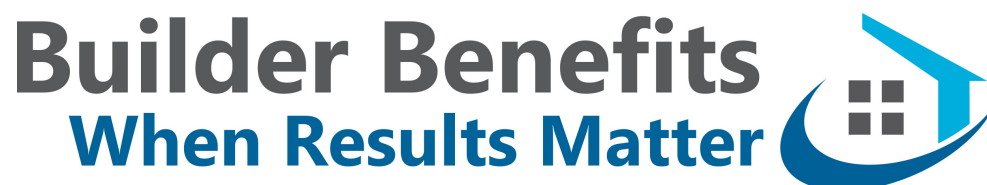


# Benefits Notices Generator Data Collection Booklet

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## Employer Information

### Employer Information

Employer Name:

Address Line 1:

Address Line 2:

City:

State:

Zip Code:

Phone:

Federal Tax ID:

Website:

### Plan Administrator at Employer

First Name:

Last Name:

Job Title / Department:

Address Line 1:

Address Line 2:

City:

State:

Zip Code:

Email:

Phone:

Phone Extension:

### Employer Size and Health Plan

How many employees do you have?

☐

1 to 19 employees

☐

20 to 49 employees

☐

50+ employees

Do you offer a health plan to some or all employees?

☐

Yes

☐

No

### Types of Benefits Offered

#### Welfare Benefit Plan Name

What is the name of your Welfare Benefit Plan?

## Summary of Material Reduction in Covered Services or Benefits/Summary of Material Modifications

Have you made a material reduction in covered services or benefits to your health plan within the last 60 days?

- ☐ Yes  
☐ No

**[Answer the following questions only if you answered "Yes" to "Have you made a material reduction in covered services or benefits to your health plan within the last 60 days?"]**

Date material reduction made:

Date material reduction effective:

Services or benefits materially reduced:

- ☐ Medical Plan
- ☐ Adoption Assistance
- ☐ Dental Plan
- ☐ Dependent Care Reimbursement Account (DCRA) Plan
- ☐ Health Flexible Spending Arrangement (FSA)
- ☐ Health Reimbursement Arrangement (HRA)
- ☐ Health Savings Account (HSA)
- ☐ Life Insurance Plan
- ☐ Long-Term Disability Plan
- ☐ Prescription Drug Plan
- ☐ Short-Term Disability Plan
- ☐ Vision Plan
- ☐ Premium Conversion Plan / Pre-Tax Contributions
- ☐ Other:

Explain all of the material reductions in covered services or benefits made to the health plan:

Have you made a material modification to your health plan that **did not result** in a material reduction in covered services or benefits?

- ☐ Yes  
☐ No

**[Answer the following questions only if you answered "Yes" to "Have you made a material modification to your health plan that did not result in a material reduction in covered services or benefits?"]**

Date material modification made:

Date material modification effective:

Services or benefits materially modified:

- ☐ Medical Plan
- ☐ Adoption Assistance
- ☐ Dental Plan
- ☐ Dependent Care Reimbursement Account (DCRA) Plan
- ☐ Health Flexible Spending Arrangement (FSA)
- ☐ Health Reimbursement Arrangement (HRA)
- ☐ Health Savings Account (HSA)
- ☐ Life Insurance Plan
- ☐ Long-Term Disability Plan
- ☐ Prescription Drug Plan
- ☐ Short-Term Disability Plan
- ☐ Vision Plan
- ☐ Premium Conversion Plan / Pre-Tax Contributions
- ☐ Other:

Explain all of the material modifications made to the health plan:

## Health Insurance Exchange Notice

Is your health plan offered to all employees or just some employees?

- ☐ All employees.  
☐ Some employees. Eligible employees are:

Does your health plan offer coverage to dependents?

- ☐ We do offer coverage. Eligible dependents are:  
☐ We do not offer coverage.

Does your group health plan satisfy the [minimum value](#) and [affordability](#) standards of the Affordable Care Act?

- ☐ Yes  
☐ No

## Disclosure of Grandfather Status

Do you offer a "grandfathered" health plan?

- ☐ Yes  
☐ No

## Notice of Patient Protections

Does your group health plan require or allow for the designation of primary care providers by participants or beneficiaries?

- ☐ Yes  
☐ No

**[Answer the following questions only if you answered "Yes" to "Does your group health plan require or allow for the designation of primary care providers by participants or beneficiaries?"]**

Your group health plan:

- ☐ Requires the designation of a primary care provider  
☐ Allows for the designation of a primary care provider

Does your group health plan designate a primary care provider automatically?

- ☐ Yes  
☐ No

Does your group health plan require or allow for the designation of a primary care provider for a child?

- ☐ Yes  
☐ No

Does your group health plan provide coverage for obstetric or gynecological care (OB/GYN care) and require the designation by a participant or beneficiary of a primary care provider?

- ☐ Yes  
☐ No

## Notice of Special Enrollment Rights

If the employee and/or his/her dependents lose eligibility for coverage under another health plan, or if employer contributions toward that coverage cease, within how many days after that coverage ends must the employee request to enroll him/herself and/or his/her dependents in your group health plan?

