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Health Plan Related Notices and Disclosures

Notice	Details	Applicable To	Provided to/ Provided by	Delivered by Date (Timing)
Mandated Participant Notices – ALL Plans				
Employer Marketplace Notification	Employers must notify employees of the existence of state health insurance marketplaces, the potential of subsidy/premium tax credit eligibility, and the loss of any employer contribution to any employer-sponsored health plan if the employee purchases insurance through a marketplace.	All plans	Notice must be distributed to all current and new employees. *Although the U.S. Department of Labor announced that there is no fine or penalty under the law for failing to comply, the law still requires that employers provide the notice.*	New employees, hired after October 1, 2013, must receive the notice within 14 days of hire.
Summary of Benefits and Coverage (SBC) and Glossary of Terms	SBC provides a uniform summary of covered benefits and limitations and provides examples. Glossary is of common health plan terms.	All plans	All participants and eligible employees. Provided by carrier if plan is insured, or by Plan Sponsor (or TPA) if plan is self-funded.	Upon application, as part of any written application materials provided for enrollment (or, if such materials are not distributed, no later than the first date the participant is eligible to enroll in coverage); By first day of coverage, if there are any changes to the SBC from the time of application; Within 90 days of special enrollment, for individuals entitled to "special enroll" in group health plan coverage when certain work or life events occur; Upon renewal, with open enrollment materials (or, if renewal is automatic, generally no later than 30 days prior to the first day of the new plan year); and No later than 7 business days following receipt of a participant or beneficiary's request.

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Women's Health and Cancer Rights Act	Informs plan participants about benefits covering mastectomies and related services and how to get detailed information on available benefits.	All plans	All plan participants. Sent by Plan Administrator. Can be delegated to the carrier.	Annually and upon initial enrollment.
Newborns' and Mothers' Health Protection Act	Explains federal and state hospitalization time provisions for newborns and mothers.	All plans	All plan participants. In SPD, or sent by Plan Administrator or carrier.	Must include in SPD; may also want to send annually with open enrollment materials.
CHIP Notice- Medicaid and Children's Health Insurance Program	Informs employees about possible state financial assistance for health insurance coverage.	All plans	All eligible employees residing in a state with CHIP premium assistance. Sent by Plan Sponsor	Annually, before beginning of plan year (recommend to include with open enrollment materials); and upon initial eligibility
HIPAA Notice of Special Enrollment Rights	Tells all eligible employees what circumstances give rise to special mid-year enrollment rights (even if they do not enroll).	All plans	All eligible Employees. Sent by Plan Administrator (Sponsor). Can be delegated to the carrier.	Initial Eligibility and each Open Enrollment; and must also be in SPD
HIPAA Notice of Privacy Practices (Privacy Notice)	Provides information about privacy rights, obligations, and complaint filing.	All plans	All plan participants. Sent by carrier if plan is insured and employer does not get PHI. Sent by employer or TPA if plan is self-funded.	Initial Enrollment; If information changes; Upon request; and Every three years

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Medicare Part D Creditable or Non-Creditable Coverage Notice	Indicates whether the plan's prescription drug coverage is creditable or non-creditable with Medicare prescription drug coverage.	All plans	All Medicare-eligible plan participants, including COBRA participants and eligible dependents (often sent to all participants). Sent by Plan Sponsor.	Annually, before October 15; Prior to the annual enrollment period for Medicare Part D that begins on Oct. 15th; Prior to an individual's initial enrollment period for Medicare Part D; Prior to the effective date of enrolling in the employer's plan and upon any change that affects whether the coverage is creditable; and Upon request by the individual. 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.
Mandated Participant Notices – Plans that Meet Specified Criteria				
Notice	**Details**	**Applicable To**	**Provided to/ Provided by**	**Delivered by Date (Timing)**
Summary Plan Description (SPD)	Communicates plan rights and obligations to participants and beneficiaries. It is a summary of the material provisions of the plan document, and it must be written in plain English.	All ERISA covered plans, plans exempt from Title I of ERISA (governmental and church plans) do not have to comply.	Plan participants. Provided by plan sponsor/ plan administrator.	Within 90 days after the employee becomes a participant in the plan. 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).

