

EXECUTIVE SUMMARY – HIPAA HEALTH COVERAGE PORTABILITY

On December 30, 2004, the Departments of Labor, Treasury and Health and Human Services jointly released the final regulations on Health Coverage Portability under HIPAA. The regulations amend the Code of Federal Regulations, as it relates to ERISA (29 CFR 2590 DOL), the Internal Revenue Code (26 CFR 54 & 602 IRS) and the Public Health Safety Act (45 CFR 144 & 146 HHS), and replace the Interim Final Rules issued in April of 1997 as of the first plan year on or after July 1, 2005.

The Health Coverage Portability Regulation applies to group health plans with two or more covered employees (self funded and fully insured), and to issuers of fully insured coverage.

DIFFERENCES FROM INTERIM REGULATIONS AND EXISTING INTERPRETATION

General Application

- Clarified definition of group of health plan to indicate it includes plans that cover employees and former employees (i.e. retiree group health plans are subject to HIPAA).
- Added provisions relating to application of HIPAA to Health Saving Accounts (HSA) and High Deductible Health Plans (HDHP), indicating that HIPAA would not apply to an HSA but would apply to the HDHP that is over the HSA.

Pre-Existing Condition Exclusions

- Notice of the plan's pre-existing condition exclusion must be provided with enrollment materials. Previously was required to be provided prior to applying the pre-existing exclusion.
- Content of Pre-existing Condition Notice has been expanded to require reference to the 6-month look back period and a reference to a contact (address or phone) for additional information or assistance.
- Notice of Determination of Creditable Coverage is no longer required if the plan's pre-existing condition exclusion is completely offset by the prior coverage.
- Content of Determination of Creditable Coverage was expanded to require inclusion of the date on which the pre-existing exclusion will end, in addition to the period of time in which it is applicable.
- The prohibition on applying pre-existing condition exclusions to newborns that have coverage within 30 days of their date of birth was expanded to require that a newborn be considered to have coverage within 30 days of birth when State law requires the charges of a newborn to be covered under the mother's coverage for a specified period of time or requires coverage of newborn expenses for a specified period of time regardless of whether the newborn is ever enrolled for coverage.

Creditable Coverage

- The definition of creditable coverage was expanded to include public health plans maintained by foreign countries or political subdivisions thereof, and to include the Medicaid CHIPS program.
- The definition of creditable coverage as it relates to a Public Health Plan was expanded by eliminating the term "insurance" from the definition of Public Health Plan and allowing any health coverage provided by a governmental entity to be considered creditable coverage (e.g. VA benefits).
- Provisions to comply with the requirements of the Trade Act of 2002 were added to state that a lapse in coverage does not include the period of time between the loss of coverage and the second COBRA election period for individuals eligible for assistance under the Trade Act of 2002.
- The definition of waiting period was clarified to indicate that the period of time between the submission of an application for individual insurance and the date that coverage is effective or the application is declined does not count as a lapse in coverage.

Certificates of Creditable Coverage

- Added specific time requirements for providing a certificate of creditable:
 - no later than the date the notice of right to elect COBRA is due when loss of coverage is a COBRA qualifying event,
 - no later than the date the notice of right to elect continuation under State law is due when loss of coverage results in a State continuation right.
- Added clarification that a certificate must be provided on request at any time during the period the person is covered.
- Content of the certificate was expanded to require a HIPAA educational statement relating to portability of coverage, special enrollment rights, non-discrimination rules and the right to obtain individual coverage.
- Added a provision that exceeding the lifetime maximum of the plan is a loss of coverage as of the date of the first claim denial.
- Added a requirement that a plan have a written procedure for requesting a certificate of creditable coverage including contact information (name, phone, address).
- Defined the steps necessary for individual to provide proof of prior coverage without a certificate of creditable coverage and required a plan to treat the individual as if they had a certificate when these steps are met.

