Modification with your other group health plan materials, EOC, or Summary Plan Description.

To obtain more information contact (Contact Name) at (Phone Number).

[For General Use – Grandfathered Plans only]
[For Review by Counsel]

(PLAN NAME) _____
AMENDMENT NO. _____

Effective Date: _____ *[enter first day of the Plan Year beginning on or after September 23, 2010]*

As of the Effective Date here above sated, (Company Name/Plan Sponsor) _____ hereby amends the (Plan Name) _____ to achieve compliance with the Patient Protection and Affordable Care Act (PPACA) and related statutes through inclusion of the following new Plan provisions:

1. Patient Protection and Affordable Care Act (PPACA)

Effective as of the first day of the new Plan Year beginning on or after September 23, 2010, the (Company Name/Plan Sponsor) _____ health care plans shall become subject to certain provisions of the Patient Protection and Affordable Care Act (PPACA). This Plan has been written to comply with the relevant provisions of PPACA.

2. Coverage for Dependents Up to Age 26

Group health plans must make dependent coverage to adult children until they turn age 26. For plan years beginning before January 1, 2014, the mandate applies only if an adult child is not eligible to enroll in some other eligible employer-sponsored group health plan. For plan years beginning on or after January 1, 2014, the mandate to provide coverage for adult children through age 26 will apply to all group health plans, even if the adult child is eligible for coverage under some other employer-sponsored group health plan. Adult children shall include those who are a child of the participant, whether or not they:

- Married or not married;
- Live at home;
- Are a dependent on the employee's tax return; or,
- Are a student.

For Plan Years beginning prior to January 1, 2014, for grandfathered plans only, this mandate applies only if the individual is not eligible to be enrolled in other employer-sponsored group health coverage.

3. Lifetime Limit Special Enrollment

As of the first day of Plan Year on or after September 23, 2010, the lifetime limit on the dollar value of benefits under the 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 notice to request enrollment.

4. Elimination or Restriction of Annual Limits on Essential Benefits

Annual dollar limits on Essential Health Benefits shall be no less than:

- For plan years beginning on or after September 23, 2010, a minimum annual limit of \$750,000;

- For plan years beginning on or after September 23, 2011, a minimum annual limit of \$1.25 million; and,
- For plan years beginning on or after September 23, 2012 (but before January 1, 2014), a minimum annual limit of \$2 million.

5. Essential Health Benefits

The law generally defines Essential Health Benefits to include the following coverage:

- 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, including chronic disease management
- Pediatric services, including oral and vision care

6. Prohibition on Preexisting Condition Exclusions (PCEs) for Children under Age 19

Effective as of Plan Years beginning on or after September 23, 2010, group health plans are prohibited from imposing any PCEs on individuals enrolled in the plan who are under 19 years of age (this includes both employees who may themselves be under 19 years of age and their dependents under age 19).

7. Prohibition on Rescissions

The health care component plans in this Plan shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this Section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Such plan or coverage may not be cancelled except with prior notice to the enrollee, and only as permitted under Section 2702(c) or Section 2742(b) of PPACA.

[Instructions only (delete this highlighted text in final amendment: If the plan contains a cafeteria plan component, add the following provision 8 and renumber accordingly)]

8. Elimination of Over-the-Counter Drug Purchases

For purposes of the cafeteria plan component, over-the-counter drug purchases are reimbursable only with a doctor's prescription (except insulin) if they are incurred after December 31, 2010.

SUMMARY OF MATERIAL MODIFICATION

To: Participants

From: _____

Re: Amendment to (Plan Name) _____

Effective (Effective Date) _____ *[enter first day of the Plan Year beginning on or after September 23, 2010]*, the (Employer Full Name) _____

has amended its group health plan to achieve compliance with the Patient Protection and Affordable Care Act (PPACA) as follows:

Patient Protection and Affordable Care Act (PPACA)

Effective as of the first day of the new Plan Year beginning on or after September 23, 2010, the (Company Name/Plan Sponsor) _____ health care plans shall become subject to certain provisions of the Patient Protection and Affordable Care Act (PPACA). This Plan has been written to comply with the relevant provisions of PPACA.

Coverage for Dependents Up to Age 26

Group health plans must make dependent coverage to adult children until they turn age 26. For plan years beginning before January 1, 2014, the mandate applies only if an adult child is not eligible to enroll in some other eligible employer-sponsored group health plan. For plan years beginning on or after January 1, 2014, the mandate to provide coverage for adult children through age 26 will apply to all group health plans, even if the adult child is eligible for coverage under some other employer-sponsored group health plan. Adult children shall include those who are a child of the participant, whether or not they:

- Married or not married;
- Live at home;
- Are a dependent on the employee's tax return; or,
- Are a student.

