

Self-Compliance Tool for Part 7 of ERISA: Affordable Care Act Provisions

INTRODUCTION

While this self-compliance tool does not necessarily cover all the specifics of these laws, it is intended to 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 and includes citations to the underlying legal provisions. The information is presented as general guidance, however, and should not be considered legal advice or a substitute for any regulations or interpretive guidance issued by EBSA. In addition, some of the provisions discussed involve issues for which the rules have not yet been finalized. Proposed rules, interim final rules, and transition periods generally are noted. Periodically check the Department of Labor's Website (www.dol.gov/ebsa) under Laws & Regulations for publication of final rules.

Under the Affordable Care Act, there are various provisions that apply to group health plans and health insurance issuers and various protections and benefits

for consumers that are beginning to take effect or that will become effective very soon. The Departments are working together with employers, issuers, States, providers and other stakeholders to help them come into compliance with the new law and are working with families and individuals to help them understand the new law and benefit from it, as intended. Compliance assistance is a high priority for the Departments. Our approach to implementation is and will continue to be marked by an emphasis on assisting (rather than imposing penalties on) plans, issuers and others that are working diligently and in good faith to understand and come into compliance with the new law. This approach includes, where appropriate, transition provisions, grace periods, safe harbors, and other policies to ensure that the new provisions take effect smoothly, minimizing any disruption to existing plans and practices. *See DOL FAQs About the Affordable Care Act Implementation Part I, question 1.*

I. Determining Compliance with the Affordable Care Act Provisions in Part 7 of ERISA

The Patient Protection and Affordable Care Act (the Affordable Care Act) was signed into law by the President on March 23, 2010. Amendments to the Affordable Care Act made through the Health Care Education and Reconciliation Act (Reconciliation Act) were signed into law on March 30, 2010. Generally, the Affordable Care Act's market reform provisions amend title XXVII of the Public Health Service Act (PHS Act), which is administered by the Department of Health and Human Services. The Affordable Care Act also creates section 715 of the Employee Retirement Income Security Act (ERISA), administered by the Department of Labor, Employee Benefits Security Administration, and section 9815 of the Internal Revenue Code, administered by the Department of Treasury (the Treasury) and the Internal Revenue Service (IRS), to incorporate the market reform provisions of the PHS Act into ERISA and the Code, and make them applicable to group health plans and health insurance issuers providing group health insurance coverage. Under section 1251 of the Affordable Care Act, grandfathered health plans are required to comply with some, but not all, of the market reform provisions. In addition, these provisions do not apply to retiree-only or excepted benefits plans (See ERISA Section 732). The Departments of Labor, HHS, and the Treasury have been issuing guidance on an ongoing basis since May 2010.

See EBSA's website: <http://www.dol.gov/ebsa/healthreform/> for the most up-to-date guidance.

This compliance aid will be updated in the future to further address additional requirements as they become applicable, as enforcement grace periods expire, or as the Departments issue additional guidance.

