

# **DOL Compliance Binder**

## CHECKLIST OF DOCUMENTS

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Type of Document	Maintained by Employer
Plan document (or insurance booklet/certificate for an insured plan)	<input type="checkbox"/>
Summary plan description (SPD), including updates or summaries of material modifications (SMMs)	<input type="checkbox"/>
Forms 5500 and attachments, including supporting documentation (if applicable)	<input type="checkbox"/>
Summary annual reports (if required for plan)	<input type="checkbox"/>
Contracts with insurance companies	<input type="checkbox"/>
Open enrollment materials, including documents describing cost responsibilities for the employer and employees	<input type="checkbox"/>
Business Associate Agreement	<input type="checkbox"/>
Newborns' and Mothers' Health Protection Act notice (may be included in the SPD)	<input type="checkbox"/>
Women's Health & Cancer Rights Act notice	<input type="checkbox"/>
Annual Children's Health Insurance Program (CHIP) notice	<input type="checkbox"/>
Materials describing any wellness programs or disease management programs offered by the plan, including rewards based on a health factor	<input type="checkbox"/>
Documents showing compliance with HIPAA's portability rules, including certificates of creditable coverage, pre-existing condition exclusions and special enrollment rights	<input type="checkbox"/>
Documents showing compliance with COBRA, including general notice, election notice, notice of COBRA unavailability, notice of early termination and notice of insufficient payment	<input type="checkbox"/>

If the plan has grandfathered status under the ACA, documents that verify the plan's status and the notice of grandfathered plan status	<input type="checkbox"/>
If the plan has rescinded coverage, a list of those participants and dependents whose coverage has been rescinded, the reasons for the rescission and the notice of rescission	<input type="checkbox"/>
Plan provisions regarding lifetime and annual limits and the notice describing enrollment opportunities for individuals who previously lost coverage due to a lifetime limit	<input type="checkbox"/>
Summary of Benefits and Coverage and any 60-day advance notice of a mid-year material change to the plan	<input type="checkbox"/>
Exchange notice	<input type="checkbox"/>
For non-grandfathered plans, notice of patient protections and selection of providers	<input type="checkbox"/>
For non-grandfathered plans, information on the plan's claims and appeals procedures	<input type="checkbox"/>
A notice describing enrollment opportunities for children up to age 26 for plans with dependent coverage	<input type="checkbox"/>

## **NEWBORNS' AND MOTHER'S HEALTH PROTECTION ACT**

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

## WOMEN'S HEALTH AND CANCER RIGHTS ACT

### **Enrollment Notice**

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

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

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

## WOMEN'S HEALTH AND CANCER RIGHTS ACT

### **Annual Notice**

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

## NOTICE OF GRANDFATHERED STATUS

This *[group health plan or health insurance issuer]* believes this *[plan or coverage]* is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your *[plan or policy]* may not include certain consumer protections of the Affordable Care Act that apply to other plans; for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act; for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at *[insert contact information]*. *[For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.] [For individual market policies and nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at [www.healthreform.gov](http://www.healthreform.gov).]*

## NOTICE OF PATIENT PROTECTIONS

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

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

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

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

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

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

## PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

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

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

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at **www.askebsa.dol.gov** or by calling toll-free **1-866-444-EBSA (3272)**.

**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2013. You should contact your state for further information on eligibility.**

ALABAMA – Medicaid	COLORADO – Medicaid
Website: <a href="http://www.medicaid.alabama.gov">www.medicaid.alabama.gov</a> Phone: 1-855-692-5447	Medicaid Website: <a href="http://www.colorado.gov">www.colorado.gov</a> Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ALASKA – Medicaid	
Website: <a href="http://health.hss.state.ak.us/dpa/programs/medicaid">http://health.hss.state.ak.us/dpa/programs/medicaid</a> Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	
ARIZONA – CHIP	FLORIDA – Medicaid
Website: <a href="http://www.azahcccs.gov/applicants">www.azahcccs.gov/applicants</a> Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: <a href="http://www.flmedicaidtplecovery.com">www.flmedicaidtplecovery.com</a> Phone: 1-877-357-3268
	GEORGIA – Medicaid
	Website: <a href="http://dch.georgia.gov">http://dch.georgia.gov</a> Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150