For Plan Years beginning prior to January 1, 2014, for grandfathered plans only, this mandate applies only if the individual is not eligible to be enrolled in other employer-sponsored group health coverage.

Lifetime Limit Special Enrollment

As of the first day of Plan Year on or after September 23, 2010, the lifetime limit on the dollar value of benefits under the 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 notice to request enrollment.

Elimination or Restriction of Annual Limits on Essential Benefits

Annual dollar limits on Essential Health Benefits shall be no less than:

- For plan years beginning on or after September 23, 2010, a minimum annual limit of \$750,000;
- For plan years beginning on or after September 23, 2011, a minimum annual limit of \$1.25 million; and,
- For plan years beginning on or after September 23, 2012 (but before January 1, 2014), a minimum annual limit of \$2 million.

Essential Health Benefits

The law generally defines Essential Health Benefits to include the following coverage:

- 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, including chronic disease management
- Pediatric services, including oral and vision care

Prohibition on Preexisting Condition Exclusions (PCEs) for Children under Age 19

Effective as of Plan Years beginning on or after September 23, 2010, group health plans are prohibited from imposing any PCEs on individuals enrolled in the plan who are under 19 years of age (this includes both employees who may themselves be under 19 years of age and their dependents under age 19).

Prohibition on Rescissions

The health care component plans in this Plan shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this Section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Such plan or coverage may not be cancelled except with prior notice to the enrollee, and only as permitted under Section 2702(c) or Section 2742(b) of PPACA.

[Instructions only (delete this highlighted text in final SMM: If the plan contains a cafeteria plan component, add the following provision, elimination of over-the-counter drug purchases)]

Elimination of Over-the-Counter Drug Purchases

For purposes of the cafeteria plan component, over-the-counter drug purchases are reimbursable only with a doctor's prescription (except insulin) if they are incurred after December 31, 2010.

Continuing Effect of This Amendment

The provisions of PPACA described in this Amendment shall continue in effect, for the health care component plans contained herein, as modified by further legislation and regulatory guidance.

All other Plan provisions remain unchanged so long as they are consistent with this modification.

Please keep this Summary of Material Modification with your other group health plan materials, EOC, or Summary Plan Description.

To obtain more information contact (Contact Name) at (Phone Number).

(PLAN NAME) _____

AMENDMENT NO. _____

Effective Date: _____ *[enter first day of the Plan Year beginning on or after September 23, 2010]*

As of the Effective Date here above sated, **(Company Name/Plan Sponsor)** _____ hereby amends the **(Plan Name)** _____ to achieve compliance with the Patient Protection and Affordable Care Act (PPACA) and related statutes through inclusion of the following new Plan provisions:

1. Patient Protection and Affordable Care Act (PPACA)

Effective as of the first day of the new Plan Year beginning on or after September 23, 2010, the **(Company Name/Plan Sponsor)** _____ health care plans shall become subject to certain provisions of the Patient Protection and Affordable Care Act (PPACA). This Plan has been written to comply with the relevant provisions of PPACA.

2. Coverage for Dependents Up to Age 26

Group health plans must make dependent coverage to adult children until they turn age 26. For plan years beginning before January 1, 2014, the mandate applies only if an adult child is not eligible to enroll in some other eligible employer-sponsored group health plan. For plan years beginning on or after January 1, 2014, the mandate to provide coverage for adult children through age 26 will apply to all group health plans, even if the adult child is eligible for coverage under some other employer-sponsored group health plan. Adult children shall include those who are a child of the participant, whether or not they:

- Married or not married;
- Live at home;
- Are a dependent on the employee's tax return; or,
- Are a student.

For Plan Years beginning prior to January 1, 2014, for grandfathered plans only, this mandate applies only if the individual is not eligible to be enrolled in other employer-sponsored group health coverage.

3. Lifetime Limit Special Enrollment

As of the first day of Plan Year on or after September 23, 2010, the lifetime limit on the dollar value of benefits under the 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 notice to request enrollment.

