Compliance Assistance Guide

Health Benefits Coverage Under Federal Law...

- The Affordable Care Act
- Health Insurance Portability and Accountability Act
- Genetic Information Nondiscrimination Act
- Mental Health Parity Provisions
- Newborns' and Mothers' Health Protection Act
- Women's Health and Cancer Rights Act

Employee Benefits Security Administration
U.S. Department of Labor

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Introduction

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

- The Patient Protection and Affordable Care Act (Affordable Care Act)
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (portability and nondiscrimination provisions only)
- The Mental Health Parity and Addiction Equity Act (MHPAEA) and the Mental Health Parity Act (MHPA) (Mental Health Parity Provisions)
- The Newborns' and Mothers' Health Protection Act of 1996 (the Newborns' Act)
- The Women's Health and Cancer Rights Act of 1998 (WHCRA)
- The Genetic Information Nondiscrimination Act of 2008 (GINA)

These health care laws are included in Part 7 of Title I of the Employee Retirement Income Security Act of 1974 (Part 7 of ERISA). Also discussed in this booklet are provisions of the Children's Health Insurance Program Reauthorization Act (CHIPRA) related to special enrollment rights, which are included as part of the HIPAA Special Enrollment section on page 19.

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

The requirements under Part 7 of ERISA generally apply to group health plans with two or more participants who are current employees.[1] However, if the coverage is insured, parallel provisions in the Public Health Service Act apply to health insurance coverage offered in connection with group health plans with as few as one employee who is a current participant under the plan. In addition,

[1]The Mental Health Parity and Addiction Equity Act as included in Part 7 of ERISA exempts group health plans of a small employer with 50 or fewer employees from its requirements. However, insured group health plans in the small group market are required to comply with the requirements of the Act in order to satisfy the essential health benefits requirements under the Affordable Care Act.

the requirements of Part 7 of ERISA do not apply to excepted benefits, such as certain dental and vision coverage*.

The laws contained in Part 7 of ERISA (which is administered by the U.S. Department of Labor) generally also appear in the Internal Revenue Code (the Code), and the Public Health Service Act (PHSA). The Department of the Treasury and the Internal Revenue Service administer the requirements under the Code, and the U.S. Department of Health and Human Services (HHS) administers the requirements under the PHSA.

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

- The first section includes general descriptions of the health care laws mentioned above and frequently asked questions.

- Following are self-compliance tools that can help to determine a plan's compliance with these laws. They include compliance tips that relate to some common mistakes. (Note: please check the Website at dol.gov/ebsa/healthlawschecksheets.html for updates to the self-compliance tools.)

- Next, a chart summarizes the notices a plan must provide.

- Finally, the last section includes model notices providing language that may be used to comply with the various notice requirements.

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

*See the *Applying and Enforcing Laws in Part 7 of ERISA* Section at page 57 of the Guide for a further discussion.

Some general notes:

- As discussed later, States can change some of these Federal rules if the State law is more protective of individuals (i.e., imposes stricter obligations on health insurance issuers).

- If the plan provides benefits through an insurance policy or health maintenance organization (HMO), you also may contact your State's insurance department. Visit the National Association of Insurance Commissioners' Website at naic.org for contact information.

- If you have questions not specifically addressed in this booklet, please contact the Employee Benefits Security Administration (EBSA) regional office nearest you. A list of these offices is on the agency's Website at dol.gov/ebsa (view "About EBSA"). Or you may contact EBSA electronically at askebsa.dol.gov or call toll free 1-866-444-3272.

The Affordable Care Act

The Patient Protection and Affordable Care Act (Affordable Care Act) was signed into law on March 23, 2010. The Affordable Care Act added certain market reform provisions to ERISA, making those provisions applicable to employment-based group health plans. These provisions provide additional protections for benefits under employment-based group health plans. They include extending dependent coverage to age 26; prohibiting preexisting condition exclusions for all individuals and prohibiting the imposition of lifetime and annual limits on essential health benefits. As of 2014, most of the Affordable Care Act protections are now in effect. The Departments of Labor, Health and Human Services, and the Treasury (Departments) were tasked with issuing guidance for the market reform provisions. The Departments continue to work with employers, issuers, States, providers and other stakeholders to help them come into compliance with the law and are working with families and individuals to help them understand the law and benefit from it, as intended.

Under the Affordable Care Act, plans can make some routine changes and generally keep the coverage under their plan the same as it was on March 23, 2010. These grandfathered health plans are required to comply with some but not all of the market reform provisions under ERISA.

What is grandfathered status and how does a grandfathered plan lose its status?

Generally, grandfathered plans are plans that were in existence, and in which at least one individual was enrolled, on March 23, 2010. Grandfathered health plans are exempt from many but not all Affordable Care Act market reforms.

Grandfathered plans lose their status if the plan makes one of the following six changes:

1) Elimination of all or substantially all benefits to diagnose or treat a particular condition.

2) Increase in a percentage cost-sharing requirement (e.g., raising an individual's coinsurance requirement from 20% to 25%).

3) Increase in a deductible or out-of-pocket maximum by an amount that exceeds medical inflation plus 15 percentage points.

4) Increase in a copayment by an amount that exceeds medical inflation plus 15 percentage points (or, if greater, $5 plus medical inflation).

5) Decrease in an employer's contribution rate towards the cost of coverage by more than 5 percentage points.

6) Imposition of annual limits on the dollar value of all benefits below specified amounts.

Additionally, plans must include a statement in any plan materials provided to a participant or beneficiary describing the benefits provided under the plan, that the plan or coverage believes it is a grandfathered health plan and it must provide contact information for questions and complaints.

Which provisions of the Affordable Care Act apply to a grandfathered health plan?

Grandfathered health plans are exempt from many, but not all Affordable Care Act market reforms. Some of the new provisions applicable to grandfathered plans include:

- prohibition on preexisting condition exclusions
- prohibition on excessive waiting periods
- prohibition on lifetime/restricted annual limits
- prohibition on rescissions
- extension of dependent coverage
- summary of benefits and coverage and uniform glossary

Some of the new provisions not applicable to grandfathered plans include:

- coverage of preventive services
- internal claims and appeals and external review
- patient protections

When do the provisions in the Affordable Care Act become applicable?

The following provisions became effective for plan years beginning on or after September 23, 2010.

- prohibition on preexisting condition exclusions - only for individuals under age 19

- prohibition on lifetime limits (and restrictions on annual limits)
- prohibition on rescissions
- coverage of preventive services
- extension of dependent coverage
- internal claims and appeals and external review
- patient protections

The Summary of Benefits and Coverage and Uniform Glossary requirement became effective as of September 23, 2012.

Other provisions became effective for plan years beginning on or after January 1, 2014.

- prohibition on preexisting condition exclusions - for all individuals
- wellness programs
- prohibition on excessive waiting periods
- prohibition on annual limits

Can plans require dependent children to be full-time students in order to receive coverage to the age of 26?

No. Plans that offer dependent coverage for children are required to make the coverage available until a child reaches the age of 26. Plans and issuers that offer dependent coverage of children must offer coverage to enrollees' adult children until age 26, even if the young adult no longer lives with his or her parents, is not a dependent on a parent's tax return, or is no longer a student. This provision applies to all group health plans regardless of grandfather status and became effective for plan years beginning on or after September 23, 2010.

Can plans impose preexisting condition exclusions on new enrollees?

No. Group health plans are prohibited from imposing any preexisting condition exclusion. This prohibition generally is effective for plan years beginning on or after January 1, 2014, but for enrollees who are under 19 years of age, this prohibition became effective for plan years beginning on or after September 23, 2010. This provision applies to all group health plans regardless of grandfathered status.

Can plans place lifetime or annual limits on the dollar value of essential health benefits?

Generally group health plans are prohibited from offering coverage that establishes any lifetime or annual limits on the dollar value of essential health benefits. This prohibition became effective for plan years beginning on or after September 23, 2010 for lifetime limits and January 1, 2014 for annual limits. For more information regarding what benefits are considered essential health benefits, visit HealthCare.gov. This provision applies to all group health plans regardless of grandfathered status.

Are plans prohibited from rescinding group health plan coverage?

In general, a rescission is a retroactive cancellation of coverage. A group health plan or a health insurance issuer can only rescind coverage in the case of fraud or an intentional misrepresentation of a material fact, regardless of whether the coverage is insured or self-insured, or whether the rescission applies to an entire group or only to an individual within the group. Plans and issuers must provide at least 30 days advance written notice to each participant who would be affected by the rescission. The prohibition against rescissions became applicable for plan years beginning on or after September 23, 2010 and applies to all group health plans regardless of grandfathered status.

Are plans required to provide preventive services?

Group health plans must provide benefits for certain recommended preventive services and generally may not impose any cost-sharing for such services. The recommended services, including immunizations and colonoscopies, are set forth by the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA) and the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention. A complete list of recommendations and guidelines that specify the services that are required to be covered can be found at HealthCare.gov/center/regulations/prevention.html. The preventive services provision became applicable for plan years beginning on or after September 23, 2010, and does not apply to grandfathered plans.

My plan requires participants to designate, among others, a primary care provider. Is my plan required to comply with certain requirements related to this designation?

If a group health plan requires the participant to choose a participating primary care provider, the plan or issuer must allow the participant to choose any participating primary care provider who is available to accept the participant. With respect to a child, the plan or issuer must allow the designation of a

pediatrician as a child's primary care provider if the provider participates in the network of the plan or issuer. Furthermore, plans or issuers may not require authorization or referral for a female participant who seeks coverage for OB/GYN care provided by an OB/GYN specialist. The plan must provide a notice informing the participants of the terms of the plan or health insurance coverage regarding designation of a primary care provider. This provision became applicable for plan years beginning on or after September 23, 2010, and does not apply to grandfathered health plans.

Can plans continue to limit payments for out-of-network emergency room services?

A group health plan that provides emergency services benefits must cover emergency services without preauthorization, even if the hospital or provider is out-of-network. If the emergency services are provided out-of-network, special rules related to cost-sharing requirements apply. Copayment amount or coinsurance rates cannot exceed the cost-sharing requirements that would be imposed if the services were provided in-network. Additionally, any other cost-sharing requirement, such as a deductible or out-of-pocket maximum, can only be imposed with respect to out-of-network emergency services if the cost-sharing requirement generally applies to out-of-network benefits. This provision became applicable for plan years beginning on or after September 23, 2010, and does not apply to grandfathered health plans.

Are all employment-based wellness programs subject to Affordable Care Act requirements?

No. Many employers offer a wide range of programs to promote health and prevent disease. For example, some employers may choose to provide or subsidize healthier food choices in the employee cafeteria, provide pedometers to encourage employee walking and exercise, pay for gym memberships, or ban smoking on employer facilities and campuses. A wellness program is subject to the Affordable Care Act and HIPAA nondiscrimination rules only if it is, or is part of, a group health plan. If an employer operates a wellness program separate from its group health plan(s), the program may be subject to other Federal or State nondiscrimination laws, but it is generally not subject to the HIPAA nondiscrimination regulations.

For a detailed discussion of the Affordable Care Act and HIPAA nondiscrimination requirements that may apply to wellness programs offered in connection with employment-based group health plan coverage, see page 27. These provisions apply to both grandfathered and non-grandfathered plans and became applicable for plan years beginning on or after January 1, 2014.

What requirements apply under the Affordable Care Act regarding the claims and appeals processes that must be made available under a group health plan?

All group health plans must maintain internal claims and appeals processes set forth in the Department of Labor Claims Procedure rules. Additional protections were added to ensure that participants have access to an effective appeals process. The scope of adverse benefit determinations eligible for internal claims and appeals now includes a rescission of coverage. If an initial adverse benefit determination is an urgent care claim, the claimant must be notified of the benefit determination no later than 72 hours after the receipt of the claim.

If the plan denies the claim after the internal appeal, the Affordable Care Act requires participants be given the opportunity to seek external review. Plans must implement an effective review process that meets the minimum requirements set forth in the regulations. The internal claims and appeals and external review provisions do not apply to grandfathered plans and are applicable for plan years beginning on or after September 23, 2010.

What is the Summary of Benefits and Coverage and when must it be provided?

Plans must provide a Summary of Benefits and Coverage (SBC) that accurately describes the benefits and coverage under the applicable plan. The SBC is a uniform template that uses clear, plain language to summarize key features of the plan, such as covered benefits, cost-sharing provisions and coverage limitations. Plans and issuers must provide the SBC to participants and beneficiaries at certain times (including with written application materials, at renewal, upon special enrollment and upon request). This provision became applicable, generally, for plan years beginning on or after September 23, 2012, and applies to all group health plans regardless of grandfathered status.

Can employers or plans require participants and beneficiaries to be in a waiting period before allowing them to enroll in a group health plan?

Any waiting period that exceeds 90 days is prohibited. A waiting period is defined as the period of time that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of the plan can become effective. Eligibility conditions that are based solely on the lapse of a time period are permissible for no more than 90 days. This provision became applicable for plan years beginning on or after January 1, 2014, and applies to all group health plans regardless of grandfather status.

What is the Marketplace and where can I learn more about it?

The Marketplace offers "one-stop shopping" for employees to find and compare private health insurance options that meet certain Federal requirements. It simplifies the search for individual health insurance by gathering all of the health plan options into one Website and presenting the price and benefit information in simple terms. By purchasing insurance in the Marketplace, some employees may be eligible for a tax credit that lowers monthly premiums or out-of-pocket expenses. Persons eligible for COBRA due to a loss of employer-sponsored coverage may choose to purchase less expensive coverage from the Marketplace and may also qualify for the tax credits. Employees can also apply for Federal health coverage programs such as Medicaid and the Children's Health Insurance Program through the Marketplace. For more information on the Marketplace, visit HealthCare.gov.

Where can I get more information about the Affordable Care Act?

For more detailed information regarding the requirements under the Affordable Care Act, visit the Employee Benefits Security Administration's Affordable Care Act Web page at dol.gov/ebsa/healthreform or contact 1-866-444-3272.

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes provisions of Federal law governing health coverage portability, health information privacy, administrative simplification, medical savings accounts, and long-term care insurance. The responsibility of the Department of Labor and the subject of this segment of the booklet are the law's portability and nondiscrimination requirements.

HIPAA's provisions affect group health plan coverage in the following ways:

- *Provide certain individuals special enrollment rights in group health coverage when specific events occur, e.g., birth of a child (regardless of any open season);*

- *Prohibit discrimination in group health plan eligibility, benefits, and premiums based on specific health factors; and*

- *While HIPAA previously provided for limits with respect to preexisting condition exclusions, new protections under the Affordable Care Act now prohibit preexisting condition exclusions for plan years beginning on or after January 1, 2014.*[2]

[2]For plan years beginning on or after January 1, 2014, plans are no longer required to issue the general notice of preexisting condition exclusion and individual notice of period of preexisting condition exclusion. Plans are also no longer required to issue certificates of creditable coverage after December 31, 2014. These amendments were made because plans are prohibited from imposing preexisting condition exclusions for plan years beginning on or after January 1, 2014.

Special Enrollment

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

Special enrollment rights can occur when:

- *An individual loses eligibility for coverage under a group health plan or other health insurance coverage (such as an employee and his/her dependents' loss of coverage under the spouse's plan) or when an employer terminates contributions toward health coverage;*

- *An individual becomes a new dependent through marriage, birth, adoption, or being placed for adoption; and*

- *An individual loses coverage under a State Children's Health Insurance Program (CHIP) or Medicaid, or becomes eligible to receive premium assistance under those programs for group health plan coverage.*

Employees must receive a description of special enrollment rights on or before the date they are first offered the opportunity to enroll in the group health plan (see model notice on page 138).

In addition, employers that maintain a group health plan in a state with a CHIP or Medicaid program that provides for premium assistance for group health plan coverage must provide a notice (referred to as the Employer CHIP Notice) to all employees to inform them of possible opportunities in the state in which they reside (for information on a model Employer CHIP notice, see page 20).

Some individuals losing coverage under an employment-based group health plan may want to consider enrolling for coverage in the Marketplace. For more information on the Marketplace, visit HealthCare.gov.

Can the special enrollment notice be provided in the Summary Plan Description (SPD)?

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

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

Employers that maintain a group health plan are required to provide the Employer CHIP Notice if they provide medical care in a State that operates a Medicaid or CHIP premium assistance program. This notice may be provided with the SPD, enrollment packets or open season materials as long as these materials are provided no later than the date explained below, are provided to all employees, and are provided in accordance with the Department of Labor's disclosure rules. The notice must be provided annually.

A model Employer CHIP Notice is available at dol.gov/ebsa/chipmodelnotice.doc. The model notice includes State contact information for States that provide Medicaid or CHIP premium assistance programs. This contact information will be updated periodically, therefore, be sure to check the EBSA Website for the most recent version.

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

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

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

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

What are examples of a loss of eligibility for coverage?

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

- Divorce or legal separation;
- A dependent is no longer considered a dependent under the plan;
- Death of the employee covered by the plan;
- Termination of employment;
- Reduction in the number of hours of employment;
- The plan decides to no longer offer any benefits to a class of similarly situated individuals; or
- An individual in an HMO or other arrangement no longer resides, lives, or works in the service area.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Can States modify HIPAA's special enrollment requirement?

Yes, in certain circumstances. States may require additional special enrollment periods with respect to insured group health plans.

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

Nondiscrimination Requirements

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

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

What are the "health factors"?

They are:

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

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

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

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

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

Yes, provided that the questionnaire does not ask for genetic information (including family medical history) and the health information is not used to deny, restrict, or delay eligibility or benefits, or to determine individual premiums.

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

Group health plans may exclude coverage for a specific disease, limit or exclude benefits for certain types of treatments or drugs, or limit or exclude benefits based on a determination that the benefits are experimental or medically unnecessary – but only if the benefit restriction applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on a health factor they may have. (Plan amendments that apply to all individuals in a group of similarly situated individuals and that are effective no earlier than the first day of the next plan year after the amendment is adopted are not considered to be directed at individual participants and beneficiaries.) Whether any plan provision or practice with respect to benefits complies with this rule under HIPAA does not affect whether the provision or practice is permitted under other laws including the Affordable Care Act. For example, the Affordable Care Act includes requirements related to coverage of certain preventive services.

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

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

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

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

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

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

How are groups of similarly situated individuals determined?

Distinctions among groups of similarly situated participants in a health plan must be based on bona-fide employment-based classifications consistent with the

employer's usual business practice. Distinctions cannot be based on any of the health factors noted earlier.

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

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

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

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

Yes. In fact, HIPAA does not restrict a health insurance issuer from charging a higher rate to one group health plan (or employer) over another. An issuer may take health factors of individuals into account when establishing blended, aggregate rates for group health plans (or employers). This may result in one health plan (or employer) being charged a higher premium than another for the same coverage through the same issuer. Whether any plan provision or practice with respect to benefits complies with this rule under HIPAA does not affect whether the provision or practice is permitted under the Affordable Care Act (including the requirements related to community rating administered by HHS).

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

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

HIPAA does not prevent issuers from taking the current health status of each individual into account when establishing a blended, aggregate rate for

providing coverage to the employment-based group overall. (However, the Affordable Care Act generally prohibits this practice with respect to small group insurance plans.) (Note: group health plans cannot adjust premium or contribution rates based on genetic information of one or more individuals in the group. For more information, refer to the section on GINA on page 33). Also, under the Affordable Care Act, the issuer may then charge the employer (or plan) a higher overall rate, or a higher blended per-participant rate.

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

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

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

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

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

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

Is it permissible for a group health plan that generally provides coverage for dependents only until age 26 to continue health coverage past that age for disabled dependents?

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

HIPAA and the Affordable Care Act Wellness Program Requirements

The U.S. Departments of Labor, Health and Human Services and the Treasury issued final regulations on incentives for nondiscriminatory wellness programs in group health plans under the Affordable Care Act and the HIPAA nondiscrimination provisions. These rules apply to both grandfathered and nongrandfathered group health plans.

Are wellness programs provided in connection with a group health plan allowed under the Affordable Care Act and HIPAA?

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

There are two types of wellness programs provided in connection with a group health plan. Participatory wellness programs are generally available without regard to an individual's health status. Either no reward is offered, or none of the conditions for obtaining a reward are based on an individual satisfying a standard related to a health factor. These programs comply with the nondiscrimination requirements so long as the program is made available to all similarly situated individuals. For example:

- A program that reimburses employees for all or part of the cost for memberships in a fitness center.
- A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.
- A program that reimburses employees for the costs of participating, or that otherwise provides a reward for participating, in a smoking cessation program without regard to whether the employee quits smoking.
- A program that provides a reward to employees for attending a monthly, no-cost health education seminar.

Health-contingent wellness programs require participants to satisfy a standard related to a health factor in order to obtain a reward. There are two types of health-contingent wellness programs: activity-only and outcome-based. Activity-only programs require an individual to perform or complete an activity related to a health factor in order to obtain a reward. Examples include a walking, diet or exercise program. Outcome-based programs require an individual to attain or maintain a specific health outcome (such as not smoking or attaining certain results on biometric screenings) in order to obtain a reward. To comply with the nondiscrimination rules, health-contingent wellness programs must meet five requirements described in the final rules.

What are the five requirements for health-contingent wellness programs under the final regulations?

1) The program must give individuals eligible to participate the opportunity to qualify for the reward at least once per year.

2) 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 30 percent (or 50 percent for programs designed to prevent or reduce tobacco use) 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 30 percent (or 50 percent) of the cost of the coverage in which an employee and any dependents are enrolled.

