

Federal Patient Protection and Affordable Care Act (ACA) Update and Related Notifications ~ December 2013

Charlotte Public Schools

The Federal Patient Protection and Affordable Care Act (ACA) mandates that employers provide accessible and affordable health care to their employees. Some of the regulations have already taken effect, while more will be implemented in the coming months and years. You will find several related pieces of information below and in the following pages that pertain to this new federal legislation. We are providing you this information in order to keep you updated on the changes that may impact you and/or your family. We will continue to provide you updates as further clarification is provided or changes come forth.

Coverage up to Age 26

Beginning in 2014, children up to age 26 may stay on their parent's employer insurance plan even if they have another offer of coverage through an employer, regardless of financial dependency, marital status, enrollment in school, residency, or other factors. Please refer to the insurance plan document for additional information.

HIPAA Special Enrollment Periods

Loss of Other Coverage

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing to the other coverage). However, you must request enrollment within 30 days after the other coverage ends (or after the employer stops contributing to the other coverage).

New Dependent

If you gain a new dependent as the result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that enrollment is requested within 30 days after the marriage, birth, adoption, or placement for adoption.

Automatic Enrollment

If you are a full-time employee health care reform law may require your employer to automatically enroll you for health care coverage. You will be notified of your enrollment and will have the right to opt-out of coverage by following instructions your employer will provide to you.

Children's Health Insurance Program and Medicaid Eligibility Changes

If you or your dependents are eligible for medical coverage in this Plan but are not enrolled, you have 60 days to enroll in the Plan in the following two circumstances:

- If you or your eligible dependents' Medicaid coverage or coverage under the state Children's Health Insurance Program (CHIP) is terminated due to loss of eligibility; or
- If you or your dependents become eligible for a premium assistance program in the state in which you reside.

Medicare Withholding Changes

Beginning January 1, 2013, the ACA increased the Medicare Part A tax withholding rate on wages, other compensation, and other self-employment income from 1.45 percent to 2.35 percent for individuals earning over \$200,000 and couples earning over \$250,000 per year, and imposes additional assessment on unearned income. While CPS does not have an individual employee over \$200,000 in earned income from the District you may find that this new ruling impacts your family's tax status.

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Notice of Women's Health and Cancer Rights Act

This Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides group health benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema (swelling caused by the removal of lymph nodes). Coverage for breast reconstruction and related services will be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the Plan.

Newborns and Mothers Health Protection Notice

Group health plans generally may not, under federal law, restrict benefits for any hospital length of stay for the mother or newborn child in connection with childbirth to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending health care provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours, if applicable). In any case, the Health Plan will not require a provider to obtain authorization from the Health Plan for prescribing a length of stay of 48 hours (or 96 hours, if applicable) or less.

Notice of Eligibility for Health Plan Related to Military Leave

If you take a military leave, the Uniformed Services Employment and Reemployment Rights Act (USERRA) provides the following rights:

- If you take a leave from your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage at your cost for you and your dependents for up to 24 months during your military service.
- If you don't elect to continue coverage during your military service, you have the right to be reinstated in the Plan when you are reemployed, without any additional waiting period or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

The Plan Administrator can provide you with information about how to elect continuation coverage under USERRA.

Patient Protection Notices

If the Plan provides for or requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator.

If you have a health emergency, you can go to any emergency room. You don't need to get approval from the plan first – even if the emergency room isn't in your plan's network. However, we do require you or your doctor to notify us of your visit after you go to the emergency room.

Your plan covers both in-network and out-of-network emergency services. Your out-of-pocket costs are the same, but you may pay more for out-of-network care in other ways. For example, an out-of-network provider is allowed to bill you for some things that in-network providers can't bill you for.

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W-2 Reporting

The health care reform law requires some employers to report the cost of employer sponsored group health coverage. You may see this reported in Box 12 of your W-2 form. This is an employer reporting requirement only and it won't have an impact on your taxable income or require you to report it on your personal income taxes.

Health Insurance Exchange

Beginning in 2014, state/federal-run programs called "health insurance exchanges" will allow individuals and qualified small employers to comparison-shop for health insurance online. Plans in the exchange will have standard levels of benefits – for example, a "gold" plan will have certain features and a "silver" plan will have certain features. Subsidies will be available to low-income people and small businesses that buy insurance through an exchange.

HIPAA Notice to Privacy Practices

Your employer is committed to maintaining the privacy of protected health information for participants in the Plan. This is a reminder that in compliance with the privacy rules under the Health Insurance Portability and Accountability Act (HIPAA) a Notice of Privacy Practices is available to employees. This notice of Privacy Practices explains participants' rights and the Plan's legal duties with respect to protected health information (PHI) and how the Plan may use and disclose PHI. To obtain a copy or for further information regarding the issues covered by this Notice of Privacy Practices, please contact the Plan Administrator.

Notice of Right to Receive A Certificate of Creditable Coverage

The Health Insurance Portability and Accountability Act (HIPAA) was enacted to help you maintain your health coverage when you need to change jobs. If you lose coverage under the Plan, the Plan will provide you with a certificate that shows how long you had coverage under the Plan. This is your "creditable coverage." Using this certificate of creditable coverage, you will be able to reduce or eliminate any pre-existing condition exclusion imposed by a new employer plan or group insurance policy. You will automatically receive a certificate:

- When you become a qualified beneficiary entitled to elect COBRA coverage.
- When you lose medical coverage, even though you are not entitled to elect COBRA coverage.
- When your COBRA continuation coverage ends.

You may also request a certificate at any time or within 24 months after your medical coverage ends.

Plan Administration Contact Information

For more information about any of the notices contained herein, or any of your rights under the Plan, please contact the Human Resources office at: (517) 541-5103.