

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
<p>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.</p> <p>HIPAA’s portability provisions affect group health plan coverage in the following ways:</p> <ul style="list-style-type: none"> • 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) (<i>see Section A</i>), and • Prohibit discrimination in group health plan eligibility, benefits, and premiums based on specific health factors (<i>see Sections B-C</i>). 			

	YES	NO	N/A
<p>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. <i>See 29 CFR 2590.701-3, 5; 29 CFR 2590.715-2704 (a).</i></p>			
<p><u>SECTION A – Compliance with the Special Enrollment Provisions</u> Group health plans must allow individuals (who are otherwise eligible) to enroll upon certain specified events, regardless of any late enrollment provisions, if enrollment is requested within 30 days (or 60 days in the case of the special enrollment rights added by the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA), discussed in Question 3) of the event. The plan must provide for special enrollment, as follows:</p>			
<p><u>Question 1 – Special enrollment upon loss of other coverage</u> Does the plan provide full special enrollment rights upon loss of other coverage?</p> <ul style="list-style-type: none"> • A plan must permit loss-of-coverage special enrollment upon: (1) loss of eligibility for group health plan coverage or health insurance coverage; and (2) termination of employer contributions toward group health plan coverage. <i>See ERISA section 701(f)(1); 29 CFR 2590.701-6(a).</i> • <u>When a current employee loses eligibility for coverage</u>, the plan must permit the employee and any dependents to special enroll. <i>See 29 CFR 2590.701-6(a)(2)(i).</i> • <u>When a dependent of a current employee loses eligibility for coverage</u>, the plan must permit the dependent and the employee to special enroll. <i>See 29 CFR 2590.701-6(a)(2)(ii).</i> <p>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. <i>See 29 CFR 2590.701-6(a)(3)(i).</i></p> <ul style="list-style-type: none"> • When employer contributions toward an employee’s or dependent’s coverage • terminates, the plan must permit special enrollment, even if the employee or 	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<ul style="list-style-type: none"> dependent did not lose eligibility for coverage. <i>See 29 CFR 2590.701-6(a)(3)(ii).</i> Plans must allow an employee a period of at least 30 days to request enrollment. <i>See 29 CFR 2590.701-6(a)(4)(i).</i> Coverage must become effective no later than the first day of the first month following a completed request for enrollment. <i>See 29 CFR 2590.701-6(a)(4)(ii).</i> <p>Tip: Ensure that the plan permits special enrollment upon <u>all</u> of the loss of coverage events described above.</p>			
<p><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?</p> <ul style="list-style-type: none"> Plans must generally permit current employees to enroll upon marriage and upon birth, adoption, or placement for adoption of a dependent child. <i>See ERISA section 701(f)(2); 29 CFR 2590.701-6(b)(2).</i> Plans must generally permit a participant’s spouse and new dependents to enroll upon marriage, birth, adoption, and placement for adoption. <i>See ERISA section 701(f)(2); 29 CFR 2590.701-6(b)(2).</i> Plans must allow an individual a period of at least 30 days to request enrollment. <i>See 29 CFR 2590.701-6(b)(3)(i).</i> In the case of marriage, coverage must become effective no later than the first day of the month following a completed request for enrollment. <i>See 29 CFR 2590.701-6(b)(3)(iii)(A).</i> In the case of birth, adoption, or placement for adoption, coverage must become effective as of the date of the birth, adoption, or placement for adoption. <i>See 29 CFR 2590.701-6(b)(3)(iii)(B).</i> <p>Tips: Remember to allow all eligible employees, spouses, and new dependents to enroll upon these events. Also, ensure that the effective date of coverage complies with HIPAA, keeping in mind that some effective dates of coverage are retroactive.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 3 – Special enrollment rights provided through CHIPRA</u> Does the plan provide full special enrollment rights as required under CHIPRA?</p> <p>Under the following conditions a group health plan must allow an employee or dependent (who is otherwise eligible) to enroll, regardless of any late enrollment provisions, if enrollment is requested within 60 days:</p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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). <p>Note: In addition, <u>employers</u> that maintain a group health plan in a state with a CHIP or Medicaid program that provides for premium assistance for group health plan coverage must provide a 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.</p>			
<p><u>Question 4 – Treatment of special enrollees</u> Does the plan treat special enrollees the same as individuals who enroll when first eligible, for purposes of eligibility for benefit packages and premiums?</p> <ul style="list-style-type: none"> 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). 	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 5 – Notice of special enrollment rights</u> Does the plan provide timely and adequate notices of special enrollment rights?</p> <ul style="list-style-type: none"> 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. 	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p>Tip: Ensure that the special enrollment notice is provided at or before the time an employee is initially offered the opportunity to enroll in the plan. This may mean breaking it off from the SPD. The plan can include its special enrollment notice in the SPD if the SPD is provided at or before the initial enrollment opportunity (for example, as part of the application materials). If not, the special enrollment notice must be provided separately to be timely. A model notice is provided in the Model Disclosures on page 138.</p>			
<p><u>SECTION B – Compliance with the HIPAA Nondiscrimination Provisions</u></p> <p><u>Overview.</u> HIPAA prohibits group health plans and health insurance issuers from discriminating against individuals in eligibility and continued eligibility for benefits and in individual premium or contribution rates based on health factors. These health factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities), and disability. <i>See ERISA section 702; 29 CFR 2590.702.</i></p> <p><u>Similarly Situated Individuals.</u> It is important to recognize that the nondiscrimination rules prohibit discrimination within a group of similarly situated individuals. Under 29 CFR 2590.702(d), plans may treat distinct groups of similarly situated individuals differently, if the distinctions between or among the groups are not based on a health factor. If distinguishing among groups of participants, plans and issuers must base distinctions on bona fide employment-based classifications consistent with the employer’s usual business practice. Whether an employment-based classification is bona fide is based on relevant facts and circumstances, such as whether the employer uses the classification for purposes independent of qualification for health coverage. Bona fide employment-based classifications might include: full-time versus part-time employee status; different geographic location; membership in a collective bargaining unit; date of hire or length of service; or differing occupations. In addition, plans may treat participants and beneficiaries as two separate groups of similarly situated individuals. Plans may also distinguish among beneficiaries. Distinctions among groups of beneficiaries may be based on bona fide employment-based classifications of the participant through whom the beneficiary is receiving coverage, relationship to the participant (such as spouse or dependent), marital status, age of dependent children, or any other factor that is not a health factor. However, see section 2714 of the PHS Act, as amended by the 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).</p> <p>Exception for benign discrimination: The nondiscrimination rules do not prohibit a plan from establishing more favorable rules for eligibility or premium rates for individuals with an adverse health factor, such as a disability. <i>See 29 CFR 2590.702(g).</i></p>			

	YES	NO	N/A
Check to see that the plan complies with HIPAA’s nondiscrimination provisions as follows:			
<p><u>Question 6 – Nondiscrimination in eligibility</u> Does the plan allow individuals eligibility and continued eligibility under the plan regardless of any adverse health factor?</p> <ul style="list-style-type: none"> • Examples of plan provisions that violate ERISA section 702(a) because they discriminate in eligibility based on a health factor include: <ul style="list-style-type: none"> ○ Plan provisions that require “evidence of insurability,” such as passing a physical exam, providing a certification of good health, or demonstrating good health through answers to a health care questionnaire in order to enroll. <i>See 29 CFR 2590.702(b)(1).</i> • Also, note that it may be permissible for plans to require individuals to complete physical exams or health care questionnaires for purposes other than for determining eligibility to enroll in the plan, such as for determining an appropriate blended, aggregate group rate for providing coverage to the plan as a whole. <i>See 29 CFR 2590.702(b)(1)(iii) Example 1.</i> <p>Tip: Eliminate plan provisions that deny individuals eligibility or continued eligibility under the plan based on a health factor, even if such provisions apply only to late enrollees.</p>	<input type="checkbox"/>	<input type="checkbox"/>	

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).			
<p><u>Question 8 – Source-of-injury restrictions</u> If the plan imposes a source-of-injury restriction, does it comply with the HIPAA nondiscrimination provisions?</p> <ul style="list-style-type: none"> • Plans may exclude benefits for the treatment of certain injuries based on the source of that injury, except that plans may not exclude benefits otherwise provided for treatment of an injury if the injury results from an act of domestic violence or a medical condition. <i>See 29 CFR 2590.702(b)(2)(iii)</i>. An example of a permissible source-of-injury exclusion would include: <ul style="list-style-type: none"> ○ A plan provision that provides benefits for head injuries generally, but excludes benefits for head injuries sustained while participating in bungee jumping. • An impermissible source-of-injury exclusion would include: <ul style="list-style-type: none"> ○ A plan provision that generally provides coverage for medical/surgical benefits, including hospital stays that are medically necessary, but excludes benefits for self-inflicted injuries or attempted suicide. This is impermissible because the plan provision excludes benefits for treatment of injuries that may result from a medical condition (depression). • If the plan does not impose a source-of-injury restriction, check “N/A” and skip to Question 9. 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.			
<p><u>Question 10 – List billing</u> Is there compliance with the list billing provisions?</p> <ul style="list-style-type: none"> Under 29 CFR 2590.702(c)(2)(ii), plans and issuers may not charge or quote an employer a different premium for an individual in a group of similarly situated individuals based on a health factor. This practice is commonly referred to as list billing. If an issuer is list billing an employer and the plan is passing the separate and different rates on to the individual participants and beneficiaries, both the plan and the issuer are violating the prohibition against discrimination in premium rates. This does not prevent plans and issuers from taking the health factors of each individual into account in establishing a blended/aggregate rate for providing coverage to the plan. <p>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.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 11 – Nonconfinement clauses</u> Is the plan free of any nonconfinement clauses?</p> <ul style="list-style-type: none"> 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) explains that these nonconfinement clauses violate ERISA sections 702(a) (if the clause delays or denies eligibility) and 702(b) (if the clause raises individual premiums). <p>Tip: Delete all nonconfinement clauses.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 12 – Actively-at-work clauses</u> Is the plan free of any impermissible actively-at-work clauses?.....</p> <ul style="list-style-type: none"> 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. 	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p>Nonetheless, an exception provides that a plan may establish a rule for eligibility that requires an individual to begin work for the employer sponsoring the plan before eligibility commences. Further, plans may establish rules for eligibility or set any individual’s premium or contribution rate in accordance with the rules relating to similarly situated individuals in 29 CFR 2590.702(d). For example, a plan that treats full-time and part-time employees differently for other employment-based purposes, such as eligibility for other employee benefits, may distinguish in rules for eligibility under the plan between full-time and part-time employees.</p> <p>Tip: Carefully examine any actively-at-work provision to ensure consistency with HIPAA.</p>			
<p><u>SECTION C – Compliance with the Wellness Program Provisions</u> Use the following questions to help determine whether the plan offers a program of health promotion or disease prevention that is required to comply with the Department’s final wellness program regulations and, if so, whether the program is in compliance with the regulations. <i>See final regulations issued by the Departments on June 6, 2013 at 29 CFR 2590.702 and 29 CFR 2590.715-2705.</i> 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 (<i>See further discussion of grandfather status under the ACA section VII, A of this tool.</i>)</p>			
<p><u>Question 13 – Does the plan have a wellness program?</u></p> <ul style="list-style-type: none"> A wide range of wellness programs exist to promote health and prevent disease. However, these programs are not always labeled “wellness programs.” Examples include: a program that reduces individuals’ cost-sharing for complying with a preventive care plan; a diagnostic testing program for health problems; and rewards for attending educational classes, following healthy lifestyle recommendations, or meeting certain biometric targets (such as weight, cholesterol, nicotine use, or blood pressure targets). <p>Tip: Ignore the labels – wellness programs can be called many things. Other common names include: disease management programs, smoking cessation programs, and case management programs.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 14 – Is the wellness program part of a group health plan?</u></p> <ul style="list-style-type: none"> 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. 	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p>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 <i>see 29 CFR 2590.702</i>, which clarifies that compliance with the HIPAA nondiscrimination rules, including the wellness program rules, is not determinative of compliance with any other provision of ERISA or any other State or Federal law, such as the Americans with Disabilities Act.)</p>			
<p><u>Question 15 – Does the program discriminate based on a health factor (i.e., is it a health-contingent program)?</u>.....</p> <ul style="list-style-type: none"> 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. <i>See 29 CFR 2590.702 (f)(1)(ii)</i>. <p>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.</p> <p>Example 2: A plan requires all eligible employees to complete a health risk assessment to enroll in the plan. Employee answers are fed into a computer that identifies risk factors and sends educational information to the employee’s home address. In this Example 2, the requirement to complete the assessment does not, itself, discriminate based on a health factor. However, if the plan used individuals’ specific health information to discriminate in individual eligibility, benefits, or premiums, there would be discrimination based on a health factor.</p> <p>Tip: Participatory wellness programs are permissible, provided the program is made available to all similarly situated individuals, regardless of health status.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>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.</p>			