3) The program must be reasonably designed to promote health and prevent disease. (Note: different requirements apply for activity-only and outcome-based programs, as described later in this section.)

4) The full reward must be available to all similarly situated individuals. This means the program must allow a reasonable alternative standard (or waiver of the otherwise applicable standard). (Note: different requirements apply for activity-only and outcome-based programs, as described later in this section.)

5) The plan must disclose in all materials describing the terms of the program the availability of a reasonable alternative standard (or the possibility of a waiver of the otherwise applicable standard). (Note: different requirements apply for activity-only and outcome-based programs, as described later in this section.) Model language is available (see page 139).

What factors may be considered in determining whether a program is reasonably designed to promote health and prevent disease?

An activity-only or outcome-based program is considered reasonably designed to promote health or prevent disease, if the program has a reasonable chance of improving the health of, or preventing disease in, participating individuals; is not overly burdensome; is not a subterfuge for discrimination based on a health factor; and is not highly suspect in the method chosen to promote health or prevent disease. The determination is based on all the relevant facts and circumstances.

To ensure that an outcome-based wellness program is reasonably designed to improve health and does not act as a subterfuge for underwriting or reducing benefits based on a health factor, a reasonable alternative standard to qualify for the reward must be provided to any individual who does not meet the initial standard based on a test or screening that is related to a health factor.

Under what circumstances must a reasonable alternative standard be offered?

For activity-only programs, a reasonable alternative standard (or waiver of the otherwise applicable standard) must be offered to any individual for whom it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard, or for whom it is medically inadvisable to attempt to satisfy the otherwise applicable standard. Plans can seek physician verification with respect to a request for a reasonable alternative standard, if the request is reasonable under the circumstances.

For outcome-based programs, the reasonable alternative standard (or waiver of the otherwise applicable standard) must be offered to any individual who does not meet the initial standard based on the measurement, test or screening. If the reasonable alternative standard is, itself, another outcome-based wellness standard, the reasonable alternative cannot be a requirement to meet a different level of the same standard without additional time to comply that takes into account the individual's circumstances and an individual must be given the opportunity to comply with the recommendations of their personal physician as a second reasonable alternative standard (if the physician joins in the request). It is not reasonable for plans to seek physician verification that a health factor makes it unreasonably difficult for the individual to satisfy, or medically inadvisable for the individual to attempt to satisfy a standard under an outcome-based wellness program.

For all health-contingent wellness programs (whether activity-only or outcome-based), all of the facts and circumstances are taken into account when determining whether a plan has provided a reasonable alternative standard, including but not limited to the following:

- If the reasonable alternative standard is completion of an educational program, the plan or issuer must make the educational program available or assist the employee in finding such a program (instead of requiring an individual to find such a program unassisted), and may not require an individual to pay for the cost of the program.

- The time commitment required must be reasonable (for example, requiring attendance nightly at a one hour class would be unreasonable).

- If the reasonable alternative standard is a diet program, the plan or issuer is not required to pay for the cost of food but must pay any membership or participation fee.

- If an individual's personal physician states that a program standard (including, if applicable, the recommendations of the plan's medical professional) is not medically appropriate for that individual, the plan or issuer must provide a reasonable alternative standard that accommodates the recommendations of the individual's personal physician with regard to medical appropriateness. Plans and issuers may impose standard cost sharing under the plan or coverage for medical items and services furnished pursuant to the physician's recommendations.

What disclosure is required for the availability of a reasonable alternative standard?

Plans and issuers must disclose the availability of a reasonable alternative standard to qualify for the reward (and, if applicable, the possibility of waiver of the otherwise applicable standard) in all plan materials describing the terms of a health-contingent wellness program (both activity-only and outcome-based wellness programs). This disclosure must include contact information for obtaining the alternative and a statement that recommendations of an individual's personal physician will be accommodated. If plan materials merely mention that such a program is available, without describing its terms, this disclosure is not required.

In addition, for outcome based-wellness programs, this notice must also be included in any disclosure that an individual did not satisfy an initial outcome-based standard, for example a notice that an individual did not meet the BMI target range to qualify for the reward.

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

Such a program is considered a participatory wellness program since it does not base any reward on the outcome of the testing. Thus, it is allowed under the HIPAA nondiscrimination provisions as long as the program is made available to all similarly situated individuals, without being subject to the five requirements that apply to health-contingent wellness programs.

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

The plan is offering a reward based on an individual's ability to stop smoking. This is considered an outcome-based wellness program. For the plan to implement this type of program, the plan's nonsmoking program would need to meet the five requirements for wellness programs that require satisfaction of a standard related to a health factor.

Accordingly, this wellness program is permitted if:

- The premium differential is not more than 50 percent of the total cost of employee-only coverage (or 50 percent of the cost of coverage if dependents can participate in the program);

- The program is reasonably designed to promote health and prevent disease;

- Individuals eligible for the program are given an opportunity to qualify for the discount at least once per year;

- The program provides a reasonable alternative standard, without physician verification that the individual met the standard, to all individuals who do not meet the otherwise applicable standard (those who use tobacco products). For example, the reasonable alternative standard could include discounts in return for attending educational classes or for trying a nicotine patch; and

- Plan materials describing the terms of the premium differential (and any disclosure that an individual did not satisfy the wellness program standard) describe the availability of a reasonable alternative standard to qualify for the lower premium.

The Genetic Information Nondiscrimination Act

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

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

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

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

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

Before the Affordable Care Act, HIPAA prevented a plan or issuer from imposing a preexisting condition exclusion based solely on genetic information. Under the Affordable Care Act, plans are prohibited from excluding coverage or benefits due to any preexisting condition. HIPAA continues to prohibit discrimination in individual eligibility, benefits, or premiums based on any health factor (including genetic information). GINA provides additional underwriting protections, prohibits requesting or requiring genetic testing, and restricts the collection of genetic information. Specifically:

- GINA provides that group health plans cannot adjust premiums or contribution amounts for a plan, or any group of similarly situated individuals under the plan, based on genetic information of one or more individuals in the group. (However, premiums may be increased for the group based upon the manifestation of a disease or disorder of an individual enrolled in the plan.)

- GINA generally prohibits plans from requesting or requiring an individual to undergo a genetic test. However, a health care professional providing health care services to an individual is permitted to request a genetic test. A plan or issuer may request the results of a genetic test to determine payment of a claim for benefits, but only the minimum amount of information necessary in order to determine payment. There is also a research exception that permits a plan or issuer under certain conditions to request (but not require) that a participant or beneficiary undergo a genetic test.

- GINA prohibits plans from collecting genetic information (including family medical history) from an individual prior to or in connection with their enrollment in the plan, or at any time for underwriting purposes. Under GINA, underwriting purposes includes rules for determination of eligibility for benefits and the computation of premium and contribution amounts. Thus, under GINA, plans are generally prohibited from offering rewards in return for the provision of genetic information, including family medical history information collected as part of a Health Risk Assessment (HRA). GINA includes an exception for incidental collection of genetic information, provided the information is not used for underwriting purposes. However, the regulations make clear that the incidental collection exception is not available if it is reasonable for the plan or issuer to anticipate that health information will be received in response to a collection, unless the collection explicitly states that genetic information should not be provided.

What is genetic information?

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

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

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

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

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

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

A manifested disease is a disease, disorder, or pathological condition for which an individual has been or could reasonably be diagnosed by a health care professional (with appropriate training and expertise in the field of medicine involved).

A disease is not manifested if a diagnosis is based principally on genetic information. For example, an individual whose genetic tests indicate a genetic variant associated with colorectal cancer and another that indicates an increased

risk of developing cancer, but who has no signs or symptoms of disease and has not and could not reasonably be diagnosed with a disease does not have a manifested disease.

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

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

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

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

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

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

A plan can take into account the costs associated with providing benefits for covered genetic tests or genetic services in determining overall premium or contribution amounts. Note, under HIPAA, a plan cannot charge an individual more for coverage than other similarly situated individuals in the group based on any health factor, including a manifested disease or disorder.

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

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

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

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

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

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

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

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

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

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

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

- The plan makes the request pursuant to research. (Research is defined in 45 CFR 46.102(d).) The research must comply with 45 CFR Part 46 or equivalent Federal regulations and any applicable State or local law or regulation for the protection of human subjects in research.

- The plan must make the request for the genetic test in writing and clearly indicate to each participant and beneficiary that the request is **voluntary** and will have **no effect on eligibility**.

- No genetic information collected pursuant to this research exception can be used for underwriting purposes.

- The plan must complete a copy of the "Notice of Research Exception under the Genetic Information Nondiscrimination Act" and provide the notice to the address specified in the instructions. You can access this notice at dol.gov/ebsa/GINAexceptioninstructions.html.

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

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

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

- Computation of premium or contribution amounts under the plan (including discounts, rebates, payments in kind, or other premium differential mechanisms in return for activities such as completing an HRA or participating in a wellness program);

- The application of any preexisting condition exclusion under the plan; and

- Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

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

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

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

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

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

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

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

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

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

A plan may offer a premium discount or other reward for completion of an HRA that does not request family medical history or other genetic information, such as information about any genetic tests the individual has undergone.

The plan should ensure that the HRA explicitly states that genetic information should not be provided. This is because GINA provides an exception for genetic information that is obtained incidental to the collection of other information, if 1) the genetic information that is obtained is not used for underwriting purposes and 2) if in connection with any collection it is reasonable to anticipate that health information will be received, the collection explicitly states that genetic information should not be provided.

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

- Participation in an annual physical examination with a physician (or other health care professional) who is providing health care services to the individual, even if the physician may ask for family medical history as part of the examination;

- More favorable cost-sharing for preventive services, including genetic screening; and

- Participation in certain disease management or prevention programs. The incentives to participate in such programs must also be available to individuals who qualify for the program but have not volunteered family medical history information through an HRA.

Mental Health Parity Provisions

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was signed into law on October 3, 2008 and became effective for plan years beginning after October 3, 2009. MHPAEA greatly expands on an earlier law, the Mental Health Parity Act of 1996 (MHPA). On November 8, 2013, the Departments of Health and Human Services, Labor and the Treasury jointly issued final regulations implementing MHPAEA, which became applicable for plan years beginning on or after July 1, 2014.

MHPAEA generally applies to group health plans and health insurance issuers that provide coverage for either mental health or substance use disorder benefits and medical/surgical benefits. These FAQs provide basic information about the important protections MHPAEA provides with respect to parity in coverage of mental health and substance use disorder benefits and medical/surgical benefits provided by employment-based group health plans.

Reviewing your group health plan for compliance with the mental health parity requirements may be complicated depending on your plan's design. If you have questions about MHPAEA or the mental health or substance use disorder benefits under your plan, contact the Department of Labor at askebsa.dol.gov or 1-866-444-3272.

What additional protections does MHPAEA provide for participants and beneficiaries?

MHPA required parity with respect to aggregate lifetime and annual dollar limits for mental health benefits and medical/surgical benefits. MHPAEA expands those provisions to include substance use disorder benefits. Thus, under MHPAEA group health plans generally may not impose a lifetime or annual dollar limit on mental health or substance use disorder benefits that is lower than the lifetime or annual dollar limit imposed on medical/surgical benefits.[3]

MHPAEA also requires group health plans to ensure that financial requirements (such as copays and deductibles), and quantitative treatment limitations (such as visit limits), applicable to mental health or substance use disorder benefits are generally no more restrictive than the requirements or limitations applied to

[3]However, note that the Affordable Care Act prohibits lifetime and annual limits on the dollar amount of essential health benefits. The definition of essential health benefits includes ``mental health and substance use disorder services, including behavioral health treatment.''

medical/surgical benefits. The MHPAEA regulations also require plans to ensure parity with respect to nonquantitative treatment limitations (such as medical management standards).

Can group health plans still apply financial requirements and treatment limitations, such as copays or visit limits on mental health and substance use disorder benefits?

Generally, yes. Group health plans may still apply financial requirements and treatment limitations with respect to mental health and substance use disorder benefits; however, they must do so in accordance with the requirements under MHPAEA.

There is a test for determining whether a financial requirement or treatment limitation for mental health or substance use disorder benefits is permissible. The general rule is that a plan may not impose a financial requirement or quantitative treatment limitation applicable to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or quantitative limitation of that type applied to substantially all medical/surgical benefits in the same classification. How to apply this test is discussed in more detail in the following FAQs.

What is a financial requirement or quantitative treatment limitation?

The most common types of financial requirements include deductibles, copays, coinsurance, and out-of-pocket maximums. Types of quantitative treatment limitations include annual, episode, and lifetime day and visit limits, for example, number of treatments, visits, or days of coverage. These are just examples; therefore, you could find a type of financial requirement and quantitative treatment limitations that is not specifically listed here.

The test for determining parity refers to *levels* of types of financial requirements or treatment limitations. What is a *level* of a type of financial requirement or treatment limitation?

The ***level*** of a type of financial requirement or treatment limitation refers to the magnitude of the type of financial requirement or treatment limitation. For example, different ***levels*** of coinsurance include 20 percent and 30 percent, different levels of copays include $15 and $20, or different levels of an episode limit include 21 inpatient days per episode and 30 inpatient days per episode.

How can I determine if a financial requirement or quantitative treatment limitation applicable to mental health and substance use disorder benefits is permissible?

To determine if a quantitative financial requirement (such as a copay) or quantitative treatment limitation (such as a visit limit) is permissible, the parity analysis must be applied for that type of financial requirement or treatment limitation within a coverage unit for each of the six classifications of benefits separately. A coverage unit refers to the way in which a plan groups individuals for purposes of determining benefits, premiums or contributions (for example, self-only, family, employee plus spouse). Under MHPAEA, the six classifications of benefits[4] are:

1) Inpatient in-network;
2) Inpatient out-of-network;
3) Outpatient in-network;
4) Outpatient out-of-network;
5) Emergency care;
6) Prescription drugs.

If a *type* of financial requirement or quantitative treatment limitation applies to substantially all medical/surgical benefits in a classification (for example, if a copay applies to substantially all medical/surgical benefits), then it may be permissible for that requirement or limitation (the copay) to apply to mental health or substance use disorder benefits in the same classification. In some circumstances plans can subdivide certain classifications to account for multiple network tiers, among other things. This is discussed later in this section.

Generally, a financial requirement or treatment limitation is considered to apply to substantially all medical/surgical benefits if it applies to two-thirds or more of the medical/surgical benefits for the same classification and coverage unit. This two-thirds calculation is based on the dollar amount of all plan payments for medical/surgical benefits expected to be paid for the year (or portion of the plan year after a change in plan benefits that affects the applicability of the financial requirement or quantitative treatment limitation).

The predominant *level* of a type of requirement or limitation applicable to medical/surgical benefits within a classification is the most restrictive level of the requirement or limitation that can be imposed on mental health or substance use disorder benefits within that classification. There is a detailed test for determining the predominant level which is discussed in the next FAQ. If, for

[4]For more information regarding the outpatient in-network and outpatient out-of-network classifications, see the FAQ at: dol.gov/ebsa/faqs/faq-mhpaea.html.

example, for self-only coverage a $10 copay is the predominant level of copay that applies to substantially all inpatient in-network medical/surgical benefits, that is the most restrictive copay level that can apply to inpatient in-network mental health or substance use disorder benefits. With respect to the prescription drug classification, there is a special rule for multi-tiered prescription drug benefits.[5]

If as determined under MHPAEA, it is permissible for my plan to impose a copay on my inpatient, in-network mental health or substance use disorder benefits, is there any restriction on the amount of copay that can apply?

Yes. The predominant level of a type of requirement or limitation applicable to medical/surgical benefits within a classification is the most restrictive level of the requirement or limitation that can be imposed on mental health or substance use disorder benefits within that classification.

Generally, the predominant level will apply to more than one-half of the medical/surgical benefits in that classification subject to the requirement or limitation. 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 requirement or limitation in the classification.[6] The least restrictive level within the combination is considered the predominant level. The determination of the portion of medical/surgical benefits in a classification subject to a financial requirement or treatment limitation is based on the dollar amount of all plan payments for medical/surgical benefits in the classification expected to be paid under the plan for the plan year.

Can I use sub-classifications within the six classifications?

The final regulations allow for a plan to create two sub-classifications for purposes of applying the financial requirement and treatment limitation rule under MHPAEA:

- Plans can sub-divide the outpatient classification into office visits and all other outpatient services.

- Plans can sub-divide in-network classifications for plans with multiple network tiers if the tiering is based on reasonable factors and without regard to whether a provider is a mental health or substance use disorder provider or a medical/surgical provider.

[5]See 29 CFR 2590.712(c)(3)(iii).
[6]For this purpose the plan may combine the most restrictive levels first, with each less restrictive level added to the combination until the combination applies to more than one-half of the benefits subject to the financial requirement or treatment limitation.

After the sub-classifications are established, the plan or issuer may not impose any financial requirement or treatment limitation on mental health or substance use disorder benefits in any sub-classification (i.e., office visits or non-office visits) that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in the sub-classification.

Plans cannot use any other type of sub-classifications, such as those based on the classification of generalists or specialists.

Can my plan impose different levels of copays on different tiers of prescription drug benefits?

In addition to the permitted sub-classifications discussed above, the regulations provide a special rule for multi-tiered prescription drug benefits. A plan can apply different levels of financial requirements to different tiers of prescription drug benefits if two conditions are met. First, the tiering must be based on reasonable factors determined in accordance with the rules relating to requirements for nonquantitative treatment limitations. Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up. Second, the tiering and financial requirements must be made without regard to whether a drug is prescribed for a medical/surgical condition or a mental health or substance use disorder condition.

Can my plan impose a higher "specialist" financial requirement with respect to mental health and substance use disorder benefits?

As stated above, a plan may not create sub-classifications for generalists and specialists to determine separate predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits. However, if the predominant level of a type of financial requirement that applies to substantially all medical/surgical benefits in a classification is the one charged for a medical/surgical specialist, then that level of that type of financial requirement can be applied for mental health or substance use disorder benefits within that classification. On the other hand, if the predominant level of a type of financial requirement that applies to substantially all medical/surgical benefits in a classification is the one charged for a medical/surgical generalist, then the level of that financial requirement charged for mental health or substance use disorder benefits within that classification cannot be higher than the level of that financial requirement for "generalist" medical/surgical benefits.

If a plan previously had separate deductibles for medical/surgical benefits and mental health or substance use disorder benefits, how should those deductibles be combined now?

While plans can no longer have separate deductibles for mental health or substance use disorder benefits and for medical/surgical benefits in a classification, they do have flexibility in how they choose to combine these deductibles. For example, if a plan previously had a $500 deductible on medical/surgical benefits, and a $500 deductible on mental health or substance use disorder benefits, the plan could now choose to have a combined $750 deductible for all benefits. As long as there is no separate deductible that applies only to mental health or substance use disorder benefits, generally the plan can set the combined deductible at whatever amount it chooses.

What are nonquantitative treatment limitations?

Nonquantitative treatment limitations include:

- 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;
- For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
- 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);
- Exclusions based on failure to complete a course of treatment; and
- Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.

This is an illustrative, non-exhaustive list.

How does MHPAEA provide for parity with respect to nonquantitative treatment limitations?

Under MHPAEA, a plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification (such as inpatient, out-of-network) unless under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the limitation to mental health or 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 limitation with respect to medical/surgical benefits in the classification.

What information must be provided to participants and beneficiaries when a request for mental health benefits is denied?

Under MHPAEA, the criteria for medical necessity determinations made under a group health plan (or health insurance coverage offered in connection with the plan) with respect to mental health or substance use disorder benefits must be made available by the plan administrator or the health insurance issuer to any current or potential participant, beneficiary, or contracting provider upon request. In addition, under the internal appeals and external review requirements added by the Affordable Care Act, non-grandfathered group health plans must provide to an individual (or a provider or other individual acting as a patient's authorized representative), upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the individual's claim for benefits consistent with the Department of Labor claims procedure regulation.[7] Documents with information on the medical necessity criteria for both medical/surgical benefits and mental health or substance use disorder benefits are plan documents, and copies must be furnished within 30 days of your request under ERISA.[8]

Are there plans that are exempt from MHPAEA?

Yes. MHPAEA applies to most employment-based group health coverage, but there are a few exceptions. MHPAEA contains an exemption for a group health plan of a small employer. However, under HHS final rules, non-grandfathered

[7]See dol.gov/ebsa/healthreform for consumer information on internal claims and appeals, external review of health plan decisions, and grandfathered health plans under the Patient Protection and Affordable Care Act.
[8]*See* 29 CFR 2520.104b-1

health insurance coverage in the individual and small group markets generally must provide all categories of essential health benefits, including mental health and substance use disorder benefits, and such benefits must be provided in compliance with the requirements of the MHPAEA rules.[9]

MHPAEA also contains an increased cost exemption available to plans that meet the requirements for the exemption. The final rules establish standards and procedures for claiming the exemption under MHPAEA.[10] Additionally, plans for State and local government employees that are self-insured may opt-out of MHPAEA's requirements if certain administrative steps are taken (such as sending notice to enrollees).[11] Finally, MHPAEA does not apply to retiree-only plans.[12]

Where can I find more information about the protections available under MHPAEA?

Additional information and FAQs regarding MHPAEA are available on the Department of Labor's Mental Health Parity Web page at dol.gov/ebsa/mentalhealthparity.

[9] 78 FR 12834

[10] For more information on MHPAEA's increased cost exemption, *see* Q7 of the FAQs available at dol.gov/ebsa/faqs/faq-aca17.html.