<p align="center"><b>IDAHO – Medicaid and CHIP</b></p> <p>Medicaid Website:  <a href="http://www.accesstohealthinsurance.idaho.gov">www.accesstohealthinsurance.idaho.gov</a>  Medicaid Phone: 1-800-926-2588  CHIP Website: <a href="http://www.medicaid.idaho.gov">www.medicaid.idaho.gov</a>  CHIP Phone: 1-800-926-2588</p>	<p align="center"><b>MONTANA – Medicaid</b></p> <p>Website:  <a href="http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml">http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml</a>  Phone: 1-800-694-3084</p>
<p align="center"><b>INDIANA – Medicaid</b></p> <p>Website: <a href="http://www.in.gov/fssa">http://www.in.gov/fssa</a>  Phone: 1-800-889-9949</p>	<p align="center"><b>NEBRASKA – Medicaid</b></p> <p>Website: <a href="http://www.ACCESSNebraska.ne.gov">www.ACCESSNebraska.ne.gov</a>  Phone: 1-800-383-4278</p>
<p align="center"><b>IOWA – Medicaid</b></p> <p>Website: <a href="http://www.dhs.state.ia.us/hipp">www.dhs.state.ia.us/hipp</a>  Phone: 1-888-346-9562</p>	<p align="center"><b>NEVADA – Medicaid</b></p> <p>Medicaid Website: <a href="http://dwss.nv.gov">http://dwss.nv.gov</a>  Medicaid Phone: 1-800-992-0900</p>
<p align="center"><b>KANSAS – Medicaid</b></p> <p>Website: <a href="http://www.kdheks.gov/hcf">www.kdheks.gov/hcf</a>  Phone: 1-800-792-4884</p>	
<p align="center"><b>KENTUCKY – Medicaid</b></p> <p>Website: <a href="http://chfs.ky.gov/dms/default.htm">http://chfs.ky.gov/dms/default.htm</a>  Phone: 1-800-635-2570</p>	<p align="center"><b>NEW HAMPSHIRE – Medicaid</b></p> <p>Website:  <a href="http://www.dhhs.nh.gov/oii/documents/hippapp.pdf">www.dhhs.nh.gov/oii/documents/hippapp.pdf</a>  Phone: 603-271-5218</p>
<p align="center"><b>LOUISIANA – Medicaid</b></p> <p>Website: <a href="http://www.lahipp.dhh.louisiana.gov">http://www.lahipp.dhh.louisiana.gov</a>  Phone: 1-888-695-2447</p>	<p align="center"><b>NEW JERSEY – Medicaid and CHIP</b></p> <p>Medicaid Website:  <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid">www.state.nj.us/humanservices/dmahs/clients/medicaid</a>  Medicaid Phone: 609-631-2392  CHIP Website: <a href="http://www.njfamilycare.org/index.html">www.njfamilycare.org/index.html</a>  CHIP Phone: 1-800-701-0710</p>
<p align="center"><b>MAINE – Medicaid</b></p> <p>Website: <a href="http://www.maine.gov/dhhs/ofi/public-assistance/index.html">www.maine.gov/dhhs/ofi/public-assistance/index.html</a>  Phone: 1-800-977-6740  TTY 1-800-977-6741</p>	
<p align="center"><b>MASSACHUSETTS – Medicaid and CHIP</b></p> <p>Website: <a href="http://www.mass.gov/MassHealth">www.mass.gov/MassHealth</a>  Phone: 1-800-462-1120</p>	<p align="center"><b>NEW YORK – Medicaid</b></p> <p>Website: <a href="http://www.nyhealth.gov/health_care/medicaid">www.nyhealth.gov/health_care/medicaid</a>  Phone: 1-800-541-2831</p>
<p align="center"><b>MINNESOTA – Medicaid</b></p> <p>Website: <a href="http://www.dhs.state.mn.us">www.dhs.state.mn.us</a>  Click on Health Care, then Medical Assistance  Phone: 1-800-657-3629</p>	<p align="center"><b>NORTH CAROLINA – Medicaid</b></p> <p>Website: <a href="http://www.ncdhhs.gov/dma">www.ncdhhs.gov/dma</a>  Phone: 919-855-4100</p>
<p align="center"><b>MISSOURI – Medicaid</b></p> <p>Website:  <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">www.dss.mo.gov/mhd/participants/pages/hipp.htm</a>  Phone: 573-751-2005</p>	<p align="center"><b>NORTH DAKOTA – Medicaid</b></p> <p>Website:  <a href="http://www.nd.gov/dhs/services/medicalserv/medicaid">www.nd.gov/dhs/services/medicalserv/medicaid</a>  Phone: 1-800-755-2604</p>

