July 7, 2011

Notice to Agencies and Plan Members

OGB Special Enrollment for children up to age 26 ends July 31; Reminder about changes for the 2011 plan year

Special Enrollment deadline is July 31

OGB is holding a Special Enrollment from April 1 through July 31 to enable employees and retirees to enroll or re-enroll newly eligible children for health coverage and life insurance effective July 1 with no pre-existing condition exclusion. This Special Enrollment period applies to children who lost coverage or were not eligible for coverage because they reached the previous maximum age for dependent coverage. However, any such child enrolled after July 31 will be considered a late applicant, and a pre-existing condition exclusion will apply if the child is age 19 or older, unless portability applies.

2011 plan year changes (July 1 – December 31, 2011)

There will be a short 6-month plan year (July 1 through December 31, 2011) for 2011 to enable OGB to change to a plan year that coincides with the calendar year (January 1 through December 31) beginning in 2012. The short plan year also applies to Flexible Benefits.

OGB offers expanded coverage in several key areas for the 2011 plan year that began July 1, as mandated by federal law (the Affordable Care Act and the Mental Health Parity and Addiction Equity Act):

- The pre-existing condition (PEC) exclusion no longer applies to any employee or dependent under age 19.

- OGB offers coverage for dependent children up to age 26, regardless of student, marital or tax status. A covered child under age 26 who is or becomes incapable of self-sustaining employment is eligible to continue coverage as an overage dependent if OGB receives required medical documents verifying his or her incapacity before he or she reaches age 26. The definition of incapacity has been broadened to include mental and physical incapacity.

- The individual lifetime maximum for benefits has been eliminated. Annual dollar limits on essential benefits are also eliminated.

- Preventive care (wellness) is paid at 100 percent (no deductibles, co-payments, coinsurance) if services are provided by a network provider. Preventive care benefit limits no longer apply. Click here for a complete list of covered preventive services.

- The plan member cost-share (deductible, coinsurance, or co-payment) for inpatient and outpatient medical care and surgery also applies to inpatient and outpatient mental health and substance abuse (MHSA) treatment. There is no longer a separate plan member cost-share for MHSA benefits.

Other important changes for the 2011 plan year are:

- The plan member cost-share for the PPO and HMO (Blue Cross) health plans did not reset on July 1, 2011. Instead, if the plan member has already met his or her deductible or out-of-pocket maximum for the 2010-11 plan year, the plan member cost-share will not reset until January 1, 2012.

- The plan member cost-share for the Consumer Driven health plan did reset on July 1, 2011. This means CDHP-HSA plan members will have only 6 months to meet the annual deductible due to the short 6-month plan year, so the state's HSA contribution for 2011 will increase. The state will make a one-time contribution to a plan member's HSA equal to half of the deductible amount—in addition to what the state normally contributes. This additional one-time contribution will be based on the plan member's level of coverage on July 1. The state's standard contribution rate is $100 per plan year, plus a match of additional plan member HSA contributions, dollar-for-dollar, up to $400 per plan year.

- The prescription drug benefit for the PPO and HMO (Blue Cross) health plans covers over-the-counter proton pump inhibitor (PPI) medications for heartburn and gastroesophageal reflux disease (GERD), such as Prilosec OTC and Prevacid. A prescription from a physician is required. The plan member pays 50 percent of the cost of the drug at the point of purchase up to a maximum of $50 per 30-day supply. These OTC medications, once available by prescription only, are equally effective for most people and far less costly. This saves money for both the plan member and the health plan, which helps OGB keep premium rates as low as possible.