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Required Health Benefit Plan Notices

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Presentation Agenda

1. Notice Basics
2. Common Annual Benefit Notices
3. Other Annual Notices That May Be Applicable
4. Model Notices

01 Notice Basics

Key Issues to Consider

- There is **not** a one size fits all approach for complying with federal notice requirements (**this presentation is not intended to address state specific notice requirements**)

- Each notice has its own specific requirements, which will depend on factors such as the rule of law that imposes the requirement, the size of the employer/health plan, the funding of the plan (fully insured vs. self-insured), the benefits provided, etc.

- The answers to the following questions will help a plan sponsor assess compliance with a notice requirement:
  - To what plans does the requirement apply?
  - Who must distribute the notice?
  - To whom must it be distributed?
  - When must it be distributed?
  - How must it be distributed?
  - What information must be included?

Key Terms and Concepts

It's important to understand key terms used in federal law.

- **Group Health Plan** – An employee welfare benefit plan to the extent that the plan provides medical care to employees or their dependents directly or through insurance, reimbursement or otherwise (ERISA §733)
- **Plan Administrator** – The person specifically designated by the terms of the plan document or, if an administrator is not so designated, the plan sponsor (ERISA §3)
- **Excepted Benefit** (non-exhaustive list)
  - Many health FSAs
  - Certain limited-scope benefits (dental, vision, long-term care)
  - On-site medical clinics
  - EAPs that do not provide significant medical benefits
  - Accident, disability, etc.
  - Certain specified disease and fixed indemnity insurance
  - Certain supplemental benefits offered as a separate insurance policy

Key Terms and Concepts

DOL Electronic Distribution Rules

- Two categories of individuals
  - Individuals who have the ability to effectively access the electronic documents at any location where the participant is reasonably expected to perform their duties as an employee and who use the employer's electronic information system as an integral part of their jobs – no prior consent needed
  - Others – Prior affirmative consent required (as specified in DOL regulations)
- Notice requirements each time a document is distributed electronically
  - Must provide a notice (in electronic or non-electronic form) that apprises the individual of the significance of the document when it is not otherwise reasonably evident as transmitted and of the right to request and obtain a paper version of such document

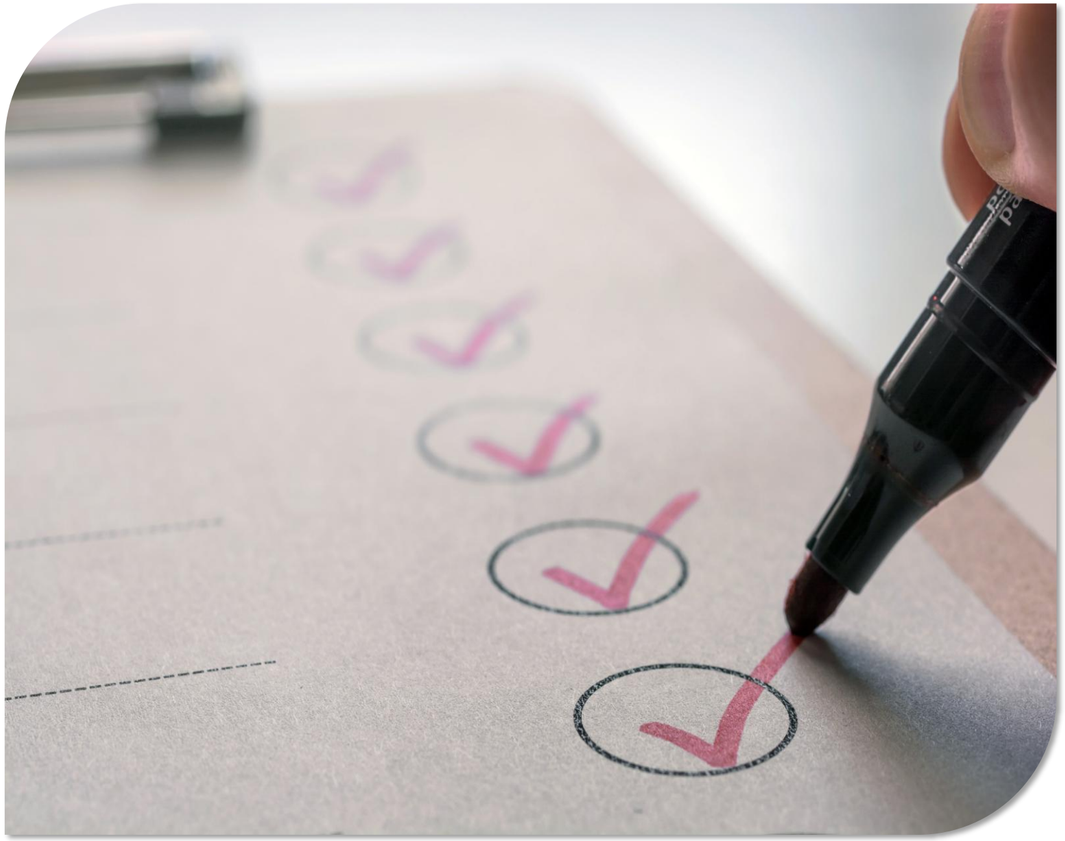
Delegation

- Third party can distribute notice on behalf of the party to whom statutory requirement applies