<b>OKLAHOMA – Medicaid and CHIP</b>	<b>UTAH – Medicaid and CHIP</b>
Website: <a href="http://www.insureoklahoma.org">www.insureoklahoma.org</a> Phone: 1-888-365-3742	Website: <a href="http://health.utah.gov/upp">http://health.utah.gov/upp</a> Phone: 1-866-435-7414
<b>OREGON – Medicaid and CHIP</b>	<b>VERMONT– Medicaid</b>
Website: <a href="http://www.oregonhealthykids.gov">www.oregonhealthykids.gov</a> <a href="http://www.hijossaludablesoregon.gov">www.hijossaludablesoregon.gov</a> Phone: 1-800-699-9075	Website: <a href="http://www.greenmountaincare.org">www.greenmountaincare.org</a> Phone: 1-800-250-8427
<b>PENNSYLVANIA – Medicaid</b>	<b>VIRGINIA – Medicaid and CHIP</b>
Website: <a href="http://www.dpw.state.pa.us/hipp">www.dpw.state.pa.us/hipp</a> Phone: 1-800-692-7462	Medicaid Website: <a href="http://www.dmas.virginia.gov">www.dmas.virginia.gov</a> Medicaid Phone: 1-800-432-5924 CHIP Website: <a href="http://www.famis.org">www.famis.org</a> CHIP Phone: 1-866-873-2647
<b>RHODE ISLAND – Medicaid</b>	<b>WASHINGTON – Medicaid</b>
Website: <a href="http://www.eohhs.ri.gov/">www.eohhs.ri.gov/</a> Phone: 401-462-5300	Website: <a href="http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm">http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm</a> Phone: 1-800-562-3022 ext. 15473
<b>SOUTH CAROLINA – Medicaid</b>	<b>WEST VIRGINIA – Medicaid</b>
Website: <a href="http://www.scdhhs.gov">www.scdhhs.gov</a> Phone: 1-888-549-0820	Website: <a href="http://www.dhhr.wv.gov/bms/">www.dhhr.wv.gov/bms/</a> Phone: 1-877-598-5820, HMS Third Party Liability
<b>SOUTH DAKOTA - Medicaid</b>	<b>WISCONSIN – Medicaid</b>
Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a> Phone: 1-888-828-0059	Website: <a href="http://www.badgercareplus.org/pubs/p-10095.htm">www.badgercareplus.org/pubs/p-10095.htm</a> Phone: 1-800-362-3002
<b>TEXAS – Medicaid</b>	<b>WYOMING – Medicaid</b>
Website: <a href="http://www.gethipptexas.com">www.gethipptexas.com</a> Phone: 1-800-440-0493	Website: <a href="http://health.wyo.gov/healthcarefin/equalitycare">http://health.wyo.gov/healthcarefin/equalitycare</a> Phone: 307-777-7531

To see if any more states have added a premium assistance program since July 31, 2013, or for more information on special enrollment rights, you can contact either:

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

U.S. Department of Health and Human  
Services  
Centers for Medicare & Medicaid Services  
[www.cms.hhs.gov](http://www.cms.hhs.gov)  
1-877-267-2323, Menu Option 4, Ext. 61565

## COBRA GENERAL NOTICE

### **\*\*Continuation Coverage Rights Under COBRA\*\***

#### **Introduction**

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

#### **What is COBRA Continuation Coverage?**

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [*choose and enter appropriate information: must pay or are not required to pay*] for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B or both); or
- The parents become divorced or legally separated.

*[If the Plan provides retiree health coverage, add the following paragraph:]*

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to *[enter name of employer sponsoring the plan]*, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

### **When is COBRA Coverage Available?**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, *[add if Plan provides retiree health coverage: commencement of a proceeding in bankruptcy with respect to the employer,]* or the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), the employer must notify the Plan Administrator of the qualifying event.

