



LEGISLATIVE BRIEF

Employee Benefit Compliance Chart: Notice and Disclosure Rules

The following chart is a summary of basic federal notice and disclosure compliance requirements that apply to group health plans and/or employers under various employee benefits and employment laws. It includes the additional reporting and disclosure obligations created by health care reform.

Note that not all notice and disclosure requirements are reflected in this chart. State laws may impose additional obligations. Users of this chart should refer to the specific federal law at issue for complete information.

Law	Governs	Notice Requirement	Summary
Health Care Reform Effective for the first plan year beginning on or after Sept. 23, 2010, unless noted otherwise	Group health plans and health insurance issuers	Statement of grandfathered status - Plan administrator or issuer should provide first statement before the first plan year beginning on or after Sept. 23, 2010. Must continue to be provided on a periodic basis with any participant materials describing plan benefits.	Grandfathered plans are group health plans or health insurance coverage in which an individual was enrolled on March 23, 2010, (the enactment date for health care reform) that satisfy certain requirements. Grandfathered plans can avoid many of the new health care reform provisions. To maintain grandfathered plan status, a plan administrator or health issuer must include a statement of the plan's grandfathered status in plan materials provided to participants describing the plan's benefits (such as the summary plan description (SPD) and open enrollment materials). The DOL's model notice is available at: www.dol.gov/ebsa/healthreform/ .
		Special enrollment notice of dependent coverage up to age 26 – Plan administrator or issuer must provide the notice no later than the first day of the first plan year beginning on or after Sept. 23, 2010. This rule applies regardless of whether the plan or coverage offers an open enrollment period and regardless of when any open enrollment period might otherwise occur. One-time notice	Group health plans and health insurance issuers that provide dependent coverage of children must make coverage available for adult children up to age 26. However, for plan years beginning before Jan. 1, 2014, grandfathered plans are not required to extend coverage to children under age 26 if they are eligible for their own employer's coverage. Before the coverage requirement was effective, a child under age 26 who was covered under a group health plan or health insurance coverage as a dependent may have lost coverage due to age. Also, a child may not have been eligible for coverage if his or her parent first became covered under the plan when the child was under age 26 but older than the plan's eligible age. Plans must provide these dependents with an opportunity to enroll which continues for at least 30 days, along with written notice of the opportunity to enroll. The coverage for dependents that enroll through a special enrollment opportunity must take effect no later than the first day of the first plan year beginning on or after Sept. 23, 2010. Also, these dependents must be treated as HIPAA special



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			<p>enrollees.</p> <p>The DOL's model notice is available at: www.dol.gov/ebsa/healthreform/.</p>
		<p>Special enrollment notice of no lifetime maximum benefit - Plan administrator or issuer must provide the notice no later than the first day of the first plan year beginning on or after Sept. 23, 2010. This rule applies regardless of whether the plan or coverage offers an open enrollment period and regardless of when any open enrollment period might otherwise occur.</p> <p>One-time notice</p>	<p>Group health plans and health insurance issuers may not establish lifetime limits on the dollar value of benefits for any participant. Before this restriction was effective, an individual who was covered under the group health plan or health insurance coverage as an employee or dependent may have lost eligibility because he or she reached the lifetime maximum benefit.</p> <p>Plans must provide these individuals with an opportunity to enroll which continues for at least 30 days, along with written notice of the opportunity to enroll. The coverage for individuals who enroll through a special enrollment opportunity must take effect no later than the first day of the first plan year beginning on or after Sept. 23, 2010. Also, these dependents must be treated as HIPAA special enrollees.</p> <p>The DOL's model notice is available at: www.gov/ebsa/healthreform/.</p>
		<p>Notice of rescission – Plan administrator or issuer must provide notice of rescission to affected participants at least 30 days before the rescission occurs.</p>	<p>Group health plans and health insurance issuers may not rescind coverage once the enrollee is covered, except in cases of fraud or intentional misrepresentation. Plan coverage may not be rescinded without prior notice to the enrollee.</p>
		<p>Notice of patient protections and selections of providers – Plan administrator or issuer must provide notice of new patient protections whenever the SPD or similar description of benefits is provided to a participant.</p> <p>The first notice should be provided no later than the first day of the first plan year beginning on or after Sept. 23, 2010.</p> <p>This requirement does not apply to grandfathered plans.</p>	<p>Group health plans and health insurance issuers that require designation of a participating primary care provider must permit each participant, beneficiary and enrollee to designate any available participating primary care provider (including a pediatrician for children). Group health plans and issuers that provide obstetrical/gynecological care and require a designation of a participating primary care provider may not require preauthorization or referral for obstetrical/gynecological care.</p> <p>The DOL's model notice is available at: www.dol.gov/ebsa/healthreform/.</p>
		<p>Uniform summary of coverage – Plan administrator or issuer must provide to applicants and enrollees before enrollment and re-enrollment. The Department of Health and Human Services (HHS) is to develop standards for the summary, and plans will have</p>	<p>Group health plans will be required to provide a uniform summary of the plan's benefits and coverage to applicants and enrollees. The summary will have to be written in easily understood language and will be limited to 4 pages.</p>

