

Compliance Assistance Guide

Health Benefits Coverage Under Federal Law...

▶ Health Insurance Portability
and Accountability Act of 1996

▶ Newborns' and Mothers'
Health Protection Act of 1996

▶ Women's Health
and Cancer Rights Act of 1998

▶ Children's Health Insurance Program
Reauthorization Act

▶ Genetic Information
Nondiscrimination Act



U.S. Department of Labor
Employee Benefits Security Administration

This publication has been developed by the U.S. Department of Labor, Employee Benefits Security Administration (EBSA). It is available on the Internet at www.dol.gov/ebsa. For a complete list of publications or to speak with a benefits advisor, call toll free:

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Introduction

Health Benefits Coverage Under Federal Law addresses the following laws that can affect the health benefits coverage provided by group health plans:

- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (portability provisions only)
- The Newborns' and Mothers' Health Protection Act of 1996 (the Newborns' Act)
- The Women's Health and Cancer Rights Act of 1998 (WHCRA)
- The Genetic Information Nondiscrimination Act of 2008 (GINA)

These four health care laws are included in Part 7 of Title I of the Employee Retirement Income Security Act of 1974 (Part 7 of ERISA). Also discussed in this booklet are provisions of the Children's Health Insurance Program Reauthorization Act (CHIPRA) related to special enrollment rights, which are included as part of the HIPAA Special Enrollment section on page 17.

The rules described in the following pages generally apply to group health plans and group health insurance issuers (i.e., insurance companies and HMOs). References in this booklet are generally limited to "group health plans" or "plans" for convenience. In addition, the booklet will help employers, plan sponsors, plan administrators, third-party administrators, and other service providers to comply with Part 7 of ERISA.

For ease of use, *Health Benefits Coverage Under Federal Law* is divided into four sections:

- The first section includes general descriptions of the four health care laws (mentioned above) and frequently asked questions.
- Following is a self-compliance tool that can help to determine a plan's compliance with these laws. It includes compliance tips that relate to some common mistakes. (Note: please check the Web site at <http://www.dol.gov/ebsa/pdf/cagappa.pdf> for updates to the self-compliance tool.)

- Next, a chart summarizes the notices a plan must provide.
- Finally, the last section includes model notices providing language that may be used to comply with the various notice requirements.

While the booklet does not cover all the specifics of these laws, it does assist those involved in operating a group health plan to understand the laws and related responsibilities. It provides an informal explanation of the statutes and the most recent regulations and interpretations. The information is presented as general guidance, however, and should not be considered legal advice. In addition, some of the provisions discussed involve issues for which the rules have not yet been finalized. The proposed rules are noted. Periodically check the Department of Labor's Web site (www.dol.gov/ebsa) under Laws & Regulations for publication of final rules.

Some general notes:

- As discussed later, States can change some of these Federal rules if the State law is more protective of individuals (i.e., imposes stricter obligations on health insurance issuers).
- If the plan provides benefits through an insurance policy or health maintenance organization (HMO), you also may contact your State's insurance department. Visit the National Association of Insurance Commissioners' Web site at www.naic.org for contact information.
- If you have questions not specifically addressed in this booklet, please contact the Employee Benefits Security Administration (EBSA) regional office nearest you. A list of these offices is on the agency's Web site at www.dol.gov/ebsa (view "About EBSA").

Note: The Affordable Care Act provides additional protections for benefits under an employer-sponsored health plan. This publication does not reflect the passage of the Affordable Care Act. For further information, visit the EBSA Web site at www.dol.gov/ebsa/healthreform/. Also visit the Department of Health and Human Services Web site at www.healthcare.gov.

HIPAA Portability Provisions

The Health Insurance Portability and Accountability Act (HIPAA) includes provisions of Federal law governing health coverage portability, health information privacy, administrative simplification, medical savings accounts, and long-term care insurance. The responsibility of the Department of Labor and the subject of this segment of the booklet are the law's portability requirements.

Some employment-based group health plans limit or deny coverage for health conditions because they are present prior to the date coverage begins (known as "preexisting condition exclusions"). HIPAA limits which types of conditions can be subject to a preexisting condition exclusion, sets a maximum preexisting condition exclusion period, and also allows individuals to receive credit for recent prior health coverage, reducing the time they can be excluded from a new employer's health plan for a preexisting condition. Among other things, this allows employees to switch jobs without permanently losing health coverage for a preexisting condition.

In addition to the preexisting condition exclusion provisions noted above, HIPAA's portability provisions affect group health plan coverage in the following ways:

- Require group health plans and health insurance issuers to provide certificates of prior health coverage;*
- Provide certain individuals special enrollment rights in group health coverage when specific events occur, e.g., birth of a child (regardless of any open season);*
- Prohibit discrimination in group health plan eligibility, benefits, and premiums based on specific health factors; and*
- Guarantee that health coverage be available to, and can be renewed by, certain employers.*

The law's portability requirements apply generally to group health plans with two or more participants who are current employees. However, if the coverage is insured, States may elect to regulate smaller groups. In addition, HIPAA does not apply to excepted benefits, such as certain dental and vision coverage.

HIPAA's portability provisions amended ERISA, the Internal Revenue Code, and the Public Health Service (PHS) Act. The agencies responsible for these laws are the U.S. Department of Labor, the Internal Revenue Service, and the U.S. Department of Health and Human Services, respectively.

The following sections address each of HIPAA's major requirements.

Preexisting Condition Exclusions

HIPAA places strict limitations on a plan's ability to impose a preexisting condition exclusion. Specifically, HIPAA:

- *Provides that any exclusion for a preexisting condition must relate to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the 6-month period prior to an individual's enrollment date in the plan. (This is known as the "6-month look-back" rule.)*
- *Limits the maximum period a preexisting condition exclusion can be applied to an individual to 12 months (or 18 months for late enrollees). The period begins on the individual's enrollment date in the plan. (This is known as the "look-forward" rule.)*
- *Reduces the 12- or 18-month maximum exclusion period by the number of days of an individual's prior "creditable coverage." (Most health coverage is "creditable coverage," as described in more detail on page 11.)*
- *Provides that certain people and conditions can never be subject to a preexisting condition exclusion.*
- *Requires that health plans give a general notice disclosing that the plan applies a preexisting condition exclusion and a separate individual notice that informs an employee or their dependent of the specific exclusion that applies to them.*

A model general notice is on page 91 and a model individual notice is on page 93.

Following are frequently asked questions about the limits on preexisting condition exclusions:

What is a preexisting condition exclusion?

A preexisting condition exclusion is any limitation or exclusion of benefits for a health condition because it was present before coverage begins, regardless of whether any medical advice, diagnosis, care, or treatment was recommended or received before that day. Some preexisting condition exclusions are

designated in the plan documents. Others are not, but operate to exclude benefits because a condition arose before coverage began. For example, a dental exclusion that covers benefits in connection with accidental injury *if the injury occurred while the individual was covered under the plan*. The timing requirement in this example makes the exclusion a preexisting condition exclusion.

Can any prior health condition be subject to a preexisting condition exclusion?

No. Only those conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period prior to an individual's enrollment date (often referred to as the "6-month look-back period") can be subject to a preexisting condition exclusion. The "enrollment date" is considered the first day of coverage under the plan; or if there is a waiting period, it is the first day of the waiting period. Typically the enrollment date is an individual's date of hire.

Consequently, if an individual had a medical condition in the past, but has not received any medical advice, diagnosis, care, or treatment for the condition within the 6 months prior to his/her enrollment date in the plan, the condition is not a preexisting condition to which an exclusion can be applied.

Are there certain people or conditions that cannot be excluded from coverage under a preexisting condition exclusion?

Yes. Preexisting condition exclusions cannot be applied to pregnancy, whether or not the woman had previous coverage. In addition, exclusions cannot apply to a newborn, an adopted child under age 18, or a child under age 18 placed with a family or individual for adoption, as long as the child became covered under creditable coverage within 30 days of birth, adoption, or placement for adoption and does not incur a subsequent 63-day break in coverage. Finally, genetic information may not be treated as a preexisting condition in the absence of a diagnosis of a condition.

My company's plan has a waiting period prior to enrollment. How does it impact our preexisting condition exclusion?

HIPAA does not prohibit a plan from having a waiting period before individuals become eligible for benefits. In fact, plans may have both a waiting period – the time that must pass before an employee or a dependent is eligible to enroll under the terms of the plan – *and* a preexisting condition exclusion.

If a plan has both a waiting period and a preexisting condition exclusion period, the maximum preexisting condition exclusion period begins when the waiting period begins. They must run concurrently.

What is creditable coverage?

Creditable coverage is most health coverage and includes coverage under a group health plan (COBRA continuation coverage is included in this category), an HMO, an individual health insurance policy, Medicaid, or Medicare. An individual's prior creditable coverage reduces the maximum preexisting condition exclusion period that a group health plan can apply to that individual.

Creditable coverage does not include coverage consisting solely of "excepted benefits," such as coverage solely for limited-scope dental or vision benefits. (Excepted benefits are described in more detail on page 28.)

Days in a waiting period during which an individual has no other coverage are not considered creditable coverage, nor are these days taken into account when determining if there is a significant break in coverage. (A significant break in coverage generally occurs when an individual has no health coverage for 63 days or more.) Any health coverage an individual had before a significant break in coverage is not counted to reduce an exclusion period.

To illustrate: Suppose an individual had health coverage for 2 years followed by a break in coverage of 70 days and then resumed health coverage for 8 months. That individual would receive credit for 8 months of coverage but not for the 2 years of coverage prior to the break of 70 days, since it was more than 63 days.

How does the plan determine the length of an individual's preexisting condition exclusion period?

The maximum length of a preexisting condition exclusion period is 12 months after the enrollment date (18 months in the case of a "late enrollee"). A late enrollee is an individual who enrolls in a plan other than on either: (1) the earliest date on which coverage can become effective under the terms of the plan, or (2) on a special enrollment date.

A plan must reduce this maximum period by the number of days of that individual's creditable coverage. However, a plan is not required to take into account any days of creditable coverage that precede a significant break in coverage.

A plan generally receives information about an individual's creditable coverage from a certificate furnished by a prior plan or health insurance issuer. However, individuals also may present other evidence of creditable coverage.

What is the first thing a plan must do before imposing a preexisting condition exclusion period?

A health plan must distribute a general notice of its preexisting condition exclusion that includes:

- A statement that the plan has a preexisting condition exclusion and the terms of the exclusion period. This includes the length of the plan's look-back period regarding preexisting conditions, the maximum exclusion period (the look-forward period) under the plan, and how the plan will reduce the maximum period by creditable coverage.
- A description of the individual's right to demonstrate prior creditable coverage and prior waiting periods through a certificate or other means. This includes a description of the right to request a certificate from a prior plan or issuer and a statement that the current plan will assist in obtaining a certificate from the prior plan or issuer, if necessary.
- The person to contact (including address and telephone number) for obtaining additional information or assistance regarding the preexisting condition exclusion.

This notice must be distributed as part of the application materials for health benefits coverage. If the plan does not distribute such materials, the notice must be provided by the earliest date following a request for enrollment that the plan, acting in a reasonable and prompt fashion, can provide the notice. (See model general notice on page 91.)

What are the next steps after an individual demonstrates creditable coverage?

When an individual presents evidence of creditable coverage (such as a certificate of creditable coverage), the plan must determine how much creditable coverage that individual has and the length of any remaining exclusion period.

A plan may not impose any limit on the amount of time that an individual has to present evidence of creditable coverage.

If an individual presents evidence of creditable coverage but does not have enough to offset the plan's entire preexisting condition exclusion period, then the plan must provide an individual notice of the preexisting condition exclusion period that will apply to that individual. The notice must include:

- The plan's determination (including the last day on which the exclusion for a preexisting condition applies);
- The basis for the determination (including the source and substance of any information on which the plan relied);
- An explanation of the individual's right to submit additional evidence of creditable coverage; and
- Any applicable appeals procedures.

Can a plan change the determination in light of additional evidence?

The plan may modify its initial determination if it later determines that an individual does not have the creditable coverage previously claimed. In this circumstance, the plan must notify the individual of its new determination. Until this notice of the new determination is provided, the plan must approve access to medical services according to its initial determination.

Evidence of Creditable Coverage

Group health plans are required to furnish a certificate of creditable coverage to an individual to document the individual's prior creditable coverage under the plan. This certificate can be used as evidence of creditable coverage for the individual's new group health plan to reduce the length of a preexisting condition exclusion period that might apply. The certificate must be provided free of charge and is given:

- Automatically (a) when an individual loses coverage under the plan or becomes entitled to elect COBRA continuation coverage, and (b) when an individual's COBRA continuation coverage ceases; and
- If requested, before that individual loses coverage or within 24 months of losing coverage.

(For more information on COBRA, see the U.S. Department of Labor's publication, *An Employer's Guide to Group Health Continuation Coverage Under COBRA*, at www.dol.gov/ebsa.)

Group health plans, in determining whether an exclusion period applies to a new employee or his/her dependents, must permit that employee (or dependents) to show prior health coverage, either by a certificate of creditable coverage, or in the absence of a certificate, by producing other evidence of creditable coverage. This evidence can include pay stubs showing a deduction for health insurance,

explanation of benefits forms (EOBs), or verification by a doctor or a former health care benefits provider that the employee or dependent had prior health insurance coverage.

Do plans that do not impose a preexisting condition exclusion period have to provide certificates?

Yes. Individuals previously covered under these plans may need to demonstrate this prior coverage, if they move to a new group health plan or individual health insurance coverage.

Are plans required to issue certificates of creditable coverage to dependents?

Yes. A plan must make reasonable efforts to collect the necessary information for dependents and issue a certificate of creditable coverage for the dependent. If the coverage information for a dependent is the same as for the employee, the plan may issue one certificate with both the employee and dependent information. If the information is not identical, it may still be provided on one certificate, if the certificate provides all the required information for each individual separately and includes a statement that the information is not identical.

However, an automatic certificate for a dependent is not required to be issued until the plan knows (or, making reasonable efforts, should know) of the dependent's loss of coverage. Dependent information can be collected annually, such as during an open enrollment period.

When must group health plans provide certificates?

It depends on the event that triggers the certificate.

- For an individual who is entitled to elect COBRA continuation coverage, the automatic certificate must be provided no later than when an election notice is required to be provided for a qualifying event under COBRA (generally 44 days). For more information on the COBRA notice requirements, see *An Employer's Guide to Group Health Continuation Coverage Under COBRA* at www.dol.gov/ebsa.
- For an individual who loses coverage under a group health plan but is not entitled to elect COBRA continuation coverage, the automatic certificate must be provided within a reasonable time after coverage ceases.

- For an individual who loses COBRA continuation coverage, the automatic certificate should be provided within a reasonable time after COBRA continuation coverage ceases (or after the expiration of any grace period for the nonpayment of COBRA premiums).
- For an individual requesting a certificate, it should be provided at the earliest time that the plan, acting in a reasonable and prompt fashion, could provide it.

What information must be included on the certificate?

Certificates of creditable coverage currently must include:

- Date issued;
- Name of plan;
- Individual's name and ID;
- Plan administrator's name, address, and phone number;
- Phone number for further information;
- Individual's creditable coverage information; and
- An educational statement explaining HIPAA, including:
 - The preexisting condition exclusion rules;
 - Special enrollment rights;
 - The prohibitions against discrimination based on any health factor;
 - The right to individual health coverage;
 - The fact that State law may require issuers to provide additional protections to individuals in that State; and
 - Where to get more information.

A model certificate is available (see page 87).

Note: The Departments of Labor, the Treasury, and Health and Human Services issued proposed rules regarding the coordination of the HIPAA portability rules with the Family and Medical Leave Act (FMLA). The proposed rules include a revised educational statement for the HIPAA certificate with new model language to explain this coordination. Some plans may wish to avoid revising their certificates when the proposed rules become final, and therefore, use the model certificate under the proposed rules, which includes FMLA language (on page 89). Check www.dol.gov/ebsa under "Laws & Regulations" periodically for the publication of the final rule.

In reporting an individual's creditable coverage information, what is the minimum period of time that should be covered by the certificate?

It will depend on whether the certificate is issued automatically or upon request:

- For a certificate that is issued automatically, the certificate should reflect the most recent period of continuous coverage.
- For a certificate that is issued upon request, the certificate should reflect each period of continuous coverage ending within 24 months prior to the date of the request. A separate certificate may be provided for each period of coverage if there is more than one.

However, the certificate does not have to reflect more than 18 months of creditable coverage that is not interrupted by a break in coverage of 63 days or more. A certificate should also include either a statement that an individual has at least 18 months of creditable coverage or the date creditable coverage (and any waiting period for coverage) began. The certificate should also include the date coverage ended or state that coverage is continuing.

Can creditable coverage information be transferred by telephone?

Yes, if the individual involved, his/her new plan, and the old plan all agree, the information may be transferred by phone. Individuals are entitled to request a written certificate for their records when coverage information is provided by phone.

Can a plan contract with a health insurance issuer to provide certificates?

Yes, a plan and issuer can make an agreement that the issuer will be responsible for providing the certificates. While the issuer is liable for noncompliance with the certificate requirements, the plan administrator has the duty to monitor the issuer's compliance with the certificate requirements under the contract.

In addition, if any entity (including a third-party administrator) provides a certificate to an individual, no other party is required to do so.

Special Enrollment

Group health plans are required to provide special enrollment periods during which individuals who previously declined health coverage for themselves and their dependents may be allowed to enroll (regardless of any open enrollment period). In addition to HIPAA special enrollment rights, the Children's Health Insurance Reauthorization Act (CHIPRA) added additional special enrollment rights under ERISA. Rights related to CHIPRA special enrollment are discussed in this section.

Special enrollment rights can occur when:

- An individual loses eligibility for coverage under a group health plan or other health insurance coverage (such as an employee and his/her dependents' loss of coverage under the spouse's plan) or when an employer terminates contributions toward health coverage;*
- An individual becomes a new dependent through marriage, birth, adoption, or being placed for adoption; and*
- An individual loses coverage under a State Children's Health Insurance Program (CHIP) or Medicaid, or becomes eligible to receive premium assistance under those programs for group health plan coverage.*

Employees must receive a description of special enrollment rights on or before the date they are first offered the opportunity to enroll in the group health plan (see model notice on page 94).

In addition, employers that maintain a group health plan in a state with a CHIP or Medicaid program that provides for premium assistance for group health plan coverage must provide a notice (referred to as the Employer CHIP Notice) to all employees to inform them of possible opportunities in the state in which they reside (for information on a model Employer CHIP notice, see page 18).

Can the special enrollment notice be provided in the summary plan description (SPD)?

Yes, if the SPD is provided to the employee at or before the time the employee is initially offered the opportunity to enroll in the plan. If the SPD is provided at a later time, the special enrollment notice should be provided separately (for example, as part of the application for coverage).

How can the employer notice regarding premium assistance under Medicaid or CHIP (the Employer CHIP Notice) be provided?

