Summit

2016 FEDERAL ANNUAL NOTICES

Women's Health and Cancer Rights Act (WHCRA)
The Women's Health and Cancer Rights Act (WHCRA) provides protections for individuals who elect breast reconstruction after a mastectomy. Under WHCRA, group health plans offering mastectomy coverage must also provide coverage for certain services relating to the mastectomy, in a manner determined in consultation with the attending physician and the patient. Required coverage includes all stages of reconstruction of the other breast to produce a symmetrical appearance, prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Medicaid and the Child Health Insurance (CHIP)
If you are eligible for health coverage from your employer, but are unable to afford the premiums, some states have a premium assistance program that can help pay for coverage. If you or your dependent(s) are **not** currently enrolled in Medicaid or CHIP and you think your dependent(s) might be eligible, you can contact your 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 the State 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 dependent(s) are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit your dependent(s) to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. **You have 60 days to request coverage after it is determined you are eligible for premium assistance.** If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.
Arizona CHIP website: www.azahcccs.gov/applicants/default.aspx
Arizona CHIP telephone: (Outside of Maricopa County): 1-877-764-5437 (Maricopa County): 602-417-5437

Health Insurance Portability and Accountability Act of 1996 (HIPAA) – Privacy Notice
One of the many components of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) is privacy of an individual's Protected Health Information (PHI). The HIPAA privacy rule requires a health plan to remind plan participants no less frequently than once every three years of the availability of its notice of privacy practices as well as how to obtain a copy. The back of this page is a sample Notice of Privacy Practices. Remember, it is the Privacy Practices adopted by your employer that must be distributed to all employees. You can access additional information about the required reminder notice to employees at the Office for Civil Rights website, http://www.hhs.gov/ocr/hipaa and clicking on FAQs, Notice of Privacy Practices.

HIPAA Special Enrollment Rights
If you and/or your dependents lose other group health coverage, or you acquire a dependent, such as, marriage, birth, or adoption, you have special enrollment rights in the employer's group health plan allowing you to enroll dependents during the year other than open enrollment. **You must submit a completed application for enrollment in the health plan to the employer within 31 days of the loss of other coverage or dependent acquisition in order to enroll the dependents. Failure to enroll within 31 days results in waiting until open enrollment.**

Affordability Care Act (ACA) / Health Care Reform Updates

Employer Mandate – For 2015 and after, employers employing at least 100 employees (2016 for employers employing 50-99) will be subject to the Employer Shared Responsibility provisions under the ACA. If these employers do not offer affordable health coverage that provides a minimum level of coverage to their full-time employees (and their dependent children), the employer may be subject to an Employer Shared Responsibility payment. As defined by the statute, a full-time employee is an individual employed on average at least 30 hours of service per service week.

Individual Mandate – Most individuals are required to maintain health coverage or they will pay a federal penalty/tax.

Reporting of Health Insurance Coverage: For the 2015 calendar year, plan sponsors will be required to report information about their health plan along with specific employee information to the IRS. The employer must also provide a written statement to their full-time employees.

Uniform Summary of Benefits Coverage (SBC): Distribution to employees and dependents is required as follows: During the annual open enrollment period; Within 7 days following a request; Under a HIPAA special enrollment, to special enrollees within 7 days of a request for enrollment; With any written application materials distributed prior to an employee enrolling in a plan option; If renewal enrollment is automatic, to employees at least 30 days prior to the renewal date; SBC must be distributed to employees and dependents if they live separately.

Patient-Centered Outcomes Research Institute (PCORI) Fee on Plans: For each plan year ending on or after 10/01/12 and before 10/01/19, the employer is responsible to file Form 720 and remit payment of the fee. The fee is equal to the average number of lives (employees and dependents) covered under the plan, times the applicable dollar amount. For plan years ending on or after 10/01/14 and before 10/01/15, the fee is $2.08; for plans ending on or after 10/1/2015 and before 10/1/2016, the fee is $2.17.

Transitional Reinsurance Program Fee: Beginning 2014, health insurance carriers will be subject to new restrictions on how they price coverage and the conditions under which they provide the insurance. This will result in insurance companies providing insurance to "high-risk" populations and could adversely affect the insurers' financial situation. ACA provides for temporary "reinsurance" payments to insurers who cover the high-risk patients. The payment to the insurers will come from a fee assessed on insurance policies for individual, small and large group markets, and self funded employer plans during the first three years of Exchange (Marketplace) operation, 2014 – 2016. The fee is per capita contribution rate of $63 per member (employees and dependents) for 2014; $44 per member for 2015; the 2016 is $27.00 per member.

In-Network Out-Of-Pocket (OOP) Maximums: Plans issued or renewed beginning January 1, 2016, cannot have In-Network OOP maximums (medical & RX combined) that exceed $6,850 for single coverage or $13,700 for family coverage which includes any deductibles, copays and coinsurance. HDHP maximums cannot exceed $6,550 for single coverage or $13,100 for family coverage.

Automatic Enrollment (Over 200 employees): Employers that have more than 200 full-time employees must automatically enroll employees in the lowest cost plan. *Delayed Until Final Regulations Released.*