Failure to Comply

- Some specific consequences are addressed below
- For ERISA plans, if plan administrator fails to provide a required notice → potential breach of fiduciary duty

State Notices



- Focus today is **federal** notice requirements
- Some state laws impose benefit-related notice requirements on employers
  - e.g., Illinois EHB comparison disclosure, California FSA disclosures, notice requirements under state continuation coverage laws
- ERISA preemption?
  - Unclear
  - Regardless, the terms of the plan could indicate employer or plan administrator will provide a particular notification

02

Common Annual Benefit Notices

CHIP Notice

CHIP Notice

Background

- The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) introduced a voluntary program allowing states to offer a premium subsidy for families to enroll their children in employer-sponsored health plans instead of state CHIP or Medicaid programs.
- Employers must inform employees residing in states that are covered under the CHIP program of the availability for premium assistance under the program or provide those contact details to employees, regardless of where the employer or its policy is based.
- Not all states or territories have a CHIP premium assistance program, even if they offer Medicaid or CHIP.
- According to the latest DOL CHIP Model Notice (dated July 31, 2025), 40 states have such a program, while 10 states, the District of Columbia, and other U.S. territories do not.
- Still, many employers send a CHIP notice to all employees for simplicity.

CHIP Notice

To What Plans Does the Requirement Apply?

- Group health plans (fully insured and self-insured) providing “medical” benefits (definition includes health benefit plans including stand-alone dental/vision plans)

Who Must Provide the Notice?

- Each employer that maintains a group health plan in a state in which a Medicaid or CHIP plan provides a premium assistance subsidy

To Whom?

- All employees (regardless of enrollment status) residing in each premium assistance subsidy state

When Must It Be Provided?

- Annually

How Is the Notice Provided?

- First-class mail/hand-delivery or electronically in accordance with the DOL’s electronic distribution requirements
- Notice can be included with open enrollment materials or SPD, but must be provided as a stand-alone document

What Information Must the Notice Contain?

- Information regarding potential opportunities available in the state in which an employee resides for premium assistance under Medicaid/CHIP for health coverage for employees/dependents

Model notice that contains this information is available.

What Are the Consequences of Failure to Comply?

- Potential penalties of $145 (indexed) per day, per employee

COBRA Notices

COBRA Notices

Background

- COBRA, a U.S. federal statute, has its requirements outlined across three key pieces of legislation: the Employee Retirement Income Security Act (ERISA), the Internal Revenue Code (Code) or the Public Health Service Act (PHSA).
  - The COBRA provisions of ERISA and the Code apply to the group health plans of private-sector employers
  - The COBRA provisions of the PHSA apply to the group health plans of state and local governments.
- Under COBRA, a qualifying individual, known as a qualified beneficiary, who might otherwise lose coverage under a group health plan can pay to continue that coverage for a limited time.
- To be a qualified beneficiary, an individual must generally satisfy three requirements:
  - Must be a covered employee, the spouse of a covered employee, or the dependent child of a covered employee
  - Must be covered by a group health plan immediately before certain events specified under COBRA (a COBRA qualifying event)
  - Must have lost their group health plan coverage because of that COBRA qualifying event
- Employers subject to COBRA must provide certain notices about COBRA to employees and covered individuals

COBRA General Notice

To What Plans Does the Requirement Apply?

- Group health plans (medical, dental, vision, health FSA, EAP, HRA, on-site medical clinics, wellness, etc.)

Who Must Provide the Notice?

- Plan Administrator

To Whom?

- Covered employees and covered spouses
- Single mailed notice addressed to both at same address is sufficient if they reside together

How Is the Notice Provided?

- First-class mail, hand, or electronic distribution
- DOL electronic distribution rules apply
- Typically included in SPD as well (SPDs must include COBRA information)

When Must It Be Provided?

- Within 90 days of commencing coverage

What Information Must the Notice Contain?

- Plan name and contact information
- General description of the continuation coverage under the plan
- Employee/qualified beneficiary notice requirements and procedures

Model notice that contains this information is available

What Are the Consequences of Failure to Comply?

- Potential penalties under ERISA ($110 per day) and excise taxes under IRC ($100 per day, per individual)
- Potential inability to enforce notice deadline(s) on employees/qualified beneficiaries

COBRA Election Notice

To What Plans Does the Requirement Apply?

- Group health plans (medical, dental, vision, health FSA, EAP, HRA, on-site medical clinics, wellness, etc.)

Who Must Provide the Notice?

- Plan Administrator

To Whom?

- Qualified beneficiaries experiencing a qualifying event
- Single mailed notice addressed to all QBs at same address is sufficient if they reside together

How is the Notice Provided?

- First-class mail, hand, or electronic distribution
- DOL electronic distribution rules apply

When Must It Be Provided?

- Within 14 days after qualifying event notice to plan or 44 days following certain qualifying events

*Employers at the time of the qualifying event should also ensure they properly delivered the COBRA General Notice to the qualified beneficiary or if not, deliver it along with the COBRA Election Notice

What Information Must the Notice Contain?