[11] If you are an employee of a State or local government that sponsors a self-insured plan and would like to know if your employment-based plan has opted out, see the list of HIPAA opt-out elections for self-funded, non-federal governmental plans, available at cms.gov/cciio/Resources/Forms-Reports-and-Other-Resources/index.html#Self-Funded Non-Federal Governmental Plans.

[12] See preamble to the final rules implementing MHPAEA published on November 13, 2013.

The Newborns' and Mothers' Health Protection Act

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

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

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

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

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

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

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

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

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

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

However, if the woman delivers outside the hospital and is later admitted to the hospital in connection with childbirth (as determined by the attending

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

Who is the attending provider?

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

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

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

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

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

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

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

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

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

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

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

Model language to describe the Federal law requirements is included on page 140.

The Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) provides protections for individuals who elect breast reconstruction after a mastectomy. Under WHCRA, group health plans offering mastectomy coverage must also provide coverage for certain services relating to the mastectomy, in a manner determined in consultation with the attending physician and the patient. Required coverage includes all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications of the mastectomy, including lymphedema.

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

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

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

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

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

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

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

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

Can my plan refuse to cover reconstructive surgery benefits because the mastectomy was performed when the participant was covered under a different insurance company?

If the plan provides coverage for mastectomies and the participant is receiving benefits under the plan that is related to a mastectomy, then the plan generally is required to cover reconstructive surgery upon request. In addition, the plan generally is required to cover the other benefits specified in WHCRA. It does not matter that the participant was not enrolled in the current plan and/or was not covered by the same insurance company at the time of the mastectomy.

There are additional related protections under the Affordable Care Act. For plan years beginning on or after January 1, 2014, a group health plan generally cannot limit or deny benefits relating to a health condition that was present before enrollment in the plan (a preexisting condition). For more information see the Affordable Care Act section of this publication at page 9 or visit the Affordable Care Act Web page of the Department of Labor's Employee Benefits Security Administration (EBSA) at dol.gov/ebsa/healthreform/ or the Department of Health and Human Services' Website at HealthCare.gov.

Is my plan required to provide preventive services related to the detection of breast cancer?

Under the Affordable Care Act, plans must provide certain preventive services, such as breast cancer mammography screenings for women 40 years of age and older, with no copayment, coinsurance or deductible (or other cost-sharing). For more information, visit HealthCare.gov/what-are-my-preventive-care-benefits/.

WHCRA does not require coverage for preventive services related to the detection of breast cancer.

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

The enrollment notice must state that, for an individual who is receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;

- Surgery and reconstruction of the other breast to produce a symmetrical appearance;

- Prostheses; and

- Treatment of physical complications of the mastectomy, including lymphedema.

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

A copy of a model enrollment notice is included on page 141.

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

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

A model annual notice is included on page 142.

How must the plan provide these notices to participants?

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

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

Where can I find more information about the requirements under WHCRA?

WHCRA is administered by the U.S. Departments of Labor and Health and Human Services.

For more information regarding an employer-sponsored group health plan's responsibilities under WHCRA, visit the Website of the Department of Labor's Employee Benefits Security Administration at dol.gov/ebsa/healthlawschecksheets.html.

For more information on WHCRA, visit the Website of the Department of Health and Human Services' Centers for Medicare & Medicaid Services at cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/whcra_factsheet.html.

Applying and Enforcing Laws in Part 7 of ERISA

Are certain benefits exempt from the requirements in Part 7 of ERISA, including HIPAA and the Affordable Care Act?

Part 7 of ERISA (Part 7) does not apply to plans with respect to their provision of "excepted benefits."

Some benefits, such as accidental death and dismemberment benefits, are always excepted benefits and are not subject to the laws in Part 7, including HIPAA and the Affordable Care Act. Other benefits, including 1) limited-scope dental and limited-scope vision benefits, 2) benefits under certain health flexible spending arrangements, 3) noncoordinated benefits, and 4) supplemental benefits may be excepted if certain criteria are met.

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

Are dental-only and vision-only coverage subject to Part 7?

It depends. These benefits may constitute limited-scope excepted benefits (and, therefore, are not subject to Part 7) if:

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

  OR

- The benefits are "not an integral part of the plan." (This is an option for both insured and self-insured plans.) Under the final rules issued in September 2014, benefits are not an integral part of the plan if participants have the right to elect not to receive coverage for the benefits.

Is supplemental health insurance coverage subject to Part 7?

It depends. Three types of coverage may qualify as supplemental excepted benefits (and, therefore, are not subject to Part 7): Medicare supplemental health insurance, TRICARE supplemental programs, and similar supplemental coverage provided to coverage under a group health plan.

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

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

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

Who enforces the requirements of Part 7 of ERISA and parallel requirements under the Internal Revenue Code and the Public Health Service Act?

The Secretary of Labor enforces the requirements under ERISA for private-sector group health plans. In addition, participants and beneficiaries can sue both plans and issuers to enforce their rights under ERISA.

The Secretary of the Treasury enforces requirements for private-sector group health plans under the Code. A taxpayer that fails to comply may be subject to certain excise taxes or penalties.

States also have enforcement responsibility, including sanctions available under State law, for requirements imposed on health insurance issuers. If a State does

not act in the areas of its responsibility or does not have authority to enforce, the Secretary of Health and Human Services may assert Federal authority to enforce, and impose sanctions on insurers as specified in the statute, including civil monetary penalties.

Can States laws apply to employment-based group health plan coverage?

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

Appendix A: Self-Compliance Tools

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

INTRODUCTION

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

The requirements described in this Part 7 tool generally apply to group health plans and group health insurance issuers. However, references in this tool generally are limited to "group health plans" or "plans" for convenience. In addition, these provisions generally do not apply to retiree-only or excepted benefits plans (*See 29 CFR 2590.732*).

This self-compliance tool is not meant to be considered legal advice. Rather, it is intended to give the user a basic understanding of Part 7 of ERISA to better carry out plan-related responsibilities. It provides a summary of the statute, recent regulations and other guidance issued by the Department.

In addition, some of the provisions discussed involve issues for which 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 (dol.gov/ebsa) under Laws & Regulations for publication of final rules.

Cumulative List of Self-Compliance Tool Questions for 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**
The Health Insurance Portability and Accountability Act (HIPAA) includes provisions of Federal law governing health coverage portability, health information privacy, administrative simplification, medical savings accounts, and long-term care insurance. The Department of Labor is responsible for the law's portability and nondiscrimination requirements. HIPAA's portability provisions affect group health plan coverage in the following ways: ◆ Provide certain individuals special enrollment rights in group health coverage when specific events occur, e.g., birth of a child (regardless of any open season) (*see Section A*), and ◆ Prohibit discrimination in group health plan eligibility, benefits, and premiums based on specific health factors (*see Sections B-C*).			

	YES	NO	N/A
While HIPAA previously provided for limits with respect to preexisting condition exclusions, new protections under the Affordable Care Act now prohibit the imposition of preexisting condition exclusions for plan years beginning on or after January 1, 2014. For plan years beginning on or after January 1, 2014, plans are no longer required to issue the general notice of preexisting condition exclusion or individual notice of period of preexisting condition exclusion. HIPAA certificates of creditable coverage must be provided through the end of 2014 (December 31, 2014) so that individuals who may need to offset a preexisting condition exclusion under a non-calendar year plan would still have access to a certificate of creditable coverage through the end of 2014. *See 29 CFR 2590.701-3, 5; 29 CFR 2590.715-2704 (a).*			
SECTION A – Compliance with the Special Enrollment Provisions 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 (CHIPRA), discussed in **Question 3**) of the event. The plan must provide for special enrollment, as follows:			
Question 1 – Special enrollment upon loss of other coverage **Does the plan provide full special enrollment rights upon loss of other coverage? .....** ◆ 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. *See ERISA section 701(f)(1); 29 CFR 2590.701-6(a).* ◆ When a current employee loses eligibility for coverage, the plan must permit the employee and any dependents to special enroll. *See 29 CFR 2590.701-6(a)(2)(i).* ◆ When a dependent of a current employee loses eligibility for coverage, the plan must permit the dependent and the employee to special enroll. *See 29 CFR 2590.701-6(a)(2)(ii).* **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, or moving out of an HMO's service area. 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. *See 29 CFR 2590.701-6(a)(3)(i).* ◆ When employer contributions toward an employee's or dependent's coverage terminates, the plan must permit special enrollment, even if the employee or	☐	☐	

	YES	NO	N/A
dependent did not lose eligibility for coverage. *See 29 CFR 2590.701-6(a)(3)(ii)*. ◆ Plans must allow an employee a period of at least 30 days to request enrollment. *See 29 CFR 2590.701-6(a)(4)(i)*. ◆ Coverage must become effective no later than the first day of the first month following a completed request for enrollment. *See 29 CFR 2590.701-6(a)(4)(ii)*. **Tip:** Ensure that the plan permits special enrollment upon <u>all</u> of the loss of coverage events described above.			
<u>Question 2 – Dependent special enrollment</u> **Does the plan provide full special enrollment rights to individuals upon marriage, birth, adoption, and placement for adoption? .....** ◆ Plans must generally permit current employees to enroll upon marriage and upon birth, adoption, or placement for adoption of a dependent child. *See ERISA section 701(f)(2); 29 CFR 2590.701-6(b)(2)*. ◆ Plans must generally permit a participant's spouse **and** new dependents to enroll upon marriage, birth, adoption, and placement for adoption. *See ERISA section 701(f)(2); 29 CFR 2590.701-6(b)(2)*. ◆ Plans must allow an individual a period of at least 30 days to request enrollment. *See 29 CFR 2590.701-6(b)(3)(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. *See 29 CFR 2590.701-6(b)(3)(iii)(A)*. ◆ 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. *See 29 CFR 2590.701-6(b)(3)(iii)(B)*. **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.	☐	☐	
<u>Question 3 – Special enrollment rights provided through CHIPRA</u> **Does the plan provide full special enrollment rights as required under CHIPRA? .....** 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:	☐	☐	

	YES	NO	N/A
◆ *When an employee or dependent's Medicaid or CHIP coverage is terminated.* When an employee or dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State Children's Health Insurance Plan (CHIP) 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. *See ERISA section 701(f)(3).* ◆ *Upon Eligibility for Employment Assistance under Medicaid or CHIP.* When an employee or dependent becomes eligible for premium 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. *See ERISA section 701(f)(3).* **Note:** In addition, employers that maintain a group health plan in a state with a CHIP or Medicaid program that provides for premium assistance for group health plan coverage must provide a written notice (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 dol.gov/ebsa/newsroom/fschip.html.			
Question 4 – 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 and premiums?** ◆ 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. *See 29 CFR 2590.701-6(d)(1).* ◆ 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. *See 29 CFR 2590.701-6(d)(2).*	☐	☐	
Question 5 – Notice of special enrollment rights **Does the plan provide timely and adequate notices of special enrollment rights? .....** ◆ 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.	☐	☐	

	YES	NO	N/A
Tip: Ensure that the special enrollment notice is provided at or before the time an employee is initially offered the opportunity to enroll in the plan. This may mean breaking it off from the SPD. The plan can include its special enrollment notice in the SPD if the SPD is provided at or before the initial enrollment opportunity (for example, as part of the application materials). If not, the special enrollment notice must be provided separately to be timely. A model notice is provided in the Model Disclosures on page 138.			
SECTION B – 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. *See ERISA section 702; 29 CFR 2590.702.* Similarly Situated Individuals. 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 Affordable Care Act and incorporated into section 715 of ERISA, for rules on defining dependents under the plan. (For information regarding the Affordable Care Act, please visit our Website at dol.gov/ebsa/healthreform). **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. *See 29 CFR 2590.702(g)*.			

	YES	NO	N/A
Check to see that the plan complies with HIPAA's nondiscrimination provisions as follows:			
Question 6 – Nondiscrimination in eligibility **Does the plan allow individuals eligibility and continued eligibility under the plan regardless of any adverse health factor? .....** ◆ Examples of plan provisions that violate ERISA section 702(a) because they discriminate in eligibility based on a health factor include: ❖ 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. *See 29 CFR 2590.702(b)(1).* ◆ 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. *See 29 CFR 2590.702(b)(1)(iii) Example 1.* **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.	☐	☐	
Question 7 – 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? .....** ◆ 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). ◆ Examples of plan provisions that may be permissible under ERISA section 702(a) include: ❖ Limits or exclusions for certain types of treatments or drugs, ❖ Limitations based on medical necessity or experimental treatment, and ❖ Cost-sharing, if the limit applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on a health factor. However, other provisions of law, such as the Affordable Care Act, may prohibit some of these limitations (such as PHS Act section 2713, requiring plans and issuers to provide coverage for, and not impose cost-sharing requirements with	☐	☐	

	YES	NO	N/A
respect to, certain recommended preventive services. (For information regarding the Affordable Care Act, please visit our Website at dol.gov/ebsa/healthreform).			
Question 8 – Source-of-injury restrictions **If the plan imposes a source-of-injury restriction, does it comply with the HIPAA nondiscrimination provisions? .....** ◆ 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. *See 29 CFR 2590.702(b)(2)(iii).* An example of a permissible source-of-injury exclusion would include: ❖ A plan provision that provides benefits for head injuries generally, but excludes benefits for head injuries sustained while participating in bungee jumping. ◆ An impermissible source-of-injury exclusion would include: ❖ 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). ◆ If the plan does not impose a source-of-injury restriction, check "N/A" and skip to **Question 9**.	☐	☐	☐
Question 9 – Nondiscrimination in premiums or contributions **Does the plan comply with HIPAA's nondiscrimination rules regarding individual premium or contribution rates? .....** ◆ Under ERISA section 702(b) and 29 CFR 2590.702(c), plans may not require an individual to pay a premium or contribution that is greater than a premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health factor. For example, it would be impermissible for a plan to require certain full-time employees to pay a higher premium than other full-time employees based on their prior claims experience. ◆ Nonetheless, the nondiscrimination rules do not prohibit a plan from providing a reward based on adherence to a wellness program. *See ERISA section 702(b)(2)(B)*; PHS Act section 2705. Final rules for wellness programs were published on June 6, 2013 at 29 CFR 2590.702 and 29 CFR 2590.715-2705. (These rules were issued through authority under the Affordable Care Act (PHS section 2705) and under the HIPAA nondiscrimination provisions. These rules apply to both grandfathered and nongrandfathered group health plans.)	☐	☐	

	YES	NO	N/A
To help evaluate whether this exception is available, refer to **Section C** on page 70. Once you have completed Section C, return to this page to continue with **Question 10**, below.			
Question 10 – List billing **Is there compliance with the list billing provisions? .....** ◆ 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 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. **Note:** Plans and issuers are not permitted to adjust premium or contribution rates based on genetic information of one or more individuals in the group. For more information on discrimination based on genetic information, refer to **Section V**. Note also that, under the Affordable Care Act, certain premium rating requirements apply to health insurance coverage in the small group market. Visit HealthCare.gov for more information.	☐	☐	
Question 11 – Nonconfinement clauses **Is the plan free of any nonconfinement clauses? .....** ◆ 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 sometimes are also 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). **Tip:** Delete all nonconfinement clauses.	☐	☐	
Question 12 – Actively-at-work clauses **Is the plan free of any impermissible actively-at-work clauses?.....** ◆ 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.	☐	☐	

	YES	NO	N/A
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. **Tip:** Carefully examine any actively-at-work provision to ensure consistency with HIPAA.			
SECTION C – 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. *See final regulations issued by the Departments on June 6, 2013 at 29 CFR 2590.702 and 29 CFR 2590.715-2705.* These regulations use joint authority under HIPAA and the ACA and apply for plan years beginning on or after January 1, 2014, however regulations under HIPAA's nondiscrimination provisions relating to wellness programs were applicable for plan years prior to the applicability of these final wellness program rules. The requirements relating to wellness programs apply to both grandfathered and non-grandfathered group health plans (*See further discussion of grandfather status under the ACA section VII, A of this tool*).			
Question 13 – Does the plan have a wellness program? ..... ◆ 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). **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.	☐	☐	
Question 14 – Is the wellness program part of a group health plan? ..... ◆ 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 separate from the group health plan, the program may be regulated by other laws, but it is not subject to the group health plan rules discussed here.	☐	☐	

	YES	NO	N/A
Example: An employer institutes a policy that any employee who smokes will be fired. Here, the anti-smoking policy is not part of the group health plan, 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.)			
Question 15 – Does the program discriminate based on a health factor (i.e., is it a health-contingent program)? ◆ A program 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 (or requires an individual to undertake more than a similarly situated individual based on a health factor in order to obtain the same 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), an additional benefit, or any other financial or other incentive. A reward can also be the avoidance of a penalty (such as the absence of a surcharge, or other financial or nonfinancial disincentive). ◆ If none of the conditions for obtaining a reward is based on an individual satisfying a standard that is related to a health factor (or if a wellness program does not provide a reward), the wellness program is a participatory wellness program. *See 29 CFR 2590.702 (f)(1)(ii)*. **Example 1:** Plan participants who have a cholesterol level under 200 will receive a premium reduction of 30 percent. In this Example 1, the plan requires individuals to meet a standard related to a health factor in order to obtain a reward. **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. **Tip:** Participatory wellness programs are permissible, provided the program is made available to all similarly situated individuals, regardless of health status.	☐	☐	

If you answered "No" to **ANY** of the above **questions 13-15, STOP**. The plan is not subject to the HIPAA wellness rules. If you are completing this section as part of a review of your plan, please continue to **Section D.**

	YES	NO	N/A
Question 16 – If the program discriminates based on a health factor, is the program saved by the benign discrimination provisions? ..... ◆ The Department's regulations at 29 CFR 2590.702(g) permit discrimination ***in favor*** of an individual based on a health factor. **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. *This is benign discrimination because the program is offering a reward to individuals based on an adverse health factor.* **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.	☐	☐	
If you answered "Yes" to this question, **STOP**. There does not appear to be a violation of the wellness program rules. If you are completing this section as part of a review of your plan, please continue to **Section D**. If you answered "No" to this question, proceed to **Questions 17 and 18**. The health-contingent wellness program must meet the 5 criteria.			
Question 17— Within the health-contingent wellness program category, is the program an activity-only program?..... ◆ An activity-only wellness program is a type of health-contingent wellness program that requires an individual to perform or complete an activity related to a health factor in order to obtain a reward but does not require the individual to attain or maintain a specific health outcome. *See 29 CFR 2590.702 (f)(1)(iv).* ❖ Examples include walking, diet or exercise programs.	☐	☐	
If you answered "Yes" to this question, proceed to **Question 19**. If you answered "No" to this question, proceed to **Question 18**.			
Question 18— Within the health-contingent wellness program category, is the program an outcome-based program?..... ◆ An outcome-based wellness program is a type of health-contingent wellness program that requires an individual to attain or maintain a specific health outcome (such as not smoking or attaining certain results on biometric screenings) in order to obtain a reward. *See 29 CFR 2590.702 (f)(1)(iv).*	☐	☐	

	YES	NO	N/A
<u>Question 19—Is the health-contingent program in compliance with the five requirements?</u>.....			
A. Is the amount of the reward offered under the plan limited to 30 percent (or 50 percent for programs designed to prevent or reduce tobacco use) of the applicable cost of coverage? (29 CFR 2590.702 (f)(3)(ii) and 29 CFR 2590.702(f)(4)(ii)).....	☐	☐	
If only employees are eligible to participate, the amount of the reward must not exceed 30 percent (or 50 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 30 percent of the cost of coverage in which an employee and any dependents are enrolled.			
The 30 percent (or 50 percent) limitation on the amount of the reward applies to all of a plan's wellness programs *that require individuals to meet a standard related to a health factor*.			
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 would meet the maximum limit on the total reward available, which is 30 percent. If instead, the program offered a 20 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 would 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.			
B. Is the plan reasonably designed to promote health or prevent disease? (29 CFR 2590.702(f)(2)(iii) and 29 CFR 2590.702(f)(4)(iii)).....	☐	☐	
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. This determination is based on all the relevant facts and circumstances.			
C. Are individuals who are eligible to participate given a chance to qualify at least once per year? (29 CFR 2590.702(f)(3)(i) and 29 CFR 2590.702(f)(4)(i)).....	☐	☐	

	YES	NO	N/A
D. Is the reward available to all similarly situated individuals? Does the program offer a reasonable alternative standard? (29 CFR 2590.702(f)(3)(iv) and 29 CFR 2590.702(f)(4)(iv)) 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) that is furnished by the plan upon a participant's request. **Activity-only programs** ◆ A reasonable alternative standard must be available for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard or medically inadvisable to attempt to satisfy the otherwise applicable standard. *See 29 CFR 2590.702(f)(3)(iv)(A)(1)* ◆ If reasonable under the circumstances, a plan or issuer may seek verification, such as a statement from an individual's personal physician, that a health factor makes it unreasonably difficult for the individual to satisfy, or medically inadvisable for the individual to attempt to satisfy, the otherwise applicable standard. *See 29 CFR 2590.702(f)(3)(iv)(A)(2)* **Outcome-based wellness programs** ◆ The reasonable alternative standard must be available to any individual who does not meet the initial standard based on the measurement, test, or screening. *See 29 CFR 2590.702(f)(4)(iv)(A)* ◆ Plans may not seek verification, such as a statement from an individual's personal physician, that a health factor makes it unreasonably difficult for the individual to satisfy, or medically inadvisable for the individual to attempt to satisfy the standard. *See 29 CFR 2590.702(f)(4)(iv)(E)*	☐	☐	
E. Does the plan disclose the availability of a reasonable alternative standard in all plan materials describing the program? (29 CFR 2590.702(f)(3)(v)) The plan or issuer must disclose the availability of a reasonable alternative standard in all plan materials describing the program and in any disclosure that an individual did not satisfy an initial outcome-based standard. If plan materials merely mention that the program is available, without describing its terms, this disclosure is not required. **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.	☐	☐	

	YES	NO	N/A
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." **Note:** This section highlights the five requirements for a health-contingent program and briefly describes the separate requirements for an activity-only program and an outcome-based program. For more information on the five requirements and differences between the activity-only and outcome-based programs, please visit our Website at dol.gov/ebsa/healthreform.			