Special Enrollment

- Expanded the right of special enrollment due to loss of other coverage to allow:
 - the employee to enroll at the time a dependent loses other coverage, even if the employee didn't have or didn't lose coverage at that time;
 - dependents to enroll at the time the employee loses other coverage, even if the dependents didn't have or didn't lose coverage at that time.
- Expanded the definition of loss of coverage to include exceeding the lifetime maximum of the plan.
- Clarified that cessation of employer contributions towards the cost of coverage is a special enrollment event, regardless of whether coverage is actually lost under the other coverage.
- Expanded the right of special enrollment to allow an employee that is covered under one plan option of an employer to change elections to another plan option when the employee or a dependent experiences a special enrollment event.
- Revised the model language for providing the required Notice of Special Enrollment Rights.

HIPAA HEALTH COVERAGE PORTABILITY REGULATION

(Eff. Date first plan year on or after 7/1/2005)

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The Health Coverage Portability Regulation applies to group health plans with two or more covered employees (self funded and fully insured), and to issuers of fully insured coverage.

A copy of the Health Coverage Portability Regulation can be downloaded from the Internet at <http://www.dol.gov/ebsa/regs/fedreg/final/2004028112.htm>. Section number references from the regulation have been provided below to assist you in finding the provisions in the regulation for more detail.

PRE-EXISTING CONDITION EXCLUSIONS

Definition

A pre-existing condition exclusion is a limitation on or exclusion of benefits based on the fact that a condition existed before the individual's effective date of coverage under a plan.

(DOL §2590.701-3(a)(1)(i), IRS §54.9801-3(a)(1)(i), HHS §146.111(a)(1)(i))

A pre-existing condition exclusion includes limits or exclusions not directly called pre-existing condition exclusions, but whose function is based on the fact that a condition existed before the effective date of coverage. For example:

- A benefit that only provides coverage if a condition occurs while covered under the plan.
- A benefit that only provides coverage if the individual has been covered under the plan from the moment of birth.
- A benefit that is limited to a specified dollar amount when a condition existed prior to the effective date.
- A benefit that excludes congenital conditions.
- The reduction of benefits under the plan by crediting maximums with dollars used under a prior coverage.
- The use of condition-specific waiting periods prior to coverage being available.

(DOL §2590.701-3(a)(1)(ii), IRS §54.9801-3(a)(1)(ii), HHS §146.111(a)(1)(ii))

General Rule

A group health plan can only impose a pre-existing condition exclusion if:

- The look back period for the exclusion does not exceed 6 months prior to the enrollment date (i.e. the beginning of the eligibility period, if any).
- The maximum length of the exclusion does not exceed 12 months (18 months for a late applicant) after the enrollment date (i.e. the beginning of the eligibility period, if any).
- The pre-existing condition exclusion is reduced by the number of days of prior, creditable coverage the individual has as of the enrollment date (i.e. the beginning of the eligibility period, if any).

(DOL §2590.701-3(a)(2), IRS §54.9801-3(a)(2), HHS §146.111(a)(2))

Conditions that are not Subject to Pre-Existing Condition Exclusions

A group health plan cannot impose a pre-existing condition exclusion for any of the following conditions:

- Any condition of a newborn child if the child was covered under any form of creditable coverage within 30 days after birth and has not had a significant break in coverage since that time. A newborn that as a result of State law had benefits under the Mother's coverage for a set period after birth is considered to have been covered within 30 days of birth regardless of whether the newborn was ever enrolled in the plan.
- Any condition of an adopted child or a child placed for adoption, if the child is less than 18 years of age at the time of adoption or placement, was covered under any form of creditable coverage within 30 days after adoption or placement and has not had a significant break in coverage since that time.
- Pregnancy.

- Any condition, if the sole basis for determination of the condition as pre-existing is genetic information and no actual diagnosis or treatment has been received for the condition.
(DOL §2590.701-3(b), IRS §54.9801-3(b), HHS §146.111(b))

Notice Requirement

A group health plan that has a pre-existing condition exclusion must provide each participating employee with written notice of the exclusion at the time of enrollment. Additionally, a group health plan is prohibited from applying a pre-existing condition exclusion to any employee or their dependent until this notice has been provided to the employee.
(DOL §2590.701-3(c), IRS §54.9801-3(c), HHS §146.111(c))