- 14 specific pieces of information

Model notice that contains this information is available

What Are the Consequences of Failure to Comply?

- Potential penalties under ERISA ($110 per day) and excise taxes under IRC ($100 per day, per individual)
- Election period does not begin to run until the election notice is received by the qualified beneficiary

HIPAA Notices

HIPAA Notices

Background

- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law with various objectives regarding improving healthcare efficiency and protecting patients' rights. Two important functions of HIPAA are:
  - Aids continuity of health insurance coverage for individuals by providing special enrollment periods when individuals experience qualifying life events (e.g., marriage, birth, loss of prior coverage)
  - Establishes requirements for securing and protecting individually identifiable health data (e.g., protected health information (PHI))
- Under HIPAA, covered entities must notify employees and their dependents of mid-year enrollment rights triggered by qualifying events (e.g., loss of coverage, marriage, birth) to avoid coverage gaps and ensure portability.
- Additionally, "covered entities" under HIPAA must take precautions to secure and protect individuals' PHI, inform individuals how their PHI may be used or inform individuals about their rights regarding their PHI under HIPAA
  - Covered entities include group health plans (both fully insured and self-funded)
- Since a group health plan cannot act on its own, plan sponsors and insurance carries act on behalf of a group health plan

HIPAA Notice of Privacy Practices

To What Plans Does the Requirement Apply?

- Plans that are covered entities under HIPAA
- Includes almost all group health plans (except some self-administered plans and on-site medical clinics)

Who Must Provide the Notice?

- Self-insured plan → plan/plan sponsor
- Fully insured plan (hands-off) → carrier
- Fully insured plan (hands-on) → plan/plan sponsor

To Whom?

- Covered individuals/plan participants (single notice to family allowed if they reside together
- Anyone upon request

When Must It Be Provided?

- Upon enrollment (and upon request)
- Notice of availability every three years

How Is the Notice Provided?

- Physical delivery to plan participant (e.g., first-class mail)
- Posted on public website of the health plan (if health plan has one)
- By mail or by e-mail, if the individual agrees to electronic notice and such agreement has not been withdrawn (no other details)

What Information Must the Notice Contain?

- The uses and disclosures of PHI that may be made by the covered entity
- The individual's HIPAA privacy rights
- The covered entity's legal duties with respect to PHI

Model notice that contains this information is available

What Are the Consequences of Failure to Comply?

- Potential civil monetary penalties

HIPAA Special Enrollment Notice

To What Plans Does the Requirement Apply?

- Group health plans other than excepted benefits and plans covering fewer than two current employees
- Typically applies only to group medical plans but can apply to other plans

Who Must Provide the Notice?

- Plan Administrator

To Whom?

- All employees who are offered the opportunity to enroll in the plan

When Must It Be Provided?

- At or before the time an employee is initially offered the opportunity to enroll in a group health plan

How Is the Notice Provided?

- Included with enrollment materials, by hand delivery or first-class mail
- Electronic distribution allowed in accordance with DOL rules
- Typically included in SPD as well

What Information Must the Notice Contain?

- Information regarding special enrollment rights provided under HIPAA

What Are the Consequences of Failure to Comply?

- Potential excise tax under IRC ($100 per day, per individual)

Medicare Part D Notice

Medicare Part D Notices

Background

- Group health plans must disclose to Medicare Part D-eligible/entitled individuals (and report to CMS) if their prescription drug benefits are "creditable“ or “non-creditable”

- Employer-sponsored or group health plan prescription drug coverage is considered creditable if:
  - The coverage is expected to pay, on average, at least as much as the standard Medicare Part D prescription drug benefit at the start of the plan year.

- If an individual delays signing up for a Medicare Part D drug plan during their initial enrollment period (IEP) and does not have creditable drug coverage for 63 continuous days or more after their IEP ends, the individual may pay a lifelong higher monthly premium as a late penalty

- Employers must affirmatively disclose to employees if coverage is creditable or not—cannot claim uncertainty
  - Simple plan designs may qualify without actuaries
  - Complex plans often require professional analysis

Medicare Part D Creditable/Non-Creditable Coverage Notice

To What Plans Does the Requirement Apply?

- Group health plans that provide prescription drug benefits
- Specific exemptions for health FSAs and HSAs

Who Must Provide the Notice?

- Plan Sponsor (typically the employer)

To Whom?

- Part D eligible individual (one who is enrolled in Medicare Part A or Part B and lives in the service area of a Part D plan) who is enrolled or seeking to enroll in a covered plan
- A single notice provided to the participant constitutes distribution to dependents if they reside at the same address
- Separate CMS reporting requirement also applies

When Must It Be Provided?

- Prior to commencement of the annual coordinated election period (ACEP) for Part D (Oct. 15)
- Prior to an individual's initial enrollment period (IEP) for Part D
  - » Can be satisfied via annual distribution of notice to all participants
- Prior to the effective date of coverage for any Part D-eligible individual that enrolls in the group health plan
- Whenever the employer no longer offers prescription drug coverage or changes it so that it is no longer creditable or becomes creditable
- Upon request by the Part D-eligible individual

Medicare Part D Creditable/Non-Creditable Coverage Notice

CONTINUED

How Is the Notice Provided?