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		<p>to start using it by March 2012.</p> <p>Waiver of Annual Limit Requirement – For applications for waivers covering plan years beginning on or after Feb. 1, 2011, the plan administrator or issuer must provide an annual notice to eligible participants as part of any plan or policy documents regarding coverage that are provided to enrollees (such as SPDs).</p>	<p>Effective in 2014, health plans will be prohibited from imposing annual limits on essential health benefits. For plan years beginning before Jan. 1, 2014, health plans may impose “restricted annual limits” on essential health benefits. The restrictions on annual limits may be waived by HHS if compliance with the restrictions would result in a significant decrease in access to benefits or a significant increase in premiums.</p> <p>Any plans that receive a waiver approval must provide a notice informing participants that the plan does not meet the annual limits and has received a waiver for the requirements. The notice must include:</p> <ul style="list-style-type: none"> • The dollar amount of the annual limit; • A description of the plan benefits to which the limit applies; and • An explanation that the plan has received a waiver of the restricted annual limit requirement. <p>Plans must use HHS’s model language to satisfy the waiver notice requirement, or they must receive HHS’s written permission to use different language. HHS’s model notice is available at: http://cciio.cms.gov/resources/files/06162011_annual_limit_guidance_2011-2012_final.pdf.</p>
Health Care Reform	Group health plan sponsors participating in the ERRP	<p>Early Retiree Reinsurance Program (ERRP) Notice – Plan sponsors must provide the notice to all plan participants, not just early retirees. The notice must be provided within a reasonable period of time after the sponsor receives its first ERRP reimbursement. Alternatively, the plan sponsor may provide the notice before receiving its first reimbursement.</p>	<p>Health care reform establishes a temporary reinsurance program to provide reimbursement to participating employment-based plans for a portion of the cost of providing health insurance coverage to early retirees and their spouses, surviving spouses and dependents. The ERRP ends no later than Jan. 1, 2014. (Funding for the program is limited to \$5 billion.)</p> <p>Plan sponsors participating in the ERRP must provide a notice to participants explaining the sponsor’s participation in the ERRP and noting that the sponsor may decide to use the reimbursements to reduce plan participants’ premium contributions, copayments, deductibles or other out-of-pocket costs.</p> <p>More information on the ERRP, including a model participant notice is available at: www.errp.gov/.</p>
Health Care Reform	Employers sponsoring group health plans	<p>IRS Form W-2 – Aggregate cost of applicable employer-sponsored coverage must be included.</p> <p>This requirement was originally effective for tax years beginning after Dec. 31, 2010. However, the IRS made reporting optional for all employees for the 2011 tax year, so the effective date is</p>	<p>Employers must disclose the aggregate cost of applicable employer-sponsored coverage provided to employees on the employees’ W-2 forms. This requirement does not mean that the cost of the coverage will be taxable to employees.</p> <p>The IRS has issued the 2011 Form W-2 with Instructions including a new category for reporting the cost of employer-sponsored coverage. Form W-2 and its Instructions are available at:</p>

