Federal Notice Requirements for Employer-Sponsored Group Health Plans

There are a number of federal laws that require group health plans to file certain information reports and provide various notices to plan participants. This chart provides a brief summary of selected notices and disclosures of general application that are required to be provided on a periodic basis. Please note that (1) not all of the requirements described below will apply to every plan, (2) not all requirements are detailed here, and (3) there may be notices and/or filing requirements that are not listed on this chart. In particular, individual notices that are required to be provided upon the occurrence of specific events (for example, notices required in connection with claims review) may not be listed here. Each plan sponsor should check the specific requirements of the notice and disclosure rules described below to determine how they apply to a specific plan.

ERISA:

- *Summary Plan Description:* This is the official summary of plan terms and conditions. It must be provided within 90 days of enrollment, and when plan terms are changed. Changes can be made by issuing a new SPD or a Summary of Material Modifications. If changes are material reductions in benefits, they must be distributed within 60 days after the effective date of the change or date of adoption. (Note that Health Care Reform requires notice of certain changes to be provided within 60 days prior to changes being made. See the requirements for the Summary of Benefits and Coverage, below.)
- *Annual Return/Report (Form 5500):* This information return must be filed with the IRS each year. Certain exemptions apply for small plans, unfunded plans and fully insured plans.
- *Summary Annual Report:* A summary of the Annual Report must be provided to plan participants on an annual basis

HIPAA Notices:

- *Wellness Program Disclosure:* A group health plan that offers a wellness program that requires individuals to meet a standard related to a health factor in order to obtain a reward (or avoid a penalty) must disclose the availability of a reasonable alternative standard for obtaining the reward or avoiding the penalty. Must be provided in all plan materials that describe the terms of the wellness program.
- *HIPAA Special Enrollment Notice:* Notice describing the group health plan's special enrollment rights including the right to enroll due to: loss of other coverage; marriage, birth of a child, adoption or placement for adoption; loss of eligibility under Medicaid or a State child health insurance program; or gaining eligibility for state assistance with premium payments. Must be provided at or before the time an employee is initially offered the opportunity to enroll in the group health plan.
- *HIPAA Privacy Practices Statement:* This notice is required to be provided at the time of enrollment. A notice reminding participants that the notice is available must be provided every three years.
- *General Notice of Preexisting Condition Exclusion:* The notice describes the plan's preexisting condition limits and how prior creditable coverage can reduce the preexisting condition period. It must be provided as part of any written application materials distributed for enrollment or upon request for enrollment (if enrollment materials are not normally distributed). **Due to changes under the ACA, this notice is no longer required as of the first day of the plan year beginning in 2014 (January 1, 2014 for a calendar year plan.)**
- *Individual Notice of Period of Preexisting Condition Exclusion:* Informs the individual that a specific preexisting condition exclusion period applies to the individual and explains the appeal procedures to be followed if the individual disputes the plan's determination. Must be provided to the individual as soon as possible following the determination of creditable coverage. **Due to changes under the ACA, this notice is no longer required**

as of the first day of the plan year beginning in 2014 (January 1, 2014 for a calendar year plan.)

- *Certificate of Creditable Coverage:* This notice provides information about an individual's coverage under a plan and is used for purposes of calculating the length of any preexisting conditions limits. It must be provided automatically upon losing group health-plan coverage, becoming eligible for COBRA coverage and when COBRA coverage ceases. It must also be provided upon request while an individual is covered and/or within 24 months after losing coverage. **Due to changes under the ACA, this notice is no longer required after December 31, 2014.**

Mothers And Newborns Health Protection Act:

A plan that offers maternity or newborn infant coverage must include a statement in the SPD that describes state and/or federal law that governs any hospital length of stay in connection with childbirth for the mother or newborn child.

Women's Health and Cancer Rights Act Notice:

Notice describing required benefits for participants who receive mastectomy-related benefits under the plan. Notice must be furnished annually and upon enrollment.

CHIPRA Notice:

Notifies employees (not just those covered under plan) that state assistance in paying premiums may be available in some states, and that eligibility for the assistance triggers special enrollment rights. Must be provided annually by employers that maintain a plan in a state that provides premium assistance under Medicaid or CHIP. Required to be sent before the beginning of each plan year.

Medicare:

- *Notice of Creditable/Non-creditable Coverage.* A plan that provides prescription drug coverage to participants who are or may become eligible for Medicare Part D must provide a notice informing participants whether or not the plan's prescription drug coverage is "creditable" coverage for purposes of Medicare Part D (Prescription Drug) Coverage. Notice must be provided prior to initial enrollment, annually on or before October 15 each year, and upon the plan's change in status to creditable or non-creditable coverage.
- *Notice to CMS.* An annual information report must be filed with CMS each year and upon certain other events.

COBRA:

There are a number of notices required to be provided to explain the right to continue plan coverage when an employee or dependent loses coverage due to a qualifying event. These include:

- General (Initial) Notice: Must be distributed when group health-plan coverage begins. This notice must be given to spouses and adult dependents upon enrollment if they enroll after the employee.
- Qualifying Event Notice: Must be provided to COBRA qualified beneficiaries, generally within 44 days after the date on which the qualifying event occurs, or if later, the date of loss of coverage
- Unavailability of Coverage: If the plan determines that a person is not eligible for COBRA coverage, it must notify the individual of the reasons for ineligibility. This notice must generally be provided within the same time frame as for the Qualifying Event Notice.
- Early Termination of COBRA Coverage: Must be provided as soon as practical after decision to terminate COBRA coverage for a reason other than expiration of the maximum COBRA period
- Notice of Conversion Rights: If applicable, must be provided within 180 days of the expiration of the maximum COBRA coverage period.

USERRA:

A notice providing information about the right of uniformed services personnel to continue coverage under the plan in the event of a military leave of absence. Must be provided at the time of enrollment in the plan.

HEALTH CARE REFORM:

- *Grandfathered Status:* If a group health plan is taking the position that it is grandfathered, the group health plan must include the model notice language on all materials that describe benefits provided under the group health plan.
- *Notice of Patient Protection Provisions:* If the group health plan is not grandfathered and offered previously restricted patient protections, participants must be provided with notice of the right to choose a primary care provider or pediatrician, and notified of the right to obtain obstetrical or gynecological care without prior authorization.
- *Summary of Benefits and Coverage:* This standardized description of plan benefits and cost-sharing provisions must be provided upon initial, annual and special enrollments and upon request. An amended SBC must be provided 60 days in advance of any changes to the information on the SBC.