### **You Must Give Notice of Some Qualifying Events**

**For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days *[or enter longer period permitted under the terms of the Plan]* after the qualifying event occurs. You must provide this notice to *[Enter name of appropriate party]*. *[Add description of any additional Plan procedures for this notice, including a description of any required information or documentation.]***

### **How is COBRA Coverage Provided?**

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

#### **Disability extension of 18-month period of continuation coverage**

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. *[Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice.]*

#### **Second qualifying event extension of 18-month period of continuation coverage**

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

## **If You Have Questions**

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

## **Keep Your Plan Informed of Address Changes**

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

## **Plan Contact Information**

*[Enter name of group health plan and name (or position), address and phone number of party or parties from whom information about the plan and COBRA continuation coverage can be obtained on request.]*

## COBRA ELECTION NOTICE

*[Enter date of notice]*

Dear *[Identify the qualified beneficiary(ies), by name or status]*:

**This notice contains important information about your right to continue your health care coverage in the *[enter name of group health plan]* (the Plan), as well as other health coverage alternatives that may be available to you through the Health Insurance Marketplace. Please read the information contained in this notice very carefully.**

To elect COBRA continuation coverage, follow the instructions on the next page to complete the enclosed Election Form and submit it to us.

If you do not elect COBRA continuation coverage, your coverage under the Plan will end on *[enter date]* due to *[check appropriate box]*:

- End of employment
- Death of employee
- Entitlement to Medicare
- Reduction in hours of employment
- Divorce or legal separation
- Loss of dependent status

Each person (“qualified beneficiary”) in the category(ies) checked below is entitled to elect COBRA continuation coverage, which will continue group health care coverage under the Plan for up to \_\_\_ months *[enter 18 or 36, as appropriate and check appropriate box or boxes; names may be added]*:

- Employee or former employee
- Spouse or former spouse
- Dependent children covered under the Plan on the day before the event that caused the loss of coverage
- Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan.

If elected, COBRA continuation coverage will begin on *[enter date]* and can last until *[enter date]*.

*[Add, if appropriate: You may elect any of the following options for COBRA continuation coverage: [list available coverage options].]*

COBRA continuation coverage will cost: *[enter amount each qualified beneficiary will be required to pay for each option per month of coverage and any other permitted coverage periods.]* You do not have to send any payment with the Election Form. Important additional information about payment for COBRA continuation coverage is included in the pages following the Election Form.

There may be other coverage options for you and your family. When key parts of the health care law take effect, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

If you have any questions about your rights to COBRA continuation coverage, you should contact *[enter name of party responsible for COBRA administration for the Plan, with telephone number and address]*.

# COBRA Continuation Coverage Election Form

Instructions: To elect COBRA continuation coverage, complete this Election Form and return it to us. Under federal law, you must have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan.

Send completed Election Form to: **[Enter Name and Address]**

This Election Form must be completed and returned by mail **[or describe other means of submission and due date]**. If mailed, it must be post-marked no later than **[enter date]**.

If you do not submit a completed Election Form by the due date shown above, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form.

Read the important information about your rights included in the pages after the Election Form.

I (We) elect COBRA continuation coverage in the **[enter name of plan]** (the Plan) as indicated below:

Name	Date of Birth	Relationship to Employee	SSN (or other identifier)
------	---------------	--------------------------	---------------------------

a. \_\_\_\_\_  
**[Add if appropriate: Coverage option elected: \_\_\_\_\_]**

b. \_\_\_\_\_  
**[Add if appropriate: Coverage option elected: \_\_\_\_\_]**

c. \_\_\_\_\_  
**[Add if appropriate: Coverage option elected: \_\_\_\_\_]**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship to individual(s) listed above

\_\_\_\_\_

\_\_\_\_\_  
Print Address

\_\_\_\_\_  
Telephone number

**Important Information**  
**About Your COBRA Continuation Coverage Rights**

**What is continuation coverage?**

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a “qualifying event” that would result in a loss of coverage under an employer’s plan. Depending on the type of qualifying event, “qualified beneficiaries” can include the employee (or retired employee) covered under the group health plan, the covered employee’s spouse, and the dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including [add if applicable: open enrollment and] special enrollment rights.

**How long will continuation coverage last?**

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued for up to a total of 18 months. In the case of losses of coverage due to an employee’s death, divorce or legal separation, the employee’s becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee’s hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- Any required premium is not paid in full on time,
- A qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary (note: there are limitations on plans’ imposing a pre-existing condition exclusion and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act),
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B or both) after electing continuation coverage, or
- The employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

*[If the maximum period shown on page 1 of this notice is less than 36 months, add the following three paragraphs:]*

### **How can you extend the length of COBRA continuation coverage?**

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify *[enter name of party responsible for COBRA administration]* of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

#### *Disability*

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. *[Describe Plan provisions for requiring notice of disability determination, including time frames and procedures.]* Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan of that fact within 30 days after SSA's determination.

