

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 some of 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.

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.

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>NOTE: These provisions are affected by section 2704 of the Public Health Service Act, as amended by the Patient Protection and Affordable Care Act. (For information regarding the Affordable Care Act, please visit our website at www.dol.gov/ebsa/healthreform).</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>			

	YES	NO	N/A
<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 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." <i>See 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. <i>See 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 EBSA publication, <i>Health Benefits Coverage Under Federal Law</i>.</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 EBSA publication, <i>Health Benefits Coverage Under Federal Law</i>.</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 EBSA publication, <i>Health Benefits Coverage Under Federal Law</i>.</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>. <i>See ERISA section 701(e)(1)(A); 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. <i>See 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). <i>See 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 EBSA publication, <i>Health Benefits Coverage Under Federal Law</i>.</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 of dependent children, or any other factor that is not a health factor. However, see section 2714 of the PHS Act, as amended by the Patient Protection and Affordable Care Act, for rules on defining dependents under the plan. (For information regarding the Affordable Care Act, please visit our website at www.dol.gov/ebsa/healthreform).</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><input type="checkbox"/> <input type="checkbox"/></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"> ❖ 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>			
<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><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></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>			

	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> <p>◆ 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.</p> <p>◆ 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. <i>See proposed regulations issued by the Departments on November 26, 2012 at 77 FR 70620</i>. 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:</p> <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 EBSA publication, <i>Health Benefits Coverage Under Federal Law</i>. <p>To help evaluate whether this exception is available, refer to Section E on page 16. 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> <p>◆ 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</p>	<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. <i>See proposed regulations issued by the Departments on November 26, 2012 at 77 FR 70620.</i></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 (together, the mental health parity provisions)

If you answer “No” to any of the questions below, the group health plan is in violation of 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 benefits¹, in addition to medical/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 or substance use disorder benefits, the mental health parity requirements apply separately with respect to each combination of medical/surgical benefits and mental health/substance use disorder 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 36-43.</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>			<input type="checkbox"/>
<p><u>Question 36 – Does the plan comply with the mental health parity requirements for lifetime dollar limits on mental health/substance use disorder 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, as contrasted with limits on what an individual may be charged.)</p> <p>NOTE: These provisions are affected by section 2711 of the Public Health Service Act, as amended by the Patient Protection and Affordable Care Act. Specifically, PHS Act section 2711 generally prohibits lifetime dollar limits on essential health benefits, which includes mental health and substance use disorder services. (For information regarding the Affordable Care Act, please visit our website at www.dol.gov/ebsa/healthreform).</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 37 – Does the plan comply with the mental health parity requirements for annual dollar limits on mental health/substance use disorder 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> (Again, only limits on what the plan is willing to pay are taken into account, as contrasted with limits on what an individual may be charged.)</p>	<input type="checkbox"/>	<input type="checkbox"/>	

¹ Mental health and substance use disorder benefits are defined under the terms of the plan, in accordance with applicable Federal and State law. Any condition or disorder defined by the plan as being or as not being a mental health condition or substance use disorder must be defined in a manner consistent with generally recognized independent standards of current medical practice (e.g., the most current version of the DSM or ICD or State guidelines).

	YES	NO	N/A
<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> <p>NOTE: These provisions are affected by section 2711 of the Public Health Service Act, as amended by the Patient Protection and Affordable Care Act. Specifically, PHS Act section 2711 generally prohibits annual dollar limits on essential health benefits, which includes mental health and substance use disorder services. (For information regarding the Affordable Care Act, please visit our website at www.dol.gov/ebsa/healthreform).</p>			
<p><u>Question 38 – Does the plan comply with the mental health parity requirements 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 limitations 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>. ❖ The six classifications of benefits are: <ul 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. <i>See 29 CFR 2590.712(c)(2)(ii)</i>. <p>(Note: see below discussion of enforcement safe harbor for determining parity with respect to outpatient benefits provided under two sub-classifications.)</p> <p>◆ Under the plan, any financial requirement or quantitative treatment limitation that applies to mental health/substance use disorder 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>Detailed steps for applying these rules are set forth below:</p> <ul style="list-style-type: none"> ❖ To determine compliance each type of financial requirement or quantitative treatment limitation within a coverage unit² must be analyzed separately within each classification. <i>See 29 CFR 2590.712(c)(2)(i)</i>. If a plan applies different 	<input type="checkbox"/>	<input type="checkbox"/>	

² 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, and employee plus spouse. *See 29 CFR 2590.712(c)(1)(iv)*.