4. Elimination or Restriction of Annual Limits on Essential Benefits

Annual dollar limits on Essential Health Benefits shall be no less than:

- For plan years beginning on or after September 23, 2010, a minimum annual limit of \$750,000;

- For plan years beginning on or after September 23, 2011, a minimum annual limit of \$1.25 million; and,
- For plan years beginning on or after September 23, 2012 (but before January 1, 2014), a minimum annual limit of \$2 million.

5. Essential Health Benefits

The law generally defines Essential Health Benefits to include the following coverage:

- 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, including chronic disease management
- Pediatric services, including oral and vision care

6. Prohibition on Preexisting Condition Exclusions (PCEs) for Children under Age 19

Effective as of Plan Years beginning on or after September 23, 2010, group health plans are prohibited from imposing any PCEs on individuals enrolled in the plan who are under 19 years of age (this includes both employees who may themselves be under 19 years of age and their dependents under age 19).

7. Prohibition on Rescissions

The health care component plans in this Plan shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this Section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Such plan or coverage may not be cancelled except with prior notice to the enrollee, and only as permitted under Section 2702(c) or Section 2742(b) of PPACA.

[INSTRUCTIONS ONLY (Delete this highlighted text in final Amendment: If the Plan contains a cafeteria plan component, add the following Provision 8)]

8. Elimination of Over-the-Counter Drug Purchases

For purposes of the cafeteria plan component, over-the-counter drug purchases are reimbursable only with a doctor's prescription (except insulin) if they are incurred after December 31, 2010.

The following provisions shall apply to non-grandfathered component plans only:

1. Patient Protections

Effective for plan years beginning on or after September 23, 2010.

- **Emergency Services.** If a group health plan provides benefits for emergency services, the plan:
 - May not require preauthorization, including for emergency services provided out-of-network;

- Must provide coverage regardless of whether the provider is in- or out-of-network;
- May not impose any administrative requirement or coverage limitation that is more restrictive than would be imposed on in-network emergency services; and
- Any co-payment amount or co-insurance rate cannot be higher for out-of-network services than for co-payment amounts and co-insurance rates imposed on in-network services. Benefits provided for out-of-network emergency must be provided in an amount equal to the greatest of the following three amounts:
 - the median of the amount negotiated with in-network providers for emergency services without regard to co-payments and co-insurance (if no per-service amount is negotiated, such as under a capitation or other similar payment, this amount is disregarded)
 - the amount the plan generally pays for out-of-network services, such as usual, customary and reasonable amount, but without regard to in-network co-payments or co-insurance and without reduction for the plan's usual cost-sharing generally applicable to out-of-network services
 - the amount that would be paid under Medicare Parts A and B, without regard to co-payments and co-insurance.
- **Primary Care Provider Designation.** If this Plan requires or allows Participants to designate primary care providers, or if the Plan automatically designates a primary care provider for a Participant, then the Participant has the right to designate any primary care provider who participates in the Plan's network and who is available to accept the Participant or Participant's family members. For children, the Participant may designate a pediatrician as the primary care provider.
- **Access to Obstetrical or Gynecological Care.** A Participant shall not need prior authorization from the 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 the Plan's network who specializes in obstetrics or gynecology.
- **Access to Pediatric Care.** If the Plan requires or provides for the designation of a participating primary care provider for a dependent child, the Plan shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if such provider participates in the network of the Plan or issuer.

2. Preventive Care

Effective for plan years beginning on or after September 23, 2010, group health plans subject to the preventive services coverage mandate must provide coverage for all of the following preventive services without imposing any co-payments, co-insurance, deductibles, or other cost-sharing requirements:

- Evidence-based items or services with an A or B rating recommended by the United States Preventive Services Task Force;
- Immunizations for routine use in children, adolescents, or adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents; and,
- Other evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women.

3. Non-discrimination Testing

Effective for Plan Years beginning on or after September 23, 2010, insured group health plans are required to satisfy the nondiscrimination rules of IRC Code §105(h)(2). These rules prohibit discrimination in favor of Highly Compensated Individuals (HCIs). For this purpose, the term “group health plan” does not include certain benefits such as plans providing limited-scope dental or vision benefits under a separate insurance policy or where coverage is elected by participants separately from the medical coverage. Therefore, the nondiscrimination rule will not apply to insured plans that provide these “excepted” benefits.

4. Claims Appeal Process

In addition to the claims appeals procedures described in Section 5 of this Plan, a group health plan shall implement an effective appeals process for appeals of coverage determinations and claims, under which the Plan or issuer shall, at a minimum:

- Have in effect an internal claims appeal process;
- Provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman to assist such enrollees with the appeals processes; and
- Allow enrollees to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.

