



TABLE A: KEY CHANGES THAT ARE EFFECTIVE FOR ALL PLAN YEARS ON OR AFTER OCTOBER 1, 2010

CHANGE REQUIRED	WHAT DOES IT MEAN?
<p>Lifetime and Annual Limits</p>	<ul style="list-style-type: none"> ▪ Lifetime Limits – Plans may not impose lifetime dollar limits on benefits offered. ▪ Annual Limits – Until 2014, plans may be able to impose restricted annual dollar limits on Essential Benefits but only as determined by the Department of Health and Human Services (HHS).* After 2014, no annual dollar limits may be imposed. <p>Essential Benefits consist of:</p> <ul style="list-style-type: none"> • Ambulatory and emergency services. • Prescription drugs. • Hospitalization. • Maternity and newborn care; pediatric care, including oral/vision. • Mental health and substance abuse services. • Preventive and wellness services. • Laboratory services. • Rehabilitative and habilitative services and devices. <p><i>* Although guidance has not yet been provided, we currently do not believe HHS will allow plans to impose annual limits on treatment for life-threatening and/or potentially life threatening injury or illness.</i></p>
<p>Coverage of Adult Children</p>	<p>Until 2014, plans that provide dependent coverage must provide coverage of their adult children (regardless of marital status*) until such child reaches age 26 but only if such adult child is not covered under another employer sponsored plan.</p> <ul style="list-style-type: none"> • There is no requirement to cover children of covered dependent children. • Individuals will be allowed to exclude amounts expended for medical care for children under the age 27 from their gross income on their personal tax filings. <p><i>*Marital status requirement was changed by the Reconciliation Bill. Beginning in 2014, this provision will apply even if the dependent child is eligible for other employer sponsored group coverage.</i></p>

CHANGE REQUIRED	WHAT DOES IT MEAN?
<p>Children's Pre-Existing Exclusions</p>	<p>Plans may not impose any pre-existing condition exclusions or limitations on children under age 19.</p> <p><i>*Beginning in 2014, plans may not impose any pre-existing condition exclusions or limitations regardless of age.</i></p>
<p>Uniform Summary of Benefits*</p> <p><i>*Although this is listed as an immediate change, the standards for this new summary have not yet been published and are not expected until early 2011. Following publication of these standards, plans will have another 12 months to begin distributing these new summaries to their participants.</i></p>	<p>Within 24 months of the enactment, plans will be required to deliver a new 4 page summary of benefits to all applicants and enrollees. This summary will be in addition to SPD's otherwise already required by ERISA. The Secretary of HHS will develop standards for this summary that will include mandated font, writing style, certain mandated content related to covered benefits and cost sharing.</p>

TABLE B: KEY CHANGES THAT ARE EFFECTIVE FOR ALL PLAN YEARS ON OR AFTER JANUARY 2014

CHANGE REQUIRED	WHAT DOES IT MEAN?
Adult Pre-Existing Condition Exclusions	Plans may not impose ANY pre-existing condition exclusions or limitations.
Limitations on Waiting Periods	Plans may not impose waiting periods in excess of 90 days.
Coverage of Adult Children	<p>Plans that provide dependent coverage must provide coverage of their adult children (regardless of either marital status or the fact that such dependent child is eligible for other employer sponsored group coverage*) until such child reaches age 26.</p> <ul style="list-style-type: none"> • There is no requirement to cover children of covered dependent children. • Individuals will be allowed to exclude amounts expended for medical care for children under the age 27 from their gross income on their personal tax filings. <p><i>*Marital status requirement was changed by the Reconciliation Bill.</i></p>
Annual Limits Prohibited	Plans may not impose annual dollar limits on benefits offered, including non-essential benefits.
Automatic Member Enrollment	Employers with 200 or more full-time employees must auto-enroll all new and existing employees in a benefit plan option annually and provide for an opt-out.
Shared Responsibility for Employers (“Employer Mandate”)	Employers with over 50 full-time equivalent (FTE) employees that do not offer health care coverage will be required to pay a per FTE penalty. FTE is defined as any employee who works 30 hours or more.
Individual Responsibility (“Individual Mandate”)	All taxpaying individuals will be required to maintain a minimum level of essential health care coverage or pay a penalty. Participation in employer sponsored coverage satisfies the individual mandate.

CHANGE REQUIRED	WHAT DOES IT MEAN?
Notification of Availability of Exchanges; Premium Subsidies and Free Choice Vouchers	<p>All new employees must be notified of the existence of the state exchange as well as the potential availability of premium subsidies for employees with household incomes below 400% of the federal poverty level (a “Qualified Employee”). Employers will also have to offer such Qualified Employees vouchers equal to the employer health plan contribution which would be used by such Qualified Employee to buy coverage through the state-based exchange.</p>
Tax on High Cost Coverage (“The Cadillac Tax”)	<p>Beginning in 2018*, a non-deductible 40% excise tax will be imposed on the monthly value of plan coverage over certain thresholds.</p> <p><i>*The effective date for this tax was delayed by the Reconciliation Bill.</i></p>

TABLE C: SOME OTHER NOTEWORTHY CHANGES AND THEIR EFFECTIVE DATES

CHANGE REQUIRED	WHAT DOES IT MEAN?
Over-the-Counter Reimbursements	Beginning January 1, 2011, over-the-counter medicines and drugs will no longer be eligible for reimbursement under an FSA, HRA or HSA without a doctor's prescription.
New Tax on Higher Income Individuals	Beginning January 1, 2013, an additional payroll tax of 0.9% for individual wages over \$200,000 and \$250,000 for couples for both employers and employees has been added. This tax goes into effect January 1, 2013.
Change to FSA Cap	Beginning January 1, 2013, health FSA salary reductions are limited to \$2,500/year, indexed for inflation in future years.* <i>*This date was changed from 1/1/11 as part of the Reconciliation Bill.</i>
Repeal of Deduction for Certain Retiree Prescription Drug Plans	Beginning January 1, 2013, employers who maintain prescription drug plans for their Medicare Part D eligible retirees will no longer be able to deduct these expenses.

TABLE D: KEY CHANGES THAT GRANDFATHERED PLANS ARE PERMANENTLY EXEMPT FROM COMPLYING WITH

CHANGE REQUIRED	WHAT DOES IT MEAN?
Preventive Care Coverage	Plans must provide first dollar coverage (no cost sharing with member) for certain preventive health services (such as well child care and immunizations).
Cost Sharing Limitations	Limitations will be placed on out-of-pocket maximums and deductibles
Appeals Process	All Plans (ERISA and Non-ERISA) must establish an HHS mandated appeals process that provides for an external review process.
Ensuring Coverage for Individuals Participating in Clinical Trials.	Prohibits new health plans from dropping coverage because an individual chooses to participate in a clinical trial, and from denying coverage for routine care they would otherwise provide because an individual is enrolled in a clinical trial. Does not require coverage by the plan of the clinical trial. Applies to all clinical trials that treat cancer or other life-threatening diseases.
Referral Requirements	Plans will be precluded from requiring prior authorization or increased cost-sharing for emergency services, whether provided by in-network or out-of-network providers. Plans are precluded from requiring authorization or referral by the plan for a female patient who seeks coverage for obstetrical or gynecological care by a specialist in these areas.