Dear Group Plan Administrator,

Your health plan renewal includes changes required by the Patient Protection and Affordable Care Act (the Affordable Care Act) effective for plan years on or after September 23, 2010.

The Affordable Care Act Provisions include benefit and eligibility enhancement language for your employees. These key changes are now included in your benefits plan:

- Lifetime limit no longer applies
- No annual dollar limits apply except as permitted by the Affordable Care Act
- Extension of dependent coverage to age 26, or older if required by state law
- Elimination of any pre-existing exclusions for anyone under age 19
- Addition of first dollar coverage for In network preventive care
- Designation of Primary Care Providers and direct access to OB-Gyn

The rates quoted are applicable to the plan design selected. We reserve the right to modify your rates in the event your plan design must be modified as a result of any change, modification or clarification in law, including the Patient Protection and Affordable Care Act.

These benefit and eligibility changes are automatically included in your renewal and do not affect your plan’s grandfathered status.

You will need to notify your employees of these changes. Attached is an employee notification form that you may want to use. If you have questions, please contact your broker or account executive.

Sincerely,

Michael Cole
National VP of Sales
Attached, you will find important Notices that you must provide to all of your employees (and COBRA or state continuation enrollees), as required by the Patient Protection and Affordable Care Act (also known as the Affordable Care Act). We understand this information may conflict with your plan due to your particular plan design and/or your state laws, and you may wish to modify or add information to this notice to explain your plan.

Instructions

**“Important Notices” section to complete:**

- **Date of Notices** — this is the date you distribute the Notice(s) to your employees. Notices must be distributed prior to the first day of the first plan year beginning on or after September 23, 2010.
- **These Notices apply to this group health plan** — indicate the name of the health plan, such as ABC Co. Welfare Benefit Plan, or indicate the name of your insurer(s).
- **Effective date of coverage is** — the date of your renewal, but no later than the first day of the first plan year beginning on or after September 23, 2010.
- **For more information contact** — indicate a phone number for someone within your company that an employee can contact if they have questions.

**“Opportunities to Enroll” section:** The 30 day enrollment period indicated can coincide with your normal annual open enrollment period, but it must last 30 days, and it must begin no later than the first day of your renewal, on or after September 23, 2010.

**“Patient Protection Notice” section:** If you have an HMO plan or a plan that requires selection of a primary care physician, you must provide the Patient Protection Notice.

**“Grandfathered Health Plan Notice” section:** A grandfathered group health plan is a plan which was in effect on 3/23/2010, complies with disclosure and recordkeeping requirements, and has not made any plan changes that would cause grandfathered status to be lost. Voluntary compliance with any of the health care reform requirements will not take away your plan’s grandfathered status if you choose to maintain it.

The federal rules (published 6/17/2010), which include examples to illustrate their application, can be found at the following internet link:

http://www.hhs.gov/ociio/regulations/grandfather/index.html

We encourage you to review these requirements with your legal advisor and benefit consultant in deciding whether you wish your plan to have grandfathered status. If you wish your plan to be grandfathered, you must provide notice that you believe it is grandfathered under the Affordable Care Act. Please see page 3 for model language in the rules that can be used for this option. If your plan will not be grandfathered, the model language should not be included.

**Completing Notices:** After you have modified these Notices for your Plan’s purposes, please fill in the “Important Notices” section, copy the form, and distribute. Also, please retain a copy of what you distributed for your records. To assist you with your compliance, or if you have any questions:

- You may wish to review the Model Notices and instructions to the notices provided by the Department of Labor at http://www.dol.gov/ebsa/healthreform. You will see the Model Notices under the “Affordable Care Act Regulations and Guidance” section of their website.
- Contact your broker or account executive.
Required Notices Due to the Patient Protection and Affordable Care Act

Date of Notices: __________ These Notices apply to this group health plan: _____________________________________________
Effective date of coverage is: ____________ For more information contact: _______________________________________

Opportunities to Enroll Notice

Extension of Dependent Coverage to Age 26
Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll. Individuals may request enrollment for such children for 30 days from the date of this notice.

Lifetime Limit No Longer Applies
The lifetime limit on the dollar value of benefits no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment.

Patient Protection Notice

Designation of Primary Care Providers
You have the right to designate any primary care provider (PCP) 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 PCP. For information on how to select a PCP, and for a list of the participating primary care providers, log on oxfordhealth.com.

