SecureOne Benefit Administrators, Inc.

NEWSLETTER

August 2012

Essential Health Benefits: A Brief Refresher

The Patient Protection and Affordable Care Act ("PPACA") has prohibited group health plans from imposing lifetime and annual limits on the dollar value of health benefits for plan years, which started with plan years on or after September 23, 2010. Many of our clients have had questions relative to how this will work in their self-funded plans and this newsletter is a general information guide that should help give you an over view of these guidelines.

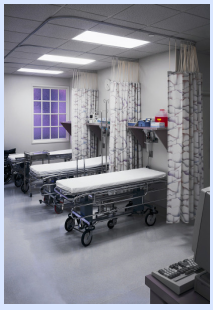
Lifetime limits are prohibited on the dollar value of both in and out of network benefits that are determined to be "Essential Health Benefits." The Affordable Care Act defines essential health benefits to "include at least the following general categories and the items and services covered within the categories" ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care."

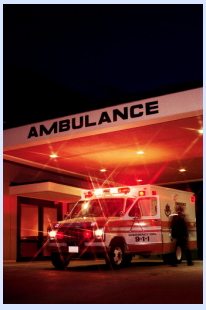
PPACA also prohibits annual limits on the dollar value of Essential Health Benefits, to the following extents:

- For plan years beginning on or after September 23, 2010, but before September 23, 2011: $750,000
- For plan years beginning on or after September 23, 2011, but before September 23, 2012: $1,250,000
- For plan years beginning on or after September 23, 2012, but before January 1, 2014: $2,000,000
- For plan years beginning January 1, 2014: no annual limits are allowed.

For your reference, here is a listing of benefits that have been determined to be Essential Health Benefits:

- Allergy
- Ambulance
- Cochlear Implant
- Diabetic Supplies/Insulin Pumps
- Emergency Health Services
- Home Health Care
- Hospital—Inpatient Stay
- Lab, X-Ray and Diagnostics
- CT, PET, MRI, Nuclear Medicine
- Mental Health Services
- Orthopedic Surgery
- Outpatient Facility—Surgery, Scopes
- Outpatient Facility—Therapeutic (Dialysis, Chemo, Radiation)
- Pediatric Services—including oral and vision care.
- Pharmaceutical Products—Outpatient
- Pharmacy
- Pregnancy
- Physician's Office—Sickness/Injury
- Preventive Care
- Rehabilitative Services—Outpatient Therapy
- Skilled Nursing/Inpatient Rehab
- Tobacco Use Cessation
- Transplant Services
- Urgent Care Services





Please Note: This information is published by SecureOne Benefit Administrators, Inc to provide a summary of significant developments to our clients. It is intended to be informational and does not constitute legal advice regarding any specific situation.

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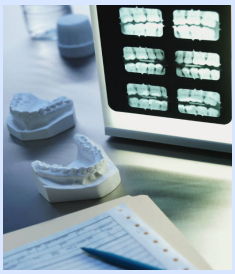
NEWSLETTER Cont.

July 2012

For the benefits listed above , all lifetime dollar limitations should be REMOVED from your plans. For annual dollar limitations, you will have to decide whether you and your client would like to remove the annual limitations completely, or use the restricted annual limits that appear above. NOTE, however, that annual limits will no longer be permitted after 2014.

A listing of some of the benefits, that to-date are classified as Non-Essential Health Benefits are:

- Acupuncture
- Chiropractic
- Dental Services (accidental)
- Food / Nutritional supplements
- Hearing aids
- Hospice
- Infertility (including Rx)
- Obesity Surgery
- Orthotic braces
- Ostomy supplies
- TMJ
- Vision Exams
- Wigs



The second part of this newsletter is the current ACA Timeline, giving a good overview of the next six (6) years of requirements should nothing change in the November elections and/or legislative alternatives.

SecureOne will continue to inform our clients and proceed with keeping your plans compliant.

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Current ACA Timeline

Caution: ACA is under constant review. Provisions could be adjusted, re-interpreted and even repealed in the future. This is a snapshot as of June 2012.

2012

Summary of Benefits and Coverage	For groups without open enrollment periods, the first day of the first plan year that begins on or after September 23, 2102. For groups with open enrollment periods, the first day of the first open enrollment period that begins on or after September 23, 2012.
$2 Million Annual Limit on Essential Health Benefits	Plan years beginning on or after September 23, 2012.