A group health plan shall also:

- Comply with the applicable State external review process for such plans and issuers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans; or,
- Implement an effective external review process that meets minimum standards established by the Secretary through guidance and that is similar to the process as applicable to the internal claims process:
 - if the applicable State has not established an external review process that meets the requirements as applicable to the internal claims process; or
 - if the plan is a self-insured plan that is not subject to State insurance regulation (including a State law that establishes an external review process as applicable to the internal claims process).

5. Continuing Effect of This Amendment

The provisions of PPACA described in this Amendment shall continue in effect, for the health care component plans contained herein, as modified by further legislation and regulatory guidance.

SUMMARY OF MATERIAL MODIFICATION

To: Participants

From: _____

Re: Amendment to (Plan Name) _____

Effective (Effective Date) _____ *[enter first day of the Plan Year beginning on or after September 23, 2010]*, the (Employer Full Name) _____

has amended its group health plan to achieve compliance with the Patient Protection and Affordable Care Act (PPACA) as follows:

Patient Protection and Affordable Care Act (PPACA)

Effective as of the first day of the new Plan Year beginning on or after September 23, 2010, the (Company Name/Plan Sponsor) _____ health care plans shall become subject to certain provisions of the Patient Protection and Affordable Care Act (PPACA). This Plan has been written to comply with the relevant provisions of PPACA.

Coverage for Dependents Up to Age 26

Group health plans must make dependent coverage to adult children until they turn age 26. For plan years beginning before January 1, 2014, the mandate applies only if an adult child is not eligible to enroll in some other eligible employer-sponsored group health plan. For plan years beginning on or after January 1, 2014, the mandate to provide coverage for adult children through age 26 will apply to all group health plans, even if the adult child is eligible for coverage under some other employer-sponsored group health plan. Adult children shall include those who are a child of the participant, whether or not they:

- Married or not married;
- Live at home;
- Are a dependent on the employee's tax return; or,
- Are a student.

For Plan Years beginning prior to January 1, 2014, for grandfathered plans only, this mandate applies only if the individual is not eligible to be enrolled in other employer-sponsored group health coverage.

Lifetime Limit Special Enrollment

As of the first day of Plan Year on or after September 23, 2010, the lifetime limit on the dollar value of benefits under the 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 notice to request enrollment.

Elimination or Restriction of Annual Limits on Essential Benefits

Annual dollar limits on Essential Health Benefits shall be no less than:

- For plan years beginning on or after September 23, 2010, a minimum annual limit of \$750,000;
- For plan years beginning on or after September 23, 2011, a minimum annual limit of \$1.25 million; and,
- For plan years beginning on or after September 23, 2012 (but before January 1, 2014), a minimum annual limit of \$2 million.

Essential Health Benefits

The law generally defines Essential Health Benefits to include the following coverage:

- 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, including chronic disease management
- Pediatric services, including oral and vision care

Prohibition on Preexisting Condition Exclusions (PCEs) for Children under Age 19

Effective as of Plan Years beginning on or after September 23, 2010, group health plans are prohibited from imposing any PCEs on individuals enrolled in the plan who are under 19 years of age (this includes both employees who may themselves be under 19 years of age and their dependents under age 19).

Prohibition on Rescissions

The health care component plans in this Plan shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this Section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Such plan or coverage may not be cancelled except with prior notice to the enrollee, and only as permitted under Section 2702(c) or Section 2742(b) of PPACA.

[INSTRUCTIONS ONLY (DELETE this highlighted text in final SMM: If the Plan contains a cafeteria plan component, add the following Provision, Elimination of Over-the-Counter Drug Purchases)]

Elimination of Over-the-Counter Drug Purchases

For purposes of the cafeteria plan component, over-the-counter drug purchases are reimbursable only with a doctor’s prescription (except insulin) if they are incurred after December 31, 2010.

The following provisions shall apply to non-grandfathered component plans only:

Patient Protections

Effective for plan years beginning on or after September 23, 2010.