	YES	NO	N/A
<p><u>Section A. Determining Grandfather Status Under the Affordable Care Act Provisions in Part 7 of ERISA</u></p> <p><i>Note: The grandfather status of a plan will affect whether a plan must comply with certain provisions of the Affordable Care Act (ACA). There are also special rules for collectively bargained plans. See also the rules at 29 CFR 2590.715-1251(f) and the amendment to the IFR published on November 17, 2010.</i></p> <p>Grandfather status is intended to allow people to keep their coverage as it existed on March 23, 2010, while giving plans some flexibility to make “normal” changes while retaining grandfather status. Grandfathered health plan coverage provides individuals’ protection from significant reductions in coverage, provides for coverage to include numerous protections implemented through the Affordable Care Act, and allows employers the flexibility to manage costs.</p> <p>The analysis for determining grandfather status applies separately to each benefit package or option. Accordingly, grandfather status might be retained for some benefit packages or options and relinquished for others. By contrast, if an employer relinquished grandfather status for self-only, family, or any other tier within a benefits package, it would relinquish grandfather status for the entire package. See 29 CFR 2590.715-1251(a)(1)(i).</p> <p>There are transitional rules regarding grandfather status as related to recent changes to plan terms.</p> <ul style="list-style-type: none"> ◆ Specifically a plan will not relinquish grandfather status for changes effective after March 23, 2010, pursuant to a legally binding contract entered into on or before March 23, 2010; changes effective after March 23, 2010, pursuant to a filing on or before March 23, 2010, with a State insurance department; or changes effective after March 23, 2010, pursuant to written amendments to a plan that were adopted on or before March 23, 2010. ◆ If after March 23, 2010, a group health plan or issuer made changes to the terms of the plan or coverage and the changes were adopted prior to June 14, 2010, the changes will not cause the plan or coverage to relinquish grandfather status, if the changes were revoked or modified effective as of the first day of the first plan year beginning on or after September 23, 2010, and the terms of the plan or health insurance coverage on that date, as modified, would not cause the plan or coverage to otherwise cease to be a grandfathered health plan. See 29 CFR 2590.715-1251(g)(2). <p>If the plan is not claiming grandfathered status, proceed to Section B.</p> <p>If the answer is “yes” to questions 1 and 2 below the group health plan may be a grandfathered health plan.</p>			
<p><u>Question 1 – Did the plan exist with at least one individual enrolled on March 23, 2010?</u>.....</p> <ul style="list-style-type: none"> ◆ A grandfathered group health plan must have been in existence with an enrolled individual on March 23, 2010. Any plan that does not meet this requirement is not in grandfathered status. See 29 CFR 2590.715-1251(a)(1)(i). 	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p><u>Question 2 – Has the plan continuously covered someone (not necessarily the same person) since March 23, 2010?</u></p> <p>◆ A group health plan will not relinquish its grandfather status merely because one or more (or all) individuals enrolled on March 23, 2010, cease to be covered. However, a grandfathered health plan must continuously cover someone (not necessarily the same person) since March 23, 2010, to maintain its status. <i>See 29 CFR 2590.715-1251(a)(1)(i).</i></p> <p>If the answers to questions 1 and 2 were “yes”, complete questions 3-11. If the answer is “no” to either question 1 or 2, the group health plan cannot claim grandfather status; proceed to Section B.</p> <p>TIP: Provided changes are made without exceeding the other standards that cause a plan to relinquish grandfather status, changes that generally will not cause plans to relinquish grandfather status include changes to: premiums; to comply with Federal or State legal requirements; to voluntarily comply with provisions of the Affordable Care Act; third party administrators; network plan’s provider network; and to a prescription drug formulary.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 3 – Has the plan eliminated all or substantially all benefits to diagnose or treat a particular condition?</u>.....</p> <p>◆ For the purpose of determining grandfather status, the elimination of benefits for any necessary element to diagnose or treat a condition is considered the elimination of all or substantially all benefits to diagnose or treat a particular condition. <i>See 29 CFR 2590.715-1251(g)(1)(i).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 4 – Has the plan increased a percentage cost-sharing requirement (such as an individual’s coinsurance)?</u></p> <p>◆ Any increase measured from March 23, 2010, in a percentage cost-sharing requirement causes a plan to relinquish grandfather status. <i>See 29 CFR 2590.715-1251(g)(1)(ii).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 5 – Has the plan increased a fixed-amount cost-sharing requirement other than a copayment (such as a deductible or out-of-pocket limit) such that the total percentage increase measured from March 23, 2010 exceeds the maximum percentage increase?</u></p> <p>◆ The maximum percentage increase is medical inflation, expressed as a percentage, plus 15 percentage points. <i>See 29 CFR 2590.715-1251(g)(3)(ii).</i> Medical inflation is the increase since March 2010, in the overall medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) (unadjusted) published by the Department of Labor using the 1982-1984 base of 100. <i>See 29 CFR 2590.715-1251(g)(3)(i).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p><u>Question 6 – Has the plan increased a fixed-amount copayment such that the increase measured from March 23, 2010 exceeds the greater of: the maximum percentage increase, or an amount equal to \$5 plus medical inflation?</u></p> <p>◆ The maximum percentage increase is medical inflation, expressed as a percentage, plus 15 percentage points. <i>See 29 CFR 2590.715-1251(g)(3)(ii)</i>. Medical inflation is the increase since March 2010 in the overall medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) (unadjusted) published by the Department of Labor using the 1982-1984 base of 100. <i>See 29 CFR 2590.715-1251(g)(3)(i)</i>.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 7 – Has there been a decrease in the contribution rate by the employer (or employee organization) towards the cost of any tier of coverage for any class of similarly situated individuals by more than 5 percentage points below the contribution rate for the coverage period that includes March 23, 2010?</u></p> <p>◆ If the contribution rate is based on a formula, was the decrease in the contribution rate based on a formula by more than 5 percent below the contribution rate for the coverage period that includes March 23, 2010? <i>See 29 CFR 2590.715-1251(g)(1)(v)(B)</i>.</p> <p>TIP: If a group health plan <u>modifies</u> the tiers of coverage it had on March 23, 2010 (for example, from self-only and family to a multi-tiered structure of self-only, self-plus-one, self-plus-two, and self-plus-three-or-more), the employer contribution for any new tier would be tested by comparison to the contribution rate for the corresponding tier on March 23, 2010. If the plan <u>adds</u> one or more new coverage tiers without eliminating or modifying any previous tiers and those new coverage tiers cover classes of individuals that were not covered previously under the plan, the new tiers would not be analyzed under the standards of paragraph (g)(1). <i>See DOL FAQs About the Affordable Care Act Implementation Part II, question 3 at http://www.dol.gov/ebsa/faqs/faq-aca2.html.</i></p> <p>In cases of a multiemployer plan that has either a fixed-dollar employee contribution or no employee contribution towards the cost of coverage, if the employer’s contribution rate changes, provided any changes in the coverage terms would not otherwise cause the plan to cease to be grandfathered and there continues to be no employee contribution or no increase in the fixed-dollar employee contribution towards the cost of coverage, the change of the employer’s contribution rate will not, in and of itself, cause a plan that is otherwise a grandfathered health plan to relinquish grandfather status. <i>See DOL FAQs About the Affordable Care Act Implementation Part I, question 4 at http://www.dol.gov/ebsa/faqs/faq-aca.html.</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p>Question 8 – Has the plan added or decreased an overall annual limit on benefits?</p> <p>◆ A plan will relinquish its grandfathered status if it:</p> <ul style="list-style-type: none"> ❖ Adds an overall annual limit on the dollar value of all benefits when it did not previously impose an overall annual limit (<i>See 29 CFR 2590.715-1251(g)(1)(vi)(A)</i>); ❖ Previously imposed an overall lifetime limit on the dollar value of benefits (but no overall annual limit) and adopts an overall annual limit at a dollar value that is lower than the dollar value of the lifetime limit on March 23, 2010 (<i>See 29 CFR 2590.715-1251(g)(1)(vi)(B)</i>); or ❖ Decreases the dollar value of the overall annual limit that was in place on March 23, 2010 (<i>See 29 CFR 2590.715-1251(g)(1)(vi)(C)</i>). <p>If the answer to any of questions 3-8 was “yes”, the plan is <u>NOT</u> a grandfathered plan, proceed to Section B.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>Question 9 – Did the plan change issuers after March 23, 2010?</p> <p>If the answer to question 9 is “yes”, if the group health plan changed issuers after March 23, 2010, and the change in issuer was effective on or after November 15, 2010, the plan will continue to be a grandfathered plan provided no other changes that would relinquish grandfather status are made. <i>See 29 CFR 2590.715-1251(a)(1)(ii), as amended.</i> Proceed to question 10.</p> <p>If a group health plan changed issuers after March 23, 2010, and the change was effective prior to November 15, 2010, the plan will have relinquished grandfather status. The plan is not a grandfathered plan; proceed to Section B.</p> <p>TIP: The operative date is the effective date of the new contract, not the date the new contract was entered into. Special rules apply for collectively bargained plans. <i>See 29 CFR 2590.715-1251(f)</i> for collectively bargained plans.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>Question 10 – Did the plan change from self-insured to fully-insured after March 23, 2010?</p> <p>If the group health plan was self-insured and changed to fully insured after March 23, 2010, and the change was effective on or after November 15, 2010, the plan will continue to be a grandfathered plan provided no other changes are made that would relinquish grandfather status. <i>See 29 CFR 2590.715-1251(a)(1)(ii), as amended.</i> Proceed to question 11.</p> <p>If a group health plan was self-insured and changed to fully-insured after March 23, 2010, and the change was effective prior to November 15, 2010, the plan will have relinquished grandfather status. The plan is not a grandfathered plan; proceed to Section B.</p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p><u>Question 11 – If the group health plan changed issuers (including a plan that was self-insured and changed to fully insured) and has maintained grandfather status did the plan provide documentation to the new issuer of the plan terms under the prior health coverage sufficient to determine whether any other change was made that would relinquish grandfather status?</u></p> <p>◆ To maintain status as a grandfathered health plan, the plan must provide to the new issuer (and the new issuer must require) documentation of plan terms (including benefits, cost sharing, employer contributions, and annual limits) under the prior health coverage sufficient to determine whether any other change is being made that would relinquish grandfathered status. <i>See 29 CFR 2590.715-1251(a)(3)(ii), as amended.</i></p> <p>For all plans that, based on questions 1 through 11, have not relinquished grandfather status, complete questions 12-13.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 12 – Does the plan include a statement that it believes it is a grandfathered health plan in any plan materials provided to participants and beneficiaries that describe the benefits provided under the plan?</u></p> <p>◆ To maintain status as a grandfathered group health plan, the plan must include a statement, in any plan materials provided to a participant or beneficiary describing the benefits under the plan, that the plan believes it is a grandfathered health plan within the meaning of section 1251 of the Affordable Care Act and must provide contact information for questions and complaints. Model language is available. <i>See 29 CFR 2590.715-1251(a)(2).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 13 – Is the plan maintaining records documenting the terms of the plan in connection with the coverage in effect on March 23, 2010, and are these records made available upon request?.....</u></p> <p>◆ To maintain status as a grandfathered group health plan the plan must maintain records documenting the terms of the plan in connection with the coverage that was in effect on March 23, 2010, and any other documents necessary to verify, explain, or clarify its status as a grandfathered health plan. These records must be maintained for as long as the plan takes the position that it is grandfathered, and must be available for examination upon request. <i>See 29 CFR 2590.715-1251(a)(3)(i)(A) & (i)(B), as amended.</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Section B. Determining Compliance with the Affordable Care Act Extension of Dependent Coverage of Children to Age 26 Provisions in Part 7 of ERISA</u></p> <p><i>Note: This provision is applicable for plan years beginning on or after Sept. 23, 2010. This provision applies to both grandfathered and non-grandfathered group health plans. A special rule for grandfathered plans is noted below.</i></p>			