	YES	NO	N/A
<p><u>Question 16 – If the program discriminates based on a health factor, is the program saved by the benign discrimination provisions?</u></p> <ul style="list-style-type: none"> The Department’s regulations at 29 CFR 2590.702(g) permit discrimination <i>in favor</i> of an individual based on a health factor. <p>Example: A plan grants participants who have diabetes a waiver of the plan’s annual deductible if they enroll in a disease management program that consists of attending educational classes and following their doctor’s recommendations regarding exercise and medication. <i>This is benign discrimination because the program is offering a reward to individuals based on an adverse health factor.</i></p> <p>Tip: The benign discrimination exception is NOT available if the plan asks diabetics to meet a standard related to a health factor (such as maintaining a certain body mass index (BMI)) in order to get a reward. In this case, an intervening discrimination is introduced and the plan cannot rely solely on the benign discrimination exception.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>If you answered “Yes” to 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.</p> <p>If you answered “No” to this question, proceed to Questions 17 and 18. The health-contingent wellness program must meet the 5 criteria.</p>			
<p><u>Question 17— Within the health-contingent wellness program category, is the program an activity-only program?.....</u></p> <ul style="list-style-type: none"> 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. <i>See 29 CFR 2590.702 (f)(1)(iv).</i> <ul style="list-style-type: none"> Examples include walking, diet or exercise programs. 	<input type="checkbox"/>	<input type="checkbox"/>	
<p>If you answered “Yes” to this question, proceed to Question 19.</p> <p>If you answered “No” to this question, proceed to Question 18.</p>			
<p><u>Question 18— Within the health-contingent wellness program category, is the program an outcome-based program?.....</u></p> <ul style="list-style-type: none"> 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. <i>See 29 CFR 2590.702 (f)(1)(iv).</i> 	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p>The following sample language can be used to satisfy this requirement: “If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call us at [insert telephone number] and we will work with you to develop another way to qualify for the reward.”</p> <p>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.</p>			
<p>Taking into consideration whether the health-contingent wellness program is activity-only or outcome-based:</p> <p>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.</p> <p>If you answered “No” to any of the 5 questions on wellness program criteria, the plan has a wellness program compliance issue. Specifically,</p> <p>Violation of the general benefit discrimination rule (29 CFR 2590.702(b)(2)(i), 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).</p> <p>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).</p>			

	YES	NO	N/A
<p><u>SECTION D – Compliance with the MEWA or Multiemployer Plan</u> <u>Guaranteed Renewability Provisions</u> If the plan is a multiple employer welfare arrangement (MEWA) or a multiemployer plan, it is required to provide guaranteed renewability of coverage in accordance with ERISA section 703. If the plan is a MEWA or multiemployer plan, it must 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.</p>			<input type="checkbox"/>
<p>Question 20 – Multiemployer plan and MEWA guaranteed renewability If the plan is a multiemployer plan, or a MEWA, does the plan provide guaranteed renewability?</p> <ul style="list-style-type: none"> • Group health plans that are multiemployer plans or MEWAs may not deny an employer continued access to the same or different coverage, other than: <ul style="list-style-type: none"> ○ For nonpayment of contributions; ○ For fraud or other intentional misrepresentation by the employer; ○ For noncompliance with material plan provisions; ○ Because the plan is ceasing to offer coverage in a geographic area; ○ In the case of a plan that offers benefits through a network plan, there is no longer any individual enrolled through the employer who lives, resides, or works in the service area of the network plan and the plan applies this paragraph uniformly without regard to the claims experience of employers or any health-related factor in relation to such individuals or dependents; or ○ For failure to meet the terms of an applicable collective bargaining agreement, to renew a collective bargaining or other agreement requiring or authorizing contributions to the plan, or to employ employees covered by such agreement. <p><i>See ERISA section 703.</i></p> <p>**Note: The Public Health Service (PHS) Act contains guaranteed renewability requirements for issuers.</p>	<input type="checkbox"/>	<input type="checkbox"/>	

**II. Determining Compliance with the Mental Health Parity Act (MHPA) and
Mental Health Parity and Addiction Equity Act (MHPAEA) Provisions in Part 7 of ERISA
(together, the mental health parity provisions)**

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

	YES	NO	N/A
<p><u>Introduction</u></p> <p>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. <i>See 29 CFR 2590.732</i> 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. <i>See 29 CFR 2590.712(e)</i>.) If this is the case, answer Questions 21-28.</p> <p>If the plan does not provide mental health or substance use disorder benefits, check “N/A” here and skip to Part III of this checklist. Also, the plan may be exempt from the mental health parity provisions under the small employer (50 employees or fewer) exception or the increased cost exception. (To be eligible for the increased cost exception, the plan must have filed a notice with EBSA and notified participants and beneficiaries.) Unless a plan is exempt as previously described, the requirements of MHPAEA generally apply to both grandfathered and non-grandfathered group health plans¹³, 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.</p> <p>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</p>			

¹³Mental health and substance use disorder benefits are defined under the terms of the plan, in accordance with applicable Federal and State law. Any condition or disorder defined by the plan as being or as not being a mental health condition or substance use disorder must be defined in a manner consistent with generally recognized independent standards of current medical practice (e.g., the most current version of the DSM or ICD or State guidelines).

	YES	NO	N/A
<p>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</p> <p>If the plan is exempt, check “N/A” here and skip to Part III of this checklist.</p>			<input type="checkbox"/>
<p>SECTION A. Lifetime and Annual Limits</p> <p><u>Question 21 – Does the plan comply with the mental health parity requirements regarding lifetime dollar limits on mental health/substance use disorder benefits?</u></p> <ul style="list-style-type: none"> 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. <i>See 29 CFR 2590.712(b)</i>. (Only limits on what the plan would pay are taken into account, as contrasted with limits on what an individual may be charged.) <p>Note: These provisions are affected by section 2711 of the Public Health Service Act, as amended by the Patient Protection and Affordable Care Act. Specifically, PHS Act section 2711 generally prohibits lifetime 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).</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 22 – Does the plan comply with the mental health parity requirements regarding annual dollar limits on mental health/substance use disorder benefits?</u></p> <ul style="list-style-type: none"> 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. <i>See 29 CFR 2590.712(b)</i>. (Again, only limits on what the plan would pay are taken into account, as contrasted with limits on what an individual may be charged.) <p>Tip: There is a different rule for cumulative limits other than aggregate lifetime or annual dollar limits discussed later in this checklist at Question 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.</p>	<input type="checkbox"/>	<input type="checkbox"/>	

¹⁴See 29 CFR 2590.712(e)(3)(i)

	YES	NO	N/A
<p>Note: These provisions are affected by section 2711 of the Public Health Service Act, as amended by the Patient Protection and Affordable Care Act. Specifically, PHS Act section 2711 generally prohibits annual dollar limits on essential health benefits, which includes mental health and substance use disorder services. 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. <i>See ACA Implementation FAQ Part XXI at dol.gov/ebsa/faqs/faq-aca21.html.</i></p> <p>(For information regarding the Affordable Care Act, please visit our Website at dol.gov/ebsa/healthreform).</p>			
<p>SECTION B. Financial Requirements and Quantitative Treatment Limitations</p> <p><u>Question 23 – Does the plan comply with the mental health parity requirements for parity in financial requirements and quantitative treatment limitations?</u></p> <ul style="list-style-type: none"> • 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. <i>See 29 CFR 2590.712(c)(2).</i> <ul style="list-style-type: none"> ○ Types of financial requirements include deductibles, copayments, coinsurance, and out-of-pocket maximums. <i>See 29 CFR 2590.712(c)(1)(ii).</i> ○ Types of quantitative treatment limitations include annual, episode, and lifetime day and visit limits, for example, number of treatments, visits, or days of coverage. <i>See 29 CFR 2590.712(c)(1)(ii).</i> • The six classifications* of benefits are: <ol style="list-style-type: none"> 1) inpatient, in-network; 2) inpatient, out-of-network; 3) outpatient, in-network; 4) outpatient, out-of-network; 5) emergency care; and 6) prescription drugs. <i>See 29 CFR 2590.712(c)(2)(ii).</i> • Under the plan, any financial requirement or quantitative treatment limitation that applies to mental health/substance use disorder benefits within a particular classification cannot be more restrictive than the predominant requirement or limitation that applies to substantially all medical/surgical benefits within the same classification. <i>See 29 CFR 2590.712(c)(2).</i> 	<input type="checkbox"/>	<input type="checkbox"/>	

*See page 81 for special rules related to classifications.

	YES	NO	N/A
<p><u>Detailed steps for applying these rules are set forth below:</u></p> <ul style="list-style-type: none"> To determine compliance, each type of financial requirement or quantitative treatment limitation within a coverage unit¹⁵ must be analyzed separately within each classification. <i>See 29 CFR 2590.712(c)(2)(i)</i>. If a plan applies different levels of a financial requirement or 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. <i>See 29 CFR 2590.712(c)(3)(ii)</i>. <u>Step One:</u> 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. <ul style="list-style-type: none"> 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. <i>See 29 CFR 2590.712(c)(3)(i)(A)</i>. This two-thirds calculation is generally based on the dollar amount of plan payments expected to be paid for the plan year. <i>See 29 CFR 2590.712(c)(3)(i)(C)</i>. (Any reasonable method can be used for this calculation. <i>See 29 CFR 2590.712(c)(3)(i)(E)</i>.) <u>Step Two:</u> If the type of financial requirement or quantitative treatment limitation applies to at least two-thirds of medical/surgical benefits in that classification, then determine the predominant level of that type of financial requirement or quantitative treatment limitation that applies to medical/ surgical benefits subject to that type of financial requirement or quantitative treatment limitation in that classification of benefits. (Note: If the type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of medical/surgical benefits in that classification, it cannot apply to mental health/substance use disorder benefits in that classification.) ▼ Generally, the predominant level will apply to more than one-half of the medical/surgical benefits in that classification subject to the financial requirement or quantitative treatment limitation. <i>See 29 CFR 2590.712(c)(3)(i)(B)(1)</i>. If there is no single level that applies to more than one-half of medical/surgical benefits in the classification, the plan can combine levels until the combination of levels applies to more than one-half of medical/surgical benefits subject to the financial requirement or quantitative treatment limitation in the classification. The least restrictive level within the combination is considered the predominant level.¹⁶ <i>See 29 CFR 2590.712(c)(3)(i)(B)(2)</i>. 			

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
<p><u>*Note: Special rules related to classifications</u></p> <p>1. Special rule for outpatient sub-classifications:</p> <ul style="list-style-type: none"> • 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.) <p>2. Special rule for prescription drug benefits:</p> <ul style="list-style-type: none"> • 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). <p>3. Special rule for multiple network tiers:</p> <ul style="list-style-type: none"> • U 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
<p>Tips: Ensure that the plan does not impose cost-sharing requirements or quantitative treatment limitations that are applicable only to mental health/substance use disorder benefits.</p> <p>Ensure that with respect to conducting the predominant/substantially all test, the analysis must be done with respect to the dollar amount of <u>all</u> 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.</p>			
<p><u>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?</u></p> <ul style="list-style-type: none"> 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. <i>See 29 CFR 2590.712(c)(2)(ii)</i>. A plan may not use a separate sub-classification under these classifications for generalists and specialists. <i>See preamble language at 75 FR 5413.</i> <p>Tip: A plan may still be able to impose the specialist level of a financial requirement or quantitative treatment limitation if it is the predominant level that applies to substantially all medical/surgical benefits within a classification. For example, if the specialist level of copay is the predominant level of copay that applies to substantially all medical/surgical benefits in the outpatient, in-network classification, the plan may apply the specialist level copay to mental health/substance use disorder benefits in the outpatient, in-network classification. <i>See 29 CFR 2590.712(c)(3)</i>.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>SECTION C. Coverage in all Classifications</p> <p><u>Question 25 – Does the plan comply with the mental health parity requirements for coverage in all classifications?</u></p> <ul style="list-style-type: none"> 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. <i>See 29 CFR 2590.712(c)(2)(ii)(A)</i>. <ul style="list-style-type: none"> In determining the classification in which a particular benefit belongs, a plan must apply the same standards to medical/surgical benefits and to mental health/substance use disorder benefits. <i>See 29 CFR 2590.712(c)(2)(ii)(A)</i>. 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 	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p>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. <i>See 29 CFR 2590.712(c)(4).</i></p> <p>Tips:</p> <ul style="list-style-type: none"> • 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. <i>See 29 CFR 2590.712(c)(2)(ii)(C), Example 1.</i> • 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. <p>The plan must ensure that all combinations of benefits comport with parity.</p> <p>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.</p>			
<p>SECTION D. Cumulative Financial Requirements and Treatment Limitations</p> <p><u>Question 26 – Does the plan comply with the mental health parity provisions on cumulative financial requirements or cumulative quantitative treatment limitations?</u></p> <ul style="list-style-type: none"> • A plan may not apply any cumulative financial requirement or cumulative quantitative treatment limitation for mental health/substance use disorder benefits in a classification that accumulates separately from any established for medical/surgical benefits in the same classification. <i>See 29 CFR 2590.712(c)(3)(v).</i> <ul style="list-style-type: none"> ○ 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 	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p>requirements). <i>See 29 CFR 2590.712(a)</i></p> <ul style="list-style-type: none"> ○ Cumulative quantitative treatment limitations are treatment limitations that determine whether or to what extent benefits are provided based on accumulated amounts, such as annual or lifetime day or visit limits. <i>See 29 CFR 2590.712(a)</i>. <ul style="list-style-type: none"> • For example, a plan may not impose an annual \$250 deductible on all medical/surgical benefits and a separate \$250 deductible on all mental health/ substance use disorder benefits. 			
<p>SECTION E. Nonquantitative Treatment Limitations</p> <p><u>Question 27 – Does the plan comply with the mental health parity provisions for parity within nonquantitative treatment limitations?.....</u></p> <ul style="list-style-type: none"> • Nonquantitative treatment limitations (NQTLs) include: <ul style="list-style-type: none"> ○ Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative; ○ Formulary design for prescription drugs; ○ 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. <p>This is an illustrative, nonexhaustive list. <i>See 29 CFR 2590.712(c)(4)(ii)</i>.</p> <p>General rules:</p> <ul style="list-style-type: none"> • 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. <i>See 29 CFR 2590.712(c)(4)(i)</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; high cost growth; variability in cost and quality; elasticity 	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p>of demand; provider discretion in determining diagnosis, or type or length of treatment; clinical efficacy of any proposed treatment or service; licensing and accreditation of providers; and claim types with a high percentage of fraud. Based on application of these or other factors in a comparable fashion, an NQTL, such as prior authorization, may be required for some (but not all) mental health/substance use disorder benefits, as well as for some medical/surgical benefits, but not for others. <i>See 29 CFR 2590.712(c)(4), Example 8.</i></p> <p>Examples: The Departments have published several examples that help illustrate how the MHPAEA regulations apply to some common plan NQTLs, including:</p> <ol style="list-style-type: none"> 1) The penalty for failure to obtain preauthorization is more punitive with respect to mental health/substance use disorder benefits than with respect to medical/surgical benefits. <i>See 2590.712(c)(4)(iii), Example 3.</i> 2) The plan uses an employee assistance program as a gatekeeper to obtaining mental health or substance use disorder benefits. <i>See 2590.712(c)(4)(iii), Example 6.</i> 3) Utilization management practices that differ among different plan benefits. <i>See 29 CFR 2590.712(c)(4)(iii), Example 8.</i> <p>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?</p> <p>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.</p> <p>Questions You Might Ask:</p> <ol style="list-style-type: none"> 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
<p>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?</p> <p>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)?</p> <p>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?</p> <p>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?</p> <p>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.</p> <p>Illustrations. Set forth below are additional illustrations of how a plan may have differences in nonquantitative treatment limitations:</p> <p>NQTLs but may still comply with the Departments’ regulations, based on the facts and circumstances involved:</p> <ul style="list-style-type: none"> Plan X covers neuropsychological testing but only for certain conditions. In such situations, look to see whether the exclusion is based on evidence addressing 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
<ul style="list-style-type: none"> <li data-bbox="147 184 1149 751"> <p>• 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.</p> <li data-bbox="147 793 1149 1098"> <p>• 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.</p> <li data-bbox="147 1140 1149 1654"> <p>• 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.</p> 			

	YES	NO	N/A
<p>SECTION F. Disclosure Requirements</p> <p><u>Question 28 – Does the plan comply with the mental health parity disclosure requirements?</u></p> <ul style="list-style-type: none"> • The plan administrator (or the health insurance issuer) must make available the criteria for medical necessity determinations made under a group health plan with respect to mental health/substance use disorder benefits (or health insurance coverage offered in connection with the plan with respect to such benefits) to any current or potential participant, beneficiary, or contracting provider upon request. <i>See 29 CFR 2590.712(d)(1).</i> • 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. <i>See 29 CFR 2590.712(d)(3).</i> • If coverage is denied based on medical necessity, medical necessity criteria for the mental health/substance use disorder benefits at issue and for medical/surgical benefits in the same classification must be provided within 30 days of the request to the participant, beneficiary, or provider or other individual if acting as an authorized representative of the beneficiary or participant. <i>See 29 CFR 2520.104b-1; 29 CFR 2590.712(d)(1).</i> <p>Make Showing Compliance Simple!</p> <p><u>Documents or Plan Instruments Participants and Beneficiaries or DOL may request:</u></p> <p>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:</p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<ul style="list-style-type: none"> • 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. <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>			

	YES	NO	N/A
<ul style="list-style-type: none"> An attending provider may, however, decide, in consultation with the mother, to discharge the mother or newborn earlier. 			
<p><u>Question 30 – Provider must not be required to obtain authorization from plan</u></p> <p>Plans may not require providers to obtain authorization from the plan to prescribe a 48/96-hour stay. Does the plan comply with this rule?.....</p> <ul style="list-style-type: none"> Plans may not require that a provider (such as a doctor) obtain authorization from the plan to prescribe a 48/96-hour stay. <i>See ERISA section 711(a)(1)(B); 29 CFR 2590.711(a)(4).</i> <p>Tips: Watch for plan preauthorization requirements that are too broad. For example, a plan may have a provision requiring preauthorization for all hospital stays. Providers cannot be required to obtain preauthorization from the plan in order for the plan to cover a 48-hour (or 96-hour) stay in connection with childbirth. Therefore, in this example, the plan must add clarifying language to indicate that the general preauthorization requirement does not apply to 48/96-hour hospital stays in connection with childbirth. (Conversely, plans generally may require participants or beneficiaries to give notice of a pregnancy or hospital admission in connection with childbirth in order to obtain, for example, more favorable cost-sharing.) Nonetheless, the Newborns’ Act does not prevent plans and issuers from requiring providers to obtain authorization for any portion of a hospital stay that exceeds 48 (or 96) hours.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 31 – Incentives/penalties to mothers or providers</u></p> <p>Does the plan comply with the Newborns’ Act by avoiding impermissible incentives or penalties with respect to mothers or attending providers?.....</p> <ul style="list-style-type: none"> 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). <ul style="list-style-type: none"> 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). 	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p><u>SECTION B – Disclosure Provisions</u></p> <p>Group health plans that provide benefits for hospital stays in connection with childbirth are required to make certain disclosures, as follows:</p>			
<p><u>Question 32 – Disclosure with respect to hospital lengths of stay in connection with childbirth</u></p> <p>Does the plan comply with the notice provisions relating to hospital stays in connection with childbirth?.....</p> <ul style="list-style-type: none"> Group health plans that provide benefits for hospital stays in connection with childbirth are required to make certain disclosures. Specifically, the group health plan’s SPD must include a statement describing any requirements under Federal or State law applicable to the plan, and any health insurance coverage offered under the plan, relating to hospital length of stay in connection with childbirth for the mother or newborn child. <i>See the SPD content regulations at 29 CFR 2520.102-3(u).</i> <p>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.</p>	<input type="checkbox"/>	<input type="checkbox"/>	