- **Emergency Services.** If a group health plan provides benefits for emergency services, the plan:
 - May not require preauthorization, including for emergency services provided out-of-network;
 - Must provide coverage regardless of whether the provider is in- or out-of-network;
 - May not impose any administrative requirement or coverage limitation that is more restrictive than would be imposed on in-network emergency services; and
 - Any co-payment amount or co-insurance rate cannot be higher for out-of-network services than for co-payment amounts and co-insurance rates imposed on in-network services. Benefits provided for out-of-network emergency must be provided in an amount equal to the greatest of the following three amounts:
 - the median of the amount negotiated with in-network providers for emergency services without regard to co-payments and co-insurance (if no per-service amount is negotiated, such as under a capitation or other similar payment, this amount is disregarded)
 - the amount the plan generally pays for out-of-network services, such as usual, customary and reasonable amount, but without regard to in-network co-payments or co-insurance and without reduction for the plan's usual cost-sharing generally applicable to out-of-network services
 - the amount that would be paid under Medicare Parts A and B, without regard to co-payments and co-insurance.
- **Primary Care Provider Designation.** If this Plan requires or allows Participants to designate primary care providers, or if the Plan automatically designates a primary care provider for a Participant, then the Participant has the right to designate any primary care provider who participates in the Plan's network and who is available to accept the Participant or Participant's family members. For children, the Participant may designate a pediatrician as the primary care provider.
- **Access to Obstetrical or Gynecological Care.** A Participant shall not need prior authorization from the 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 the Plan's network who specializes in obstetrics or gynecology.
- **Access to Pediatric Care.** If the Plan requires or provides for the designation of a participating primary care provider for a dependent child, the Plan shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if such provider participates in the network of the Plan or issuer.

Preventive Care

Effective for plan years beginning on or after September 23, 2010, group health plans subject to the preventive services coverage mandate must provide coverage for all of the following preventive services without imposing any co-payments, co-insurance, deductibles, or other cost-sharing requirements:

- Evidence-based items or services with an A or B rating recommended by the United States Preventive Services Task Force;

- Immunizations for routine use in children, adolescents, or adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents; and,
- Other evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women.

Non-discrimination Testing

Effective for Plan Years beginning on or after September 23, 2010, insured group health plans are required to satisfy the nondiscrimination rules of IRC Code §105(h)(2). These rules prohibit discrimination in favor of Highly Compensated Individuals (HCIs). For this purpose, the term “group health plan” does not include certain benefits such as plans providing limited-scope dental or vision benefits under a separate insurance policy or where coverage is elected by participants separately from the medical coverage. Therefore, the nondiscrimination rule will not apply to insured plans that provide these “excepted” benefits.

Claims Appeal Process

In addition to the claims appeals procedures described in Section 5 of this Plan, a group health plan shall implement an effective appeals process for appeals of coverage determinations and claims, under which the Plan or issuer shall, at a minimum:

- Have in effect an internal claims appeal process;
- Provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman to assist such enrollees with the appeals processes; and
- Allow enrollees to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.

A group health plan shall also:

- Comply with the applicable State external review process for such plans and issuers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans; or,
- Implement an effective external review process that meets minimum standards established by the Secretary through guidance and that is similar to the process as applicable to the internal claims process:
 - if the applicable State has not established an external review process that meets the requirements as applicable to the internal claims process; or
 - if the plan is a self-insured plan that is not subject to State insurance regulation (including a State law that establishes an external review process as applicable to the internal claims process).

Continuing Effect of This Amendment

The provisions of PPACA described in this Amendment shall continue in effect, for the health care component plans contained herein, as modified by further legislation and regulatory guidance.

All other Plan provisions remain unchanged so long as they are consistent with this modification.

Please keep this Summary of Material Modification with your other group health plan materials, EOC, or Summary Plan Description.

To obtain more information contact (Contact Name) at (Phone Number).

[For General Use – Non-grandfathered Plans only]
[For Review by Counsel]

(PLAN NAME) _____

AMENDMENT NO. _____

Effective Date: _____ *[enter first day of the Plan Year beginning on or after September 23, 2010]*

As of the Effective Date here above sated, (Company Name/Plan Sponsor) hereby amends the (Plan Name) to achieve compliance with the Patient Protection and Affordable Care Act (PPACA) and related statutes through inclusion of the following new Plan provisions:

1. Patient Protection and Affordable Care Act (PPACA)

Effective as of the first day of the new Plan Year beginning on or after September 23, 2010, the (Company Name/Plan Sponsor) health care plans shall become subject to certain provisions of the Patient Protection and Affordable Care Act (PPACA). This Plan has been written to comply with the relevant provisions of PPACA.