Taking into consideration whether the health-contingent wellness program is activity-only or outcome-based:

If you answered "Yes" to **all** of the 5 questions on wellness program criteria, there does not appear to be a violation of the HIPAA wellness program rules.

If you answered "No" to **any** of the 5 questions on wellness program criteria, the plan has a wellness program compliance issue. Specifically,

Violation of the general benefit discrimination rule (29 CFR 2590.702(b)(2)(i), 29 CFR 2590.715-2705(a)) – 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) and 29 CFR 2590.715-2705(a).

Violation of general premium discrimination rule (29 CFR 2590.702(c)(1), 29 CFR 2590.715-2705(a)) – 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) and 29 CFR 2590.715.2705(a).

	YES	NO	N/A
SECTION D – Compliance with the MEWA or Multiemployer Plan Guaranteed Renewability Provisions 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 meet the criteria described in **Question 20**. If the plan is not a MEWA or multiemployer plan, check "N/A" and go to **Part II** of this self-compliance tool.			☐
Question 20 – Multiemployer plan and MEWA guaranteed renewability **If the plan is a multiemployer plan, or a MEWA, does the plan provide guaranteed renewability? .....** ◆ Group health plans that are multiemployer plans or MEWAs may not deny an employer continued access to the same or different coverage, other than: ❖ 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. *See ERISA section 703.* ****Note:** The Public Health Service (PHS) Act contains guaranteed renewability requirements for issuers.	☐	☐	

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**
Introduction If the plan provides either mental health or substance use disorder benefits, in addition to medical/surgical benefits, the plan may be subject to the mental health parity provisions in Part 7 of ERISA. Retiree-only plans, and those offering excepted benefits, are generally not subject to the mental health parity provisions under part 7 of ERISA. *See 29 CFR 2590.732* for further discussion. (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. *See 29 CFR 2590.712(e).*) If this is the case, answer **Questions 21-28**. 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.) Unless a plan is exempt as previously described, the requirements of MHPAEA generally apply to both grandfathered and non-grandfathered group health plans[13], as defined under the Affordable Care Act. Note that the Department of Health and Human Services' final rule regarding essential health benefits (EHB) requires health insurance issuers offering non-grandfathered health insurance coverage in the small group market through an Affordable Health Insurance Exchange (Marketplace) or outside of a Marketplace to comply with MHPAEA in order to satisfy the requirement to provide EHB. In addition, under MHPAEA, if a plan or issuer provides mental health or substance use disorder benefits in any classification described in the MHPAEA final regulation, mental health or substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided. Under the Affordable Care Act, PHSA section 2713, non-grandfathered group health plans are required to provide certain preventive services with no cost-sharing, which includes, among			

[13] 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
other things, alcohol misuse screening and counseling, depression screening, and tobacco use screening. However, the Departments clarified that nothing in MHPAEA requires a group health plan that provides mental health or substance use disorder benefits only to the extent required under PHSA section 2713, to provide additional mental health or substance use disorder benefits in any classification.[14] If the plan is exempt, check "N/A" here and skip to Part III of this checklist.			☐
SECTION A. Lifetime and Annual Limits **Question 21 – Does the plan comply with the mental health parity requirements regarding lifetime dollar limits on mental health/substance use disorder benefits? .....** ◆ A plan generally 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. *See 29 CFR 2590.712(b).* (Only limits on what the plan would pay are taken into account, as contrasted with limits on what an individual may be charged.) **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 and annual dollar limits on essential health benefits (EHB), which includes mental health and substance use disorder services. Accordingly, for mental health and substance use disorder benefits that are EHB, plans cannot impose lifetime limits. For mental health and substance use disorder benefits that are not EHB, parity requirements regarding aggregate lifetime dollar limits apply. (For information regarding the Affordable Care Act, please visit our Website at dol.gov/ebsa/healthreform).	☐	☐	
Question 22 – Does the plan comply with the mental health parity requirements regarding annual dollar limits on mental health/substance use disorder benefits? ..... ◆ A plan generally 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. *See 29 CFR 2590.712(b).* (Again, only limits on what the plan would pay are taken into account, as contrasted with limits on what an individual may be charged.) **Tip:** There is a different rule for cumulative limits other than aggregate lifetime or annual dollar limits discussed later in this checklist at **Question 26.** A plan may impose annual out-of-pocket dollar limits on participants and beneficiaries if done in accordance with the rule regarding cumulative limits.	☐	☐	

[14] See 29 CFR 2590.712(e)(3)(i)

	YES	NO	N/A
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. Accordingly, the parity requirements regarding annual dollar limits only apply to the provision of mental health and substance use disorder benefits that are not Essential Health Benefits. Note also that for plan years beginning in 2015, the annual limitation on an individual's maximum out-of-pocket (MOOP) costs in effect under ACA is $6,600 for self-only coverage and $13,200 for coverage other than self-only coverage. *See ACA Implementation FAQ Part XXI at dol.gov/ebsa/faqs/faq-aca21.html*. (For information regarding the Affordable Care Act, please visit our Website at dol.gov/ebsa/healthreform).			
SECTION B. Financial Requirements and Quantitative Treatment Limitations **Question 23 – Does the plan comply with the mental health parity requirements for parity in financial requirements and quantitative treatment limitations? .....** ◆ 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 that is applied to substantially all medical/surgical benefits in the same classification. *See 29 CFR 2590.712(c)(2).* ❖ Types of financial requirements include deductibles, copayments, coinsurance, and out-of-pocket maximums. *See 29 CFR 2590.712(c)(1)(ii).* ❖ Types of quantitative treatment limitations include annual, episode, and lifetime day and visit limits, for example, number of treatments, visits, or days of coverage. *See 29 CFR 2590.712(c)(1)(ii).* ◆ The six classifications* of benefits are: **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. *See 29 CFR 2590.712(c)(2)(ii).* ◆ 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. *See 29 CFR 2590.712(c)(2).*	☐	☐	

*See page 81 for special rules related to classifications.

	YES	NO	N/A
Detailed steps for applying these rules are set forth below: ◆ To determine compliance, each type of financial requirement or quantitative treatment limitation within a coverage unit[15] must be analyzed separately within each classification. *See 29 CFR 2590.712(c)(2)(i).* If a plan applies different levels of a financial requirement or quantitative treatment limitation to different coverage units in a classification of medical/surgical benefits (for example, a $15 copayment for self-only and a $20 copayment for family coverage), the predominant level is determined separately for each coverage unit. *See 29 CFR 2590.712(c)(3)(ii).* ◆ **Step One:** 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 at least two-thirds of the medical/surgical benefits in the classification. *See 29 CFR 2590.712(c)(3)(i)(A).* This two-thirds calculation is generally based on the dollar amount of plan payments expected to be paid for the plan year. *See 29 CFR 2590.712(c)(3)(i)(C).* (Any reasonable method can be used for this calculation. *See 29 CFR 2590.712(c)(3)(i)(E).*) ◆ **Step Two:** 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. *See 29 CFR 2590.712(c)(3)(i)(B)(1).* 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.[16] *See 29 CFR 2590.712(c)(3)(i)(B)(2).*			

[15] 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).*

[16] 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
*<u>Note: Special rules related to classifications</u> **1. Special rule for outpatient sub-classifications:** ◆ For purposes of determining parity for outpatient benefits (in-network and out-of network), a plan or issuer may divide 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 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 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 final rules. ◆ Other than as explicitly permitted under the final rules, sub-classifications are not permitted when applying the financial requirement and treatment limitation rules under MHPAEA. Accordingly, separate sub-classifications for generalists and specialists are not permitted. (*See* **Question 24** for more information regarding specialists and generalists.) **2. Special rule for prescription drug benefits:** ◆ 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. *See 29 CFR 2590.712(c)(3)(iii).* **3. Special rule for multiple network tiers:** ◆ There is a special rule for multiple network tiers. If a plan provides benefits through multiple tiers of in-network providers (such as in-network preferred and in-network participating providers), the plan may divide its benefits furnished on an in-network basis into sub-classifications that reflect network tiers, if the tiering is based on reasonable factors (such as quality, performance, and market standards) and without regard to whether a provider provides services with respect to medical/surgical benefits or mental health or substance use disorder benefits. After the sub-classifications are established, the plan or issuer may not impose any financial requirement or treatment limitation on mental health or substance use disorder benefits in any sub-classification that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in the sub-classification.			

	YES	NO	N/A
Tips: Ensure that the plan does not impose cost-sharing requirements or quantitative treatment limitations that are applicable **only** to mental health/ substance use disorder benefits. Ensure that with respect to conducting the predominant/substantially all test, the analysis must be done with respect to the dollar amount of all plan payments expected to be paid for the relevant plan year. Basing the analysis on an insurer's entire overall book of business for the year or book of business in a specific region or State is not a permissible analysis for demonstrating compliance with MHPAEA.			
Question 24 – 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? ..... ◆ The six classifications outlined in **Question 23** 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. *See 29 CFR 2590.712(c)(2)(ii)*. A plan may not use a separate sub-classification under these classifications for generalists and specialists. *See preamble language at 75 FR 5413.* **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. *See 29 CFR 2590.712(c)(3).*	☐	☐	
SECTION C. Coverage in all Classifications **Question 25 – Does the plan comply with the mental health parity requirements for coverage in all classifications? .....** ◆ If a plan provides mental health/substance use disorder benefits in any classification of benefits (the classifications are listed in **Question 23**), mental health/substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided. *See 29 CFR 2590.712(c)(2)(ii)(A).* ❖ 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. *See 29 CFR 2590.712(c) (2)(ii)(A).* This rule also applies to intermediate services provided under the plan or coverage. Plans must assign covered intermediate mental health and substance use disorder benefits (such as residential treatment, partial hospitalization and intensive outpatient treatment) to the	☐	☐	

	YES	NO	N/A
existing six classifications in the same way that they assign comparable intermediate medical/surgical benefits to these classifications. For example, if a plan classifies skilled nursing and rehabilitation hospitals for medical/surgical benefits as inpatient benefits, it must classify residential treatment facilities for mental health and substance use disorder benefits as inpatient benefits. If a plan treats home health care as an outpatient benefit, then any covered intensive outpatient mental health/substance use disorder services and partial hospitalization must be considered outpatient benefits as well. A plan must also comply with MHPAEA's NQTL rules, discussed in the following section, in assigning any benefits to a particular classification. *See 29 CFR 2590.712(c)(4).* **Tips:** ◆ 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 inpatient 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. *See 29 CFR 2590.712(c)(2)(ii)(C), Example 1.* ◆ If a plan covers the full range of medical/surgical benefits (in all classifications, both in-network and out-of-network), beware of exclusions on out-of-network mental health and substance use disorder benefits. The plan must ensure that all combinations of benefits comport with parity. **Note:** As explained in the Introduction to this section, nothing in MHPAEA requires a non-grandfathered group health plan that provides mental health or substance use disorder benefits only to the extent required under PHSA section 2713, to provide additional mental health or substance use disorder benefits in any classification.			
SECTION D. Cumulative Financial Requirements and Treatment Limitations **Question 26 – Does the plan comply with the mental health parity provisions on cumulative financial requirements or cumulative quantitative treatment limitations? .....** ◆ 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. *See 29 CFR 2590.712(c)(3)(v).* ❖ 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	☐	☐	

	YES	NO	N/A
requirements). *See 29 CFR 2590.712(a).* ❖ 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. *See 29 CFR 2590.712(a).* ◆ 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.			
SECTION E. Nonquantitative Treatment Limitations **<u>Question 27 – Does the plan comply with the mental health parity provisions for parity within nonquantitative treatment limitations?</u>.....** ◆ Nonquantitative treatment limitations (NQTLs) include: ❖ 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; ❖ For plans with multiple network tiers (such as preferred providers and participating providers), network tier design; ❖ 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); ❖ Exclusions based on failure to complete a course of treatment; and ❖ Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage. This is an **illustrative**, **nonexhaustive** list. *See 29 CFR 2590.712(c)(4)(ii).* **General rules:** ◆ 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. *See 29 CFR 2590.712(c)(4)(i).* ◆ 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;	☐	☐	

	YES	NO	N/A
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. *See 29 CFR 2590.712(c)(4), Example 8.* **Examples:** The Departments have published several examples that help illustrate how the MHPAEA regulations apply to some common plan NQTLs, including: **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. *See 2590.712(c)(4)(iii), Example 3.* **2)** The plan uses an employee assistance program as a gatekeeper to obtaining mental health or substance use disorder benefits. *See 2590.712(c)(4)(iii), Example 6.* **3)** Utilization management practices that differ among different plan benefits. *See 29 CFR 2590.712(c)(4)(iii), Example 8.* **Tips: Do not focus on results.** Look at the **underlying processes and strategies** used in applying NQTLs (such as utilization review (UR) and standards for network admission). Are there arbitrary or discriminatory differences in how the plan is applying those processes and strategies to medical/surgical benefits versus mental health/substance use disorder benefits? A plan or issuer that limits eligibility for mental health and substance use disorder benefits until after benefits under an EAP are exhausted has established an NQTL subject to the parity requirements. If no comparable requirement applies to medical/surgical benefits such a requirement could not be applied to mental health or substance use disorder benefits. **Questions You Might Ask:** **1)** What classification of benefits is being analyzed? Does the plan clearly define which benefits are treated as medical/surgical and which benefits are treated as mental health/substance use disorder under the plan. Are benefits (such as non-hospital inpatient and partial hospitalization) assigned to classifications using a comparable methodology across medical/surgical benefits and mental health/substance use disorder benefits? **2)** What is the type and description of any NQTL being applied and is it applied in parity? **3)** Overall explanation of how each NQTL is applied with respect to medical/surgical benefits and mental health and substance use disorder benefits. (Note: this includes requirements that both the participant and provider may be subject to pursuant to the NQTL). If only certain benefits are subject to an NQTL, such as meeting a fail first protocol or requiring preauthorization, how were the specific medical/surgical and			

	YES	NO	N/A
mental health or substance use disorder benefits subject to the NQTL determined? To the extent medical guidelines are relied upon, is there a process for determining variation/application of the guidelines that is comparable with respect to both medical/surgical and mental health or substance use disorder benefits? 4) Even if benefits are subject to the same NQTL, does the plan impose stricter penalties for noncompliance with respect to mental health and substance use disorder benefits (for example, reducing benefits to 50% of eligible expenses for failure to obtain prior authorization for mental health and substance use disorder benefits, vs. 20% for medical/surgical benefits)? 5) If utilization review is conducted by different entities/individuals for medical/surgical and mental health or substance use disorder benefits provided under the plan, what processes are in place to ensure comparability in the standards used for UR and comparability in the independence and qualifications of the individuals performing UR? 6) Has the plan documented its analysis that its NQTL processes and strategies (such as UR) are comparable across medical/surgical and mental health/substance use disorder benefits? **Tip:** Plans should keep records documenting NQTL processes and how they are being applied to both medical/surgical as well as mental health and substance use disorder benefits to ensure they can demonstrate compliance with the law. Such records may also be helpful to plans in responding to inquiries from participants and beneficiaries regarding benefits under the plan. See a more detailed discussion of disclosure requirements in the following section. **Illustrations.** Set forth below are additional illustrations of how a plan may have differences in nonquantitative treatment limitations: NQTLs but may still comply with the Departments' regulations, based on the facts and circumstances involved: ◆ Plan X covers neuropsychological testing but only for certain conditions. In such situations, look to see whether the exclusion is based on evidence addressing for example, 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 rely on criteria and evidence from comparable sources with respect to medical/surgical and mental health 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? The result may be that the plan covers neuropsychological testing for some medical/surgical or mental health conditions, but not for all. This outcome may be permissible to the extent the plan has based the exclusion on clinical efficacy and/or other factors if done in a comparable manner and applies the NQTL in a comparable manner.			

	YES	NO	N/A
◆ Plan Y uses diagnosis related group (DRG) codes in their standard utilization review process to actively manage hospitalization utilization. For all non-DRG hospitalizations (whether due to an underlying medical/surgical condition or a mental health or substance use disorder condition), the plan requires precertification for hospital admission and incremental concurrent review. The precertification and concurrent review processes review unique clinical presentation, condition severity, expected course of recovery, quality and efficiency. The evidentiary standards and other factors used in the development of the concurrent review process are comparable across medical/surgical benefits and mental health/substance use disorder benefits, and are well documented. These evidentiary standards and other factors are available to participants and beneficiaries free of charge upon request. In this example, it appears that, under the terms of the plan as written and in practice, the processes, strategies, evidentiary standards, and other factors considered by the plan in implementing its precertification and concurrent review of hospitalizations is comparable and applied no more stringently with respect to mental health and substance use disorder benefits than those applied with respect to medical/surgical benefits. ◆ Plan Z classifies care in skilled nursing facilities or rehabilitation hospitals as inpatient benefits and likewise treats any covered care in residential treatment facilities for mental health or substance use disorders as an inpatient benefit. In addition, the plan treats home health care as an outpatient benefit and, likewise treats intensive outpatient and partial hospitalization for mental health or substance use disorder services as outpatient benefits. In this example, the plan assigns covered intermediate mental health and substance use disorder benefits to the six classifications in the same way that it assigns comparable intermediate medical/surgical benefits. ◆ Master's degree training and state licensing requirements often vary among provider types. 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.			

	YES	NO	N/A
SECTION F. Disclosure Requirements **<u>Question 28 – Does the plan comply with the mental health parity disclosure requirements?</u>**	☐	☐	
◆ 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. *See 29 CFR 2590.712(d)(1).*			
◆ 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 DOL claims procedure rule) and 29 CFR 2590.715-2719. (internal claims and appeals and external review processes).			
◆ Pursuant to the internal claims and appeals and external review rules under the Affordable Care Act, applicable to all non-grandfathered group health plans, claims related to medical judgment (including mental health/substance use disorder) are eligible for external review. The internal claims and appeals rules include the right of claimants (or their authorized representative) to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits. This includes documents with information about the processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to medical/surgical benefits and mental health/substance use disorder benefits under the plan. *See 29 CFR 2590.712(d)(3).*			
◆ 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. *See 29 CFR 2520.104b-1; 29 CFR 2590.712(d)(1).*			
Make Showing Compliance Simple!			
<u>Documents or Plan Instruments Participants and Beneficiaries or DOL may request</u>: Participants and beneficiaries may request documents and plan instruments regarding whether the plan is providing benefits in accordance with MHPAEA and copies must be furnished within 30 days of request. This may include documentation that illustrates how the health plan has determined that any financial requirement, quantitative treatment limitation, or nonquantitative treatment limitation is in compliance with MHPAEA. For example, participants and beneficiaries may ask for:			

	YES	NO	N/A
◆ An analysis showing that the plan meets the predominant/substantially all test. The plan may need to provide information regarding the amount of medical/surgical claims subject to a certain type of QTL, such as a co-payment, in the prior year in a classification or its basis for calculating claims expected to be subject to a certain type of QTL in the current plan year in a classification, for purposes of determining the plan's compliance with the predominant/substantially all test. ◆ A description of an applicable requirement or limitation, such as preauthorization or concurrent review, that the plan has authorized for mental health/substance use disorder services and medical/surgical benefits within the relevant classification (in- or out-of-network, in- or outpatient). These might include references to specific plan documents, for example provisions as stated on specified pages of the SPD, or other underlying guidelines or criteria not included in the SPD that the Plan has consulted or relied upon; ◆ Information regarding factors, such as cost or recommended standards of care, that are relied upon by a plan for determining which medical/surgical or mental health or substance use disorder benefits are subject to a specific requirement or limitation. These might include references to specific related factors or guidelines, such as applicable utilization review criteria; ◆ A description of the applicable requirement or limitation that the plan believes have been used in any given mental health/substance use disorder service adverse benefit determination (ABD) within the relevant classification; ◆ Medical necessity guidelines relied upon for in and out-of-network medical/surgical and mental health and substance use disorder benefits. **Tips:** Participants, beneficiaries and contracting providers may request information to determine whether benefits under a plan are being provided in parity even in the absence of any specific adverse benefit determination. Plans may need to work with insurance carriers providing coverage on behalf of an insured group health plan or with third party administrators administering the plan to ensure that such service providers either directly or in coordination with the plan are providing participants and beneficiaries any documents or information to which they are entitled. If a plan uses mental health and substance use disorder vendors and carve-out service providers, the plan must ensure that all combinations of benefits comport with parity, therefore vendors and carve out providers should provide documentation of the necessary information to the Plan to ensure that all combination of benefits comport with parity. **Note:** Compliance with the disclosure requirements of MHPAEA is not determinative of compliance with any other provision or other applicable Federal or State law. Be sure that the Plan, in addition to these disclosure requirements, is disclosing information relevant to medical/surgical, mental health, and substance use disorder benefits as required pursuant to other applicable provisions of law.			