Employers that maintain a group health plan are required to provide the Employer CHIP Notice. This notice may be provided with the SPD, enrollment packets or open season materials as long as these materials are provided no later than the date explained below, are provided to all employees, and are provided in accordance with the Department of Labor's disclosure rules. The notice must be provided annually beginning on the first day of the first plan year after February 4, 2010.

A model Employer CHIP Notice is included on page 95. The model notice includes State contact information for States that provide Medicaid or CHIP premium assistance programs. This contact information will be updated periodically, therefore, be sure to check the EBSA Web site at: <http://www.dol.gov/ebsa/chipmodelnotice.doc> for the most recent version.

Upon loss of eligibility for health coverage or termination of employer contributions for health coverage, what are a plan's obligations to offer special enrollment?

When an employee or dependent loses eligibility for coverage under any group health plan or health insurance coverage, or if employer contributions toward group health plan coverage cease, a special enrollment opportunity may be triggered. The employee or dependent must have had health coverage when the group health plan benefit package was previously declined. If the other coverage was COBRA continuation coverage, special enrollment need not be made available until the COBRA coverage is exhausted.

For example, if an employee's spouse declined coverage when previously offered due to coverage under her own employer's plan, she and the employee must be offered a special enrollment opportunity when her coverage ceases under that plan or her employer terminates contributions to that plan.

Another example is if an employer offering two benefit package options, an HMO and an indemnity option, eliminates coverage under the indemnity option. Employees, spouses, and other dependents must be offered a special enrollment opportunity in the HMO option (and may also be eligible to special enroll in any other plan for which they are otherwise eligible, such as any plan offered by the spouse's employer).

What are examples of a loss of eligibility for coverage?

Some examples of events that cause an individual to lose eligibility for health coverage (there are other reasons as well):

- Divorce or legal separation;
- A dependent is no longer considered a dependent under the plan because of age, work, or school status;
- Death of the employee covered by the plan;
- Termination of employment;
- Reduction in the number of hours of employment;
- The plan decides to no longer offer any benefits to a class of similarly situated individuals;
- An individual incurs a claim that would meet or exceed a lifetime limit on all benefits; or
- An individual in an HMO or other arrangement no longer resides, lives, or works in the service area.

If an employer terminates all contributions to a group health plan, but individuals have the option to continue coverage and pay 100 percent of the cost themselves, would these individuals still have a special enrollment right because the employer has terminated contributions?

Yes. If all employer contributions have ended, individuals covered under the plan would have a special enrollment right, regardless of their option to continue coverage under the plan by paying the full cost of coverage.

If a plan has to offer a special enrollment period upon loss of eligibility or termination of employer contributions, how long must the special enrollment period run?

The plan has to provide at least 30 days for the employee or dependent to request coverage after the loss of other coverage or termination of employer contributions.

If an individual does request coverage within the 30-day period, the plan must make the coverage effective no later than the first day of the first calendar month beginning after the date the plan receives the enrollment request.

Upon marriage, birth, adoption, or placement for adoption, what are a plan's obligations to offer special enrollment?

Employees, as well as their spouses and dependents, may have special enrollment rights after a marriage, birth, adoption, or placement for adoption. In addition, new spouses and new dependents of retirees in a group health plan also may have special enrollment rights after these events.

The plan has to provide at least 30 days for the employee or dependents to request coverage after the occurrence of one of these events.

If the event was a marriage, the coverage is required to be effective no later than the first day of the first calendar month beginning after the date the completed request for enrollment is received by the plan.

In the case of birth, adoption, or placement for adoption, coverage is required to be effective no later than the date of the event.

If an employee or dependent loses coverage under CHIP or Medicaid, or becomes eligible for State premium assistance under those programs, what are a plan's obligations to offer special enrollment?

A special enrollment opportunity is triggered if the employee or dependent who is otherwise eligible, but not enrolled in, a group health plan:

- loses eligibility for coverage under a State Medicaid or CHIP program, or
- becomes eligible for State premium assistance under a Medicaid or CHIP program.

The plan must provide at least 60 days for the employee or dependent to request coverage after the employee or dependent loses eligibility for coverage or becomes eligible for premium assistance.

Can special enrollees be treated as late enrollees when imposing a preexisting condition exclusion or benefits offered under the plan?

A special enrollee may not be treated as a late enrollee (see page 11). In fact, the plan must treat special enrollees the same as similarly situated individuals who enroll when first eligible.

In addition, a newborn, adopted child, or child placed for adoption generally cannot be subject to a preexisting condition exclusion period if the child is covered under creditable coverage within 30 days of birth, adoption, or placement for adoption.

Nondiscrimination Requirements

Under HIPAA, individuals may not be denied eligibility or continued eligibility to enroll in a group health plan based on any health factors they may have. In addition, an individual may not be charged more for coverage than any similarly situated individual is being charged based on any health factor.

***Note:** Compliance with HIPAA's nondiscrimination provisions does not in any way reflect compliance with any other provision of ERISA (including COBRA and ERISA's fiduciary provisions). Nor does it reflect compliance with other State or Federal laws (such as the Americans with Disabilities Act).*

What are the “health factors”?

They are:

- health status;
- medical condition, including both physical and mental illnesses;
- claims experience;
- receipt of health care;
- medical history;
- genetic information;
- evidence of insurability; and
- disability.

The term “evidence of insurability” includes conditions arising from acts of domestic violence, as well as participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities.

Can a group health plan require an individual to pass a physical examination in order to be eligible to enroll in the plan?

No. A group health plan may not require an individual to pass a physical exam for enrollment, even if the individual is a late enrollee.

Can a plan require an individual to complete a health care questionnaire in order to enroll?

Yes, provided that the health information is not used to deny, restrict, or delay eligibility or benefits, or to determine individual premiums.

Can plans exclude or limit benefits for certain conditions or treatments?

Group health plans may exclude coverage for a specific disease, limit or exclude benefits for certain types of treatments or drugs, or limit or exclude benefits based on a determination that the benefits are experimental or medically unnecessary – but only if the benefit restriction applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on a health factor they may have. (Plan amendments that apply to all individuals in a group of similarly situated individuals and that are effective no earlier than the first day of the next plan year after the amendment is adopted are not considered to be directed at individual participants and beneficiaries.)

Can a plan deny benefits otherwise provided for the treatment of an injury based on the source of that injury?

If the injury results from a medical condition or an act of domestic violence, a plan may not deny benefits for the injury – if it is an injury the plan would otherwise cover.

For example, a plan may not exclude coverage for self-inflicted injuries (or injuries resulted from attempted suicide) if the individual's injuries are otherwise covered by the plan and if the injuries are the result of a medical condition (such as depression).

However, a plan may exclude coverage for injuries that do not result from a medical condition or domestic violence, such as injuries sustained in high-risk activities (for example, bungee jumping). But the plan could not exclude an individual from *enrollment* for coverage because the individual participated in bungee jumping.

Can a plan charge individuals with histories of high claims more than similarly situated individuals based on their claims experience?

No. Group health plans cannot charge an individual more for coverage than other similarly situated individuals based on any health factor.

How are groups of similarly situated individuals determined?

Distinctions among groups of similarly situated participants in a health plan must be based on bona-fide employment-based classifications consistent with the employer's usual business practice. Distinctions cannot be based on any of the health factors noted earlier.

For example, part-time and full-time employees, employees working in different geographic locations, and employees with different dates of hire or lengths of service can be treated as distinct groups of similarly situated individuals, with different eligibility provisions, different benefit restrictions, or different costs, provided the distinction is consistent with the employer's usual business practice.

In addition, a plan generally may treat participants and beneficiaries as two separate groups of similarly situated individuals. The plan also may distinguish between beneficiaries based on, for example, their relationship to the plan participant (such as spouse or dependent child) or based on the age or student status of dependent children.

In any case, a plan cannot create or modify a classification directed at individual participants or beneficiaries based on one or more of the health factors.

Is it permissible for a health insurance issuer to charge a higher premium to one group health plan (or employer) that covers individuals, some of whom have adverse health factors, than it charges another group health plan comprised of fewer individuals with adverse health factors?

Yes. In fact, HIPAA does not restrict a health insurance issuer from charging a higher rate to one group health plan (or employer) over another. An issuer may take health factors of individuals into account when establishing blended, aggregate rates for group health plans (or employers). This may result in one health plan (or employer) being charged a higher premium than another for the same coverage through the same issuer.

Can a health insurance issuer charge an employer different premiums for each individual within a group of similarly situated individuals based on each individual's health status?

No. Issuers may not charge or quote an employer or group health plan separate rates that vary for individuals (commonly referred to as "list billing") based on any of the health factors.

This does not prevent issuers from taking the health factors of each individual into account when establishing a blended, aggregate rate for providing coverage to the employment-based group overall. The issuer may then charge the employer (or plan) a higher overall rate, or a higher blended per-participant rate.

While HIPAA prohibits list billing based on health factors, it does not restrict communications between issuers and employers (or plans) regarding the factors considered in the rate calculations.

Can a group health plan impose a nonconfinement clause (e.g., a clause stating that if an individual is confined to a hospital at the time coverage would otherwise take effect, coverage would not begin until that individual is no longer confined)?

No. A group health plan may not deny or delay an individual's eligibility, benefits, or the effective date of coverage because that individual is confined to a hospital or other health care facility. In addition, a health plan may not set an individual's premium rate based on that individual's confinement.

Can a group health plan impose an “actively-at-work” provision (e.g., a requirement that an employee be actively at work after a waiting period for enrollment in order to have health coverage become effective on that day)?

No. Generally a group health plan may not refuse to provide benefits because an individual is not actively at work on the day that individual would otherwise become eligible for benefits. However, plans may have actively-at-work clauses if the plan treats individuals who are absent from work due to a health factor (for example, individuals taking sick leave) as if they are actively at work for purposes of health coverage.

Plans may require individuals to report for the first day of work before coverage may become effective. In addition, plans may distinguish among groups of similarly situated individuals in their eligibility provisions. For example, a plan may require an individual to work full time, such as 250 hours per quarter or 30 hours per week, to be eligible for health plan coverage.

Is it permissible for a group health plan that generally provides coverage for dependents only until age 25 to continue health coverage past that age for disabled dependents?

Yes, a plan can treat an individual with an adverse health factor more favorably by offering extended coverage.

Nondiscrimination and Wellness Programs

In December 2006, the U.S. Departments of Labor, Health and Human Services, and the Treasury issued final nondiscrimination regulations, including rules on wellness programs under HIPAA.

Are wellness programs allowed under HIPAA's nondiscrimination rules?

The HIPAA nondiscrimination provisions generally prohibit group health plans from charging similarly situated individuals different premiums or contributions or imposing different deductible, copayment or other cost sharing requirements based on a health factor. However, there is an exception that allows plans to offer wellness programs.

If none of the conditions for obtaining a reward under a wellness program are based on an individual satisfying a standard related to a health factor, or if no reward is offered, the program complies with the nondiscrimination requirements (assuming participation in the program is made available to all similarly situated individuals). For example:

- A program that reimburses all or part of the cost for memberships in a fitness center.
- A diagnostic testing program that provides a reward for participation rather than outcomes.
- A program that encourages preventive care by waiving the copayment or deductible requirement for the costs of, for example, prenatal care or well-baby visits.
- A program that reimburses employees for the costs of smoking cessation programs without regard to whether the employee quits smoking.
- A program that provides a reward to employees for attending a monthly health education seminar.

Wellness programs that condition a reward on an individual satisfying a standard related to a health factor must meet five requirements described in the final rules in order to comply with the nondiscrimination rules.

What are the five requirements for wellness programs which base a reward on satisfying a standard related to a health factor?

1. The total reward for all the plan's wellness programs that require satisfaction of a standard related to a health factor is limited – generally, it must not exceed 20 percent of the cost of employee-only coverage under the plan. If dependents (such as spouses and/or dependent children) may participate in the wellness program, the reward must not exceed 20 percent of the cost of the coverage in which an employee and any dependents are enrolled.
2. The program must be reasonably designed to promote health and prevent disease.
3. The program must give individuals eligible to participate the opportunity to qualify for the reward at least once per year.
4. The reward must be available to all similarly situated individuals. The program must allow a reasonable alternative standard (or waiver of initial standard) for obtaining the reward to any individual for whom it is unreasonably difficult due to a medical condition, or medically inadvisable, to satisfy the initial standard.
5. The plan must disclose in all materials describing the terms of the program the availability of a reasonable alternative standard (or the possibility of a waiver of the initial standard). Model language is available (see page 99).

How do the wellness program rules apply to a group program that offers a reward to individuals who participate in voluntary testing for early detection of health problems? The plan does not use the test results to determine whether an individual receives a reward or the amount of an individual's reward.

The plan's program does not base any reward on the outcome of the testing. Thus, it is allowed under the HIPAA nondiscrimination provisions without being subject to the five requirements for wellness programs that do require satisfaction of a standard related to a health factor.

Can a plan provide a premium differential between smokers and nonsmokers?

The plan is offering a reward based on an individual's ability to stop smoking. Medical evidence suggests that smoking may be related to a health factor. *The Diagnostic and Statistical Manual of Mental Disorders*, which states that nicotine

addiction is a medical condition, supports that position. In addition, a report of the Surgeon General adds that scientists in the field of drug addiction agree that nicotine, a substance common to all forms of tobacco, is a powerfully addictive drug.

For a group health plan to maintain a premium differential between smokers and nonsmokers and not be considered discriminatory, the plan's nonsmoking program would need to meet the five requirements for wellness programs that require satisfaction of a standard related to a health factor.

Accordingly, this wellness program is permitted if:

- The premium differential is not more than 20 percent of the total cost of employee-only coverage (or 20 percent of the cost of coverage if dependents can participate in the program);
- The program is reasonably designed to promote health and prevent disease;
- Individuals eligible for the program are given an opportunity to qualify for the discount at least once per year;
- The program accommodates individuals for whom it is unreasonably difficult to quit using tobacco products due to addiction by providing a reasonable alternative standard (such as a discount in return for attending educational classes or for trying a nicotine patch); and
- Plan materials describing the terms of the premium differential describe the availability of a reasonable alternative standard to qualify for the lower premium.

Applying and Enforcing HIPAA; State Flexibility

Are certain benefits exempt from HIPAA's portability requirements?

HIPAA does not apply to plans with respect to their provision of "excepted benefits." Likewise, if an individual provides evidence of prior health coverage under a plan that provides only excepted benefits, this coverage is not considered creditable coverage.

Some benefits, such as accidental death and dismemberment benefits, are always excepted benefits and are not subject to HIPAA. Other benefits, including (1) limited-scope dental and limited-scope vision benefits, (2) benefits under a health flexible spending arrangement, (3) noncoordinated benefits, and (4) supplemental benefits may be excepted if certain criteria are met.

More specific information on dental-only and vision-only coverage and supplemental excepted benefits is provided in this section. For more information on other types of excepted benefits, see 29 CFR 2590.732(c) or contact the EBSA office nearest you.

Are dental-only and vision-only coverage subject to HIPAA?

It depends. These benefits may constitute limited-scope excepted benefits (and, therefore, are not subject to HIPAA) if:

- The benefits are offered under a separate insurance policy, certificate, or contract of insurance. (This is an option for insured plans only.)

OR

- The benefits are "not an integral part of the plan." (This is an option for both insured and self-insured plans.) Benefits are not an integral part of the plan if:
 - Participants have the right to elect not to receive coverage for the benefits; and
 - Participants that do elect to receive coverage for the benefits must pay an additional premium or contribution.

Is supplemental health insurance coverage subject to HIPAA?

It depends. Three types of coverage may qualify as supplemental excepted benefits (and, therefore, are not subject to HIPAA): Medicare supplemental health insurance, TRICARE supplemental programs, and similar supplemental coverage provided to coverage under a group health plan.

Coverage will be treated as “similar supplemental coverage” if it is provided under a separate policy, certificate, or contract of insurance, and it satisfies these requirements:

- The supplemental coverage must be issued by an entity that does not provide the plan’s primary coverage;
- It must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles (but does not include coverage that becomes secondary or supplemental only under a coordination-of-benefits provision);
- The cost of supplemental coverage must not exceed 15 percent of the cost of primary coverage; and
- The supplemental coverage must not differentiate among individuals and dependents in eligibility, benefits, or premiums based on any health factor.

See Field Assistance Bulletin 2007-04 at www.dol.gov/ebsa for more information.

Can States modify HIPAA’s portability requirements?

Yes, in certain circumstances. States may impose stricter obligations on health insurance issuers in the seven areas in the following list. States may:

- Shorten the 6-month “look-back period” prior to the enrollment date to determine what preexisting conditions may be subject to the preexisting condition exclusion;
- Shorten the 12- and 18-month maximum preexisting condition exclusion periods;
- Increase the 63-day significant break in coverage period;
- Increase the 30-day period for newborns, adopted children, and children placed for adoption to enroll in creditable coverage without a preexisting condition exclusion;
- Expand the circumstances in which a preexisting condition exclusion period may not be applied;
- Require additional special enrollment periods; and

- Reduce the maximum HMO affiliation period to less than 2 months (3 months for late enrollees). (An affiliation period is the maximum period of time that must pass before coverage provided by an HMO becomes effective. HMOs that impose an affiliation period cannot impose a preexisting condition exclusion period.)

In addition, State laws related to health insurance issuers generally continue to apply except to the extent that such State law “prevents the application of” a requirement of Part 7 of ERISA. Therefore, if health coverage is offered through an HMO or an insurance policy, check with your State insurance department for more information on that State’s insurance laws.

Who enforces the HIPAA portability provisions?

The Secretary of Labor enforces these requirements under ERISA for group health plans. In addition, participants and beneficiaries can sue both plans and issuers to enforce their rights under ERISA, as amended by HIPAA.

The Secretary of the Treasury also enforces these requirements for group health plans. A taxpayer that fails to comply may be subject to an excise tax.

States also have enforcement responsibility, including sanctions available under State law, for requirements imposed on health insurance issuers. If a State does not act in the areas of its responsibility, the Secretary of Health and Human Services may make a determination that the State has failed “to substantially enforce” the law, assert Federal authority to enforce, and impose sanctions on insurers as specified in the statute, including civil monetary penalties.

Guaranteeing Employers the Availability and Renewability of Group Health Coverage

Does HIPAA require health insurance issuers to make health coverage available to small employers?

Yes. Under the PHS Act, small firms (50 or fewer employees) are guaranteed access to health insurance. For more information, contact your State insurance department.

How does HIPAA affect group health coverage renewal and termination?

A group health plan that is a multiemployer plan or multiple employer welfare arrangement (MEWA) generally may not deny an employer whose employees are covered under that plan continued access to the same or different coverage. This rule does not apply if the plan no longer offers service or has any providers in a geographic area. In addition, this rule would not apply where an employer:

- Fails to make payment of contributions;
- Commits fraud or other intentional misrepresentation of material fact;
- Fails to comply with a material plan provision; or
- Fails to meet the terms of, renew, or employ workers covered by a collective bargaining agreement.