2. Coverage for Dependents Up to Age 26

Group health plans must make dependent coverage to adult children until they turn age 26. For plan years beginning before January 1, 2014, the mandate applies only if an adult child is not eligible to enroll in some other eligible employer-sponsored group health plan. For plan years beginning on or after January 1, 2014, the mandate to provide coverage for adult children through age 26 will apply to all group health plans, even if the adult child is eligible for coverage under some other employer-sponsored group health plan. Adult children shall include those who are a child of the participant, whether or not they:

- Married or not married;
- Live at home;
- Are a dependent on the employee's tax return; or,
- Are a student.

For Plan Years beginning prior to January 1, 2014, for grandfathered plans only, this mandate applies only if the individual is not eligible to be enrolled in other employer-sponsored group health coverage.

3. Lifetime Limit Special Enrollment

As of the first day of Plan Year on or after September 23, 2010, the lifetime limit on the dollar value of benefits under the 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 notice to request enrollment.

4. Elimination or Restriction of Annual Limits on Essential Benefits

Annual dollar limits on Essential Health Benefits shall be no less than:

- For plan years beginning on or after September 23, 2010, a minimum annual limit of \$750,000;

- For plan years beginning on or after September 23, 2011, a minimum annual limit of \$1.25 million; and,
- For plan years beginning on or after September 23, 2012 (but before January 1, 2014), a minimum annual limit of \$2 million.

5. Essential Health Benefits

The law generally defines Essential Health Benefits to include the following coverage:

- 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, including chronic disease management
- Pediatric services, including oral and vision care

6. Prohibition on Preexisting Condition Exclusions (PCEs) for Children under Age 19

Effective as of Plan Years beginning on or after September 23, 2010, group health plans are prohibited from imposing any PCEs on individuals enrolled in the plan who are under 19 years of age (this includes both employees who may themselves be under 19 years of age and their dependents under age 19).

7. Prohibition on Rescissions

The health care component plans in this Plan shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this Section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Such plan or coverage may not be cancelled except with prior notice to the enrollee, and only as permitted under Section 2702(c) or Section 2742(b) of PPACA.

8. Patient Protections

Effective for plan years beginning on or after September 23, 2010.

- **Emergency Services.** If a group health plan provides benefits for emergency services, the plan:
 - May not require preauthorization, including for emergency services provided out-of-network;
 - Must provide coverage regardless of whether the provider is in- or out-of-network;
 - May not impose any administrative requirement or coverage limitation that is more restrictive than would be imposed on in-network emergency services; and
 - Any co-payment amount or co-insurance rate cannot be higher for out-of-network services than for co-payment amounts and co-insurance rates imposed on in-network services. Benefits provided for out-of-network emergency must be provided in an amount equal to the greatest of the following three amounts:
 - the median of the amount negotiated with in-network providers for emergency services without regard to co-payments and co-insurance (if no per-service amount is negotiated, such as under a capitation or other similar payment, this amount is disregarded)

- the amount the plan generally pays for out-of-network services, such as usual, customary and reasonable amount, but without regard to in-network co-payments or co-insurance and without reduction for the plan's usual cost-sharing generally applicable to out-of-network services
 - the amount that would be paid under Medicare Parts A and B, without regard to co-payments and co-insurance.
- **Primary Care Provider Designation.** If this Plan requires or allows Participants to designate primary care providers, or if the Plan automatically designates a primary care provider for a Participant, then the Participant has the right to designate any primary care provider who participates in the Plan's network and who is available to accept the Participant or Participant's family members. For children, the Participant may designate a pediatrician as the primary care provider.
 - **Access to Obstetrical or Gynecological Care.** A Participant shall not need prior authorization from the 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 the Plan's network who specializes in obstetrics or gynecology.
 - **Access to Pediatric Care.** If the Plan requires or provides for the designation of a participating primary care provider for a dependent child, the Plan shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if such provider participates in the network of the Plan or issuer.

9. Preventive Care

Effective for plan years beginning on or after September 23, 2010, group health plans subject to the preventive services coverage mandate must provide coverage for all of the following preventive services without imposing any co-payments, co-insurance, deductibles, or other cost-sharing requirements:

- Evidence-based items or services with an A or B rating recommended by the United States Preventive Services Task Force;
- Immunizations for routine use in children, adolescents, or adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents; and,
- Other evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women.