	YES	NO	N/A
<p>Question 1 – Does the plan provide coverage for dependent children?.....</p> <p>If the answer to this question is no, proceed to Section C. These provisions are only applicable to group health plans that provide coverage to dependent children. If the answer is “yes”, proceed to question 2.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>Question 2 – Is the plan a grandfathered health plan?.....</p> <p>If yes, note:</p> <p>Special Rule for Grandfathered Plans: Grandfathered group health plans are not required to cover dependent children to age 26 if the dependent is eligible to enroll in another employer-sponsored group health plan (other than the group health plan of a parent). <i>See 29 CFR 2590.715-2714(g)(1).</i></p> <p>If the answer to ALL of the questions below is “yes”, the plan is in compliance with the rules regarding Dependent Coverage to Age 26.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>Question 3 – Does the plan make dependent coverage available for children to age 26? ...</p> <p>Plans and issuers cannot deny or restrict dependent coverage for a child who is under age 26 other than in terms of a relationship between a child and the participant. Thus, plans and issuers cannot deny or restrict dependent coverage for a child who is under age 26 based on the presence or absence of financial dependency upon or residency with the participant or any other person, student status, employment or any combination of these factors. In addition, plans and issuers cannot limit dependent coverage based on whether the child under age 26 is married. The Affordable Care Act and implementing regulations do not require plans to cover children of children. <i>See 29 CFR 2590.715-2714(b) & (c).</i></p> <p>The terms of the plan or coverage cannot vary based on age, except for children who are age 26 or older. <i>See 29 CFR 2590.715-2714(d).</i></p> <p>TIP: A plan or issuer does not fail to satisfy the requirements regarding Dependent Coverage to Age 26 because the plan limits health coverage for children until the child turns 26 to only those children who are described in section 152(f)(1) of the Code. For an individual not described in Code section 152(f)(1), such as a grandchild or niece, a plan may impose additional conditions on eligibility for health coverage, such as a condition that the individual be a dependent for income tax purposes. <i>See DOL FAQs About the Affordable Care Act Implementation Part I, question 14 at http://www.dol.gov/ebsa/faqs/faq-aca.html.</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>Question 4 – Did the plan provide the one-time notice and an opportunity to enroll?</p> <p>There is a special transitional rule for children who satisfy two requirements – (a) their coverage ended, or they were denied coverage (or were not eligible for coverage) because the availability of dependent coverage of children ended before the attainment of age 26; and (b) by reason of the application of this provision, they become eligible for coverage on the first day of the first plan year beginning on or after September 23, 2010.</p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p>With respect to children, plans and issuers must comply with the following transitional rules: <i>See 29 CFR 2590.715-2714(f).</i></p> <ul style="list-style-type: none"> ◆ An enrollment opportunity (including written notice) must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010 and the enrollment period must continue for at least 30 days. <i>See 29 CFR 2590.715-2714(f)(2)(i).</i> ◆ The written notice must include a statement that children whose coverage ended, or who were denied (or were not eligible for) coverage because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll. The notice may be provided to an employee on behalf of a child and the notice may be included with other enrollment materials, provided the statement is prominent. <i>See 29 CFR 2590.715-2714(f)(2)(ii).</i> ◆ Under this enrollment opportunity, a child must be treated as a HIPAA special enrollee. Therefore, the child must be offered all the benefit packages available to similarly situated individuals who did not lose coverage because they ceased to be dependents and cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage because they ceased to be dependents. Further, if the participant, through whom the child is eligible, is not enrolled, the plan must provide that participant an enrollment opportunity. <i>See 29 CFR 2590.715-2714(f)(4), cross-referencing 29 CFR 2590.701-6(d).</i> ◆ Plans may coordinate this enrollment opportunity with open season, if an open season occurs before the first day of the next plan year. For example, if a calendar year plan has an open season coming up in advance of January 1, 2011, the plan may coordinate this enrollment period with that open season. Under the enrollment opportunity, coverage must take effect not later than the first day of the first plan year on or after September 23, 2010. <i>See 29 CFR 2590.715-2714(f)(3).</i> 			
<p><u>Section C. Determining Compliance with the Affordable Care Act Rescission Provisions in Part 7 of ERISA</u></p> <p><i>Note: This provision is applicable for plan years beginning on or after Sept. 23, 2010. This provision applies to both grandfathered and non-grandfathered group health plans.</i></p> <p>A rescission is a cancellation or discontinuance of coverage that has retroactive effect; this includes a cancellation that treats a policy as void from the time of the group’s enrollment or a cancellation that voids benefits paid up to one year before the cancellation. A rescission is not the cancellation or discontinuance of coverage that has only a prospective effect; or the cancellation or discontinuance of coverage if effective retroactively to the extent it is based on a failure to timely pay required premiums or contributions towards the cost of coverage. <i>See 29 CFR 2590.715-2712(a)(2).</i></p> <p>If the answer to the question below is “yes” the plan is in compliance with the rules regarding rescission of coverage.</p>			

	YES	NO	N/A
<p><u>Question 1 – Does the plan only rescind coverage for instances where an act, practice, or omission that constitutes fraud, or an intentional misrepresentation of material fact has occurred?</u></p> <p>◆ A group health plan, or health insurance issuer offering group health insurance coverage, must not rescind coverage with respect to an individual (including a group to which the individual belongs, or family coverage in which the individual is included) once the individual is covered under the plan or coverage, unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage. <i>See 29 CFR 2590.715-2712(a)(1).</i></p> <p>TIP: Some employers’ human resource departments may reconcile lists of eligible individuals with their plan or issuer via data feed only once per month. If a plan covers only active employees (subject to the COBRA continuation coverage provisions) and an employee pays no premiums for coverage after termination of employment, the Departments do not consider the retroactive elimination of coverage back to the date of termination of employment, due to delay in administrative record-keeping, to be a rescission. Similarly, if a plan does not cover ex-spouses (subject to the COBRA continuation coverage provisions) and the plan is not notified of a divorce and the full COBRA premium is not paid by the employee or ex-spouse for coverage, the Departments do not consider a plan’s termination of coverage retroactive to the divorce to be a rescission of coverage. (Of course, in such situations COBRA may require coverage to be offered for up to 36 months if the COBRA applicable premium is paid by the qualified beneficiary.) <i>See DOL FAQs About the Affordable Care Act Implementation Part II, question 7 at http://www.dol.gov/ebsa/faqs/faq-aca2.html.</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Section D. Determining Compliance with the Affordable Care Act Prohibitions on Lifetime Limits and Restrictions on Annual Limits in Part 7 of ERISA</u></p> <p><i>Note: This provision is applicable for plan years beginning on or after Sept. 23, 2010. This provision applies to both grandfathered and non-grandfathered group health plans.</i></p> <p>The restrictions on annual limits do not apply to health flexible spending arrangements (FSAs), medical savings accounts (MSAs), or health savings accounts (HSAs). In the case of health reimbursement accounts (HRAs) that are integrated with other group health plan coverage which complies with the prohibitions on lifetime and annual limits, the fact that benefits under the HRA by itself are limited does not violate these rules. Stand-alone HRAs limited to retirees only are not subject to these rules.</p> <p>1. Lifetime Limits</p> <p>If the answer to ALL of the questions below is “yes” the plan is in compliance with the rules regarding prohibitions on lifetime limits.</p>			