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

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

	YES	NO	N/A
<p>WHCRA applies only to plans that offer benefits with respect to a mastectomy. If the plan does not offer these benefits, check “N/A” and go to Part V of this self-compliance tool.....</p> <p>If the plan does offer benefits with respect to a mastectomy, answer Questions 33-36.</p>			<input type="checkbox"/>
<p><u>Question 33 – Four required coverages under WHCRA</u> Does the plan provide the four coverages required by WHCRA?</p> <ul style="list-style-type: none"> • In the case of a participant or beneficiary who is receiving benefits in connection with a mastectomy, the plan shall provide coverage for the following benefits for individuals who elect them: <ul style="list-style-type: none"> ○ All stages of reconstruction of the breast on which the mastectomy has been performed; ○ Surgery and reconstruction of the other breast to produce a symmetrical appearance; ○ Prostheses; and ○ Treatment of physical complications of mastectomy, including lymphedema, in a manner determined in consultation with the attending provider and the patient. <i>See ERISA section 713(a).</i> • These required coverages can be subject to annual deductibles and coinsurance provisions if consistent with those established for other medical/surgical benefits under the plan or coverage. <p>Tip: Plans that cover benefits for mastectomies cannot categorically exclude benefits for reconstructive surgery or certain post-mastectomy services. In addition, time limits for seeking treatment may run afoul of the general requirement to provide the four required coverages.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 34 – Incentive provisions</u> Does the plan comply with WHCRA by not providing impermissible incentives or penalties with respect to patients or attending providers?</p> <ul style="list-style-type: none"> • A plan may not deny a patient eligibility to enroll or renew coverage solely to avoid WHCRA’s requirements under ERISA section 713(c)(1). • In addition, under ERISA section 713(c)(2), a plan may not penalize or offer incentives to an attending provider to induce the provider to furnish care in a manner inconsistent with WHCRA. 	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p><u>Question 35 – Enrollment notice</u> Does the plan provide adequate and timely enrollment notices as required by WHCRA?</p> <ul style="list-style-type: none"> • Upon enrollment, a plan must provide a notice describing the benefits required under WHCRA. <i>See ERISA section 713(a).</i> • The enrollment notice must describe the benefits that WHCRA requires the group health plan to cover, specifically: <ul style="list-style-type: none"> ○ All stages of reconstruction of the breast on which the mastectomy was performed, ○ Surgery and reconstruction of the other breast to produce a symmetrical appearance, ○ Prostheses, and ○ Physical complications resulting from mastectomy (including lymphedema). • The enrollment notice must describe any deductibles and coinsurance limitations applicable to such coverage. (Note: Under WHCRA, coverage of the required benefits may be subject only to deductibles and coinsurance limitations consistent with those established for other medical/surgical benefits under the plan or coverage.) <p>Tip: A model notice is provided in the Model Disclosures on page 141.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 36 – Annual notice</u> Does the plan provide adequate and timely annual notices as required by WHCRA?</p> <ul style="list-style-type: none"> • Plans must provide notices describing the benefits required under WHCRA once each year. <i>See ERISA section 713(a).</i> • To satisfy this requirement, the plan may redistribute the WHCRA enrollment notice or the plan may use a simplified disclosure that: <ul style="list-style-type: none"> ○ Provides notice of the availability of benefits under the plan for reconstructive surgery, surgery to achieve symmetry between the breasts, prostheses, and physical complications resulting from mastectomy (including lymphedema); and ○ Contact information (e.g., telephone number) for obtaining a detailed description of WHCRA benefits available under the plan. <p>Tip: The WHCRA annual notice can be provided in the SPD if the plan distributes SPDs annually. If not, the plan should break off the annual notice into a separate disclosure. A model notice is provided in the Model Disclosures on page 142.</p>	<input type="checkbox"/>	<input type="checkbox"/>	

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

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

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

	YES	NO	N/A
<p><i>Genetic services</i> means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information) or genetic education.</p> <p><i>Genetic test</i> means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, if the analysis detects genotypes, mutations, or chromosomal changes.</p> <p>A genetic test does NOT include an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition. For example, a test to determine whether an individual has a BRCA1 or BRCA2, genetic variants associated with a significantly increased risk for breast cancer, is a genetic test. An HIV test, complete blood count, cholesterol test, liver function test, or test for the presence of alcohol or drugs is not a genetic test.</p>			
<p><u>Question 37 – Does the plan comply with GINA’s prohibition against group-based discrimination based on genetic information?</u></p> <ul style="list-style-type: none"> • A group health plan cannot adjust premium or contribution amounts for the plan, or any similarly situated individuals under the plan, on the basis of genetic information. <i>See 29 CFR 2590.702-1(b)(1).</i> • Nothing limits a plan from increasing the premium for the group health plan or for a group of similarly situated individuals under the plan based on the manifestation of a disease or disorder of an individual enrolled in the plan. However, the manifestation of the disease in one individual cannot be used as genetic information about other group members to further increase the premium for a group health plan or a group of similarly situated individuals under the plan. <i>See 29 CFR 2590.702-1(b)(2).</i> 	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 38 – Does the plan comply with GINA’s limitation on requesting or requiring genetic testing?</u></p> <ul style="list-style-type: none"> • A group health plan generally must not request or require an individual or family member of the individual to undergo a genetic test. <i>See 29 CFR 2590.702-1(c)(1).</i> • Exceptions: <ul style="list-style-type: none"> ○ A health care professional who is providing health care services to an individual can request that the individual undergo a genetic test. <i>See 29 CFR 2590.702-1(c)(2).</i> ○ A plan can obtain and use the results of a genetic test for making a determination regarding payment. However, the plan is permitted to request only the minimum amount of information necessary to make the determination. <i>See 29 CFR 2590.702-1(c)(4).</i> ○ Exception for research: a plan or issuer may request, but not require, that a participant or beneficiary undergo a genetic test if the request is pursuant to research and several conditions are met. <i>See 29 CFR 2590.702-1(c)(5).</i> 	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p><u>Question 39 – Does the plan comply with GINA’s prohibition on collection of genetic information, prior to or in connection with enrollment?.....</u></p> <ul style="list-style-type: none"> • A plan cannot collect genetic information prior to an individual’s effective date of coverage under that plan or coverage, nor in connection with the rules for eligibility that apply to that individual. <i>See 29 CFR 2590.702-1(d)(2)(i).</i> • 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: <ul style="list-style-type: none"> ○ If a plan obtains genetic information incidental to the collection of other information concerning any individual, the collection is not a violation, as long as the collection is not for underwriting purposes. <i>See 29 CFR 2590.702-1(d)(2)(ii)(A).</i> ○ However, the incidental collection exception does not apply in connection with any collection where it is reasonable to anticipate that health information would be received, unless the collection explicitly states that genetic information should not be provided. <i>See 29 CFR 2590.702-1(d)(2)(ii)(B).</i> 	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 40 – Does the plan comply with GINA’s prohibition on collection of genetic information, for underwriting purposes?</u></p> <ul style="list-style-type: none"> • A plan cannot request, require, or purchase (“collect”) genetic information for underwriting purposes. <i>See 29 CFR 2590.702-1(d)(1)(i).</i> • <i>Underwriting purposes</i> means, with respect to any group health plan: <ul style="list-style-type: none"> ○ Rules for determination of eligibility (including enrollment and continued eligibility) for benefits under the plan or coverage (including changes in deductibles or other cost-sharing mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program); ○ The computation of premium or contribution amounts under the plan or coverage (including discounts, rebates, payments in kind, or other premium differential mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program); ○ The application of any preexisting condition exclusion under the plan or coverage; and ○ Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits. <i>See 29 CFR 2590.702-1(d)(1)(ii).</i> • Exception for medical appropriateness (only if an individual seeks a <u>benefit</u> under the plan): <ul style="list-style-type: none"> ○ If an individual seeks a benefit under a plan, the plan may limit or exclude the benefit based on whether the benefit is medically appropriate <i>and the determination of whether the benefit is medically appropriate is not for underwriting purposes.</i> 	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<ul style="list-style-type: none"> ○ If a plan conditions a benefit on medical appropriateness, and medical appropriateness depends on the genetic information of an individual, the plan can condition the benefit on genetic information. A plan or issuer is permitted to request only the minimum amount of genetic information necessary to determine medical appropriateness. <i>See 29 CFR 2590.702- 1(d) (1)(iii) and (e).</i> 			
<p>If you answered “Yes” to ALL of the above questions, there does not appear to be a violation of the GINA regulations.</p>			

VI. Compliance with Michelle’s Law

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

	YES	NO	N/A
<p>**Note: Under the Affordable Care Act group health plans and issuers are generally required to provide dependent coverage to age 26 regardless of student status of the dependent. Nonetheless, under some circumstances, such as a plan that provides dependent coverage beyond age 26, Michelle’s Law provisions may apply.</p>			
<p><u>Question 41 – Does the plan comply with the Michelle’s Law requirement not to terminate coverage of dependent students on medically necessary leave of absence?</u></p> <p><i>Medically necessary leave of absence means with respect to a dependent child in connection with a group health plan or health insurance coverage offered in connection with a group health plan, a leave of absence from or other change in enrollment status in a postsecondary educational institution that begins while the child is suffering from a serious illness or injury; is medically necessary; and causes the child to lose student status for purposes of coverage under the terms of the plan or coverage.</i></p> <p><i>A dependent child is a beneficiary who is a dependent child under the terms of the plan or coverage, of a participant or beneficiary under the plan or coverage and who was enrolled in the plan or coverage on the basis of being a student at a postsecondary educational institution immediately before the first day of the medically necessary leave of absence involved.</i></p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ○ the date that is one year after the first day of the medically necessary leave of absence; or ○ the date on which such coverage would otherwise terminate under the terms of the plan or health insurance coverage. <i>See ERISA section 714(b).</i> <p>Tip: The group health plan or issuer can require receipt of written certification by a treating physician of the dependent child which states that the dependent child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary.</p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p><u>Question 42 – Does the plan comply with Michelle’s Law’s notice requirement?</u></p> <ul style="list-style-type: none"> A group health plan or issuer must include with any notice regarding a requirement for certification of student status for coverage, a description of the Michelle’s law provision for continued coverage during medically necessary leaves of absence. <i>See ERISA section 714(c).</i> 	<input type="checkbox"/>	<input type="checkbox"/>	

