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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 the Affordable Care Act (ACA). 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
Affordable Care Act	Group health plans and health insurance issuers	**Statement of grandfathered status—**Plan administrator or issuer must provide 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 ACA's enactment date) that satisfy certain requirements. Grandfathered plans can avoid certain ACA reforms, such as the requirement to cover preventive care services without cost-sharing. To maintain grandfathered plan status, a plan administrator or health issuer must include a statement of grandfathered status in plan materials provided to participants describing the plan's benefits (such as the summary plan description (SPD) and open enrollment materials). A model notice is available from the Department of Labor (DOL).
		Notice of rescission—Plan administrator or issuer must provide notice of rescission to affected participants at least 30 days before the rescission occurs	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 Plan coverage may not be rescinded without prior notice to the enrollee.
		Notice of patient protections and selections of providers— Plan administrator or issuer must provide notice of patient protections whenever the SPD or similar description of benefits is provided to participants This requirement does not apply to grandfathered plans.	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. These reforms do not apply to grandfathered plans. A model notice is available from the DOL.
		Uniform summary of benefits and coverage—Plan administrator and issuer must provide to participants and	Group health plans are required to provide a uniform summary of the plan's benefits and coverage to applicants and enrollees. The Departments of Labor, Health and Human Services and the Treasury (Departments) have

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		beneficiaries at the following times: • With any written application materials distributed for enrollment; • If written application materials for enrollment are not provided, no later than when the participant is first eligible to enroll in coverage; • By the first day of coverage, if there was any change to the information that was provided upon application and before the first day of coverage; • To special enrollees, no later than the deadline for providing the SPD; • Upon renewal, if participants and beneficiaries must renew to maintain coverage; and • Upon request. The SBC requirement became effective starting with the first open enrollment periods and plan years beginning on or after Sept. 23, 2012.	provided a template for the summary of benefits and coverage (SBC) that plans and issuers must use, as well as additional instructional guidance and sample language for completing the template. The Departments have also provided a uniform glossary of health-coverage-related terms and medical terms for plans and issuers to make available to plan participants and beneficiaries. The template, glossary and other related guidance are available on the Center for Consumer Information & Insurance Oversight (CCIIO) website.
		60-Day Advance Notice of Plan Changes—Plans and issuers must provide at least 60 days' advance notice of mid-year material modifications in plan terms or coverage that would affect the content of the SBC and are not reflected in the most recent SBC. This notice requirement became effective when the SBC requirement went into effect.	A health plan or issuer must provide 60 days' advance notice of any material modifications to the plan that are not reflected in the most recent SBC. This notice requirement is limited to material modifications that do not occur in connection with a renewal or reissuance of coverage. A "material modification" is any change to a plan's coverage that independently, or in connection with other changes taking place at the same time, would be considered by the average plan participant to be an important change in covered benefits or other terms of coverage. A material modification may include: • An enhancement in covered benefits or services or other more generous plan or policy terms (for example, reduced cost-sharing or coverage of previously excluded benefits); or • A material reduction in covered services or benefits or

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			more strict requirements for receiving benefits (for example, a new referral requirement or increased premiums or cost-sharing).
Affordable Care Act	Employers sponsoring group health plans	**IRS Form W-2**—Aggregate cost of applicable employer-sponsored coverage must be included on employees' Forms W-2. This requirement was originally effective for tax years beginning after Dec. 31, 2010. However, the IRS made reporting optional for all employers for the 2011 tax year. 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. Large employers must comply with the W-2 requirement beginning in 2012.	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. The Form W-2 and Instructions, including a category for reporting the cost of employer-sponsored coverage, are available on the IRS website.
Affordable Care Act	All employers subject to the FLSA	**Exchange Notice—**The ACA requires employers to provide all new hires with a written notice about the health insurance Exchanges. This requirement became effective on Oct. 1, 2013. Employers were also required to provide all current employees with an Exchange Notice no later than Oct. 1, 2013.	Employers must provide all new hires with an Exchange notice that: • Includes information regarding the existence of the Exchange, as well as contact information and a description of the services provided by the Exchange; • Explains how an employee may be eligible for a premium tax credit if the employee purchases a qualified health plan through the Exchange; and • Contains a statement informing the employee that, if the employee purchases a qualified health plan through an Exchange, the employee may lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of this employer contribution may be excludable for federal income tax purposes. The DOL has provided **model Exchange notices** for employers to use, which will require some customization. The model Exchange notices areavailable on the DOL's website.
Affordable Care Act	Applicable large employers with full-time	**Code §6056 Reporting—** Effective for 2015, applicable large employers (those with at least 50 full-time employees,	Code section 6056 requires applicable large employers to report to the IRS information about the health care coverage, if any, they offered to full-time employees. Section 6056 also requires those employers to furnish