- By mail (first-class mail recommended) or hand delivery
- Via electronic distribution
  - To participants who have the ability to access electronic documents at their regular place of work and who have access to the plan sponsor's electronic information system on a daily basis as part of their work duties
    - Must notify recipients of the significance of the document and a right to a paper copy
    - Must inform participants it is their responsibility to share notice with Part D-eligible dependents
  - To Part D-eligible individuals who indicate they have adequate access to electronic information and provide informed written consent to receive information electronically
- Special rule if provided with other documents – must be called out on the first page (14-point font, reference to where to find the notice)
- Often included in SPD as well

Medicare Part D Creditable/Non-Creditable Coverage Notice

CONTINUED

What Information Must the Notice Contain?

- Differs depending on the plan's status
- Creditable Coverage
  - » Employer has determined that the prescription drug coverage is creditable
  - » Meaning of creditable coverage
  - » Why creditable coverage is important, etc.
- Non-creditable coverage notice requirements similar

Model notices are available

What Are the Consequences of Failure to Comply?

- No specific penalties to employers/plan sponsors for failure to provide Notices to Medicare eligibles
- Potential adverse impact on employees and former employees (i.e., potential penalties to Part D-eligible)

Notice of Exchange

Notice of Exchange

Background

- The Affordable Care Act modified the Fair Labor Standards Act (FLSA) to mandate that employers furnish written notifications to employees regarding health insurance choices offered via the Marketplace (or Exchange), along with potential repercussions for opting into a Marketplace-qualified plan instead of employer-provided benefits.

Notice of Exchange

To What Plans Does the Requirement Apply?

- This notice is not tied to any health & welfare plan or plans
- It applies to all employers subject to the Fair Labor Standards Act (FLSA) regardless of whether they offer health coverage

Who Must Provide the Notice?

- All employers subject to the FLSA
  - Companies/organizations with $500,000 or more in annual sales or revenue
  - A federal, state, or local government agency
  - A hospital or facility that mainly cares for sick, elderly, or mentally ill or developmentally disabled people living there (whether public or private, for-profit or nonprofit)
  - A preschool, elementary or high school, college, or school for children with mental or physical disabilities or gifted children (whether public or private, for-profit or nonprofit)

To Whom?

- All new employees regardless of whether they are benefit eligible

When Must It Be Provided?

- Within 14 days following an employee's start date

How Is the Notice Provided?

- First-class mail
- Electronically in accordance with the DOL's electronic distribution requirements (as previously described)

What Information Must the Notice Contain?

- Various pieces of information regarding the ability to obtain coverage via the Exchange/Marketplace

Model notice that contains this information is available

What Are the Consequences of Failure to Comply?

- No monetary penalties to the employer
- Failure to comply with federal laws could be considered a breach of general fiduciary duties under ERISA

Summary Annual Report

Summary Annual Report (SAR)

Background

- Under ERISA, a plan administrator must furnish an annual summary report to eligible participants and select beneficiaries, recapping the plan's most recent Form 5500 annual report. Referred to as the Summary Annual Report (SAR), this document offers a plain-language overview of the key details from the Form 5500.

- Plans that qualify for an exemption from the ERISA Form 5500 annual reporting obligations have no Form 5500 to summarize, so they are relieved of the duty to issue an SAR

- Additionally, an employee welfare benefit plan that is totally unfunded need not provide a SAR (regardless of size) even though a large, unfunded plan (100 or more covered participants) must file a Form 5500

  - Unfunded plans are those that pay benefits solely from an employer’s general assets and not from insurance, a trust, an account dedicated for paying benefits, or plan assets

Summary Annual Report (SAR)

To What Plans Does the Requirement Apply?

- Employee welfare benefit plans subject to Form 5500 filings
  - » Unfunded, self-insured plans exempt even if subject to Form 5500 filing

Who Must Provide the Notice?

- Plan Administrator (typically the plan sponsor)

To Whom?

- Participants and beneficiaries receiving benefits (including former employees)

When Must It Be Provided?

- Furnished within nine (9) months after the end of the plan year or two (2) months after the due date for filing Form 5500 (including any extensions)

How Is the Notice Provided?

- May be distributed by any method permissible for SPDs under DOL rules (e.g., via first-class mail with potential for electronic delivery)

What Information Must the Notice Contain?

- Narrative summary of the important financial information contained in the plan's Form 5500 and a statement of the rights of individuals to receive a full copy of the plan's annual report

What Are the Consequences of Failure to Comply?

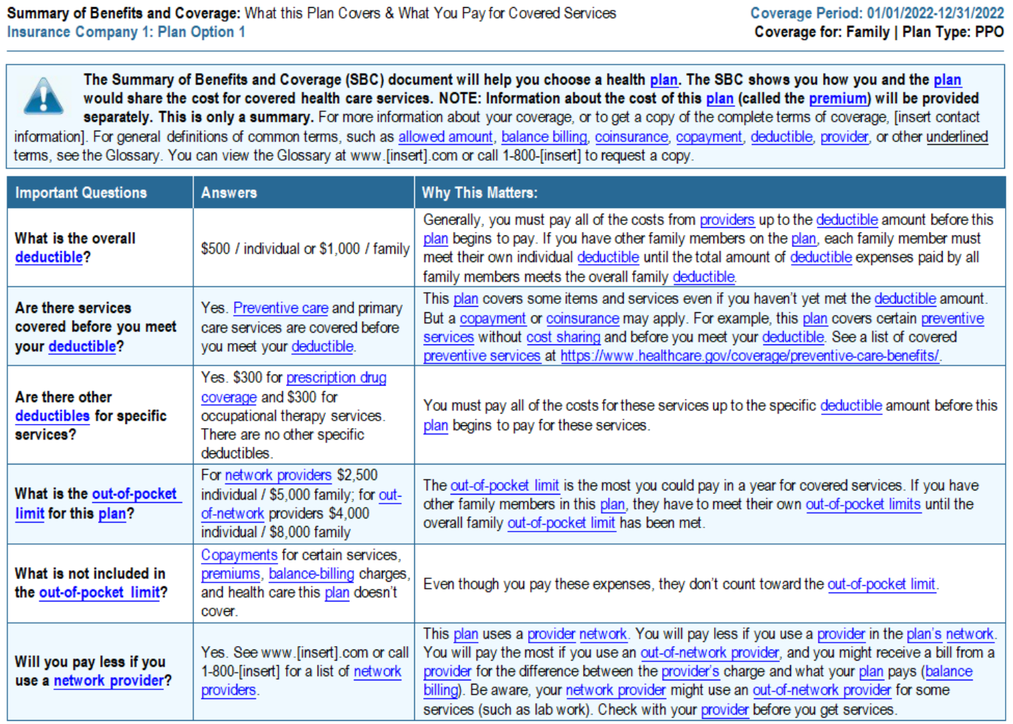
- No specific penalty for failure to distribute SARs
  - » May lead to participant/beneficiary lawsuit enforcing the ERISA provision
- Failure to provide within 30 days of a request for the SAR could lead to potential penalties of $110 per day
- Criminal penalties for willful violation of ERISA

Summary of Benefits and Coverage (SBC)

Summary of Benefits and Coverage (SBC)

Background

- Healthcare reform initiatives broadened ERISA's obligations for disclosures, mandating the delivery of a "summary of benefits and coverage" (and Uniform Glossary) to prospective and current plan participants and beneficiaries prior to enrollment or renewal
- Known as the SBC, this document must precisely outline the "benefits and coverage" offered by the relevant plan or policy
- The SBC mandate extends to "grandfathered" health plans, meaning it is not among the provisions from which these longstanding group health plans and coverages are exempt.
- Joint regulations from the DOL, HHS or IRS provide guidance on the SBC's prescribed content, form or style, including a template SBC.



Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Insurance Company 1: Plan Option 1

Coverage Period: 01/01/2022-12/31/2022
Coverage for: Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, [insert contact information]. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.[insert].com or call 1-800-[insert] to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500 / individual or $1,000 / family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $300 for prescription drug coverage and $300 for occupational therapy services. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers $2,500 individual / $5,000 family; for out-of-network providers $4,000 individual / $8,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.[insert].com or call 1-800-[insert] for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Summary of Benefits and Coverage (SBC)

To What Plans Does the Requirement Apply?

- Group health plans other than excepted benefits or health plans covering fewer than two current employees

Who Must Provide the Notice?

- Self-insured plan → Plan Administrator
- Fully insured plan → Plan Administrator and issuer
  - » If either provides the SBC, obligation of the other is satisfied
- Special rules for contracting with a third party

To Whom?

- Applicants and enrollees
- A single SBC provided to the participant constitutes distribution to dependents if they reside at the same address

When Must It Be Provided?

- At open enrollment (with enrollment materials) or, if enrollment is automatic, no later than 30 days prior to the first day of the new plan year
  - » If a fully insured plan's new policy isn't issued 30 days before the plan year starts, the SBC must be provided as soon as possible, but no later than seven business days after the policy is issued.
- At initial enrollment (with any application materials) or, if no application, no later than the first date the participant is eligible to enroll in coverage
- Within 90 days after enrollment pursuant to a special enrollment right
- Upon request
- Notice of material modification must be provided at least 60 days prior to the date on which a material modification will become effective if it is not reflected in the most recent SBC provided and occurs mid-plan year

Summary of Benefits and Coverage (SBC)

CONTINUED

How Is the Notice Provided?

- Paper (e.g., first-class mail or hand delivery)
- Electronically
  - In connection with a participant's online enrollment or renewal of coverage
  - To participants and beneficiaries who request an SBC online
  - To participants covered under the plan in accordance with the DOL electronic disclosure requirements
  - To participants who are eligible, but not enrolled in the plan, so long as the format is readily accessible or a paper form is provided free of charge upon request
    - Via internet posting if the participants are notified in paper form or via email that the documents are available on the internet

What Information Must the Notice Contain?

- Specific information contained in the mandatory SBC template provided by the federal government

What Are the Consequences of Failure to Comply?