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
<p><u>Section A. Determining Grandfather Status Under the Affordable Care Act Provisions in Part 7 of ERISA</u></p> <p>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. <i>See also the rules at 29 CFR 2590.715-1251(f).</i></p> <p>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.</p> <p>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. <i>See 29 CFR 2590.715-1251(a)(1)(i).</i></p> <p>If the plan is not claiming grandfathered status, proceed to Section B.</p> <p>If the answer is “yes” to questions 43 and 44 below the group health plan may be a grandfathered health plan.</p>			
<p><u>Question 43 – Did the plan exist with at least one individual enrolled on March 23, 2010?.....</u></p> <ul style="list-style-type: none"> A grandfathered group health plan must have been in existence with an enrolled individual on March 23, 2010. Any plan that does not meet this requirement is not in grandfathered status. <i>See 29 CFR 2590.715-1251(a)(1)(i).</i> 	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 44 – Has the plan continuously covered someone (not necessarily the same person) since March 23, 2010?</u></p> <ul style="list-style-type: none"> 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. <i>See 29 CFR 2590.715-1251(a)(1)(i).</i> <p>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.</p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p>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.</p>			
<p><u>Question 45 – Has the plan eliminated all or substantially all benefits to diagnose or treat a particular condition?</u></p> <ul style="list-style-type: none"> 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. <i>See 29 CFR 2590.715-1251(g)(1)(i).</i> 	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 46 – Has the plan increased a percentage cost-sharing requirement (such as an individual’s coinsurance)?</u></p> <ul style="list-style-type: none"> Any increase measured from March 23, 2010, in a percentage cost-sharing requirement causes a plan to relinquish grandfathered status. <i>See 29 CFR 2590.715-1251(g)(1)(ii).</i> 	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>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?</u></p> <ul style="list-style-type: none"> The maximum percentage increase is medical inflation, expressed as a percentage, plus 15 percentage points. <i>See 29 CFR 2590.715-1251(g)(3)(ii).</i> Medical inflation is the increase since March 2010, in the overall medical care component of the Consumer Price Index for All Urban Consumers <ul style="list-style-type: none"> (CPI-U) (unadjusted) published by the Department of Labor using the 1982-1984 base of 100. <i>See 29 CFR 2590.715-1251(g)(3)(i).</i> 	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>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?</u></p> <ul style="list-style-type: none"> The maximum percentage increase is medical inflation, expressed as a percentage, plus 15 percentage points. <i>See 29 CFR 2590.715-1251(g)(3)(ii).</i> Medical inflation is the increase since March 2010 in the overall medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) (unadjusted) published by the Department of Labor using the 1982-1984 base of 100. <i>See 29 CFR 2590.715-1251(g)(3)(i).</i> 	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p><u>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?</u></p> <ul style="list-style-type: none"> 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? <i>See 29 CFR 2590.715-1251(g)(1)(v)(B).</i> <p>Tip: If a group health plan <u>modifies</u> the tiers of coverage it had on March 23, 2010 (for example, from self-only and family to a multi-tiered structure of self-only, self-plus-one, self-plus-two, and self-plus-three-or-more), the employer contribution for any new tier would be tested by comparison to the contribution rate for the corresponding tier on March 23, 2010. If the plan <u>adds</u> one or more new coverage tiers without eliminating or modifying any previous tiers and those new coverage tiers cover classes of individuals that were not covered previously under the plan, the new tiers would not be analyzed under the standards of paragraph (g)(1). <i>See DOL FAQs About the Affordable Care Act Implementation Part II, question 3 at dol.gov/ebsa/faqs/faq-aca2.html.</i></p> <p>In cases of a multiemployer plan that has either a fixed-dollar employee contribution or no employee contribution towards the cost of coverage, if the employer’s contribution rate changes, provided any changes in the coverage terms would not otherwise cause the plan to cease to be grandfathered and there continues to be no employee contribution or no increase in the fixed-dollar employee contribution towards the cost of coverage, the change of the employer’s contribution rate will not, in and of itself, cause a plan that is otherwise a grandfathered health plan to relinquish grandfathered status. <i>See DOL FAQs About the Affordable Care Act Implementation Part I, question 4 at dol.gov/ebsa/faqs/faq-aca.html.</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 50 – Has the plan added or decreased an overall annual limit on benefits?</u></p> <ul style="list-style-type: none"> A plan will relinquish its grandfathered status if it: <ul style="list-style-type: none"> ○ Adds an overall annual limit on the dollar value of all benefits when it did not previously impose an overall annual limit (<i>See 29 CFR 2590.715-1251(g)(1)(vi)(A)</i>); ○ Previously imposed an overall lifetime limit on the dollar value of benefits (but no overall annual limit) and adopts an overall annual limit at a dollar value that is lower than the dollar value of the lifetime limit on March 23, 2010 (<i>See 29 CFR 2590.715-1251(g)(1)(vi)(B)</i>); or ○ Decreases the dollar value of the overall annual limit that was in place on March 23, 2010 (<i>See 29 CFR 2590.715-1251(g)(1)(vi)(C)</i>). 	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p>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. <i>See 29 CFR 2590.715-2711(b)(1).</i></p> <p>If the answer to any of questions 45-50 was “yes”, the plan is <u>NOT</u> a grandfathered plan, proceed to Section B.</p>			
<p><u>Question 51 – Did the plan change issuers after March 23, 2010?</u></p> <p>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. <i>See 29 CFR 2590.715-1251(a)(1)(ii), as amended.</i> Proceed to question 53.</p> <p>If a group health plan changed issuers after March 23, 2010, and the change was effective prior to November 15, 2010, the plan will have relinquished grandfather status. The plan is not a grandfathered plan; proceed to Section B.</p> <p>Tip: The operative date is the effective date of the new contract, not the date the new contract was entered into. Special rules apply for collectively bargained plans. <i>See 29 CFR 2590.715-1251(f)</i> for collectively bargained plans.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 52 – Did the plan change from self-insured to fully-insured after March 23, 2010?</u></p> <p>If the group health plan was self-insured and changed to fully insured after March 23, 2010, and the change was effective on or after November 15, 2010, the plan will continue to be a grandfathered plan provided no other changes are made that would relinquish grandfathered status. <i>See 29 CFR 2590.715-1251(a)(1)(ii), as amended.</i> Proceed to question 53.</p> <p>If a group health plan was self-insured and changed to fully-insured after March 23, 2010, and the change was effective prior to November 15, 2010, the plan will have relinquished grandfathered status. The plan is not a grandfathered plan; proceed to Section B.</p> <p>If Questions 51 and 52 are not applicable to the group health plan, continue to Question 54 to continue the grandfather status analysis.</p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p><u>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?</u></p> <ul style="list-style-type: none"> To maintain status as a grandfathered health plan, the plan must provide to the new issuer (and the new issuer must require) documentation of plan terms (including benefits, cost sharing, employer contributions, and annual limits) under the prior health coverage sufficient to determine whether any other change is being made that would relinquish grandfathered status. <i>See 29 CFR 2590.715-1251(a)(3)(ii), as amended.</i> 	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>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?</u></p> <ul style="list-style-type: none"> To maintain status as a grandfathered group health plan, the plan must include a statement, in any plan materials provided to a participant or beneficiary describing the benefits under the plan, that the plan believes it is a grandfathered health plan within the meaning of section 1251 of the Affordable Care Act and must provide contact information for questions and complaints. Model language is available. <i>See 29 CFR 2590.715-1251(a)(2).</i> <p>For all plans that, based on questions 43 through 54, have not relinquished grandfathered status, complete question 55.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>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?.....</u></p> <ul style="list-style-type: none"> To maintain status as a grandfathered group health plan the plan must maintain records documenting the terms of the plan in connection with the coverage that was in effect on March 23, 2010, and any other documents necessary to verify, explain, or clarify its status as a grandfathered health plan. These records must be maintained for as long as the plan takes the position that it is grandfathered, and must be available for examination upon request. <i>See 29 CFR 2590.715-1251(a)(3)(i)(A) & (i)(B), as amended.</i> 	<input type="checkbox"/>	<input type="checkbox"/>	