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	employees	including full-time equivalents) with full-time employees must file an annual return with the IRS regarding the health coverage, if any,provided to full-time employees. These employers must also provide arelated annual statement to full-time employees. Reporting is required for 2015, with the first returns due in 2016. The deadlines for these returns and employee statements are as follows: • Section 6056 returns must be filed with the IRS annually, no later than Feb. 28 (March 31, if filed electronically) of the year after the calendar year to which the return relates. • The employee statements for each calendar year must be furnished to full-time employees by Jan. 31 of the next calendar year. Extensions may be available in certain circumstances.	related statements to employees.Reporting is required for 2015, with the first returns due in 2016. According to the IRS, this information reporting is necessary in order to administer the employer shared responsibility "pay or play" rules. The IRS information return will give the IRS information about the employer's compliance with the pay or play rules. These rules impose penalties on applicable large employers that do not offer required coverage to full-time employees and dependents. The employee statements provide information to employees about coverage that was provided in the prior year. The information will be used to determine whether employees can claim a premium tax credit on their tax returns for coverage purchased through an Exchange.
Affordable Care Act	Employers with self-insured health plans that provide minimum essential coverage (MEC)	**Code §6055 Reporting—** Effective for 2015, sponsors of self-insured health plans that provide MEC must file an annual return with the IRS regarding the health coverage. These employers must also provide a related annual statement to covered individuals. Reporting is required for 2015, with the first returns due in 2016. The deadlines for these returns and statements are as follows: • Section 6055 returns must be filed with the IRS annually, no later than Feb. 28 (March 31, if filed electronically) of the year after the calendar year in	The ACA requires health insurance issuers, self-insured health plan sponsors, government agencies that administer government-sponsored health insurance programs and any other entity that provides MEC to report information on that coverage to the IRS and covered individuals. This requirement is found in Code section 6055.Reporting is required for 2015, with the first returns due in 2016. These reporting requirements are intended to provide the IRS with information necessary to administer other ACA mandates, such as the large employer shared responsibility penalty and the individual mandate. To simplify the reporting process, the IRS will allow applicable large employers with self-insured plans to use a single combined form for reporting the information required under both section 6055 and section 6056.

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		which MEC is provided. • The statements for covered individuals must be provided by Jan. 31 of the year after the calendar year in which MEC is provided. Employers showing good cause may be allowed the flexibility to apply for an extension of time, not exceeding 30 days, to furnish statements.	
COBRA	Employers that had 20 or more employees on more than 50 percent of the typical business days during the previous calendar year Government and church plans are exempt	**Initial/General COBRA notice**—Plan administrator must provide generally within 90 days of when group health plan coverage begins.	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. A model General COBRA Notice is available on the DOL website under COBRA guidance.
		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.	Notice of certain qualifying events must be sent to plan administrator when employer is not plan administrator (for example, employer has contracted with a third party to administer COBRA). 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.
		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).	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. A model COBRA Election Notice is available on the DOL website under COBRA guidance.
		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 also plan administrator).	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.

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		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.
		Notice of insufficient payment—Plan administrator must provide reasonable period of time to cure deficiency before terminating COBRA (for example, 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.	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. Also, COBRA requires equal coverage and, to some extent, equal treatment between COBRA qualified beneficiaries and similarly situated non-COBRA beneficiaries. 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.
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). Updated SPD must be furnished every 5 years if changes made to SPD information or plan is amended. Otherwise, must furnish every 10 years.	The 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.
		Summary of material modification—Plan administrators must provide automatically to participants within 210 days after the end of the plan year in which the change is adopted. If benefits or services are	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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		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.	
		Plan documents—Plan administrator must provide copies no later than 30 days after a written request and make copies available at specified locations.	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.
		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. 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.	Form 5500 filing requirements vary according to type of filer (that is, 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. The DOL website and the latest Form 5500 instructions provide information on who is required to file and detailed information on filing.
		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.	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.More information about the M-1 filing requirement, and the online filing system, is available on the DOL website.
		Summary annual report –Plan administrators must provide automatically to participants within 9 months after end of plan year, or 2 months after due date for filing Form 5500 (with approved extension). Plans that are exempt from the annual 5500 filing requirement are not required to provide an SAR. Large, completely	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).