- Potential penalty of $1,443 per failure, in 2025 (indexed)
- Potential excise tax under IRC ($100 per day, per individual)

Women’s Health and Cancer Rights Act

Women’s Health and Cancer Rights Act (WHCRA) Notices

Background

- The Women's Health and Cancer Rights Act (WHCRA) mandates that group health plans offering medical and surgical coverage for mastectomies must also cover reconstructive surgery.
- Such reconstructive benefits can include annual deductibles and coinsurance provisions, provided they align with those applied to other plan benefits.
- Nothing in this law limits entitlement to WHCRA benefits to cancer patients or limits WHCRA entitlements to women.
- WHCRA is found in parallel provisions of Employee Retirement Income Security Act (ERISA) and the Public Health Service Act (PHSA).
- Healthcare reform also incorporated WHCRA into the Internal Revenue Code (Code).
- No exceptions for non-federal governmental plans, fully insured governmental plans or church plans
    - Self-funded non-federal governmental plans may opt out of WHCRA, provided they submit an opt-out election with the Centers for Medicare & Medicaid Services (CMS) and provide initial and annual notices to plan enrollees

Women’s Health and Cancer Rights Act (WHCRA) Notice

To What Plans Does the Requirement Apply?

- Group health plans that provide medical and surgical benefits for mastectomy (requires them to also provide benefits for reconstructive surgery)
- Not applicable to excepted benefits or health plans covering fewer than two current employees

Who Must Provide the Notice?

- Plan Administrator or health insurer (for fully insured plans)

To Whom?

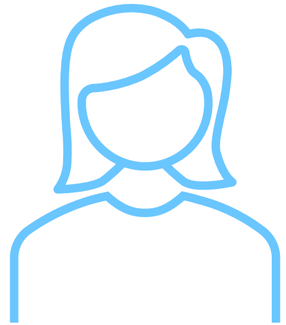
- Participants and beneficiaries under the group health plan
- Single mailed notice to married participants in the same household is sufficient to meet the requirements if they reside at the same household address

When Must It Be Provided?

- Provided upon enrollment in group health plan
- Annually thereafter

How Is the Notice Provided?

- First-class mail, by hand or electronically in accordance with the DOL’s electronic distribution requirements



Women's Health and Cancer Rights Act (WHCRA) Notice

CONTINUED

What Information Must the Notice Contain?

- Enrollment notice must include:
  - » Information regarding the plan's coverage for reconstructive surgery and certain procedures following a mastectomy
  - » Description of any deductible and coinsurance limitations applicable to such coverage
- Annual notice requirement may be satisfied by providing notice with the same content as the enrollment notice, or:
  - » Providing a shorter notice describing the coverage required under WHCRA and information on how to obtain a more detailed description of the mastectomy-related benefits

Model notices are available

What Are the Consequences of Failure to Comply?

- Potential excise tax under IRC ($100 per day, per individual)

03

Other Annual Notices That May Be Applicable

Grandfathered Health Plan Notice

Grandfathered Health Plans

Background

- Group health plans or insurance coverage that had at least one participant as of March 23, 2010 (ACA enactment) may be excused from certain healthcare reform provisions provided they meet certain requirements
  - Must have continuously covered someone since March 23, 2010 to retain “grandfathered” status
  - Must not make any prohibited changes to the plan design to retain “grandfathered” status
- Some of the ACA’s mandates that do not apply to grandfathered plans include:
  - Coverage of Preventive Services Without Cost-Sharing
  - Annual and Lifetime Dollar Limits (exception only applies in the individual market)
  - Coverage of Preexisting Conditions for Children Under 19
- To retain grandfathered plan status, the plan may not :
  - Add or lower annual limits
  - Eliminate all (or substantially all) of the benefits for a medical condition
  - Increase cost sharing amounts above 15%
  - Decrease employer contributions more than 5%

Statement of Grandfathered Status

To What Plans Does the Requirement Apply?

- Grandfathered health plans are group health plans or insurance coverage that are excused from some healthcare reform requirements
- Must have had at least one participant as of March 23, 2010 (ACA enactment) and continuously covered someone since that date to retain “grandfathered” status
- Must not have made any prohibited changes to the plan design to retain “grandfathered” status

Who Must Provide the Notice?

- All employers or insurers who provide a grandfathered plan

To Whom?

- All plan participants and beneficiaries

When Must It Be Provided?

- Whenever a summary of benefits is provided

How Is the Notice Provided?

- Along with a Summary Plan Description (SPD), Summary of Material Modfication (SMM) or enrollment materials
- Electronically in accordance with the DOL’s electronic distribution requirements (as previously described)

What Information Must the Notice Contain?

- A statement that the plan or coverage is believed to be a grandfathered plan
- Contact information for questions or complaints
- May also include additional disclosure elements, such as the entire list of the healthcare reform provisions that do not apply to grandfathered health plans

Model notice that contains this information is available

What Are the Consequences of Failure to Comply?

- Unclear. May not automatically cause loss of grandfathered plan status. Consult legal counsel.

Patient Protection Notice

Patient Protection Disclosure

To What Plans Does the Requirement Apply?