In addition, for all group health plans, the PHS Act requires that, at an employer's option (as the plan sponsor), the issuer offering the group health insurance coverage must renew or continue in force the employer's current coverage. However, the issuer may discontinue insurance coverage when:

- Premiums are not paid or are not paid timely;
- Fraud is committed;
- Participation or contribution rules are violated;
- The issuer ceases to offer that particular coverage or all health insurance coverage;
- All individuals move outside the service area; or

- Membership in a bona fide association ceases.

For more information, contact your State insurance department.

The Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act (the Newborns' Act) provides protections for mothers and their newborn children relating to the length of their hospital stays following childbirth.

Group health plans that are subject to the Newborns' Act may not restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the attending provider may decide, after consulting with the mother, to discharge the mother and/or her newborn child earlier.

Many states have enacted their own version of the Newborns' Act for insured coverage. In these states, State law can govern in lieu of the Federal requirements.

What group health plans must comply with the Newborns' Act?

If a plan offers benefits for hospital stays in connection with childbirth, the Newborns' Act applies if the coverage is "self-insured" by an employment-based plan.

If the coverage is provided by an insurance company or HMO (an "insured" plan), and your State has a law regulating coverage for newborns and mothers that meets specific criteria, then State law, rather than the Newborns' Act, applies. If this is the case, the State law may differ slightly from the Newborns' Act requirements, so it is important to know which law applies to the coverage offered by your plan.

For those plans with coverage that is insured by an insurance company or HMO, contact your State insurance department for the most current information on the State laws that pertain to hospital length of stay in connection with childbirth.

For those plans covered by the Federal law, the following questions apply:

When does the 48-hour (or 96-hour) period start?

If a woman delivers her baby in the hospital, the 48-hour period (or 96-hour period) starts at the time of delivery. As an example: if a woman goes into labor and is admitted to the hospital at 10 p.m. on June 11, but gives birth by vaginal delivery at 6 a.m. on June 12, the 48-hour period begins at 6 a.m. on June 12.

However, if the woman delivers outside the hospital and is later admitted to the hospital in connection with childbirth (as determined by the attending provider), the period begins at the time of the hospital admission. For example, if a woman gives birth at home by vaginal delivery, but begins bleeding excessively in connection with childbirth and is admitted to the hospital, the 48-hour period starts at the time of admission.

Who is the attending provider?

An attending provider is an individual licensed under State law who is directly responsible for providing maternity or pediatric care to a mother or newborn child. A nurse midwife or a physician assistant may be an attending provider if licensed in the State to provide maternity or pediatric care in connection with childbirth. A health plan, hospital, insurance company, or HMO, however, would not be an attending provider.

The attending provider cannot receive incentives or disincentives to discharge the mother or her child earlier than 48 hours (or 96 hours).

May a group health plan require an individual to get permission (sometimes called prior authorization or precertification based upon medical necessity) for a 48-hour or 96-hour hospital stay?

A plan cannot deny a mother or her newborn child coverage for a 48-hour stay (or 96-hour stay) because the plan claims that the mother or her attending provider has failed to show that the 48-hour stay (or 96-hour stay) is medically necessary.

However, plans generally can require an individual to notify the plan of the pregnancy in advance of an admission in order to use certain providers or facilities or to reduce the individual's out-of-pocket costs.

Under the Newborns' Act, may group health plans impose deductibles or other cost-sharing provisions for hospital stays in connection with childbirth?

Yes, but only if the deductible, coinsurance, or other cost-sharing for the latter part of a 48-hour (or 96-hour) stay is not greater than that imposed for the earlier part of the stay. For example, with respect to a 48-hour stay, a group health plan is permitted to cover only 80 percent of the cost of the hospital stay. However, a plan covering 80 percent of the cost of the first 24 hours could not reduce coverage to 50 percent for the second 24 hours.

Does the Newborns' Act require a plan to offer maternity benefits?

No. The Newborns' Act does not require plans to provide coverage for hospital stays in connection with childbirth. However, other legal requirements, including Title VII of the Civil Rights Act of 1964, may require this type of coverage. Questions regarding Title VII should be directed to the Equal Employment Opportunity Commission. See the agency's Web site at www.eeoc.gov.

Are group health plans required to tell participants and beneficiaries about the Newborns' Act and any applicable State law protections?

A group health plan that provides maternity or newborn infant coverage must include in its SPD a statement describing the Federal or State law requirements applicable to the plan (or any health insurance coverage offered under the plan) relating to hospital length of stay in connection with childbirth for the mother or newborn child. If the Federal Newborns' Act law applies in some areas in which the plan operates and State laws apply in others, the SPD must describe the Federal and State law requirements that apply in each area covered by the plan.

Model language to describe the Federal law requirements is included on page 100.

The Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) provides protections for individuals who elect breast reconstruction after a mastectomy. Under WHCRA, group health plans offering mastectomy coverage must also provide coverage for certain services relating to the mastectomy, in a manner determined in consultation with the attending physician and the patient. Required coverage includes 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.

Written notice about the availability of these mastectomy-related benefits must be delivered to participants in a group health plan upon enrollment and then each year afterwards.

Does WHCRA apply to individuals who have not been diagnosed with cancer but who must undergo a mastectomy due to other medical reasons?

Despite the title, nothing in the law limits entitlement to WHCRA benefits to cancer patients. If an individual is receiving benefits in connection with a mastectomy and the group health plan covers mastectomies, then the individual should be entitled to WHCRA benefits.

Also, despite the title, nothing in the law limits WHCRA entitlements to women.

Does WHCRA mandate minimum hospital lengths of stay in connection with mastectomy or breast reconstruction?

No, but many State laws applicable to insured coverage provide more protections than WHCRA. Thus, if a plan provides coverage through an insurance company or HMO, covered individuals may be entitled to minimum hospital stays under State law. If your plan is insured, check with your State insurance department for more information.

May group health plans impose deductibles or coinsurance requirements on the coverage specified in WHCRA?

Yes, but only if the deductibles and coinsurance are consistent with those established for other medical/surgical benefits under the plan or coverage.

Can an insurance company refuse to cover reconstructive surgery benefits because an individual's mastectomy was performed when the individual was covered under a different insurance company?

Even though the new insurance company did not cover the individual's mastectomy, as long as the new insurance company provides benefits for mastectomies, it is generally required to provide coverage for breast reconstruction as well as other required benefits under WHCRA if the individual is receiving benefits under the plan related to the mastectomy.

Any restrictions on benefits imposed by the new insurance company because the mastectomy occurred before it covered the individual must comply with HIPAA's rules limiting a plan or health insurance issuer's ability to impose a preexisting condition exclusion.

What information should be included in the notice provided when participants enroll in the plan?

The enrollment notice must state that, for an individual who is 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 enrollment notice must also describe any deductibles and coinsurance limitations applicable to such coverage. Under WHCRA, coverage of breast reconstruction and other benefits specified in WHCRA may be subject only to deductibles and coinsurance limits consistent with those established for other medical/surgical benefits under the plan or coverage.

A copy of a model enrollment notice is included on page 101.

What information should be included in the annual notice to participants in the plan?

The annual notice should describe the four categories of coverage required and should contain information on how to obtain a detailed description of the mastectomy-related benefits available under the plan. To satisfy this annual notice requirement, your plan may provide the same notice it provided to individuals upon enrollment in the plan if it contains the appropriate information as described above.

A model annual notice is included on page 102.

How must the plan provide these notices to participants?

These notices must be delivered in accordance with the Department of Labor's disclosure rules applicable to furnishing summary plan descriptions. For example, the notices may be provided by first class mail or any other means of delivery prescribed in the regulation. A separate notice must be furnished to a group health plan beneficiary where the last known address of the beneficiary is different than the last known address of the covered participant.

To avoid duplication of notices, a group health plan can satisfy the WHCRA notice requirements by contracting with another party that provides the required notice. For example, in the case of an insured group health plan, the plan will satisfy the notice requirements with respect to a particular participant if the issuer timely provides the notice including the information required by WHCRA.

The Genetic Information Nondiscrimination Act

Title I of the Genetic Information Nondiscrimination Act of 2008 (GINA) includes provisions that generally prohibit group health plans and health insurance issuers from discriminating based on genetic information. These provisions amend the Employee Retirement Income Security Act (ERISA), administered by the Department of Labor; the Public Health Service Act (PHS Act), administered by the Department of Health and Human Services; and the Internal Revenue Code (the Code), administered by the Department of Treasury (the Treasury) and the Internal Revenue Service (IRS). The Department of Labor has jurisdiction with respect to employment-based group health plans. HHS in conjunction with the States administers these provisions with respect to health insurance issuers. The Treasury and IRS administer these provisions with respect to employers. Title I of GINA also includes individual insurance market provisions under the PHS Act and privacy and confidentiality provisions under the Social Security Act, which are both within the jurisdiction of HHS. Title II of GINA, under the jurisdiction of the Equal Employment Opportunity Commission, addresses discrimination in employment based on genetic information.

The subject of these Frequently Asked Questions are the requirements of Title I of GINA under ERISA, prohibiting discrimination in group health plan coverage based on genetic information.

GINA expands the genetic information nondiscrimination protections included in Title I of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Under GINA, group health plans and health insurance issuers cannot base premiums for a plan or a group of similarly situated individuals on genetic information. GINA generally prohibits plans and issuers from requesting or requiring an individual to undergo genetic tests, and prohibits a plan from collecting genetic information (including family medical history) prior to or in connection with enrollment, or for underwriting purposes.

GINA applies generally to group health plans. Unlike the provisions under Title I of HIPAA, there is no exception for very small health plans with less than two participants who are current employees.

The statutory provisions of GINA are effective for plan years beginning on or after May 21, 2009. The regulations implementing the provisions of GINA were published on October 7, 2009 and are applicable for plan years beginning on or after December 7, 2009. Therefore, for calendar year plans the statute and regulations apply as of January 1, 2010. You can access a copy of these regulations at <http://www.dol.gov/federalregister/PdfDisplay.aspx?DocId=23182>.

How does GINA expand the genetic information nondiscrimination protections in HIPAA?

HIPAA prevents a plan or issuer from imposing a preexisting condition exclusion based solely on genetic information, and prohibits discrimination in individual eligibility, benefits, or premiums based on any health factor (including genetic information). GINA provides additional underwriting protections, prohibits requesting or requiring genetic testing, and restricts the collection of genetic information. Specifically:

- GINA provides that group health plans and health insurance issuers cannot adjust premiums or contribution amounts for a plan, or any group of similarly situated individuals under the plan, based on genetic information of one or more individuals in the group. (However, premiums may be increased for the group based upon the manifestation of a disease or disorder of an individual enrolled in the plan.)
- GINA generally prohibits plans and issuers from requesting or requiring an individual to undergo a genetic test. However, a health care professional providing health care services to an individual is permitted to request a genetic test. A plan or issuer may request the results of a genetic test to determine payment of a claim for benefits, but only the minimum amount of information necessary in order to determine payment. There is also a research exception that permits a plan or issuer under certain conditions to request (but not require) that a participant or beneficiary undergo a genetic test.
- GINA prohibits a plan from collecting genetic information (including family medical history) from an individual prior to or in connection with their enrollment in the plan, or at any time for underwriting purposes. Under GINA, underwriting purposes includes rules for determination of eligibility for benefits and the computation of premium and contribution amounts. Thus, under GINA, plans and issuers are generally prohibited from offering rewards in return for the provision of genetic information, including family medical history information collected as part of a Health

Risk Assessment (HRA). GINA includes an exception for incidental collection of genetic information, provided the information is not used for underwriting purposes. However, the regulations make clear that the incidental collection exception is not available if it is reasonable for the plan or issuer to anticipate that health information will be received in response to a collection, unless the collection explicitly states that genetic information should not be provided.

What is genetic information?

Genetic information means information about an individual's genetic tests, the genetic tests of family members of the individual, the manifestation of a disease or disorder in family members of the individual or any request for or receipt of genetic services, or participation in clinical research that includes genetic services by the individual or a family member of the individual. The term genetic information includes, with respect to a pregnant woman (or a family member of a pregnant woman) genetic information about the fetus and with respect to an individual using assisted reproductive technology, genetic information about the embryo.

Genetic information does not include information about the sex or age of any individual.

Genetic information includes information about an individual's genetic services and tests. What do these include?

Genetic services mean genetic tests, genetic counseling, or genetic education. Genetic test means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, if the analysis detects genotypes, mutations, or chromosomal changes. A genetic test does not include an analysis of proteins or metabolites directly related to a manifested disease, disorder, or pathological condition.

Therefore, some examples of genetic tests are tests to determine whether an individual has a BRCA1, BRCA2, or colorectal cancer genetic variant. In contrast, an HIV test, complete blood count, cholesterol test, liver function test, or test for the presence of alcohol or drugs is not a genetic test.

Genetic information includes an individual's genetic tests and information about the manifestation of a disease or disorder in an individual's family member. A genetic test does not include an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition. What is a manifested disease?

A manifested disease is a disease, disorder, or pathological condition for which an individual has been or could reasonably be diagnosed by a health care

professional (with appropriate training and expertise in the field of medicine involved).

A disease is not manifested if a diagnosis is based principally on genetic information. For example, an individual whose genetic tests indicate a genetic variant associated with colorectal cancer and another that indicates an increased risk of developing cancer, but who has no signs or symptoms of disease and has not and could not reasonably be diagnosed with a disease does not have a manifested disease.

While plans and issuers are prohibited from adjusting group premiums or contributions based on genetic information, plans and issuers can increase the premium or contribution based on the manifested disease or disorder of an individual enrolled in the plan. This is because information about an individual's manifested disease or disorder is not genetic information with respect to that individual. This is discussed further below.

GINA prohibits a plan from collecting genetic information (including family medical history) prior to or in connection with enrollment, or at any time for underwriting purposes. What does “collect” include?

Collect means to request, require, or purchase genetic information.

Can a group health plan adjust the premium that an employer or group of similarly situated individuals must pay under the plan based on genetic information of an individual or individuals covered under the group?

No. GINA prohibits a group health plan from adjusting group premium or contribution amounts for a group of similarly situated individuals based on the genetic information of members of the group. This is a change from HIPAA's prior nondiscrimination requirements, which allowed plans to adjust premiums or contributions for the group health plan or group of similarly situated individuals (but not for specific individuals within the group) based on genetic information, as well as other health factors. Therefore, even if a plan obtained individual genetic information about group members before GINA's effective date, it cannot be used to adjust the group premium.

Under GINA and HIPAA, a plan can charge a higher overall, blended per-participant amount based on the manifestation of a disease or a disorder of an individual enrolled in the plan. However, a plan cannot use the manifestation of a disease or disorder in one individual as genetic information about other group members to further increase the group premium.

A plan can take into account the costs associated with providing benefits for covered genetic tests or genetic services in determining overall premium or

contribution amounts. Note, under HIPAA, a plan cannot charge an individual more for coverage than other similarly situated individuals in the group based on any health factor, including a manifested disease or disorder.

For further discussion of what “manifested disease” means, see above.

Can an individual’s doctor or other health care provider request that the individual undergo a genetic test?

Generally, yes. GINA prohibits a group health plan from requesting or requiring an individual or a family member of an individual to undergo genetic tests. Nonetheless, under GINA, a health care professional who is providing health care services to an individual can request that an individual undergo a genetic test. A health care professional includes but is not limited to a physician, nurse, physician’s assistant, or technicians that provide health care services to patients.

For example, if during the course of a routine physical exam, a physician learns that an individual has family medical history indicating a potential risk for Huntington’s disease, the physician can recommend that the individual undergo a related genetic test. This would not violate GINA. This would be true even if the doctor were employed by an HMO, so long as the physician was providing health care services to the individual for whom the genetic test was recommended.

Can a health plan obtain the results of a genetic test to make a determination regarding payment of a claim for benefits under the plan?

Generally, yes. If a plan conditions payment for an item or service based on medical appropriateness and the medical appropriateness depends on the genetic makeup of the patient, then the plan is permitted to condition payment for the item or service on the outcome of a genetic test. The plan may also refuse payment in that situation if the patient does not undergo the genetic test. The plan may request only the minimum amount of information necessary to make a determination regarding payment.

If a plan normally covers mammograms for participants and beneficiaries starting at age 40, but covers them at age 30 for individuals with a high risk of breast cancer, may the plan require that an individual under 40 submit genetic test results or family medical history as evidence of high risk of breast cancer, in order to have a claim for a mammogram paid?

Generally, yes. Under GINA, a plan may request and use the results of a genetic test to make a determination regarding payment, as long as the plan requests only the minimum amount of information necessary.

Plans may also request genetic information for the purpose of determining the medical appropriateness of a treatment or service. Because the medical appropriateness of the mammogram depends on the patient's genetic makeup, the minimum amount of information necessary for determining payment of the claim may include the results of a genetic test or the individual's family medical history.

Can a plan request that a participant or beneficiary undergo a genetic test for research purposes?

Under GINA, a plan is permitted to request, but not to require, that a participant or beneficiary undergo a genetic test for research purposes if the following four requirements are met:

- The plan makes the request pursuant to research. (Research is defined in 45 CFR 46.102(d).) The research must comply with 45 CFR Part 46 or equivalent Federal regulations and any applicable State or local law or regulation for the protection of human subjects in research.
- The plan must make the request for the genetic test in writing and clearly indicate to each participant and beneficiary that the request is **voluntary** and will have **no effect on eligibility**.
- No genetic information collected pursuant to this research exception can be used for underwriting purposes.
- The plan must complete a copy of the "Notice of Research Exception under the Genetic Information Nondiscrimination Act" and provide the notice to the address specified in the instructions. You can access this notice at <http://www.dol.gov/ebsa/GINAexceptioninstructions.html>.

GINA prohibits a group health plan from collecting genetic information for underwriting purposes. What does underwriting purposes mean?

Under GINA, the definition of underwriting purposes is broader than merely activities relating to rating and pricing a group policy. Under GINA, underwriting purposes means, with respect to a group health plan:

- Rules for or determination of eligibility (including enrollment and continued eligibility) for benefits under the plan or coverage (including changes in deductibles or other cost-sharing mechanisms in return for activities such as completing a health risk assessment (HRA) or participating in a wellness program);
- Computation of premium or contribution amounts under the plan (including discounts, rebates, payments in kind, or other premium

differential mechanisms in return for activities such as completing an HRA or participating in a wellness program);

- The application of any preexisting condition exclusion under the plan; and
- Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

Can a plan require an individual to complete a health risk assessment (HRA) prior to or as part of the enrollment process for the plan?

GINA prohibits a plan from collecting genetic information (including family medical history) prior to or in connection with enrollment. Thus, under GINA, plans and issuers must ensure that any HRA conducted prior to or in connection with enrollment does not collect genetic information, including family medical history.

