Health Insurance

Changes Effective September 23, 2010

For many men and their families, September 23, 2010 ushered in a few important changes to health insurance law. Men's Health Network (MHN), urges men and women to read through the following changes, understand how they may apply to them, and take appropriate action to help themselves and their families.

Young Adult Coverage on Parents' Policy Up to 26 Years of Age*

Parents, if your plan covers children, you can now add or keep your children on your health insurance policy until they turn 26 years old. Your plan is required to provide a 30-day period—no later than the first day of your plan's next "plan year" or "policy year" that begins on or after September 23, 2010—to allow you to enroll your adult child. Your plan must notify you of this enrollment opportunity in writing. If you enroll your adult child during this 30-day enrollment period, your plan must cover your adult child from the first day of that plan year or policy year.

Sons and daughters please approach your parents and notify them of this new provision. Health plans must be notified in writing of your parents' desire to add you to their health insurance. Staying on your parents' health insurance will help you with your expenses.

Coverage for Children with Preexisting Conditions*

Parents, health plans cannot limit or deny benefits or deny coverage for a child younger than age 19 simply because the child has a "pre-existing condition." A pre-existing condition is a health problem that developed before the child applied to join the plan. The rule will affect your plan as soon as it begins a "plan year" or "policy year" on or after September 23, 2010. If your child has a pre-existing condition and was not on your insurance before, make sure to add your child to your plan during the next open enrollment period through your employer or the next time your purchase individual insurance.

Free Preventive Care Coverage for You and Your Family*

You and/or your family may be eligible for some important preventive services, which can help you avoid illness and improve your health, at no additional cost. **To know which covered preventive services are right for you and your family based on age, gender, and health status, ask your health care provider.**

If your plan is subject to these new requirements, you would not have to pay a copayment, co-insurance, or any deductible to receive preventive health services, such as recommended screenings, vaccinations, and counseling.

If your health plan uses a network of providers, be aware that health plans are only required to provide these preventive services through an in-network provider. Your

health plan may allow you to receive these services from an out-of-network provider, but may charge you a fee.

Your doctor may provide a preventive service, such as a cholesterol screening test, as part of an office visit. Be aware that your plan can require you to pay some costs of the office visit, if the preventive service is not the primary purpose of the visit, or if your doctor bills you for the preventive services separately from the office visit.

Preventive coverage varies from state to state. If you have questions about whether these new provisions apply to your plan, contact your insurer or plan administrator. If you still have questions, contact your State insurance department (http://www.naic.org/state_web_map.htm).

This preventive services provision applies to people enrolled in job-related health plans or individual health insurance policies created after March 23, 2010. If you are in such a health plan, this provision will affect you as soon as your plan begins its first new “plan year” or “policy year” on or after September 23, 2010.

Coverage Cannot Be Canceled “After the Fact” if You Made An Honest Mistake on Your Insurance Application

Previously, if your insurance company found that you’d made a mistake on your insurance application, the insurance company might declare your policy invalid from the day it began. Your insurance company might also ask you to pay back any money already spent for your medical care.

As of September 23, 2010, an insurer cannot declare your policy invalid simply because you made an honest mistake or left out information that has little bearing on your health. Your insurance company can still declare your coverage invalid if you intentionally put false or incomplete information on your insurance application, and it can cancel your coverage if you fail to pay your premiums on time. However, your insurance company must give you at least 30-days notice before it can declare your coverage invalid. During that time you may be able to appeal the decision or find new coverage.

This provision applies to “plan years” or “policy years” that begin on or after September 23, 2010. To find out when your plan year or policy year begins, ask your insurer or plan administrator.

Doctor and Emergency Room (ER) Choice and Access*

The new rules permit you to choose any available participating primary care provider as your doctor and to choose any available participating pediatrician as your child’s primary care doctor. The new rules also prohibit health plans from requiring a referral from a primary care provider before your family can seek coverage for obstetrical or gynecological (OB-GYN) care from a participating OB-GYN specialist.

In an emergency, emergency rooms will be treated as equal options under your health plan and you will not need to seek approval or be penalized for using particular emergency rooms. You still may be responsible for the difference between the amount

billed by the provider for out-of-network emergency room services and the amount paid by your health plan.

If your health plan or health insurance policy was created or issued after March 23, 2010, your plan will be affected as soon as it begins a new “plan year” or “policy year” on or after September 23, 2010.

Elimination of Limits on Benefits*
Lifetime limits on most benefits are prohibited in any health plan or insurance policy issued or renewed on or after September 23, 2010.If the new rules apply to your plan, they will affect you as soon as you begin a new plan year or policy year on or after September 23, 2010. (For example, if your policy has a calendar plan year, the new rules would apply to your coverage beginning January 1, 2011.)

The new law restricts and phases out the annual dollar limits that all job-related plans, and those individual health insurance plans issued after March 23, 2010, can put on most covered health benefits. Specifically, the law says that none of these plans can set an annual dollar limit lower than:

- $750,000—for a “plan year” or “policy year” starting on or after September 23, 2010 but before September 23, 2011.

- $1.25 million—for a plan year or policy year starting on or after September 23, 2011 but before September 23, 2012.

- $2 million—for a plan year or policy year starting on or after September 23, 2012 but before January 1, 2014.

Some plans may be eligible for a waiver from the rules concerning annual dollar limits, if complying with the limit would mean a significant decrease in your benefits coverage or a significant increase in your premiums.

* The new rule doesn’t apply to “grandfathered” individual health insurance policies. A grandfathered individual health insurance policy is a policy that you bought for yourself or your family (and is not a job-related health plan) on or before March 23, 2010 (the date that the new law was passed).

For more information please visit www.healthcare.gov .