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		unfunded health plans are also generally exempt from the SAR requirement.	
Internal Revenue Code	Group health plans	**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. 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.	The Form 8928 excise tax reporting requirement applies to failures to comply with certain group health plan mandates included in the IRC, such as: • 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	**General Notice**—Must be posted in a location available to both employees and applicants and included inwritten guidance, if it exists.	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.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. The DOL has issued a model poster.
		Notice of Eligibility and Rights & Responsibilities—Employer must provide written guidance, upon employee notice of need for FMLA leave.	Written guidance must be provided to an employee upon the employee's notice to the employer of the need for FMLA leave. The employer must detail the specific expectations and obligations of the employee, and explain the consequences of the failure to meet these obligations. The DOL has issued an optionalnotice which may be used to satisfy this requirement.
		Designation Notice—Employer must notify employer of whether leave has been designated as FMLA leave.	Within five days of receiving sufficient information to grant or deny FMLA leave, it must provide a designation notice informing the employee whether the leave is designated as FMLA leave.The DOL has issued an optional notice which may be used to satisfy this requirement.
Genetic Information Non-discrimination Act (GINA)	Group health plans and health insurance issuers	**Notice of Research Exception**—To satisfy the research exception, plans or issuers must provide participants with a written request and must file a Notice of Research Exception with the designated federal agency.	Title I of GINA prohibits health plans and health insurance issuers from requiring or requesting that an individual undergo a genetic test, subject to some narrow exceptions. The research exception 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. The plan or issuer must:

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			• Make the request in writing to the participant; • Clearly indicate that the test is voluntary and will not impact plan eligibility or contributions; and • Complete a Notice of Research Exception.
Genetic Information Non-discrimination Act (GINA)	Employers in the private sector and state and local governments that employ 15 or more employees	**General Notice**—Must be posted in a conspicuous place.	Covered entities must post notices describing GINA's provisions in conspicuous places where notices to employees, applicants and members are customarily posted. A modelposter is available.
		Request for Medical Information—Notice is not generally required; however, model language can be used by an employer lawfully requesting medical information so that any genetic information included with the response will be deemed inadvertent.	Any receipt of genetic information in response to the request for medical information will be deemed inadvertent if the employer's request includes the model (or similar) language. The model language can be found at EEOC Reg. § 1635.8(b)(1)(i)(B)
		Request for Genetic Information for Toxic Substance Monitoring—Written notice required if genetic information is acquired for toxic substance monitoring.	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 each affected employee with: • Written notice of the genetic monitoring; and • The individual monitoring results. The employee must authorize the monitoring, unless it is required by law.
		Notice of Disclosure—Notice is required for certain permitted disclosures of genetic information.	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.
HIPAA and the ACA—Wellness Programs	Group health plans and issuers that offer health-contingent wellness programs	**Notice of Alternative Standard—**Plans and issuers must disclose the availability of an alternative standard in all materials describing the wellness program.	Health-contingent wellness programs, or wellness programs that require individuals to satisfy a standard related to a health factor in order to receive a reward, violate federal nondiscrimination rules unless the program satisfies a number of conditions: • Limit reward to 30 percent of cost of coverage (or 50 percent for health-contingent wellness programs designed to prevent or reduce tobacco use). For plan years beginning before Jan. 1, 2014, the maximum permissible reward was 20 percent of the cost of health coverage; • Designed to reasonably promote health and prevent disease;

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			• Provide annual opportunity to qualify; • Provide reasonable alternative standard for obtaining the reward for certain individuals; and • Disclose availability of an alternative standard. The disclosure must include contact information for obtaining the alternative and a statement that recommendations of an individual's personal physician will be accommodated. If plan materials merely mention that a wellness program is available, without describing its terms, this disclosure is not required.Final regulations provide sample language that can be used to satisfy this requirement.
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: entities that create, receive, maintain or transmit protected health information (PHI) on behalf of a Covered Entity	**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. At least once every three years, participants must be notified about the availability of the Notice of Privacy Practices.	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. HHS has developed three model privacy notices for health plans—a booklet version, a full page version and a layered version. These model notices, as well as instructions on how to use them, are available on HHS' website.
		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.	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—Transaction Standards and Operating Rules	Controlling health plans	**HIPAA Certification—**Controlling health plans must file a statement with HHS certifying their compliance with HIPAA's electronic transaction standards and operating rules.	Health plans must file a statement with HHS certifying their compliance with HIPAA's electronic transaction standards and operating rules. The ACA specified an initial certification deadline of Dec. 31, 2013, for the following transactions:

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		The first certification deadline is Dec. 31, 2015, although small health plans may have additional time to comply.	• Eligibility for a health plan; • Health care claim status; and • Health care electronic funds transfers (EFT) and remittance advice. HHS extended the first certification deadline to Dec. 31, 2015, although small health plans may have additional time to comply. Controlling health plans (CHPs) are responsible for providing the initial HIPAA certification on behalf of themselves and their subhealth plans, if any. Based on HHS' definition of CHPs, an employer's self-insured plan will likely qualify as a CHP, even if it does not directly conduct HIPAA-covered transactions. For employers with insured health plans, the health insurance issuer will likely be the CHP responsible for providing the certification. However, more definitive guidance from HHS on this point would be helpful.
HIPAA-Portability	Group health plans and issuers of group health plan insurance coverage, unless exception applies	**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.	Notice from group health plan to individuals who lose coverage, documenting prior group health plan creditable coverage and length of time covered. Effective for plan years beginning on or after Jan. 1, 2014, the Affordable Care Act prohibits plans from imposing preexisting condition exclusions. In connection with this reform, the requirement to provide HIPAA certificates was eliminated, beginning Dec. 31, 2014. Thus, beginning in 2015, health plans and issuers are no longer required to provide HIPAA certificates.
		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.	Notice to participants describing a group health plan's preexisting condition exclusion and how prior creditable coverage can reduce the preexisting condition exclusion period. Effective for plan years beginning on or after Jan. 1, 2014, the Affordable Care Act prohibits plans from imposing preexisting condition exclusions.
		Individual notice of period of preexisting condition exclusion—Planadministrators and issuers must provide as soon as possible following the determination of creditable coverage.	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.Effective for plan years beginning on or after Jan. 1, 2014, the Affordable Care Act prohibits plans from imposing preexisting condition exclusions.

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		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.	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.
CHIPRA	Employers that maintain group health plans covering employees in states that provide premium assistance subsidies under a Medicaid plan or CHIP	**Annual Employer CHIP Notice—**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.	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.
Medicare Part D	Group health plan sponsors that provide prescription drug coverage, except entities that contract with or become a Part D plan	**Disclosure Notices for Creditable or Non-creditable Coverage—**At a minimum, must be provided by the plan sponsor at the following times: 1) Prior to the Medicare Part D Annual Coordinated Election Period—Oct. 15 through Dec. 7of 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 changes so that it is no longer creditable or becomes creditable; and 5) Upon request by a Medicare Part D eligible individual. *If the plan sponsor provides	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 individualswho 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. Model forms are available from CMS.

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		notice to all participants annually, CMS will consider 1 & 2 above to be met. "Prior to" means in the prior 12 months.	
		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)	Employers must disclose to CMS whether the coverage is creditable. An entity is required to provide the Disclosure Notice through completion of the Disclosure Noticeform, unless specifically exempt as outlined in related CMS guidance. This is the sole method for compliance with the disclosure requirement.
Medicare Part D-Retiree Drug Subsidy	Employers with group health plans that cover retirees who are entitled to enroll in Part D but who elect not to do so	**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.	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. *The Affordable Care Act provides that, beginning in 2013, employers receiving the Medicare Part D retiree drug subsidy cannot deduct the amount of the subsidy.
Mental Health Parity and Addiction Equity Act (MHPAEA)	Group health plans (of employers with over 50 employees) offering mental health and substance use disorder benefits Exemption available for group health plans that can demonstrate a certain cost increase	**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. Notice must also be provided upon request.	The cost exemption will apply to a group health plan if its cost increase exceeds 2 percent in the first plan year and 1 percent in a subsequent year. If the 2-percent or 1-percent increased cost is incurred, the plan is exempt for the plan year following the year the cost was incurred. Thus, the exemption lasts one year and then the plan is required to comply again. A group health plan or health insurance issuer must 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 must include: • A description of the number of covered lives under the plan (or coverage) involved at the time of the notification, and as applicable, at the time of any prior election of the cost-exemption by such plan (or coverage); • 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

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			• 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. 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.
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.*	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. *Under the Affordable Care Act (ACA), group health plans are required to cover dependent children up to age 26, regardless of student status. The ACA's coverage mandate for adult children limits the impact of Michelle's Law. However, group health plans that extend coverage past the age of 26 for adult children who are students will still be subject to the requirements of Michelle's Law.
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.	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.
Qualified Medical Child Support Orders	Plan administrators of group health plans and state child support enforcement agencies	**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 reasonable time after its receipt, plan administrator must also issue separate notice as to whether the medical child	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.

Employee Benefit Compliance Chart: Notice and Disclosure Rules

LAW	GOVERNS	NOTICE REQUIREMENT	SUMMARY
		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.	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 on the CMS website.
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 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

Employee Benefit Compliance Chart: Notice and Disclosure Rules

LAW	GOVERNS	NOTICE REQUIREMENT	SUMMARY
			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. 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.