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

	YES	NO	N/A
<p><u>Section C. Determining Compliance with the Affordable Care Act Rescission Provisions in Part 7 of ERISA</u></p> <p><i>Note: This provision is applicable for plan years beginning on or after Sept. 23, 2010. This provision applies to both grandfathered and non-grandfathered group health plans.</i></p> <p>A rescission is a cancellation or discontinuance of coverage that has retroactive effect; this includes a cancellation that treats a policy as void from the time of the group’s enrollment or a cancellation that voids benefits paid up to one year before the cancellation. A rescission is not the cancellation or discontinuance of coverage that has only a prospective effect; or the cancellation or discontinuance of coverage if effective retroactively to the extent it is based on a failure to timely pay required premiums or contributions towards the cost of coverage. <i>See 29 CFR 2590.715-2712(a)(2).</i></p> <p>If the answer to the question below is “yes” the plan is in compliance with the rules regarding rescission of coverage.</p>			
<p><u>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?</u></p> <ul style="list-style-type: none"> A group health plan, or health insurance issuer offering group health insurance coverage, must not rescind coverage with respect to an individual (including a group to which the individual belongs, or family coverage in which the individual is included) once the individual is covered under the plan or coverage, unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage. <i>See 29 CFR 2590.715- 2712(a)(1).</i> <p>Tip: Some employers’ human resource departments may reconcile lists of eligible individuals with their plan or issuer via data feed only once per month. If a plan covers only active employees (subject to the COBRA continuation coverage provisions) and an employee pays no premiums for coverage after termination of employment, the Departments do not consider the retroactive elimination of coverage back to the date of termination of employment, due to delay in administrative record-keeping, to be a rescission. Similarly, if a plan does not cover ex-spouses (subject to the COBRA continuation coverage provisions) and the plan is not notified of a divorce and the full COBRA premium is not paid by the employee or ex-spouse for coverage, the Departments do not consider a plan’s termination of coverage retroactive to the divorce to be a rescission of coverage. (Of course, in such situations COBRA may require coverage to be offered for up to 36 months if the COBRA applicable premium is paid by the qualified beneficiary.) <i>See DOL FAQs About the Affordable Care Act Implementation Part II, question 7 at dol.gov/ebsa/faqs/faq-aca2.html.</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p><u>Section D. Determining Compliance with the Affordable Care Act Prohibitions on Lifetime Limits and Restrictions on Annual Limits in Part 7 of ERISA</u></p> <p><i>Note: This provision is applicable for plan years beginning on or after Sept. 23, 2010. This provision applies to both grandfathered and non-grandfathered group health plans.</i></p> <p>The restrictions on annual limits do not apply to health flexible spending arrangements (FSAs), medical savings accounts (MSAs), or health savings accounts (HSAs). In the case of health reimbursement accounts (HRAs) that are integrated with other group health plan coverage which complies with the prohibitions on lifetime and annual limits, the fact that benefits under the HRA by itself are limited does not violate these rules. Stand-alone HRAs limited to retirees only are not subject to these rules. (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.)</p> <p>1. Lifetime Limits</p> <p>If the answer to the question below is “yes” the plan is in compliance with the rules regarding prohibitions on lifetime limits.</p>			
<p><u>Question 59 – Does the plan comply with the Affordable Care Act’s prohibition on lifetime limits?.....</u></p> <ul style="list-style-type: none"> A group health plan or issuer may not establish any lifetime limit on the dollar amount of benefits for any individual. This prohibition applies for plan years beginning on or after September 23, 2010. <i>See 29 CFR 2590.715-2711(a)(1).</i> <p>Tip: These rules do not prevent a plan or issuer from placing lifetime dollar limits with respect to any individual on specific covered benefits that are not essential health benefits (to the extent this is permissible under applicable Federal and State law). <i>See 29 CFR 2590.715-2711(b)(1).</i></p> <p>Note: “Essential health benefits” refers to essential benefits under Section 1302(b) of the Affordable Care Act and applicable regulations (issued by HHS) including the Frequently Asked Question on Essential Health Benefits Bulletin.</p> <p>For plan years beginning before the issuance of regulations defining “essential health benefits,” for purposes of enforcement, the Departments will take into account good faith efforts to comply with a reasonable interpretation of the term “essential health benefits.” For this purpose, a plan or issuer must apply the definition of essential health benefits consistently. See Preamble to Interim Final Regulations, at 75 FR 37188, 37191.</p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p>2. Annual Limits</p> <p>If the answer to the question below is “yes” the plan is in compliance with the rules regarding prohibitions/restrictions on annual limits.</p>			
<p><u>Question 60 – Does the plan comply with the Affordable Care Act’s prohibition on annual limits?</u>.....</p> <p>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.</p> <p>Tip: These rules do not prevent a plan or issuer from placing annual dollar limits with respect to any individual on specific covered benefits that are not essential health benefits (to the extent this is permissible under applicable Federal and State law). <i>See 29 CFR 2590.715-2711(b)(1).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>Section E. Determining Compliance with the Affordable Care Act Prohibition on Preexisting Condition Exclusions</p> <p><i>This provision applies to both grandfathered and non-grandfathered group health plans.</i></p> <p>The definition of preexisting condition exclusion includes any limitation or exclusion of benefits (including a denial of coverage) applicable to an individual as a result of information relating to an individual’s health status before the individual’s effective date of coverage (or if coverage is denied, the date of denial), such as a condition identified as a result of a pre-enrollment questionnaire or a physical examination given to the individual, or a review of medical records relating to the pre-enrollment period. <i>See 29 CFR 2590.701-2.</i></p> <p>If the answer to the following question is “yes” the plan is in compliance with the prohibition on preexisting condition exclusions.</p>			
<p><u>Question 61 – Does the plan comply with the Affordable Care Act by not imposing a preexisting condition exclusion?</u></p> <ul style="list-style-type: none"> For plan years beginning on or after January 1, 2014, group health plans may not impose any preexisting condition exclusions. <i>See 29 CFR 2590.715- 2704(a)(1).</i> <p>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.</p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p>Example: A plan excludes coverage for cosmetic surgery unless the surgery is required by reason of an accidental injury <u>occurring after the effective date of coverage</u>. This plan provision operates as a preexisting condition exclusion because only people who were injured while covered under the plan receive benefits for treatment. People who were injured while they had no coverage (or while they had prior coverage) do not receive benefits for treatment. Accordingly, this plan provision limits benefits relating to a condition because the condition was present before the effective date of coverage, and is considered a preexisting condition exclusion.</p>			
<p><u>SECTION F- Compliance with the 90-day Waiting Period Limitation Provision</u></p> <p>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.</p> <p><i>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 <u>applies</u> to grandfathered health plans and non-grandfathered plans.</i></p> <p><u>Question 62- Does the plan apply a waiting period that exceeds 90-days?</u></p> <ul style="list-style-type: none"> • 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). <i>See 29 CFR 2590-715.2708(c)(1).</i> <p>Variable Hour Employees:</p> <ul style="list-style-type: none"> • 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. <i>See 29 CFR 2590.715-2708(c)(3)(i).</i> 	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p>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.</p> <p>Cumulative Hours of Service Requirements:</p> <ul style="list-style-type: none"> 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. <i>See 29 CFR 2590.715-2708(c)(3)(ii).</i> <p>Limitation on Orientation Periods</p> <p>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. <i>See 29 CFR 2590.715-2708 (c)(3)(iii).</i></p> <p>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. <i>See 29 CFR 2590.715-2708 (e).</i></p> <p>If you answered “Yes” to the above question under Section F, the plan violates PHS Act Section 2708.</p>			
<p><u>Section G. Determining Compliance with the Affordable Care Act Provisions Regarding the provision of the Summary of Benefits and Coverage (SBC) and Uniform Glossary</u></p> <p><i>Note: These provisions do apply to grandfathered health plans.</i></p> <p>The Affordable Care Act provides for new disclosure tools, the Summary of Benefits and Coverage (SBC) and Uniform Glossary, to help consumers better compare coverage options available to them in both the individual and group health insurance coverage markets. Generally, group health plans and health insurance issuers are required to provide the SBC and Uniform Glossary free of charge. The Departments published a final rule setting forth the requirements for who must provide and who is entitled to receive an SBC and Uniform Glossary, when these documents must be provided, the content required in the documents, and the form and manner of how the documents can be provided. In addition, the Departments published a notice that sets forth the required template for the SBC and Uniform Glossary documents along with instructions and sample</p>			

	YES	NO	N/A
<p>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.</p> <p>Transitional Relief Providing Flexibility and Emphasizing Good Faith Progress Towards Compliance</p> <p>The Department is working together with employers and issuers to assist them in coming into compliance with these requirements. Specifically, in the instructions for completing the SBC, the Department stated that to the extent a plan’s terms do not reasonably correspond to the template and instructions, the template should be completed in a manner that is as consistent with the instructions as reasonably as possible, while still accurately reflecting the plan’s terms. <i>See Instructions Guide for Group Coverage, page 1 General Instructions.</i> In addition, compliance assistance is a high priority for the Departments. Implementation will be marked by an emphasis on assisting (rather than imposing penalties on) plans and issuers that are working diligently and in good faith to understand and come into compliance with the new law. During the first year of applicability,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. <i>See ACA Implementation FAQ Part XIX, Q8.</i></p> <p>The questions below focus on provision of the SBC by group health plans to participants and beneficiaries. The final regulations also require health insurance issuers to provide the SBC to group health plan sponsors and participants and beneficiaries. More information on these requirements can be found at dol.gov/ebsa/healthreform/.</p> <p>The following questions have been developed to assist in determining compliance with the rules regarding the Summary of Benefits and Coverage and Uniform Glossary.</p>			

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
<p><u>Question 63 – Does the plan provide an SBC, as required?</u></p> <p><u>In Connection with Enrollment</u></p> <p>When providing the SBC to participants and beneficiaries, group health plans and issuers must provide the SBC with respect to each benefit package offered for which they are eligible (<i>See 29 CFR 2590.715-2715(a)(1)(ii)(A)</i>) as part of any written application materials distributed by the plan or issuer for enrollment. If no written application materials are distributed for enrollment, the SBC must be provided no later than the first date a participant is eligible to enroll in coverage for themselves or any beneficiaries. <i>See 29 CFR 2590.715-2715(a)(1)(ii)(B)</i>. For this purpose, written application materials include any forms or requests for information, in paper form or through a Website or email, that must be completed for enrollment. <i>See ACA Implementation FAQ Part VIII, Q9.</i></p> <p>Tips: The requirement to provide an SBC by both a health insurance issuer and a group health plan to participants and beneficiaries can be satisfied for both entities as long as one entity provides the required SBC within the required timeframes. <i>See 29 CFR 2590.715-2715(a)(1)(iii)(A).</i></p> <p>If a participant and any beneficiaries are known to reside at the same address, a single SBC provided to that address will satisfy the obligation to provide for all individuals at the address. Under this circumstance, the obligation will also be satisfied if the SBC is furnished to the participant in electronic form. However if a beneficiary’s last known address is different than the participant’s address, a separate SBC must be mailed to the beneficiary’s address. <i>See 29 CFR 2590.715-2715(a)(1)(iii)(B) and ACA Implementation FAQ Part VIII, Q10.</i></p> <p>Group health plans are permitted to integrate the SBC with other summary materials, such as the SPD, as long as the SBC is intact and prominently displayed at the beginning of the materials (for example, immediately after the table of contents in an SPD) and all of the timing requirements are met. <i>See 77 FR 8707.</i></p> <p>The Departments generally allow electronic delivery of the SBC and Uniform Glossary where appropriate. For participants and beneficiaries who are already enrolled in coverage under a group health plan, an SBC may be provided electronically if the requirements of the Department of Labor’s electronic safe harbor are met. <i>See ACA Implementation FAQ Part VIII, Q10 citing the Department of Labor’s disclosure regulation at 29 CFR 2520.104b-1.</i> For participants and beneficiaries who are eligible but not enrolled for coverage, the SBC may be provided electronically if the format is readily accessible; the SBC is provided in paper form upon request; and if the electronic form is an Internet posting, the plan or issuer timely notifies the individual that the documents are available in paper form upon request. <i>See 29 CFR 2590.715-2715(a)(3).</i> An SBC may be provided electronically to participants and beneficiaries in connection with their online enrollment or online renewal of coverage under the plan. SBCs</p>	<input data-bbox="1177 178 1226 241" type="checkbox"/>	<input data-bbox="1291 178 1339 241" type="checkbox"/>	