	YES	NO	N/A
<p><u>Question 1 – Does the plan comply with the Affordable Care Act’s prohibition on lifetime limits?</u>.....</p> <p>◆ A group health plan or issuer may not establish any lifetime limit on the dollar amount of benefits for any individual. This prohibition applies for plan years beginning on or after September 23, 2010. <i>See 29 CFR 2590.715-2711(a)(1).</i></p> <p>TIP: These rules do not prevent a plan or issuer from placing lifetime dollar limits with respect to any individual on specific covered benefits that are not essential health benefits (to the extent this is permissible under applicable Federal and State law). <i>See 29 CFR 2590.715-2711(b)(1).</i></p> <p>Note: “Essential health benefits” refers to essential benefits under Section 1302(b) of the Affordable Care Act and applicable regulations (issued by HHS).</p> <p>For plan years beginning before the issuance of regulations defining “essential health benefits,” for purposes of enforcement, the Departments will take into account good faith efforts to comply with a reasonable interpretation of the term “essential health benefits.” For this purpose, a plan or issuer must apply the definition of essential health benefits consistently. <i>See Preamble to Interim Final Regulations, at 75 FR 37188, 37191.</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 2 – Does the plan comply with the requirements regarding one-time notice and opportunity to enroll?</u></p> <p>There are transitional rules for any individual who satisfies two requirements – (a) their coverage or benefits under a group health plan or health insurance coverage ended by reason of reaching a lifetime limit; and (b) by reason of the application of this provision, they become eligible (or are required to become eligible) for benefits not subject to a lifetime limit on the first day of the first plan year on or after September 23, 2010. Such individuals must be provided notice and an enrollment opportunity. <i>See 29 CFR 2590.715-2711(e)(1).</i></p> <p>With respect to these individuals, plans and issuers must comply with the following transitional rules:</p> <p>◆ An enrollment opportunity (including written notice) must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010 and must continue for at least 30 days. <i>See 29 CFR 2590.715-2711(e)(2)(i).</i></p> <p>◆ The notice may be provided to an employee on behalf of the employee’s dependent and the notice may be included with other enrollment materials, provided the statement is prominent. <i>See 29 CFR 2590.715-2711(e)(2)(ii).</i></p> <p>❖ Notice to Individuals Still Covered: The plan and issuer are required to give the individual written notice that the lifetime limit on the dollar value of benefits no longer applies and that the individual, if covered, is once again eligible for benefits under the plan. <i>See 29 CFR 2590.715-2711(e)(2)(i).</i></p> <p>❖ Notice and Enrollment Opportunity to Individuals Who Are Not Enrolled: If an individual is not enrolled (or if an enrolled individual is eligible for but not enrolled in any benefit package under the plan or coverage), the plan and issuer must give the individual written notice that the lifetime limit on the dollar value of benefits no longer applies and that the individual is once again eligible for benefits under the plan. <i>See 29 CFR 2590.715-2711(e)(2)(i).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<ul style="list-style-type: none"> ◆ For individuals who enroll under this opportunity, coverage must take effect not later than the first day of the first plan year beginning on or after September 23, 2010. <i>See 29 CFR 2590.715-2711(e)(3).</i> ◆ Individuals who enroll under this opportunity must be treated as special enrollees. Therefore, the individual must be offered all the benefit packages available to similarly situated individuals who did not lose coverage by reason of reaching a lifetime limit and cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of reaching a lifetime limit. Further, if the participant, through whom the individual is eligible, is not enrolled, the plan must provide that participant an enrollment opportunity. <i>See 29 CFR 2590.715-2711(e)(4).</i> 			
<p>2. Annual Limits</p> <p>The interim final regulations provide that for plan years prior to January 1, 2014, the Secretary of HHS may establish a program under which the requirements relating to restricted annual limits may be waived if compliance with the rules would result in a significant decrease in access to benefits or a significant increase in premiums. Limited benefit insurance plans, also known as mini-medical plans, which are often used by employers to provide benefits to part-time workers, are examples of plans that might seek this kind of delay. If a plan has been granted an HHS waiver, the plan is not required to comply with the annual limit requirements during the applicable waiver period. Proceed to Section E.</p> <p>If the answer to the question below is “yes” the plan is in compliance with the rules regarding prohibitions/restrictions on annual limits.</p>			
<p><u>Question 1 – Does the plan comply with the Affordable Care Act’s restrictions on annual limits?</u>.....</p> <p>For plan years beginning prior to January 1, 2014, a plan may establish, for any individual, an annual limit on the dollar amount of benefits that are essential health benefits, if the limit is no less than:</p> <ul style="list-style-type: none"> ◆ For a plan year beginning on or after September 23, 2010 but before September 23, 2011, \$750,000; ◆ For a plan year beginning on or after September 23, 2011 but before September 23, 2012, \$1.25 million; and ◆ For plan years beginning on or after September 23, 2012 but before January 1, 2014, \$2 million. <i>See 29 CFR 2590.715-2711(d)(1).</i> <p>TIP: These rules do not prevent a plan or issuer from placing annual dollar limits with respect to any individual on specific covered benefits that are not essential health benefits (to the extent this is permissible under applicable Federal and State law). <i>See 29 CFR 2590.715-2711(b)(1).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p><u>Section E. Determining Compliance with the Affordable Care Act Prohibition on Preexisting Condition Exclusion for Individuals Under 19 in Part 7 of ERISA</u></p> <p><i>Note: This provision is applicable for plan years beginning on or after Sept. 23, 2010. This provision applies to both grandfathered and non-grandfathered group health plans.</i></p> <p>The definition of preexisting condition exclusion includes any limitation or exclusion of benefits (including a denial of coverage) applicable to an individual as a result of information relating to an individual’s health status before the individual’s effective date of coverage (or if coverage is denied, the date of denial), such as a condition identified as a result of a pre-enrollment questionnaire or a physical examination given to the individual, or a review of medical records relating to the pre-enrollment period. <i>See 29 CFR 2590.701-2 (as revised – see 75 FR 37229).</i></p> <p>If the answer to the following question is “yes” the plan is in compliance with the prohibition on preexisting condition exclusions for individuals under the age of 19.</p>			
<p><u>Question 1 – Does the plan comply with the Affordable Care Act by not imposing a preexisting condition exclusion on individuals under the age of 19?.....</u></p> <p>◆ For plan years beginning on or after September 23, 2010, group health plans may not impose any preexisting condition exclusion on enrollees, including applicants for enrollment, under the age of 19. <i>See 29 CFR 2590.715-2704(a)(1); 29 CFR 2590.715-2704(b)(2)&(3).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Section F. Determining Compliance with the Affordable Care Act Provisions Regarding the provision of the Summary of Benefits and Coverage (SBC) and Uniform Glossary</u></p> <p><i>Note: This provision is applicable for participants and beneficiaries who enroll or re-enroll through an open enrollment period beginning on the first day of the first open enrollment period that begins on or after September 23, 2012. For participants and beneficiaries who enroll other than through an open enrollment period (such as newly eligible or special enrollees), SBCs must be provided beginning on the first day of the first plan year beginning on or after September 23, 2012. See 29 CFR 2590.715-2715(f). These provisions do apply to grandfathered health plans.</i></p> <p>The Affordable Care Act provides for new disclosure tools, the Summary of Benefits and Coverage (SBC) and Uniform Glossary, to help consumers better compare coverage options available to them in both the individual and group health insurance coverage markets. Generally, group health plans and health insurance issuers are required to provide the SBC and Uniform Glossary free of charge. The Departments published a final rule setting forth the requirements for who must provide and who is entitled to receive an SBC and Uniform Glossary, when these documents must be provided, the content required in the documents, and the form and manner of how the documents can be provided. In addition, the Departments published a notice that sets forth the required template for the SBC and Uniform Glossary documents along with instructions and sample language for completing the template. These</p>			

	YES	NO	N/A
<p>documents are available on the EBSA website at: http://www.dol.gov/ebsa/healthreform/. The SBC and Uniform Glossary must be provided in a culturally and linguistically appropriate manner. The rules for determining whether a language other than English must be made available are the same as the rules for Internal Claims and Appeals and External Review, discussed in Section I of this compliance aid. HHS has made available translated versions of the template and glossary available in the potential required languages at: http://cciio.cms.gov/resources/other/index.html.</p> <p>Transitional Relief Providing Flexibility and Emphasizing Good Faith Progress Towards Compliance</p> <p>The Department is working together with employers and issuers to assist them in coming into compliance with these requirements. Specifically, in the instructions for completing the SBC, the Department stated that to the extent a plan’s terms do not reasonably correspond to the template and instructions, the template should be completed in a manner that is as consistent with the instructions as reasonably as possible, while still accurately reflecting the plan’s terms. <i>See Instructions Guide for Group Coverage, page 1 General Instructions</i>. In addition, compliance assistance is a high priority for the Departments. Implementation will be marked by an emphasis on assisting (rather than imposing penalties on) plans and issuers that are working diligently and in good faith to understand and come into compliance with the new law. During the first year of applicability,¹ the Departments will not impose penalties on plans and issuers that are working diligently and in good faith to comply. The Departments will continue to work with stakeholders over time to achieve maximum uniformity for consumers and certainty for the regulated community. <i>See ACA Implementation FAQ Part VIII, Q2 and Part IX, Q8</i>.</p> <p>The questions below focus on provision of the SBC by group health plans to participants and beneficiaries. The final regulations also require health insurance issuers to provide the SBC to group health plan sponsors and participants and beneficiaries. More information on these requirements can be found at www.dol.gov/ebsa.</p> <p>The following questions have been developed to assist in determining compliance with the rules regarding the Summary of Benefits and Coverage and Uniform Glossary.</p>			
<p>Question 1 – Does the plan provide an SBC, as required?</p> <p><u>In Connection with Enrollment</u></p> <p>◆ When providing the SBC to participants and beneficiaries, group health plans and issuers must provide the SBC with respect to each benefit package offered for which they are eligible (<i>See 29 CFR 2590.715-2715(a)(1)(ii)(A)</i>) as part of any written application materials distributed by the plan or issuer for enrollment. If no written application materials are distributed for enrollment, the SBC must be provided no later than the first date a participant is eligible to enroll in coverage for themselves or any beneficiaries. <i>See 29 CFR 2590.715-2715(a)(1)(ii)(B)</i>. For this purpose, written application materials include any forms or requests for information, in paper form or through a website or email, that must be completed for enrollment. <i>See ACA Implementation FAQ Part VIII, Q9</i>.</p>	<input type="checkbox"/>	<input type="checkbox"/>	

¹ The term “first year of applicability” refers to SBCs and uniform glossaries provided with respect to coverage beginning before January 1, 2014.