III. Determining Compliance with the Newborns' Act 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 Newborns' Act provisions in Part 7 of ERISA.			
	YES	**NO**	**N/A**
SECTION A – Newborns' Act Substantive Provisions The substantive provisions of the Newborns' Act apply only to certain plans, as follows: If the plan does not provide benefits for hospital stays in connection with childbirth, check "N/A" and go to **Part IV** of this self-compliance tool. (Note: Under the Pregnancy Discrimination Act, most plans are required to cover maternity benefits.) ☐ Special applicability rule for *insured coverage* that provides benefits for hospital stays in connection with childbirth: If the plan provides benefits for hospital stays in connection with childbirth, the plan is insured, and the coverage is in Wisconsin and several U.S. territories, it appears that the Federal Newborns' Act applies to the plan. If this is the case, answer the questions in **SECTION A and SECTION B**. If the plan provides benefits for hospital stays in connection with childbirth and is insured, whether the plan is subject to the Newborns' Act depends on State law. Based on a recent preliminary review of State laws, if the coverage is in any other state or the District of Columbia, it appears that State law applies in lieu of the Federal Newborns' Act. If this is the case, check "N/A" and skip to **SECTION B**. ☐ *Self-insured* coverage that provides benefits for hospital stays in connection with childbirth: If the plan provides benefits for hospital stays in connection with childbirth and is *self-insured*, the Federal Newborns' Act applies. Answer the questions in **SECTION A and SECTION B**.			
Question 29 – General 48/96-hour stay rule **Does the plan comply with the general 48/96-hour rule? .....** ◆ Plans generally may not restrict benefits for a hospital length of stay in connection with childbirth to less than 48 hours in the case of a vaginal delivery (*See ERISA section 711(a)(1)(A)(i)*), or less than 96 hours in the case of a cesarean section (*See ERISA section 711(a)(1)(A)(ii)*). ◆ Therefore, a plan cannot deny a mother or her newborn benefits within a 48/96-hour stay based on medical necessity. (A plan may require a mother to notify the plan of a pregnancy to obtain more favorable cost-sharing for the hospital stay. This second type of plan provision is permissible under the Newborns' Act if the cost-sharing is consistent throughout the 48/96-hour stay.)	☐	☐	

	YES	NO	N/A
◆ An attending provider may, however, decide, in consultation with the mother, to discharge the mother or newborn earlier.			
Question 30 – Provider must not be required to obtain authorization from plan **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?.....** ◆ Plans may not require that a provider (such as a doctor) obtain authorization from the plan to prescribe a 48/96-hour stay. *See ERISA section 711(a)(1)(B); 29 CFR 2590.711(a)(4).* **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.	☐	☐	
Question 31 – Incentives/penalties to mothers or providers **Does the plan comply with the Newborns' Act by avoiding impermissible incentives or penalties with respect to mothers or attending providers?.....** ◆ Penalties to attending providers to discourage 48/96-hour stays violate ERISA section 711(b)(3) and 29 CFR 2590.711(b)(3)(i). ◆ Incentives to attending providers to encourage early discharges violate ERISA section 711(b)(4) and 29 CFR 2590.711(b)(3)(ii). ◆ 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). ◆ Incentives to mothers to encourage early discharges violate ERISA section 711(b)(2) and 29 CFR 2590.711(b)(1)(i)(B). ❖ An example of this would be if the plan waived the mother's copayment or deductible if the mother or newborn leaves within 24 hours. ◆ 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).	☐	☐	

	YES	NO	N/A
SECTION B – Disclosure Provisions Group health plans that provide benefits for hospital stays in connection with childbirth are required to make certain disclosures, as follows:			
Question 32 – Disclosure with respect to hospital lengths of stay in connection with childbirth **Does the plan comply with the notice provisions relating to hospital stays in connection with childbirth?.....** ◆ 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. *See the SPD content regulations at 29 CFR 2520.102-3(u).* **Tip:** Whether the plan is insured or self-insured, and whether the Federal Newborns' Act provisions or State law provisions apply to the coverage, the plan must provide a notice describing any requirements relating to hospital length of stays in connection with childbirth. A model notice is provided in the Model Disclosures on page 140.	☐	☐	

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**
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..... If the plan does offer benefits with respect to a mastectomy, answer **Questions 33-36**.			☐
<u>Question 33 – Four required coverages under WHCRA</u> **Does the plan provide the four coverages required by WHCRA? .....** ◆ 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: ❖ 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. *See ERISA section 713(a).* ◆ 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. **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.	☐	☐	
<u>Question 34 – Incentive provisions</u> **Does the plan comply with WHCRA by not providing impermissible incentives or penalties with respect to patients or attending providers? .....** ◆ A plan may not deny a patient eligibility to enroll or renew coverage solely to avoid WHCRA's requirements under ERISA section 713(c)(1). ◆ In addition, under ERISA section 713(c)(2), a plan may not penalize or offer incentives to an attending provider to induce the provider to furnish care in a manner inconsistent with WHCRA.	☐	☐	

	YES	NO	N/A
Question 35 – Enrollment notice **Does the plan provide adequate and timely enrollment notices as required by WHCRA? .....** ◆ Upon enrollment, a plan must provide a notice describing the benefits required under WHCRA. *See ERISA section 713(a).* ◆ The enrollment notice must describe the benefits that WHCRA requires the group health plan to cover, specifically: ❖ All stages of reconstruction of the breast on which the mastectomy was performed, ❖ Surgery and reconstruction of the other breast to produce a symmetrical appearance, ❖ Prostheses, and ❖ Physical complications resulting from mastectomy (including lymphedema). ◆ 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.) **Tip:** A model notice is provided in the Model Disclosures on page 141.	☐	☐	
Question 36 – Annual notice **Does the plan provide adequate and timely annual notices as required by WHCRA? .....** ◆ Plans must provide notices describing the benefits required under WHCRA once each year. *See ERISA section 713(a).* ◆ To satisfy this requirement, the plan may redistribute the WHCRA enrollment notice or the plan may use a simplified disclosure that: ❖ Provides notice of the availability of benefits under the plan for reconstructive surgery, surgery to achieve symmetry between the breasts, prostheses, and physical complications resulting from mastectomy (including lymphedema); and ❖ Contact information (e.g., telephone number) for obtaining a detailed description of WHCRA benefits available under the plan. **Tip:** The WHCRA annual notice can be provided in the SPD if the plan distributes SPDs annually. If not, the plan should break off the annual notice into a separate disclosure. A model notice is provided in the Model Disclosures on page 142.	☐	☐	

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**
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.			
Definitions (for all defined terms under GINA, see 29 CFR 2590.702-1(a)): *Genetic information* 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. ◆ 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. *Family member* 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. *Manifestation* 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.			

	YES	NO	N/A
Genetic services means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information) or genetic education. *Genetic test* means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, if the analysis detects genotypes, mutations, or chromosomal changes. A genetic test does **NOT** include an analysis of proteins or metabolites 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.			
Question 37 – Does the plan comply with GINA's prohibition against group-based discrimination based on genetic information? ..... ◆ 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. *See 29 CFR 2590.702-1(b)(1).* ◆ 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. *See 29 CFR 2590.702-1(b)(2).*	☐	☐	
Question 38 – Does the plan comply with GINA's limitation on requesting or requiring genetic testing? ..... ◆ A group health plan generally must not request or require an individual or family member of the individual to undergo a genetic test. *See 29 CFR 2590.702-1(c)(1).* ◆ Exceptions: ❖ A health care professional who is providing health care services to an individual can request that the individual undergo a genetic test. *See 29 CFR 2590.702-1(c)(2).* ❖ 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. *See 29 CFR 2590.702-1(c)(4).* ❖ 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. *See 29 CFR 2590.702-1(c)(5).*	☐	☐	

	YES	NO	N/A
Question 39 – Does the plan comply with GINA's prohibition on collection of genetic information, *prior to or in connection with enrollment*?..... ◆ 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. *See 29 CFR 2590.702-1(d)(2)(i).* ◆ 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. ◆ Exception for incidental collection: ❖ 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. *See 29 CFR 2590.702-1(d)(2)(ii)(A).* ❖ 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. *See 29 CFR 2590.702-1(d)(2)(ii)(B).*	☐	☐	
Question 40 – Does the plan comply with GINA's prohibition on collection of genetic information, *for underwriting purposes*? ..... ◆ A plan cannot request, require, or purchase ("collect") genetic information for underwriting purposes. *See 29 CFR 2590.702-1(d)(1)(i).* ◆ *Underwriting purposes* means, with respect to any group health plan: ❖ 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. *See 29 CFR 2590.702-1(d)(1)(ii).* ◆ Exception for medical appropriateness (only if an individual seeks a benefit under the plan): ❖ 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 *and the determination of whether the benefit is medically appropriate is not for underwriting purposes.*	☐	☐	

	YES	NO	N/A
❖ 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. *See 29 CFR 2590.702-1(d) (1)(iii) and (e).*			
If you answered "Yes" to **ALL** of the above questions, there does not appear to be a violation of the GINA regulations.			

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**
****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.**			
Question 41 – Does the plan comply with the Michelle's Law requirement not to terminate coverage of dependent students on medically necessary leave of absence? ..... *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.* *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.* ◆ 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: ❖ 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. *See ERISA section 714(b).* **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.	☐	☐	

	YES	NO	N/A
Question 42 – Does the plan comply with Michelle's Law's notice requirement? ..... ◆ 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. *See ERISA section 714(c).*	☐	☐	

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

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

Note, that the Affordable Care Act, PHSA Section 2705 included requirements relating to wellness programs. The Departments issued final regulations June 6, 2013 at 29 CFR 2590.702 and 29 CFR 2590.715-2705 using joint authority under HIPAA and the ACA. These requirements relating to wellness programs are discussed in the HIPAA section of this tool at I (C).

See EBSA's Website: dol.gov/ebsa/healthreform/ for the most up-to-date guidance.

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

	YES	NO	N/A
Section A. Determining Grandfather Status Under the Affordable Care Act Provisions in Part 7 of ERISA **Note:** The grandfathered status of a plan will affect whether a plan must comply with certain provisions of the Affordable Care Act (ACA). There are also special rules for collectively bargained plans. *See also the rules at 29 CFR 2590.715-1251(f).* Grandfathered status is intended to allow people to keep their coverage as it existed on March 23, 2010, while giving plans some flexibility to make "normal" changes while retaining grandfathered status. Restrictions and requirements on grandfathered health plan coverage provides individuals' protection from significant reductions in coverage, provides for coverage to include numerous protections implemented through the Affordable Care Act, and allows employers the flexibility to manage costs. The analysis for determining grandfathered status applies separately to each benefit package or option. Accordingly, grandfathered status might be retained for some benefit packages or options and relinquished for others. By contrast, if an employer relinquished grandfathered status for self-only, family, or any other tier within a benefits package, it would relinquish grandfathered status for the entire package. *See 29 CFR 2590.715-1251(a)(1)(i).* **If the plan is not claiming grandfathered status, proceed to Section B.** **If the answer is "yes" to questions 43 and 44 below the group health plan may be a grandfathered health plan.**			
Question 43 – Did the plan exist with at least one individual enrolled on March 23, 2010?..... ◆ A grandfathered group health plan must have been in existence with an enrolled individual on March 23, 2010. Any plan that does not meet this requirement is not in grandfathered status. *See 29 CFR 2590.715-1251(a)(1)(i).*	☐	☐	
Question 44 – Has the plan continuously covered someone (not necessarily the same person) since March 23, 2010? ..... ◆ A group health plan will not relinquish its grandfathered status merely because one or more (or all) individuals enrolled on March 23, 2010, cease to be covered. However, a grandfathered health plan must continuously cover someone (not necessarily the same person) since March 23, 2010, to maintain its status. *See 29 CFR 2590.715-1251(a)(1)(i).* **If the answers to questions 43 and 44 were "yes", complete questions 45-53. If the answer is "no" to either question 43 or 44, the group health plan cannot claim grandfathered status; proceed to Section B.**	☐	☐	

	YES	NO	N/A
Tip: Provided changes are made without exceeding the other standards that cause a plan to relinquish grandfathered status, changes that generally will not cause plans to relinquish grandfathered status include changes to: premiums; to comply with Federal or State legal requirements; to voluntarily comply with provisions of the Affordable Care Act; third party administrators; network plan's provider network; and to a prescription drug formulary.			
Question 45 – Has the plan eliminated all or substantially all benefits to diagnose or treat a particular condition? ..... ◆ For the purpose of determining grandfathered status, the elimination of benefits for any necessary element to diagnose or treat a condition is considered the elimination of all or substantially all benefits to diagnose or treat a particular condition. *See 29 CFR 2590.715-1251(g)(1)(i).*	☐	☐	
Question 46 – Has the plan increased a percentage cost-sharing requirement (such as an individual's coinsurance)? ..... ◆ Any increase measured from March 23, 2010, in a percentage cost-sharing requirement causes a plan to relinquish grandfathered status. *See 29 CFR 2590.715-1251(g)(1)(ii).*	☐	☐	
Question 47 – Has the plan increased a fixed-amount cost-sharing requirement other than a copayment (such as a deductible or out-of-pocket limit) such that the total percentage increase measured from March 23, 2010 exceeds the maximum percentage increase? ..... ◆ The maximum percentage increase is medical inflation, expressed as a percentage, plus 15 percentage points. *See 29 CFR 2590.715-1251(g)(3)(ii).* Medical inflation is the increase since March 2010, in the overall medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) (unadjusted) published by the Department of Labor using the 1982-1984 base of 100. *See 29 CFR 2590.715-1251(g)(3)(i).*	☐	☐	
Question 48 – Has the plan increased a fixed-amount copayment such that the increase measured from March 23, 2010 exceeds the greater of: the maximum percentage increase, or an amount equal to $5 plus medical inflation? ..... ◆ The maximum percentage increase is medical inflation, expressed as a percentage, plus 15 percentage points. *See 29 CFR 2590.715-1251(g)(3)(ii).* Medical inflation is the increase since March 2010 in the overall medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) (unadjusted) published by the Department of Labor using the 1982-1984 base of 100. *See 29 CFR 2590.715-1251(g)(3)(i).*	☐	☐	

	YES	NO	N/A
Question 49 – Has there been a decrease in the contribution rate by the employer (or employee organization) towards the cost of any tier of coverage for any class of similarly situated individuals by more than 5 percentage points below the contribution rate for the coverage period that includes March 23, 2010? ..... ◆ If the contribution rate is based on a formula, was there a decrease in the contribution rate by more than 5 percentage points below the contribution rate for the coverage period that includes March 23, 2010? *See 29 CFR 2590.715-1251(g)(1)(v)(B).* **Tip:** If a group health plan modifies the tiers of coverage it had on March 23, 2010 (for example, from self-only and family to a multi-tiered structure of self-only, self-plus-one, self-plus-two, and self-plus-three-or-more), the employer contribution for any new tier would be tested by comparison to the contribution rate for the corresponding tier on March 23, 2010. If the plan adds one or more new coverage tiers without eliminating or modifying any previous tiers and those new coverage tiers cover classes of individuals that were not covered previously under the plan, the new tiers would not be analyzed under the standards of paragraph (g)(1). *See DOL FAQs About the Affordable Care Act Implementation Part II, question 3 at dol.gov/ebsa/faqs/faq-aca2.html.* In cases of a multiemployer plan that has either a fixed-dollar employee contribution or no employee contribution towards the cost of coverage, if the employer's contribution rate changes, provided any changes in the coverage terms would not otherwise cause the plan to cease to be grandfathered and there continues to be no employee contribution or no increase in the fixed-dollar employee contribution towards the cost of coverage, the change of the employer's contribution rate will not, in and of itself, cause a plan that is otherwise a grandfathered health plan to relinquish grandfathered status. *See DOL FAQs About the Affordable Care Act Implementation Part I, question 4 at dol.gov/ebsa/faqs/faq-aca.html.*	☐	☐	
Question 50 – Has the plan added or decreased an overall annual limit on benefits? ..... ◆ A plan will relinquish its grandfathered status if it: ❖ Adds an overall annual limit on the dollar value of all benefits when it did not previously impose an overall annual limit (*See 29 CFR 2590.715-1251(g)(1)(vi)(A)*); ❖ Previously imposed an overall lifetime limit on the dollar value of benefits (but no overall annual limit) and adopts an overall annual limit at a dollar value that is lower than the dollar value of the lifetime limit on March 23, 2010 (*See 29 CFR 2590.715-1251(g)(1)(vi)(B)*); or ❖ Decreases the dollar value of the overall annual limit that was in place on March 23, 2010 (*See 29 CFR 2590.715-1251(g)(1)(vi)(C)).*	☐	☐	

	YES	NO	N/A
Note: For plan years beginning on or after January 1, 2014, a plan may not establish, for any individual, an annual limit on the dollar amount of benefits that are essential health benefits. *See 29 CFR 2590.715-2711(b)(1).* **If the answer to any of questions 45-50 was "yes", the plan is <u>NOT</u> a grandfathered plan, proceed to Section B.**			
<u>Question 51 – Did the plan change issuers after March 23, 2010?</u> ..... If the answer to question 51 is "yes", if the group health plan changed issuers after March 23, 2010, and the change in issuer was effective on or after November 15, 2010, the plan will continue to be a grandfathered plan provided no other changes that would relinquish grandfathered status are made. *See 29 CFR 2590.715-1251(a)(1)(ii), as amended.* Proceed to question 53. **If a group health plan changed issuers after March 23, 2010, and the change was effective prior to November 15, 2010, the plan will have relinquished grandfather status. The plan is not a grandfathered plan; proceed to Section B.** **Tip:** The operative date is the effective date of the new contract, not the date the new contract was entered into. Special rules apply for collectively bargained plans. *See 29 CFR 2590.715-1251(f)* for collectively bargained plans.	☐	☐	
<u>Question 52 – Did the plan change from self-insured to fully-insured after March 23, 2010?</u> ..... If the group health plan was self-insured and changed to fully insured after March 23, 2010, and the change was effective on or after November 15, 2010, the plan will continue to be a grandfathered plan provided no other changes are made that would relinquish grandfathered status. *See 29 CFR 2590.715-1251(a)(1)(ii), as amended.* Proceed to question 53. **If a group health plan was self-insured and changed to fully-insured after March 23, 2010, and the change was effective prior to November 15, 2010, the plan will have relinquished grandfathered status. The plan is not a grandfathered plan; proceed to Section B.** **If Questions 51 and 52 are not applicable to the group health plan, continue to Question 54 to continue the grandfather status analysis.**	☐	☐	

	YES	NO	N/A
Question 53 – If the group health plan changed issuers (including a plan that was self-insured and changed to fully insured) and has maintained grandfathered status, did the plan provide documentation to the new issuer of the plan terms under the prior health coverage sufficient to determine whether any other change was made that would relinquish grandfathered status? ..... ◆ To maintain status as a grandfathered health plan, the plan must provide to the new issuer (and the new issuer must require) documentation of plan terms (including benefits, cost sharing, employer contributions, and annual limits) under the prior health coverage sufficient to determine whether any other change is being made that would relinquish grandfathered status. *See 29 CFR 2590.715-1251(a)(3)(ii), as amended.*	☐	☐	
Question 54 – Does the plan include a statement that it believes it is a grandfathered health plan in any plan materials provided to participants and beneficiaries that describe the benefits provided under the plan? ..... ◆ To maintain status as a grandfathered group health plan, the plan must include a statement, in any plan materials provided to a participant or beneficiary describing the benefits under the plan, that the plan believes it is a grandfathered health plan within the meaning of section 1251 of the Affordable Care Act and must provide contact information for questions and complaints. Model language is available. *See 29 CFR 2590.715-1251(a)(2).* **For all plans that, based on questions 43 through 54, have not relinquished grandfathered status, complete question 55.**	☐	☐	
Question 55 – Is the plan maintaining records documenting the terms of the plan in connection with the coverage in effect on March 23, 2010, and are these records made available upon request?..... ◆ To maintain status as a grandfathered group health plan the plan must maintain records documenting the terms of the plan in connection with the coverage that was in effect on March 23, 2010, and any other documents necessary to verify, explain, or clarify its status as a grandfathered health plan. These records must be maintained for as long as the plan takes the position that it is grandfathered, and must be available for examination upon request. *See 29 CFR 2590.715-1251(a)(3)(i)(A) & (i)(B), as amended.*	☐	☐	

	YES	NO	N/A
Section B. Determining Compliance with the Affordable Care Act Extension of Dependent Coverage of Children to Age 26 Provisions in Part 7 of ERISA **Note:** *This provision is applicable for plan years beginning on or after Sept. 23, 2010. This provision applies to both grandfathered and non-grandfathered group health plans.*			
Question 56 – Does the plan provide coverage for dependent children?..... If the answer to this question is no, proceed to **Section C**. These provisions are only applicable to group health plans that provide coverage to dependent children. If the answer is "yes", proceed to question 57. **If the answer to the question below is "yes", the plan is in compliance with the rules regarding Dependent Coverage to Age 26.**	☐	☐	
Question 57 – Does the plan make dependent coverage available for children to age 26? ..... Plans and issuers cannot deny or restrict dependent coverage for a child who is under age 26 other than in terms of a relationship between a child and the participant. Thus, plans and issuers cannot deny or restrict dependent coverage for a child who is under age 26 based on the presence or absence of financial dependency upon or residency with the participant or any other person, student status, employment or any combination of these factors. In addition, plans and issuers cannot limit dependent coverage based on whether the child under age 26 is married. The Affordable Care Act and implementing regulations do not require plans to cover children of children. *See 29 CFR 2590.715-2714(b) & (c).* The terms of the plan or coverage cannot vary based on age, except for children who are age 26 or older. *See 29 CFR 2590.715-2714(d).* **Tip:** A plan or issuer does not fail to satisfy the requirements regarding Dependent Coverage to Age 26 because the plan limits health coverage for children until the child turns 26 to only those children who are described in section 152(f)(1) of the Code (That section of the Code defines children to include only sons, daughters, stepchildren, adopted children (including children placed for adoption), and foster children.). For an individual not described in Code section 152(f)(1), such as a grandchild or niece, a plan may impose additional conditions on eligibility for health coverage, such as a condition that the individual be a dependent for income tax purposes. *See DOL FAQs About the Affordable Care Act Implementation Part I, question 14 at dol.gov/ebsa/faqs/faq-aca.html.*	☐	☐	