	YES	NO	N/A
<p>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 <i>ACA Implementation FAQ Part IX, Q1</i>.</p>			
<p>Question 64 – Does the plan make available the Uniform Glossary, as required?</p> <ul style="list-style-type: none"> 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). 	<input type="checkbox"/>	<input type="checkbox"/>	
<p>If you are completing this section as part of a review of a grandfathered health plan, STOP here. The following sections address provisions that do not apply to grandfathered health plans.</p>			
<p>Section H. Determining Compliance with the Patient Protection Provisions of the Affordable Care Act in Part 7 of ERISA</p> <p><i>Note: This provision is applicable for plan years beginning on or after Sept. 23, 2010. This provision does not apply to grandfathered health plans.</i></p> <p>1. <u>Choice of Healthcare Professional</u></p> <p>A plan or issuer that requires or provides for a participant or beneficiary to designate a participating primary care provider must permit each participant or beneficiary to designate any participating primary care provider who is available to accept the participant or beneficiary. With respect to a child, the plan or issuer must permit the designation of a physician who specializes in pediatrics as a child’s primary care provider, if the provider participates in the network of the plan or issuer and is available to accept the child. See 29 CFR 2590.715-2719A(a)(1) & (a)(2).</p> <p>A group health plan or issuer that provides obstetrical or gynecological (OB/GYN) care and requires the designation of an in-network primary care provider, may not require authorization or referral by the plan, issuer, or any person (including a primary care provider) for a female participant or beneficiary who seeks coverage for OB/GYN care provided by a participating health care professional who specializes in obstetrics and gynecology. (This includes any individual authorized under State law to provide OB/GYN care, including a person other than a physician). See 29 CFR 2590.715-2719A(a)(3).</p>			

	YES	NO	N/A
<p><u>Question 65 – Does the plan require or provide for designation of a participating primary care provider by any participant or beneficiary?</u>.....</p> <p>If the answer is ‘no’, enter ‘N/A’ for the following questions and proceed to Question 72.</p> <p>If the answer to ALL of the questions below is “yes” the plan is in compliance with the choice of healthcare professional provisions of the rules regarding patient protections.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 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?</u></p> <ul style="list-style-type: none"> If a group health plan, or a health insurance issuer offering group health insurance coverage, requires or provides for designation by a participant or beneficiary of a participating primary care provider, then the plan or issuer must permit each participant or beneficiary to designate any participating primary care provider who is available to accept the participant or beneficiary. <i>See 29 CFR 2590.715-2719A(a)(1)(i).</i> 	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>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?</u></p> <ul style="list-style-type: none"> If a group health plan or health insurance issuer requires the designation by a participant or beneficiary of a primary care provider, the plan or issuer must provide a notice informing each participant of the terms of the plan or health insurance coverage regarding designation of a primary care provider that any participating primary care provider who is available to accept the participant or beneficiary can be designated. <i>See 29 CFR 2590.715-2719A(a)(4)(i)(A).</i> <p>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. <i>See 29 CFR 2590.715-2719A(a)(4)(ii).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>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?</u></p> <ul style="list-style-type: none"> If a group health plan, or a health insurance issuer offering group health insurance coverage, requires or provides for the designation of a participating primary care provider for a child by a participant or beneficiary, the plan or issuer must permit the participant or beneficiary to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child’s primary care provider if the provider participates in the network of the plan or issuer and is available to accept the child. <i>See 29 CFR 2590.715-2719A(a)(2)(i).</i> 	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p><u>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?</u></p> <ul style="list-style-type: none"> If a group health plan or health insurance issuer requires the designation by a participant or beneficiary of a primary care provider, the plan or issuer must provide a notice informing each participant of the terms of the plan or health insurance coverage regarding designation of a primary care provider with respect to a child, that any participating physician who specializes in pediatrics can be designated as the primary care provider. <i>See 29 CFR 2590.715-2719A(a)(4)(i)(B).</i> <p>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. <i>See 29 CFR 2590.715-2719A(a)(4)(ii).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>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)?</u></p> <ul style="list-style-type: none"> For purposes of this provision, a health care professional who specializes in obstetrics or gynecology is any individual (including a person other than a physician) who is authorized under applicable State law to provide obstetrical or gynecological care. The plan or issuer may require such a professional to agree to otherwise adhere to the plan’s or issuer’s policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer. <i>See 29 CFR 2590.715-2719A(a)(3)(i)(A).</i> 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. <i>See 29 CFR 2590.715-2719A(a)(3)(i)(B).</i> 	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>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?</u></p> <ul style="list-style-type: none"> 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 	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p>care by a participating health care professional who specializes in obstetrics or gynecology. <i>See 29 CFR 2590.715-2719A(a)(4)(i)(C).</i></p> <p>Tip: This notice must be provided anytime the plan provides a participant with an SPD or other similar description of benefits under the plan. <i>See 29 CFR 2590.715-2719A(a)(4)(ii).</i></p>			
<p>2. Coverage of Emergency Services</p> <p><u>Question 72 – Does the plan provide any benefits with respect to services in an emergency department of a hospital?</u></p> <p>If the answer is ‘no,’ enter ‘N/A’ for the following questions and proceed to Section I.</p> <p>Note: Small group insured plans are required to cover essential health benefits, which include emergency services.</p> <p>If the answer to ALL of the questions below is “yes” the plan is in compliance with the coverage of emergency services provisions of the rules regarding patient protections.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><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></p> <ul style="list-style-type: none"> A plan or issuer subject to the requirements of this section must provide coverage for emergency services without the need for any prior authorization determination, even if the emergency services are provided on an out-of-network basis. <i>See 29 CFR 2590.715-2719A(b)(2)(i).</i> 	<input type="checkbox"/>	<input type="checkbox"/>	
<p><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></p> <ul style="list-style-type: none"> A plan or issuer subject to the requirements of this section must provide coverage for emergency services without regard to whether the health care provider furnishing the emergency services is a participating network provider with respect to the services. <i>See 29 CFR 2590.715-2719A(b)(2)(ii).</i> 	<input type="checkbox"/>	<input type="checkbox"/>	
<p><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></p> <ul style="list-style-type: none"> If the emergency services are provided out-of-network, the plan must provide the emergency services without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or 	<input type="checkbox"/>	<input type="checkbox"/>	

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

	YES	NO	N/A
<p><u>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?</u></p> <ul style="list-style-type: none"> A plan or issuer subject to the requirements of this section must provide coverage for emergency services without regard to any other term or condition of the coverage, other than the exclusion or coordination of benefits, an affiliation or waiting period permitted under part 7 of ERISA, part A of title XXVII of the PHS Act, or chapter 100 of the Internal Revenue Code, or applicable cost sharing. <i>See 29 CFR 2590.715-2719A(b)(2)(v).</i> 	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Section I. Determining Compliance with the Affordable Care Act Coverage of Preventive Services Provisions in Part 7 of ERISA</u></p> <p><i>Note: This provision is applicable for plan years beginning on or after Sept. 23, 2010. This provision does not apply to grandfathered health plans.</i></p> <p>Group health plans and health insurance issuers must provide coverage for, and must not impose cost-sharing requirements with respect to, certain recommended preventive services. Nothing prevents plans or issuers from providing coverage for preventive items and services in addition to the recommended preventive services required under these regulations. <i>See 29 CFR 2590.715-2713(a)(1) & (a)(5).</i></p> <p>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.</p>			
<p>If the answer to ALL of the questions below is “yes” the plan is in compliance with the rules regarding preventive services.</p> <p><u>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?</u></p> <ul style="list-style-type: none"> Plans and issuers must provide coverage for evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force. <i>See 29 CFR 2590.715-2713(a)(1)(i).</i> 	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p>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.</p>			
<p><u>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?.....</u></p> <ul style="list-style-type: none"> For the purpose of this section, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention. <i>See 29 CFR 2590.715-2713(a)(1)(ii).</i> 	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>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?.....</u></p> <ul style="list-style-type: none"> With respect to infants, children, and adolescents, a plan or issuer must provide coverage for evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration. <i>See 29 CFR 2590.715-2713(a)(1)(iii).</i> 	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>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?</u></p> <ul style="list-style-type: none"> 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. <i>See 29 CFR 2590.715-2713(a)(1)(iv).</i> 	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p><u>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?</u></p> <ul style="list-style-type: none"> If a recommended preventive service or item is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such a service or item, then a plan or issuer may not impose cost-sharing requirements with respect to the office visit. <i>See 29 CFR 2590.715-2713(a)(2)(ii).</i> <p>Tip: If a recommended preventive service is billed separately from an office visit, or if the recommended preventive service is not billed separately and the primary purpose of the office visit is not delivery of the recommended preventive service, then a plan or issuer may impose cost-sharing with respect to the office visit. <i>See 29 CFR 2590.715-2713(a)(2)(i) & (iii).</i></p> <p><u>Additional tips:</u></p> <ul style="list-style-type: none"> Plans and issuers that have a network of providers are not required to provide coverage for and may impose cost-sharing requirements for recommended preventive services delivered by an out-of-network provider. <i>See 29 CFR 2590.715-2713(a)(3).</i> Plans and issuers may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for the recommended preventive services to the extent these are not specified in the recommendations or guidelines. <i>See 29 CFR 2590.715-2713(a)(4).</i> Plans and issuers can impose cost-sharing for a treatment that is not a recommended preventive service under these regulations, even if the treatment resulted from a recommended preventive service. <i>See 29 CFR 2590.715-2713(a)(5) and ACA Implementation FAQs Part XII Q5.</i> 	<input type="checkbox"/>	<input type="checkbox"/>	