	YES	NO	N/A
<ul style="list-style-type: none"> ◆ If there is any change to the information required to be in the SBC prior to the first day of coverage, the plan or issuer must provide an updated SBC to the participants and beneficiaries no later than the first day of coverage. <i>See 29 CFR 2590.715-2715(a)(1)(ii)(C).</i> ◆ An SBC must also be provided to special enrollees no later than the date by which an SPD is required to be provided under ERISA section 104(b)(1)(A), which is 90 days from enrollment. <i>See 29 CFR 2590.715-2715(a)(1)(ii)(D).</i> <p><u>In Connection with Renewal</u></p> <ul style="list-style-type: none"> ◆ Group health plans and issuers are required to provide an SBC to participants and beneficiaries upon renewal or reissuance of coverage. <i>See 29 CFR 2590.715-2715(a)(1)(ii)(E).</i> If written application materials are required for renewal (paper or electronic), the SBC must be provided no later than the date on which these materials are distributed. <i>See 29 CFR 2590.715-2715(a)(1)(ii)(E)(1).</i> If renewal is automatic, the SBC must be provided no later than 30 days before the first day of coverage in the new plan or policy year. For insured coverage, if the policy, certificate, or contract of insurance has not been issued or renewed before such 30-day period, the SBC must be provided as soon as practicable but in no event later than seven business days after issuance of, or after receiving confirmation of the policyholder's intent to renew, the policy, certificate, or contract of insurance, whichever is earlier. <i>See 29 CFR 2590.715-2715(a)(1)(ii)(E)(2).</i> ◆ With respect to a group health plan that offers multiple benefit packages, the plan or issuer is required to provide a new SBC automatically upon renewal only with respect to the benefit package in which a participant or beneficiary is enrolled. <i>See 29 CFR 2590.715-2715(a)(1)(iii)(C).</i> <p><u>Upon Request</u></p> <ul style="list-style-type: none"> ◆ SBCs are required to be provided by group health plans and issuers, as applicable, to participants and beneficiaries upon request, as soon as practicable, but no later than seven business days following the receipt of a request. <i>See 29 CFR 2590.715-2715(a)(1)(ii)(F).</i> <p><u>Guidance Regarding Applicability</u></p> <ul style="list-style-type: none"> ◆ Disclosures (including the SBC and Uniform Glossary) provided to participants and beneficiaries who enroll or re-enroll through an open enrollment period must be provided beginning on the first day of the first open enrollment period that begins on or after September 23, 2012. For participants and beneficiaries who enroll other than through open enrollment (such as newly eligible or special enrollees), these disclosures must be provided beginning on the first day of the first plan year beginning on or after September 23, 2012. <i>See 29 CFR 2590.715-2715(f).</i> ◆ Due to additional administrative complexities with respect to providing SBCs for insurance products that are no longer being offered for purchase (sometimes referred to as closed blocks of business), the Departments will not take any enforcement action against a plan or issuer for failing to provide an SBC <i>before</i> September 23, 2013 with respect to an insured product that is no longer being actively marketed for purchase. However, the SBC must be provided <i>no later than</i> September 23, 2013. <i>See ACA Implementation FAQ Part IX, Q12.</i> 			

	YES	NO	N/A
<p>◆ With respect to expatriate coverage, the Departments will not take any enforcement action against a group health plan or group health insurance issuer for failing to provide an SBC for such coverage during the first year of applicability. <i>See ACA Implementation FAQ Part IX, Q13.</i></p> <p>TIPS: The requirement to provide an SBC by both a health insurance issuer and a group health plan to participants and beneficiaries can be satisfied for both entities as long as one entity provides the required SBC within the required timeframes. <i>See 29 CFR 2590.715-2715(a)(1)(iii)(A).</i></p> <p>If a participant and any beneficiaries are known to reside at the same address, a single SBC provided to that address will satisfy the obligation to provide for all individuals at the address. Under this circumstance, the obligation will also be satisfied if the SBC is furnished to the participant in electronic form. However if a beneficiary’s last known address is different than the participant’s address, a separate SBC must be mailed to the beneficiary’s address. <i>See 29 CFR 2590.715-2715(a)(1)(iii)(B) and ACA Implementation FAQ Part VIII, Q10.</i></p> <p>Group health plans are permitted to integrate the SBC with other summary materials, such as the SPD, as long as the SBC is intact and prominently displayed at the beginning of the materials (for example, immediately after the table of contents in an SPD) and all of the timing requirements are met. <i>See 77 FR 8707.</i></p> <p>The Departments generally allow electronic delivery of the SBC and Uniform Glossary where appropriate. For participants and beneficiaries who are already enrolled in coverage under a group health plan, an SBC may be provided electronically if the requirements of the Department of Labor’s electronic safe harbor are met. For participants and beneficiaries who are eligible but not enrolled for coverage, the SBC may be provided electronically if the format is readily accessible; the SBC is provided in paper form upon request; and if the electronic form is an Internet posting, the plan or issuer timely notifies the individual that the documents are available in paper form upon request. <i>See 29 CFR 2590.715-2715(a)(3).</i> An SBC may be provided electronically to participants and beneficiaries in connection with their online enrollment or online renewal of coverage under the plan. SBCs may also be provided electronically to participants and beneficiaries who request an SBC online. In either instance, a paper copy must be provided upon request. <i>See ACA Implementation FAQ Part IX, Q1.</i></p>			
<p><u>Question 2 – Does the plan make available the Uniform Glossary, as required?</u></p> <p>◆ The Uniform Glossary includes statutorily required terms, as well as multiple additional terms recommended by the NAIC. The Uniform Glossary is available on the DOL website at http://www.dol.gov/ebsa/healthreform/. The Uniform Glossary may not be modified by plans or issuers. <i>See 29 CFR 2590.715-2715(c)(3); 77 FR 8708.</i></p> <p>◆ The final rule requires group health plans and issuers to make the Uniform Glossary available upon request within seven business days. <i>See 29 CFR 2590.715-2715(c)(4).</i> This requirement may be satisfied by providing an internet address where an individual may review and obtain the Uniform Glossary. <i>See 29 CFR 2590.715-2715(a)(2)(i)(L).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>If you are completing this section as part of a review of a grandfathered health plan, STOP here. The following sections address provisions that do not apply to grandfathered health plans.</p>			