☐ 30 days

☐ Other: (Must be more than 30 days)

If the employee gains a new dependent as a result of marriage, birth, adoption, or placement for adoption, within how many days must the employee request to enroll him/herself and/or his/her dependents in your group health plan?

☐ 30 days

☐ Other: (Must be more than 30 days)

## Wellness Program Disclosure

Do your group health plan offer a health-contingent wellness program?

☐ Yes

☐ No

## Notice of Privacy Practices

Does your health plan create or receive protected health information?

☐ Yes

☐ No

Select an effective date for your Notice of Privacy Practices:

The federal HIPAA Privacy Rule requires covered entities to describe any state or other laws that require greater limits on disclosures. Insert this type of information below. **If no greater limits apply to your health plan, no information needs to be added.** For further assistance, contact the U.S. Department of Health and Human Services' Office of Civil Rights at 1-800-368-1019.

## Women's Health and Cancer Rights Act (WHCRA) Notices

Does your health plan provide coverage for medical and surgical benefits related to a mastectomy?

☐ Yes

☐ No

Deductible amount applicable to mastectomy benefits:

Coinsurance percentage applicable to mastectomy benefits:

## Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure

Does your health plan offer medical/surgical benefits AND mental health or substance use disorder benefits?

- ☐ Yes  
☐ No

## Michelle's Law Notice

Does your health plan require a certification of student status before providing dependent coverage beyond age 26?

- ☐ Yes  
☐ No

**[Answer the following question only if you answered "Yes" to "Does your health plan require a certification of student status before providing dependent coverage beyond age 26?"]**

Enter any other permissible eligibility conditions a plan participant must satisfy to be eligible to continue coverage upon a medically necessary leave of absence from school in the box below. **Note:** A requirement that the group health plan must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary will be **auto-generated**. [If there are no other permissible eligibility conditions, leave this box blank]

## Newborns' and Mothers' Health Protection Act Notice

Does your health plan provide maternity or newborn infant coverage?

- ☐ Yes  
☐ No

**[Answer the following question only if you answered "Yes" to "Does your health plan provide maternity or newborn infant coverage?"]**

Enter any additional information regarding maternity or newborn infant coverage required by state law:  
[Enter any additional information. If none is applicable, leave this box blank]

## Medicare Part D Creditable or Non-Creditable Coverage Notice

Does your health plan offer prescription drug coverage to Medicare-eligible individuals (in general, people age 65 or older, younger people with disabilities, or people with End Stage Renal Disease [permanent kidney failure requiring dialysis or transplant])?

- ☐ Yes  
☐ No

**[Answer the following questions only if you answered "Yes" to "Does your health plan offer prescription drug coverage to Medicare-eligible individuals (in general, people age 65 or older, younger people with disabilities, or people with End Stage Renal Disease (permanent kidney failure requiring dialysis or transplant))?"]**

Does your health plan provide Medicare Part D creditable coverage?

- ☐ Yes  
☐ No

**[Answer the following questions only if you answered "Yes" to "Does your health plan provide Medicare Part D creditable coverage?"]**

If the participant decides to join a Medicare drug plan, will his or her current prescription drug coverage under your group health plan be affected?

- ☐ Yes  
☐ No

Insert a sentence explaining the prescription drug coverage plan provisions/options under your group health plan that Medicare-eligible individuals have available to them when they become eligible for Medicare Part D:

Will the plan participant and his/her dependents be able to get prescription drug coverage back under your group health plan if they decide to enroll in Medicare Part D prescription drug coverage and drop their current prescription drug coverage under your group health plan?

- ☐ Yes  
☐ No

**[Answer the following questions only if you answered "No" to "Does your health plan provide Medicare Part D creditable coverage?"]**

Is this an Employer/Union sponsored group plan?

- ☐ Yes  
☐ No

Was the previous employer-sponsored coverage creditable coverage under Medicare Part D?

- ☐ Yes  
☐ No

Insert a sentence explaining the prescription drug coverage plan provisions/options under your group health plan that Medicare eligible individuals have available to them when they become eligible for Medicare Part D:



Will the plan participant and his/her dependents be able to get prescription drug coverage back under your group health plan if they decide to enroll in Medicare Part D prescription drug coverage and drop their current prescription drug coverage under your group health plan?

- ☐ Yes  
☐ No

### ADA Notice Regarding Wellness Program (Only Applicable to Employers with 15 or More Employees)

Do you offer a wellness program that collects employee health information?

- ☐ Yes  
☐ No/Not Applicable (fewer than 15 employees)

**[Answer the questions below only if you answered "Yes" to "Do you offer a wellness program that collects employee health information?"]**

Does your wellness program ask employees to complete a voluntary health risk assessment or similar assessment that asks a series of questions about their health-related activities and behaviors, and whether they have or have had certain medical conditions (e.g. cancer, diabetes, or heart disease)?

- ☐ Yes  
☐ No

Will the information from an employee's health risk assessment be used to provide him/her with services through the wellness program?