Notice	Details	Applicable To	Provided to/ Provided by	Delivered by Date (Timing)
Summary of Material Modification (SMM)	Communicates material modifications to the plan or any changes to the information that is required to be provided in the SPD to plan participants.	All ERISA covered plans, plans exempt from Title I of ERISA (governmental and church plans) do not have to comply.	Plan participants. Provided by plan sponsor/ plan administrator.	No later than 210 days after the end of the plan year in which the change is adopted, for material changes to the plan that do not result in a material reduction in covered services or benefits. Within 60 days of adoption of a material reduction in covered services or benefits.
General Notice of COBRA Rights	Notice of the right to purchase a temporary extension of group health coverage when coverage is lost due to certain qualifying events.	Plans sponsored by employers with 20 or more employees; state and local government plans.	All plan participants and their covered spouses. Sent by Plan Administrator.	Within 90 days after the date group health plan coverage commences (recommend to include with annual Open Enrollment materials); and to new dependents upon initial enrollment if enrolled after employee. Must be included in the plan's SPD and Summary of Benefit Coverage (SBC). May satisfy this requirement by including the general notice in the SPD and giving the SPD to the employee and spouse within the time limit.
Summary Annual Report	Summary of Form 5500 information; plan benefits and total amount paid by plan.	Large Plans 100+ (All plans that file Form 5500)	All plan participants. Sent by Plan Administrator.	Annually within 9 months after the end of the plan year (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.)
Patient Protection "Provider Choice" Disclosure	Tells participants they can designate a primary care provider (PCP) or a pediatrician as PCP and that no referral is required to see an OB-Gyn provider.	Plans with PCP selection requirements	All plan participants. Sent by Plan Sponsor or carrier.	Annually, with carrier's Certificate of Coverage; and upon initial enrollment; and whenever Plan Sponsor provides SPD or other similar benefits description.

Notice	Details	Applicable To	Provided to/ Provided by	Delivered by Date (Timing)
Notice of Grandfathered Status	Statement that plan sponsor or carrier believes plan has met requirements under Health Care Reform for "grandfathered status".	All Grandfathered Plans	All plan participants. Sent by Plan Sponsor or carrier.	With all employee plan materials (E.G. SPDs, SMMs, but not with every Explanation of Benefits (EOB)).
HIPAA/HITECH Breach Notice (if breach involved 500 or fewer individuals)	Notifies affected participants and Health and Human Services (HHS) that there was a breach of Protected Health Information (PHI).	Plans that had a breach of PHI (During the past plan year for notice to HHS; During past 60 days for	Affected Plan participants (directly) And HHS (on HHS website). Plan Sponsor must provide notice.	Notice to HHS: Within 60 days after end of plan year. Notice to affected participants; without unreasonable delay and not more than 60 days after discovery of breach.
HIPAA/HITECH Breach Notice (if breach involved more than 500 individuals)	Notifies affected participants and Health and Human Services (HHS) that there was a breach of Protected Health Information (PHI) during the prior 60 days.	Plans that had a breach of PHI during the past 60 days.	Affected Plan participants (directly) And HHS (on HHS website). Plan Sponsor must provide notice.	Without unreasonable delay and not more than 60 days after discovery of breach.
Wellness Program disclosures	Tells eligible individuals they can satisfy an alternate standard if they are medically unable to meet Wellness Program standards that are related to a health factor.	Wellness programs with a reward or penalty that affects employee's cost for coverage under the group health plan and that requires achievement of performance standards.	All plan participants. Sent by Plan Administrator.	Annually and at open Enrollment. If the wellness program affects premiums, cost-sharing, or benefits under the group health plan, then the terms of the program must be provided in writing and disclosed in the Summary Plan Description and corresponding plan documents.
COBRA Election Notice	Describes the right to COBRA continuation coverage and how to make an election upon the occurrence of a qualifying event	Plans sponsored by employers with 20 or more employees; state and local government plans.	Plan participants, covered spouses, and dependent children who are qualified beneficiaries. Provided by Plan Administrator.	Generally within 14 days after receiving notice of a qualifying event. 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).