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		<p>delayed and employers are not required to include this information on W-2 forms issued for 2011.</p> <p>Small employers (those filing fewer than 250 W-2-Forms) and employers contributing only to certain plans, such as multiemployer plans or HSAs, are exempt at least until further guidance is issued.</p>	<p>www.irs.gov/formspubs/index.html.</p> <p>The IRS has provided guidance on the Form W-2 reporting requirement in Notice 2011-28, which is available at: www.irs.gov/pub/irs-drop/n-11-28.pdf.</p>
COBRA	<p>Employers that had 20 or more employees on more than 50% of the typical business days during the previous calendar year</p> <p>Government and church plans are exempt</p>	<p>Initial/General COBRA notice – Plan administrator must provide generally within 90 days of when group health plan coverage begins</p>	<p>Notice to covered employees and covered spouses of the right to purchase temporary extension of group health coverage when coverage is lost due to a qualifying event.</p> <p>The DOL's model General COBRA Notice is available at: www.dol.gov/ebsa/compliance_assistance.html under COBRA guidance.</p>
		<p>Notice to plan administrator - Employer must notify plan administrator within 30 days of a) qualifying event or b) the date coverage would be lost as a result of the qualifying event, whichever is later.</p>	<p>Notice of certain qualifying events must be sent to plan administrator when employer is not plan administrator (e.g., employer has contracted with a third party to administer COBRA).</p> <p>The following qualifying events trigger the employer's notice requirement: (a) employee's termination or reduction in hours; (b) employee's death; (c) employee's Medicare entitlement; and (d) employer's bankruptcy.</p>
		<p>COBRA election notice – Plan administrator must generally provide within 14 days after being notified by the employer or qualified beneficiary of the qualifying event (or 44 days after qualifying event if employer is also plan administrator)</p>	<p>Notice to qualified beneficiaries of their right to elect COBRA coverage upon occurrence of qualifying event. Qualified beneficiaries may be covered employees, covered spouses and dependent children.</p> <p>The DOL's model COBRA Election Notice is available at: www.dol.gov/ebsa/compliance_assistance.html under COBRA guidance.</p> <p>NOTE: The American Recovery and Reinvestment Act of 2009 (ARRA), as amended, mandated that plans notify certain current and former participants and beneficiaries about the COBRA premium reduction. The premium reduction generally applies to individuals who lost health plan coverage due to an involuntary termination of employment between Sept. 1, 2009, and May 31, 2010.</p>
		<p>Notice of unavailability of COBRA – Plan administrator must provide this notice generally within 14 days after being notified by the individual of the qualifying event (or 44 days after qualifying event if employer is</p>	<p>Plan administrator must send a notice that an individual is not entitled to COBRA coverage to those individuals who provide notice to the plan administrator of a qualifying event whom the plan administrator determines are not eligible for COBRA coverage.</p>

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		also plan administrator).	
		Notice of early termination of COBRA coverage – Plan administrator must provide as soon as practicable following the plan administrator's determination that coverage will terminate	Notice to qualified beneficiaries that COBRA coverage will terminate earlier than the maximum period of coverage. The notice must include the reason for early termination, date of termination and any rights that qualified beneficiary may have to elect alternative group or individual coverage, such as a conversion right. May be sent with HIPAA certificate of creditable coverage.
		Notice of insufficient payment – Plan administrator must provide reasonable period of time to cure deficiency before terminating COBRA (e.g., 30-day grace period).	Plan administrator must notify qualified beneficiary that payment for COBRA was not significantly less than the correct amount before coverage is terminated for nonpayment. A payment is not significantly less than the amount required if the deficiency is no greater than the lesser of \$50.00 or 10 percent of the amount the plan requires to be paid.
		Premium change notice – Plan administrator should provide at least one month prior to effective date	<p>COBRA does not explicitly require advance notice of a premium increase. However, COBRA regulations provide that if a COBRA premium payment is short by an amount that is insignificant, the qualified beneficiary must be provided notice of such underpayment and a reasonable amount of time to make the payment difference.</p> <p>Also, COBRA requires equal coverage and, to some extent, equal treatment between COBRA qualified beneficiaries and similarly situated non-COBRA beneficiaries.</p> <p>The DOL has stated that continuation coverage should not be terminated for insufficient payment if COBRA qualified beneficiaries are not provided a reasonable advance notice of increased premiums and a reasonable opportunity to pay the increased premium.</p>
ERISA	ERISA employee welfare benefit plans, unless exempted	Summary plan descriptions - Plan administrator must provide automatically to participants within 90 days of becoming covered by the plan (though a new plan has 120 days after becoming subject to ERISA to distribute SPD)	SPD is the primary vehicle for informing participants and beneficiaries about their plan and how it operates. Must be written for average participant and be sufficiently comprehensive to apprise covered persons of their benefits, rights, and obligations under the plan.
		Updated SPD must be furnished every 5 years if changes made to SPD information or plan is amended. Otherwise, must furnish every 10 years.	
		Summary of material modification – Plan administrators must provide	Describes material modifications to a plan and changes in the information required to be in the SPD. Distribution of updated SPD satisfies this requirement.

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		<p>automatically to participants within 210 days after the end of the plan year in which the change is adopted</p> <p>If benefits or services are materially reduced, participants must be provided notice within 60 days from adoption; or, where participants receive such information from the plan administrator at regular intervals of not more than 90 days, notice of materially reduced benefits or services must be provided within the regular interval.</p>	
		<p>Plan documents – Plan administrator must provide copies no later than 30 days after a written request. Plan administrator must make copies available at its principal office and certain other locations as specified in regulations.</p>	<p>The plan administrator must furnish copies of certain documents upon written request by a participant and/or beneficiary and must have copies available for examination. The documents include the latest updated SPD, latest Form 5500, trust agreement, and other instruments under which the plan is established or operated.</p>
		<p>Form 5500 – Plan administrator generally must file by the last day of the seventh month following the end of the plan year, unless an extension has been granted. For calendar year plans, the deadline is normally July 31 of the following year.</p> <p>Small health plans (less than 100 participants) that are fully insured, unfunded or a combination insured/unfunded, are generally exempt from the Form 5500 filing requirement.</p>	<p>Form 5500 filing requirements vary according to type of filer (i.e., small plans, large plans and direct filing entities). Certain employee benefit plans are exempt from the annual reporting requirements or are eligible for limited reporting options.</p> <p>The Department of Labor (DOL) Web Page at www.dol.gov/EBSA/5500MAIN.HTML and the latest Form 5500 instructions provide information on who is required to file and detailed information on filing. Effective Jan. 1, 2010, plan administrators must complete and file Form 5500 electronically.</p>
		<p>Form M-1 – Plan administrator must file with the DOL by March 1st of each year for the previous calendar year. A 60-day automatic extension is available upon request.</p>	<p>Form M-1 is the annual report that must be filed by multiple employer welfare arrangements (MEWAs) and entities claiming exception from MEWA status. In general, a MEWA offers health benefits to the employees of two or more employers.</p> <p>More information about the M-1 filing requirement, and the online filing system, is available at: www.dol.gov/ebsa/forms.html.</p>
		<p>Summary annual report – Plan administrators must provide automatically to participants within 9 months after end of plan year, or 2 months after due date</p>	<p>The summary annual report is a narrative summary of the Form 5500 and includes a statement of the right to receive the annual report. Model notices are found in 29 CFR 2520.104b-10(d).</p>

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		<p>for filing Form 5500 (with approved extension).</p> <p>Plans that are exempt from the annual 5500 filing requirement are not required to provide an SAR. Large, completely unfunded health plans are also generally exempt from the SAR requirement.</p>	
Internal Revenue Code	Group health plans	<p>IRS Form 8928 – Report and Pay Excise Taxes – Generally must be filed (with the applicable excise tax) by the due date for filing the plan sponsor’s or administrator’s federal income tax return for the year in which the failure occurred.</p> <p>An automatic extension for filing is available, although the extension does not affect the time to pay the excise tax. There is also limited relief for certain inadvertent failures and “reasonable cause” mistakes that are corrected within 30 days.</p>	<p>The Form 8928 excise tax reporting requirement became effective for returns due on or after Jan. 1, 2010. In general, it applies to failures to comply with certain group health plan mandates included in the IRC, such as:</p> <ul style="list-style-type: none"> • Required levels of coverage for pediatric vaccines; • COBRA continuation coverage requirements; • HIPAA’s portability, access and renewability and nondiscrimination rules; • Genetic information nondiscrimination requirements; • Mental health parity requirements; and • Health care reform mandates.
Family and Medical Leave Act (federal FMLA)	Private sector employers with 50 or more employees in 20 or more workweeks in current or preceding calendar year, as well as all public agencies and all public and private elementary and secondary schools	<p>Post notice in a location available to both employees and applicants.</p> <p>Include in written guidance, if it exists.</p> <p>Provide written guidance, upon employee notice of need for FMLA leave.</p>	<p>All covered employers are required to post a notice explaining the FMLA, including the family military leave amendments, regardless of whether they have eligible employees.</p> <p>If written guidance regarding employee benefits or leave rights exists, such as in an employee handbook, then FMLA information regarding entitlements and obligations must be included in it as well.</p> <p>Written guidance must be provided to an employee upon the employee’s notice to the employer of the need for FMLA leave (i.e., eligibility notice, and rights and responsibilities notice). The employer must detail the specific expectations and obligations of the employee, and explain the consequences of the failure to meet these obligations. After the employer has sufficient information, it must provide a designation notice informing the employee whether the leave is designated as FMLA leave.</p> <p>The DOL has issued optional forms which may be used to satisfy these notice requirements. They can be accessed at: www.dol.gov/dol/topic/benefits-leave/fmla.htm.</p>

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Genetic Information Non-discrimination Act (GINA) – Health Plan Provisions	Group health plans and health insurance issuers	<p>No general notice requirements.</p> <p>To satisfy the requirements for the research exception, plans or issuers must provide the participant(s) with a written request and must complete a Notice of Research Exception and file it with the designated federal agency.</p>	<p>Title I of GINA generally prohibits health plans and health insurance issuers from discriminating based on genetic information.</p> <p>To comply with GINA, health plans and health insurance issuers may not require or request that an individual undergo a genetic test, subject to some narrow exceptions. One exception is a research exception that allows a health plan or issuer to request (but not require) that an individual undergo a genetic test if the information is not used for underwriting and some additional requirements are met. To fall under this exception, the plan or issuer must make the request in writing to the participant and clearly indicate that the test is voluntary and will not impact plan eligibility or contributions. The plan or issuer must also complete a Notice of Research Exception, available at: www.dol.gov/ebsa/GINAexceptioninstructions.html.</p>
Genetic Information Non-discrimination Act (GINA) – Employment Provisions	Employers in the private sector and state and local governments that employ 15 or more employees	<p>No general notice requirements.</p> <p>Individual notice required if genetic information used for toxic substance monitoring or for certain disclosures of genetic information.</p>	<p>Title II of GINA generally prohibits employment discrimination based on genetic information.</p> <p>Employers that want to obtain genetic information of employees in order to monitor the biological effects of exposure to toxic substances in the workplace must provide written notice to each affected employee of the genetic monitoring. The employee must authorize the monitoring, unless it is required by law. Additional requirements apply to genetic monitoring.</p> <p>Employers generally may not disclose an employee's genetic information. Certain exceptions apply to this rule, including disclosure of genetic information in response to a court order or to public health agencies regarding contagious, life-threatening illness. Notice to the employee is required if the employer discloses genetic information for these purposes.</p>
HIPAA-Wellness Programs	Group health plans and insurers that offer Wellness Programs which condition a reward based on outcome	Notice of Alternative Standard - Plans and insurers must disclose the availability of an alternative standard in all materials describing the wellness program.	<p>Wellness programs which offer a reward conditioned upon an individual's ability to meet a standard that is related to a health factor will violate HIPAA's nondiscrimination rules unless the program satisfies a number of conditions:</p> <ul style="list-style-type: none"> • Limit reward to 20% of cost of coverage; • Design to reasonably promote health and prevent disease; • Provide annual opportunity to qualify; • Provide reasonable alternative standard for obtaining the reward for certain individuals; and • Disclose availability of an alternative standard.