A sample General Notice of Pre-Existing Condition Exclusion is attached. The notice is required to contain the following information:

- The length of the look back period (not to exceed 6 months) for purposes of determining a pre-existing condition.
- The length of the pre-existing condition exclusion period (not to exceed 12 months or 18 months for late applicants).
- A statement that the maximum period of exclusion will be reduced by the number of days of creditable coverage.
- A description of the right to demonstrate creditable coverage and waiting periods through a certificate of creditable coverage or by other means.
- A statement of the right to request a certificate of creditable coverage from the prior plan.
- A statement that the current plan will assist in obtaining a certificate of creditable coverage from the prior plan, if necessary.
- The address or telephone number of a person to contact for additional information or assistance.
(DOL §2590.701-3(c)(2), IRS §54.9801-3(c)(2), HHS §146.111(c)(2))

If notice is provided by another party (e.g. the insurance company), the plan's obligation to provide notice is satisfied. Duplicate notices are not required to be provided when more than one party is obligated to provide notice.
(DOL §2590.701-3(c)(3), IRS §54.9801-3(c)(3), HHS §146.111(c)(3))

CREDITABLE COVERAGE

Definition

Creditable coverage is coverage under any of the following provided there has not been a lapse in coverage of 63 days or more:

- A group health plan.
- Individual, group or other form of health insurance.
- Medicare (Part A or Part B).
- Medicaid.
- CHAMPUS/TRICARE.
- A medical care program of the Indian Health Service or a tribal organization.
- A State health benefits risk pool.
- The Federal Employees Health Benefits Program.
- A public health plan, including any plan established by a State, the U.S. government, a foreign country, or any political subdivision thereof, that provides health coverage to individuals through insurance or other means.
- A health benefit plan provided through the Peace Corps.
- A State Children's Health Insurance Program (CHIPs).
(DOL §2590.701-4(a)(1), IRS §54.9801-4(a)(1), HHS §146.113(a)(1))

Creditable coverage does not include the following types of coverage:

- Accident only.
- Disability income.
- Liability insurance, including general and auto.
- Supplemental liability insurance.
- Workers' Compensation or similar coverage.
- Automobile medical payment insurance.

- Credit only insurance.
- Coverage under an on-site medical clinic.
- Limited scope dental, vision or long-term care insurance.
- Health flexible spending accounts, provided other group health coverage is available during the year and the maximum reimbursement does not exceed the greater of twice the salary reduction or \$500 plus the salary reduction.
- Non-coordinated benefits such as specified disease coverage (cancer only policy) or fixed indemnity policies (\$x per day of hospitalization).

(DOL §2590.701-4(a)(2) & 2590.732(c), IRS §54.9801-4(a)(2) & 54.9831-1(c), HHS §146.113(a)(2) & 146.145(c))

Counting Creditable Coverage

Creditable coverage may be counted in one of two ways:

- Standard Method.** The amount of creditable coverage is determined by counting each day that the individual has one or more types of creditable coverage as one day of creditable coverage. Days that happened prior to a significant break in coverage (63 days or more) are not counted as creditable. Days that occur during any waiting period are not counted as creditable, but do not count as a break in coverage either. In addition, in the case of a person who obtained a second election period under COBRA due to the Trade Act of 2002, the period of time between the initial loss coverage and the second election period under COBRA are not counted as a break in coverage.

(DOL §2590.701-4(b), IRS §54.9801-4(b), HHS §146.113(b))

- Alternative Method.** This method allows for the crediting of a pre-existing exclusion by specified benefit categories (mental health, substance abuse, prescription drugs, dental, and vision). All other benefits under the plan that do not fall within these five categories must use the Standard Method for counting creditable coverage. For the five alternative method categories, creditable coverage is counted by determining the amount of creditable coverage using the Standard Method and then counting the number days within that period that coverage existed for the alternative category. Significant breaks in coverage are not applied by category. In order to use the Alternative Method, a plan must prominently disclose at the time of enrollment that the method is being used and provide a description of the effect of using this method and the categories of benefits on which it will be used.

(DOL §2590.701-4(c), IRS §54.9801-4(c), HHS §146.113(c))

Reduction of Pre-Existing Condition Exclusion

A group health plan is required to reduce any pre-existing condition exclusion one day for each day of creditable coverage an individual has under a prior plan.

(DOL §2590.701-3(a)(2)(iii), IRS §54.9801-3(a)(2)(iii), HHS §146.111(a)(2)(iii))

A group health plan is prohibited from placing a time limit on how long an individual has to provide a certificate of creditable coverage or other evidence of creditable coverage.

(DOL §2590.701-3(d)(2), IRS §54.9801-3(d)(2), HHS §146.111(d)(2))

Determination of Creditable Coverage and Notice Requirement

A group health plan is required to make a determination regarding the amount of creditable coverage and the remaining pre-existing condition exclusion within a reasonable time of receiving the information.

(DOL §2590.701-3(d)(1), IRS §54.9801-3(d)(1), HHS §146.111(d)(1))

After a determination has been made in relation to the creditable coverage information, a group health plan is required to provide written notice of the amount of the remaining pre-existing condition exclusion after any credit has been applied. Such notice is not required if after credit for prior coverage, the plan's pre-existing condition exclusion has been fully satisfied.

(DOL §2590.701-3(e), IRS §54.9801-3(e), HHS §146.111(e))

A sample Notice of Determination is attached. The notice must be provided as soon as reasonably possible after determination of creditable coverage and must contain the following information:

- The length of any applicable pre-existing exclusion period and the date on which the pre-existing exclusion is no longer applicable.
- The source of all information used to make the determination and substance of what that information indicated.
- A statement of the right to submit additional information or evidence of creditable coverage.

A description of any plan appeal procedure.
(DOL §2590.701-3(e)(2), IRS §54.9801-3(e)(2), HHS §146.111(e)(2))

If notice is provided by another party (e.g. the insurance company), the plan's obligation to provide notice is satisfied. Duplicate notices are not required to be provided when more than one party is obligated to provide notice.
(DOL §2590.701-3(e)(3), IRS §54.9801-3(e)(3), HHS §146.111(e)(3))

If after an initial determination has been made and communicated a plan determines an individual did not have as much creditable coverage as originally determined, the plan can modify the pre-existing exclusion credit given. Notice of the new determination must be provided to the individual and the plan must act in accordance with the original determination until such notice is provided.
(DOL §2590.701-3(f), IRS §54.9801-3(f), HHS §146.111(f))

CERTIFICATES OF CREDITABLE COVERAGE

Who Must Provide a Certificate of Creditable Coverage

In general, all group health plans (self funded and fully insured) and all health insurers are required to provide certificates of creditable coverage upon termination of an individual's coverage under a plan.
(DOL §2590.701-5(a)(1), IRS §54.9801-5(a)(1), HHS §146.115(a)(1))

If a certificate of creditable coverage is provided by another party (e.g. the insurance company), the plan's obligation to provide notice is satisfied. Duplicate notices are not required to be provided when more than one party is obligated to provide notice.
(DOL §2590.701-5(a)(1)(ii), IRS §54.9801-5(a)(1)(ii), HHS §146.115(a)(1)(ii))

In the case of a plan that is fully insured, the insurer is required to provide the plan with the information necessary for the plan to provide certificates of creditable coverage at a later date if coverage under the insurance policy terminates prior to the individual's termination date under the plan (e.g. at the time an employer changes carriers).
(DOL §2590.701-5(a)(1)(iv)(B)(1), IRS §54.9801-5(a)(1)(iv)(B)(1), HHS §146.115(a)(1)(iv)(B)(1))

If an individual requests that a certificate of creditable coverage be provided to another party, the plan satisfies its obligation to provide the certificate to the individual by providing the information to the other party in a manner acceptable to that party.
(DOL §2590.701-5(a)(3)(i)(B), IRS §54.9801-5(a)(3)(i)(B), HHS §146.115(a)(3)(i)(B))

When Must a Certificate of Creditable Coverage be Provided?