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
<p>1. Internal Claims and Appeals</p> <p>Under the Affordable Care Act group health plans and health insurance issuers offering group health insurance coverage were required to implement an effective internal claims and appeals process for plan years beginning on or after September 23, 2010. In general, the interim final regulations require plans and issuers to comply with the DOL claims procedure rule under <i>29 CFR 2560.503-1</i> and impose specific additional requirements and include some clarifications (referred to as the “additional standards” for internal claims and appeals). In addition to meeting the following requirements, the plan is required to comply with all of the requirements of the DOL claims procedure rule under <i>29 CFR 2560.503-1</i>.</p> <p>The following questions have been developed to assist in determining compliance with the <u>additional standards</u> for internal claims and appeals processes and is not intended to determine compliance with the DOL claims procedure rule.</p>			
<p><u>Question 83 – Does the plan provide internal claims and appeals processes with respect to rescissions of coverage?</u></p> <ul style="list-style-type: none"> Under the DOL claims procedure rule, adverse benefit determinations eligible for internal claims and appeals processes generally include denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit (including a denial, reduction, termination, or failure to make a payment based on the imposition of a preexisting condition exclusion, a source of injury exclusion, or other limitation on covered benefits). <i>See 29 CFR 2560.503-1(m)(4)</i>. The Department’s regulations broaden the DOL claims procedure rule’s definition of “adverse benefit determination” to include rescissions of coverage. Therefore, rescissions of coverage are also eligible for internal claims and appeals processes, whether or not the rescission has an adverse effect on any particular benefit at the time of an appeal. <i>See 29 CFR 2590.715-2719(a)(2)(i); 29 CFR 2560.503-1</i>. This provision is applicable for plan years beginning on or after September 23, 2010. <i>See 29 CFR 2590.715-2719(g)</i>. 	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 84 – Does the plan provide claimants with any new or additional evidence or rationale considered in connection with a claim?</u></p> <ul style="list-style-type: none"> 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 	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p>adverse benefit determination is required to be provided in order to give the claimant a reasonable opportunity to respond prior to that date. Similarly, before a plan or issuer can issue a final internal adverse benefit determination based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale. This rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided in order to give the claimant a reasonable opportunity to respond prior to that date. <i>See 29 CFR 2590.715-2719(b)(2)(ii)(C).</i></p> <ul style="list-style-type: none"> This provision is applicable for plan years beginning on or after September 23, 2010. <i>See 29 CFR 2590.715-2719(g).</i> 			
<p><u>Question 85 – Does the plan ensure that claims and appeals are adjudicated in a manner that maintains independence and impartiality of decision making?</u></p> <ul style="list-style-type: none"> The Department’s regulations clarify that plans or issuers must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood or perceived likelihood that the individual will support or tend to support a denial of benefits. <i>See 29 CFR 2590.715-2719(b)(2)(ii)(D).</i> This provision is applicable for plan years beginning on or after September 23, 2010. <i>See 29 CFR 2590.715-2719(g).</i> 	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>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:</u></p> <p><u>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?</u></p> <ul style="list-style-type: none"> 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. <i>See 29 CFR 2590.715-2719(b)(2)(ii)(E)(1).</i> This provision is applicable for plan years beginning on or after July 1, 2011. <i>See T.R. 2011-01 at dol.gov/ebsa/newsroom/tr11-01.html.</i> 	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<ul style="list-style-type: none"> Plans or issuers must also provide to participants and beneficiaries, as soon as practicable, upon request, the diagnosis and treatment codes (and their meanings), associated with any adverse benefit determination or final internal adverse benefit determination. The plan or issuer must not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or external review. <i>See 29 CFR 2590.715-2719(b)(2)(ii)(E) (1)</i>, as amended. This provision is applicable for plan years beginning on or after January 1, 2012. <i>See T.R. 2011-01 at dol.gov/ebsa/newsroom/tr11-01.html.</i> 			
<p><u>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?</u></p> <ul style="list-style-type: none"> The Department’s regulations provide that plans and issuers must ensure that the reasons for the adverse benefit determination or final internal adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the standard that was used in denying the claim. In the case of a notice of final internal adverse benefit determination, this description must include a discussion of the decision. <i>See 29 CFR 2590.715-2719(b)(2)(ii)(E)(3)</i>. This provision is applicable for plan years beginning on or after July 1, 2011. <i>See T.R. 2011-01 at dol.gov/ebsa/newsroom/tr11-01.html.</i> 	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>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?.....</u></p> <ul style="list-style-type: none"> The Department’s regulations provide that plans and issuers must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal. <i>See 29 CFR 2590.715-2719(b)(2)(ii)(E)(4)</i>. This provision is applicable for plan years beginning on or after July 1, 2011. <i>See T.R. 2011-01 at dol.gov/ebsa/newsroom/tr11-01.html.</i> 	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>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?.....</u></p> <ul style="list-style-type: none"> The Department’s regulations provide that plans and issuers must disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist enrollees with the internal claims and appeals and external review processes. <i>See 29 CFR 2590.715-2719(b)(2)(ii)(E)(5)</i>. 	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<ul style="list-style-type: none"> An updated list of the State Consumer Assistance Programs is available on the Department of Labor Website at dol.gov/ebsa/capupdatelist.doc. These provisions are applicable for plan years beginning on or after July 1, 2011. <i>See T.R. 2011-01 at dol.gov/ebsa/newsroom/tr11-01.html.</i> 			
<p><u>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?</u>.....</p> <ul style="list-style-type: none"> As under 29 CFR 2560.503-1(f)(2)(i), plans or issuers must notify a claimant of a benefit determination (whether adverse or not) with respect to a claim involving urgent care as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the receipt of the claim by the plan or issuer. <i>29 CFR 2590.715-2719(b)(2)(ii)(B), as amended.</i> The determination as to whether a claim involves urgent care is determined by the attending provider and the plan or issuer must defer to such determination. <i>See 29 CFR 2590.715-2719(b)(2)(ii)(B), as amended.</i> This provision is applicable for plan years beginning on or after January 1, 2012. <i>See T.R. 2011-01 at dol.gov/ebsa/newsroom/tr11-01.html.</i> 	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 88 – Does the plan comply with the requirements regarding deemed exhaustion of internal claims and appeals processes?</u></p> <ul style="list-style-type: none"> In the case of a plan or issuer that fails to adhere to all the requirements of the Interim Final Rules relating to the Internal Claims and Appeals process with respect to a claim, the claimant is deemed to have exhausted the internal claims and appeals process. The internal claims and appeals process will not be deemed exhausted as long as the violation was: <i>de minimus</i>, does not cause, and is not likely to cause, prejudice or harm to the claimant, attributable to good cause or due to matters beyond the control of the plan or issuer, in the context of an ongoing, good faith exchange of information between the plan and the claimant, and is not reflective of a pattern or practice of non-compliance. <i>See 29 CFR 2590.715-2719(b)(2)(ii)(F), as amended.</i> In the event that the claimant requests a written explanation of the violation, the plan or issuer must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. <i>See 29 CFR 2590.715-2719(b)(2)(ii)(F), as amended.</i> In the case that the external review rejects the claimant’s immediate review, the plan must provide the claimant notice of the opportunity to resubmit and pursue the internal appeal of the claim. This notice must be sent within a reasonable time after the external reviewer rejects the claim for immediate review, not later than 10 days. <i>See 29 CFR 2590.715-2719(b)(2)(ii)(F), as amended.</i> 	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<ul style="list-style-type: none"> These provisions are applicable for plan years beginning on or after January 1, 2012. <i>See T.R. 2011-01 at dol.gov/ebsa/newsroom/tr11-01.html.</i> 			
<p><u>Question 89 – Does the plan provide culturally and linguistically appropriate notices in a county that meets the applicable threshold?.....</u></p> <ul style="list-style-type: none"> The Department’s regulations provide that plans and issuers must provide relevant notices in a culturally and linguistically appropriate manner. 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-class-data.pdf. This list will be updated annually. <i>See 29 CFR 2590.715-2719(e) (3), as amended.</i> <p>If the answer to this question is “Yes,” proceed to question 90. If the answer is “No,” proceed to the next section.</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 90 – Does the plan provide notices in a culturally and linguistically appropriate manner with respect to internal claims and appeals processes?</u></p> <ul style="list-style-type: none"> To meet this requirement the plan or issuer must: <ul style="list-style-type: none"> include a one-sentence statement in the relevant non-English language about the availability of language services on each notice sent to an address in a county that meets the threshold; provide, upon request, a notice in any applicable non-English language;and provide a customer assistance process (such as a telephone hotline) with oral language services in the non-English language and provide written notices in the non-English language upon request. <i>See 29 CFR 2590.715-2719(e), as amended.</i> The translated statements are available at dol.gov/ebsa/IABDModelNotice2.doc. <p>These provisions are applicable for plan years beginning on or after January 1, 2012. <i>See T.R. 2011-01 at dol.gov/ebsa/newsroom/tr11-01.html.</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p><u>2. External Review</u></p> <p><i>Plans and issuers must comply with either a State external review process or the Federal external review process. The external review provisions of Part 7 of ERISA <u>do not apply</u> to grandfathered health plans.</i></p> <p>The following questions have been developed to assist in determining compliance with the rules regarding the external review processes.</p>			
<p><u>Question 91 – Is the plan subject to the requirements of a State external review process or the HHS-Administered Federal External Review Process?</u></p> <ul style="list-style-type: none"> • Non-grandfathered, self-insured group health plans subject to ERISA and the Code: <ul style="list-style-type: none"> ○ Generally follow requirements of the private accredited IRO process (<i>established by TR 2010-01, modified by TR 2011-02</i>). • Non-grandfathered, insured coverage: <ul style="list-style-type: none"> ○ Generally, issuers must follow the State process if the external review process meets either the NAIC-Similar or NAIC-Parallel process as determined by HHS. ○ However, issuers in States without a conforming State process and self-insured non-federal governmental plans may either: <ul style="list-style-type: none"> – 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. <p>Background information regarding external review processes for insured plans:</p> <ul style="list-style-type: none"> • 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. <p>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.</p>	<input type="checkbox"/>	<input type="checkbox"/>	

	YES	NO	N/A
<p><u>Question 92 – DOL Private Accredited IRO process: Does the plan provide external review for the required scope of adverse benefit determinations?</u></p> <p>Under the Department’s regulations the scope of the Federal external review process applies to:</p> <ul style="list-style-type: none"> • An adverse benefit determination, including a final internal adverse benefit determination, by a plan or issuer that involves medical judgment, including but not limited to those based on the plan’s or issuer’s requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational; and • A rescission of coverage (regardless of whether or not the rescission has any effect on any particular benefit at that time). <i>See 29 CFR 2590.715-2719(d)(1)(ii), as amended.</i> • 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. <i>See 29 CFR 2590.715-2719(d)(1)(i), as amended.</i> 	<input type="checkbox"/>	<input type="checkbox"/>	
<p><u>Question 93 – DOL Private Accredited IRO process: Does the plan provide an effective external review process?</u></p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ○ Providing effective written notice of external review ○ Providing limits related to filing fees ○ Providing claimant at least 4 months to file for external review ○ Requiring that IROs must be accredited ○ Requiring that IROs may not have conflicts of interest that influence independence ○ Providing that IRO decisions are binding on the insurer and the claimant ○ Requiring IROs to maintain written records for at least three years • 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. <p><i>See TR 2010-01 at dol.gov/ebsa/pdf/ACATEchnicalRelease2010-01.pdf, and TR-2011-02 at dol.gov/ebsa/newsroom/tr11-02.html</i></p>	<input type="checkbox"/>	<input type="checkbox"/>	