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HIPAA-Privacy and Security	Covered Entities: Group health plans, health care clearing-houses, health care providers that transmit any health information electronically, and enrolled sponsors of Medicare prescription drug discount card, unless exception applies Business Associates: service providers to Covered Entities that use protected health information (PHI)	<p>Notice of Privacy Practices – The plan administrator or insurer must provide the Notice of Privacy Practices when a participant enrolls, upon request and within 60 days of a material revision to the notice.</p> <p>At least once every three years, participants must be notified about the availability of the Notice of Privacy Practices.</p>	HHS regulations require that participants be provided with a detailed explanation of their privacy rights, the plan's legal duties with respect to protected health information, the plan's uses and disclosures of protected health information, and how to obtain a copy of the Notice of Privacy Practices.
		<p>Notice of Breach of Unsecured PHI – Covered entities and their business associates must provide notification following a breach of unsecured PHI without unreasonable delay and in no case later than 60 days following the discovery of a breach.</p>	Following a breach of unsecured PHI, covered entities must provide notification of the breach to affected individuals, HHS, and, in certain circumstances, to the media. If the unsecured PHI is held by a business associate, the business associate must notify the covered entity that a breach has occurred.
HIPAA-Portability	Group health plans and issuers of group health plan insurance coverage, unless exception applies	<p>Certificate of Creditable Coverage – Plan administrators and issuers must provide automatically when covered individuals lose group health plan coverage, become eligible for COBRA coverage, and when COBRA coverage ceases. A certificate may be requested free of charge any time prior to losing coverage and within 24 months of losing coverage.</p>	Notice from group health plan to individuals who lose coverage, documenting prior group health plan creditable coverage and length of time covered.
		<p>General notice of preexisting condition exclusion – Plan administrators and issuers must provide as part of any written application materials distributed for enrollment. If the plan or issuer does not distribute such materials, by the earliest date following a request for enrollment that a plan or issuer, acting in a reasonable and prompt fashion, can provide the notice.</p>	Notice to participants describing a group health plan's preexisting condition exclusion and how prior creditable coverage can reduce the preexisting condition exclusion period.

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		<p>Individual notice of period of preexisting condition exclusion – Plan administrators and issuers must provide as soon as possible following the determination of creditable coverage.</p>	<p>Notice to an individual that a specific preexisting condition exclusion period applies after consideration of creditable coverage evidence, as well as an explanation of appeal procedures if the individual disputes the plan's determination.</p>
		<p>Notice of special enrollment rights – Plan administrators must provide at or before the time an employee is initially offered the opportunity to enroll in the group health plan.</p>	<p>Notice to employees eligible to enroll in a group health plan describing the group health plan's special enrollment rules including the right to enroll within 30 days of the loss of other coverage or of marriage, birth of a child, adoption, or placement for adoption, or within 60 days of the loss of coverage under a Medicaid plan or CHIP, or within 60 days of a determination of eligibility for a premium assistance subsidy under Medicaid or CHIP.</p>
CHIPRA	Employers that maintain group health plans covering employees in states that provide premium assistance subsidies under a Medicaid plan or CHIP	<p>Annual Employer CHIP Notice</p> <p>First annual notice must be sent by the first day of the first plan year beginning after Feb. 4, 2010.</p> <p>*In the future, plan administrators will need to provide information to State Medicaid or CHIP programs, upon request, regarding plan benefits. States may not request the information until the first plan year beginning after a model disclosure form is issued.</p>	<p>States may offer eligible low-income children and their families a premium assistance subsidy to help pay for employer-sponsored coverage. If an employer's group health plan covers residents in a state that provides a premium subsidy, the employer must send an annual notice about the available assistance to all employees residing in that state. Employers may use the model notice provided by the DOL as a national notice to meet their obligations under CHIPRA. The notice may be provided in writing by first-class mail or electronically if DOL electronic disclosure requirements are satisfied.</p> <p>For a copy of the model notice, see: www.dol.gov/ebsa/pdf/chipmodelnotice.pdf.</p>
Medicare Part D	Group health plan sponsors that provide prescription drug coverage, except entities that contract with or become a Part D plan	<p>Disclosure Notices for creditable or non-creditable coverage – At a minimum, must be provided by the plan sponsor at the following times:</p> <ol style="list-style-type: none"> 1) Prior to the Medicare Part D Annual Coordinated Election Period – Oct. 15 through Dec. 7 of each year; 2) Prior to an individual's Initial Enrollment Period for Part D; 3) Prior to the effective date of coverage for any Medicare eligible individual that joins the plan; 4) Whenever prescription drug coverage ends or 	<p>Group health plan sponsors — or entities that offer prescription drug coverage on a group basis to active and retired employees and to Medicare Part D eligible individuals — must provide, or arrange to provide, a notice of creditable or non-creditable prescription drug coverage to Medicare Part D eligible individuals who are covered by, or who apply for, prescription drug coverage under the entity's plan. This creditable coverage notice alerts the individuals as to whether or not their prescription drug coverage is at least as good as the Medicare Part D coverage.</p> <p>Model forms are available from the Centers for Medicare & Medicaid Services (CMS) at: www.cms.gov/creditablecoverage/.</p>