A certificate of creditable coverage must be provided, without charge and within a reasonable period of time after coverage ends unless stated otherwise below, at the following times:

- When an individual loses coverage under the plan. If loss of coverage is a qualifying event under COBRA, the certificate must be provided within 44 days of the date the plan is notified of the qualifying event. If loss of coverage is an event under State continuation laws, the certificate must be provided within the time notice of continuation is required to be provided under State law.
- When an individual reaches the plan's lifetime maximum.
- When COBRA continuation ceases.
- Upon request from the individual at any time while coverage is in effect and for up to 24 months after coverage ends.
(DOL §2590.701-5(a)(2), IRS §54.9801-5(a)(2), HHS §146.115(a)(2))

Certificate of Creditable Coverage

A sample Certificate of Creditable Coverage is attached. Certificates must be provided in writing and include the following information:

- The date the certificate is issued.
- The name of the group health plan.
- The name of individual(s) to whom the certificate applies and other information necessary to identify the individual(s) (e.g. identification number, participant name)
- The name, address and telephone number of the plan administrator or insurer required to provide the certificate.
- The telephone number to call for information regarding the certificate.
- The date the waiting period for coverage began and the effective date of coverage, or a statement that there is at least 18 months of creditable coverage.
- The date coverage ended or a statement that coverage is continuing as of the date of the certificate.
- An educational statement regarding HIPAA which includes an explanation of:
 - the right to receive credit under the pre-existing condition exclusion of another plan for this coverage,
 - the Special Enrollment Rights under HIPAA,
 - the prohibition against discrimination based on any health factor,
 - the right to individual health coverage,
 - the fact that State law may provide additional protections in relation to fully insured coverage, and
 - a statement of where to get additional information on HIPAA.

(DOL §2590.701-5(a)(3)(ii), IRS §54.9801-5(a)(3)(ii), HHS §146.115(a)(3)(ii))

A plan or insurer is required to establish written procedures relating to how to request a certificate of creditable coverage. The procedure must include all contact information necessary to make the request, including name, phone number or address.

(DOL §2590.701-5(a)(4)(ii), IRS §54.9801-5(a)(4)(ii), HHS §146.115(a)(4)(ii))

Alternate Means of Providing Proof of Creditable Coverage

If a certificate of creditable coverage is not available or is contested, the individual has a right to present other forms of proof of prior coverage.

(DOL §2590.701-5(c)(2), IRS §54.9801-5(c)(2), HHS §146.115(c)(2))

A plan or insurer is required to consider all evidence in determining if an individual has creditable coverage. In considering all evidence an individual will be deemed to have provided proof of other coverage if the individual:

- Attests to the period of creditable coverage.
- Presents relevant corroborating evidence of coverage during the period attested to, such as, EOBs or other correspondence from the plan, pay stubs showing deduction for health coverage, ID cards, a copy of the plan or policy, records from providers indicating coverage, and third party statements. Verification may also be made by direct contact with the prior plan by phone or e-mail.
- Cooperates with the plan in verifying the coverage.

(DOL §2590.701-5(c)(3), IRS §54.9801-5(c)(3), HHS §146.115(c)(3))

Similar rules apply to providing evidence of dependent status. If the individual attests to such dependent status and the period of coverage, and cooperates with the plan in verifying the coverage, the individual is to be deemed as having provided proof of other coverage for the dependent.

(DOL §2590.701-5(c)(5), IRS §54.9801-5(c)(5), HHS §146.115(c)(5))

SPECIAL ENROLLMENT RIGHTS

Loss of Other Coverage

Upon the occurrence of a loss of eligibility, as described below, the plan must provide a 30 day period to enroll in the plan with an effective date no later than the first of the month following the receipt of the request for enrollment. In the case of a loss of eligibility due to reaching the lifetime maximum of the plan, the 30-day enrollment period will not begin until the first claim is denied due to this reason.

(DOL §2590.701-6(a)(4), IRS §54.9801-6(a)(4), HHS §146.117(a)(4))

If an employee loses eligibility under other group health coverage, the plan must provide a special enrollment period for the employee to enroll in any benefit option available under the plan. The employee must be allowed to enroll any eligible dependents regardless of whether the dependents were covered under the other coverage or experienced a loss of other coverage.