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Notice of Unavailability of COBRA Coverage	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.	Plans sponsored by employers with 20 or more employees; state and local government plans.	Individuals who have submitted a notice of qualifying event whom the plan determines are not eligible for COBRA continuation coverage.	Generally within 14 days after receiving notice of a qualifying event.
Notice of Underpayment of COBRA Premium	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.	Plans sponsored by employers with 20 or more employees; state and local government plans.	Qualified beneficiary who makes timely payment in an amount that is not significantly less than the amount due for a period of COBRA coverage. Provided by Plan Administrator or Employer.	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	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.	Plans sponsored by employers with 20 or more employees; state and local government plans.	Qualified beneficiaries whose COBRA coverage will terminate earlier than the maximum period of coverage. Provided by Plan Administrator.	As soon as practicable following the administrator's determination that COBRA coverage will terminate.
Michigan Abortion Insurance Opt-Out Act Notice (Public Act 182 of 2013)	Fully insured plans issued or renewed on or after March 13, 2014 may not provide coverage of "elective abortions." Instead, an optional rider must be purchased to provide coverage for these abortions. If the rider is purchased, notice must be given to each employee.	Fully-insured plans that purchase the elective abortion rider.	All employees. Provided by Plan Administrator.	The statute does not provide guidance on how or when the notice must be supplied; however, it is recommended that the notice be provided annually at open enrollment.

HIPAA Opt-Out Notice for Self-funded Nonfederal Governmental Plans	Tells participants that the self-funded non-federal governmental plan (ie. state/local gov't) has elected to opt-out of some or all of the requirements of title XXVII of the Public Health Service Act.	Self-funded nonfederal governmental plans (state / local gov'ts) that have opted out of specific provisions of HIPAA.	Plan Participants / Self-funded nonfederal governmental plans (state / local gov'ts)	
Other Actionable Items				
Action Items	**Details**	**Plans Affected**	**Action**	**Effective Date**
New Internal Claims and Appeals and External Appeals Processes	Changes imposed by HCR include changes to translated notice requirement, binding nature of external review, narrower scope of claims eligible for federal external review.	Non-Grandfathered insured and self-funded plans	Plan sponsor should update SPD to include changes in plan procedures. For insured plans, carrier probably has updated its appeals procedures to comply.	New procedures apply as of January 1, 2012.
External Appeals Process and Independent Review Organizations (IROs)	To be eligible for a safe-harbor from enforcement, group health plans must have contracted with at least 2 IROs for external appeals by January 1, 2012 and at least 3 IROs by July 1, 2012.	All non-grandfathered self-funded plans; and non-grandfathered insured plans in states whose external review processes are not NAIC- parallel or NAIC-similar.	Check with your TPA for self-funded plans. Check with your carrier for affected insured plans.	By January 1, 2012 (2 IROs) and by July 1, 2012 (3 IROs) to be eligible for enforcement safe-harbor.
Loss of Grandfathered Status	HCR FAQs specify 6 actions that will cause loss of grandfathered status. E.G. any increase in employee co-insurance rates, decrease in employer contribution rate by >5 percentage points below rate on 3/23/10.	Group health plans that have been grandfathered but will lose grandfathered status in 2012.	Amend your plan to comply with requirements on non-grandfathered plans and comply in operation, if your plan will lose grandfathered status.	Any required amendments should be made prior to beginning of plan year (but plan must comply even if not yet formally amended).
Mental Health Parity & Addiction Equity Act	Describes criteria for medical necessity determinations made under a group health plan	Group health plans subject to HIPAA portability rules	Provide to any current or potential participant,	The regulation is effective January 13, 2014 and generally applies to plan years (in the individual

(MHPAEA) Disclosure 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, for plan years starting in 2014.	with respect to mental health or substance use disorder benefits. (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.)	that offer both medical/surgical benefits and mental health/substance use disorder benefits (other than preventive care benefits provided to comply with PHSA §2713). MHPAEA requirements do not apply to: Non-Federal governmental plans that have 100 or fewer employees; Small private employers that have 50 or fewer employees; Group health plans and health insurance issuers that are exempt from MHPAEA based on their increased cost.	beneficiary, or contract provider, upon request.	market, policy years) beginning on or after July 1, 2014.