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		<p>changes so that it is no longer creditable or becomes creditable; and</p> <p>5) Upon request by a Medicare Part D eligible individual.</p> <p>*If the plan sponsor provides notice to all participants annually, CMS will consider #1 and #2 above to be met. "Prior to" means in the prior 12 months.</p>	
		<p>Disclosure to CMS – Plan sponsor must make on an annual basis (60 days after the beginning of the plan year) and upon any change that affects creditable coverage status (within 30 days of the change)</p>	<p>Employers must disclose to CMS whether the coverage is creditable. An entity is required to provide the Disclosure Notice through completion of the Disclosure Notice form on the CMS web page at: www.cms.gov/CreditableCoverage/08_CCAfterJanuary1.asp, unless specifically exempt as outlined in related CMS guidance. This is the sole method for compliance with the disclosure requirement.</p>
<p>Medicare Part D-Retiree Drug Subsidy</p>	<p>Employers with group health plans that cover retirees who are entitled to enroll in Part D but who elect not to do so</p>	<p>Retiree drug subsidy application - At least 90 days before the beginning of each plan year, plan sponsors must apply for retiree drug subsidy, unless CMS approves request for extension.</p>	<p>An employer who wishes to sponsor a prescription drug plan with retiree prescription drug coverage that is at least as good as Part D coverage may apply for the retiree drug subsidy, which is exempt from federal income tax. The subsidy is available to employers with group health plans that cover retirees who are entitled to enroll in Part D but who elect not to do so. Each plan sponsor that seeks the retiree drug subsidy must electronically complete the application through the RDS Center at http://rds.cms.hhs.gov.</p> <p>*Health care reform provides that, beginning in 2013, employers receiving the Medicare Part D retiree drug subsidy will no longer be able to deduct the amount of the subsidy.</p>
<p>Mental Health Parity and Addiction Equity Act (MHPAEA)</p>	<p>Group health plans (of employers with over 50 employees) offering mental health and substance use disorder benefits</p> <p>Exemption available for group health plans that can demonstrate a certain cost</p>	<p>Notice of cost exemption - Group health plans claiming the increased cost exemption must promptly notify the appropriate federal and state agencies, plan participants and beneficiaries.</p> <p>Notice must also be provided upon request.</p>	<p>The cost exemption will apply to a group health plan if its cost increase exceeds 2% in the first plan year and 1% in each subsequent year. Cost-increase determinations must be made and certified in a written actuarial report. The plan must comply with the parity requirements for the first 6 months of the plan year involved. The written report and underlying documentation must be maintained for 6 years following the notification to elect the cost exemption.</p> <p>A group health plan or health insurance issuer shall promptly notify the Secretaries of the DOL, HHS and the Treasury, the appropriate State agencies, and participants and beneficiaries in the plan of such election. A notification to the Secretaries shall include:</p> <ul style="list-style-type: none"> • A description of the number of covered lives under the plan (or coverage) involved at the time of the

