

Benefit Reminders

This notice contains important information about your benefits. Save it for your records.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance carriers that offer group health coverage generally cannot restrict benefits for a mother or newborn's hospital stay related to childbirth to:

- Less than 48 hours following a vaginal delivery or
- Less than 96 hours following a delivery by cesarean section.

Health plans may pay for a shorter hospital stay if the attending provider (physician, nurse, midwife or physician assistant) consults with the mother and discharges the mother or newborn sooner.

Plans cannot set the level of benefits or out-of-pocket costs so that any later portion of the 48- or 96-hour stay is treated in a less favorable manner for the mother or newborn than any earlier part.

In addition, a plan cannot require a physician or other healthcare provider to get prior approval for prescribing a length of stay up to 48 or 96 hours. However, a mother may be required to receive prior approval to use certain providers or facilities, or to reduce out-of-pocket costs.

If your plan contains a precertification requirement, you or your provider must still get prior approval for the stay to avoid any additional out-of-pocket expenses. However, your stay will automatically be approved for 48 or 96 hours, as specified by this law.

HIPAA Privacy Policy

Want to receive a copy of the Group Health Plan's Notice of Privacy Practices? Contact your employer's privacy or benefits department.

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act requires group health plans that provide medical and surgical benefits related to a mastectomy to provide the following coverage for participants who elect breast reconstruction resulting from a mastectomy:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Coverage for prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas, as determined during a consultation with the attending physician and patient.

This coverage may be subject to annual deductibles and coinsurance provisions as appropriate and consistent with those established for other benefits under the health plan.

COBRA

If you receive a COBRA notice, be sure to read it carefully and contact your employer's benefits department if you have any questions. A complete copy of the COBRA provisions can be found in your Summary Plan Description or by contacting your employer's benefits department.

Children’s Health Insurance Program Reauthorization Act (CHIPRA)

If you are eligible for health coverage from your employer, but cannot afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people in this situation.

If you or your dependent are already enrolled in Medicaid or CHIP and you live in a state that offers a premium assistance program (not applicable in Ohio), you can contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are not enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office to find out how to apply by calling (877) KIDS-NOW (877) 543-7669 or visiting insurekidsnow.gov. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer’s health plan is required to permit you and your dependent to enroll in the plan—as long as you and your dependents are eligible, but not already enrolled in the employer’s plan. This is called a special enrollment opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

Michelle’s Law

Michelle’s Law prevents a group health plan from terminating your dependent child’s coverage if he or she is no longer a full-time student due to a medically necessary leave of absence. A medically necessary leave of absence is a leave of absence from a post-secondary educational institution resulting from a serious illness or injury that causes your child to lose eligibility under your health plan. To qualify for this protection, your child must:

- Be qualified as a dependent under the terms of your health plan;
- Be enrolled in your health plan as a student attending a post-secondary educational institution as of the day before the medically necessary leave of absence started; and
- Have written certification by a treating physician indicating he or she is suffering from a serious illness or injury and the leave of absence is medically necessary.

Keep in mind, your children can be covered to age 26, regardless of student status.

Genetic Information Nondiscrimination Act (GINA)

GINA, along with the Health Insurance Portability and Accountability Act (HIPAA), prohibits discrimination in group health plan coverage based on genetic information. GINA also prohibits a health plan from requesting or requiring you or your dependents to take a genetic test, requesting or requiring genetic information (including family medical history) or imposing a pre-existing condition exclusion provision based solely on genetic information.

Keep In Touch

It’s important to keep your information up-to-date when you have a change in status, such as a birth, marriage, divorce, death or even a change of address. Contact your employer’s benefits department to make sure your information is accurate.