



BlueCross BlueShield of Texas

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Dear Group Administrator,

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires employers to notify all eligible employees of two important provisions in their health care plans:

The first is the employees' right to enroll in the plan under the "special enrollment provision" as the result of acquiring new dependents.

The second is to advise employees of the plan's pre-existing condition exclusion rules that may temporarily exclude coverage for certain pre-existing conditions that they, or members of their families, may have.

In addition, new language has also been added to this notice (in compliance with other federal mandates) to advise all eligible employees of their right to enroll children under the age of 26, and (under certain plans) to designate a primary care provider.

Please copy and distribute the enclosed *Initial Notice about Special Enrollment Rights and Pre-existing Condition Exclusion Rules in Your Group Health Plan* and *Additional Notices* directly to all of your employees as soon as possible.

NOTE: This notice must also be given to each new employee prior to his or her enrollment in, or declination, of health coverage, and must be redistributed each year at open enrollment.

Thank you in advance for your assistance in meeting this federal requirement.



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Important Notices

I. Initial Notice About Special Enrollment Rights and Pre-existing Condition Exclusion Rules in Your Group Health Plan

A federal law called Health Insurance Portability and Accountability Act (HIPAA) requires that we notify you about two very important provisions in the plan. The first is your right to enroll in the plan under its “special enrollment provision” without being considered a late applicant if you acquire a new dependent or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons. Second, this notice advises you of the plan’s pre-existing condition exclusion rules that may temporarily exclude coverage for certain pre-existing conditions that you or a member of your family may have. Section I of this notice may not apply to certain self-insured, non-federal governmental plans. Contact your employer or plan administrator for more information.

A. SPECIAL ENROLLMENT PROVISIONS

Loss of Other Coverage (Excluding Medicaid or a State Children’s Health Insurance Program) If you are declining enrollment for yourself or your eligible dependents (including your spouse) because of other health insurance or group health plan 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 you move out of an HMO service area, or the employer stops contributing toward your or your dependents’ other coverage). However, you must request enrollment within 31 days after your or your dependents’ other coverage ends (or move out of the prior plan’s HMO service area, or after the employer stops contributing toward the other coverage).

Loss of Coverage For Medicaid or a State Children’s Health Insurance Program

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children’s health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents’ coverage ends under Medicaid or a state children’s health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for State Premium Assistance for Enrollees of Medicaid or a State Children’s Health Insurance Program

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children’s health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents’ determination of eligibility for such assistance.

You or your spouse or dependents may also have special enrollment rights in another group health plan at the time a claim is denied as a result of a lifetime limit on all benefits, if you request enrollment within 30 days after the claim has been denied.

To request special enrollment or obtain more information, call Customer Service at the phone number on the back of your Blue Cross and Blue Shield ID card.

B. PRE-EXISTING CONDITION EXCLUSION RULES

Most health plans impose pre-existing condition exclusions. This means that if you have a medical condition before coming to our plan you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period before your enrollment date. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. "Waiting period" generally refers to a delay between the first day of employment and the first day of coverage under the plan. The pre-existing condition exclusion does not apply to pregnancy or to an individual under the age of 19.

This pre-existing condition exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days you had prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, you have a right to request one from your prior plan or issuers. We will help you obtain one from your prior plan or issuer, if necessary. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

For more information about the pre-existing condition exclusion and creditable coverage rules affecting your plan, call Customer Service at the phone number on the back of your Blue Cross and Blue Shield ID card.

II. Additional Notices

Other federal laws require we notify you of additional provisions of your plan.

A. ENROLLMENT NOTICE FOR ADULT CHILDREN UNDER AGE 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the plan. Individuals may request enrollment for such children during an enrollment period that continues for at least 30 days, beginning not later than the first day of the first plan year beginning on or after September 23, 2010. If an individual is timely enrolled, enrollment will be effective retroactively to the first day of the first plan year, beginning on or after September 23, 2010. For more information, call Customer Service at the phone number on the back of your Blue Cross and Blue Shield ID card.

Special Rule for grandfathered group health plans – The plan may exclude an adult child who has not obtained age 26 from coverage only if the adult child is eligible to enroll in an eligible employer-sponsored health plan other than a group health plan of a parent.

B. NOTICES OF RIGHT TO DESIGNATE A PRIMARY CARE PROVIDER (FOR NON-GRANDFATHERED HEALTH PLANS ONLY)

For plans that require or allow for the designation of primary care providers by participants or beneficiaries:

If the plan generally requires or allows 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, call Customer Service at the phone number on the back of your Blue Cross and Blue Shield ID card.

For plans that require or allow for the designation of a primary care provider for a child: For children, you may designate a pediatrician as the primary care provider.

For plans that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a 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 obstetrical or gynecological care from 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, call Customer Service at the phone number on the back of your Blue Cross and Blue Shield ID card.