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Law	Governs	Notice Requirement	Summary
	increase		<p>notification, and as applicable, at the time of any prior election of the cost-exemption by such plan (or coverage);</p> <ul style="list-style-type: none"> • For both the plan year upon which a cost exemption is sought and the year prior, a description of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan; and • For both the plan year upon which a cost exemption is sought and the year prior, the actual total costs of coverage with respect to mental health and substance use disorder benefits under the plan. <p>Upon request – The plan administrator or health insurance issuer must provide the criteria for medical necessity determinations made under a group health plan with respect to mental health or substance use disorder benefits, upon request by a current or potential participant, beneficiary or contracting provider. The plan administrator or health insurance issuer must also make available upon request, or as otherwise required, the reason for any denial of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary.</p>
Michelle's Law	Employer-sponsored group health plans	Michelle's Law Notice – Plan administrators and group health plan insurers must include with any notice regarding a requirement for certification of student status.	<p>If a group health plan (or insurance issuer providing coverage for the plan) requires a certification of student status for coverage under the plan, it must send a Michelle's Law Notice along with any notice regarding the certification requirement. The Michelle's Law Notice must be written in language understandable to a typical plan participant and must describe the terms of the continuation coverage available under Michelle's Law during medically necessary leaves of absence.</p> <p>*Under health care reform, group health plans are required to cover dependent children up to age 26, regardless of student status.</p>
Newborns' and Mothers' Health Protection Act (NMHPA)	Group health plans that provide maternity or newborn infant coverage	NMHPA Notice - Plan administrators must include a statement within the SPD (or SMM) timeframe.	<p>The plan's SPD must include a statement describing any requirements under federal or state law applicable to the plan, and any health insurance coverage offered under the plan, relating to any hospital length of stay in connection with childbirth for a mother or newborn child. If the federal law applies in some areas in which the plan operates and state law applies in other areas, the SPD should describe the different areas and the federal or state requirements applicable in each.</p>
Qualified Medical Child Support Orders	Plan administrators of group health plans and state child support enforcement	Medical child support order notice - Upon receipt of medical child support order, plan administrator must promptly issue notice, including plan's procedures for determining its qualified status. Within a	<p>This is a notification from the plan administrator regarding receipt and qualification determination on a medical child support order directing the plan to provide health insurance coverage to a participant's noncustodial children.</p>

Employee Benefit Compliance Chart: Notice and Disclosure Rules for Employers and Group Health Plans

Law	Governs	Notice Requirement	Summary
	agencies	reasonable time after its receipt, plan administrator must also issue separate notice as to whether the medical child support order is qualified.	
		National Medical Support notice - Within 20 days after the date of notice or sooner, if reasonable, employer must either send Part A to State agency, or Part B to plan administrator. Plan administrator must promptly notify affected persons of receipt of notice and procedures for determining its qualified status. Plan administrator must within 40-business days after its date or sooner, if reasonable, complete and return Part B to State agency and must also provide required information to affected persons. Under certain circumstances, employer may be required to send Part A to State agency after plan administrator has processed Part B.	Notice used by State agency responsible for enforcing health care coverage provisions in a medical child support order. Depending upon certain conditions, employer must complete and return Part A of the National Medical Support 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 medical child support order.
Uniformed Services Employment and Reemployment Rights Act (USERRA)	All public and private employers, regardless of size	USERRA Notice – Employers must provide notice by posting where other employee notices are customarily posted, or provide to employees by alternate means.	Employers must provide notice of rights, benefits and obligations of persons entitled to USERRA and of employers.
Medicare Secondary Payer (MSP) – Reporting Requirements (Medicare, Medicaid and SCHIP Extension Act of 2007)	Responsible Reporting Entities (RREs) – For group health plans, RREs are insurers and administrators of group health plans	MSP Reporting Requirements – Plan administrators and issuers must file quarterly reports with CMS containing information on certain participants and beneficiaries for MSP purposes. All group health plans should be registered and reporting, except some Health Reimbursement Accounts (HRAs) that have until the end of the first quarter of 2011 to comply.	The Medicare, Medicaid and SCHIP Extension Act of 2007 amended the MSP rules to require plan administrators and health insurance issuers to report certain participant information to CMS for purposes of coordinating benefits with Medicare. More information about this reporting requirement, including a health plan user guide, is available at: www.cms.gov/MandatoryInsRep/ .
Women’s Health and Cancer Rights Act (WHCRA)	Group health plans that provide coverage for mastectomy benefits	WHCRA Notice – Plan administrators and issuers must provide notice upon enrollment in the plan and annually thereafter.	The DOL has published sample language for both the enrollment notice and the annual notice. Enrollment notice should include a statement that for participants and beneficiaries who are receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending

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Law	Governs	Notice Requirement	Summary
			<p>physician and the patient, for all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications of the mastectomy, including lymphedema. Notice should also include a description of any deductibles and coinsurance limitations applicable to such coverage.</p> <p>Annual notice should include a copy of the WHCRA enrollment notice, or a simplified disclosure providing notice of the availability of benefits for the four required coverages and information on how to obtain a detailed description.</p>