	YES	NO	N/A
<p><u>Section G. Determining Compliance with the Patient Protection Provisions of the Affordable Care Act in Part 7 of ERISA</u></p> <p><i>Note: This provision is applicable for plan years beginning on or after Sept. 23, 2010. This provision does not apply to grandfathered health plans.</i></p>			
<p>1. Choice of Healthcare Professional</p> <p>A plan or issuer that requires or provides for a participant or beneficiary to designate a participating primary care provider must permit each participant or beneficiary to designate any participating primary care provider who is available to accept the participant or beneficiary. With respect to a child, the plan or issuer must permit the designation of a physician who specializes in pediatrics as a child’s primary care provider, if the provider participates in the network of the plan or issuer and is available to accept the child. <i>See 29 CFR 2590.715-2719A(a)(1) & (a)(2).</i></p> <p>A group health plan or issuer that provides obstetrical or gynecological (OB/GYN) care and requires the designation of an in-network primary care provider, may not require authorization or referral by the plan, issuer, or any person (including a primary care provider) for a female participant or beneficiary who seeks coverage for OB/GYN care provided by a participating health care professional who specializes in obstetrics and gynecology. (This includes any individual authorized under State law to provide OB/GYN care, including a person other than a physician). <i>See 29 CFR 2590.715-2719A(a)(3).</i></p>			
<p><u>Question 1 – Does the plan require or provide for designation of a participating primary care provider by any participant or beneficiary?</u>.....</p> <p>If the answer is ‘no’, enter ‘N/A’ for the following questions and proceed to Question 8.</p> <p>If the answer to ALL of the questions below is “yes” the plan is in compliance with the choice of healthcare professional provisions of the rules regarding patient protections.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 2 – Does the plan permit each participant or beneficiary to designate any participating primary care provider who is available to accept the participant or beneficiary?</u></p> <p>◆ If a group health plan, or a health insurance issuer offering group health insurance coverage, requires or provides for designation by a participant or beneficiary of a participating primary care provider, then the plan or issuer must permit each participant or beneficiary to designate any participating primary care provider who is available to accept the participant or beneficiary. <i>See 29 CFR 2590.715-2719A(a)(1)(i).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO	N/A
<p><u>Question 3 – Does the plan provide a notice informing each participant of the terms of the plan or health insurance coverage regarding designation of a primary care provider?</u></p> <p>◆ If a group health plan or health insurance issuer requires the designation by a participant or beneficiary of a primary care provider, the plan or issuer must provide a notice informing each participant of the terms of the plan or health insurance coverage regarding designation of a primary care provider that any participating primary care provider who is available to accept the participant or beneficiary can be designated. <i>See 29 CFR 2590.715-2719A(a)(4)(i)(A).</i></p> <p>TIP: This notice must be provided anytime the plan provides a participant with an SPD or other similar description of benefits under the plan. <i>See 29 CFR 2590.715-2719A(a)(4)(ii).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p><u>Question 4 – With respect to a child, does the plan permit the participant or beneficiary to designate a physician who specializes in pediatrics as the child’s primary care provider if the provider participates in the network of the plan or issuer and is available to accept the child?</u></p> <p>◆ If a group health plan, or a health insurance issuer offering group health insurance coverage, requires or provides for the designation of a participating primary care provider for a child by a participant or beneficiary, the plan or issuer must permit the participant or beneficiary to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child’s primary care provider if the provider participates in the network of the plan or issuer and is available to accept the child. <i>See 29 CFR 2590.715-2719A(a)(2)(i).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p><u>Question 5 – With respect to a child, does the plan provide a notice informing each participant of the terms of the plan or health insurance coverage regarding designation of a primary care provider and the right to designate any participating physician who specializes in pediatrics as the primary care provider?</u></p> <p>◆ If a group health plan or health insurance issuer requires the designation by a participant or beneficiary of a primary care provider, the plan or issuer must provide a notice informing each participant of the terms of the plan or health insurance coverage regarding designation of a primary care provider with respect to a child, that any participating physician who specializes in pediatrics can be designated as the primary care provider. <i>See 29 CFR 2590.715-2719A(a)(4)(i)(B).</i></p> <p>TIP: This notice must be provided anytime the plan provides a participant with an SPD or other similar description on benefits under the plan. <i>See 29 CFR 2590.715-2719A(a)(4)(ii).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO	N/A
<p><u>Question 6 – Does the plan provide coverage for OB/GYN care provided by a participating health care professional who specializes in obstetrics or gynecology for a female participant or beneficiary without requiring authorization or referral by the plan, issuer, or any person (including a primary care provider)?</u></p> <p>◆ For purposes of this provision, a health care professional who specializes in obstetrics or gynecology is any individual (including a person other than a physician) who is authorized under applicable State law to provide obstetrical or gynecological care. The plan or issuer may require such a professional to agree to otherwise adhere to the plan’s or issuer’s policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer. <i>See 29 CFR 2590.715-2719A(a)(3)(i)(A).</i></p> <p>◆ A plan or issuer must treat the provision of OB/GYN care, and the ordering or related OB/GYN items and services, by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider. <i>See 29 CFR 2590.715-2719A(a)(3)(i)(B).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p><u>Question 7 – Does the plan provide a notice informing each participant of the terms of the plan or coverage regarding designation of a primary care provider and that the plan may not require authorization or referral for obstetrical or gynecological care by a participating health care professional who specializes in obstetrics or gynecology?</u></p> <p>◆ If a group health plan or health insurance issuer requires the designation by a participant or beneficiary of a primary care provider, the plan or issuer must provide a notice informing each participant of the terms of the plan or health insurance coverage regarding designation of a primary care provider that the plan may not require authorization or referral for obstetrical or gynecological care by a participating health care professional who specializes in obstetrics or gynecology. <i>See 29 CFR 2590.715-2719A(a)(4)(i)(C).</i></p> <p>TIP: This notice must be provided anytime the plan provides a participant with an SPD or other similar description on benefits under the plan. <i>See 29 CFR 2590.715-2719A(a)(4)(ii).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>2. Coverage of Emergency Services</p> <p><u>Question 8 – Does the plan provide any benefits with respect to services in an emergency department of a hospital?</u></p> <p>If the answer is ‘no,’ enter ‘N/A’ for the following questions and proceed to Section H.</p> <p>If the answer to ALL of the questions below is “yes” the plan is in compliance with the coverage of emergency services provisions of the rules regarding patient protections.</p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p><u>Question 9 – Does the plan provide coverage of emergency services without the need for any prior authorization determination, even if the emergency services are provided on an out-of-network basis?</u>.....</p> <p>◆ A plan or issuer subject to the requirements of this section must provide coverage for emergency services without the need for any prior authorization determination, even if the emergency services are provided on an out-of-network basis. <i>See 29 CFR 2590.715-2719A(b)(2)(i).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p><u>Question 10 – Does the plan provide coverage of emergency services without regard to whether the health care provider furnishing the emergency services is a participating network provider with respect to the services?</u>.....</p> <p>◆ A plan or issuer subject to the requirements of this section must provide coverage for emergency services without regard to whether the health care provider furnishing the emergency services is a participating network provider with respect to the services. <i>See 29 CFR 2590.715-2719A(b)(2)(ii).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p><u>Question 11 – Does the plan provide coverage of emergency services provided out of network without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements that apply to emergency services provided in-network?</u></p> <p>◆ If the emergency services are provided out-of-network, the plan must provide the emergency services without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from in-network providers <i>See 29 CFR 2590.715-2719A(b)(2)(iii).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p><u>Question 12 – When providing emergency services out-of-network, does the plan impose cost-sharing requirements that comply with the requirements of the interim final regulations?</u></p> <p>◆ Any cost-sharing requirement expressed as a copayment amount or coinsurance rate imposed with respect to a participant or beneficiary for out-of-network emergency services cannot exceed the cost-sharing requirement imposed with respect to a participant or beneficiary if the services were provided in-network. However, a participant or beneficiary may be required to pay, in addition to the in-network cost sharing, the excess of the amount the out-of-network provider charges over the amount the plan or issuer is required to pay under this section. <i>See 29 CFR 2590.715-2719A(b)(3)(i).</i></p> <p>A plan or issuer complies with the requirements if it provides benefits with respect to an emergency service in an amount equal to the greatest of the following three amounts (which are adjusted for in-network cost-sharing requirements):</p> <p>(A) The amount negotiated with in-network providers for the emergency service furnished, excluding any in-network copayment or coinsurance imposed. (<i>See 29</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO	N/A
<p><i>CFR 2590.715-2719A(b)(3)(i)(A)</i> for more detailed information, including how to determine this amount if there is more than one amount negotiated with in-network providers for the emergency service.)</p> <p>(B) The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable amount), excluding any in-network copayment or coinsurance imposed. <i>See 29 CFR 2590.715-2719A(b)(3)(i)(B)</i>.</p> <p>(C) The amount that would be paid under Medicare for the emergency service, excluding any in-network copayment or coinsurance imposed. <i>See 29 CFR 2590.715-2719A(b)(3)(i)(C)</i>.</p> <p>TIP: Any other cost-sharing requirement, such as a deductible or out-of-pocket maximum, may be imposed with respect to out-of-network emergency services only if the cost-sharing requirement generally applies to out-of-network benefits. <i>See 29 CFR 2590.715-2719A(b)(3)(ii)</i>.</p>			
<p><u>Question 13 – Does the plan provide coverage of emergency services without regard to any other term or condition of the coverage, other than the exclusion or coordination of benefits, a permissible affiliation or waiting period, or applicable cost-sharing requirements?</u></p> <p>◆ A plan or issuer subject to the requirements of this section must provide coverage for emergency services without regard to any other term or condition of the coverage, other than the exclusion or coordination of benefits, an affiliation or waiting period permitted under part 7 of ERISA, part A of title XXVII of the PHS Act, or chapter 100 of the Internal Revenue Code, or applicable cost sharing. <i>See 29 CFR 2590.715-2719A(b)(2)(v)</i>.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p><u>Section H. Determining Compliance with the Affordable Care Act Coverage of Preventive Services Provisions in Part 7 of ERISA</u></p> <p><i>Note: This provision is applicable for plan years beginning on or after Sept. 23, 2010. Make sure the plan you are examining is required to comply as of the date you are looking at it. This provision does not apply to grandfathered health plans.</i></p> <p>Group health plans and health insurance issuers must provide coverage for, and must not impose cost-sharing requirements with respect to, certain recommended preventive services. Nothing prevents plans or issuers from providing coverage for preventive items and services in addition to the recommended preventive services required under these regulations. <i>See 29 CFR 2590.715-2713(a)(1) & (a)(5)</i>.</p> <p>If the answer to ALL of the questions below is “yes” the plan is in compliance with the rules regarding preventive services.</p>			

	YES	NO	N/A
<p><u>Question 1 – Does the plan provide coverage without imposing any cost-sharing requirements for evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force?</u></p> <p>◆ Plans and issuers must provide coverage for evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force. <i>See 29 CFR 2590.715-2713(a)(1)(i).</i></p> <p>◆ <i>Note:</i> Recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention issued in or around November 2009 are not considered to be current.</p> <p>◆ A complete list of recommendations and guidelines that are required to be covered under these interim final regulations can be found at http://www.Healthcare.Gov/center/regulations/prevention.html. Any changes to or new recommendations and guidelines will be noted at this site. Therefore, by visiting the site once per year, plans and issuers will have straightforward access to all the information necessary to determine any additional items and services that must be covered without cost-sharing and any items or services that are no longer required to be covered.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 2 – Does the plan provide coverage without imposing any cost-sharing requirements for immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention?.....</u></p> <p>◆ For the purpose of this section, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention. <i>See 29 CFR 2590.715-2713(a)(1)(ii).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 3 – With respect to infants, children, and adolescents, does the plan provide coverage without imposing any cost-sharing requirements for evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration?.....</u></p> <p>◆ With respect to infants, children, and adolescents, a plan or issuer must provide coverage for evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration. <i>See 29 CFR 2590.715-2713(a)(1)(iii).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p><u>Question 4 – With respect to women, does the plan provide coverage without imposing any cost-sharing requirements for evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration? A complete list of guidelines that are required to be covered can be found at: http://www.hrsa.gov/womensguidelines/. (Note: there is a limited exception for religious employers regarding coverage for certain women’s preventive services).....</u></p> <p>◆ With respect to women, a plan or issuer must provide coverage for evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration. <i>See 29 CFR 2590.715-2713(a)(1)(iv).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 5 – Does the plan provide coverage for office visits without imposing cost sharing requirements when recommended preventive services are not billed separately from an office visit and is the primary purpose of the office visit?</u></p> <p>◆ If a recommended preventive service or item is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such a service or item, then a plan or issuer may not impose cost-sharing requirements with respect to the office visit. <i>See 29 CFR 2590.715-2713(a)(2)(ii).</i></p> <p>TIP: If a recommended preventive service is billed separately from an office visit, or if the recommended preventive service is not billed separately and the primary purpose of the office visit is not delivery of the recommended preventive service, then a plan or issuer may impose cost-sharing with respect to the office visit. <i>See 29 CFR 2590.715-2713(a)(2)(i) & (iii).</i></p> <p>Additional tips:</p> <p>◆ Plans and issuers that have a network of providers are not required to provide coverage for and may impose cost-sharing requirements for recommended preventive services delivered by an out-of-network provider. <i>See 29 CFR 2590.715-2713(a)(3).</i></p> <p>◆ Plans and issuers may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for the recommended preventive services to the extent these are not specified in the recommendations or guidelines. <i>See 29 CFR 2590.715-2713(a)(4).</i></p> <p>◆ Plans and issuers can impose cost-sharing for a treatment that is not a recommended preventive service under these regulations, even if the treatment resulted from a recommended preventive service. <i>See 29 CFR 2590.715-2713(a)(5).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p><u>Section I. Determining Compliance with the Affordable Care Act Provisions Regarding Internal Claims and Appeals and External Review in Part 7 of ERISA</u></p> <p><i>The internal claims and appeals and external review provisions of Part 7 of ERISA do not apply to grandfathered health plans.</i></p> <p><i>Note: There have been several phases of guidance issued regarding the internal claims and appeals and external review provisions under the ACA. More information about the requirements regarding internal claims and appeals and external review processes under ERISA is available at www.dol.gov/ebsa.</i></p> <p>1. Internal Claims and Appeals</p> <p>Under the Affordable Care Act group health plans and health insurance issuers offering group health insurance coverage were required to implement an effective internal claims and appeals process for plan years beginning on or after September 23, 2010. In general, the interim final regulations require plans and issuers to comply with the DOL claims procedure rule under <i>29 CFR 2560.503-1</i> and impose specific additional requirements and include some clarifications (referred to as the “additional standards” for internal claims and appeals). In addition to meeting the following requirements, the plan is required to comply with all of the requirements of the DOL claims procedure rule under <i>29 CFR 2560.503-1</i>.</p> <p>The following questions have been developed to assist in determining compliance with the additional standards for internal claims and appeals processes.</p>			
<p><u>Question 1 – Does the plan provide internal claims and appeals processes with respect to rescissions of coverage?</u>.....</p> <p>◆ Under the DOL claims procedure rule, adverse benefit determinations eligible for internal claims and appeals processes generally include denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit (including a denial, reduction, termination, or failure to make a payment based on the imposition of a preexisting condition exclusion, a source of injury exclusion, or other limitation on covered benefits). <i>See 29 CFR 2560.503-1(m)(4)</i>.</p> <p>◆ The Department’s regulations broaden the DOL claims procedure rule’s definition of “adverse benefit determination” to include rescissions of coverage. Therefore, rescissions of coverage are also eligible for internal claims and appeals processes, whether or not the rescission has an adverse effect on any particular benefit at the time of an appeal. <i>See 29 CFR 2590.715-2719(a)(2)(i); 29 CFR 2560.503-1</i>.</p> <p>◆ This provision is applicable for plan years beginning on or after September 23, 2010. <i>See 29 CFR 2590.715-2719(g)</i>.</p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p><u>Question 2 – Does the plan provide claimants with any new or additional evidence or rationale considered in connection with a claim?</u>.....</p> <p>◆ The Department’s regulations clarify that plans or issuers must provide to claimants, free of charge, any new or additional evidence considered, relied upon, or generated by (or at the direction of) the plan or issuer in connection with a claim. This evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided in order to give the claimant a reasonable opportunity to respond prior to that date. Similarly, before a plan or issuer can issue a final internal adverse benefit determination based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale. This rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided in order to give the claimant a reasonable opportunity to respond prior to that date. <i>See 29 CFR 2590.715-2719(b)(2)(ii)(C).</i></p> <p>◆ This provision is applicable for plan years beginning on or after September 23, 2010. <i>See 29 CFR 2590.715-2719(g).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 3 – Does the plan ensure that claims and appeals are adjudicated in a manner that maintains independence and impartiality of decision making?</u></p> <p>◆ The Department’s regulations clarify that plans or issuers must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood or perceived likelihood that the individual will support or tend to support a denial of benefits. <i>See 29 CFR 2590.715-2719(b)(2)(ii)(D).</i></p> <p>◆ This provision is applicable for plan years beginning on or after September 23, 2010. <i>See 29 CFR 2590.715-2719(g).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 4 – Complete the following questions to ensure that the plan complies with the additional content requirements for any notice of adverse benefit determination or final internal adverse benefit determination:</u></p> <p><u>4a. Does the plan or issuer ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes information sufficient to identify the claim involved?</u></p> <p>◆ The Department’s regulations provide that plans and issuers must ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes information sufficient to identify the claim involved including the date of service, the health care provider, and the claim amount (if applicable). <i>See 29 CFR 2590.715-2719(b)(2)(ii)(E)(1).</i> This provision is applicable for plan years beginning on or after July 1, 2011. <i>See T.R. 2011-01 at http://www.dol.gov/ebsa/newsroom/tr11-01.html</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p>◆ Plans or issuers must also provide to participants and beneficiaries, as soon as practicable, upon request, the diagnosis and treatment codes (and their meanings), associated with any adverse benefit determination or final internal adverse benefit determination. The plan or issuer must not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or external review. <i>See 29 CFR 2590.715-2719(b)(2)(ii)(E)(1), as amended.</i> This provision is applicable for plan years beginning on or after January 1, 2012. <i>See T.R. 2011-01 at http://www.dol.gov/ebsa/newsroom/tr11-01.html.</i></p>			
<p><u>4b. Does the plan or issuer ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes an adequate description of the reasons for the adverse benefit determination or final internal adverse benefit determination?</u>.....</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>◆ The Department’s regulations provide that plans and issuers must ensure that the reasons for the adverse benefit determination or final internal adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the standard that was used in denying the claim. In the case of a notice of final internal adverse benefit determination, this description must include a discussion of the decision. <i>See 29 CFR 2590.715-2719(b)(2)(ii)(E)(2).</i></p> <p>◆ This provision is applicable for plan years beginning on or after July 1, 2011. <i>See T.R. 2011-01 at http://www.dol.gov/ebsa/newsroom/tr11-01.html.</i></p>			
<p><u>4c. Does the plan or issuer ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes a description of available internal appeals and external review processes?</u>.....</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>◆ The Department’s regulations provide that plans and issuers must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal. <i>See 29 CFR 2590.715-2719(b)(2)(ii)(E)(3).</i></p> <p>◆ This provision is applicable for plan years beginning on or after July 1, 2011. <i>See T.R. 2011-01 at http://www.dol.gov/ebsa/newsroom/tr11-01.html.</i></p>			
<p><u>4d. Does the plan or issuer ensure that any notice of adverse benefit determination or final internal adverse benefit determination disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793?</u>.....</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>◆ The Department’s regulations provide that plans and issuers must disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist enrollees with the internal claims and appeals and external review processes. <i>See 29 CFR 2590.715-2719(b)(2)(ii)(E)(4).</i></p>			