#### *Second Qualifying Event*

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

### **How can you elect COBRA continuation coverage?**

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several or all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

### **How much does COBRA continuation coverage cost?**

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

### **When and how must payment for COBRA continuation coverage be made?**

#### *First payment for continuation coverage*

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact *[enter appropriate contact information, e.g., the Plan Administrator or other party responsible for COBRA administration under the Plan]* to confirm the correct amount of your first payment.

#### *Periodic payments for continuation coverage*

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the *[enter due date for each monthly payment]* for that coverage period. *[If Plan offers other payment schedules, enter with appropriate dates: You may instead make payments for continuation coverage for the following coverage periods, due on the following dates:].* If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan *[select one: will or will not]* send periodic notices of payments due for these coverage periods.

#### *Grace periods for periodic payments*

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period *[or enter longer period permitted by Plan]* to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for

that payment. [*If Plan suspends coverage during grace period for nonpayment, enter and modify as necessary:* However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.]

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be sent to:

*[enter appropriate payment address]*

### **For more information**

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator.

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, you should contact *[enter name of party responsible for COBRA administration for the Plan, with telephone number and address]*.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa) or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit [www.healthcare.gov](http://www.healthcare.gov).

### **Keep Your Plan Informed of Address Changes**

In order to protect your and your family's rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

## NOTICE OF UNAVAILABILITY OF COBRA COVERAGE

*[Enter date of notice]*

To: *[Identify the covered employee, qualified beneficiary or other individual]*

From: *[Plan Administrator]*

The Plan Administrator of the company's group health plan was notified on *[insert date]* of the occurrence of a COBRA qualifying event, a second COBRA qualifying event or a determination of disability by the Social Security Administration regarding a covered employee, qualified beneficiary or other individual. However, the Plan Administrator has determined that you and your dependents, if any, are NOT ENTITLED to COBRA continuation coverage of the company's group health benefits. Thus, your coverage under the company's group health benefits will terminate on *[insert date]*.

The reason you are not entitled to COBRA continuation coverage is as follows:

*[Describe reason]*

If any of the individuals listed above does not reside at this same address, please immediately notify the Plan Administrator so that we may provide a copy of this notice to that individual.

### **Appeal Procedure**

You may appeal this decision to deny your COBRA coverage if you believe your rights to COBRA continuation coverage have been improperly denied. The procedures to appeal this decision are as follows:

*[Describe appeal procedure for plan.]*

### **Additional Information**

Please contact the Plan Administrator immediately if you have questions about this notice or your COBRA rights. The Plan Administrator can be reached at *[insert contact information]*.

## NOTICE OF EARLY TERMINATION OF COBRA COVERAGE AND CONVERSION RIGHTS

*[Enter date of notice]*

To: *[Identify the qualified beneficiary]*

From: *[Plan Administrator]*

Effective *[insert date]*, COBRA continuation coverage of your group health benefits will terminate. This termination is earlier than the end of the maximum period of COBRA continuation coverage that applies to your original qualifying event.

If any of the individuals listed above does not reside at this same address, please immediately notify the Plan Administrator so that we may provide a copy of this notice to that individual.

### Reason for Early Termination of COBRA Coverage

Your COBRA continuation coverage is terminating before the end of the maximum coverage period due to *[check appropriate box]*:

- Coverage under another group health plan that does not limit or exclude pre-existing conditions of the individual
- Failure to pay required premium on time
- Termination of all company group health plans
- Eligibility for Medicare
- During a 29-month maximum coverage period based on disability, the Social Security Administration made a determination that the individual is no longer disabled
- Other *[describe other event]*

### Conversion Rights

You may have the right to convert your group health benefits under COBRA to an alternative group or individual health insurance policy. The Plan Administrator can provide you eligibility information, enrollment forms and other information on your conversion rights. If you qualify for a conversion policy, you will have *[insert number of days]* to submit your insurance application and first premium once your COBRA coverage ends.

### Appeal Procedure

Please notify the Plan Administrator as soon as possible if you believe the termination date of your COBRA coverage is inaccurate. You may request a review of this decision. The procedures to appeal this decision are as follows: *[Describe appeal procedure for plan.]*

### Additional Information

Please contact the Plan Administrator immediately if you have questions about this notice or your COBRA rights. The Plan Administrator can be reached at *[insert contact information]*.

## HIPAA SPECIAL ENROLLMENT NOTICE

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

### Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates his employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under our health plan.

### Marriage, Birth or Adoption

If you have a new dependent as a result of a marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth or placement for adoption.

