



MEWA Coverage Requirements
760 IAC 1-68-4, 760 IAC 1-68-16, IC 27-1-34-9 and PPACA

This checklist must be submitted with any health form filing(s) for Multiple Employer Welfare Arrangement (MEWA). Please attach a completed checklist to each form filing.

MEWA Name: _____ Plan Name: _____

Contact Name: _____ Email: _____ Phone: _____

Instructions:

The checklist contains specific requirements/provisions and certifications that the MEWA must acknowledge with particular laws, regulations and bulletins. When providing the completed checklist, the MEWA is expected to address each checklist line item in the columns as follows:

- Provide the specific location(s) in the document provided which addresses the requirement, or
- Provide an explanation as to why the MEWA believes the item is not applicable.

All checklist line items require a response. Failure to provide fully completed checklist may result in a delay of regulatory approval.

Requirement	Location in Document (note page #)	IDOI use
760 IAC 1-68-4(g) The initial enrollment period for employees meeting the participation criteria must be at least thirty-one (31) days. If dependent coverage is offered, the dependent's open enrollment must also comply with this time period.		
760 IAC 1-68-4 (h) A MEWA may establish a waiting period during which a new employee is not eligible for coverage in accordance with the plan document.		
760 IAC 1-68-4 (j) A MEWA shall provide that the benefits applicable to an individual or family member shall be payable with respect to a newly born or adopted child of an insured. The coverage shall: (1) consist of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities; and (2) include, but not be limited to, benefits for inpatient or outpatient expenses arising from medical and dental treatment (including orthodontic and oral surgery treatment) involved in the management of birth defects known as cleft lip and cleft palate. If payment of a specific premium or fee is required to provide coverage for a child, the policy or contract may require that notification of the birth or adoption and payment of the required premium or fee must be furnished to the MEWA within thirty-one (31) days after the date of birth or adoption in order to have continuous coverage beyond the thirty-one (31) day period.		
760 IAC 1-68-4 (k) Coverage offered by the MEWA shall comply with the following: (1) The federal Women's Health and Cancer Rights Act. (2) The federal Mental Health Parity Act. (3) The federal Pregnancy Discrimination Act.		
760 IAC 1-68-4(m) The MEWA shall provide coverage for the following: (1) The medically necessary treatment for diabetes, including medically necessary supplies and equipment as ordered in writing by a: (A) physician licensed under IC 25-22.5; or (B) podiatrist licensed under IC 25-29; subject to general provisions of the health benefit plan. (2) At least one (1) prostate specific antigen test annually for an insured who is:		

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(A) at least fifty (50) years of age; or (B) younger than fifty (50) years of age and at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society. (3) Colorectal cancer examinations and laboratory tests for cancer for any nonsymptomatic insured, in accordance with the current American Cancer Society guidelines for a covered individual who is: (A) fifty (50) years of age; or (B) less than fifty (50) years of age and at high risk for colorectal cancer according to the most recent published guidelines of the American Cancer Society.		
760 IAC 1-68-4(n) A MEWA may not deny enrollment of a child of a covered individual because the child was born out of wedlock, the child is not claimed as a dependent on the parent's federal income tax return, or the child does not reside with the parent or in the MEWA's service area. Whenever a child of a noncustodial parent is eligible for coverage with or covered by the MEWA, the MEWA shall do the following: (1) Provide any information to the custodial parent that is necessary for the child to obtain benefits through the MEWA. (2) Permit the custodial parent, or the provider of medical services with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent. (3) Make payments on insurance claims submitted under subdivision (2) directly to the: (A) custodial parent; (B) provider of the medical services; or (C) office of Medicaid policy and planning. (4) When a parent is required by a court or an administrative order to provide health coverage for a child and the parent is eligible for family health coverage with the MEWA, the MEWA must do all of the following: (A) Permit the parent to enroll under the family coverage a child who is otherwise eligible for the coverage, without regard to any enrollment season restriction. (B) Enroll a child under the family coverage upon application by: (i) the child's custodial parent; (ii) the office of Medicaid policy and planning; or (iii) a Title IV-D agency whenever a noncustodial parent who is enrolled fails to apply for coverage of the child. (C) The MEWA may not disenroll or eliminate coverage of a child who is otherwise eligible for coverage unless the MEWA is provided satisfactory written evidence that the: (i) court order or administrative order is no longer in effect; or (ii) child is or will be enrolled in comparable health coverage not later than the effective date of the disenrollment.		
760 IAC 1-68-4(o) If the MEWA coordinates benefits, the coordination of benefits provision must comply with 760 IAC 1-38.1.		
760 IAC 1-68-16(a) A MEWA shall provide to each participating employer the written notice, "In the event the plan or the MEWA does not ultimately pay medical expenses that are eligible for payment under the plan for any reason, the participating employer may be liable for those expenses."		

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760 IAC 1-68-16(b) Every application and coverage form, including certificates of coverage, must contain in not less than twelve (12) point type the notice, "Your coverage is issued by a multiple employer welfare arrangement. The multiple employer welfare arrangement may not be subject to all of the insurance laws and regulations of Indiana. State insurance guaranty funds are not available for your multiple employer welfare arrangement."		
The following are Patient Protection and Affordable Care Act (PPACA) requirements:		
(Section 2714 - PHSA/Section 101 – PPACA) Extends Dependent Coverage for Children Until age 26: Plans and issuers that offer dependent coverage must make the coverage available to adult children up to age 26. Coverage cannot be restricted regardless of financial dependency, residency, marital status, student status, employment, eligibility for other coverage, or IRS qualification. This requirement applies to natural and adopted children, stepchildren, and children subject to legal guardianship.		
(Section 2711 – PHSA/Section 1302(b) – PPACA) Eliminate Dollar Limits on Essential Health Benefits: ALL health plans are prohibited from applying <u>annual</u> and <u>lifetime</u> dollar limits to Essential Health Benefits. Essential health Benefits include ambulatory services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventative and wellness services and chronic disease management, and pediatric services, including oral and vision care.		
(Section 2704 - PHSA/Section 1201 – PPACA) Eliminate Pre-existing Condition Exclusions: Prohibits preexisting condition exclusions on any participant or beneficiary.		
(Section 2713 - PHSA/Section 1001 – PPACA) Coverage of Preventive Health Services: Plans must provide coverage without cost-sharing for: 1) Services recommended by the US Preventive Services Task Force- https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics . 2) Immunizations recommended by the CDC. 3) Preventive Care & Screening for infants, children & adolescents. 4) Preventive care and screenings for women. Plans that have a network of providers may impose cost sharing delivered by out of network providers. If billed separately from an office visit, the plan may impose cost sharing on the office visit.		
(Section 2719A - PHSA/Section 10101 – PPACA) Choice of Health Care Professional: A plan that requires the designation of a PCP must allow the choice of any in-network PCP who is accepting patients.		
(Section 2719A - PHSA/Section 10101 - PPACA) Access to Pediatric Care: If designation of a PCP for a child is required, the plan must allow the choice to designate a physician who specializes in pediatrics as the child's PCP, if the provider is in-network and is accepting patients.		
(Section 2719A - PHSA/Section 10101 – PPACA) Access to OB/GYNs: Prohibits authorization or referral requirements for OB/GYN care provided by in-network providers who specialize in obstetrics or gynecology.		
(Section 2719A - PHSA/Section 10101 – PPACA)		