10. Non-discrimination Testing

Effective for Plan Years beginning on or after September 23, 2010, insured group health plans are required to satisfy the nondiscrimination rules of IRC Code §105(h)(2). These rules prohibit discrimination in favor of Highly Compensated Individuals (HCIs). For this purpose, the term "group health plan" does not include certain benefits such as plans providing limited-scope dental or vision benefits under a separate insurance policy or where coverage is elected by participants separately from the medical coverage. Therefore, the nondiscrimination rule will not apply to insured plans that provide these "excepted" benefits.

11. Claims Appeal Process

In addition to the claims appeals procedures described in Section 5 of this Plan, a group health plan shall implement an effective appeals process for appeals of coverage determinations and claims, under which the Plan or issuer shall, at a minimum:

- Have in effect an internal claims appeal process;
- Provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman to assist such enrollees with the appeals processes; and
- Allow enrollees to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.

A group health plan shall also:

- Comply with the applicable State external review process for such plans and issuers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans; or,
- Implement an effective external review process that meets minimum standards established by the Secretary through guidance and that is similar to the process as applicable to the internal claims process:
 - if the applicable State has not established an external review process that meets the requirements as applicable to the internal claims process; or
 - if the plan is a self-insured plan that is not subject to State insurance regulation (including a State law that establishes an external review process as applicable to the internal claims process.

[Instructions only (delete this highlighted text in final amendment: If the plan contains a cafeteria plan component include Provision 12 below. If it doesn't, delete Provision 12 and renumber accordingly)]

12. Elimination of Over-the-Counter Drug Purchases

For purposes of the cafeteria plan component, over-the-counter drug purchases are reimbursable only with a doctor's prescription (except insulin) if they are incurred after December 31, 2010.

13. Continuing Effect of This Amendment

The provisions of PPACA described in this Amendment shall continue in effect, for the health care component plans contained herein, as modified by further legislation and regulatory guidance.

SUMMARY OF MATERIAL MODIFICATION

To: Participants

From: _____

Re: Amendment to (Plan Name) _____

Effective (Effective Date) _____ *[enter first day of the Plan Year beginning on or after September 23, 2010]*, the (Employer Full Name) _____

has amended its group health plan to achieve compliance with the Patient Protection and Affordable Care Act (PPACA) as follows:

Patient Protection and Affordable Care Act (PPACA)

Effective as of the first day of the new Plan Year beginning on or after September 23, 2010, the (Company Name/Plan Sponsor) _____ health care plans shall become subject to certain provisions of the Patient Protection and Affordable Care Act (PPACA). This Plan has been written to comply with the relevant provisions of PPACA.

Coverage for Dependents Up to Age 26

Group health plans must make dependent coverage to adult children until they turn age 26. For plan years beginning before January 1, 2014, the mandate applies only if an adult child is not eligible to enroll in some other eligible employer-sponsored group health plan. For plan years beginning on or after January 1, 2014, the mandate to provide coverage for adult children through age 26 will apply to all group health plans, even if the adult child is eligible for coverage under some other employer-sponsored group health plan. Adult children shall include those who are a child of the participant, whether or not they:

- Married or not married;
- Live at home;
- Are a dependent on the employee's tax return; or,
- Are a student.

For Plan Years beginning prior to January 1, 2014, for grandfathered plans only, this mandate applies only if the individual is not eligible to be enrolled in other employer-sponsored group health coverage.

Lifetime Limit Special Enrollment

As of the first day of Plan Year on or after September 23, 2010, the lifetime limit on the dollar value of benefits under the 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 notice to request enrollment.

Elimination or Restriction of Annual Limits on Essential Benefits

Annual dollar limits on Essential Health Benefits shall be no less than:

- For plan years beginning on or after September 23, 2010, a minimum annual limit of \$750,000;

- For plan years beginning on or after September 23, 2011, a minimum annual limit of \$1.25 million; and,
- For plan years beginning on or after September 23, 2012 (but before January 1, 2014), a minimum annual limit of \$2 million.

Essential Health Benefits

The law generally defines Essential Health Benefits to include the following coverage:

- 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, including chronic disease management
- Pediatric services, including oral and vision care

Prohibition on Preexisting Condition Exclusions (PCEs) for Children under Age 19

Effective as of Plan Years beginning on or after September 23, 2010, group health plans are prohibited from imposing any PCEs on individuals enrolled in the plan who are under 19 years of age (this includes both employees who may themselves be under 19 years of age and their dependents under age 19).

Prohibition on Rescissions

The health care component plans in this Plan shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this Section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Such plan or coverage may not be cancelled except with prior notice to the enrollee, and only as permitted under Section 2702(c) or Section 2742(b) of PPACA.

Patient Protections

Effective for plan years beginning on or after September 23, 2010.

- **Emergency Services.** If a group health plan provides benefits for emergency services, the plan:
 - May not require preauthorization, including for emergency services provided out-of-network;
 - Must provide coverage regardless of whether the provider is in- or out-of-network;
 - May not impose any administrative requirement or coverage limitation that is more restrictive than would be imposed on in-network emergency services; and
 - Any co-payment amount or co-insurance rate cannot be higher for out-of-network services than for co-payment amounts and co-insurance rates imposed on in-network services. Benefits provided for out-of-network emergency must be provided in an amount equal to the greatest of the following three amounts:
 - the median of the amount negotiated with in-network providers for emergency services without regard to co-payments and co-insurance (if no per-service amount is negotiated, such as under a capitation or other similar payment, this amount is disregarded)

- the amount the plan generally pays for out-of-network services, such as usual, customary and reasonable amount, but without regard to in-network co-payments or co-insurance and without reduction for the plan's usual cost-sharing generally applicable to out-of-network services
 - the amount that would be paid under Medicare Parts A and B, without regard to co-payments and co-insurance.
- **Primary Care Provider Designation.** If this Plan requires or allows Participants to designate primary care providers, or if the Plan automatically designates a primary care provider for a Participant, then the Participant has the right to designate any primary care provider who participates in the Plan's network and who is available to accept the Participant or Participant's family members. For children, the Participant may designate a pediatrician as the primary care provider.
 - **Access to Obstetrical or Gynecological Care.** A Participant shall not need prior authorization from the 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 the Plan's network who specializes in obstetrics or gynecology.
 - **Access to Pediatric Care.** If the Plan requires or provides for the designation of a participating primary care provider for a dependent child, the Plan shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if such provider participates in the network of the Plan or issuer.

Preventive Care

Effective for plan years beginning on or after September 23, 2010, group health plans subject to the preventive services coverage mandate must provide coverage for all of the following preventive services without imposing any co-payments, co-insurance, deductibles, or other cost-sharing requirements:

- Evidence-based items or services with an A or B rating recommended by the United States Preventive Services Task Force;
- Immunizations for routine use in children, adolescents, or adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children, and adolescents; and,
- Other evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women.

Non-discrimination Testing

Effective for Plan Years beginning on or after September 23, 2010, insured group health plans are required to satisfy the nondiscrimination rules of IRC Code §105(h)(2). These rules prohibit discrimination in favor of Highly Compensated Individuals (HCIs). For this purpose, the term "group health plan" does not include certain benefits such as plans providing limited-scope dental or vision benefits under a separate insurance policy or where coverage is elected by participants separately from the medical coverage. Therefore, the nondiscrimination rule will not apply to insured plans that provide these "excepted" benefits.

Claims Appeal Process

In addition to the claims appeals procedures described in Section 5 of this Plan, a group health plan shall implement an effective appeals process for appeals of coverage determinations and claims, under which the Plan or issuer shall, at a minimum:

- Have in effect an internal claims appeal process;
- Provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman to assist such enrollees with the appeals processes; and
- Allow enrollees to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.

A group health plan shall also:

- Comply with the applicable State external review process for such plans and issuers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans; or,
- Implement an effective external review process that meets minimum standards established by the Secretary through guidance and that is similar to the process as applicable to the internal claims process:
 - if the applicable State has not established an external review process that meets the requirements as applicable to the internal claims process; or
 - if the plan is a self-insured plan that is not subject to State insurance regulation (including a State law that establishes an external review process as applicable to the internal claims process).

[INSTRUCTIONS ONLY (DELETE this highlighted text in final SMM: If the Plan contains a cafeteria plan component, add the following Provision, Elimination of Over-the-Counter Drug Purchases)]

Elimination of Over-the-Counter Drug Purchases

For purposes of the cafeteria plan component, over-the-counter drug purchases are reimbursable only with a doctor's prescription (except insulin) if they are incurred after December 31, 2010.

Continuing Effect of This Amendment

The provisions of PPACA described in this Amendment shall continue in effect, for the health care component plans contained herein, as modified by further legislation and regulatory guidance.

All other Plan provisions remain unchanged so long as they are consistent with this modification.

Please keep this Summary of Material Modification with your other group health plan materials, EOC, or Summary Plan Description.

To obtain more information contact (Contact Name) at (Phone Number).