(DOL §2590.701-6(a)(2)(i), IRS §54.9801-6(a)(2)(i), HHS §146.117(a)(2)(i))

If a dependent of an employee loses eligibility under other group health coverage, the plan must provide a special enrollment period for the employee and that dependent to enroll in any benefit option available under the plan. The plan must allow the employee to enroll regardless of whether the employee was covered under the other coverage or experienced a loss of other coverage. Other dependents that did not experience a loss of other coverage are not required to be enrolled under the plan.

(DOL §2590.701-6(a)(2)(ii), IRS §54.9801-6(a)(2)(ii), HHS §146.117(a)(2)(ii))

Individuals that enroll in the plan during a special enrollment event are required to be considered timely applicants under the terms of the plan. The plan is prohibited from applying late applicant provisions to these individuals and must make all benefit packages for which the individual is eligible available for enrollment.

(DOL §2590.701-6(d), IRS §54.9801-6(d), HHS §146.117(d))

Loss of eligibility for coverage means:

- Termination of coverage due to any reason other than failure to pay premiums or for cause (e.g. fraud, intentional misrepresentation), regardless of whether the person is eligible for or elects COBRA.
- In the case of an HMO, termination of coverage because the individual no longer resides in the HMO service area.
- Meeting the lifetime maximum of the plan for all benefits.
- The cessation of employer or former employer contributions toward the cost of coverage, regardless of whether coverage actually ends.
- Exhaustion of the maximum COBRA period.

(DOL §2590.701-6(a)(3), IRS §54.9801-6(a)(3), HHS §146.117(a)(3))

Special enrollment rights resulting for loss of other coverage due not have to be provided, if at the time of initial enrollment:

- The plan requires the individual to state in writing that coverage is being waived due to other group health coverage.
- The plan provides notice to the employee, at or before the time of decline, that the plan requires a written statement of waiver and what the consequences of failing to provide the statement are.
- The employee did not provide a waiver or indicated the reason for waiver was not other coverage.

(DOL §2590.701-6(a)(3)(iv), IRS §54.9801-6(a)(3)(iv), HHS §146.117(a)(3)(iv))

Marriage

Upon the employee's marriage the plan must provide a 30 day period for the employee to enroll in the plan with an effective date no later than the first of the month following the receipt of the request for enrollment. Any eligible dependents that were acquired as a result of the marriage (e.g. spouse or children) must also be provided the opportunity to enroll at this time.

(DOL §2590.701-6(b)(2), IRS §54.9801-6(b)(2), HHS §146.117(b)(2))

Individuals that enroll in the plan during a special enrollment event are required to be considered timely applicants under the terms of the plan. The plan is prohibited from applying late applicant provisions to these individuals and must make all benefit packages for which the individual is eligible available for enrollment.

(DOL §2590.701-6(d), IRS §54.9801-6(d), HHS §146.117(d))

Birth, Adoption or Placement for Adoption

Upon the birth of the employee's child or the adoption or placement for adoption of a child with the employee the plan must provide a 30 day period for the employee to enroll in the plan with an effective date no later than the date of one of these events. The employee's spouse and the newborn or adopted/placed for adoption child must also be provide the opportunity to enroll at this time.

(DOL §2590.701-6(b)(2), IRS §54.9801-6(b)(2), HHS §146.117(b)(2))

Individuals that enroll in the plan during a special enrollment event are required to be considered timely applicants under the terms of the plan. The plan is prohibited from applying late applicant provisions to these individuals and must make all benefit packages for which the individual is eligible available for enrollment.

(DOL §2590.701-6(d), IRS §54.9801-6(d), HHS §146.117(d))

Notice Requirement

No later than at the time of enrollment, a group health plan is required to provide an employee with written notice of their Special Enrollment Rights under HIPAA. A sample Notice of Special Enrollment Rights is attached.