	YES	NO	N/A
Section C. Determining Compliance with the Affordable Care Act Rescission Provisions in Part 7 of ERISA **Note:** *This provision is applicable for plan years beginning on or after Sept. 23, 2010. This provision applies to both grandfathered and non-grandfathered group health plans.* A rescission is a cancellation or discontinuance of coverage that has retroactive effect; this includes a cancellation that treats a policy as void from the time of the group's enrollment or a cancellation that voids benefits paid up to one year before the cancellation. A rescission is not the cancellation or discontinuance of coverage that has only a prospective effect; or the cancellation or discontinuance of coverage if effective retroactively to the extent it is based on a failure to timely pay required premiums or contributions towards the cost of coverage. *See 29 CFR 2590.715-2712(a)(2).* **If the answer to the question below is "yes" the plan is in compliance with the rules regarding rescission of coverage.**			
Question 58 – Does the plan only rescind coverage for instances where an act, practice, or omission that constitutes fraud, or an intentional misrepresentation of material fact has occurred? ..... ◆ A group health plan, or health insurance issuer offering group health insurance coverage, must not rescind coverage with respect to an individual (including a group to which the individual belongs, or family coverage in which the individual is included) once the individual is covered under the plan or coverage, unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage. *See 29 CFR 2590.715-2712(a)(1).* **Tip**: Some employers' human resource departments may reconcile lists of eligible individuals with their plan or issuer via data feed only once per month. If a plan covers only active employees (subject to the COBRA continuation coverage provisions) and an employee pays no premiums for coverage after termination of employment, the Departments do not consider the retroactive elimination of coverage back to the date of termination of employment, due to delay in administrative record-keeping, to be a rescission. Similarly, if a plan does not cover ex-spouses (subject to the COBRA continuation coverage provisions) and the plan is not notified of a divorce and the full COBRA premium is not paid by the employee or ex-spouse for coverage, the Departments do not consider a plan's termination of coverage retroactive to the divorce to be a rescission of coverage. (Of course, in such situations COBRA may require coverage to be offered for up to 36 months if the COBRA applicable premium is paid by the qualified beneficiary.) *See DOL FAQs About the Affordable Care Act Implementation Part II, question 7 at dol.gov/ebsa/faqs/faq-aca2.html.*	☐	☐	

	YES	NO	N/A
Section D. Determining Compliance with the Affordable Care Act Prohibitions on Lifetime Limits and Restrictions on Annual Limits in Part 7 of ERISA **Note:** *This provision is applicable for plan years beginning on or after Sept. 23, 2010. This provision applies to both grandfathered and non-grandfathered group health plans.* The restrictions on annual limits do not apply to health flexible spending arrangements (FSAs), medical savings accounts (MSAs), or health savings accounts (HSAs). In the case of health reimbursement accounts (HRAs) that are integrated with other group health plan coverage which complies with the prohibitions on lifetime and annual limits, the fact that benefits under the HRA by itself are limited does not violate these rules. Stand-alone HRAs limited to retirees only are not subject to these rules. (For more information about the application of the market reforms and other provisions of the Affordable Care Act to HRAs, health FSAs, and certain other employer healthcare arrangements, see Technical Release 2013-03, available at dol.gov/ebsa/newsroom/tr13-03.html. **1. Lifetime Limits** **If the answer to the question below is "yes" the plan is in compliance with the rules regarding prohibitions on lifetime limits.**			
Question 59 – Does the plan comply with the Affordable Care Act's prohibition on lifetime limits?..... ◆ A group health plan or issuer may not establish any lifetime limit on the dollar amount of benefits for any individual. This prohibition applies for plan years beginning on or after September 23, 2010. *See 29 CFR 2590.715-2711(a)(1).* **Tip:** These rules do not prevent a plan or issuer from placing lifetime dollar limits with respect to any individual on specific covered benefits that are not essential health benefits (to the extent this is permissible under applicable Federal and State law). *See 29 CFR 2590.715-2711(b)(1).* **Note:** "Essential health benefits" refers to essential benefits under Section 1302(b) of the Affordable Care Act and applicable regulations (issued by HHS) including the Frequently Asked Question on Essential Health Benefits Bulletin. For plan years beginning before the issuance of regulations defining "essential health benefits," for purposes of enforcement, the Departments will take into account good faith efforts to comply with a reasonable interpretation of the term "essential health benefits." **For this purpose, a plan or issuer must apply the definition of essential health benefits consistently.** ***See Preamble to Interim Final Regulations, at 75 FR 37188, 37191.***	☐	☐	

	YES	NO	N/A
2. Annual Limits **If the answer to the question below is "yes" the plan is in compliance with the rules regarding prohibitions/restrictions on annual limits.**			
Question 60 – Does the plan comply with the Affordable Care Act's prohibition on annual limits?..... For plan years beginning on or after January 1, 2014, a plan may not establish, for any individual, an annual limit on the dollar amount of benefits that are essential health benefits. **Tip:** These rules do not prevent a plan or issuer from placing annual dollar limits with respect to any individual on specific covered benefits that are not essential health benefits (to the extent this is permissible under applicable Federal and State law). *See 29 CFR 2590.715-2711(b)(1).*	☐	☐	
Section E. Determining Compliance with the Affordable Care Act Prohibition on Preexisting Condition Exclusions *This provision applies to both grandfathered and non-grandfathered group health plans.* The definition of preexisting condition exclusion includes any limitation or exclusion of benefits (including a denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage (or if coverage is denied, the date of denial), such as a condition identified as a result of a pre-enrollment questionnaire or a physical examination given to the individual, or a review of medical records relating to the pre-enrollment period. *See 29 CFR 2590.701-2.* **If the answer to the following question is "yes" the plan is in compliance with the prohibition on preexisting condition exclusions.**			
Question 61 – Does the plan comply with the Affordable Care Act by not imposing a preexisting condition exclusion? ..... ◆ For plan years beginning on or after January 1, 2014, group health plans may not impose any preexisting condition exclusions. *See 29 CFR 2590.715-2704(a)(1).* **Tip:** Some preexisting condition exclusions are clearly designated as such in the plan documents. Others are not. Check for hidden 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.	☐	☐	

	YES	NO	N/A
Example: A plan excludes coverage for cosmetic surgery unless the surgery is required by reason of an accidental injury occurring after the effective date of coverage. 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.			
SECTION F- Compliance with the 90-day Waiting Period Limitation Provision Use the following questions to help determine whether the group health plan complies with the Departments' 90-day waiting period limitation regulations. See final regulations issued by the Departments on February 24, 2014 at 29 CFR 2590.715-2708. ***Note:*** *PHS Act section 2708, as added by the Affordable Care Act and incorporated into section 715 of ERISA, prohibits the application of any waiting period that exceeds 90 days. Plans are not required to have a waiting period, and the provision does not require plan sponsors to offer coverage to any particular employee or class of employees. This provision applies to grandfathered health plans and non-grandfathered plans.* **Question 62- Does the plan apply a waiting period that exceeds 90-days? .....** ◆ A waiting period is defined as the period that must pass before coverage for an individual who is otherwise eligible to enroll under the terms of a group health plan can become effective. See ERISA section 701(b)(4); 29 CFR 2590.715-2708(b) ◆ Being eligible for coverage under the terms of the plan generally means having met the plan's substantive eligibility conditions (such as, for example, being in an eligible job classification, achieving job-related licensure requirements specified in the plan's terms, or satisfying a reasonable and bona fide employment-based orientation period). *See 29 CFR 2590-715.2708(c)(1).* **Variable Hour Employees:** ◆ If a plan conditions eligibility on an employee regularly having a specified number of hours of service per period (or working full-time), and it cannot be determined that a newly hired employee is reasonably expected to regularly work that number of hours per period (or work full-time), the plan may take a reasonable period of time, not to exceed 12 months and beginning on any date between the employee's start date and the first day of the first calendar month following the employee's start date, to determine whether the employee meets the plan's eligibility condition. *See 29 CFR 2590.715-2708(c)(3)(i).*	☐	☐	

	YES	NO	N/A
Tip: Except in cases in which a waiting period that exceeds 90 days is imposed in addition to a measurement period, the time period for determining whether an employee meets the plan's eligibility condition will not be considered to be designed to avoid compliance with the 90-day waiting period limitation if the coverage is made effective no later than 13 months from the employee's start date, plus any time remaining until the first day of the next calendar month. **Cumulative Hours of Service Requirements:** ◆ If a plan conditions eligibility on an employee having completed a number of cumulative hours of service, the eligibility condition is not considered to be designed to avoid compliance with the 90-day waiting period limitation if the cumulative hours-of-service requirement does not exceed 1,200 hours. The plan's waiting period must begin once the new employee satisfies the plan's cumulative hours-of-service requirement. *See 29 CFR 2590.715-2708(c)(3)(ii).* **Limitation on Orientation Periods** To the extent that an orientation period is not used as a subterfuge for the passage of time, or designed to avoid compliance with the 90-day waiting period limitation, an orientation period is permitted only if it does not exceed one month. One month is determined by adding one calendar month and subtracting one calendar day, measured from an employee's start date in a position that is otherwise eligible for coverage. *See 29 CFR 2590.715-2708 (c)(3)(iii).* **Tip:** It is not permissible under the 90-day rule to delay coverage until the first day of the month following completion of a 90-day waiting period. *See 29 CFR 2590.715-2708 (e).* **If you answered "Yes" to the above question under Section F, the plan violates PHS Act Section 2708.**			
Section G. Determining Compliance with the Affordable Care Act Provisions Regarding the provision of the Summary of Benefits and Coverage (SBC) and Uniform Glossary ***Note:*** *These provisions* ***do apply*** *to grandfathered health plans.* The Affordable Care Act provides for new disclosure tools, the Summary of Benefits and Coverage (SBC) and Uniform Glossary, to help consumers better compare coverage options available to them in both the individual and group health insurance coverage markets. Generally, group health plans and health insurance issuers are required to provide the SBC and Uniform Glossary free of charge. The Departments published a final rule setting forth the requirements for who must provide and who is entitled to receive an SBC and Uniform Glossary, when these documents must be provided, the content required in the documents, and the form and manner of how the documents can be provided. In addition, the Departments published a notice that sets forth the required template for the SBC and Uniform Glossary documents along with instructions and sample			

	YES	NO	N/A
language for completing the template. These documents are available on the EBSA Website at: dol.gov/ebsa/healthreform/. The SBC and Uniform Glossary must be provided in a culturally and linguistically appropriate manner. The rules for determining whether a language other than English must be made available are the same as the rules for Internal Claims and Appeals and External Review, discussed in **Section J** of this compliance aid. HHS has made available translated versions of the template and glossary in the potentially required languages at: cciio.cms.gov/resources/other/index.html. **Transitional Relief Providing Flexibility and Emphasizing Good Faith Progress Towards Compliance** The Department is working together with employers and issuers to assist them in coming into compliance with these requirements. Specifically, in the instructions for completing the SBC, the Department stated that to the extent a plan's terms do not reasonably correspond to the template and instructions, the template should be completed in a manner that is as consistent with the instructions as reasonably as possible, while still accurately reflecting the plan's terms. *See Instructions Guide for Group Coverage, page 1 General Instructions.* In addition, compliance assistance is a high priority for the Departments. Implementation will be marked by an emphasis on assisting (rather than imposing penalties on) plans and issuers that are working diligently and in good faith to understand and come into compliance with the new law. During the first year of applicability,[17] the Departments did not impose penalties on plans and issuers that were working diligently and in good faith to comply. The Departments are extending the previously-issued enforcement and transition relief until further guidance is issued. The Departments will continue to work with stakeholders over time to achieve maximum uniformity for consumers and certainty for the regulated community. *See ACA Implementation FAQ Part XIX, Q8.* **The questions below focus on provision of the SBC by group health plans to participants and beneficiaries. The final regulations also require health insurance issuers to provide the SBC to group health plan sponsors and participants and beneficiaries. More information on these requirements can be found at dol.gov/ebsa/healthreform.** **The following questions have been developed to assist in determining compliance with the rules regarding the Summary of Benefits and Coverage and Uniform Glossary.**			

[17]The term "first year of applicability" refers to SBCs and uniform glossaries provided with respect to coverage beginning before January 1, 2014.

	YES	NO	N/A
Question 63 – Does the plan provide an SBC, as required? ..... **In Connection with Enrollment** When providing the SBC to participants and beneficiaries, group health plans and issuers must provide the SBC with respect to each benefit package offered for which they are eligible (*See 29 CFR 2590.715-2715(a)(1)(ii)(A)*) as part of any written application materials distributed by the plan or issuer for enrollment. If no written application materials are distributed for enrollment, the SBC must be provided no later than the first date a participant is eligible to enroll in coverage for themselves or any beneficiaries. *See 29 CFR 2590.715-2715(a)(1)(ii)(B).* For this purpose, written application materials include any forms or requests for information, in paper form or through a Website or email, that must be completed for enrollment. *See ACA Implementation FAQ Part VIII, Q9.* **Tips:** The requirement to provide an SBC by both a health insurance issuer and a group health plan to participants and beneficiaries can be satisfied for both entities as long as one entity provides the required SBC within the required timeframes. *See 29 CFR 2590.715-2715(a)(1)(iii)(A).* If a participant and any beneficiaries are known to reside at the same address, a single SBC provided to that address will satisfy the obligation to provide for all individuals at the address. Under this circumstance, the obligation will also be satisfied if the SBC is furnished to the participant in electronic form. However if a beneficiary's last known address is different than the participant's address, a separate SBC must be mailed to the beneficiary's address. *See 29 CFR 2590.715-2715(a)(1)(iii)(B) and ACA Implementation FAQ Part VIII, Q10.* Group health plans are permitted to integrate the SBC with other summary materials, such as the SPD, as long as the SBC is intact and prominently displayed at the beginning of the materials (for example, immediately after the table of contents in an SPD) and all of the timing requirements are met. *See 77 FR 8707.* The Departments generally allow electronic delivery of the SBC and Uniform Glossary where appropriate. For participants and beneficiaries who are already enrolled in coverage under a group health plan, an SBC may be provided electronically if the requirements of the Department of Labor's electronic safe harbor are met. *See ACA Implementation FAQ Part VIII, Q10 citing the Department of Labor's disclosure regulation at 29 CFR 2520.104b-1.* For participants and beneficiaries who are eligible but not enrolled for coverage, the SBC may be provided electronically if the format is readily accessible; the SBC is provided in paper form upon request; and if the electronic form is an Internet posting, the plan or issuer timely notifies the individual that the documents are available in paper form upon request. *See 29 CFR 2590.715-2715(a)(3).* An SBC may be provided electronically to participants and beneficiaries in connection with their online enrollment or online renewal of coverage under the plan. SBCs	☐	☐	

	YES	NO	N/A
may also be provided electronically to participants and beneficiaries who request an SBC online. In either instance, a paper copy must be provided upon request. *See ACA Implementation FAQ Part IX, Q1.*			
Question 64 – Does the plan make available the Uniform Glossary, as required? ..... ◆ The Uniform Glossary includes statutorily required terms, as well as multiple additional terms recommended by the NAIC. The Uniform Glossary is available on the DOL Website at dol.gov/ebsa/healthreform/. The Uniform Glossary may not be modified by plans or issuers. *See 29 CFR 2590.715-2715(c)(3); 77 FR 8708.* ◆ The final rule requires group health plans and issuers to make the Uniform Glossary available upon request, in either paper or electronic form (as requested), within seven business days. *See 29 CFR 2590.715-2715(c)(4).* This requirement may be satisfied by providing an internet address where an individual may review and obtain the Uniform Glossary as well as a contact phone number to obtain a paper copy of the Uniform Glossary. *See 29 CFR 2590.715-2715(a)(2)(i)(L).*	☐	☐	
If you are completing this section as part of a review of a grandfathered health plan, STOP here. The following sections address provisions that do not apply to grandfathered health plans.			
Section H. Determining Compliance with the Patient Protection Provisions of the Affordable Care Act in Part 7 of ERISA ***Note:*** *This provision is applicable for plan years beginning on or after Sept. 23, 2010. This provision* ***does not apply*** *to grandfathered health plans.* **1. Choice of Healthcare Professional** A plan or issuer that requires or provides for a participant or beneficiary to designate a participating primary care provider must permit each participant or beneficiary to designate any participating primary care provider who is available to accept the participant or beneficiary. With respect to a child, the plan or issuer must permit the designation of a physician who specializes in pediatrics as a child's primary care provider, if the provider participates in the network of the plan or issuer and is available to accept the child. *See 29 CFR 2590.715-2719A(a)(1) & (a)(2).* A group health plan or issuer that provides obstetrical or gynecological (OB/GYN) care and requires the designation of an in-network primary care provider, may not require authorization or referral by the plan, issuer, or any person (including a primary care provider) for a female participant or beneficiary who seeks coverage for OB/GYN care provided by a participating health care professional who specializes in obstetrics and gynecology. (This includes any individual authorized under State law to provide OB/GYN care, including a person other than a physician). *See 29 CFR 2590.715-2719A(a)(3).*			

	YES	NO	N/A
Question 65 – Does the plan require or provide for designation of a participating primary care provider by any participant or beneficiary?..... If the answer is 'no', enter 'N/A' for the following questions and proceed to Question 72. **If the answer to ALL of the questions below is "yes" the plan is in compliance with the choice of healthcare professional provisions of the rules regarding patient protections.**	☐	☐	
Question 66 – Does the plan permit each participant or beneficiary to designate any participating primary care provider who is available to accept the participant or beneficiary? ..... ◆ If a group health plan, or a health insurance issuer offering group health insurance coverage, requires or provides for designation by a participant or beneficiary of a participating primary care provider, then the plan or issuer must permit each participant or beneficiary to designate any participating primary care provider who is available to accept the participant or beneficiary. *See 29 CFR 2590.715-2719A(a)(1)(i).*	☐	☐	
Question 67 – Does the plan provide a notice informing each participant of the terms of the plan or health insurance coverage regarding designation of a primary care provider? ..... ◆ If a group health plan or health insurance issuer requires the designation by a participant or beneficiary of a primary care provider, the plan or issuer must provide a notice informing each participant of the terms of the plan or health insurance coverage regarding designation of a primary care provider that any participating primary care provider who is available to accept the participant or beneficiary can be designated. *See 29 CFR 2590.715-2719A(a)(4)(i)(A).* **Tip:** This notice must be provided any time the plan provides a participant with an SPD or other similar description of benefits under the plan. *See 29 CFR 2590.715-2719A(a)(4)(ii).*	☐	☐	
Question 68 – With respect to a child, does the plan permit the participant or beneficiary to designate a physician who specializes in pediatrics as the child's primary care provider if the provider participates in the network of the plan or issuer and is available to accept the child? ..... ◆ If a group health plan, or a health insurance issuer offering group health insurance coverage, requires or provides for the designation of a participating primary care provider for a child by a participant or beneficiary, the plan or issuer must permit the participant or beneficiary to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if the provider participates in the network of the plan or issuer and is available to accept the child. *See 29 CFR 2590.715-2719A(a)(2)(i).*	☐	☐	

	YES	NO	N/A
Question 69 – With respect to a child, does the plan provide a notice informing each participant of the terms of the plan or health insurance coverage regarding designation of a primary care provider and the right to designate any participating physician who specializes in pediatrics as the primary care provider? ..... ◆ If a group health plan or health insurance issuer requires the designation by a participant or beneficiary of a primary care provider, the plan or issuer must provide a notice informing each participant of the terms of the plan or health insurance coverage regarding designation of a primary care provider with respect to a child, that any participating physician who specializes in pediatrics can be designated as the primary care provider. *See 29 CFR 2590.715-2719A(a)(4)(i)(B).* **Tip:** This notice must be provided any time the plan provides a participant with an SPD or other similar description of benefits under the plan. *See 29 CFR 2590.715-2719A(a)(4)(ii).*	☐	☐	
Question 70 – Does the plan provide coverage for OB/GYN care provided by a participating health care professional who specializes in obstetrics or gynecology for a female participant or beneficiary without requiring authorization or referral by the plan, issuer, or any person (including a primary care provider)? ..... ◆ For purposes of this provision, a health care professional who specializes in obstetrics or gynecology is any individual (including a person other than a physician) who is authorized under applicable State law to provide obstetrical or gynecological care. The plan or issuer may require such a professional to agree to otherwise adhere to the plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer. *See 29 CFR 2590.715-2719A(a)(3)(i)(A).* ◆ A plan or issuer must treat the provision of OB/GYN care, and the ordering of related OB/ GYN items and services, by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider. *See 29 CFR 2590.715-2719A(a)(3)(i)(B).*	☐	☐	
Question 71 – Does the plan provide a notice informing each participant of the terms of the plan or coverage regarding designation of a primary care provider and that the plan may not require authorization or referral for obstetrical or gynecological care by a participating health care professional who specializes in obstetrics or gynecology? ..... ◆ If a group health plan or health insurance issuer requires the designation by a participant or beneficiary of a primary care provider, the plan or issuer must provide a notice informing each participant of the terms of the plan or health insurance coverage regarding designation of a primary care provider that the plan may not require authorization or referral for obstetrical or gynecological	☐	☐	

	YES	NO	N/A
care by a participating health care professional who specializes in obstetrics or gynecology. *See 29 CFR 2590.715-2719A(a)(4)(i)(C).* **Tip:** This notice must be provided anytime the plan provides a participant with an SPD or other similar description of benefits under the plan. *See 29 CFR 2590.715-2719A(a)(4)(ii).*			
2. <u>Coverage of Emergency Services</u> **<u>Question 72 – Does the plan provide any benefits with respect to services in an emergency department of a hospital?</u> .....** If the answer is 'no,' enter 'N/A' for the following questions and proceed to **Section I**. **Note:** Small group insured plans are required to cover essential health benefits, which include emergency services. **If the answer to ALL of the questions below is "yes" the plan is in compliance with the coverage of emergency services provisions of the rules regarding patient protections.**	☐	☐	
<u>Question 73 – Does the plan provide coverage of emergency services without the need for any prior authorization determination, even if the emergency services are provided on an out-of-network basis?</u>..... ◆ A plan or issuer subject to the requirements of this section must provide coverage for emergency services without the need for any prior authorization determination, even if the emergency services are provided on an out-of-network basis. *See 29 CFR 2590.715-2719A(b)(2)(i).*	☐	☐	
<u>Question 74 – Does the plan provide coverage of emergency services without regard to whether the health care provider furnishing the emergency services is a participating network provider with respect to the services?</u>..... ◆ A plan or issuer subject to the requirements of this section must provide coverage for emergency services without regard to whether the health care provider furnishing the emergency services is a participating network provider with respect to the services. *See 29 CFR 2590.715-2719A(b)(2)(ii).*	☐	☐	
<u>Question 75 – Does the plan provide coverage of emergency services provided out-of-network without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements that apply to emergency services provided in-network?</u> ..... ◆ If the emergency services are provided out-of-network, the plan must provide the emergency services without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements	☐	☐	

	YES	NO	N/A
or limitations that apply to emergency services received from in-network providers. *See 29 CFR 2590.715-2719A(b)(2)(iii).*			
Question 76 – When providing emergency services out-of-network, does the plan impose cost-sharing requirements that comply with the requirements of the interim final regulations? ..... ◆ Any cost-sharing requirement expressed as a copayment amount or coinsurance rate imposed with respect to a participant or beneficiary for out-of-network emergency services cannot exceed the cost-sharing requirement imposed with respect to a participant or beneficiary if the services were provided in-network. However, a participant or beneficiary may be required to pay, in addition to the in-network cost sharing, the excess of the amount the out-of-network provider charges over the amount the plan or issuer is required to pay under this section. *See 29 CFR 2590.715-2719A(b)(3)(i).* ◆ A plan or issuer complies with the requirements if it provides benefits with respect to an emergency service in an amount equal to the greatest of the following three amounts (which are adjusted for in-network cost-sharing requirements): **(A)** The amount negotiated with in-network providers for the emergency service furnished, excluding any in-network copayment or coinsurance imposed. (*See 29 CFR 2590.715-2719A(b)(3)(i)(A)* for more detailed information, including how to determine this amount if there is more than one amount negotiated with in-network providers for the emergency service.) **(B)** The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable amount), excluding any in-network copayment or coinsurance imposed. *See 29 CFR 2590.715-2719A(b)(3)(i)(B).* **(C)** The amount that would be paid under Medicare for the emergency service, excluding any in-network copayment or coinsurance imposed. *See 29 CFR 2590.715-2719A(b)(3)(i)(C).* **Tip:** Any other cost-sharing requirement, such as a deductible or out-of-pocket maximum, may be imposed with respect to out-of-network emergency services only if the cost-sharing requirement generally applies to out-of-network benefits. *See 29 CFR 2590.715-2719A(b)(3)(ii).*	☐	☐	

	YES	NO	N/A
Question 77 – Does the plan provide coverage of emergency services without regard to any other term or condition of the coverage, other than the exclusion or coordination of benefits, a permissible affiliation or waiting period, or applicable cost-sharing requirements? ..... ◆ A plan or issuer subject to the requirements of this section must provide coverage for emergency services without regard to any other term or condition of the coverage, other than the exclusion or coordination of benefits, an affiliation or waiting period permitted under part 7 of ERISA, part A of title XXVII of the PHS Act, or chapter 100 of the Internal Revenue Code, or applicable cost sharing. *See 29 CFR 2590.715-2719A(b)(2)(v).*	☐	☐	
Section I. Determining Compliance with the Affordable Care Act Coverage of Preventive Services Provisions in Part 7 of ERISA ***Note:*** *This provision is applicable for plan years beginning on or after Sept. 23, 2010. This provision does not apply to grandfathered health plans.* Group health plans and health insurance issuers must provide coverage for, and must not impose cost-sharing requirements with respect to, certain recommended preventive services. Nothing prevents plans or issuers from providing coverage for preventive items and services in addition to the recommended preventive services required under these regulations. *See 29 CFR 2590.715-2713(a)(1) & (a)(5).* A complete list of recommendations and guidelines that include services that are required to be covered under these interim final regulations can be found at HealthCare.gov/center/regulations/prevention.html. Any changes to or new recommendations and guidelines will be noted at this site. Plans must cover any new recommended service within one year after the date the recommendation or guidance is issued. Therefore, by visiting the site once per year, plans and issuers will have straightforward access to all the information necessary to determine any additional items and services that must be covered without cost-sharing and any items or services that are no longer required to be covered.			
If the answer to ALL of the questions below is "yes" the plan is in compliance with the rules regarding preventive services. **Question 78 – Does the plan provide coverage without imposing any cost-sharing requirements for evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force? .....** ◆ Plans and issuers must provide coverage for evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force. *See 29 CFR 2590.715-2713(a)(1)(i).*	☐	☐	

	YES	NO	N/A
Note: Recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention issued in or around November 2009 are not considered to be current.			
Question 79 – Does the plan provide coverage without imposing any cost-sharing requirements for immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention?..... ◆ For the purpose of this section, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention. *See 29 CFR 2590.715-2713(a)(1)(ii).*	☐	☐	
Question 80 – With respect to infants, children, and adolescents, does the plan provide coverage without imposing any cost-sharing requirements for evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration?..... ◆ With respect to infants, children, and adolescents, a plan or issuer must provide coverage for evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration. *See 29 CFR 2590.715-2713(a)(1)(iii).*	☐	☐	
Question 81 – With respect to women, does the plan provide coverage without imposing any cost-sharing requirements for evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration? ..... ◆ A complete list of guidelines that are required to be covered can be found at: hrsa.gov/womensguidelines/. (Note: there is a limited exception for certain employers regarding coverage for certain women's preventive services; see dol.gov/ebsa/healthreform for updated guidance). ◆ With respect to women, a plan or issuer must provide coverage for evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration. *See 29 CFR 2590.715-2713(a)(1)(iv).*	☐	☐	

	YES	NO	N/A
Question 82 – Does the plan provide coverage for office visits without imposing cost sharing requirements when recommended preventive services are not billed separately from an office visit and is the primary purpose of the office visit? ..... ◆ If a recommended preventive service or item is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such a service or item, then a plan or issuer may not impose cost-sharing requirements with respect to the office visit. *See 29 CFR 2590.715-2713(a)(2)(ii).* **Tip:** If a recommended preventive service is billed separately from an office visit, or if the recommended preventive service is not billed separately and the primary purpose of the office visit is not delivery of the recommended preventive service, then a plan or issuer may impose cost-sharing with respect to the office visit. *See 29 CFR 2590.715-2713(a)(2)(i) & (iii).* **Additional tips:** ◆ Plans and issuers that have a network of providers are not required to provide coverage for and may impose cost-sharing requirements for recommended preventive services delivered by an out-of-network provider. *See 29 CFR 2590.715-2713(a)(3).* ◆ Plans and issuers may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for the recommended preventive services to the extent these are not specified in the recommendations or guidelines. *See 29 CFR 2590.715-2713(a)(4).* ◆ Plans and issuers can impose cost-sharing for a treatment that is not a recommended preventive service under these regulations, even if the treatment resulted from a recommended preventive service. *See 29 CFR 2590.715-2713(a)(5) and ACA Implementation FAQs Part XII Q5.*	☐	☐	
Section J. Determining Compliance with the Affordable Care Act Provisions Regarding Internal Claims and Appeals and External Review in Part 7 of ERISA *The internal claims and appeals and external review provisions of Part 7 of ERISA **do not apply** to grandfathered health plans.* **Note:** *There have been several phases of guidance issued regarding the internal claims and appeals and external review provisions under the Affordable Care Act. More information about the requirements regarding internal claims and appeals and external review processes under ERISA is available at dol.gov/ebsa.*			

	YES	NO	N/A
1. Internal Claims and Appeals Under the Affordable Care Act group health plans and health insurance issuers offering group health insurance coverage were required to implement an effective internal claims and appeals process for plan years beginning on or after September 23, 2010. In general, the interim final regulations require plans and issuers to comply with the DOL claims procedure rule under 2*9 CFR 2560.503-1* and impose specific additional requirements and include some clarifications (referred to as the "additional standards" for internal claims and appeals). In addition to meeting the following requirements, the plan is required to comply with all of the requirements of the DOL claims procedure rule under *29 CFR 2560.503-1*. **The following questions have been developed to assist in determining compliance with the <u>additional standards</u> for internal claims and appeals processes and is not intended to determine compliance with the DOL claims procedure rule.**			
<u>Question 83 – Does the plan provide internal claims and appeals processes with respect to rescissions of coverage?</u> ..... ◆ Under the DOL claims procedure rule, adverse benefit determinations eligible for internal claims and appeals processes generally include denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit (including a denial, reduction, termination, or failure to make a payment based on the imposition of a preexisting condition exclusion, a source of injury exclusion, or other limitation on covered benefits). *See 29 CFR 2560.503-1(m)(4).* ◆ The Department's regulations broaden the DOL claims procedure rule's definition of "adverse benefit determination" to include rescissions of coverage. Therefore, rescissions of coverage are also eligible for internal claims and appeals processes, whether or not the rescission has an adverse effect on any particular benefit at the time of an appeal. *See 29 CFR 2590.715-2719(a)(2)(i); 29 CFR 2560.503-1.* ◆ This provision is applicable for plan years beginning on or after September 23, 2010. *See 29 CFR 2590.715-2719(g).*	☐	☐	
<u>Question 84 – Does the plan provide claimants with any new or additional evidence or rationale considered in connection with a claim?</u> ..... ◆ The Department's regulations clarify that plans or issuers must provide to claimants, free of charge, any new or additional evidence considered, relied upon, or generated by (or at the direction of) the plan or issuer in connection with a claim. This evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal	☐	☐	

	YES	NO	N/A
adverse benefit determination is required to be provided in order to give the claimant a reasonable opportunity to respond prior to that date. Similarly, before a plan or issuer can issue a final internal adverse benefit determination based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale. This rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided in order to give the claimant a reasonable opportunity to respond prior to that date. *See 29 CFR 2590.715-2719(b)(2)(ii)(C).* ◆ This provision is applicable for plan years beginning on or after September 23, 2010. *See 29 CFR 2590.715-2719(g).*			
Question 85 – Does the plan ensure that claims and appeals are adjudicated in a manner that maintains independence and impartiality of decision making? ..... ◆ The Department's regulations clarify that plans or issuers must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood or perceived likelihood that the individual will support or tend to support a denial of benefits. *See 29 CFR 2590.715-2719(b)(2)(ii)(D).* ◆ This provision is applicable for plan years beginning on or after September 23, 2010. *See 29 CFR 2590.715-2719(g).*	☐	☐	
Question 86 – Complete the following questions to ensure that the plan complies with the additional content requirements for any notice of adverse benefit determination or final internal adverse benefit determination: **86a. Does the plan or issuer ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes information sufficient to identify the claim involved? .....** ◆ The Department's regulations provide that plans and issuers must ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes information sufficient to identify the claim involved including the date of service, the health care provider, and the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code, and its corresponding meaning. *See 29 CFR 2590.715-2719(b)(2)(ii)(E)(1).* This provision is applicable for plan years beginning on or after July 1, 2011. *See T.R. 2011-01 at dol.gov/ebsa/newsroom/tr11-01.html.*	☐	☐	

	YES	NO	N/A
◆ Plans or issuers must also provide to participants and beneficiaries, as soon as practicable, upon request, the diagnosis and treatment codes (and their meanings), associated with any adverse benefit determination or final internal adverse benefit determination. The plan or issuer must not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or external review. *See 29 CFR 2590.715-2719(b)(2)(ii)(E)(1)*, as amended. This provision is applicable for plan years beginning on or after January 1, 2012. *See T.R. 2011-01 at dol.gov/ebsa/newsroom/tr11-01.html.*			
86b. Does the plan or issuer ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes an adequate description of the reasons for the adverse benefit determination or final internal adverse benefit determination? ..... ◆ The Department's regulations provide that plans and issuers must ensure that the reasons for the adverse benefit determination or final internal adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the standard that was used in denying the claim. In the case of a notice of final internal adverse benefit determination, this description must include a discussion of the decision. *See 29 CFR 2590.715-2719(b)(2)(ii)(E)(3).* ◆ This provision is applicable for plan years beginning on or after July 1, 2011. *See T.R. 2011-01 at dol.gov/ebsa/newsroom/tr11-01.html.*	☐	☐	
86c. Does the plan or issuer ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes a description of available internal appeals and external review processes?..... ◆ The Department's regulations provide that plans and issuers must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal. *See 29 CFR 2590.715-2719(b)(2)(ii)(E)(4).* ◆ This provision is applicable for plan years beginning on or after July 1, 2011. *See T.R. 2011-01 at dol.gov/ebsa/newsroom/tr11-01.html.*	☐	☐	
86d. Does the plan or issuer ensure that any notice of adverse benefit determination or final internal adverse benefit determination disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793?..... ◆ The Department's regulations provide that plans and issuers must disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist enrollees with the internal claims and appeals and external review processes. *See 29 CFR 2590.715-2719(b)(2)(ii)(E)(5).*	☐	☐	

	YES	NO	N/A
◆ An updated list of the State Consumer Assistance Programs is available on the Department of Labor Website at dol.gov/ebsa/capupdatelist.doc. ◆ These provisions are applicable for plan years beginning on or after July 1, 2011. *See T.R. 2011-01 at dol.gov/ebsa/newsroom/tr11-01.html.*			
Question 87 – Does the plan defer to the attending provider as to whether a claim involves urgent care and provide notice regarding such urgent care claim as required?..... ◆ As under 29 CFR 2560.503-1(f)(2)(i), plans or issuers must notify a claimant of a benefit determination (whether adverse or not) with respect to a claim involving urgent care as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the receipt of the claim by the plan or issuer. *29 CFR 2590.715-2719(b)(2)(ii)(B), as amended.* ◆ The determination as to whether a claim involves urgent care is determined by the attending provider and the plan or issuer must defer to such determination. *See 29 CFR 2590.715-2719(b)(2)(ii)(B), as amended.* ◆ This provision is applicable for plan years beginning on or after January 1, 2012. *See T.R. 2011-01 at dol.gov/ebsa/newsroom/tr11-01.html.*	☐	☐	
Question 88 – Does the plan comply with the requirements regarding deemed exhaustion of internal claims and appeals processes? ..... ◆ In the case of a plan or issuer that fails to adhere to all the requirements of the Interim Final Rules relating to the Internal Claims and Appeals process with respect to a claim, the claimant is deemed to have exhausted the internal claims and appeals process. The internal claims and appeals process will not be deemed exhausted as long as the violation was: *de minimus*, does not cause, and is not likely to cause, prejudice or harm to the claimant, attributable to good cause or due to matters beyond the control of the plan or issuer, in the context of an ongoing, good faith exchange of information between the plan and the claimant, and is not reflective of a pattern or practice of non-compliance. *See 29 CFR 2590.715-2719(b)(2)(ii)(F), as amended.* ◆ In the event that the claimant requests a written explanation of the violation, the plan or issuer must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. *See 29 CFR 2590.715-2719(b)(2)(ii)(F), as amended.* ◆ In the case that the external review rejects the claimant's immediate review, the plan must provide the claimant notice of the opportunity to resubmit and pursue the internal appeal of the claim. This notice must be sent within a reasonable time after the external reviewer rejects the claim for immediate review, not later than 10 days. *See 29 CFR 2590.715-2719(b)(2)(ii)(F), as amended.*	☐	☐	

	YES	NO	N/A
◆ These provisions are applicable for plan years beginning on or after January 1, 2012. *See T.R. 2011-01 at dol.gov/ebsa/newsroom/tr11-01.html.*			
Question 89 – Does the plan provide culturally and linguistically appropriate notices in a county that meets the applicable threshold?..... ◆ The Department's regulations provide that plans and issuers must provide relevant notices in a culturally and linguistically appropriate manner. ◆ The Department's regulations establish a single threshold with respect to the percentage of people who are literate only in the same non-English language for both the group and individual markets. With respect to plans and issuers, the threshold percentage is set at 10 percent or more of the population residing in the claimant's county, as determined based on American Community Survey (ACS) data published by the United States Census Bureau. The list of counties determined to meet the threshold is available at cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/2013-clas-data.pdf. This list will be updated annually. *See 29 CFR 2590.715-2719(e)(3), as amended.* **If the answer to this question is "Yes," proceed to question 90. If the answer is "No," proceed to the next section.**	☐	☐	
Question 90 – Does the plan provide notices in a culturally and linguistically appropriate manner with respect to internal claims and appeals processes? ◆ To meet this requirement the plan or issuer must: ❖ include a one-sentence statement in the relevant non-English language about the availability of language services on each notice sent to an address in a county that meets the threshold; ❖ provide, upon request, a notice in any applicable non-English language; and ❖ provide a customer assistance process (such as a telephone hotline) with oral language services in the non-English language and provide written notices in the non-English language upon request. *See 29 CFR 2590.715-2719(e), as amended.* ◆ The translated statements are available at *dol.gov/ebsa/IABDModelNotice2.doc.* These provisions are applicable for plan years beginning on or after January 1, 2012. *See T.R. 2011-01 at dol.gov/ebsa/newsroom/tr11-01.html.*	☐	☐	

	YES	NO	N/A
2. External Review *Plans and issuers must comply with either a State external review process or the Federal external review process. The external review provisions of Part 7 of ERISA do not apply to grandfathered health plans.* **The following questions have been developed to assist in determining compliance with the rules regarding the external review processes.**			
Question 91 – Is the plan subject to the requirements of a State external review process or the HHS-Administered Federal External Review Process? ..... ◆ Non-grandfathered, self-insured group health plans subject to ERISA and the Code: ❖ Generally follow requirements of the private accredited IRO process *(established by TR 2010-01, modified by TR 2011-02).* ◆ Non-grandfathered, insured coverage: ❖ Generally, issuers must follow the State process if the external review process meets either the NAIC-Similar or NAIC-Parallel process as determined by HHS. ❖ However, issuers in States without a conforming State process and self-insured non-federal governmental plans may either: – Utilize the private accredited IRO process (established by TR 2010-01, and modified by TR 2011-02); or – Utilize the HHS-Administered Federal External Review Process. **Background information regarding external review processes for insured plans:** ◆ For insured coverage, HHS has determined which State external review processes meet the minimum requirements to apply to issuers in those States. *See cms.gov/CCIIO/Resources/Files/external_appeals.html.* **If you answered "Yes" to Question 91 above, STOP. The plan is not subject to the DOL Private Accredited IRO process. If you answered "No" to Question 91 above, continue to Question 92.**	☐	☐	

	YES	NO	N/A
Question 92 – DOL Private Accredited IRO process: Does the plan provide external review for the required scope of adverse benefit determinations? ..... Under the Department's regulations the scope of the Federal external review process applies to: ◆ An adverse benefit determination, including a final internal adverse benefit determination, by a plan or issuer that involves medical judgment, including but not limited to those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational; and ◆ A rescission of coverage (regardless of whether or not the rescission has any effect on any particular benefit at that time). *See 29 CFR 2590.715-2719(d)(1)(ii), as amended.* ◆ An adverse benefit determination that relates to a participant's or beneficiary's failure to meet the requirements for eligibility under the terms of a group health plan (i.e., worker classification or similar issue) is not within the scope of the Federal external review process. *See 29 CFR 2590.715-2719(d)(1)(i), as amended.*	☐	☐	
Question 93 – DOL Private Accredited IRO process: Does the plan provide an effective external review process? ..... ◆ Self-insured coverage subject to ERISA and the Code may either comply with the standards of the private accredited IRO process or voluntarily comply with a State external review process if the State allows access. ◆ If the plan is complying with the private accredited IRO process, ensure the plan complies with all of the standards articulated in TR 2011-02 including: ❖ Providing effective written notice of external review ❖ Providing limits related to filing fees ❖ Providing claimant at least 4 months to file for external review ❖ Requiring that IROs must be accredited ❖ Requiring that IROs may not have conflicts of interest that influence independence ❖ Providing that IRO decisions are binding on the insurer and the claimant ❖ Requiring IROs to maintain written records for at least three years ◆ Department of Labor clarified in TR 2011-02 that to be eligible for a safe harbor from enforcement from the Department of Labor and the IRS (as previously set forth in sub-regulatory guidance issued in ACA FAQs Part 1 on September 20, 2010), self-insured plans will be required to contract with at least three IROs by July 1, 2012. *See TR 2010-01 at dol.gov/ebsa/pdf/ACATechnicalRelease2010-01.pdf, and TR-2011-02 at dol.gov/ebsa/newsroom/tr11-02.html.*	☐	☐	

Appendix B:
Chart of Required Notices

For group health plans subject to Part 7 of ERISA, required disclosures include:

Type of Disclosure	Applicability	Content Summary	Timing
Notice of special enrollment rights (29 CFR 2590.701-6(c))	All group health plans.	A description of individuals' special enrollment rights.	At or before the time an employee is initially offered the opportunity to enroll in a group health plan.
Wellness program disclosure (§702; 29 CFR 2590.702(f)(2)(v))	For group health plans offering a health contingent wellness program in order to obtain a reward.	◆ The notice must disclose the availability of a reasonable alternative standard (or possibility of waiver of the otherwise applicable standard). ◆ Disclosure must include contact information for obtaining the alternative standard and a statement that recommendations of an individual's personal physician will be accommodated.	◆ In all plan materials that describe the terms of a health contingent wellness program (both activity-only and outcome-based wellness programs). If the plan materials merely mention that a program is available, without describing its terms, this disclosure is not required. ◆ For outcome-based wellness programs, this notice must also be included in any disclosure that an individual did not satisfy an initial outcome-based standard.
Description of rights with respect to hospital stays in connection with childbirth (§711(d); 29 CFR 2520.102-3(u))	Group health plans that provide maternity or newborn infant coverage.	The plan's SPD must include a statement describing any requirements under Federal or State law applicable to the plan, and any health insurance coverage offered under the plan, relating to any hospital length of stay in connection with childbirth for a mother or newborn child. If the Federal law applies in some areas in which the plan operates and State law applies in other areas, the SPD should describe the different areas and the Federal or State requirements applicable in each.	In the SPD (or SMM).

Type of Disclosure	Applicability	Content Summary	Timing
WHCRA enrollment notice (§713(a))	Group health plans that provide coverage for mastectomy benefits.	◆ A statement that for participants and beneficiaries who are receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for: ❖ All stages of reconstruction of the breast on which the mastectomy was performed; ❖ Surgery and reconstruction of the other breast to produce a symmetrical appearance; ❖ Prostheses; and ❖ Treatment of physical complications of the mastectomy, including lymphedema. ◆ A description of any annual deductibles and coinsurance limitations applicable to such coverage.	Upon enrollment in the plan.
WHCRA annual notice (§713(a))	Group health plans that provide coverage for mastectomy benefits.	◆ A copy of the WHCRA enrollment notice, or ◆ A simplified disclosure providing notice of the availability of benefits for the four required coverages and information on how to obtain a detailed description.	Once each year after enrollment in the plan.
Employer Notice regarding Premium Assistance under Medicaid or CHIP (29 CFR 2590.701(f)(3)(B)(i)) * Note, the employer (rather than the group health plan or issuer) is required to provide this notice.	Employers that maintain a group health plan in a state with a CHIP or Medicaid program that provides for premium assistance for group health plan coverage must provide this notice to all employees.	◆ Potential opportunities currently available in the State in which the employee resides for premium assistance under CHIP or Medicaid for health coverage for the employee or the employee's dependents. ◆ Information on how to contact the State in which the employee resides for additional information on premium assistance under these programs. ◆ Description of special enrollment opportunity if eligible for premium assistance under these programs.	May be provided with enrollment packets, open season materials, or the Summary Plan Description.

Type of Disclosure	Applicability	Content Summary	Timing
Michelle's Law Enrollment Notice	All group health plans	Must include a description of the Michelle's law provision for continued coverage during medically necessary leaves of absence.	◆ Notice must be included with any notice regarding a requirement for certification of student status for coverage under the plan. ◆ Note: Under the Affordable Care Act, plans cannot deny or restrict coverage for a child under the age of 26 based on student status.
Mental Health Parity and Addiction Equity Act (MHPAEA) Criteria for Medically Necessary Determination Notice	All group health plans subject to MHPAEA	Notice must provide the criteria for medically necessary determinations with respect to mental health/substance use disorder benefits.	Notice must be provided to any current or potential participant, beneficiary, or contracting provider upon request.
MHPAEA Claims Denial Notice	All group health plans subject to MHPAEA	Notice must provide the reason for any denial of reimbursement or payment for services with respect to mental health/substance use disorder benefits.	Notice must be provided to participants and beneficiaries upon request or as otherwise required by other laws.
MHPAEA Increased Cost Exemption	Group health plans claiming a MHPAEA cost exemption	A group health plan claiming MHPAEA's increased cost exemption must notify plan participants and beneficiaries, the Department of Labor, and the appropriate State agencies of the plan's exemption from the parity requirements.	Notice must be provided if using the cost exemption.
Grandfathered Plan Disclosure/Notice	Group health plans claiming grandfathered status[1]	Notice must disclose that the plan is grandfathered and must include contact information.	Notice must be included in any plan materials describing the benefits or health coverage.

[1] Under the Affordable Care Act, generally, grandfathered plans are plans that were in existence, and in which at least one individual was enrolled, on March 23, 2010. Grandfathered health plans are exempt from many but not all Affordable Care Act market reforms. For further discussion, see the Affordable Care Act section of this publication or visit dol.gov/ebsa.

Type of Disclosure	Applicability	Content Summary	Timing
Summary of Benefits and Coverage (SBC) and Uniform Glossary	All group health plans	◆ A template that describes the benefits and coverage under the plan, and a uniform glossary defining statutorily and NAIC recommended terms. ◆ The SBC must include an internet address where an individual can review the Uniform Glossary as well as contact information for obtaining a paper copy. ◆ The required SBC template is available at dol.gov/ebsa/pdf/correctedsbctemplate2.pdf ◆ The Uniform Glossary is available at dol.gov/ebsa/pdf/SBCUniformGlossary.pdf.	◆ SBC must be provided to participants and beneficiaries with enrollment materials and upon renewal or reissuance of coverage. SBC must also be provided to special enrollees no later than the date by which an SPD is required to be provided (90 days from enrollment). ◆ The SBC and a copy of the Uniform Glossary must also be provided upon request within 7 days.
Summary of Benefits and Coverage: Notice of Modification	All group health plans	If a plan makes a material modification in any of the plan terms that would affect the content of the SBC that is not reflected in the most recently provided SBC, the plan must provide notice of such change. This does not apply to changes that occur in connection with a renewal or reissuance.	Notice must be provided no later than 60 days prior to the date on which the modification will become effective.
Notice Regarding Designation of a Primary Care Provider	All non-grandfathered group health plans[2]	If a plan requires a participant or beneficiary to designate a primary care provider, the plan must provide notice of the terms of the plan or coverage regarding designation of a primary care provider and participants' rights to designate any participating primary care provider who is available to accept the participant; with respect to a child, to designate any participating physician who specializes in pediatrics; and that the plan may not require authorization or referral for OB/GYN care by a participating OB/GYN professional.	Notice must be provided with the Summary Plan Description or any other similar description of benefits.

[2] Under the Affordable Care Act, generally, grandfathered plans are plans that were in existence, and in which at least one individual was enrolled, on March 23, 2010. Grandfathered health plans are exempt from many but not all Affordable Care Act market reforms. For further discussion, see the Affordable Care Act section of this publication or visit dol.gov/ebsa.

Type of Disclosure	Applicability	Content Summary	Timing
Internal Claims and Appeals and External Review Notices	All non-grandfathered group health plans	◆ Internal Claims and Appeals: Plans must provide notice of adverse benefit determination and notice of final internal adverse benefit determination. ◆ External Review: ❖ For plans following the independent review organization (IRO) process, the IRO must issue a notice of final external review decision. ❖ For plans following a State process, the state office administering external appeals process for health insurance companies must issue a notice of final external review decision.	◆ For internal claims and appeals, timing of the notices vary based on the type of claim. ◆ For external review the timing of the notice may vary based on the type of claims and whether the state or the federal process applies.
External Review Process Disclosure	All non-grandfathered group health plans	Plans must provide a description of the external review process in or attached to the Summary Plan Description, policy, certificate, or other evidence of coverage provided to participants, beneficiaries, or enrollees.	The description of external review processes must be provided in the Summary Plan Description or other evidence of coverage provided to enrollees.
Employer Notice to Employees of Coverage Options	All employers subject to the Fair Labor Standards Act	◆ Employers subject to the Fair Labor Standards Act must provide a written notice informing the employee of the existence of the Marketplace, the potential availability of a tax credit and that an employee may lose the employer contribution if the employee purchases a qualified health plan. ◆ Model notices are available at dol.gov/ebsa/healthreform/regulations/coverageoptionsnotice.html	Notice must be provided to all new employees.

Preexisting Condition Exclusion Notices and Certificates of Creditable Coverage

For plan years beginning on or after January 1, 2014, plans are no longer required to issue the general notice of preexisting condition exclusion and individual notice of period of preexisting condition exclusion. Plans are also no longer required to issue certificates of creditable coverage after December 31, 2014. These amendments were made because plans are prohibited from imposing preexisting condition exclusions for plan years beginning on or after January 1, 2014. For more information see 79 Fed. Reg. 10296-317 (Feb. 24, 2014)

Appendix C: Model Notices

Model Special Enrollment Notice

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

> If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within [insert "30 days" or any longer period that applies under the plan] after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).
>
> In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within [insert "30 days" or any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption.
>
> To request special enrollment or obtain more information, contact [insert the name, title, telephone number, and any additional contact information of the appropriate plan representative].

Model Wellness Program Disclosure

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

> Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at [insert contact information] and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Model Newborns' Act Disclosure

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

> Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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

Model WHCRA Enrollment Notice

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

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: [insert deductibles and coinsurance applicable to these benefits]. If you would like more information on WHCRA benefits, call your plan administrator [insert phone number].

Model WHCRA Annual Notice

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

> Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at [insert phone number] for more information.

Date of Notice
Name of Plan **Telephone/Fax**
Address **Website/Email Address**

This document contains important information that you should retain for your records.
This document serves as notice of an adverse benefit determination. We have declined to provide benefits, in whole or in part, for the requested treatment or service described below. If you think this determination was made in error, you have the right to appeal (see the back of this page for information about your appeal rights).

Case Details:

Patient Name:	**ID Number:**
Address: (street, county, state, zip)	
Claim #:	**Date of Service:**
Provider:	

Reason for Denial (in whole or in part):

Amt. Charged	**Allowed Amt.**	**Other Insurance**	**Deductible**	**Co-pay**	**Coinsurance**	**Other Amts. Not Covered**	**Amt. Paid**

YTD Credit toward Deductible:	**YTD Credit toward Out-of-Pocket Maximum:**
Description of service:	**Denial Codes:**

[If denial is not related to a specific claim, only name and ID number need to be included in the box. The reason for the denial would need to be clear in the narrative below.]

Explanation of Basis for Determination:
If the claim is denied (in whole or in part) and there is more explanation for the basis of the denial, such as the definition of a plan or policy term, include that information here.

[Insert language assistance disclosure here, if applicable.
SPANISH (Español): Para obtener asistencia en Español, llame al [insert telephone number].
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].
CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 [insert telephone number]。
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number]. **]**

OMB Control Number 1210-0144 (expires 07/31/2015)

Important Information about Your Appeal Rights

What if I need help understanding this denial? Contact us at [insert contact information] if you need assistance understanding this notice or our decision to deny you a service or coverage.

What if I don't agree with this decision? You have a right to appeal any decision not to provide or pay for an item or service (in whole or in part).

How do I file an appeal? [Complete the bottom of this page, make a copy, and send this document to {insert address}.] [or] [insert alternative instructions] See also the "Other resources to help you" section of this form for assistance filing a request for an appeal.

What if my situation is urgent? If your situation meets the definition of urgent under the law, your review will generally be conducted within 72 hours. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal by following the instructions above for filing an internal appeal and also [insert instructions for filing request for simultaneous external review)].

Who may file an appeal? You or someone you name to act for you (your authorized representative) may file an appeal. [Insert information on how to designate an authorized representative.]

Can I provide additional information about my claim? Yes, you may supply additional information. [Insert any applicable procedures for submission of additional information.]

Can I request copies of information relevant to my claim? Yes, you may request copies (free of charge). If you think a coding error may have caused this claim to be denied, you have the right to have billing and diagnosis codes sent to you, as well. You can request copies of this information by contacting us at [insert contact information].

What happens next? If you appeal, we will review our decision and provide you with a written determination. If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

Other resources to help you: For questions about your rights, this notice, or for assistance, you can contact: [if coverage is group health plan coverage, insert: the Employee Benefits Security Administration at 1-866-444-EBSA (3272)] [and/or] [if coverage is insured, insert State Department of Insurance contact information]. [Insert, if applicable in your state: Additionally, a consumer assistance program can help you file your appeal. Contact [insert contact information].]

Appeal Filing Form

NAME OF PERSON FILING APPEAL: _____
Circle one: Covered person Patient Authorized Representative
Contact information of person filing appeal (if different from patient)
Address:_____**Daytime phone:**_____**Email:**_____

If person filing appeal is other than patient, patient must indicate authorization by signing here:
_____

Are you requesting an urgent appeal? Yes No

Briefly describe why you disagree with this decision (you may attach additional information, such as a physician's letter, bills, medical records, or other documents to support your claim)**:**
_____
_____

Send this form and your denial notice to: [Insert name and contact information]
Be certain to keep copies of this form, your denial notice, and all documents and correspondence related to this claim.

Date of Notice
Name of Plan **Telephone/Fax**
Address **Website/Email Address**

This document contains important information that you should retain for your records.
This document serves as notice of a final internal adverse benefit determination. We have declined to provide benefits, in whole or in part, for the requested treatment or service described below. If you think this determination was made in error, you may have the right to appeal (see the back of this page for information about your appeal rights).

Internal Appeal Case Details:

Patient Name:			**ID Number:**				
Address: (street, county, state, zip)							
Claim #:			**Date of Service:**				
Provider:							
Reason for Upholding Denial (in whole or in part):							
Amt. Charged	**Allowed Amt.**	**Other Insurance**	**Deductible**	**Co-pay**	**Coinsurance**	**Other Amts. Not Covered**	**Amt. Paid**
YTD Credit toward Deductible:			**YTD Credit toward Out-of-Pocket Maximum:**				
Description of Service:			**Denial Codes:**				

[If denial is not related to a specific claim, only name and ID number need to be included in the box. The reason for the denial would need to be clear in the narrative below.]

Background Information: *Describe facts of the case including type of appeal and date appeal filed.*

Final Internal Adverse Benefit Determination: *State that adverse benefit determination has been upheld. List all documents and statements that were reviewed to make this final internal adverse benefit determination*.

Findings: *Discuss the reason or reasons for the final internal adverse benefit determination*.

[Insert language assistance disclosure here, if applicable.
SPANISH (Español): Para obtener asistencia en Español, llame al [insert telephone number].
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].
CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 [insert telephone number]。
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number]. **]**

Important Information about Your Rights to External Review

What if I need help understanding this denial? Contact us [insert contact information] if you need assistance understanding this notice or our decision to deny you a service or coverage.

What if I don't agree with this decision? For certain types of claims, you are entitled to request an independent, external review of our decision. Contact [insert external review contact information] with any questions on your rights to external review. [For insured coverage, insert: If your claim is not eligible for independent external review but you still disagree with the denial, your state insurance regulator may be able to help to resolve the dispute.] See the "Other resources section" of this form for help filing a request for external review.

How do I file a request for external review? Complete the bottom of this page, make a copy, and send this document to {insert address}.] [or] [insert alternative instructions.] See also the "Other resources to help you" section of this form for assistance filing a request for external review.

What if my situation is urgent? If your situation meets the definition of urgent under the law, the external review of your claim will be conducted as expeditiously as possible. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. If you believe your situation is urgent, you may request an expedited external review by [insert instructions to begin the process (such as by phone, fax, electronic submission, etc.)].

Who may file a request for external review? You or someone you name to act for you (your authorized representative) may file a request for external review. [Insert information on how to designate an authorized representative.]

Can I provide additional information about my claim? Yes, once your external review is initiated, you will receive instructions on how to supply additional information.

Can I request copies of information relevant to my claim? Yes, you may request copies (free of charge) by contacting us at [insert contact information].

What happens next? If you request an external review, an independent organization will review our decision and provide you with a written determination. If this organization decides to overturn our decision, we will provide coverage or payment for your health care item or service.

Other resources to help you: For questions about your rights, this notice, or for assistance, you can contact: [if coverage is group health plan coverage, insert: the Employee Benefits Security Administration at 1-866-444-EBSA (3272)] [and/or] [if coverage is insured, insert State Department of Insurance contact information]. [Insert, if applicable in your state: Additionally, a consumer assistance program can help you file your appeal. Contact:[insert contact information].]

NAME OF PERSON FILING REQUEST FOR EXTERNAL REVIEW: _____

Circle one: Covered person Patient Authorized Representative

Contact information of person filing request for external review (if different from patient)

Address:_____ **Daytime phone:**_____ **Email:**_____

If person filing request for external review is other than patient, patient must indicate authorization by signing here:_____

Are you requesting an urgent review? Yes No

Briefly describe why you disagree with this decision (you may attach additional information, such as a physician's letter, bills, medical records, or other documents to support your claim)**:**

_____

_____

Send this form and your denial notice to: [Insert name and contact information]

Be certain to keep copies of this form, your denial notice, and all documents and correspondence related to this claim.

Model Notice of Final External Review Decision – Revised July 3, 2014

Date of Notice

Name of Plan **Telephone/Fax**

Address **Website/Email Address**

<u>This document contains important information that you should retain for your records.</u>

This document serves as notice of a final external review decision. We have **[upheld/overturned/modified]** the denial of your request for the provision of, or payment for, a health care service or course of treatment.

<u>Historical Case Details:</u>

Patient Name:			**ID Number:**				
Address: (street, county, state, zip)							
Claim #:			**Date of Service:**				
Provider:							
Reason for Denial (in whole or in part):							
Amt. Charged	**Allowed Amt.**	**Other Insurance**	**Deductible**	**Co-pay**	**Coinsurance**	**Other Amts. Not Covered**	**Amt. Paid**
YTD Credit toward Deductible:			**YTD Credit toward Out-of-Pocket Maximum:**				
Description of Service:			**Denial Codes:**				

[If denial is not related to a specific claim, only name and ID number need to be included in the box. The reason for the denial would need to be clear in the narrative below.]

Background Information: *Describe facts of the case including type of appeal, date appeal filed, date appeal was received by IRO and date IRO decision was made.*

Final External Review Decision: *State decision. List all documents and statements that were reviewed to make this final external review decision.*

Findings: *Discuss the principal reason or reasons for IRO decision, including the rationale and any evidence-based standards or coverage provisions that were relied on in making this decision.*

Model Notice of Final External Review Decision – Revised July 3, 2014

Important Information about Your Appeal Rights

What if I need help understanding this decision?
Contact us [insert IRO contact information] if you need assistance understanding this notice.

What happens now? If we have overturned the denial, your plan or health insurance issuer will now provide service or payment.

If we have upheld the denial, there is no further review available under the appeals process. However, you may have other remedies available under State or Federal law, such as filing a lawsuit.

Other resources to help you: For questions about your appeal rights, this notice, or for assistance, you can contact [if coverage is group health plan coverage, insert: the Employee Benefits Security Administration at 1-866-444-EBSA (3272)] [and/or] [if coverage is insured, insert State Department of Insurance contact information]. [Insert, if applicable in your state: Additionally, you can contact your consumer assistance program at [insert contact information].]

Model Notice for Grandfathered Health Plans

To maintain status as a grandfathered health plan, a plan or health insurance coverage must include a statement, in any plan materials provided to a participant or beneficiary describing the benefits provided under the plan or health insurance coverage, that the plan or coverage believes it is a grandfathered health plan within the meaning of section 1251 of the Patient Protection and Affordable Care Act and must provide contact information for questions and complaints.

The following model language can be used to satisfy this disclosure requirement:

> This [group health plan or health insurance issuer] believes this [plan or coverage] is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.
>
> Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information]. [For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or dol.gov/ebsa/healthreform. This Website has a table summarizing which protections do and do not apply to grandfathered health plans.] [For individual market policies and nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at healthreform.gov.]

Patient Protection Model Disclosure

When applicable, it is important that individuals enrolled in a plan or health insurance coverage know of their rights to (1) choose a primary care provider or a pediatrician when a plan or issuer requires designation of a primary care physician; or (2) obtain obstetrical or gynecological care without prior authorization. Accordingly, the interim final regulations regarding patient protections under section 2719A of the Affordable Care Act require plans and issuers to provide notice to participants of these rights when applicable. The notice must be provided whenever the plan or issuer provides a participant with a Summary Plan Description or other similar description of benefits under the plan or health insurance coverage. This notice must be provided no later than the first day of the first plan year beginning on or after September 23, 2010.

The following model language can be used to satisfy the notice requirement:

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries, insert:

> [Name of group health plan or health insurance issuer] generally [requires/allows] the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. [If the plan or health insurance coverage designates a primary care provider automatically, insert: Until you make this designation, [name of group health plan or health insurance issuer] designates one for you.] For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the [plan administrator or issuer] at [insert contact information].

For plans and issuers that require or allow for the designation of a primary care provider for a child, add:

For children, you may designate a pediatrician as the primary care provider.

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add:

> You do not need prior authorization from [name of group health plan or issuer] or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the [plan administrator or issuer] at [insert contact information].

September 2014