	YES	NO	N/A
<p>levels of a financial requirement or quantitative 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></p> <ul style="list-style-type: none"> ❖ First determine if a particular type of financial requirement or quantitative treatment limitation applies to substantially all medical/surgical benefits in the relevant classification of benefits. ❖ Generally, a financial requirement or quantitative 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>) ❖ If the type of financial requirement or quantitative treatment limitation applies to at least two-thirds of medical/surgical benefits in that classification, then determine the predominant level of that type of financial requirement or quantitative treatment limitation that applies to medical/surgical benefits subject to that type of financial requirement or quantitative treatment limitation in that classification of benefits. (Note: If the type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of medical/surgical benefits in that classification, it cannot apply to mental health/substance use disorder benefits in that classification.) ❖ Generally, the predominant level will apply to more than one-half of the medical/surgical benefits in that classification subject to the financial requirement or quantitative treatment limitation. <i>See 29 CFR 2590.712(c)(3)(i)(B)(1).</i> If there is no single level that applies to more than 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 financial requirement or quantitative treatment limitation in the classification. The least restrictive level within the combination is considered the predominant level.³ <i>See 29 CFR 2590.712(c)(3)(i)(B)(2).</i> <p>Safe Harbor:</p> <ul style="list-style-type: none"> ◆ 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: (1) office visits and (2) all other outpatient items and services, for purposes of applying the financial requirement and quantitative treatment limitation rules. ❖ After the sub-classifications are established, the plan or issuer may not impose any financial requirement or quantitative treatment limitation on mental health/substance use disorder benefits in any sub-classification (i.e., office visits 			

³ For a simpler method of compliance, a plan may treat the least restrictive level of financial requirement or treatment limitation applied to medical/surgical benefits as predominant.

	YES	NO	N/A
<p>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.</p> <p>❖ Other than as permitted under this enforcement policy and except as permitted under the interim final rules for multi-tiered prescription drug benefits, sub-classifications are not permitted when applying the financial requirement and quantitative 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. (See Question 39 for more information regarding specialists and generalists.)</p> <p>Special rule for prescription drug benefits:</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 and without regard to whether a drug is generally prescribed for medical/surgical or mental health/substance use disorder 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> <p>Tip: 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><u>Question 39 – If the plan imposes a higher, specialist financial requirement, such as a copay, on mental health/substance use disorder benefits, can the plan demonstrate that the specialist level of the financial requirement is the predominant level that applies to substantially all medical/surgical benefits within the classification?</u></p> <p>◆ The six classifications outlined in Question 38 are the only classifications that may be used when determining the predominant financial requirements or quantitative treatment limitations that apply to substantially all medical/surgical benefits. <i>See 29 CFR 2590.712(c)(2)(ii).</i> A plan may not use a separate sub-classification under these classifications for generalists and specialists. <i>See preamble language at 75 FR 5413.</i></p> <p>Tip: A plan may still be able to impose the specialist level of a financial requirement or quantitative treatment limitation if it is the predominant level that applies to substantially all medical/surgical benefits within a classification. For example, if the specialist level of copay is the predominant level of copay that applies to substantially all medical/surgical benefits in the outpatient, in-network classification, the plan may apply the specialist level copay to mental health/substance use disorder benefits in the outpatient, in-network classification. <i>See ACA Implementation FAQ Part VII, Question 7.</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p><u>Question 40 – Does the plan comply with the mental health parity requirements for coverage in all classifications?</u></p> <p>◆ If a plan provides mental health/substance use disorder benefits in any classification of benefits (the classifications are listed in Question 38), mental health/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/substance use disorder benefits. <i>See 29 CFR 2590.712(c)(2)(ii)(A).</i></p> <p>Tip: 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)(C), Example 1.</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 mental health/substance use disorder 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> <p>❖ Cumulative financial requirements are financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and include deductibles and out-of-pocket maximums (but do not include aggregate lifetime or annual dollar limits because these two terms are excluded from the meaning of financial requirements). <i>See 29 CFR 2590.712(a).</i></p> <p>❖ Cumulative quantitative treatment limitations are treatment limitations that determine whether or to what extent benefits are provided based on accumulated amounts, such as annual or lifetime day or visit limits. <i>See 29 CFR 2590.712(a).</i></p> <p>◆ For example, a plan may not impose an annual \$250 deductible on all medical/surgical benefits and a separate \$250 deductible on all mental health/substance use disorder benefits.</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 (NQTLs) 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>General rules:</p> <p>◆ A plan may not impose an NQTL with respect to mental health/substance use disorder benefits in any classification (such as inpatient, out-of-network) unless, under the terms of the plan (as written and in operation), any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health/substance use disorder 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 NQTL 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> <p>◆ A group health plan may consider a wide array of factors in designing medical management techniques for both mental health/substance use disorder benefits and medical/surgical benefits, such as cost of treatment; high cost growth; variability in cost and quality; elasticity of demand; provider discretion in determining diagnosis, or type or length of treatment; clinical efficacy of any proposed treatment or service; licensing and accreditation of providers; and claim types with a high percentage of fraud. Based on application of these or other factors in a comparable fashion, an NQTL, such as prior authorization, may be required for some (but not all) mental health/substance use disorder benefits, as well as for some medical/surgical benefits, but not for others. <i>See ACA Implementation FAQ Part VII, Question 4.</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p>Examples: The Departments have published several examples that help illustrate how the MHPAEA regulations apply to some common plan NQTLs, including:</p> <ol style="list-style-type: none"> 1) The penalty for failure to obtain preauthorization is more punitive with respect to mental health/substance use disorder benefits than with respect to medical/surgical benefits. <i>See 2590.712(c)(4)(iii), Example 2.</i> 2) The plan uses an employee assistance program as a gatekeeper to obtaining mental health or substance use disorder benefits. <i>See 2590.712(c)(4)(iii), Example 5.</i> 3) Utilization management practices that differ among different plan benefits. <i>See ACA Implementation FAQ Part VII, Questions 4, 5, and 6.</i> <p>Tip: Do not focus on results. Look at the underlying processes and strategies used in applying NQTLs (such as utilization review and standards for network admission). Are there arbitrary or discriminatory differences between those for medical/surgical benefits versus those for mental health/substance use disorder benefits? Are differences justified based on clinically appropriate standards of care?</p> <p>Questions You Might Ask:</p> <ol style="list-style-type: none"> 1) Has the plan documented its analysis that its NQTL processes and strategies (such as utilization review) are comparable across medical/surgical and mental health/substance use disorder benefits? 2) If there are differences in these processes and strategies, has the plan documented the recognized, clinically appropriate standards that would permit a difference under the Departments' regulations? <p>Additional Illustrations. Set forth below are additional illustrations of how a plan may have differences in NQTLs but may still comply with the Departments' regulations, based on the facts and circumstances involved:</p> <ul style="list-style-type: none"> ◆ Plan X covers neuropsychological testing but only for certain conditions. In such situations, look to see whether the exclusion is based on evidence addressing the clinical efficacy of such testing for different conditions and the degree to which such testing is used for educational purposes with regard to different conditions. Does the plan have documentation indicating the criteria used and evidence supporting the plan's determination of the diagnoses for which they will cover this service and the rationale for excluding certain diagnoses? ◆ Plan Y applies concurrent review to inpatient psychiatric care and retrospective review for general medical hospitalizations that are reimbursed based on diagnosis related group (DRG) codes. The plan explains that DRG-based reimbursement creates incentives for hospitals to actively manage utilization but DRG-based fees do not exist for psychiatric hospitalizations. Thus, it appears that concurrent management by the plan is clinically appropriate and permissible for psychiatric hospitalizations as long as general medical hospitalizations that are not reimbursed based on DRGs are also subject to concurrent review. 			

	YES	NO	N/A
<p>◆ Master’s degree training and state licensing requirements often vary. Plan Z consistently applies its standard that any provider must meet whatever is the most stringent licensing requirement standard related to supervised clinical experience requirements in order to participate in the network. Therefore, Plan Z requires master’s-level therapists to have post-degree, supervised clinical experience in order to join their provider network. There is no parallel requirement for master’s-level general medical providers because their licensing does require supervised clinical experience. In addition, the plan does not require post-degree, supervised clinical experience for psychiatrists or PhD level psychologists since their licensing already requires supervised training. The requirement that master’s-level therapists must have supervised clinical experience to join the network is permissible, as the plan consistently applies the same standard to all providers even though it may have a disparate impact on certain mental health providers.</p>			
<p><u>Question 43 – Does the plan comply with the mental health parity disclosure requirements?</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/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> <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/substance use disorder benefits to any participant or beneficiary in a form and manner consistent with the rules in 29 CFR 2560.503-1 (the claims procedure rule). <i>See 29 CFR 2590.712(d)(2).</i></p> <p>◆ If coverage is denied based on medical necessity, medical necessity criteria for the mental health/substance use disorder benefits at issue and for medical/surgical benefits in the same classification must be provided within 30 days of the request to the participant, beneficiary, or provider or other individual if acting as an authorized representative of the beneficiary or participant. <i>See 29 CFR 2520.104b-1; 29 CFR 2590.712(d)(1); ACA Implementation FAQ Part V, Question 10.</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p><u>Question 45 – 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 46 – 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 47 – 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 EBSA publication, <i>Health Benefits Coverage Under Federal Law</i>.</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 48-51.</p>			<input type="checkbox"/>
<p><u>Question 48 – Four required coverages under WHCRA</u> Does the plan provide the four coverages required by WHCRA?</p> <p>◆ 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:</p> <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> <p>◆ 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> <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 49 – Incentive provisions</u> Does the plan comply with WHCRA by not providing impermissible incentives or penalties with respect to patients or attending providers?</p> <p>◆ 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).</p> <p>◆ 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.</p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p>Question 50 – 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, ❖ Protheses, 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 EBSA publication, <i>Health Benefits Coverage Under Federal Law</i>.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>Question 51 – 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, protheses, 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 EBSA publication, <i>Health Benefits Coverage Under Federal Law</i>.</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><u>Question 52 – Does the plan comply with GINA’s prohibition against group-based discrimination based on genetic information?</u></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><u>Question 53 – Does the plan comply with GINA’s limitation on requesting or requiring genetic testing?</u></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><u>Question 54 – Does the plan comply with GINA’s prohibition on collection of genetic information, prior to or in connection with enrollment?</u></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 55 – 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 56 – 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 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.</i></p> <p><i>A dependent child 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.</i></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 57 – 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"/>	