- Group health plans and group health insurers that requires or allows a participant, beneficiary or enrollee to chose a primary care provider (PCP)
  - » e.g., a health maintenance organization (HMO)
- Excepted benefit plans are excepted
- Plans covering fewer than two current employees also excepted

Who Must Provide the Notice?

- Plan administrator or health insurer

To Whom?

- All plan participants and beneficiaries

When Must It Be Provided?

- Whenever a summary of benefits is provided

How Is the Notice Provided?

- Along with a Summary Plan Description (SPD), Summary of Material Modification (SMM) or enrollment materials

What Information Must the Notice Contain?

- The plan's rules for selecting a PCP and inform participants and beneficiaries of the rights to:
  - » Choose any available participating PCP who is accepting new patients
  - » Select a pediatrician as the PCP for a child
  - » Access obstetrical or gynecological care without prior authorization or referral

Model notice that contains this information is available

What Are the Consequences of Failure to Comply?

- No specific penalty for failure to provide notice
- May lead to participant/beneficiary or DOL lawsuit enforcing the ERISA provisions

Newborns’ and Mothers’ Health Protection Act (NMHPA) Notice

Newborns' and Mothers' Health Protection Act (NMHPA)

Background

- The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) mandates that group health plans cannot restrict benefits for hospital stays related to childbirth for a mother or newborn to:
  - Less than 48 hours after a vaginal delivery
  - Less than 96 hours after a cesarean section
- During these required minimum hospital stays, plans subject to NMHPA are prohibited from:
  - Lowering the level of benefits provided at any point during the minimum hospital stay compared to earlier portions of that stay
  - Requiring a doctor or other healthcare provider to seek plan approval for a hospital stay for the mother or newborn if it does not exceed the NMHPA's minimum stay requirements
  - Offering incentives, such as payments, refunds or waivers of deductibles or copayments, to the mother or healthcare provider to encourage discharge before the minimum hospital stay is complete

Newborns' and Mothers' Health Protection Act (NMHPA) Notice

To What Plans Does the Requirement Apply?

- Group health plans and group health insurers
- Excepted benefit plans are excepted
- Self-funded, non-federal government plan can opt out of NMPHA's requirements

Who Must Provide the Notice?

- Plan administrator or health insurer

To Whom?

- All plan participants and beneficiaries

When Must It Be Provided?

- Whenever a Summary Plan Description (SPD) is provided

How Is the Notice Provided?

- Included in the Summary Plan Description (SPD), by hand delivery or first-class mail
- Electronic distribution allowed in accordance with DOL rules

What Information Must the Notice Contain?

- A description of NMHPA's requirements for hospital stays for newborns and mothers following childbirth
- If a plan operates in areas where both federal (e.g., NMHPA) and state laws apply, such as with mixed insured and self-insured components, the SPD must specify the different regions and the applicable requirements for each

Model notice that contains this information is available

What Are the Consequences of Failure to Comply?

- Potential penalties under ERISA ($110 per day) and excise taxes under IRC ($100 per day, per individual)

Wellness Program Notice

Generally: Wellness Programs

Definition of a Wellness Program

- An employer-sponsored program that seeks to improve and promote health and fitness in the workplace
- This typically includes premium discounts, but can also include cash rewards, paid gym memberships or other incentives to participate
- Some wellness programs focus on assisting employees in diabetes management, promoting active lifestyles, smoking cessation, weight loss or attending a preventive health screening

Related to Healthcare

- Program focus is on health-based improvement/incentives.

Related to Group Health Plans

- We will be briefly discussing some notices that may be required under federal law depending on a wellness program's design

Generally: Regulations Surrounding Wellness Programs

Regulations

HIPAA

Prohibits discrimination among similarly situated individuals based on the presence or absence of a health factor in relation to eligibility, premiums or contributions. There is an exception for voluntary wellness programs that meet specific standards.

ADA

Prohibits employers from making disability-related inquiries or requiring medical examinations of their employees. There is an exception for voluntary wellness programs that maintain information according to confidentiality requirements and do not use the information to discriminate against an employee.

GINA

Prohibits employers from using or requesting genetic information of employees and employees' family members for underwriting purposes or in the determination of employee contributions towards benefits. There is an exception for voluntary wellness programs that meet specific standards.

Wellness Program Types Under HIPAA

Participatory

- A program that either does not provide an incentive; or
- Provides an incentive but the conditions to obtain the reward are not based on a health factor.

Health-Contingent

- A program that provides an incentive based on a health factor
- Two kinds of Health-Contingent Programs
  - ***Activity-Based*** – The reward is contingent on the completion of an activity
  - ***Outcomes-Based*** – The reward is contingent on a health outcome

Wellness Program Disclosure - HIPAA

To What Plans Does the Requirement Apply?

- Wellness programs that are group health plans (or that are connected to a group health plan) and require individuals to meet a standard related to a health factor in order to obtain a reward (i.e., health contingent programs),
- Examples of health-contingent programs:
  - Rewards for achieving tobacco-free status.
  - Incentives for specific health risk assessment scores.
  - Benefits for completing a set amount of physical activity.