Direct Access to OB/Gyns
You do not need prior authorization to obtain direct access to obstetrical or gynecological care from a health care professional in the 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, log on oxfordhealth.com.

If you wish to maintain status as a grandfathered health plan, you must provide notice that the plan believes it is a grandfathered health plan within the meaning of Section 1251 of the Patient Protection and Affordable Act.

Grandfathered Notice

Grandfathered Health Plan
This group health plan believes this plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the contact stated previously. For ERISA plans, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For non-Federal governmental plans, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.
Information on Rescissions

The Affordable Care Act, which was signed into law in March 2010, prohibits the rescission of health plan coverage except for fraud or intentional misrepresentation of a material fact. A rescission of a person's health plan coverage means that we would treat that person as never having had the coverage. The prohibition on rescissions applies to group health plans, including grandfathered plans, effective for plan years beginning on or after September 23, 2010.

In June 2010, the Interim Final Regulations (IFRs) on rescissions were issued. These regulations provide that a rescission includes any retroactive terminations or retroactive cancellations of coverage except to the extent that the termination or cancellation is due to the failure to timely pay premiums. Rescissions are prohibited except in the case of fraud or intentional misrepresentation of a material fact. For example, if an employee is enrolled in the plan and makes the required contributions, then the employee’s coverage may not be rescinded if it is later discovered that the employee was mistakenly enrolled and was not eligible to participate. If a mistake was made, and there was no fraud or intentional misrepresentation of a material fact, then the employee’s coverage may be cancelled prospectively but not retroactively.

Should a member’s coverage be rescinded, then the member must be provided 30 days advance written notice of the rescission. The notice must also include the member’s appeal rights as required by law and as provided in the member’s plan benefit documents. Please be aware that if you rescind a member’s coverage, you must provide the proper notice to the member.

The IFRs on rescission can be found at the following Internet link: http://edocket.access.gpo.gov/2010/2010-15278.htm; with a clarifying FAQ on rescissions at http://www.dol.gov/ebsa/faqs/faq-aca2.html. You can also find out more by going to http://www.uhc.com/united_for_reform_resource_center.htm and searching for the word “rescission.”

Information on Nondiscrimination 105(h) Rules

The Affordable Care Act also extended the Section 105(h) rules of the Internal Revenue Code to non-grandfathered fully insured group health plans. Section 105(h) prohibits employers from discriminating in favor of highly compensated individuals (HCIs) relative to other employees in eligibility and benefits under a group health plan.

The Affordable Care Act stated that the 105(h) rules would apply to non-grandfathered fully insured group health plans on their first plan year on or after September 23, 2010. On December 22, 2010, however, the IRS (with the support of the Departments of Labor and HHS) announced that compliance with the rules will not be required of insured plans until guidance is provided regarding their application. Until that time, sanctions for failure to comply with the rules will not apply. Furthermore, the agencies expect that when such guidance is issued, its effective date will be delayed until plan years beginning a certain time after issuance.

Under 105(h), HCIs generally consist of officers and owners and individuals in the top quartile of employees (when ranked according to compensation). Certain types of non-grandfathered plans, such as class/carve-out plans (that only cover a class of employees that consist primarily of HCIs or cover such class at a higher benefit level than another class that does not include HCIs), are either prohibited or suspect under 105(h). Insured plan sponsors that violate the 105(h) rules are subject to a $100 per day per failure penalty. This penalty would likely apply to each non-HCI who is impermissibly excluded under the plan.

Under the amended grandfather rules, the following fully insured plans are not grandfathered and may be impacted by the 105(h) rules:

- an insured plan sold with a new coverage effective date after March 23 and before November 15, 2010; or
- an insured plan that was grandfathered on March 23, 2010, and subsequently lost its grandfather status due to changes in the plan.

If these non-grandfathered plans are class/carve-out plans as described above, they may face compliance issues under the 105(h) rules, depending on how the future guidance takes shape. Customers that have a fully insured non-grandfathered class/carve-out plan, or have questions about the application of the 105(h) rules to their plan, should review the matter with their tax or legal counsel. Customers concerned that their plans may be considered discriminatory under 105(h) may contact their broker or UnitedHealthcare representative to discuss alternatives. UnitedHealthcare will not provide nondiscrimination testing or consulting services regarding 105(h) compliance.