

LGC HEALTHTRUST
HEALTHCARE REFORM - SUMMARY OF MEDICAL COVERAGE AND ELIGIBILITY CHANGES

Effective 1/1/2011 for January Renewal Groups and 7/1/2011 for July Renewal Groups
Applies to All Non-Medicomp Medical Plans

Benefit Changes for Non-Grandfathered Plans with Member Cost Share for Preventive Care and Benefit Maximums or Limits as Outlined Below:

Benefit	Current	Changes for 2011
Preventive Care* Routine Physical Exams, including OBGYN Routine Vision Exams*** Routine Hearing Exams Nutrition Counseling	You pay your office visit copay, coinsurance or deductible (if applicable). Three visits per person per calendar year for Nutrition Counseling.	\$0 copay, coinsurance or deductible.** Unlimited medically necessary visits for Nutrition Counseling.
Physical, Occupational and Speech Therapy	Some plans have a combined benefit maximum of \$5,000 per person per calendar year.	Combined benefit limit of 60 visits per person per calendar year.
Durable Medical Equipment	Some plans have a benefit maximum of \$3,500 or \$5,000 per person per calendar year.	All calendar year benefit limits removed (separate benefit limits continue to apply for certain covered services).
Maximum Lifetime Benefit	Some plans include a lifetime benefit of \$1 million for major medical; \$50,000 or \$2 million for self-referred benefits.	All lifetime benefit limits removed.

*Visit these websites to learn more about preventive health care:

www.healthcare.gov/center/regulations/prevention/recommendations.html or www.hhs.gov

**In-network providers only; deductible or coinsurance still applies if the plan provides out-of-network coverage.

***Routine Vision Exams were previously not covered under Indemnity plans (e.g., JY, JW, Comp 100); however, beginning in 2011 exams will be covered once every two calendar years for all ages.

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Eligibility Changes for both Grandfathered or Non-Grandfathered Plans for Dependent Children Age 19 to 26

	Current	Changes for 2010 or 2011
Eligibility	Eligible up to age 26 if unmarried, a NH resident, or a full or part-time student, and not covered under any other health plan unless a full-time student.	Eligible up to age 26 regardless of state residency, marriage or student status, even if enrolled or eligible for other coverage.
Spouses and Newborns of Covered Dependents	Spouses are not covered; Newborns covered under the subscriber's policy for the first 31 days.	No change; same as current.
Imputed Income	Value of coverage subject to federal taxation as imputed income for non tax-qualified dependent children age 19 up to 26.	Effective 3/30/2010 , no imputed income for dependent children up to age 26.
Premium Contributions and Benefits	N/A	Rules prohibit a plan or an employer from charging a different premium, or from varying benefits or other terms of the plan, for covered dependents age 19 up to 26.
Dependent Child Certification Process and Forms	Forms are required for all dependent children age 19 up to 26 upon enrollment to confirm eligibility.	January Groups: Forms are not required for new dependent children enrollees age 19 up to 26; July Groups: Forms are required upon enrollment until 6/30/2011 to confirm eligibility.
	Annual recertification is required for currently covered dependent children age 19 up to 26.	Annual recertification is no longer required for currently covered dependent children age 19 up to 26.

**HEALTHCARE REFORM - SUMMARY OF MEDICAL COVERAGE AND ELIGIBILITY CHANGES
CONTINUED**

<i>Effective 1/1/2011 for both January and July Renewal Groups</i>		
Healthcare FSA Changes, HRA and HSA Plans		
Changes apply for both Grandfathered or Non-Grandfathered Plans		
Benefit	Current	Changes for 2011
Over-the-Counter (OTC) Products	OTC drugs and medicines are an eligible expense, such as allergy or cold medicine.	January and July Groups: Effective 1/1/2011 OTC drugs and medicines, such as allergy or cold medicine, are not an eligible expense unless a prescription is obtained. Enrollees may file a paper claim and submit with a copy of their receipt and prescription, or use the prepaid benefits card as long as the prescription is filled by a pharmacist and an RX number is assigned.
	OTC equipment, devices and supplies are eligible (i.e. crutches, contact lens solution, blood sugar kits); insulin also eligible with or without a prescription.	No change; same as current.
Potential Change to Healthcare FSA Contribution (2013 Tax Year)	Employers can set various contribution maximums.	Effective 1/1/2013 (regardless of plan year); maximum contribution will be reduced to \$2,500.

OTHER COVERAGE CHANGES (NOT DUE TO HEALTHCARE REFORM)

<i>Effective 1/1/2010 for January Renewal Groups and 7/1/2010 for July Renewal Groups</i>		
<i>Applies to All Medical Plans</i>		
Mental Health Parity Act - Coverage Changes apply for both Grandfathered or Non-Grandfathered Plans		
Benefit	Current	Changes for 2010
Behavioral Healthcare and Substance Abuse Treatment	Some plans include calendar year visit limits and annual or lifetime benefit maximums.	All calendar year visit limits and annual or lifetime benefit maximums removed. Anthem may review for medical necessity after 5th visit; a treatment plan may also be required after the 12th visit for all plans (submitted to Anthem by the physician).

**OTHER COVERAGE CHANGES (NOT DUE TO HEALTHCARE REFORM)
CONTINUED**

*Effective 1/1/2011 for January Renewal Groups and 7/1/2011 for July Renewal Groups
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Routine Hearing Exams and Aids - Coverage Changes for Non-Grandfathered Plans

Benefit	Current	Changes for 2011
Routine Hearing Exams	One exam each year for children 18 years old or younger; routine exams are not covered for adults age 19 or older.	No change; same as current.
Exam or Treatment of Ear Disease or Injury	Covered benefit for adults and children.	No change; same as current.
Hearing Aids	One initial hearing aid per ear or each time a prescription changes for children 18 years old or younger; hearing aids are not covered for adults age 19 or older.	One initial hearing aid per ear and each time a prescription changes for adults and children . Hearing aids are generally covered as Durable Medical Equipment; same referral guidelines (HMO/POS plans) and member cost share apply.
Other Important Information About Hearing Aid Benefits and Hearing Provider Services	Benefits for hearing aids are limited to the Maximum Allowable Benefit (MAB)* for the least expensive medically necessary hearing aid. If the hearing aid is more costly than is medically necessary, enrollees will be responsible for paying the provider the difference between the MAB for the least expensive hearing aid and the charge for the more expensive service. The difference in cost may be substantial; always discuss options and cost share in advance with the provider.	
	Hearing aids must be ordered in advance by the physician and furnished by a Network Provider; otherwise, only out-of-network benefits (if applicable) are available. Hearing aids must be prescribed, fitted, serviced and dispensed by a licensed audiologist or other Network Provider who is a hearing instrument dispenser or other hearing care professional; otherwise, no benefits are available.	

**The Maximum Allowable Benefit (MAB) is the amount that the plan contract allows for a particular service in your geographical area.*

This chart is for summary purposes only. Details of coverage are set forth in the Subscriber Certificate and other coverage documents, which govern LGC HealthTrust's plans.