Takeaways

Here's a summary of major notice requirements under ERISA and the ACA for group health plans. It is **not** a comprehensive list.

Summary Plan Description

A summary of plan provisions and plan rights and obligations

- Within 30 days of request by currently covered participants and beneficiaries
- Within 90 days of eligibility for new participants
- Within 120 days of effective date or date of adoption, whichever is later, for a new plan
- Within 120 days of effective date or date of adoption, whichever is later, for a new plan
- Every five years if there have been plan changes
- Every 10 years if there have been no changes to the plan
- After each bargaining contract is ratified, if you have so negotiated

Summary of Material Modifications

A detailed summary of changes to the plan document or to language that must be in the SPD

- Within 210 days after the end of the plan year in which the change was adopted
- Any change to a health plan that would be considered by the average plan participant to be an important reduction in benefits or services must be disclosed within 60 days after the change was adopted

Summary Annual Report

A summary of the financial activity that occurred in the plan during the plan year, including premiums and benefits paid

- Annually

Summary of Benefits and Coverage

A four-page summary of medical plans, including specific content and definitions

- First day of each annual enrollment period
- Within seven days of request
- At least 30 days before the start of the plan year if coverage continues automatically

COBRA Notice

Notice describing a participant's right to continue coverage under a health plan under certain circumstances after coverage would otherwise end (includes multiple notices, typically handled by the employer's COBRA administrator)

HIPAA Privacy and Security Notice

A description of an individual's legal rights, and the employer's legal duties, with respect to protected health information

- Reminder to participants every three years (next reminder due April 14, 2021)
- Reissue when there has been a material change to a state privacy law
- At enrollment, for new enrollees

Womens' Health Care Rights Act

A statement that for participants and beneficiaries 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 symmetrical appearance;**
- **Prostheses; and**
- **Treatment of physical complications of the mastectomy, including lymphedema.**

Must include a description of any annual deductibles and coinsurance limitations applicable to such coverage.

- At enrollment, and annually

Newborns' & Mothers' Health Protection Act

Notice that the plan may not restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section.

- **The attending provider may decide, after consulting with the patient, to discharge her or her newborn child earlier.**
- **The attending provider is any individual licensed under state law to provide maternity or pediatric care and is providing such care to a mother or newborn child. This may include a physician, physician assistance or nurse midwife; however, this may NOT include a health plan, insurer or hospital.**
- **A mother cannot be encouraged to accept less than the minimum protections available to her under the NMHPA and an attending provider cannot be induced to discharge a mother or newborn earlier than 48 or 96 hours after delivery.**

- Notice must be included in SPD

CHIPRA Notice

Notice to ALL employees of an employer who maintains a group health plan in any state which provides premium assistance of special enrollment rights. These CHIPRA enrollment opportunities must be offered when an employee or eligible dependent is covered under a Medicaid plan or state children's health insurance program ("CHIP"), and loses eligibility under that plan; or when they become eligible under a CHIP or Medicaid plan for premium assistance that could be used toward the cost of an employer plan.

- Notice must be provided annually. May be distributed with or incorporated into other materials (such as enrollment materials or the SPD).

Medicare Part D Creditable Coverage Notice

A notice to Medicare-eligible individuals describing whether the prescription drug benefits under the employer's plan is creditable (e.g., the plan's expected amount of paid claims is at least as much as the expected paid claims under the standard Medicare prescription drug benefit)

- Before the beginning of Medicare Part D annual enrollment (usually October)
- Before the individual is first eligible for Medicare
- On request

Notice of Coverage Options

Notice to all employees and new hires that they are eligible to choose a plan in the Health Insurance Marketplace. The notice must include:

- **A description of the services provided by the Marketplace and how the employee can contact the Marketplace for help**
- **A notice that the employee may be eligible for a premium tax credit if s/he purchases coverage through the Marketplace**
- **A statement that if the employees buys a plan through the Marketplace, s/he may lose any employer contribution to any plan the employer offers, and that some or all of that contribution may be excludable for federal income tax purposes**

- For new hires, within 14 days of date of hire
- No requirement to provide to current employees annually

Form 1095-C, Employer-Provided Health Insurance Offer and Coverage

Notice to employees and qualified beneficiaries with certain information about the coverage offered by the employer and about whether the individual is enrolled

- January 31 (however, the IRS has been extending the deadline in past years. The 2021 deadline is March 2)