Patient Protection Disclosure – Selecting Your Primary Physician

The CareFirst BlueCross BlueShield HMO Plan requires 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, contact CareFirst BlueCross BlueShield at:

CareFirst BlueCross BlueShield
Phone: Please call the number on the back of your ID card
www.carefirst.com

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from CareFirst BlueCross BlueShield 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, contact CareFirst BlueCross BlueShield at the number or website listed above.

Women’s Health & Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, 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;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

The plan will determine the manner of coverage in consultation with you and your attending doctor. These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under your plan. If you would like more information on WHCRA benefits, please contact the HR Department.
Patient Protection Notice – Prohibition on Rescission

Under the Patient Protection and Affordable Care Act (PPACA) of March 23, 2010, for Plan Years beginning on or after September 23, 2010, a group health Plan, or a health insurance issuer offering group or individual health insurance coverage, must not rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact. Under the new standard for rescissions, Plans and issuers cannot rescind coverage unless an individual was involved in fraud or made an intentional misrepresentation of material fact. These provisions generally provide that a health insurance issuer in the group and individual markets cannot cancel, or fail to renew, coverage for an individual or a group for any reason other than those enumerated in the statute (that is, nonpayment of premiums; fraud or intentional misrepresentation of material fact; withdrawal of a product or withdrawal of an issuer from the market; movement of an individual or an employer outside the service area; or, for bona fide association coverage, cessation of association membership).

These interim final regulations clarify that, to the extent that an omission constitutes fraud, that omission would permit the plan or issuer to rescind coverage under this section. For purposes of these interim final regulations, a rescission is a cancellation or discontinuance of coverage that has retroactive effect. For example, a cancellation that treats a policy as void from the time of the individual's or group's enrollment is a rescission. As another example, a cancellation that voids benefits paid up to a year before the cancellation is also a rescission for this purpose.

A cancellation or discontinuance of coverage with only a prospective effect is not a rescission, and neither is a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. Coverage may not be cancelled unless prior notice is provided. These interim final regulations provide that a group health Plan, or health insurance issuer offering group health insurance coverage, must provide at least 30 calendar days advance notice to an individual before coverage may be rescinded. Even though prior notice must be provided in the case of a rescission, applicable law may permit the rescission to void coverage retroactively.

HIPAA Special Enrollment Rights Notice

Under If you are declining enrollment either for yourself or for your 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 the employer stops contributing toward your coverage or your dependents’ coverage). However, you must request enrollment within 31 days after the date your coverage, or your dependents’ coverage, ends (or after the employer stops contributing toward the other coverage).*

In addition, 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. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

*Documentation is required for each life event within 31 days from the life event.