Example: When you were hired by us, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

### Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired by us, your children received health coverage under CHIP and you did not enroll them in our health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

### For More Information or Assistance

To request special enrollment or obtain more information, please contact *[insert contact information]*.

Note: If you or your dependents enroll during a **special enrollment period**, as described above, you will not be considered a late enrollee. Therefore, your group health plan may not impose a pre-existing condition exclusion period of more than 12 months. Any pre-existing condition exclusion period will be reduced by the amount of your prior creditable health coverage. Effective for plan years beginning on or after Jan. 1, 2014, the Affordable Care Act prohibits group health plans from imposing pre-existing conditions exclusions.

## CERTIFICATE OF GROUP HEALTH PLAN COVERAGE

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

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

### **Statement of HIPAA Portability Rights**

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

### **Pre-existing Condition Exclusions**

Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as “pre-existing condition exclusions.” A pre-existing condition exclusion can apply only to conditions for which medical advice, diagnosis, care or

treatment was recommended or received within the six months before your “enrollment date.” Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a pre-existing condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a pre-existing condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption or placement for adoption.

Under the health care reform law, effective for plan years beginning on or after Sept. 23, 2010, a pre-existing condition exclusion cannot apply to an individual under age 19. For plan years beginning on or after Jan. 1, 2014, the law’s prohibition on pre-existing condition exclusions applies to all enrollees.

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

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

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

### **Right to Get Special Enrollment in another Plan**

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

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

### **Prohibition against Discrimination Based Upon a Health Factor**

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

## **Right to Individual Health Coverage**

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

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

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

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

## **State Flexibility**

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

## **For More Information**

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

## **HIPAA GENERAL NOTICE OF PRE-EXISTING CONDITION EXCLUSION**

### **Pre-existing Condition Exclusion**

This plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy or to a child who is enrolled in the plan within 30 days after birth, adoption or placement for adoption. Effective for plan years beginning on or after Sept. 23, 2010, the pre-existing condition exclusion does not apply to enrollees who are under the age of 19. Also, effective for plan years beginning on or after Jan. 1, 2014, the plan's pre-existing condition exclusion does not apply to any enrollees.

### **Length of Pre-existing Condition Exclusion**

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period.

### **Reduction of Pre-existing Condition Exclusion**

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

### **For More Information or Assistance**

All questions about the pre-existing condition exclusion and creditable coverage should be directed to *[insert contact information for plan administrator]*

## DETERMINATION OF CREDITABLE COVERAGE NOTICE

*[Enter date of notice]*

To: *[Insert individual's name and address]*

From: *[Insert Plan administrator's name and address]*

*[Name of Health Plan]* (the "Plan")

The Plan contains a pre-existing condition exclusion of 12 months (18 months if you are a late enrollee), which begins on the first day of coverage, or, if you were in a waiting period, on the first day of your waiting period. Your pre-existing condition exclusion period began on *[insert date]* (Enrollment Date).

Based upon the information you submitted to us regarding your prior creditable coverage, we have determined that you will satisfy your pre-existing condition exclusion period as of *[insert date]*.

We originally determined that your pre-existing condition exclusion period is 12 months (365 days), beginning on the Enrollment Date. Based upon the information provided to us, we determined that you have *[insert number]* days of creditable coverage. Upon reducing the 12-month pre-existing condition exclusion period, we determined that you are required to satisfy an additional *[insert number]* days. The plan has a right to modify this determination if it learns that the information provided to us and used to make this determination is not accurate.

In the event you were not covered by insurance for a period of more than 63 days, that prior coverage is no longer "creditable coverage" for purposes of reducing your pre-existing condition exclusion period. Time spent within a waiting period will not be taken into account when calculating the break in coverage.

During the pre-existing condition exclusion period, the plan will not pay benefits for any pre-existing condition for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period immediately preceding your Enrollment Date.

In the event you have additional coverage that you wish the plan to consider, please provide us with that additional information as soon as possible. If you have difficulty obtaining a Certificate of Coverage (HIPAA Certificate) for that additional coverage, please let us know and we will try to help you. You may show that you have additional coverage by means other than by a HIPAA Certificate.

You have a right to appeal this determination. You may send your appeal to *[insert address]*. Your appeal must be filed within 60 days of the date of this letter and should include additional facts which you feel should be considered during our review. We will respond to your appeal within 60 days. Our response will include the specific reasons for our determination and reference any specific plan provisions within the plan documents which support our decision.