2013

W-2 Reporting	January 2013 (for 2012 W-2 Forms). Annual Reporting Begins
Health FSA Limit	Plan years beginning January 1, 2013. The annual limit on health FSAs is $2,500.
Administrative Simplification Eligibility and Claim Status Operating Rules.	January 1, 2013.
FICA Medicare Tax Rate Increase	January 1, 2013. FICA Medicare tax rate increases for wages over $200,000 ($250,000 for married couples filling jointly).
Medicare Part D Retiree Drug Subsidy Payments	January 1, 2013. Elimination of the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments.
Exchanges	January 1, 2013. States must inform HHS Whether they will operate and Exchange.
Exchange and Subsidy Notice	March 1, 2013. Notices to plan participants explaining the Exchanges and potential Federal subsidies if the employer-sponsored coverage is “unaffordable”.
CO-OP	Beginning July 1, 2013, non-profit, member-run health insurance companies may apply to become Consumer Operated and Oriented Plans.
Patient-Centered Outcomes Research Institute (PCORI) Fee on Plans	First Fee due July 31, 2013. The fees are effective for each plan year ending on or after October 1, 2012 and before October 1, 2019.

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2014

Employer Play or Pay	January 1, 2014. Employers with 50 or more full-time employees (or full-time equivalents) are liable for a penalty tax if "affordable" coverage is not offered and an employee receives a federal subsidy through an Exchange
No Annual Dollar Limits on Essential Health Benefits	Plan years beginning on or after January 1, 2014.
No Preexisting Condition Exclusions	Plan years beginning on or after January 1, 2014.
90-Day limitation on Waiting Periods	Plan Years beginning on or after January 1, 2014.
Tax on Plans to Fund Temporary Reinsurance Program	January 1, 2014. States must establish transitional reinsurance programs to help stabilize premiums for individual market coverage from 2014-2016. Plans and insurers will be taxed.
Wellness Rewards	January 1, 2014. Employers will be permitted to vary premiums up to 30% (possibly increasing to 50%) for participation in wellness programs.
Exchanges	States selecting to operate an Exchange must establish them by January 1, 2014. The Federal government will set up and operate an Exchange in those States that choose not to. Between 2014-2016, only individuals and small group employers with up to 100 employees are eligible to participate in the Exchanges. Until the year 2016, States can limit the small groups to firms with 50 or fewer employees. January 1, 2014. Exchange products must provide guaranteed availability of insurance for individuals and small groups.
Federal Subsidies	January 1, 2014. Premium assistance tax credits and co-sharing subsidies become available for those eligible through the Exchanges.
Coverage of Clinical Trials	Plan years beginning on or after January 1, 2014.
Individual Mandate	January 1, 2014.

Note—Substantial guidance is expected on many of the provisions scheduled to take effect in 2014.

2015

Employer Reporting	First information returns due January 31, 2015 (for coverage provided on or after January 1, 2014). Employers with 50 or more full-time employees report names of workers covered under the plan and other plan information to the IRS and individual.
Plan and Insurer Reporting	First information returns due January 31, 2015 (for coverage provided on our after January 1, 2014). Sponsors of self-funded plans and health insurers report individual coverage dates, the portion of the premium the individual must pay and more.
Exchanges	Beginning January 1, 2015, state based exchanges must be self-sustaining. Exchanges may charge assessments or user fees.

2016

Exchanges	All Exchanges must be open to employers with up to 100 employees. Until the year 2016, States can limit the small group market to firms with 50 or fewer employees.

2017

Exchanges	Beginning in 2017, States may elect to allow large group plans (100 or more) to be sold in the Exchanges.

2018

Tax on High-Cost Plans	An excise tax of 40% will be imposed on employer-sponsored health benefits that exceed the value of $10,200 times the "health cost adjustment percentage" for self-only coverage and $27,500 times the

2018

Automatic Enrollment	IRS notice 2012-17 states that guidance on automatic enrollment will not be ready to take effect by 2014. The compliance date will be addressed in future guidance.
Nondiscrimination Rules for Insured Plans	Effective date depends on future guidance
Quality Care Reporting	Effective date depends on future guidance.