(DOL §2590.701-6(c), IRS §54.9801-6(c), HHS §146.117(c))

GENERAL NOTICE OF PRE-EXISTING CONDITION LIMITATION

This plan excludes coverage for conditions that existed prior to your enrollment date. The exclusion applies only to conditions that you received medical advice, diagnosis, care or treatment for during the six-month period prior to your enrollment date in this plan. The exclusion will not exceed a period of 12 months (18 months for a late applicant) from your enrollment date. Your enrollment date is the first day of your eligibility period. If you are not subject to an eligibility period, your enrollment date is your effective date under the plan. If you are a late applicant, your enrollment date is your effective date under the plan. This exclusion complies with federal laws.

The exclusion does not apply to claims for pregnancy. The exclusion will not be applied to a child that is enrolled under the plan within 30 days of the child's birth, adoption or placement for adoption.

You have the right under federal law to have the pre-existing condition limit reduced. Credit is based on the number of days of creditable coverage you can show. Creditable coverage is a period of continuous coverage, without a lapse of more than 63 days (not including waiting periods), under any of the following:

- A group health plan,
- Health insurance coverage (group, individual, or other),
- Part A or B of Medicare,
- Medicaid,
- The Active Military Health Program or TRICARE,
- A medical care program of the Indian Health Service or of a tribal organization,
- A State sponsored health benefits risk sharing pool,
- The Federal Employees Health Plan,
- The Peace Corp. Health Program,
- A State Children's Health Insurance Program,
- A public health plan that provides health coverage to enrolled individuals and is sponsored by the U.S. government, a State, a foreign country, or any political subdivision thereof.

Credit may be obtained by providing the plan with a Certificate of Creditable Coverage from your prior health plan or coverage. If you do not have a certificate from the prior plan or coverage, federal law requires them to provide you with one in most cases. If you are unable to obtain a certificate after requesting one in writing, you should contact this plan. This plan will assist you in obtaining the certificate or in demonstrating proof of prior coverage in other ways.

For more information regarding the plan's pre-existing condition exclusion or on obtaining credit for prior health coverage, contact the Human Resources Department of your employer as follows:

Group Name
Address
Phone

NOTICE OF DETERMINATION OF CREDITABLE COVERAGE

1. Name of Plan:
2. Employee Name:
3. Employee Identification Number:
4. Covered Individual(s)
Determination Applies To:
5. Type of Coverage:
6. Remaining pre-existing condition limitation period, after credit:
Date pre-existing condition limitation will no longer apply:

Source of Creditable Coverage Information:

Reason for exclusion of any period of prior coverage, if applicable:

You have a right to submit new information or evidence of prior coverage at any time. The plan will review it and make a determination if it is creditable. You will be provided notice of the plan's determination and credit will be given based on that determination.

If you do not agree with this determination, you may appeal the plan's decision by requesting a review, in writing. Your request should include a statement of the reasons for the appeal. A request for a review must be filed with the plan within 180 days after receipt of this determination. If your request for review is not received within 180 days, your right to appeal is forfeited. Requests for appeal should be sent to:

Group Name
Address

Note: Separate determinations will be furnished if information is not identical for the employee and each dependent.

GROUP NAME

Date of Determination

CERTIFICATE OF GROUP HEALTH PLAN COVERAGE

1. Date of Certificate:
2. Name of Plan:
3. Employee Name:
4. Employee Identification Number:
5. Covered Individual(s)
Certification Applies To:
6. Type of Coverage:
7. Name, address and telephone of plan administrator or issuer responsible for providing this certificate:
Group Name
Address
Phone
8. If the individual(s) identified in line 5 above has at least 18 months of creditable coverage (disregarding periods of coverage before a 63-day break), check here: _____. Otherwise, complete the following:

Date waiting period or affiliation period (if any) began:

Date coverage began:
9. Check here if coverage is continuing: _____. Otherwise, complete the following:

Date coverage ended:
10. For further information call: Group Phone Number

Note: Separate certificates will be furnished if information is not identical for the employee and each dependent.

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 6 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.

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 on 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 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 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: <http://www.dol.gov/ebsa>, the DOL's interactive web pages - Health Elaws, or <http://www.cms.hhs.gov/hipaa1>.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards 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).

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

To request special enrollment or obtain more information, contact [insert the name, title, telephone number, and any additional contact information of the appropriate plan representative].