General Group Health Plan Notices

Patient Protection Disclosure

If your health plan generally allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from your health insurance carrier 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 your 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.

The Women's Health and Cancer Rights Act of 1998

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prosthesis and complications resulting from a mastectomy, including lymph edema? Contact your employer for more information.

The Women's Health and Cancer Rights Act (WHCRA), signed into law on October 21, 1998, contains protections for patients who select breast reconstruction in connection with a mastectomy. Plans offering coverage for a mastectomy must also cover reconstructive surgery and other benefits related to a mastectomy.

Women's Health and Cancer Rights Act (WHCRA):

- Applies to group health plans for plan years starting on or after October 21, 1998.
- Applies to group health plans, health insurance companies or HMOs, if the plan or coverage provides medical and surgical benefits with respect to mastectomy.
- Requires coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient.

Under WHCRA, mastectomy benefits must include coverage for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis and treatment of physical complications of the mastectomy, including lymph edema;

Under WHCRA mastectomy benefits may be subject to annual deductibles and coinsurance consistent with those established for other benefits under the plan or coverage. Therefore, the following **in-network** copays, deductibles and coinsurance apply:

Benefit	CDPHP	Emblem Health	MVP NY HMO	Empire NYSHIP
Deductible	$0	$0	$0	N/A
PCP Office Visit	$25 copay	$25 copay	$20 copay	$25
Specialist Office Visit	$25 copay	$25 copay	$20 copay	$25
Inpatient Hospital Admission	No copay	No copay	$500 copay	Covered in Full
Emergency Room	$100 copay	$100 copay	$50 copay	$70

The law also contains prohibitions against:

- Plans and issuers denying patients eligibility or continued eligibility to enroll or renew coverage under the plans to avoid the requirements of WHCRA.
- Plans and issuers providing incentives to, or penalizing, physicians to induce them to provide care in a manner inconsistent with the WHCRA.

If you would like more information on WHCRA benefits, call your plan administrator.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child 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 provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependent(s), including your spouse, because of other health insurance or group health plan coverage, you may be able to enroll yourself or your dependent(s) in this plan if you or your dependent(s) lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependent's other coverage). However, you must request enrollment within "30 days" after your or your dependent's other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, this special enrollment opportunity will not be available when other coverage ends unless you provide a written statement now explaining the reason that you are declining coverage for yourself or your dependent(s). Failing to accurately complete and return this form for each person for whom you are declining coverage will eliminate this special enrollment opportunity for the person(s) for whom a statement is not completed, even if other coverage is currently in effect and is later lost. In addition, unless you indicate in the statement that you are declining coverage because other coverage is in effect, you will not have this special enrollment opportunity for the person(s) covered by the statement. (See the paragraph below, however, regarding enrollment in the event of marriage, birth, adoption or placement for adoption.)

If you have a new dependent as result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must enroll within "30 days" after the marriage, birth, adoption, or placement for adoption.

A special enrollment opportunity may be available in the future if you or your dependent(s) lose other coverage. This special enrollment opportunity will not be available when other coverage ends, however, unless you provide a written statement now explaining the reason that you are declining coverage for yourself or your dependent(s). Failing to accurately complete and return this form for each person for whom you are declining coverage will eliminate this special enrollment opportunity for the person(s) for whom a statement is not completed, even if other coverage is currently in effect and is later lost. In addition, unless you indicate in the statement that you are declining coverage because other coverage is in effect, you will not have this special enrollment opportunity for the person(s) covered by the statement. (See the paragraph above, however, regarding enrollment in the event of marriage, birth, adoption or placement for adoption.)

Effective April 1, 2009 special enrollment rights also exist in the following circumstances:

- If you or your dependent(s) experience a loss of eligibility for Medicaid or your State Children's Health Insurance Program (SCHIP) coverage; or
- If you or your dependent(s) become eligible for premium assistance under an optional state Medicaid or SCHIP program that would pay the employee's portion of the health insurance premium.

Note: In the two above listed circumstances only, you or your dependent(s) will have sixty (60) days to request special enrollment in the group health plan coverage. An individual must request this special enrollment within sixty (60) days of the loss of coverage described at bullet one, and within sixty (60) days of when eligibility is determined as described at bullet two.

To request special enrollment or obtain more information, contact:
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