	YES	NO	N/A
<ul style="list-style-type: none"> ◆ An updated list of the State Consumer Assistance Programs is available on the Department of Labor website at http://www.dol.gov/ebsa/capupdatelist.doc . ◆ These provisions are applicable for plan years beginning on or after July 1, 2011. <i>See T.R. 2011-01 at http://www.dol.gov/ebsa/newsroom/tr11-01.html.</i> 			
<p><u>Question 5 – Does the plan defer to the attending provider as to whether a claim involves urgent care and provide notice regarding such urgent care claim as required?...</u></p> <ul style="list-style-type: none"> ◆ As under 29 CFR 2560.503-1(f)(2)(i), plans or issuers must notify a claimant of a benefit determination (whether adverse or not) with respect to a claim involving urgent care as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the receipt of the claim by the plan or issuer. <i>29 CFR 2590.715-2719(b)(2)(ii)(B), as amended.</i> ◆ The determination as to whether a claim involves urgent care is determined by the attending provider and the plan or issuer must defer to such determination. <i>See 29 CFR 2590.715-2719(b)(2)(ii)(B), as amended.</i> ◆ This provision is applicable for plan years beginning on or after January 1, 2012. <i>See T.R. 2011-01 at http://www.dol.gov/ebsa/newsroom/tr11-01.html.</i> 	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 6 – Does the plan comply with the requirements regarding deemed exhaustion of internal claims and appeals processes?</u></p> <ul style="list-style-type: none"> ◆ In the case of a plan or issuer that fails to adhere to all the requirements of the Interim Final Rules relating to the Internal Claims and Appeals process with respect to a claim, the claimant is deemed to have exhausted the internal claims and appeals process. The internal claims and appeals process will not be deemed exhausted as long as the violation was: <i>de minimus</i>, does not cause, and is not likely to cause, prejudice or harm to the claimant, attributable to good cause or due to matters beyond the control of the plan or issuer, in the context of an ongoing, good faith exchange of information between the plan and the claimant, and is not reflective of a pattern or practice of non-compliance. <i>See 29 CFR 2590.715-2719(b)(2)(ii)(F), as amended.</i> ◆ In the event that the claimant requests a written explanation of the violation, the plan or issuer must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. <i>See 29 CFR 2590.715-2719(b)(2)(ii)(F), as amended.</i> ◆ In the case that the external review rejects the claimant’s immediate review, the plan must provide the claimant notice of the opportunity to resubmit and pursue the internal appeal of the claim. This notice must be sent within a reasonable time after the external reviewer rejects the claim for immediate review, not later than 10 days. <i>See 29 CFR 2590.715-2719(b)(2)(ii)(F), as amended.</i> ◆ These provisions are applicable for plan years beginning on or after January 1, 2012. <i>See T.R. 2011-01 at http://www.dol.gov/ebsa/newsroom/tr11-01.html.</i> 	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p><u>Question 7 – Does the plan provide notices in a culturally and linguistically appropriate manner with respect to internal claims and appeals processes?</u></p> <ul style="list-style-type: none"> ◆ The Department’s regulations provide that plans and issuers must provide relevant notices in a culturally and linguistically appropriate manner. To meet this requirement the plan or issuer must: <ul style="list-style-type: none"> ❖ include a one-sentence statement in the relevant non-English language about the availability of language services on each notice sent to an address in a county that meets the threshold; ❖ provide, upon request, a notice in any applicable non-English language; and ❖ provide a customer assistance process (such as a telephone hotline) with oral language services in the non-English language and provide written notices in the non-English language upon request. <i>See 29 CFR 2590.715-2719(e), as amended.</i> ◆ The Department’s regulations establish a single threshold with respect to the percentage of people who are literate only in the same non-English language for both the group and individual markets. With respect to plans and issuers, the threshold percentage is set at 10 percent or more of the population residing in the claimant’s county, as determined based on American Community Survey (ACS) data published by the United States Census Bureau. The list of counties determined to meet the threshold is available on the Department of Labor website at http://www.cciio.cms.gov/resources/factsheets/clas-data.html. This list will be updated annually. <i>See 29 CFR 2590.715-2719(e)(3), as amended.</i> <p>These provisions are applicable for plan years beginning on or after January 1, 2012. <i>See T.R. 2011-01 at http://www.dol.gov/ebsa/newsroom/tr11-01.html.</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>2. External Review</p> <p><i>Plans and issuers must comply with either a State external review process or the Federal external review process. The external review provisions of Part 7 of ERISA do not apply to grandfathered health plans.</i></p> <p>The following questions have been developed to assist in determining compliance with the rules regarding the external review processes.</p>			
<p><u>Question 1 – Is the plan subject to the requirements of a State external review process or the HHS-Administered Federal External Review Process?</u></p> <ul style="list-style-type: none"> ◆ Non-grandfathered, self-insured group health plans subject to ERISA and the Code: <ul style="list-style-type: none"> ❖ Generally follow requirements of the private accredited IRO process (<i>established by TR 2010-01, modified by TR 2011-02</i>). ◆ Non-grandfathered, insured coverage: <ul style="list-style-type: none"> ❖ Generally, issuers must follow the State process if the external review process meets either the NAIC-Similar or NAIC-Parallel process as determined by HHS. 	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p>❖ However, issuers in States without a conforming State process and self-insured non-federal governmental plans may either:</p> <ul style="list-style-type: none"> - Utilize the private accredited IRO process (<i>established by TR 2010-01, and modified by TR 2011-02</i>); or - Utilize the HHS-Administered Federal External Review Process. <p>*Background information regarding external review processes for insured plans:</p> <p>◆ For insured coverage, HHS has determined which State external review processes meet the minimum requirements to apply to issuers in those States. See http://cciio.cms.gov/resources/files/external_appeals.html.</p> <p>◆ As of July 10, 2012, issuers in Alabama, Alaska, Florida, Georgia, Louisiana, Mississippi², Montana, Nebraska, Pennsylvania, West Virginia, Wisconsin, US Virgin Islands, Guam, American Samoa, Puerto Rico and Northern Mariana Islands are currently using one of these two federal external review processes.</p> <p>If you answered “Yes” to Question 1 above, STOP. The plan is not subject to the DOL Private Accredited IRO process. If you answered “No” to Question 1 above, continue to Question 2.</p>			
<p><u>Question 2 – DOL Private Accredited IRO process: Does the plan provide external review for the required scope of adverse benefit determinations?</u></p> <p>Under the Department’s regulations the scope of the Federal external review process applies to:</p> <ul style="list-style-type: none"> ◆ An adverse benefit determination, including a final internal adverse benefit determination, by a plan or issuer that involves medical judgment, including but not limited to those based on the plan’s or issuer’s requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational; and ◆ A rescission of coverage (regardless of whether or not the rescission has any effect on any particular benefit at that time). See 29 CFR 2590.715-2719(d)(1)(ii), as amended. ◆ An adverse benefit determination that relates to a participant’s or beneficiary’s failure to meet the requirements for eligibility under the terms of a group health plan (i.e., worker classification or similar issue) is not within the scope of the Federal external review process. See 29 CFR 2590.715-2719(d)(1)(i), as amended. 	<input type="checkbox"/>	<input type="checkbox"/>	

² Issuers in this state are scheduled to transition to a state process on 1/1/13.

	YES	NO	N/A
<p><u>Question 3 – DOL Private Accredited IRO process: Does the plan provide an effective external review process?</u></p> <p>◆ Self-insured coverage subject to ERISA and the Code may either comply with the standards of the private accredited IRO process or voluntarily comply with a State external review process if the State allows access.</p> <p>◆ If the plan is complying with the private accredited IRO process, ensure the plan complies with all of the standards articulated in TR 2011-02 including:</p> <ul style="list-style-type: none"> ❖ Providing effective written notice of external review ❖ Providing limits related to filing fees ❖ Providing claimant at least 4 months to file for external review ❖ Requiring that IROs must be accredited ❖ Requiring that IROs may not have conflicts of interest that influence independence ❖ Providing that IRO decisions are binding on the insurer and the claimant ❖ Requiring IROs to maintain written records for at least three years <p>◆ Department of Labor clarified in TR 2011-02 that to be eligible for a safe harbor from enforcement from the Department of Labor and the IRS (as previously set forth in sub-regulatory guidance issued in ACA FAQs Part 1 on September 20, 2010), self-insured plans will be required to contract with at least two independent review organizations (IROs) by January 1, 2012 and at least three IROs by July 1, 2012.</p> <p><i>See TR 2010-01 at http://www.dol.gov/ebsa/pdf/ACATEchnicalRelease2010-01.pdf, and TR-2011-02 at http://www.dol.gov/ebsa/newsroom/tr11-02.html.</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	