- ☐ Yes  
☐ No

What services may be offered through the wellness program as a result of an employee's health risk assessment? **[Do not capitalize or place a period after your response. Answer this question only if you answered "Yes" to "Will the information from an employee's health risk assessment be used to provide him/her with services through the wellness program?"]**

As part of the wellness program, will employees be asked to complete a biometric screening that includes a blood test?

- ☐ Yes  
☐ No

In the biometric screening blood test, what are the conditions for which blood will be tested? **[Do not capitalize or place a period after your response. Answer this question only if you answered "Yes" to "As part of the wellness program, will employees be asked to complete a biometric screening that includes a blood test?"]**

Will the information from an employee's biometric screening be used to provide him/her with services through the wellness program?

- ☐ Yes  
☐ No

What services may be offered through the wellness program as a result of an employee's biometric screening? **[Do not capitalize or place a period after your response. Answer this question only if you answered "Yes" to "Will the information from an employee's biometric screening be used to provide him/her with services through the wellness program?"]**

Will employees who choose to participate in the wellness program receive an incentive?

- ☐ Yes  
☐ No

What incentive will employees who choose to participate in the wellness program receive? **[Do not capitalize or place a period after your response. Answer this question only if you answered "Yes" to "Will employees who choose to participate in the wellness program receive an incentive?"]**

Are employees required to complete a health risk assessment to receive an incentive? **[Answer this question only if you answered "Yes" to "Will employees who choose to participate in the wellness program receive an incentive?"]**

- ☐ Yes  
☐ No

Are employees required to participate in a biometric screening to receive an incentive? **[Answer this question only if you answered "Yes" to "Will employees who choose to participate in the wellness program receive an incentive?"]**

- ☐ Yes  
☐ No

What are the criteria to achieve a participation incentive under the wellness program? **[Do not capitalize or place a period after your response. Answer this question only if you answered "Yes" to "Will employees who choose to participate in the wellness program receive an incentive?"]**

Are additional incentives made available to employees who participate in certain health-related activities? **[Answer this question only if you answered "Yes" to "Will employees who choose to participate in the wellness program receive an incentive?"]**

- ☐ Yes [List any additional incentives made available. Do not capitalize or place a period after your response.]  
☐ No

Are specific activities required to receive the additional incentives? **[Answer this question only if you answered "Yes" to "Will employees who choose to participate in the wellness program receive an incentive?"]**

- ☐ Yes [List any additional services that may be offered. Do not capitalize or place a period after your response.]  
☐ No

Do particular health outcomes need to be achieved to receive the additional incentives? **[Answer this question only if you answered "Yes" to "Will employees who choose to participate in the wellness program receive an incentive?"]**

- ☐ Yes [Explain the particular health outcomes that need to be achieved. Do not capitalize or place a period after your response.]
- ☐ No

Insert the name and contact information of each individual who will receive the employee's personally identifiable health information as part of the wellness program. **(Please type a complete sentence, but do not include a period at the end of your sentence.)**

**If applicable**, specify any other or additional confidentiality protections put in place for medical information obtained through the wellness program beyond (a) maintaining the medical information separate from personnel records, (b) encrypting the medical information if electronically stored, and (c) not making any employment decision based on information provided as part of the wellness program. **(Please type a complete sentence, but do not include a period at the end of your sentence.)**

## General Notice of COBRA Rights

If qualified beneficiaries elect COBRA continuation coverage, must the qualified beneficiaries pay for COBRA continuation coverage?

- ☐ Must pay
- ☐ Aren't required to pay

Does your plan provide retiree health coverage?

- ☐ Yes
- ☐ No

When must the employee notify the plan administrator of the following qualifying events: Divorce of the employee and spouse, legal separation of the employee and spouse, or a dependent child losing eligibility for coverage as a dependent child?

- ☐ 60 Days
- ☐ Other: (Must be more than 60 days)

Explain any **additional plan procedures** an employee must follow to notify the plan administrator of the following COBRA qualifying events: Divorce of the employee and spouse, legal separation of the employee and spouse, or a dependent child losing eligibility for coverage as a dependent child. **(If Applicable):** [For example, describe any required information or documentation]

Explain any **additional plan procedures** an employee must follow to notify the plan administrator of a request for a disability extension of his/her COBRA coverage. **(If Applicable):** [For example, describe any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice.]

## ACA Section 1557 Nondiscrimination Notice

Do you offer a health program or activity, any part of which receives funding from the U.S. Department of Health and Human Services (ex: Hospitals that accept Medicare or doctors who accept Medicaid)?

- ☐ Yes  
☐ No

**[Answer the following question only if you answered "Yes" to "Do you offer a health program or activity, any part of which receives funding from the U.S. Department of Health and Human Services (ex: Hospitals that accept Medicare or doctors who accept Medicaid)?"]**

Use the Plan Administrator as the Civil Rights Coordinator?

- ☐ Yes  
☐ No  
☐ Not Applicable (fewer than 15 employees)

**[Answer the following question only if you answered "No" to "Use the Plan Administrator as the Civil Rights Coordinator?"]**

## Civil Rights Coordinator

First Name:

Last Name:

Title:

Address Line 1:

Address Line 2:

City:

State:

Zip Code:

Website:

Phone:

Phone Extension:

Fax:

TTY Number:

Email: