## Employee Benefits Series

PATTERSON SMITH ASSOCIATES, LLC

*We design, build and manage employee benefit programs*

# Group Health Plan Notices

## 2016 CALENDAR

**Key ERISA-Required Notices and Filings**

## Basic Notice and Filing Requirements (SPD · SMM · Form 5500)

**In This Section:** Summary Plan Description > Summary of Material Modifications > Summary of Material Reduction in Covered Services or Benefits > Form 5500 > Summary Annual Report > Plan Documents

| Document | Type of Information | Provide To | Provided By | When Due |
|---|---|---|---|---|
| Summary Plan Description (SPD) ***(Model notice unavailable)*** ***See also "Summary of Benefits and Coverage," below, for additional requirements.*** | Provides plan participants and beneficiaries with information about their rights, benefits, and responsibilities under the plan and how it works, including:<br>• Basic rights and responsibilities of participants under ERISA (model language is available—see 29 C.F.R. § 2520.102-3(t)(2));<br>• Eligibility requirements;<br>• Description of plan benefits and how to file a claim for benefits;<br>• Applicable premiums, cost-sharing, deductibles and copayments; and<br>• Notices and descriptions required under COBRA, HIPAA, and other health coverage laws | Each participant covered under the plan<br><br>(Plan participants and beneficiaries, as well as the U.S. Department of Labor, or DOL, also have the right to obtain a copy of the SPD upon request—see "Plan Documents," below, for requirements.) | Plan administrator<br><br>(all plans, regardless of size) | Within 90 days after the employee becomes covered under the group plan<br><br>(New plans have 120 days after becoming subject to ERISA to distribute the SPD.)<br><br>The SPD must be current within 120 days prior to the date of distribution, and must be accompanied by any summary of material modification or change in information required to be included in the SPD which has not been incorporated into the document being furnished.<br><br>An updated SPD must be furnished every 5 years if changes are made to SPD information or the plan is amended. Otherwise, it must be furnished every 10 years. |
| Summary of Material Modifications (SMM) and Summary of Material Reduction in Covered Services or Benefits ***(Click on the SMM link above for model notices)*** ***See also "Notice of Modification," below, for related requirements.*** | Describes changes to information required to be included in the SPD and any material modification to the plan (a change that would be considered by an average plan participant to be an important change in covered benefits or other terms of coverage under the plan)<br><br>Changes that constitute a material reduction in covered services or benefits must be disclosed through either a revised SPD or an SMM.<br><br>**Note:** Under Health Care Reform, a plan may lose "grandfathered" status if it makes certain significant changes. | Each participant covered under the plan<br><br>(Plan participants and beneficiaries, as well as the DOL, also have the right to obtain a copy of the SMM upon request—see "Plan Documents," below, for requirements.) | Plan administrator<br><br>(all plans, regardless of size) | Within 60 days of adoption of a material reduction in covered services or benefits<br><br>(Alternatively, notice of a material reduction may be provided with plan information that is furnished at regular intervals of not more than 90 days, if certain conditions are met.)<br><br>Material changes that do not result in a reduction in covered services or benefits must be disclosed not later than 210 days after the end of the plan year in which the change is adopted. Timely distribution of a Notice of Modification may satisfy this requirement. |

## Basic Notice and Filing Requirements (SPD · SMM · Form 5500) (cont'd)

**In This Section:** Summary Plan Description > Summary of Material Modifications > Summary of Material Reduction in Covered Services or Benefits > Form 5500 > Summary Annual Report > Plan Documents

| Document | Type of Information | Provide To | Provided By | When Due |
|---|---|---|---|---|
| Form 5500—Annual Return/Report of Employee Benefit Plan<br>and<br>Schedules to Form 5500<br>***(Click on the links above for model notices)*** | Used to report various information about a plan, its finances, and its operation (requirements vary depending on the particular type of plan and its size)<br>**Note: A group health plan with fewer than 100 participants that is either fully insured or self-funded (or a combination of both) is generally not required to file Form 5500.** | Filed electronically with the U.S. Department of Labor through the ERISA Filing Acceptance System (EFAST2), using either EFAST2-approved vendor software or the IFILE web-based filing system<br>(Even though Form 5500 is filed electronically, the administrator must keep a copy on file, and must make a paper copy available upon request to participants, beneficiaries, and the DOL—see "Plan Documents," below, for requirements.) | Plan administrator<br>(depending on the number of participants covered and plan design, certain plans may be exempt from filing requirements) | Generally by the last day of the 7th calendar month after the end of the plan year (not to exceed 12 months in length)<br>A plan may obtain a one-time extension of time to file (up to 2½ months) by filing Form 5558, *Application for Extension of Time To File Certain Employee Plan Returns*, **with the IRS** on or before the date the Form 5500 would otherwise be due, without extension |
| Summary Annual Report (SAR)<br>***(Model language can be located at 29 C.F.R. § 2520.104b-10(d)(4))*** | Narrative summary of the Form 5500 annual financial report | Each plan participant | Plan administrator<br>(plans subject to Form 5500 annual reporting requirements) | Annually within 9 months after the end of the plan year<br>(When an extension of the due date for filing Form 5500 has been granted by the IRS, the SAR must be provided within 2 months after the extended due date.) |
| Plan Documents<br>***(Model notice unavailable—plan documents are specific to each plan)*** | Instruments under which the plan is established or operated, including the latest updated SPD, any SMMs, the latest Form 5500, and other documents | Participants and beneficiaries<br>(The DOL also has the authority to request any documents relating to an employee benefit plan.) | Plan administrator<br>(all plans, regardless of size) | Copies must be furnished to participants and beneficiaries no later than 30 days after a written request.<br>The plan administrator also must make copies available for examination at its principal office. |

## Health Care Reform (ACA) Required Notices and Filings

**In This Section:** IRS Forms 1094 & 1095 > Summary of Benefits and Coverage > Notice of Modification > Notice of Rescission of Coverage > Notice Regarding Availability of Health Insurance Exchanges > Disclosure of Grandfather Status > Notice of Patient Protections > Patient-Centered Outcomes Research Institute (PCORI) Fees

| Document | Type of Information | Provide To | Provided By | When Due |
|---|---|---|---|---|
| 2015 Forms 1094-C (*Transmittal*) and 1095-C (*Employer-Provided Health Insurance Offer and Coverage*)<br>***(Click on the links above for the forms)*** | Provides information about the health care coverage offered (if any) by an "applicable large employer" (ALE) to report compliance with the employer shared responsibility ("pay or play") provisions | **For ALEs with fully-insured plans:** Each employee who was a full-time employee for any month of the calendar year (and who was not in a limited non-assessment period)<br>**For ALEs with self-insured plans:** Any employee who enrolls in the health coverage, whether or not the employee is a full-time employee for any month of the calendar year | Applicable large employers (generally those with **50 or more full-time employees**, including full-time equivalents) | **Form 1095-C** must be furnished to covered individuals/full-time employees by **March 31, 2016**<br>**Forms 1094-C and 1095-C** must be filed with the IRS by **May 31, 2016** (or **June 30, 2016**, if filing electronically) |
| 2015 Forms 1094-B (*Transmittal*) and 1095-B (*Health Coverage*)<br>***(Click on the links above for the forms)*** | Used to report information about individuals who are covered by minimum essential coverage and therefore are not liable for the individual shared responsibility payment | Covered individuals | Self-insuring employers that are not ALEs, and other providers of minimum essential health coverage | **Form 1095-B** must be furnished to covered individuals by **March 31, 2016**<br>**Forms 1094-B and 1095-B** must be filed with the IRS by **May 31, 2016** (or **June 30, 2016**, if filing electronically) |

## Health Care Reform (ACA) Required Notices and Filings (cont'd)

**In This Section:** IRS Forms 1094 & 1095 > Summary of Benefits and Coverage > Notice of Modification > Notice of Rescission of Coverage > Notice Regarding Availability of Health Insurance Exchanges > Disclosure of Grandfather Status > Notice of Patient Protections > Patient-Centered Outcomes Research Institute (PCORI) Fees

| Document | Type of Information | Provide To | Provided By | When Due |
|---|---|---|---|---|
| Summary of Benefits and Coverage (SBC) and Uniform Glossary<br><br>**Note:** For plan years beginning **on or after April 1, 2017**, a new proposed SBC template and other related documents are generally expected to apply.<br><br>***(Click here for a list of all available templates and related documents)*** | A summary of benefits and coverage under the plan, including information on cost-sharing requirements and coverage limitations, as well as definitions of certain coverage-related terms, such as "deductible" and "co-pay"<br><br>**Note:** For coverage beginning on or after January 1, 2014, SBCs must include language indicating whether the plan provides "minimum essential coverage" and "minimum value." Until further guidance is issued, the previously authorized template may be used without penalty, provided the SBC is furnished with a cover letter or similar disclosure that includes the additional language. | Plan participants and beneficiaries | Group health plan and health insurance issuer offering group coverage (plans with 2 or more participants who are current employees)<br><br>**Note:** For insured group coverage, if *either* the issuer or the plan provides the SBC, the requirement is satisfied for *both*. For SBCs with respect to coverage that begins **on or after September 1, 2015**, additional obligations apply to group health plans that utilize a binding contract with another party to provide the SBC. | Must be provided at specified times during the enrollment process and upon a participant or beneficiary's request, generally as follows:<br><br>• **Prior to initial enrollment** in the plan;<br>• Upon **renewal** of plan coverage;<br>• **Within 90 days** of special enrollment; and<br>• **Within 7 business days** following receipt of a request<br><br>(The SBC may be provided together with other summary materials such as an SPD, if the SBC information is intact and prominently displayed at the beginning of the materials and in accordance with the timing requirements for providing an SBC.) |
| Notice of Modification<br><br>***(Model notice unavailable)*** | Advance notice of a material change in any plan terms that would affect the content of the SBC and that occurs other than in connection with a renewal or reissuance of coverage<br><br>**Note:** Certain significant plan changes may cause a loss of "grandfathered" status. | Plan participants and beneficiaries | Group health plan or health insurance issuer offering group coverage (plans with 2 or more participants who are current employees) | No later than 60 days prior to the effective date of the change<br><br>(Notice provided in a complete and timely manner may also satisfy the requirement to provide a summary of material modifications or SMM.) |
| Notice of Rescission of Coverage<br><br>***(Model notice unavailable)*** | Advance written notice that coverage will be rescinded (declared invalid from the time of enrollment) due to fraud or intentional misrepresentation by a person covered by the plan | Each participant who would be affected | Group health plan or health insurance issuer offering group coverage (plans with 2 or more participants who are current employees) | At least 30 days before the coverage is rescinded |

## Health Care Reform (ACA) Required Notices and Filings (cont'd)

**In This Section:** IRS Forms 1094 & 1095 > Summary of Benefits and Coverage > Notice of Modification > Notice of Rescission of Coverage > Notice Regarding Availability of Health Insurance Exchanges > Disclosure of Grandfather Status > Notice of Patient Protections > Patient-Centered Outcomes Research Institute (PCORI) Fees

| Document | Type of Information | Provide To | Provided By | When Due |
|---|---|---|---|---|
| Notice Regarding Availability of Health Insurance Exchanges<br>***(There is one model notice for employers who offer a health plan to some or all employees, and another model notice for employers who do not offer a plan)*** | Provides employees with certain information about the existence of Health Insurance Exchanges (also known as Marketplaces), including notice that the employee may lose employer health plan contributions if the employee buys coverage through the Exchange | New employees | All employers covered by the Fair Labor Standards Act | Must be provided to each new employee at the time of hiring, within 14 days of the employee's start date |
| Disclosure of Grandfathered Status<br>***(Click on the link above for model notice)*** | A statement that the plan believes it is a grandfathered health plan and providing contact information for questions and complaints (required to maintain grandfathered status) | Plan participants and beneficiaries | Grandfathered group health plan<br>(plans with 2 or more participants who are current employees) | In any plan materials provided to a participant or beneficiary describing benefits provided under the plan |
| Notice of Patient Protections<br>***(Click on the link above for model notice)*** | Informs participants of the plan's terms regarding designation of a primary care provider, including the right to choose a primary care provider or a pediatrician, as well as the right to obtain OB/GYN care without prior authorization or referral (if coverage is provided for OB/GYN care under the plan) | Plan participants | Non-grandfathered group health plan that requires or provides for the designation of a participating primary care provider by a participant/beneficiary<br>(plans with 2 or more participants who are current employees) | Whenever a participant is provided with a summary plan description or other similar description of benefits under the plan |
| Patient-Centered Outcomes Research Institute (PCORI) Fees<br>**Note:** Fees apply for plan years ending on or after October 1, 2012, and before October 1, 2019. | Employers that sponsor certain self-insured health plans are responsible for fees that support research to evaluate and compare health outcomes and the clinical effectiveness of medical treatments, services, and drugs. | Filed with the Internal Revenue Service | Plan sponsors of certain self-insured health plans (including HRAs that are not treated as excepted benefits) | IRS Form 720 must be filed annually to report and pay the fees no later than July 31st of the calendar year immediately following the last day of the plan year to which a fee applies. |

## COBRA Required Notices

**In This Section:** General Notice of COBRA Rights > Notice of Qualifying Event > COBRA Election Notice > Notice of Unavailability of COBRA Coverage > Notice of Underpayment of COBRA Premium > Notice of Early Termination of COBRA Coverage

| Document | Type of Information | Provide To | Provided By | When Due |
|---|---|---|---|---|
| General Notice of COBRA Rights<br>***(Click on the link above for model notice)*** | Notice of the right to purchase a temporary extension of group health coverage when coverage is lost due to certain qualifying events, as well as other health coverage options that may be available (such as the Health Insurance Marketplace)<br><br>The following are qualifying events if they cause a loss of coverage:<br>*For employee/spouse/dependent child*:<br>• Termination of employment (other than for gross misconduct)<br>• Reduction in hours of employment<br>*For spouse and dependent child only:*<br>• Death of covered employee<br>• Covered employee becomes entitled to Medicare<br>• Divorce or legal separation of the covered employee from spouse<br>*For dependent child only:*<br>• Loss of dependent child status under the plan rules<br><br>(Under Health Care Reform, when a plan covers dependents, it generally must continue to make the coverage available until a child reaches age 26.) | Covered employees and their spouses | Plan administrator<br>(group health plans sponsored by employers with 20 or more employees) | Within 90 days after the date group health plan coverage commences<br><br>Group health plans may satisfy this requirement by including the general notice in the summary plan description and giving the SPD to the employee and spouse within the time limit.<br><br>(Information regarding the right to continue coverage also must be included in the plan's SPD and the "Summary of Benefits and Coverage.") |

***Special Note:*** *Group health plans sponsored by employers with **20 or more employees**, including both full and part-time employees, on more than 50% of typical business days in the prior calendar year are subject to the federal Consolidated Omnibus Budget Reconciliation Act (COBRA). Each part-time employee counts as a fraction of a full-time employee, equal to the number of hours the part-time employee worked divided by the hours an employee must work to be considered full time. Companies that have common ownership interests should contact a knowledgeable attorney for issues related to headcount.*

Many states have enacted what are commonly referred to as "mini-COBRA" laws, which require group health plans to provide continuation of benefits, including plans sponsored by employers with fewer than 20 employees. **Be sure to review your state's law for applicable "mini-COBRA" requirements.**

## COBRA Required Notices (cont'd)

**In This Section:** General Notice of COBRA Rights > Notice of Qualifying Event > COBRA Election Notice > Notice of Unavailability of COBRA Coverage > Notice of Underpayment of COBRA Premium > Notice of Early Termination of COBRA Coverage

| Document | Type of Information | Provide To | Provided By | When Due |
|---|---|---|---|---|
| Notice of Qualifying Event<br>***(Model notice unavailable)*** | Notice of the occurrence of a qualifying event that is the covered employee's death, termination of employment (other than for gross misconduct), reduction in hours, or entitlement to Medicare<br><br>**Note:** The employee or one of the qualified beneficiaries is responsible for notifying the plan if the qualifying event is divorce, legal separation, or loss of dependent status under the plan. | Plan administrator | Employer<br><br>(group health plans sponsored by employers with 20 or more employees) | Within 30 days after the qualifying event<br><br>**Note:** The plan may not require employees or qualified beneficiaries to provide notice earlier than 60 days from the latest of:<br>• The date the qualifying event occurs;<br>• The date the qualified beneficiary loses (or would lose) coverage under the plan due to the qualifying event; or<br>• The date the qualified beneficiary is informed of the responsibility to notify the plan and the process for doing so. |
| COBRA Election Notice<br>***(Click on the link above for model notice)*** | Describes the right to COBRA continuation coverage and how to make an election upon the occurrence of a qualifying event, as well as other health coverage options that may be available (including coverage through the Health Insurance Marketplace) | Covered employees, spouses, and dependent children who are qualified beneficiaries | Plan administrator<br><br>(group health plans sponsored by employers with 20 or more employees) | Generally within 14 days after receiving notice of a qualifying event<br><br>If the employer is also the plan administrator, the notice must be provided not later than 44 days after the date the qualifying event occurred or the date of loss of coverage due to the qualifying event (if the plan provides that COBRA coverage starts on the date of loss of coverage). |

***Special Note:*** *Group health plans sponsored by employers with **20 or more employees**, including both full and part-time employees, on more than 50% of typical business days in the prior calendar year are subject to the federal Consolidated Omnibus Budget Reconciliation Act (COBRA). Each part-time employee counts as a fraction of a full-time employee, equal to the number of hours the part-time employee worked divided by the hours an employee must work to be considered full time. Companies that have common ownership interests should contact a knowledgeable attorney for issues related to headcount.*

Many states have enacted what are commonly referred to as "mini-COBRA" laws, which require group health plans to provide continuation of benefits, including plans sponsored by employers with fewer than 20 employees. **Be sure to review your state's law for applicable "mini-COBRA" requirements.**

## COBRA Required Notices (cont'd)

**In This Section:** General Notice of COBRA Rights > Notice of Qualifying Event > COBRA Election Notice > Notice of Unavailability of COBRA Coverage > Notice of Underpayment of COBRA Premium > Notice of Early Termination of COBRA Coverage

| Document | Type of Information | Provide To | Provided By | When Due |
|---|---|---|---|---|
| Notice of Unavailability of COBRA Coverage<br>***(No model notice provided by the federal government. Sample notice available by clicking on the link above for general reference purposes only.)*** | Notice that an individual is not entitled to COBRA continuation coverage or an extension of continuation coverage, which explains the reason the group health plan is denying the request | Individuals who have submitted a notice of qualifying event whom the plan determines are not eligible for COBRA continuation coverage | Plan administrator<br>(group health plans sponsored by employers with 20 or more employees) | Generally within 14 days after receiving notice of a qualifying event |
| Notice of Underpayment of COBRA Premium<br>***(Model notice unavailable)*** | If the amount of a COBRA premium payment made to the plan is wrong, but is not significantly less than the amount due, the plan must either treat the amount submitted as full payment, or must notify the qualified beneficiary of the deficiency and grant a reasonable period (for this purpose, 30 days is considered reasonable) to pay the difference. | Qualified beneficiary who makes timely payment in an amount that is not significantly less than the amount due for a period of COBRA coverage | Employer or plan administrator<br>(group health plans sponsored by employers with 20 or more employees) | A plan must grant a reasonable period of time (no less than 30 days) for payment of a deficiency, where the incorrect amount is not significantly less than the amount due, before taking action to terminate coverage. |
| Notice of Early Termination of COBRA Coverage<br>***(No model notice provided by the federal government. Sample notice available by clicking on the link above for general reference purposes only.)*** | Notice that COBRA coverage will terminate earlier than the maximum period of coverage, which describes the date coverage will terminate, the reason for termination, and any rights to elect alternative coverage | Qualified beneficiaries whose COBRA coverage will terminate earlier than the maximum period of coverage | Plan administrator<br>(group health plans sponsored by employers with 20 or more employees) | As soon as practicable following the administrator's determination that COBRA coverage will terminate |

***Special Note:*** *Group health plans sponsored by employers with **20 or more employees**, including both full and part-time employees, on more than 50% of typical business days in the prior calendar year are subject to the federal Consolidated Omnibus Budget Reconciliation Act (COBRA). Each part-time employee counts as a fraction of a full-time employee, equal to the number of hours the part-time employee worked divided by the hours an employee must work to be considered full time. Companies that have common ownership interests should contact a knowledgeable attorney for issues related to headcount.*

Many states have enacted what are commonly referred to as "mini-COBRA" laws, which require group health plans to provide continuation of benefits, including plans sponsored by employers with fewer than 20 employees. **Be sure to review your state's law for applicable "mini-COBRA" requirements.**

## HIPAA Portability and Nondiscrimination Required Notices

**In This Section:** Notice of Special Enrollment Rights > Wellness Program Disclosure

| Document | Type of Information | Provide To | Provided By | When Due |
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| Notice of Special Enrollment Rights<br>***(Click on the link above and scroll to page 2 of the PDF for model notice—marked as page 138)*** | Describes the group health plan's special enrollment rules, including the right to special enroll within at least 30 days of the loss of other coverage or of marriage, birth of a child, adoption, or placement for adoption | Employees eligible to enroll in the group health plan | Group health plans with 2 or more participants who are current employees | At or before the time an employee is initially offered the opportunity to enroll in the group health plan |
| Wellness Program Disclosure<br>***(Click on the link above and scroll to page 3 of the PDF for model notice—marked as page 139)*** | Notice by a group health plan offering a wellness program that requires individuals to meet a standard related to a health factor in order to obtain a reward, which discloses the availability of a reasonable alternative standard to qualify for the reward and states that recommendations of an individual's personal physician will be accommodated | Participants and beneficiaries eligible to participate in a wellness program that requires individuals to meet a standard related to a health factor in order to obtain a reward | Group health plan or health insurance issuer offering a wellness program that requires individuals to meet a standard related to a health factor in order to obtain a reward<br>(plans with 2 or more participants who are current employees) | In all plan materials that describe the terms of the wellness program (if the plan materials merely mention that a program is available, without describing its terms, disclosure is not required) and in any disclosure that an individual did not satisfy an initial outcome-based standard |

## Special Health Care Notices

**In This Section:** Women's Health and Cancer Rights Act Notices > Mental Health Parity and Addiction Equity Act Disclosure > Employer CHIP Notice > Genetic Information Nondiscrimination Act Disclosures > Michelle's Law Notice > Notice Regarding Newborns' and Mothers' Health Protection Act > Medical Child Support Order Notices > National Medical Support Notice

| Document | Type of Information | Provide To | Provided By | When Due |
|---|---|---|---|---|
| Women's Health and Cancer Rights Act (WHCRA) Notices<br>***(Click on the link above and scroll to pages 5 and 6 of the PDF for model notices—marked as pages 141-142)*** | Describes required benefits for mastectomy-related reconstructive surgery, prostheses, and treatment of the physical complications of a mastectomy | Plan participants and beneficiaries | Group health plan, and insurance company or HMO, providing coverage for medical and surgical benefits with respect to a mastectomy | Upon enrollment in the plan and annually thereafter |
| Mental Health Parity & Addiction Equity Act (MHPAEA) Disclosure<br>***(Model notice unavailable)***<br><br>**Note:** Under Health Care Reform, most non-grandfathered small group plans are required to cover mental health and substance use disorder services (as one category of "essential health benefits"), at parity with medical and surgical benefits. | Describes criteria for medical necessity determinations made under a group health plan with respect to mental health or substance use disorder benefits<br><br>(Certain plans that are exempt from the requirements under the MHPAEA based on increased cost may be subject to alternative disclosure rules. Non-grandfathered plans in the small group market that must provide "essential health benefits" that comply with MHPAEA requirements may not qualify for this exemption.) | Any current or potential participant, beneficiary, or contracting provider | Plan administrator of group health plan offering medical/ surgical benefits and mental health or substance use disorder benefits (or health insurance issuer offering such coverage) | Upon request<br><br>**Note:** The reason(s) for any denial of reimbursement or payment for services with respect to mental health or substance use disorder benefits must also be made available to the participant or beneficiary, in a form and manner consistent with the rules regarding reasonable claims procedures for group health plans (which require, among other things, that such disclosures be provided within maximum timeframes and free of charge). |
| Employer CHIP Notice<br>***(Click on the link above for model notice)*** | Informs employees of potential opportunities currently available in the state in which they reside for group health plan premium assistance under Medicaid and the Children's Health Insurance Program (CHIP), as well as the option to purchase coverage through the Health Insurance Marketplace | All employees | Employers that provide group health coverage in states with premium assistance through Medicaid or CHIP | Annually before the start of each plan year (may be provided concurrently with materials notifying the employee of health plan eligibility, or in connection with an open season or election process conducted under the plan, or concurrently with the SPD) |

## Special Health Care Notices (cont'd)

**In This Section:** Women's Health and Cancer Rights Act Notices > Mental Health Parity and Addiction Equity Act Disclosure > Employer CHIP Notice > Genetic Information Nondiscrimination Act Disclosures > Michelle's Law Notice > Notice Regarding Newborns' and Mothers' Health Protection Act > Medical Child Support Order Notices > National Medical Support Notice

| Document | Type of Information | Provide To | Provided By | When Due |
|---|---|---|---|---|
| Genetic Information Nondiscrimination Act (GINA) Disclosures<br>***(Model "warning" language is available in Q&A #11 from the U.S. Equal Employment Opportunity Commission; other model disclosure unavailable)*** | Informs health care providers not to collect genetic information, including family medical history, as part of an employment-related medical examination<br>An additional "warning" not to provide genetic information may be required when requesting medical information (**Note:** This warning may be in writing or oral, if the employer typically does not make such requests in writing.) | Entities from whom requests for health-related information are made | Employers with 15 or more employees | Whenever an applicant or employee is sent for a medical examination<br>The additional "warning" is required when requests for health-related information are made (e.g., to support an employee's request for reasonable accommodation or a request for sick leave), but only if the request for medical documentation is made in a way that is likely to result in receipt of genetic information |
| Michelle's Law Notice<br>***(Model notice unavailable)*** | Describes the right of a dependent child who has lost student status for purposes of coverage, as a result of a medically necessary leave of absence from a post-secondary educational institution, to continued coverage during the leave of absence for up to one year, or until coverage would otherwise terminate (whichever is earlier) | Plan participants | Group health plans that base eligibility for coverage on student status, and the health insurance issuer providing group coverage | With any notice regarding a requirement for certification of student status for coverage under the plan<br>**Note:** Under Health Care Reform, group health plans and issuers are generally required to provide dependent coverage to age 26, regardless of student status of the dependent. Nonetheless, in some circumstances, such as where a plan provides dependent coverage beyond age 26, Michelle's Law may apply. |
| Notice Regarding Newborns' and Mothers' Health Protection Act<br>***(Click on the link above and scroll to page 4 of the PDF for model notice—marked as page 140)*** | Statement describing applicable requirements under federal and/or state law relating to any hospital length of stay in connection with childbirth for a mother or newborn | Plan participants | Group health plans that provide maternity or newborn infant coverage | Must be included in the SPD |

## Special Health Care Notices (cont'd)

**In This Section:** Women's Health and Cancer Rights Act Notices > Mental Health Parity and Addiction Equity Act Disclosure > Employer CHIP Notice > Genetic Information Nondiscrimination Act Disclosures > Michelle's Law Notice > Notice Regarding Newborns' and Mothers' Health Protection Act > Medical Child Support Order Notices > National Medical Support Notice

| Document | Type of Information | Provide To | Provided By | When Due |
|---|---|---|---|---|
| Medical Child Support Order (MCSO) Notices<br>***(Model notices unavailable, but a sample checklist is available for general reference purposes only by clicking on the link above)*** | Notification regarding receipt of a MCSO directing the plan to provide health insurance coverage to a participant's noncustodial children (including the plan's procedures for determining qualified status), and a separate notice as to whether the MCSO is qualified | Participants, any child named in a MCSO, and the child's representative | Plan administrator<br>(all group health plans) | **Notice of Receipt of MCSO**: Promptly upon receipt of the MCSO<br>**Notice of Qualification Determination**: Within a reasonable time after receipt of the MCSO |
| National Medical Support (NMS) Notice<br>***(Click on the link above to download form and instructions)*** | Notice used by state child support enforcement agencies responsible for enforcing health care coverage provisions in a MCSO<br><br>**Note:** Depending upon certain conditions, an employer must complete and return Part A of the NMS notice to the state agency or transfer Part B of the notice to the plan administrator for a determination on whether the notice is a qualified MCSO. | State agencies, employers, plan administrators, participants, custodial parents, children, representatives | Employer and plan administrator<br>(all group health plans) | Employer must either send Part A to the state agency, or Part B to the plan administrator, within 20 days after the date of the notice or sooner, if reasonable<br>Plan administrator must promptly notify affected persons of receipt of the notice and the procedures for determining qualified status<br>Plan administrator must within 40 business days complete and return Part B to the state agency and also provide required information to affected persons<br>In certain instances, the employer may be required to send Part A to the state agency after the plan administrator has processed Part B |

## Notices Related to Benefit Claims

**In This Section:** Notice of Benefit Determination > Notice of Adverse Benefit Determination and Final Internal Adverse Benefit Determination

| Document | Type of Information | Provide To | Provided By | When Due |
|---|---|---|---|---|
| Notice of Benefit Determination<br>***(Model notice unavailable, but click here for an example from the Centers for Medicare & Medicaid Services)***<br>(also called claims notice or "explanation of benefits") | Information regarding benefit claim determinations<br>Adverse benefit determinations must include certain information, including the specific reason(s) for the denial, reference to the specific plan provisions on which the decision is based, and a description of the plan's appeal procedures. | Participants and beneficiaries<br>(or their authorized representatives) | Plan administrator<br>(all plans, regardless of size) | Requirements vary depending on the type of benefit claim involved (e.g., urgent care, pre-service or "prior authorization," or post-service claims) |
| Notice of Adverse Benefit Determination<br>(additional requirements for non-grandfathered group health plans)<br>and<br>Notice of Final Internal Adverse Benefit Determination<br>***(Click on the links above for model notices)*** | In addition to required disclosures described under "Notice of Benefit Determination," above, non-grandfathered plans must, as part of the new rules for internal appeals under Health Care Reform, include additional information in each notice of adverse benefit determination.<br>When a claim is denied, the individual may request that the plan reconsider its decision—this review is called an "internal appeal." If the plan continues to deny the service or payment, the claimant must be provided a written decision (called the "final internal adverse benefit determination") which includes information on how to request an external review and other disclosures. | Participants and beneficiaries<br>(or their authorized representatives) | Plan administrator<br>(non-grandfathered group health plans) | Requirements vary depending on the type of benefit claim involved and the stage of review<br>Decisions on internal appeals generally must be provided within:<br>• 72 hours for denials of claims for urgent care;<br>• 30 days for denials of non-urgent care not yet received ("prior authorization claims"); and<br>• 60 days for denials of services already received by the individual ("post-service claims"). |

## HIPAA Privacy and Security-Related Notices

**In This Section:** Notice of Privacy Practices for Protected Health Information > Notice of Breach of Unsecured Protected Health Information

| Document | Type of Information | Provide To | Provided By | When Due |
|---|---|---|---|---|
| Notice of Privacy Practices for Protected Health Information<br>***(Click on the link above to download model notices in 4 different formats)***<br>**Note:** Fully insured group plans that do not create or receive PHI—other than summary health information and enrollment information—are **not** required to develop this notice. | Describes how a covered entity, including a group health plan, may use and disclose an individual's protected health information (PHI), and the individual's rights and the plan's legal duties with respect to that information | Individuals enrolled in group health plan coverage | Covered entities, including group health plans, unless a specific exception applies | Fully insured group plans that create or receive PHI in addition to summary health information and enrollment information must maintain a notice and provide it to any person upon request. Other health plans must provide the notice as follows:<br>**To new enrollees**: At the time of enrollment<br>**To individuals covered by the plan**: Within 60 days of a material revision to the policy (special rules apply for website notice postings)<br>A health plan also must notify individuals covered by the plan of the availability of, and how to obtain, the notice at least once every 3 years, and make it available to any person who asks for it. |
| Notice of Breach of Unsecured Protected Health Information<br>***(Model notice unavailable)*** | Provides certain information related to the discovery of a breach of unsecured protected health information, including:<br>• A description of the breach;<br>• The types of information that were involved in the breach;<br>• Steps affected individuals should take to protect themselves from potential harm;<br>• A brief description of what the covered entity is doing to investigate, mitigate the harm, and prevent further breaches; and<br>• Contact information for the covered entity | Affected individuals, the U.S. Department of Health and Human Services, and prominent media outlets (for a breach affecting more than 500 residents of a state or jurisdiction) | Covered entities, including group health plans<br>(business associates also have certain responsibilities for providing notice of a breach) | **To affected individuals**: No later than 60 calendar days after the discovery of a breach (notice must be provided by first-class mail, or alternatively, by email if the affected individual has agreed to receive such notices electronically)<br>**To HHS Secretary (submitted electronically)**:<br>*Breaches affecting fewer than 500 individuals*–annual report required no later than 60 days after the end of the calendar year in which the breaches were discovered<br>*Breaches affecting 500 or more individuals*–no later than 60 calendar days after discovery<br>**To media (breaches affecting more than 500 residents of a state or jurisdiction)**: No later than 60 calendar days after discovery of a breach |

## Medicare Part D Creditable Coverage Notices

**In This Section:** Medicare Part D Creditable Coverage Disclosure Notices

| Document | Type of Information | Provide To | Provided By | When Due |
|---|---|---|---|---|
| Medicare Part D—Creditable Coverage Disclosure Notice<br>or<br>Non-Creditable Coverage Disclosure Notice<br>***(Click on the links above for model notices. Word versions unavailable.)*** | Notifies Medicare-eligible individuals whether the plan's prescription drug coverage is creditable coverage, meaning the coverage is expected to pay, on average, as much as the standard Medicare prescription drug coverage<br>**Note:** Individuals who do not maintain creditable coverage for 63 days or longer following their initial enrollment period for Medicare Part D may be required to pay a late enrollment penalty. Accordingly, this information is essential to the decision to enroll in a Medicare Part D prescription drug plan. | • Medicare-eligible active employees and their dependents<br>• Medicare-eligible COBRA individuals and their dependents<br>• Medicare-eligible disabled individuals covered under the prescription drug plan<br>• Any retirees and their dependents | Employers who sponsor group health plans that offer prescription drug coverage to Medicare-eligible individuals | • Prior to the annual enrollment period for Medicare Part D that begins on Oct. 15th<br>• Prior to an individual's initial enrollment period for Medicare Part D<br>• Prior to the effective date of enrolling in the employer's prescription drug plan and upon any change that affects whether the coverage is creditable<br>• Upon request by the individual<br>Online disclosure to the Centers for Medicare & Medicaid Services is also required annually, no later than 60 days from the beginning of a plan year, within 30 days after termination of a prescription drug plan, or within 30 days after any change in creditable coverage status. |

***Please Note:*** *This calendar provides information on key required notices and filings for group health plans under the federal Employee Retirement Income Security Act (ERISA). The information is subject to change and should be used for general reference purposes only. Plan administrators, sponsors, and employers are advised to refer to the current law, regulations and applicable form instructions, or other guidance issued by the U.S. Employee Benefits Security Administration. For the most up-to-date information on Health Care Reform, please visit http://www.dol.gov/ebsa/healthreform/.*

*The reporting and disclosure requirements for group health plans are very complex. The applicability of certain requirements may depend on a number of factors, including the number of employees in your organization and the type of benefits offered under your health plan. Additionally, your plan may be subject to other requirements that are not included in this calendar, such as certain reporting and disclosures required by the Internal Revenue Service or under state law. Employers who have questions are encouraged to consult with their plan administrators, the U.S. Employee Benefits Security Administration (1-866-444-3272), the Internal Revenue Service (1-877-829-5500), or a knowledgeable employment law attorney for further guidance.*

## Provided by:


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*The information and materials herein are provided for general information purposes only and are not intended to constitute legal or other advice or opinions on any specific matters and are not intended to replace the advice of a qualified attorney, plan provider or other professional advisor. This information has been taken from sources believed to be reliable, but there is no guarantee as to its accuracy. In accordance with IRS Circular 230, this communication is not intended or written to be used, and cannot be used as or considered a 'covered opinion' or other written tax advice and should not be relied upon for any purpose other than its intended purpose.*