Under GINA, there is an exception for genetic information that is obtained incidental to the collection of other information, if 1) the genetic information that is obtained is not used for underwriting purposes and 2) if it is reasonable to anticipate that the collection will result in the plan receiving health information, the plan explicitly notifies the person providing the information that genetic information should not be provided.

Therefore, a plan conducting an HRA prior to or in connection with enrollment, should ensure that the HRA explicitly states that genetic information should not be provided.

Can a plan require that an individual complete a health risk assessment (HRA) that requests family medical history in order to receive a wellness program reward, such as a financial incentive, in return for the completion of the HRA?

GINA prohibits a plan from collecting genetic information (including family medical history):

- prior to or in connection with enrollment; or
- at any time for underwriting purposes.

Because completing the HRA results in a reward, the request is for underwriting purposes and is prohibited.

A plan may use an HRA that requests family medical history, if it is requested to be completed after and unrelated to enrollment and if there is no premium reduction or any other reward for completing the HRA.

A plan may offer a premium discount or other reward for completion of an HRA that does not request family medical history or other genetic information, such as information about any genetic tests the individual has undergone. The plan should ensure that the HRA explicitly states that genetic information should not be provided. This is because GINA provides an exception for genetic information that is obtained incidental to the collection of other information, if 1) the genetic information that is obtained is not used for underwriting purposes and 2) if in connection with any collection it is reasonable to anticipate that health information will be received, the collection explicitly states that genetic information should not be provided.

Plans may use two separate HRAs; one that collects genetic information, such as family medical history, which is conducted after and unrelated to enrollment and is not tied to a reward, and another HRA that does not request genetic information, which can be tied to a reward. In addition, under GINA group health plans may also reward:

- Participation in an annual physical examination with a physician (or other health care professional) who is providing health care services to the individual, even if the physician may ask for family medical history as part of the examination;
- More favorable cost-sharing for preventive services, including genetic screening; and
- Participation in certain disease management or prevention programs. The incentives to participate in such programs must also be available to individuals who qualify for the program but have not volunteered family medical history information through an HRA.

Appendix A: Self-Compliance Tool

Self-Compliance Tool for Part 7 of ERISA: HIPAA and Other Health Care-Related Provisions

INTRODUCTION

This self-compliance tool is useful for group health plans, plan sponsors, plan administrators, health insurance issuers, and other parties to determine whether a group health plan is in compliance with the provisions of Part 7 of ERISA.

The requirements described in the Part 7 tool generally apply to group health plans and group health insurance issuers. However, references in this tool are generally limited to “group health plans” or “plans” for convenience.

Cumulative List of Self-Compliance Tool Questions for HIPAA and Other Health Care-Related Statutes Added to Part 7 of ERISA

I. Determining Compliance with the HIPAA Provisions in Part 7 of ERISA

**If you answer "No" to any of the questions below, the group health plan
is in violation of the HIPAA provisions in Part 7 of ERISA.**

	YES	NO	N/A
<p><u>SECTION A - Limits on Preexisting Condition Exclusions</u> If the plan imposes a preexisting condition exclusion period, the plan must comply with this section.</p> <p>Definition: Generally, a preexisting condition exclusion is a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage under a group health plan or group health insurance coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. <i>See ERISA section 701(b)(1); 29 CFR 2590.701-3(a)(1).</i></p> <p>Tip: Some preexisting condition exclusions are clearly designated as such in the plan documents. Others are not. Check for <i>hidden</i> preexisting condition exclusion provisions. A hidden preexisting condition exclusion is not designated as a preexisting condition exclusion, but restricts benefits based on when a condition arose in relation to the effective date of coverage.</p> <p>◆ Example: A plan excludes coverage for cosmetic surgery unless the surgery is required by reason of an accidental injury <u>occurring after the effective date of coverage</u>. This plan provision operates as a preexisting condition exclusion</p>			

	YES	NO	N/A
<p>because only people who were injured while covered under the plan receive benefits for treatment. People who were injured while they had no coverage (or while they had prior coverage) do not receive benefits for treatment. Accordingly, this plan provision limits benefits relating to a condition because the condition was present before the effective date of coverage, and is considered a preexisting condition exclusion.</p> <p>A plan imposing a preexisting condition exclusion is required to comply with all the rules described in this SECTION A. Therefore, if the plan is not mindful that a provision operates as a preexisting condition exclusion, there could be multiple violations of this SECTION A.</p> <p>Tip: To comply with HIPAA, a plan imposing a <i>hidden</i> preexisting condition exclusion can rewrite its plan provision so that it is not a preexisting condition exclusion (i.e., benefits are not limited based on whether the condition arose before an individual's effective date of coverage) or the plan must limit the preexisting condition exclusion to comply with the rules of this SECTION A.</p> <p>If the plan does not impose a preexisting condition exclusion period, including a <i>hidden</i> preexisting condition exclusion period, check "N/A" and skip to SECTION B</p>			<input type="checkbox"/>
<p>Question 1 – Six-month look-back period Does the plan comply with the 6-month look-back rule?</p> <p>◆ A preexisting condition exclusion may apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received during the 6-month period ending on an individual's "enrollment date." See <i>ERISA section 701(a)(1); 29 CFR 2590.701-3(a)(2)(i)</i>.</p> <p>Definitions: An individual's <u>enrollment date</u> is the earlier of: (1) the first day of coverage; or (2) the first day of any waiting period for coverage. (<u>Waiting period</u> means the period that must pass before an employee or dependent is eligible to enroll under the terms of the plan. If an employee or dependent enrolls as a late enrollee or special enrollee, any period before such enrollment date is not a waiting period.) Therefore, if the plan has a waiting period, the 6-month look-back period ends on the first day of the waiting period, not the first day of coverage. See <i>ERISA sections 701(b)(1) and (4); 29 CFR 2590.701-3(a)(3)</i>.</p> <p>Tip: If the plan has a waiting period for coverage, ensure that the 6-month look-back period is measured from the first day of the waiting period, not the first day of coverage.</p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p>Question 2 – Twelve/eighteen-month look-forward period Does the plan comply with HIPAA's 12-month (or 18-month) look-forward rule?</p> <p>◆ The maximum preexisting condition exclusion period is 12 months (18 months for late enrollees), measured from an individual's enrollment date. <i>See ERISA section 701(a)(2); 29 CFR 2590.701-3(a)(2)(ii).</i></p> <p>Tip: If the plan has a waiting period, the 12-month (or 18-month) look-forward period must begin on the first day of the waiting period, not the first day of coverage. Therefore, the preexisting condition exclusion period runs concurrently with the waiting period, rather than beginning after the waiting period ends.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>Question 3 – Offsetting the length of preexisting condition exclusions by creditable coverage Does the plan offset the length of its preexisting condition exclusion by an individual's creditable coverage?</p> <p>◆ The length of the plan's preexisting condition exclusion must be offset by the number of days of an individual's creditable coverage. However, days of coverage prior to a "significant break in coverage" are not required to be counted as creditable coverage. Under Federal law, a significant break in coverage is a period of 63 days or more without any health coverage. <i>See ERISA section 701(a)(3); 29 CFR 2590.701-3(a)(2)(iii).</i></p> <p>Definition: Creditable coverage means coverage of an individual under any of the following:</p> <ul style="list-style-type: none"> ◆ A group health plan (including COBRA coverage), ◆ Health insurance coverage, ◆ Medicare, ◆ Medicaid, ◆ TRICARE, ◆ The Indian Health Service, ◆ A State health risk benefit pool, ◆ The Federal Employee Health Benefit Program, ◆ A public health plan, ◆ Peace Corps Act health benefits, or ◆ The State Children's Health Insurance Program. <p><i>See ERISA section 701(c); 29 CFR 2590.701-4(a)(1).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>Question 4 – Preexisting condition exclusion on genetic information Does the plan comply with HIPAA by not imposing a preexisting condition exclusion with respect to genetic information?</p> <p>◆ Genetic information alone cannot be treated as a preexisting condition in the absence of a diagnosis of a condition related to such information. <i>See ERISA section 701(a)(1) and (b)(1); 29 CFR 2590.701-3(b)(6).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p><u>Question 5 – Preexisting condition exclusion on newborns</u> Does the plan comply with HIPAA by not imposing an impermissible preexisting condition exclusion on newborns?</p> <p>◆ A plan generally may not impose a preexisting condition exclusion on a child who enrolls in creditable coverage within 30 days of birth. <i>See ERISA section 701(d)(1); 29 CFR 2590.701-3(b)(1).</i></p> <p>Tip: Even if a child is not covered under the plan within 30 days of birth, the child still cannot be subject to a preexisting condition exclusion if he or she was enrolled in any creditable coverage within 30 days of birth and does not incur a subsequent 63-day break in coverage.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 6 – Preexisting condition exclusion on children adopted or placed for adoption</u> Does the plan comply with HIPAA by not imposing an impermissible preexisting condition exclusion on adopted children or children placed for adoption?</p> <p>◆ A plan generally may not impose a preexisting condition exclusion on a child who enrolls in creditable coverage within 30 days of adoption or placement for adoption. <i>See ERISA section 701(d)(2); 29 CFR 2590.701-3(b)(2).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 7 – Preexisting condition exclusion on pregnancy</u> Does the plan comply with HIPAA by not imposing a preexisting condition exclusion on pregnancy?</p> <p>◆ A plan may not impose a preexisting condition exclusion relating to pregnancy. <i>See ERISA section 701(d)(3); 29 CFR 2590.701-3(b)(5).</i></p> <p>Tip: A plan provision that denies benefits for pregnancy until 12 months after an individual generally becomes eligible for benefits under the plan is a preexisting condition exclusion and is prohibited. <i>See 29 CFR 2590.701-3(a)(1)(ii) Example 5.</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 8 – General notices of preexisting condition exclusion</u> Does the plan provide adequate and timely general notices of preexisting condition exclusions?</p> <p>◆ A group health plan may not impose a preexisting condition exclusion with respect to a participant or dependent before notifying the participant, in writing, of:</p> <ul style="list-style-type: none"> ❖ The existence and terms of any preexisting condition exclusion under the plan. This includes the length of the plan’s look-back period, the maximum preexisting condition exclusion period under the plan, and how the plan will reduce this maximum by creditable coverage. 	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<ul style="list-style-type: none"> ❖ A description of the rights of individuals to demonstrate creditable coverage (and any applicable waiting periods) through a certificate of creditable coverage or through other means. This must include: (1) a description of the right of the individual to request a certificate from a prior plan or issuer, if necessary; and (2) a statement that the current plan or issuer will assist in obtaining a certificate from any prior plan or issuer, if necessary. ❖ A person to contact (including an address or telephone number) for obtaining additional information or assistance regarding the preexisting condition exclusion. <p><i>See 29 CFR 2590.701-3(c)(2).</i></p> <ul style="list-style-type: none"> ◆ The general notice is required to be provided as part of any written application materials distributed for enrollment. If a plan does not distribute such materials, the notice must be provided by the earliest date following a request for enrollment that the plan, acting in a reasonable and prompt fashion, can provide the notice. <i>See 29 CFR 2590.701-3(c)(1).</i> <p>Tips: Ensure that the general notice is both complete and timely. The plan can include its general notice of preexisting condition exclusion in the summary plan description (SPD) if the SPD is provided as part of the application materials. If not, this general notice must be provided separately to be timely. A model notice is provided in the Model Disclosures on page 99.</p>			
<p><u>Question 9 – Determination of creditable coverage</u> Does the plan comply with the requirements relating to determination of individuals’ creditable coverage?</p> <ul style="list-style-type: none"> ◆ If a plan receives creditable coverage information from an individual, the plan is required to make a determination regarding the amount of the individual’s creditable coverage and the length of any preexisting condition exclusion that remains. This determination must be made within a reasonable time following the receipt of the creditable coverage information. Whether this determination is made within a reasonable time depends on all the relevant facts and circumstances, including whether the plan’s application of a preexisting condition exclusion would prevent an individual from having access to urgent medical care. <i>See 29 CFR 2590.701-3(d)(1).</i> ◆ A plan may not impose any limit on the amount of time an individual has to present a certificate or other evidence of creditable coverage. <i>See 29 CFR 2590.701-3(d)(2).</i> 	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p><u>Question 10 – Individual notices of preexisting condition exclusions</u> Does the plan provide adequate and timely individual notices of preexisting condition exclusion?</p> <p>◆ After an individual has presented evidence of creditable coverage and after the plan has made a determination of creditable coverage (<i>See 29 CFR 2590.701-3(d)</i>), the plan must provide the individual a written notice of the length of preexisting condition exclusion that remains after offsetting for prior creditable coverage. <i>See 29 CFR 2590.701-3(e)</i>.</p> <p>◆ Exception: A plan is not required to provide this notice if the plan’s preexisting condition exclusion is completely offset by the individual’s prior creditable coverage. <i>See 29 CFR 2590.701-3(e)</i>.</p> <p>◆ The notice must disclose:</p> <ul style="list-style-type: none"> ❖ The determination of the length of any preexisting condition exclusion that applies to the individual (including the last day on which the preexisting condition exclusion applies); ❖ The basis for the determination, including the source and substance of any information on which the plan relied; ❖ An explanation of the individual’s right to submit additional evidence of creditable coverage; and ❖ A description of any applicable appeal procedures established by the plan. <i>See 29 CFR 2590.701-3(e)(2)</i>. <p>◆ The individual notice must be provided by the earliest date following a determination that the plan, acting in a reasonable and prompt fashion, can provide the notice. <i>See 29 CFR 2590.701-3(e)(1)</i>.</p> <p>Tips: Ensure that individual notices are complete and timely as well. A model notice is provided in the Model Disclosures on page 101.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 11 – Reconsideration</u> If the plan determines that an individual does not have the creditable coverage claimed, and the plan wants to modify an initial determination of creditable coverage, does the plan comply with the rules relating to reconsideration?</p> <p>◆ A plan may modify an initial determination of an individual’s creditable coverage if the plan determines that the individual did not have the claimed creditable coverage, provided that:</p> <ul style="list-style-type: none"> ❖ A notice of the new determination is provided to the individual; and ❖ Until the new notice is provided, the plan, for purposes of approving access to medical services, acts in a manner consistent with the initial determination of creditable coverage. <p><i>See 29 CFR 2590.701-3(f)</i>.</p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p><u>SECTION B - Compliance with the Certificate of Creditable Coverage Provisions</u></p> <p>Regardless of whether the plan imposes a preexisting condition exclusion, the plan is required to issue certificates of creditable coverage when coverage ceases and upon request.</p> <p>To be complete, under 29 CFR 2590.701-5(a)(3)(ii), each certificate must include:</p> <ol style="list-style-type: none"> 1. Date issued; 2. Name of plan; 3. The individual's name and identification information (**Note: Dependent information can be included on the same certificate with the participant information or on a separate certificate. The plan is required to have used <u>reasonable efforts to get dependent information.</u> See 29 CFR 2590.701-5(a)(5)(i)); 4. Plan administrator name, address, and telephone number; 5. Telephone number for further information (if different); 6. Individual's creditable coverage information: <ul style="list-style-type: none"> ❖ Either: (1) that the individual has at least 18 months of creditable coverage; or (2) the date any waiting period (or affiliation period) began and the date creditable coverage began. ❖ Also, either: (1) the date creditable coverage ended; or (2) that creditable coverage is continuing. ❖ Automatic certificates of creditable coverage should reflect the last period of continuous coverage. ❖ Requested certificates should reflect periods of continuous coverage that an individual had in the 24 months prior to the date of the request (up to 18 months of creditable coverage). See 29 CFR 2590.701-5(a)(3)(iii). 7. An educational statement regarding HIPAA, which explains: <ul style="list-style-type: none"> ❖ The restrictions on the ability of a plan or issuer to impose a preexisting condition exclusion (including an individual's ability to reduce a preexisting condition exclusion by creditable coverage); ❖ Special enrollment rights; ❖ The prohibitions against discrimination based on any health factor; ❖ The right to individual health coverage; ❖ The fact that State law may require issuers to provide additional protections to individuals in that State; and ❖ Where to get more information. <p>Tips: Remember to include information about waiting periods and dependents. If a plan imposes a waiting period, the date the waiting period began is required to be reflected on the certificate. In addition, if the certificate applies to more than one person (such as a participant and dependents), the dependents' creditable coverage information is required to be reflected on the certificate (or the plan can issue a separate certificate to each dependent). (**Note: If a dependent's last known address is different from the participant's last known address, a separate certificate is required to be provided to the dependent at the dependent's last known address.) A model notice is provided in the Model Disclosures on page 95.</p>			

	YES	NO	N/A
<p>** Special Accountability Rule for Insured Plans:</p> <ul style="list-style-type: none"> ◆ Under a special accountability rule in ERISA section 701(e)(1)(C) and 29 CFR 2590.701-5(a)(1)(iii), a health insurance issuer, rather than the plan, may be responsible for providing certificates of creditable coverage by virtue of an agreement between the two that makes the issuer responsible. In this case, the issuer, but not the plan, violates the certificate requirements of section 701(e) if a certificate is not provided in compliance with these rules. (**Note: An agreement with a third-party administrator (TPA) that is not insuring benefits will not transfer responsibility from the plan.) ◆ Despite this special accountability rule, other responsibilities, such as a plan administrator's duty to monitor compliance with a contract, remain unaffected. <p>Accordingly, this section of the self-compliance tool is organized differently to take into account this special accountability rule.</p>			
<p><u>Question 12 – Automatic certificates of creditable coverage upon loss of coverage</u> Does the plan provide complete and timely certificates of creditable coverage to individuals automatically upon loss of coverage?</p> <ul style="list-style-type: none"> ◆ Plans are required to provide each participant and dependent covered under the plan an <u>automatic</u> certificate, free of charge, when coverage ceases. (If the plan is insured and there is an agreement with the issuer that the issuer is responsible for providing the certificates, check "N/A" and go to Question 13.) ◆ Under 29 CFR 2590.701-5(a)(2)(ii), plans and issuers must furnish an automatic certificate of creditable coverage: <ul style="list-style-type: none"> ❖ To an individual who is entitled to elect COBRA, at a time no later than when a notice is required to be provided for a qualifying event under COBRA (usually not more than 44 days); ❖ To an individual who loses coverage under the plan and who is not entitled to elect COBRA, within a reasonable time after coverage ceases; and ❖ To an individual who ceases COBRA, within a reasonable time after COBRA coverage ceases (or after the expiration of any grace period for nonpayment of premiums). 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p><u>Question 13 – Automatic certificate upon loss of coverage – Issuer Responsibility</u> If there is an agreement between the plan and the issuer stating that the issuer is responsible for providing certificates of creditable coverage, does the issuer provide complete and timely certificates?</p> <ul style="list-style-type: none"> ◆ Even if the plan is not responsible for issuing certificates of creditable coverage, the plan should monitor issuer compliance with the certification provisions. ◆ If the plan is self-insured, or if there is no such agreement between the plan and the issuer, check "N/A" and skip to Question 14. 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO	N/A
<p><u>Question 14 – Certificates of creditable coverage upon request</u> Does the plan provide complete certificates of creditable coverage upon request?</p> <p>(If the plan is insured and the issuer is responsible for issuing certificates pursuant to an agreement, check "N/A" and go to Question 15.)</p> <p>◆ Certificates of creditable coverage must be provided free of charge to individuals who request a certificate <u>while covered under the plan and for up to 24 months after coverage ends</u>. See <i>ERISA section 701(e)(1)(A)</i>; <i>29 CFR 2590.701-5(a)(2)(iii)</i>.</p> <p>◆ Requested certificates must be provided, at the earliest time that a plan or issuer, acting in a reasonable and prompt fashion, can provide the certificate of creditable coverage. See <i>29 CFR 2590.701-5(a)(2)(iii)</i>.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p><u>Question 15 – Certificates upon request – Issuer Responsibility</u> If the plan is insured and there is an agreement between the plan and the issuer stating that the issuer is responsible for providing certificates of creditable coverage, does the issuer provide complete certificates?</p> <p>◆ Even if the plan is not responsible for issuing certificates of creditable coverage, the plan should monitor issuer compliance with the certification provisions.</p> <p>◆ If the plan is self-insured, or if there is no such agreement between the plan and the issuer, check "N/A" and skip to Question 16.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p><u>Question 16 – Written Procedure for Requesting Certificates</u> Does the plan have a written procedure for individuals to request and receive certificates of creditable coverage?</p> <p>◆ The plan must have a written procedure for individuals to request and receive certificates of creditable coverage. The written procedure must include all contact information necessary to request a certificate (such as name and phone number or address). See <i>29 CFR 2590.701-5(a)(4)(ii)</i>.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p><u>SECTION C – Compliance with the Special Enrollment Provisions</u> Group health plans must allow individuals (who are otherwise eligible) to enroll upon certain specified events, regardless of any late enrollment provisions, if enrollment is requested within 30 days (or 60 days in the case of the special enrollment rights added by the Children's Health Insurance Program Reauthorization Act of 2009, discussed in Question 19) of the event. The plan must provide for special enrollment, as follows:</p>			

	YES	NO	N/A
<p>Question 17 – Special enrollment upon loss of other coverage Does the plan provide full special enrollment rights upon loss of other coverage?</p> <p>◆ A plan must permit loss-of-coverage special enrollment upon: (1) loss of eligibility for group health plan coverage or health insurance coverage; and (2) termination of employer contributions toward group health plan coverage. <i>See ERISA section 701(f)(1); 29 CFR 2590.701-6(a).</i></p> <p>◆ <u>When a current employee loses eligibility for coverage</u>, the plan must permit the employee and any dependents to special enroll. <i>See 29 CFR 2590.701-6(a)(2)(i).</i></p> <p>◆ <u>When a dependent of a current employee loses eligibility for coverage</u>, the plan must permit the dependent and the employee to special enroll. <i>See 29 CFR 2590.701-6(a)(2)(ii).</i></p> <p>Examples: Examples of reasons for loss of eligibility include: legal separation, divorce, death of an employee, termination or reduction in the number of hours of employment - voluntary or involuntary (with or without electing COBRA), exhaustion of COBRA, reduction in hours, "aging out" under other parent's coverage, moving out of an HMO's service area, and meeting or exceeding a lifetime limit on all benefits. Loss of eligibility for coverage does not include loss due to the individual's failure to pay premiums or termination of coverage for cause - such as for fraud. <i>See 29 CFR 2590.701-6(a)(3)(i).</i></p> <p>◆ When employer contributions toward an employee's or dependent's coverage terminates, the plan must permit special enrollment, even if the employee or dependent did not lose eligibility for coverage. <i>See 29 CFR 2590.701-6(a)(3)(ii).</i></p> <p>◆ Plans must allow an employee a period of at least 30 days to request enrollment. <i>See 29 CFR 2590.701-6(a)(4)(i).</i></p> <p>◆ Coverage must become effective no later than the first day of the first month following a completed request for enrollment. <i>See 29 CFR 2590.701-6(a)(4)(ii).</i></p> <p>Tip: Ensure that the plan permits special enrollment upon <u>all</u> of the loss of coverage events described above.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>Question 18 – Dependent special enrollment Does the plan provide full special enrollment rights to individuals upon marriage, birth, adoption, and placement for adoption?</p> <p>◆ Plans must generally permit current employees to enroll upon marriage and upon birth, adoption, or placement for adoption of a dependent child. <i>See ERISA section 701(f)(2); 29 CFR 2590.701-6(b)(2).</i></p> <p>◆ Plans must generally permit a participant's spouse and new dependents to enroll upon marriage, birth, adoption, and placement for adoption. <i>See ERISA section 701(f)(2); 29 CFR 2590.701-6(b)(2).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<ul style="list-style-type: none"> ◆ Plans must allow an individual a period of at least 30 days to request enrollment. <i>See 29 CFR 2590.701-6(b)(3)(i).</i> ◆ In the case of marriage, coverage must become effective no later than the first day of the month following a completed request for enrollment. <i>See 29 CFR 2590.701-6(b)(3)(iii)(A).</i> ◆ In the case of birth, adoption, or placement for adoption, coverage must become effective as of the date of the birth, adoption, or placement for adoption. <i>See 29 CFR 2590.701-6(b)(3)(iii)(B).</i> <p>Tips: Remember to allow all eligible employees, spouses, and new dependents to enroll upon these events. Also, ensure that the effective date of coverage complies with HIPAA, keeping in mind that some effective dates of coverage are retroactive.</p>			
<p><u>Question 19 – Special enrollment rights provided through CHIPRA</u> Does the plan provide full special enrollment rights as required under CHIPRA?</p> <p>Under the following conditions a group health plan must allow an employee or dependent (who is otherwise eligible) to enroll, regardless of any late enrollment provisions, if enrollment is requested within 60 days:</p> <ul style="list-style-type: none"> ◆ <i>When an employee or dependent’s Medicaid or CHIP coverage is terminated.</i> When an employee or dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of the Social Security Act and coverage of the employee or dependent is terminated as a result of loss of eligibility, a group health plan must allow special enrollment. The employee or dependent must request special enrollment within 60 days after the date of termination of Medicaid or CHIP coverage. <i>See ERISA section 701(f)(3).</i> ◆ <i>Upon Eligibility for Employment Assistance under Medicaid or CHIP.</i> When an employee or dependent becomes eligible for assistance, with respect to coverage under the group health plan or health insurance coverage under a Medicaid plan or State CHIP plan, the group health plan must allow special enrollment. The employee or dependent must request special enrollment within 60 days after the employee or dependent is determined to be eligible for assistance. <i>See ERISA section 701(f)(3).</i> <p>NOTE: In addition, <u>employers</u> that maintain a group health plan in a state with a CHIP or Medicaid program that provides for premium assistance for group health plan coverage must provide a notice of eligibility (referred to as the Employer CHIP Notice) to each employee to inform them of possible opportunities available in the state in which they reside for premium assistance for health coverage of employees or dependents. A model notice is available at www.dol.gov/ebsa.</p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p>Question 20 – Treatment of special enrollees Does the plan treat special enrollees the same as individuals who enroll when first eligible, for purposes of eligibility for benefit packages, premiums, and imposing a preexisting condition exclusion?</p> <p>◆ If an individual requests enrollment while the individual is entitled to special enrollment, the individual is a special enrollee, even if the request for enrollment coincides with a late enrollment opportunity under the plan. <i>See 29 CFR 2590.701-6(d)(1).</i></p> <p>◆ Special enrollees must be offered the same benefit packages available to similarly situated individuals who enroll when first eligible. (Any difference in benefits or cost-sharing requirements for different individuals constitutes a different benefit package.) In addition, a special enrollee cannot be required to pay more for coverage than a similarly situated individual who enrolls in the same coverage when first eligible. The length of any preexisting condition exclusion that may be applied cannot exceed that applied to other similarly situated individuals who enroll when first eligible. <i>See 29 CFR 2590.701-6(d)(2).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>Question 21 – Notice of special enrollment rights Does the plan provide timely and adequate notices of special enrollment rights?</p> <p>◆ On or before the time an employee is offered the opportunity to enroll in the plan, the plan must provide the employee with a description of special enrollment rights.</p> <p>Tip: Ensure that the special enrollment notice is provided at or before the time an employee is initially offered the opportunity to enroll in the plan. This may mean breaking it off from the SPD. The plan can include its special enrollment notice in the SPD if the SPD is provided at or before the initial enrollment opportunity (for example, as part of the application materials). If not, the special enrollment notice must be provided separately to be timely. A model notice is provided in the Model Disclosures on page 102.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>SECTION D – Compliance with the HIPAA Nondiscrimination Provisions Overview. HIPAA prohibits group health plans and health insurance issuers from discriminating against individuals in eligibility and continued eligibility for benefits and in individual premium or contribution rates based on health factors. These health factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities), and disability. <i>See ERISA section 702; 29 CFR 2590.702.</i></p>			

	YES	NO	N/A
<p><u>Similarly Situated Individuals.</u> It is important to recognize that the nondiscrimination rules prohibit discrimination within a group of similarly situated individuals. Under 29 CFR 2590.702(d), plans may treat distinct groups of similarly situated individuals differently, if the distinctions between or among the groups are not based on a health factor. If distinguishing among groups of participants, plans and issuers must base distinctions on bona fide employment-based classifications consistent with the employer's usual business practice. Whether an employment-based classification is bona fide is based on relevant facts and circumstances, such as whether the employer uses the classification for purposes independent of qualification for health coverage. Bona fide employment-based classifications might include: full-time versus part-time employee status; different geographic location; membership in a collective bargaining unit; date of hire or length of service; or differing occupations. In addition, plans may treat participants and beneficiaries as two separate groups of similarly situated individuals. Plans may also distinguish among beneficiaries. Distinctions among groups of beneficiaries may be based on bona fide employment-based classifications of the participant through whom the beneficiary is receiving coverage, relationship to the participant (such as spouse or dependent), marital status, age or student status of dependent children, or any other factor that is not a health factor.</p> <p>Exception for benign discrimination: The nondiscrimination rules do not prohibit a plan from establishing more favorable rules for eligibility or premium rates for individuals with an adverse health factor, such as a disability. <i>See 29 CFR 2590.702(g).</i></p> <p>Check to see that the plan complies with HIPAA's nondiscrimination provisions as follows:</p>			
<p><u>Question 22 – Nondiscrimination in eligibility</u> Does the plan allow individuals eligibility and continued eligibility under the plan regardless of any adverse health factor?</p> <p>◆ Examples of plan provisions that violate ERISA section 702(a) because they discriminate in eligibility based on a health factor include:</p> <ul style="list-style-type: none"> ❖ Plan provisions that require "evidence of insurability," such as passing a physical exam, providing a certification of good health, or demonstrating good health through answers to a health care questionnaire in order to enroll. <i>See 29 CFR 2590.702(b)(1).</i> <p>◆ Also, note that it may be permissible for plans to require individuals to complete physical exams or health care questionnaires for purposes other than for determining eligibility to enroll in the plan, such as for determining an appropriate blended, aggregate group rate for providing coverage to the plan as a whole. <i>See 29 CFR 2590.702(b)(1)(iii) Example 1.</i></p> <p>Tip: Eliminate plan provisions that deny individuals eligibility or continued eligibility under the plan based on a health factor, even if such provisions apply only to late enrollees.</p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p>Question 23 – Nondiscrimination in benefits Does the plan uniformly provide benefits to participants and beneficiaries, without directing any benefit restrictions at individual participants and beneficiaries based on a health factor?</p> <p>◆ A plan is not required to provide any benefits, but benefits provided must be uniformly available and any benefit restrictions must be applied uniformly to all similarly situated individuals and cannot be directed at any individual participants or beneficiaries based on a health factor. If benefit exclusions or limitations are applied only to certain individuals based on a health factor, this would violate ERISA section 702(a) and 29 CFR 2590.702(b)(2).</p> <p>◆ Examples of plan provisions that would be permissible under ERISA section 702(a) include:</p> <ul style="list-style-type: none"> ❖ A lifetime or annual limit on all benefits, ❖ A lifetime or annual limit on the treatment of a particular condition, ❖ Limits or exclusions for certain types of treatments or drugs, ❖ Limitations based on medical necessity or experimental treatment, and ❖ Cost-sharing, <p>if the limit applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on a health factor.</p> <p>◆ A plan amendment applicable to all similarly situated individuals and made effective no earlier than the first day of the next plan year is not considered directed at individual participants and beneficiaries. <i>See 29 CFR 2590.702(b)(2)(i)(C).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>Question 24 – Source-of-injury restrictions If the plan imposes a source-of-injury restriction, does it comply with the HIPAA nondiscrimination provisions?</p> <p>◆ Plans may exclude benefits for the treatment of certain injuries based on the source of that injury, except that plans may not exclude benefits otherwise provided for treatment of an injury if the injury results from an act of domestic violence or a medical condition. <i>See 29 CFR 2590.702(b)(2)(iii).</i> An example of a permissible source-of-injury exclusion would include:</p> <ul style="list-style-type: none"> ❖ A plan provision that provides benefits for head injuries generally, but excludes benefits for head injuries sustained while participating in bungee jumping, as long as the injuries do not result from a medical condition or domestic violence. <p>◆ An impermissible source-of-injury exclusion would include:</p> <ul style="list-style-type: none"> ❖ A plan provision that generally provides coverage for medical/surgical benefits, including hospital stays that are medically necessary, but excludes benefits for self-inflicted injuries or attempted suicide. This is impermissible because the plan provision excludes benefits for treatment of injuries that may result from a medical condition (depression). <p>◆ If the plan does not impose a source-of-injury restriction, check "N/A" and skip to Question 25.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO	N/A
<p>Question 25 – Nondiscrimination in premiums or contributions Does the plan comply with HIPAA’s nondiscrimination rules regarding individual premium or contribution rates?</p> <ul style="list-style-type: none"> ◆ Under ERISA section 702(b) and 29 CFR 2590.702(c), plans may not require an individual to pay a premium or contribution that is greater than a premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health factor. For example, it would be impermissible for a plan to require certain full-time employees to pay a higher premium than other full-time employees based on their prior claims experience. ◆ Nonetheless, the nondiscrimination rules do not prohibit a plan from providing a reward based on adherence to a wellness program. <i>See ERISA section 702(b)(2)(B); 29 CFR 2590.702(b)(2)(ii) and (c)(3)</i>. Final rules for wellness programs were published on December 13, 2006, at 71 FR 75014. These rules permit rewards that are not contingent on an individual meeting a standard related to a health factor. In addition, these rules permit rewards that are contingent on an individual meeting a standard related to a health factor if: <ul style="list-style-type: none"> ❖ The total reward for all the plan’s wellness programs that require satisfaction of a standard related to a health factor is limited – generally, it must not exceed 20 percent of the cost of employee-only coverage under the plan. If dependents (such as spouses and/or dependent children) may participate in the wellness program, the reward must not exceed 20 percent of the cost of the coverage in which an employee and any dependents are enrolled. ❖ The program must be reasonably designed to promote health and prevent disease. ❖ The program must give individuals eligible to participate the opportunity to qualify for the reward at least once per year. ❖ The reward must be available to all similarly situated individuals. The program must allow a reasonable alternative standard (or waiver of initial standard) for obtaining the reward to any individual for whom it is unreasonably difficult due to a medical condition, or medically inadvisable, to satisfy the initial standard. ❖ The plan must disclose in all materials describing the terms of the program the availability of a reasonable alternative standard (or the possibility of a waiver of the initial standard). A model notice is provided in the Model Disclosures on page 107. <p>To help evaluate whether this exception is available, refer to Section E on page 65. Once you have completed Section E, return to this page to continue with Question 26, below.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>Question 26 – List billing Is there compliance with the list billing provisions?</p> <ul style="list-style-type: none"> ◆ Under 29 CFR 2590.702(c)(2)(ii), plans and issuers may not charge or quote an employer a different premium for an individual in a group of similarly situated individuals based on a health factor. This practice is commonly referred to as list billing. If an issuer is list billing an employer and the plan is passing the separate and different rates on to the individual participants and beneficiaries, both the 	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p>plan and the issuer are violating the prohibition against discrimination in premium rates. This does not prevent plans and issuers from taking the health factors of each individual into account in establishing a blended/aggregate rate for providing coverage to the plan.</p>			
<p>Question 27 – Nonconfinement clauses Is the plan free of any nonconfinement clauses?</p> <p>◆ Typically, a nonconfinement clause will deny or delay eligibility for some or all benefits if an individual is confined to a hospital or other health care institution. Sometimes nonconfinement clauses also deny or delay eligibility if an individual cannot perform ordinary life activities. Often a nonconfinement clause is imposed only with respect to dependents, but they may also be imposed with respect to employees. 29 CFR 2590.702(e)(1) explains that these nonconfinement clauses violate ERISA sections 702(a) (if the clause delays or denies eligibility) and 702(b) (if the clause raises individual premiums).</p> <p>Tip: Delete all nonconfinement clauses.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>Question 28 – Actively-at-work clauses Is the plan free of any impermissible actively-at-work clauses?</p> <p>◆ Typically, actively-at-work provisions delay eligibility for benefits based on an individual being absent from work. 29 CFR 2590.702(e)(2) explains that actively-at-work provisions generally violate ERISA sections 702(a) (if the clause delays or denies eligibility) and 702(b) (if the clause raises individual premiums or contributions), unless absence from work due to a health factor is treated, for purposes of the plan, as if the individual is at work. Nonetheless, an exception provides that a plan may establish a rule for eligibility that requires an individual to begin work for the employer sponsoring the plan before eligibility commences. Further, plans may establish rules for eligibility or set any individual's premium or contribution rate in accordance with the rules relating to similarly situated individuals in 29 CFR 2590.702(d). For example, a plan that treats full-time and part-time employees differently for other employment-based purposes, such as eligibility for other employee benefits, may distinguish in rules for eligibility under the plan between full-time and part-time employees.</p> <p>Tip: Carefully examine any actively-at-work provision to ensure consistency with HIPAA.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>SECTION E – Compliance with the Wellness Program Provisions Use the following questions to help determine whether the plan offers a program of health promotion or disease prevention that is required to comply with the Department's final wellness program regulations and, if so, whether the program is in compliance with the regulations.</p>			

	YES	NO	N/A
<p>Question 29 – Does the plan have a wellness program?</p> <p>◆ A wide range of wellness programs exist to promote health and prevent disease. However, these programs are not always labeled “wellness programs.” Examples include: a program that reduces individuals’ cost-sharing for complying with a preventive care plan; a diagnostic testing program for health problems; and rewards for attending educational classes, following healthy lifestyle recommendations, or meeting certain biometric targets (such as weight, cholesterol, nicotine use, or blood pressure targets).</p> <p>Tip: Ignore the labels – wellness programs can be called many things. Other common names include: disease management programs, smoking cessation programs, and case management programs.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>Question 30 – Is the wellness program part of a group health plan?</p> <p>◆ The wellness program is only subject to Part 7 of ERISA if it is part of a group health plan. If the employer operates the wellness program as an employment policy separate from the group health plan, the program may be covered by other laws, but it is not subject to the group health plan rules discussed here.</p> <p>Example: An employer institutes a policy that any employee who smokes will be fired. Here, the plan is not acting, so the wellness program rules do not apply. (But see 29 CFR 2590.702, which clarifies that compliance with the HIPAA nondiscrimination rules, including the wellness program rules, is not determinative of compliance with any other provision of ERISA or any other State or Federal law, such as the Americans with Disabilities Act.)</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>Question 31 – Does the program discriminate based on a health factor?</p> <p>◆ A plan discriminates based on a health factor if it requires an individual to meet a standard related to a health factor in order to obtain a reward. A reward can be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan.</p> <p>Example 1: Plan participants who have a cholesterol level under 200 will receive a premium reduction of 20 percent. In this Example 1, the plan requires individuals to meet a standard related to a health factor in order to obtain a reward.</p> <p>Example 2: A plan requires all eligible employees to complete a health risk assessment to enroll in the plan. Employee answers are fed into a computer that identifies risk factors and sends educational information to the employee’s home address. In this Example 2, the requirement to complete the assessment does not, itself, discriminate based on a health factor. However, if the plan used individuals’ specific health information to discriminate in individual eligibility, benefits, or premiums, there would be discrimination based on a health factor.</p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p>If you answered “No” to ANY of the above questions, STOP. The plan does not maintain a program subject to the group health plan wellness program rules. If you are completing this section as part of a review of your plan, please return to Question 26.</p>			
<p>Question 32 – If the program discriminates based on a health factor, is the program saved by the benign discrimination provisions?</p> <p>◆ The Department’s regulations at 29 CFR 2590.702(g) permit discrimination <i>in favor</i> of an individual based on a health factor.</p> <p>Example: A plan grants participants who have diabetes a waiver of the plan’s annual deductible if they enroll in a disease management program that consists of attending educational classes and following their doctor’s recommendations regarding exercise and medication. <i>This is benign discrimination because the program is offering a reward to individuals based on an adverse health factor.</i></p> <p>Tip: The benign discrimination exception is NOT available if the plan asks diabetics to meet a standard related to a health factor (such as maintaining a certain body mass index (BMI)) in order to get a reward. In this case, an intervening discrimination is introduced and the plan cannot rely solely on the benign discrimination exception.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>If you answered “Yes” to the previous question, STOP. There are no violations of the wellness program rules. If you are completing this section as part of a review of your plan, please return to Question 26.</p> <p>If you answered “No” to the previous question, the wellness program must meet the following 5 criteria.</p>			
<p>Question 33 – Compliance Criteria</p> <p>A. Is the amount of the reward offered under the plan limited to 20 percent of the applicable cost of coverage? (29 CFR 2590.702(f)(2)(i))</p> <p>Keep in mind these considerations when analyzing the reward amount:</p> <p>Who is eligible to participate in the wellness program?</p> <p>If only employees are eligible to participate, the amount of the reward must not exceed 20 percent of the cost of employee-only coverage under the plan. If employees and any class of dependents are eligible to participate, the reward must not exceed 20 percent of the cost of coverage in which an employee and any dependents are enrolled.</p> <p>Does the plan have more than one wellness program?</p> <p>The 20 percent limitation on the amount of the reward applies to all of a plan’s wellness programs <i>that require individuals to meet a standard related to a health factor</i>.</p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p>Example: If the plan has two wellness programs with standards related to a health factor, a 20 percent reward for meeting a BMI target and a 10 percent reward for meeting a cholesterol target, it must decrease the total reward available from 30 percent to 20 percent. However, if instead, the program offered a 10 percent reward for meeting a body mass index target, a 10 percent reward for meeting a cholesterol target, and a 10 percent reward for completing a health risk assessment (regardless of any individual’s specific health information), the rewards do not need to be adjusted because the 10 percent reward for completing the health risk assessment does not require individuals to meet a standard related to a health factor.</p>			
<p>B. Is the plan reasonably designed to promote health or prevent disease? (29 CFR 2590.702(f)(2)(ii))</p> <p>The program must be reasonably designed to promote health or prevent disease. The program should have a reasonable chance of improving the health of or preventing disease in participating individuals, not be overly burdensome, not be a subterfuge for discriminating based on a health factor, and not be highly suspect in the method chosen to promote health or prevent disease.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>C. Are individuals who are eligible to participate given a chance to qualify at least once per year? (29 CFR 2590.702(f)(2)(iii))</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>D. Is the reward available to all similarly situated individuals? Does the program offer a reasonable alternative standard? (29 CFR 2590.702(f)(2)(iv))</p> <p>The wellness program rules require that the reward be available to all similarly situated individuals. A component of meeting this criterion is that the program must have a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period:</p> <ul style="list-style-type: none"> * It is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; or * It is medically inadvisable to attempt to satisfy the otherwise applicable standard. It is permissible for the plan or issuer to seek verification, such as a statement from the individual’s physician, that a health factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the otherwise applicable standard. 	<input type="checkbox"/>	<input type="checkbox"/>	
<p>E. Does the plan disclose the availability of a reasonable alternative in all plan materials describing the program? (29 CFR 2590.702(f)(2)(v))</p> <p>The plan or issuer must disclose the availability of a reasonable alternative standard <i>in all plan materials describing the program</i>. If plan materials merely mention that the program is available, without describing its terms, this disclosure is not required.</p> <p>Tip: The disclosure does not have to say what the reasonable alternative standard is in advance. The plan can individually tailor the standard for each individual, on a case-by-case basis.</p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p>The following sample language can be used to satisfy this requirement: “If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call us at [insert telephone number] and we will work with you to develop another way to qualify for the reward.”</p>			
<p>If you answered “Yes” to all of the 5 questions on wellness program criteria, there are no violations of the HIPAA wellness program rules.</p> <p>If you answered “No” to any of the 5 questions on wellness program criteria, the plan has a wellness program compliance issue. Specifically,</p> <p>Violation of the general benefit discrimination rule (29 CFR 2590.702(b)(2)(i)) – If the wellness program varies benefits, including cost-sharing mechanisms (such as deductible, copayment, or coinsurance) based on whether an individual meets a standard related to a health factor and the program does not satisfy the requirements of 29 CFR 2590.702(f), the plan is impermissibly discriminating in benefits based on a health factor. The wellness program exception at 29 CFR 2590.702(b)(2)(ii) is not satisfied and the plan is in violation of 29 CFR 2590.702(b)(2)(i).</p> <p>Violation of general premium discrimination rule (29 CFR 2590.702(c)(1)) – If the wellness program varies the amount of premium or contribution it requires similarly situated individuals to pay based on whether an individual meets a standard related to a health factor and the program does not satisfy the requirements of 29 CFR 2590.702(f), the plan is impermissibly discriminating in premiums based on a health factor. The wellness program exception at 29 CFR 2590.702(c)(3) is not satisfied and the plan is in violation of 29 CFR 2590.702(c)(1).</p>			
<p><u>SECTION F – Compliance with the HMO Affiliation Period Provisions</u> If the plan provides benefits through an HMO and imposes an HMO affiliation period in lieu of a preexisting condition exclusion period, answer Question 34. If the plan does not provide benefits through an HMO, or if there is no HMO affiliation period, check "N/A" and go to Section G.</p>			<input type="checkbox"/>
<p><u>Question 34 – HMO affiliation period provisions</u> Does the plan comply with the limits on HMO affiliation periods?</p> <p>◆ An affiliation period is a period of time that must expire before health insurance coverage provided by an HMO becomes effective and during which the HMO is not required to provide benefits.</p> <p>◆ A group health plan offering coverage through an HMO may impose an affiliation period only if:</p> <ul style="list-style-type: none"> ❖ No preexisting condition exclusion is imposed; ❖ No premium is charged to a participant or beneficiary for the affiliation period; ❖ The affiliation period is applied uniformly without regard to any health factor; 	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<ul style="list-style-type: none"> ❖ The affiliation period does not exceed 2 months (or 3 months for late enrollees); ❖ The affiliation period begins on an individual's "enrollment date"; and ❖ The affiliation period runs concurrently with any waiting period. <p><i>See ERISA section 701(g); 29 CFR 2590.701-7.</i></p>			
<p><u>SECTION G – Compliance with the MEWA or Multiemployer Plan</u> <u>Guaranteed Renewability Provisions</u> If the plan is a multiple employer welfare arrangement (MEWA) or a multiemployer plan, it is required to provide guaranteed renewability of coverage in accordance with ERISA section 703. If the plan is a MEWA or multiemployer plan, it must comply with Question 35. If the plan is not a MEWA or multiemployer plan, check "N/A" and go to Part II of this self-compliance tool.</p>			<input type="checkbox"/>
<p><u>Question 35 – Multiemployer plan and MEWA guaranteed renewability</u> <u>If the plan is a multiemployer plan, or a MEWA, does the plan provide guaranteed renewability?</u></p> <ul style="list-style-type: none"> ◆ Group health plans that are multiemployer plans or MEWAs may not deny an employer continued access to the same or different coverage, other than: <ul style="list-style-type: none"> ❖ For nonpayment of contributions; ❖ For fraud or other intentional misrepresentation by the employer; ❖ For noncompliance with material plan provisions; ❖ Because the plan is ceasing to offer coverage in a geographic area; ❖ In the case of a plan that offers benefits through a network plan, there is no longer any individual enrolled through the employer who lives, resides, or works in the service area of the network plan and the plan applies this paragraph uniformly without regard to the claims experience of employers or any health-related factor in relation to such individuals or dependents; or ❖ For failure to meet the terms of an applicable collective bargaining agreement, to renew a collective bargaining or other agreement requiring or authorizing contributions to the plan, or to employ employees covered by such agreement. <p><i>See ERISA section 703.</i></p> <p>**Note: The Public Health Service (PHS) Act contains different guaranteed renewability requirements for issuers.</p>	<input type="checkbox"/>	<input type="checkbox"/>	

II. Determining Compliance with the Mental Health Parity Act (MHPA) and Mental Health Parity and Addiction Equity Act (MHPAEA) Provisions in Part 7 of ERISA

If you answer “No” to any of the questions below, the group health plan is in violation of the MHPA or MHPAEA (the mental health parity) provisions in Part 7 of ERISA.

	YES	NO	N/A
<p>If the plan provides either mental health or substance use disorder benefits and medical and surgical benefits, the plan may be subject to the mental health parity provisions in Part 7 of ERISA. (Note, if under an arrangement(s) to provide medical care by an employer or employee organization, any participant or beneficiary can simultaneously receive coverage for medical/surgical benefits and mental health benefits, the mental health requirements apply separately with respect to each combination of medical/surgical benefits and mental health benefits and all such combinations are considered to be a single group health plan. <i>See 29 CFR 2590.712(e).</i>) If this is the case, answer Questions 36-44.</p> <p>If the plan does not provide mental health or substance use disorder benefits, check “N/A” here and skip to Part III of this checklist. Also, the plan may be exempt from the mental health parity provisions under the small employer (50 employees or fewer) exception or the increased cost exception. (To be eligible for the increased cost exception, the plan must have filed a notice with EBSA and notified participants and beneficiaries.) If the plan is exempt, check “N/A” here and skip to Part III of this checklist.</p> <p>*NOTE: Any reference in this checklist to mental health benefits includes both mental health and substance use disorder benefits.</p>			<input type="checkbox"/>
<p><u>Question 36 – Does the plan comply with the mental health parity provisions for lifetime dollar limits on mental health benefits?</u></p> <p>◆ A plan may not impose a lifetime dollar limit on mental health/substance use disorder benefits that is lower than the lifetime dollar limit imposed on medical/surgical benefits. <i>See 29 CFR 2590.712(b).</i> (Only limits on what the plan is willing to pay are taken into account.)</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 37 – Does the plan comply with the mental health parity provisions for annual dollar limits on mental health benefits?</u></p> <p>◆ A plan may not impose an annual dollar limit on mental health/substance use disorder benefits that is lower than the annual dollar limit imposed on medical/surgical benefits. <i>See 29 CFR 2590.712(b).</i> (Only limits on what the plan is willing to pay are taken into account.)</p> <p>Tip: There is a different rule for cumulative limits other than aggregate lifetime or annual dollar limits, discussed later in this checklist at question 41. A plan may impose annual dollar out-of-pocket limits on participants and beneficiaries if done in accordance with the rule regarding cumulative limits.</p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p><u>Question 38 – Does the plan comply with the mental health parity provisions for parity in financial requirements and quantitative treatment limitations?</u></p> <p>◆ A plan may not impose a financial requirement or quantitative treatment limitation applicable to mental health/substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or quantitative treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. <i>See 29 CFR 2590.712(c)(2).</i></p> <ul style="list-style-type: none"> ❖ Types of financial requirements include deductibles, copayments, coinsurance, and out-of-pocket maximums. <i>See 29 CFR 2590.712(c)(1)(ii).</i> ❖ Types of quantitative treatment limits include annual, episode, and lifetime day and visit limits, for example, number of treatments, visits, or days of coverage. <i>See 29 CFR 2590.712(c)(1)(ii).</i> <ul style="list-style-type: none"> ❖ The six classifications of benefits are: <ol style="list-style-type: none"> 1) inpatient, in-network; 2) inpatient, out-of-network; 3) outpatient, in-network; 4) outpatient, out-of-network; 5) emergency care; and 6) prescription drugs <p><i>See 29 CFR 2590.712(c)(2)(ii).</i></p> <p>◆ Under the plan, any financial requirement or quantitative treatment limitation that applies to mental health benefits within a particular classification cannot be more restrictive than the predominant requirement or limitation that applies to substantially all medical/surgical benefits within the same classification. <i>See 29 CFR 2590.712(c)(2).</i></p> <p>(Note, see below discussion of enforcement safe harbor for determining parity with respect to outpatient benefits provided under two sub-classifications.)</p> <ul style="list-style-type: none"> ❖ To determine parity each type of financial requirement or treatment limitation within a coverage unit (Coverage unit refers to the way in which a plan groups individuals for purposes of determining benefits, or premiums or contributions, for example, self-only, family, employee plus spouse. <i>See 29 CFR 2590.712(c)(1)(iv).</i>) must be analyzed separately within each classification. <i>See 29 CFR 2590.712(c)(2)(i).</i> If a plan applies different levels of a financial requirement or treatment limitation to different coverage units in a classification of medical/surgical benefits (for example, a \$250 deductible for self-only and a \$500 deductible for family coverage), the predominant level is determined separately for each coverage unit. <i>See 29 CFR 2590.712(c)(3)(ii).</i> ❖ Generally, a financial requirement or treatment limitation is considered to apply to substantially all medical/surgical benefits if it applies to two-thirds or more of the medical/surgical benefits. <i>See 29 CFR 2590.712(c)(3)(i)(A).</i> This two-thirds calculation is based on the dollar amount of plan payments expected to be paid for the year. <i>See 29 CFR 2590.712(c)(3)(i)(C).</i> (Any reasonable method can be used for this calculation. <i>See 29 CFR 2590.712(c)(3)(i)(E).</i>) 	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p>❖ Generally, the predominant level will apply to more than one-half of the medical/surgical benefits in that classification subject to the requirement or limitation. <i>See 29 CFR 2590.712(c)(3)(i)(B)(1)</i>. If there is no single level that applies to one-half of medical/surgical benefits in the classification, the plan can combine levels until the combination of levels applies to more than one-half of medical/surgical benefits subject to the requirement or limitation in the classification. The least restrictive level within the combination is considered the predominant level. <i>See 29 CFR 2590.712(c)(3)(i)(B)(2)</i>.</p> <p>Safe Harbor:</p> <p>◆ Until the issuance of final regulations, for purposes of determining parity for outpatient benefits (in-network and out-of network), the Departments have established an enforcement safe harbor under which no enforcement action will be taken against a plan or issuer that divides its benefits furnished on an outpatient basis into two sub-classifications, specifically 1) office visits and 2) all other outpatient items and services, for purposes of applying the financial requirement and treatment limitation rules under MHPAEA.</p> <ul style="list-style-type: none"> ❖ After the sub-classifications are established, the plan or issuer may not impose any financial requirement or treatment limitation on mental health or substance use disorder benefits in any sub-classification (i.e., office visits or non-office visits) that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in the sub-classification using the methodology set forth in the interim final rules. ❖ Other than as permitted under this enforcement policy, and except as permitted under the interim final rules for multi-tier prescription drug formularies, sub-classifications are not permitted when applying the financial requirement and treatment limitation rules under MHPAEA. Accordingly, and as stated in the preamble to the interim final rules, separate sub-classifications for generalists and specialists are not permitted. <p>Tips: Ensure that the plan does not impose cost-sharing requirements or quantitative treatment limitations that are applicable only to mental health/substance use disorder benefits.</p> <p>For a simpler method of compliance when a type of financial requirement or treatment limitation applies to at least two-thirds of medical surgical benefits in the classification, but no single level is predominant, a plan can treat the least restrictive level of financial requirement or treatment limitation applied to medical/surgical benefits as predominant.</p>			

	YES	NO	N/A
<p><u>Question 39 – Does the plan comply with the mental health parity provisions for parity in classifications of benefits?</u></p> <p>◆ If a plan provides mental health or substance use disorder benefits in any classification of benefits (The classifications are listed in question 32.), mental health or substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided. <i>See 29 CFR 2590.712(c)(2)(ii)(A).</i></p> <p>◆ In determining the classification in which a particular benefit belongs, a plan must apply the same standards to medical/surgical benefits and to mental health or substance use disorder benefits. <i>See 29 CFR 2590.712(c)(2)(ii)(A).</i></p> <p>Tip: This rule applies to out-of-network providers. If the plan does not contract with a network of providers, all benefits are out-of-network. If a plan that has no network imposes a financial requirement or treatment limitation on in-patient or outpatient benefits, the plan is imposing the requirement or limitation within classifications (inpatient, out-of-network or outpatient, out-of-network), and the rules for parity will be applied separately for the different classifications. <i>See 29 CFR 2590.712(c)(2)(ii)(B).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 40 – Does the plan comply with the mental health parity provisions for multi-tiered prescription drug benefits?</u></p> <p>◆ There is a special rule for multi-tiered prescription drug benefits. A plan complies with the mental health parity provisions if the plan applies different levels of financial requirements to different tiers of prescription drug benefits based on reasonable factors (determined in accordance with the mental health provisions relating to nonquantitative treatment limitations discussed in this checklist at question 42) and without regard to whether a drug is generally prescribed for medical/surgical or mental health benefits. Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up. <i>See 29 CFR 2590.712(c)(3)(iii).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 41 – Does the plan comply with the mental health parity provisions on cumulative financial requirements or cumulative quantitative treatment limitations?</u></p> <p>◆ A plan may not apply any cumulative financial requirement or cumulative quantitative treatment limitation (for example a \$250 deductible) for mental health benefits in a classification that accumulates separately from any established for medical/surgical benefits in the same classification. <i>See 29 CFR 2590.712(c)(3)(v).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p>Question 42 – Does the plan comply with the mental health parity provisions for parity within nonquantitative treatment limitations?</p> <p>◆ Nonquantitative treatment limitations include:</p> <ul style="list-style-type: none"> ❖ medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative; ❖ formulary design for prescription drugs; ❖ standards for provider admission to participate in a network, including reimbursement rates; ❖ plan methods for determining usual, customary, and reasonable charges; ❖ refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols); and ❖ exclusions based on failure to complete a course of treatment. <p>This is an illustrative, nonexhaustive list. <i>See 29 CFR 2590.712(c)(4)(ii).</i></p> <p>◆ A plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification (such as inpatient, out-of-network) unless under the terms of the plan, as written or in operation, any processes, strategies, evidentiary standards, or other factors used in applying the limitation to mental health benefits in the classification are comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used in applying the limitation with respect to medical/surgical benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference. <i>See 29 CFR 2590.712(c)(4)(i).</i></p> <ul style="list-style-type: none"> ❖ An example of a permissible nonquantitative treatment limitation would be a plan requirement that participants obtain prior approval that a course of treatment is medically necessary for out-patient, in-network medical/surgical and mental health benefits. The plan denies payment for any medical/surgical or mental health treatments that did not have prior approval. <i>See 2590.712(c)(4)(iii).</i> ❖ An example of an impermissible nonquantitative treatment limitation would be a plan requirement that participants obtain prior approval that a course of treatment is medically necessary for out-patient, in-network medical/surgical and mental health benefits. The plan denies payment for mental health treatments that did not receive prior approval. However, for medical/surgical benefits that did not have prior approval, the plan pays for the treatments at a 25 percent reduction in benefits the plan would otherwise pay. <i>See 2590.712(c)(4)(iii).</i> <p>Tip: Do not focus on results. Look at the processes used in applying nonquantitative limitations to mental health and medical/surgical benefits to determine that there are not arbitrary, discriminatory differences and that any differences in processes are based on recognized, clinically appropriate standards.</p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p><u>Question 43 – Does the plan comply with the mental health parity provisions requiring the availability of plan information regarding criteria for medical necessity determinations?</u></p> <p>◆ The plan administrator (or the health insurance issuer) must make available the criteria for medical necessity determinations made under a group health plan with respect to mental health or substance use disorder benefits (or health insurance coverage offered in connection with the plan with respect to such benefits) to any current or potential participant, beneficiary, or contracting provider upon request. <i>See 29 CFR 2590.712(d)(1).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 44 – Does the plan comply with the mental health parity provisions requiring the availability of plan information regarding the reason for a denial of reimbursement or payment ?</u></p> <p>◆ The plan administrator (or health insurance issuer) must make available the reason for any denial under a group health plan (or health insurance coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits to any participant or beneficiary in a form and manner consistent with the rules in 2560.503-1(The Claims Procedure Rule). <i>See 29 CFR 2590.712(d)(2).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p><u>Question 46 – Provider must not be required to obtain authorization from plan</u> Plans may not require providers to obtain authorization from the plan to prescribe a 48/96-hour stay. Does the plan comply with this rule?</p> <p>◆ Plans may not require that a provider (such as a doctor) obtain authorization from the plan to prescribe a 48/96-hour stay. <i>See ERISA section 711(a)(1)(B); 29 CFR 2590.711(a)(4).</i></p> <p>Tips: Watch for plan preauthorization requirements that are too broad. For example, a plan may have a provision requiring preauthorization for all hospital stays. Providers cannot be required to obtain preauthorization from the plan in order for the plan to cover a 48-hour (or 96-hour) stay in connection with childbirth. Therefore, in this example, the plan must add clarifying language to indicate that the general preauthorization requirement does not apply to 48/96-hour hospital stays in connection with childbirth. (Conversely, plans generally may require participants or beneficiaries to give notice of a pregnancy or hospital admission in connection with childbirth in order to obtain, for example, more favorable cost-sharing.) Nonetheless, the Newborns’ Act does not prevent plans and issuers from requiring providers to obtain authorization for any portion of a hospital stay that exceeds 48 (or 96) hours.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 47 – Incentives/penalties to mothers or providers</u> Does the plan comply with the Newborns' Act by avoiding impermissible incentives or penalties with respect to mothers or attending providers?</p> <p>◆ Penalties to attending providers to discourage 48/96-hour stays violate ERISA section 711(b)(3) and 29 CFR 2590.711(b)(3)(i).</p> <p>◆ Incentives to attending providers to encourage early discharges violate ERISA section 711(b)(4) and 29 CFR 2590.711(b)(3)(ii).</p> <p>◆ Penalties imposed on mothers to discourage 48/96-hour stays violate ERISA section 711(b)(1) and 29 CFR 2590.711(b)(1)(i)(A).</p> <p>◆ Incentives to mothers to encourage early discharges violate ERISA section 711(b)(2) and 29 CFR 2590.711(b)(1)(i)(B).</p> <p>❖ An example of this would be if the plan waived the mother's copayment or deductible if mother or newborn leaves within 24 hours.</p> <p>◆ Benefits and cost-sharing may not be less favorable for the latter portion of any 48/96-hour hospital stay. In this case less favorable benefits would violate ERISA section 711(b)(5) and 29 CFR 2590.711(b)(2) and less favorable cost-sharing would violate ERISA section 711(c)(3) and 29 CFR 2590.711(c)(3).</p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p><u>SECTION B – Disclosure Provisions</u> Group health plans that provide benefits for hospital stays in connection with childbirth are required to make certain disclosures, as follows:</p>			
<p><u>Question 48 – Disclosure with respect to hospital lengths of stay in connection with childbirth</u> Does the plan comply with the notice provisions relating to hospital stays in connection with childbirth?</p> <p>◆ Group health plans that provide benefits for hospital stays in connection with childbirth are required to make certain disclosures. Specifically, the group health plan’s SPD must include a statement describing any requirements under Federal or State law applicable to the plan, and any health insurance coverage offered under the plan, relating to hospital length of stay in connection with childbirth for the mother or newborn child. <i>See the SPD content regulations at 29 CFR 2520.102-3(u).</i></p> <p>Tips: Whether the plan is insured or self-insured, and whether the Federal Newborns’ Act provisions or State law provisions apply to the coverage, the plan must provide a notice describing any requirements relating to hospital length of stays in connection with childbirth. A model notice is provided in the Model Disclosures on page 108.</p>	<input type="checkbox"/>	<input type="checkbox"/>	

IV. Determining Compliance with the WHCRA Provisions in Part 7 of ERISA

If you answer "No" to any of the questions below, the group health plan is in violation of the WHCRA provisions in Part 7 of ERISA.

	YES	NO	N/A
<p>WHCRA applies only to plans that offer benefits with respect to a mastectomy. If the plan does not offer these benefits, check "N/A" and go to Part V of this self-compliance tool.....</p> <p>If the plan does offer benefits with respect to a mastectomy, answer Questions 49-52.</p>			<input type="checkbox"/>
<p><u>Question 49 – Four required coverages under WHCRA</u> Does the plan provide the four coverages required by WHCRA?</p> <ul style="list-style-type: none"> ◆ In the case of a participant or beneficiary who is receiving benefits in connection with a mastectomy, the plan shall provide coverage for the following benefits for individuals who elect them: <ul style="list-style-type: none"> ❖ All stages of reconstruction of the breast on which the mastectomy has been performed; ❖ Surgery and reconstruction of the other breast to produce a symmetrical appearance; ❖ Prostheses; and ❖ Treatment of physical complications of mastectomy, including lymphedema, in a manner determined in consultation with the attending provider and the patient. <i>See ERISA section 713(a).</i> ◆ These required coverages can be subject to annual deductibles and coinsurance provisions if consistent with those established for other medical/surgical benefits under the plan or coverage. <p>Tip: Plans that cover benefits for mastectomies cannot categorically exclude benefits for reconstructive surgery or certain post-mastectomy services. In addition, time limits for seeking treatment may run afoul of the general requirement to provide the four required coverages.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 50 – Incentive provisions</u> Does the plan comply with WHCRA by not providing impermissible incentives or penalties with respect to patients or attending providers?</p> <ul style="list-style-type: none"> ◆ A plan may not deny a patient eligibility to enroll or renew coverage solely to avoid WHCRA's requirements under ERISA section 713(c)(1). ◆ In addition, under ERISA section 713(c)(2), a plan may not penalize or offer incentives to an attending provider to induce the provider to furnish care in a manner inconsistent with WHCRA. 	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p>Question 51 – Enrollment notice Does the plan provide adequate and timely enrollment notices as required by WHCRA?</p> <p>◆ Upon enrollment, a plan must provide a notice describing the benefits required under WHCRA. <i>See ERISA section 713(a).</i></p> <p>◆ The enrollment notice must describe the benefits that WHCRA requires the group health plan to cover, specifically:</p> <ul style="list-style-type: none"> ❖ 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 ❖ Physical complications resulting from mastectomy (including lymphedema). <p>◆ The enrollment notice must describe any deductibles and coinsurance limitations applicable to such coverage. (Note: Under WHCRA, coverage of the required benefits may be subject only to deductibles and coinsurance limitations consistent with those established for other medical/surgical benefits under the plan or coverage.)</p> <p>Tip: A model notice is provided in the Model Disclosures on page 109.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>Question 52 – Annual notice Does the plan provide adequate and timely annual notices as required by WHCRA?</p> <p>◆ Plans must provide notices describing the benefits required under WHCRA once each year. <i>See ERISA section 713(a).</i></p> <p>◆ To satisfy this requirement, the plan may redistribute the WHCRA enrollment notice or the plan may use a simplified disclosure that:</p> <ul style="list-style-type: none"> ❖ Provides notice of the availability of benefits under the plan for reconstructive surgery, surgery to achieve symmetry between the breasts, prostheses, and physical complications resulting from mastectomy (including lymphedema); and ❖ Contact information (e.g., telephone number) for obtaining a detailed description of WHCRA benefits available under the plan. <p>Tip: The WHCRA annual notice can be provided in the SPD if the plan distributes SPDs annually. If not, the plan should break off the annual notice into a separate disclosure. A model notice is provided in the Model Disclosures on page 110.</p>	<input type="checkbox"/>	<input type="checkbox"/>	

V. Determining Compliance with the GINA Provisions in Part 7 of ERISA

If you answer "No" to any of the questions below, the group health plan is in violation of the GINA provisions in Part 7 of ERISA.

	YES	NO	N/A
<p>Unlike HIPAA, the GINA provisions generally do apply to very small health plans (plans with less than two participants who are current employees), including retiree-only health plans.</p> <p>Definitions (for all defined terms under GINA, see 29 CFR 2590.702-1(a)):</p> <p><i>Genetic information</i> means, with respect to an individual, information about the individual’s genetic tests, the genetic tests of family members of the individual, the manifestation (see definition below) of a disease or disorder in family members of the individual or any request for or receipt of genetic services or participation in clinical research which includes genetic services by the individual or any family member of the individual.</p> <ul style="list-style-type: none"> ◆ Genetic information includes, with respect to a pregnant woman or family member of the pregnant woman, genetic information of any fetus carried by the pregnant woman. ◆ Genetic information includes, with respect to an individual who is utilizing an assisted reproductive technology, genetic information of any embryo legally held by the individual or family member. ◆ Genetic information does NOT include information about the sex or age of any individual. <p><i>Family member</i> means, with respect to an individual, a dependent of the individual or any person who is a first-degree, second-degree, third-degree, or fourth-degree relative of the individual or a dependent of the individual. Relatives of affinity (such as by marriage or adoption) are treated the same as relatives by consanguinity (that is, relatives who share a common biological ancestor). Relatives by less than full consanguinity (such as half-siblings, who share only one parent) are treated the same as relatives by full consanguinity (such as siblings who share both parents). Therefore, family members include parents, spouses, siblings, children, grandparents, grandchildren, aunts, uncles, nephews, nieces, great-grandparents, great-grandchildren, great aunts, great uncles, first cousins, great-great grandparents, great-great grandchildren, and children of first cousins.</p> <p><i>Manifestation</i> means, with respect to a disease, disorder, or pathological condition, that an individual has been or could reasonably be diagnosed with the disease, disorder, or pathological condition by a health care professional with appropriate training and expertise in the field of medicine involved. A disease, disorder, or pathological condition is not manifested if a diagnosis is based principally on genetic information.</p> <p><i>Genetic services</i> means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information) or genetic education.</p> <p><i>Genetic test</i> means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, if the analysis detects genotypes, mutations, or chromosomal changes.</p>			

	YES	NO	N/A
<p>A genetic test does NOT include an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition. For example, a test to determine whether an individual has a BRCA1 or BRCA2, genetic variants associated with a significantly increased risk for breast cancer, is a genetic test. An HIV test, complete blood count, cholesterol test, liver function test, or test for the presence of alcohol or drugs is not a genetic test.</p>			
<p>Question 53 – Does the plan comply with GINA’s prohibition against group-based discrimination based on genetic information?</p> <p>◆ A group health plan cannot adjust premium or contribution amounts for the plan, or any similarly situated individuals under the plan, on the basis of genetic information. <i>See 29 CFR 2590.702-1(b)(1).</i></p> <p>◆ Nothing limits a plan from increasing the premium for the group health plan or for a group of similarly situated individuals under the plan based on the manifestation of a disease or disorder of an individual enrolled in the plan. However, the manifestation of the disease in one individual cannot be used as genetic information about other group members to further increase the premium for a group health plan or a group of similarly situated individuals under the plan. <i>See 29 CFR 2590.702-1(b)(2).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>Question 54 – Does the plan comply with GINA’s limitation on requesting or requiring genetic testing?</p> <p>◆ A group health plan generally must not request or require an individual or family member of the individual to undergo a genetic test. <i>See 29 CFR 2590.702-1(c)(1).</i></p> <p>◆ Exceptions:</p> <ul style="list-style-type: none"> ❖ A health care professional who is providing health care services to an individual can request that the individual undergo a genetic test. <i>See 29 CFR 2590.702-1(c)(2).</i> ❖ A plan can obtain and use the results of a genetic test for making a determination regarding payment. However, the plan is permitted to request only the minimum amount of information necessary to make the determination. <i>See 29 CFR 2590.702-1(c)(4).</i> ❖ Exception for research: a plan or issuer may request, but not require, that a participant or beneficiary undergo a genetic test if the request is pursuant to research and several conditions are met. <i>See 29 CFR 2590.702-1(c)(5).</i> 	<input type="checkbox"/>	<input type="checkbox"/>	
<p>Question 55 – Does the plan comply with GINA’s prohibition on collection of genetic information, prior to or in connection with enrollment?</p> <p>◆ A plan cannot collect genetic information prior to an individual’s effective date of coverage under that plan or coverage, nor in connection with the rules for eligibility that apply to that individual. <i>See 29 CFR 2590.702-1(d)(2)(i).</i></p> <p>◆ Whether or not an individual’s information is collected prior to that individual’s effective date of coverage is determined at the time of collection.</p> <p>◆ Exception for incidental collection:</p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<ul style="list-style-type: none"> ❖ If a plan obtains genetic information incidental to the collection of other information concerning any individual, the collection is not a violation, as long as the collection is not for underwriting purposes. <i>See 29 CFR 2590.702-1(d)(2)(ii)(A).</i> ❖ However, the incidental collection exception does not apply in connection with any collection where it is reasonable to anticipate that health information would be received, unless the collection explicitly states that genetic information should not be provided. <i>See 29 CFR 2590.702-1(d)(2)(ii)(B).</i> 			
<p><u>Question 56 – Does the plan comply with GINA’s prohibition on collection of genetic information, for underwriting purposes?</u></p> <ul style="list-style-type: none"> ◆ A plan cannot request, require, or purchase (“collect”) genetic information for underwriting purposes. <i>See 29 CFR 2590.702-1(d)(1)(i).</i> ◆ <i>Underwriting purposes</i> means, with respect to any group health plan: <ul style="list-style-type: none"> ❖ Rules for determination of eligibility (including enrollment and continued eligibility) for benefits under the plan or coverage (including changes in deductibles or other cost-sharing mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program); ❖ The computation of premium or contribution amounts under the plan or coverage (including discounts, rebates, payments in kind, or other premium differential mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program); ❖ The application of any preexisting condition exclusion under the plan or coverage; and ❖ Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits. <i>See 29 CFR 2590.702-1(d)(1)(ii).</i> ◆ Exception for medical appropriateness (only if an individual seeks a <u>benefit</u> under the plan): <ul style="list-style-type: none"> ❖ If an individual seeks a benefit under a plan, the plan may limit or exclude the benefit based on whether the benefit is medically appropriate <i>and the determination of whether the benefit is medically appropriate is not for underwriting purposes.</i> ❖ If a plan conditions a benefit on medical appropriateness, and medical appropriateness depends on the genetic information of an individual, the plan can condition the benefit on genetic information. A plan or issuer is permitted to request only the minimum amount of genetic information necessary to determine medical appropriateness. <i>See 29 CFR 2590.702-1(d)(1)(iii) and (e).</i> 	<input type="checkbox"/>	<input type="checkbox"/>	
<p>If you answered “Yes” to ALL of the above questions, there are no violations of the GINA regulations.</p>			

VI. Compliance with Michelle’s Law

If you answer “No” to any of the questions below, the group health plan is in violation of the Michelle’s Law provisions in Part 7 of ERISA.

