



Patient Protection and Affordability Care Act (PPACA) Insured Benefit Change Notification

This is a notification of changes to your current health benefit plan, effective on your renewal date.

The Patient Protection and Affordable Care Act of 2010 (PPACA) was signed into law on March 23, 2010. PPACA will have significant impact on employer-sponsored group health plans and individual/family consumer policies. This document is specific to the provisions related to annual and lifetime maximums, essential health benefits, dependent eligibility age to 26, pre-existing condition exclusion elimination for individuals up to age 19. For non-grandfathered plans only, this document also covers preventive health services.

Annual and Lifetime Maximums

PPACA prohibits annual and lifetime dollar limits on essential health benefits. As required by PPACA, annual and lifetime dollar limits on essential health benefits will be removed on plan anniversary dates beginning on and after September 23, 2010. In some instances day/visit limits may be applied.

Essential Health Benefits

Section 1302(b) of PPACA defines essential health benefits to include at least the following general categories and the items and services covered within the categories:

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

Benefit Changes

The benefit changes shown in this chart will apply to all BCBSIL insured and self-funded standard product health plans on each plan's renewal date occurring on or after September 23, 2010. Contract and benefit booklets will be modified accordingly.

- All existing lifetime maximums will be removed on all essential health benefits.
- Existing annual dollar maximums will be removed from the following essential health benefits and, where indicated, replaced with a visit or day maximum.

Benefit	Non-HMO Administration	HMO Administration
Autism Spectrum Disorder	Dollar maximum can only apply to ABA Providers and services: Dollar maximum: \$36,000	Dollar maximum can only apply to ABA providers and services. Dollar maximum: \$36,000
Chiropractor providing medical services	Osteopathic Manipulation/ Spinal Adjustments \$1,000 per calendar/benefit year	No change from current benefit
Occupational therapy	Unlimited number of visits per calendar/benefit year	No change from current benefit
Physical Therapy	Unlimited number of visits per calendar/benefit year	No change from current benefit
Speech Therapy	Unlimited number of visits per calendar/benefit year	No change from current benefit
Private Duty Nursing	Unlimited number of visits per calendar/benefit year	No change from current benefit
TMJ	No dollar maximum	No change from current benefit

Eligibility

For Insured health plans, the eligibility age for dependents is up to age 26, and up to age 30 if active military, as of May 1, 2010.

Benefit	PPACA Benefit
Dependent Age	Eligible dependent children to age 26 (30 military) will be covered regardless of marital, student or employee status
Dependent Age End Date	Coverage ends at the end of the month of the birth date
Pre-Existing Condition Exclusion	Pre-existing condition exclusion waived for employee and spouse up to age 19 and dependent children up to age 26. Pre-existing condition exclusion will apply to employees and spouses age 19 and over.

Preventive Health Services (Applies to non-grandfathered health plans only)

Benefits will be provided for the following Covered Services and will not be subject to a coinsurance, deductible, copayment or benefit maximum when using in-network providers. Benefits for services provided by out-of-network providers will be subject to the coinsurance, deductible and copayment of the health plan.

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF);
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
- 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;
- Additional preventive care and screenings provided for in comprehensive guidelines supported by the HRSA;
- For purposes of this benefit, the current recommendations of the USPSTF regarding breast cancer screening mammography and prevention will be considered the most current (other than those issued around November 2009).

- Health Education & Counseling Services
- Immunizations
- Preventive Care Services
- Routine Bone Density Test
- Routine Breast Exam
- Routine Colonoscopy
- Routine Colorectal Cancer Screening
- Routine Digital Rectal Exam
- Routine Gynecological Exam
- Routine Lab Procedures
- Routine Mammogram
- Routine Pap Smear
- Routine Physical
- Routine Prostate Test
- Smoking Cessation (Counseling Services)
- Well Baby Exam

Disclaimer

The information and elections provided in this document should not be construed as legal advice for implementation of the Patient Protection and Affordable Care Act. Agencies of the federal and state governments (e.g., HHS and the Illinois Department of Insurance) are expected to issue regulations or other directives to implement the new law. If those regulations or directives require that we make changes to our policies or products, BCBSIL will make the changes to comply with the law. Penalties may be assessed for non-compliance. The Plan Sponsor retains the final authority and responsibility to establish the terms and conditions of the group health plan and is encouraged to seek legal counsel with any questions concerning compliance with this federal law.