Who Must Provide the Notice?

- Plan Administrator or Plan Sponsor

To Whom?

- Plan participants and beneficiaries

When Must It Be Provided?

- Must be included in any materials that describe the wellness program
- Disclosure not required if wellness plan materials merely mention that a wellness plan program is available without describing the plan's terms.

What Information Must the Notice Contain?

- The availability of a Reasonable Alternative Standard (RAS) to qualify for the incentives provided under the wellness program
- Contact information on how to obtain a RAS
- Statement that recommendations of an individual's personal physician will be accommodated

ADA: Wellness Programs

Subject to the ADA

Wellness program that includes a disability inquiry or medical examination.

Disability Inquiry – Question(s) that are likely to elicit information about a disability.

Medical Examination – A procedure/test that seeks information about an individual's physical/mental impairment/health.

ADA: Wellness Programs

Examples of ADA Wellness Programs

The following examinations/inquiries are examples of wellness programs that could implicate application of the ADA rules:

- Health Risk Assessment (HRA)
- Blood pressure screening
- Testing for tobacco as part of a tobacco cessation program
- Range-of-motion tests for muscle strength and motor function
- Medical exams measuring heart rate or blood pressure
- Asking an employee whether they have (or ever had) a disability, how they became disabled or the severity of an employee's disability
- Asking for information related to an employee's disability

Wellness Program Disclosure - ADA

To What Plans Does the Requirement Apply?

- Wellness programs that that collect employee health information (e.g., health risk assessments, biometric screenings, etc.).
- Wellness programs that include a disability inquiry

Who Must Provide the Notice?

- Employer

To Whom?

- Employees from whom health information will be collected

When Must It Be Provided?

- In advance of an employee's provision of any health information with sufficient time for the employee to decide whether to participate in the program

What Information Must the Notice Contain?

- What medical information will be obtained
- How the collected medical information will be used
- Who may receive the collected medical information
- Restrictions on disclosing the medical information
- Methods the employer will use to prevent improper disclosures

Model notice that contains this information is available

What Are the Consequences of Failure to Comply?

- Enforcement actions by the Equal Employment Opportunity Commission (EEOC)
- Consult legal counsel

GINA: Wellness Programs

Subject to GINA

If a group health plan or employer requests information that is related to an employee's (or family member's) medical history or genetic information.

Title I – Group health plans are prohibited from collecting genetic information (e.g., family medical history) for underwriting purposes. **Employers should use caution when asking for the genetic information of a spouse or should speak to legal counsel as to whether this is prohibited under GINA Title I as this could be considered an inquiry of a manifested health condition.**

Title II – Genetic information or medical information can be requested, so long as it is "voluntary".

GINA: Wellness Programs

Examples of GINA Wellness Programs

Examples

- Analysis of human DNA, RNA, chromosomes; or
- Metabolites that detect genotypes, mutations and chromosomal changes
- Requests for individual's family medical history or spouse's medical history

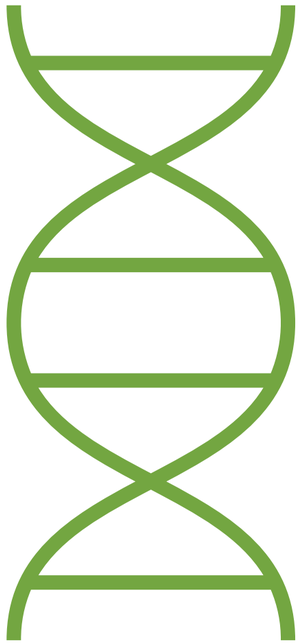
Not Considered GINA Information

- Body mass index
- Blood pressure
- Cholesterol
- Age
- Sex
- Tobacco use

Wellness Programs Disclosure- GINA

Key Requirements

- Employers may request genetic information (including family medical history) in connection with a wellness program (e.g., as part of health risk assessment) only if:
  - Employees voluntarily provide the genetic information through a written authorization that specifies:
    - Type of genetic information collected
    - How the genetic information may used
    - The restrictions on disclosing the provided genetic information
  - The employer informs the employee that any inducement for participating in the wellness program will be provided regardless of whether the genetic information (including family medical history) is provided.
- The employee's written authorization must be obtained prior to requesting genetic information from the employee



04

Model Notices

Agency-Provided Model Notices

- CHIP
- COBRA Notices
- EEOC Wellness Notice
- Exchange Notice
- Grandfathered Status
- HIPAA Notice of Privacy Practices
- Medicare Part D Notice of Creditable (or Non-Creditable) Coverage
- Newborns' and Mothers' Health Protection Act
- Patient Protection Disclosure – Non – Grandfathered Health Plans Only
- Surprise Billing Rights Notice
- Women's Health and Cancer Rights Act (WHCRA) Notice

HRCI and SHRM Credits

This Program, **ID No. 712541**, has been approved for 1.00 HR (General) recertification credit hours toward aPHR™, aPHRi™, PHR®, PHRca®, SPHR®, GPHR®, PHRi™ and SPHRi™ recertification through HR Certification Institute® (HRCI®).

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THANK YOU!

Brown & Brown