	YES	NO	N/A
<p>**Note: Under the Affordable Care Act group health plans and issuers are generally required to provide dependent coverage to age 26 regardless of student status of the dependent. Nonetheless, under some circumstances, such as a plan that provides dependent coverage beyond age 26, Michelle’s Law provisions may apply.</p>			
<p><u>Question 57—Does the plan comply with the Michelle’s Law requirement not to terminate coverage of dependent students on medically necessary leave of absence?</u>.....</p> <p><i>Medically necessary leave of absence</i> means with respect to a dependent child in connection with a group health plan or health insurance coverage offered in connection with a group health plan, a leave of absence from or other change in enrollment status in a postsecondary educational institution that begins while the child is suffering from a serious illness or injury; is medically necessary; and causes the child to lose student status for purposes of coverage under the terms of the plan or coverage.</p> <p>A <i>dependent child</i> is a beneficiary who is a dependent child under the terms of the plan or coverage, of a participant or beneficiary under the plan or coverage and who was enrolled in the plan or coverage on the basis of being a student at a postsecondary educational institution immediately before the first day of the medically necessary leave of absence involved.</p> <p>◆ A group health plan or issuer shall not terminate coverage of a dependent child due to a medically necessary leave of absence that causes the child to lose student status before the date that is the earlier of:</p> <ul style="list-style-type: none"> ❖ the date that is one year after the first day of the medically necessary leave of absence; or ❖ the date on which such coverage would otherwise terminate under the terms of the plan or health insurance coverage. <i>See ERISA section 714(b).</i> <p>Tip: The group health plan or issuer can require receipt of written certification by a treating physician of the dependent child which states that the dependent child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 58—Does the plan comply with Michelle’s Law’s notice requirement?</u></p> <p>◆ A group health plan or issuer must include with any notice regarding a requirement for certification of student status for coverage, a description of the Michelle’s law provision for continued coverage during medically necessary leaves of absence. <i>See ERISA section 714(c).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	

Appendix B: Chart of Required Notices

For group health plans subject to Part 7 of ERISA, the following disclosures are required:

Type of Disclosure	Applicability	Content Summary	Timing
<p>HIPAA certificate of creditable coverage (§701(e); 29 CFR 2590.701-5)</p>	<p>All group health plans.</p>	<ul style="list-style-type: none"> ◆ Date issued; ◆ Name of plan; ◆ Individual's name and ID; ◆ Plan administrator's name, address, and phone number; ◆ Phone number for further information; ◆ Individual's creditable coverage information; and ◆ An educational statement¹ regarding HIPAA, which explains: <ul style="list-style-type: none"> ❖ The preexisting condition exclusion rules, ❖ Special enrollment rights, ❖ The prohibitions against discrimination based on any health factor, ❖ The right to individual health coverage, ❖ The fact that state law may require issuers to provide additional protections to individuals in that state, and ❖ Where to get more information. 	<ul style="list-style-type: none"> ◆ When the certificate is provided upon request, as soon as possible. ◆ When the certificate is provided automatically upon loss of coverage and a COBRA qualifying event, not later than the end of the period for providing a COBRA election notice (generally 44 days). ◆ When the certificate is provided automatically upon loss of coverage and not a COBRA qualifying event, within a reasonable time after coverage ceases (as soon as possible).
<p>General notice of preexisting condition exclusion (29 CFR 2590.701-3(c))</p>	<p>Any group health plan that contains a preexisting condition exclusion.</p>	<ul style="list-style-type: none"> ◆ The existence and terms of any preexisting condition exclusion under the plan, including: <ul style="list-style-type: none"> ❖ The length of the plan's look-back period, ❖ The maximum preexisting condition exclusion period under the plan, and ❖ How the plan will reduce the maximum preexisting condition exclusion period by creditable coverage. ◆ A description of the rights of individuals to demonstrate creditable coverage, and any applicable waiting periods, through a certificate of creditable coverage or through 	<p>Must be provided as part of any written application materials distributed for enrollment. If the plan or issuer does not distribute such materials, the notice must be provided by the earliest date following a request for enrollment that a plan or issuer, acting in a reasonable and prompt fashion, can provide the notice.</p>

¹ In December 2004, rules were proposed regarding the coordination of the HIPAA portability rules with the rules under the Family and Medical Leave Act (FMLA). The proposed rules also include a revised educational statement for the HIPAA certificate and new model language to explain this coordination. Some plans may wish to avoid revising their certificates twice. Accordingly, until the proposed rules are final, plans can use either model certificate to fulfill its certificate obligations.

Type of Disclosure	Applicability	Content Summary	Timing
		<p>other means, including:</p> <ul style="list-style-type: none"> ❖ A description of the right of the individual to request a certificate from a prior plan or issuer, if necessary; and ❖ A statement that the current plan or issuer will assist in obtaining a certificate from any prior plan or issuer, if necessary. ◆ A person to contact (including an address or telephone number) for obtaining additional information or assistance. 	
<p>Individual notice of preexisting condition exclusion (29 CFR 2590.701-3(e))</p>	<p>Group health plans that contain a preexisting condition exclusion, but only after receiving creditable coverage information from an individual that is not enough to offset the preexisting condition exclusion period.</p>	<ul style="list-style-type: none"> ◆ The plan's or issuer's determination of any preexisting condition exclusion period that applies to the individual (including the last day on which the exclusion applies); ◆ The basis for such determination, including the source and substance of any information on which the plan or issuer relied; ◆ An explanation of the individual's right to submit additional evidence of creditable coverage; and ◆ A description of any applicable appeal procedures. 	<p>Must be provided as soon as possible following determination of creditable coverage.</p>
<p>Notice of special enrollment rights (29 CFR 2590.701-6(c))</p>	<p>All group health plans.</p>	<p>A description of individuals' special enrollment rights.</p>	<p>At or before the time an employee is initially offered the opportunity to enroll in a group health plan.</p>
<p>Wellness program disclosure (§702; 29 CFR 2590.702 (f)(2)(v))</p>	<p>For group health plans offering wellness programs that require individuals to satisfy a standard related to a health factor.</p>	<p>A statement that: If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call us at [insert telephone number] and we will work with you to develop another way to qualify for the reward.</p>	<p>In all plan material that describe the terms of the wellness program.</p>

Type of Disclosure	Applicability	Content Summary	Timing
<p>Description of rights with respect to hospital stays in connection with childbirth (§711(d); 29 CFR 2520.102-3(u))</p>	<p>Group health plans that provide maternity or newborn infant coverage.</p>	<p>The plan's SPD must include a statement describing any requirements under Federal or State law applicable to the plan, and any health insurance coverage offered under the plan, relating to any hospital length of stay in connection with childbirth for a mother or newborn child. If the Federal law applies in some areas in which the plan operates and State law applies in other areas, the SPD should describe the different areas and the Federal or State requirements applicable in each.</p>	<p>In the SPD (or SMM).</p>
<p>WHCRA enrollment notice (§713(a))</p>	<p>Group health plans that provide coverage for mastectomy benefits.</p>	<ul style="list-style-type: none"> ◆ A statement that for participants and beneficiaries who are receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for: <ul style="list-style-type: none"> ❖ 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. ◆ A description of any annual deductibles and coinsurance limitations applicable to such coverage. 	<p>Upon enrollment in the plan.</p>
<p>WHCRA annual notice (§713(a))</p>	<p>Group health plans that provide coverage for mastectomy benefits.</p>	<ul style="list-style-type: none"> ◆ A copy of the WHCRA enrollment notice, or ◆ A simplified disclosure providing notice of the availability of benefits for the four required coverages and information on how to obtain a detailed description. 	<p>Once each year after enrollment in the plan.</p>

For employers with a group health plan in a State that provides premium assistance under CHIP or Medicaid, the following disclosure is required:

Type of Disclosure	Applicability	Content Summary	Timing
<p>Employer Notice regarding Premium Assistance under Medicaid or CHIP (29 CFR 2590.701(f)(3)(B)(i))</p> <p>* Note, the employer (rather than the group health plan or issuer) is required to provide this notice.</p>	<p>Employers that maintain a group health plan in a state with a CHIP or Medicaid program that provides for premium assistance for group health plan coverage must provide this notice to all employees.</p>	<ul style="list-style-type: none"> ◆ Potential opportunities currently available in the State in which the employee resides for premium assistance under CHIP or Medicaid for health coverage for the employee or the employee's dependents. ◆ Information on how to contact the State in which the employee resides for additional information on premium assistance under these programs. ◆ Description of special enrollment opportunity if eligible for premium assistance under these programs. 	<ul style="list-style-type: none"> ◆ This notice must be provided annually beginning on the first day of the first plan year after February 4, 2010. ◆ May be provided with enrollment packets, open season materials, or the Summary Plan Description.

Appendix C: Model Notices

Model certificate, as included in the final regulations

CERTIFICATE OF GROUP HEALTH PLAN COVERAGE	
1. Date of this certificate: _____	7. For further information, call: _____
2. Name of group health plan: _____	8. If the individual(s) identified in line 5 has (have) at least 18 months of creditable coverage (disregarding periods of coverage before a 63-day break), check here ___ and skip lines 9 and 10.
3. Name of participant: _____ _____	9. Date waiting period or affiliation period (if any) began: _____
4. Identification number of participant: _____	10. Date coverage began: _____
5. Name(s) of individuals to whom this certificate applies: _____ _____	11. Date coverage ended (or check if coverage has not ended, enter "continuing"): _____
6. Name, address, and telephone number of plan administrator or issuer responsible for providing this certificate: _____ _____ _____	

*Note: separate certificates will be furnished if information is not identical for the participant and each beneficiary.

Statement of HIPAA Portability Rights

IMPORTANT — KEEP THIS CERTIFICATE. This certificate is evidence of your coverage under this plan. Under a Federal law known as HIPAA, you may need evidence of your coverage to reduce a preexisting condition exclusion period under another plan, to help you get special enrollment in another plan, or to get certain types of individual health coverage even if you have health problems.

Preexisting condition exclusions. Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "preexisting condition exclusions." A preexisting condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a preexisting condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a preexisting condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a preexisting condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. **Most health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If you do not receive a certificate for past coverage, talk to your new plan administrator.**

You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

- Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any preexisting condition exclusion if you enroll in another plan.

Right to get special enrollment in another plan. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

- Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

Prohibition against discrimination based on a health factor. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Right to individual health coverage. Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a preexisting condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan (which can be shown by this certificate);
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

- Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

State flexibility. This certificate describes minimum HIPAA protections under federal law. States may require insurers and HMOs to provide additional protections to individuals in that state.

For more information. If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA), toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for *Protecting Your Health Insurance Coverage*). These publications and other useful information are also available on the Internet at: <http://www.dol.gov/ebsa>, the DOL's interactive Web pages - Health Elaws, or <http://www.cms.hhs.gov/healthinsreformforconsume/>.

Model certificate, as included in the proposed regulations (includes FMLA information in the educational statement)

CERTIFICATE OF GROUP HEALTH PLAN COVERAGE	
1. Date of this certificate: _____	7. For further information, call: _____
2. Name of group health plan: _____	8. If the individual(s) identified in line 5 has (have) at least 18 months of creditable coverage (disregarding periods of coverage before a 63-day break), check here ___ and skip lines 9 and 10.
3. Name of participant: _____ _____	9. Date waiting period or affiliation period (if any) began: _____
4. Identification number of participant: _____	10. Date coverage began: _____
5. Name(s) of individuals to whom this certificate applies: _____ _____	11. Date coverage ended (or check if coverage has not ended, enter "continuing"): _____
6. Name, address, and telephone number of plan administrator or issuer responsible for providing this certificate: _____ _____ _____	
*Note: separate certificates will be furnished if information is not identical for the participant and each beneficiary.	

Statement of HIPAA Portability Rights

IMPORTANT — KEEP THIS CERTIFICATE. This certificate is evidence of your coverage under this plan. Under a Federal law known as HIPAA, you may need evidence of your coverage to reduce a preexisting condition exclusion period under another plan, to help you get special enrollment in another plan, or to get certain types of individual health coverage even if you have health problems.

Preexisting condition exclusions. Some group health plans restrict coverage for medical conditions present before an individual’s enrollment. These restrictions are known as “preexisting condition exclusions.” A preexisting condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before your “enrollment date.” Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a preexisting condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a preexisting condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a preexisting condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. **Most health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children’s Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If you do not receive a certificate for past coverage, talk to your new plan administrator.**

You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

- Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any preexisting condition exclusion if you enroll in another plan.

Right to get special enrollment in another plan. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

- Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

Prohibition against discrimination based on a health factor. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Right to individual health coverage. Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a preexisting condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan (which can be shown by this certificate);
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

- Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

Special information for people on FMLA leave. If you are taking leave under the Family and Medical Leave Act (FMLA) and you drop health coverage during your leave, any days without health coverage while on FMLA leave will not count toward a 63-day break in coverage. In addition, if you do not return from leave, the 30-day period to request special enrollment in another plan will not start before your FMLA leave ends.

- Therefore, when you apply for other health coverage, you should tell your plan administrator or health insurer about any prior FMLA leave.

State flexibility. This certificate describes minimum HIPAA protections under federal law. States may require insurers and HMOs to provide additional protections to individuals in that state.

For more information. If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA), toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for *Protecting Your Health Insurance Coverage*). These publications and other useful information are also available on the Internet at: <http://www.dol.gov/ebsa>, the DOL's interactive Web pages - Health Elaws, or <http://www.cms.hhs.gov/healthinsreformforconsume/>.

Guidelines for General Notice of Preexisting Condition Exclusion

The following are the guidelines that group health plans should consider when crafting the general notice of preexisting condition exclusion:

A group health plan (or issuer) may not impose a preexisting condition exclusion with respect to an individual before notifying the participant, in writing, of the following –

- ➔ The existence and terms of any preexisting condition exclusion under the plan. This includes –
 - The length of the plan’s look-back period,
 - The maximum preexisting condition exclusion under the plan, and
 - How the plan will reduce the maximum preexisting condition exclusion by creditable coverage.
- ➔ A description of the rights of individuals to demonstrate creditable coverage, and any applicable waiting periods, through a certificate of creditable coverage or other means. This includes –
 - A description of the right of the individual to request a certificate from a prior plan or issuer, if necessary, and
 - A statement that the current plan or issuer will assist in obtaining a certificate from a prior plan or issuer, if necessary.
- ➔ A person to contact (including an address or telephone number) for obtaining additional information or assistance regarding the preexisting condition exclusion.

Example

The following is language that group health plans may use as a guide when crafting the general notice of preexisting condition exclusion:

This plan imposes a preexisting condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a 6-month period. Generally, this 6-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 6-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the preexisting condition exclusion and creditable coverage should be directed to (insert name or position of contact person) at (insert telephone number or address).

Guidelines for Individual Notice of Preexisting Condition Exclusion

The following are the guidelines that group health plans should consider when crafting the individual notices of preexisting condition exclusion:

A group health plan (or issuer) seeking to impose a preexisting condition exclusion is required to disclose to the individual, in writing –

- Its determination of any preexisting condition that applies to the individual, including the last day on which the preexisting condition exclusion applies;
- The basis of such determination, including the source and substance of any information on which the plan or issuer relied;
- An explanation of the individual's right to submit additional evidence of creditable coverage; and
- A description of any applicable appeal procedures established by the plan or issuer.

Example

A group health plan imposes a preexisting condition exclusion period of 12 months. After receiving the general notice of preexisting condition exclusion, Individual G presents a certificate of creditable coverage indicating 240 days of creditable coverage. Within 7 days of receipt of the certificate, the plan determines that G is subject to a preexisting condition exclusion of 125 days, the last day of which is March 5. Five days later, the plan notifies G that, based on the certificate G submitted, G is subject to a preexisting condition exclusion period of 125 days, ending on March 5. The notice also explains the opportunity to submit additional evidence of creditable coverage and the plan's appeal procedures. The notice does not identify any of G's medical conditions that could be subject to the exclusion.

Model Special Enrollment Notice

The following is language that group health plans may use as a guide when crafting the special enrollment notice:

If you are declining enrollment for yourself or 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 or your dependents' other coverage). However, you must request enrollment within [insert "30 days" or any longer period that applies under the plan] after your or your dependents' other 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 [insert "30 days" or any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact [insert the name, title, telephone number, and any additional contact information of the appropriate plan representative].

Model Children’s Health Insurance Program Notice

Medicaid and the Children’s Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer’s health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer’s plan. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2011. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504	Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-866-298-8443

ALASKA – Medicaid		COLORADO – Medicaid and CHIP	
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529		Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943 CHIP Website: http:// www.CHPplus.org CHIP Phone: 303-866-3243	
ARIZONA – CHIP			
Website: http://www.azahcccs.gov/applicants/default.aspx Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437			
ARKANSAS – CHIP		FLORIDA – Medicaid	
Website: http://www.arkidsfirst.com/ Phone: 1-888-474-8275		Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml Phone: 1-877-357-3268	
GEORGIA – Medicaid		MONTANA – Medicaid	
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150		Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Telephone: 1-800-694-3084	
IDAHO – Medicaid and CHIP		NEBRASKA – Medicaid	
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588		Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092	
INDIANA – Medicaid		NEVADA – Medicaid and CHIP	
Website: http://www.in.gov/fssa/ Phone: 1-800-889-9948		Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900 CHIP Website: http://www.nevadacheckup.nv.org/ CHIP Phone: 1-877-543-7669	
IOWA – Medicaid			
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562			

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: https://www.khpa.ks.gov Phone: 1-800-792-4884	Website: www.dhhs.nh.gov/ombp/index.htm Phone: 603-271-4238
KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-342-6207	
MAINE – Medicaid	NEW MEXICO – Medicaid and CHIP
Website: http://www.maine.gov/dhhs/OIAS/public-assistance/index.html Phone: 1-800-321-5557	Medicaid Website: http://www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1-888-997-2583 CHIP Website: http://www.hsd.state.nm.us/mad/index.html Click on Insure New Mexico CHIP Phone: 1-888-997-2583
MASSACHUSETTS – Medicaid and CHIP	
Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120	
MINNESOTA – Medicaid	NEW YORK – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone (Outside of Twin City area): 800-657-3739 Phone (Twin City area): 651-431-2670	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MISSOURI – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nc.gov Phone: 919-855-4100
NORTH DAKOTA – Medicaid	UTAH – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604	Website: http://health.utah.gov/upp Phone: 1-866-435-7414

OKLAHOMA – Medicaid	VERMONT– Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://www.greenmountaincare.org/ Telephone: 1-800-250-8427
OREGON – Medicaid and CHIP	VIRGINIA – Medicaid and CHIP
Medicaid & CHIP Website: http://www.oregonhealthykids.gov Medicaid & CHIP Phone: 1-877-314-5678	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
PENNSYLVANIA – Medicaid	WASHINGTON – Medicaid
Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
RHODE ISLAND – Medicaid	WEST VIRGINIA – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604
SOUTH CAROLINA – Medicaid	WISCONSIN – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.health.wyo.gov/healthcarefin/index.html Phone: 307-777-7531

To see if any more States have added a premium assistance program since January 31, 2011, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security
Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and
Human Services
Centers for Medicare & Medicaid
Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

Model Wellness Program Disclosure

For group health plans offering a wellness program that requires an individual to satisfy a standard related to a health factor, the following is model language that may be used to satisfy the requirement that the availability of a reasonable alternative standard be disclosed:

If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call us at [insert telephone number] and we will work with you to develop another way to qualify for the reward.

Model Newborns' Act Disclosure

The following is language that group health plans subject to the Newborns' Act may use in their SPDs to describe the Federal requirements relating to hospital lengths of stay in connection with childbirth:

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).

Plans subject to State law requirements will need to prepare SPD statements describing any applicable State law.

Model WHCRA Enrollment Notice

The following is language that group health plans may use as a guide when crafting the WHCRA enrollment notice:

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.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: [insert deductibles and coinsurance applicable to these benefits].

If you would like more information on WHCRA benefits, call your plan administrator [insert phone number].

Model WHCRA Annual Notice

The following is language that group health plans may use as a guide when crafting the WHCRA annual notice:

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, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at [insert phone number] for more information.

