FOOTHILL-DE ANZA
Community College District

HEALTH CARE REFORM CHANGES EFFECTIVE JULY 1, 2011

The new Patient Protection and Affordable Care Act (PPACA) passed on March 23, 2010, and as result, Foothill – De Anza Community College District Health plans will implement, as required by law, the following mandated Health Care Reform provisions effective July 1, 2011. You may also reference these mandated Health Care Reform provisions on our Benefits Web site at**:** **http://hr.fhda.edu/benefits/reform** under Important Notice regarding Health Care Reform 2010.

A. EXTENSION OF DEPENDENT COVERAGE UP TO AGE 26

Under the new new Patient Protection and Affordable Care Act (PPACA) requires group health plan to cover dependent children to age 26. If you have dependent child(ren) who have previously lost coverage under the plan due to age, you may now add to your medical, dental and vision plan during open enrollment. Coverage will be effective July 1, 2011. The dependents can remain enrolled until the end of the month of their 2^{6th} birthday regardless of student, residency or marital status. The definition of a dependent under existing law remains unchanged.

NOTE: *Please be advised that copy of social security cards are requested for ALL Dependents to be covered under any of the plans. A birth certificate or legal document will be required to show eligibility as a dependent.*

B. ANNUAL AND LIFETIME DOLLAR LIMITS ON "ESSENTIAL BENEFITS"

The new Patient Protection and Affordable Care Act limits health plans from imposing lifetime and annual dollar limits on "essential benefits". Beginning July 1, 2011, FHDA group health plans will eliminate the lifetime and annual dollars limits on "essential benefits". Individuals whose coverage ended due to lifetime dollar limits are eligible to enroll during open enrollment.

C. PREVENTIVE SERVICES

The new Patient Protection and Affordable Care Act requires group health plan to eliminate cost sharing (deductibles, copayments, coinsurance, etc.) when provider is in network. Preventive care is defined as items or services with an A or B rating by the U.S. Preventive Task Force, immunizations recommended by the CDC, preventive care and screenings for infants, children and adolescents supported by HRSA, and screenings for women supported by Health Resources and Services Administration (HRSA).

D. APPEALS STANDARDS

According to the Patient Protection and Affordable Care Act (PPACA), group health plans and health insurers offering group or individual health insurance coverage must have an effective appeals process for appeals of coverage determinations and claims. This includes notice to enrollees of available appeals process, along with an opportunity to review their file and present evidence. UnitedHealthcare and Kaiser has traditionally provided the enrollee the right to submit information and review their file. Beginning

with plan year July 1, 2011, in addition to the existing appeals standards, enrollees must also be offered an external appeals process, and this shall include the consumer protections in the NAIC Uniform Review Model Act and the minimum standards established by the US Department of Health and Human Services.

E. RULE OF RECISSION

Beginning with the plan year July 1, 2011, FHDA group health Plans and insurers cannot retroactively cancel coverage (rescind) unless there is fraud or a misrepresentation of a material fact as prohibited by the plan or coverage. A rescission for purposes of the health care reform law does *not include* a prospective cancellation of coverage or cancellation of coverage due to failure to pay premiums on a timely basis. A 30 days advance written notice will be provided to the affected insured of the rescission.

F. PRE-EXISTING CONDITIONS EXCLUSIONS FOR AGE UNDER 19

Beginning with the plan year July 1, 2011, FHDA group health plans cannot apply pre-existing condition limitations to enrollees *who are under 19 years of age*. The definition of pre-existing exclusion under the Patient Protection and Affordable Care Act (PPACA) includes a complete exclusion of coverage under the plan based on a preexisting condition. Pre-existing condition limitations will continue to apply to enrollees age 19 and older.

F. COVERAGE OF EMERGENCY SERVICES:

Prior authorization is no longer required for emergency services. If the emergency care is provided out of network, the plan cannot impose any coverage limit or other requirement that is more restrictive requirements that apply to in-network care. In addition, cost sharing requirement such as copay and coinsurance for out-of-network emergency services cannot be greater than the cost sharing requirement for in-network emergency care.