Employee Benefits Series

Group Health Plan Notices
2020 Calendar

Key Required Notices and Filings

NP Benefit Services

Key Required Notices and Filings

Basic Notice and Filing Requirements (SPD • SMM • Form 5500)

In This Section: Summary Plan Description > Summary of Material Modifications > Summary of Material Reduction in Covered Services or Benefits > Form 5500 > Summary Annual Report > Plan Documents

Document	Type of Information	Provide To	Provided By	When Due
Summary Plan Description (SPD) ***(Model notice unavailable)*** ***See also*** "Summary of Benefits and Coverage," *below, for additional requirements.*	Provides plan participants and beneficiaries with information about their rights, benefits, and responsibilities under the plan and how it works, including: • Basic rights and responsibilities of participants under ERISA (model language is available—see 29 C.F.R. § 2520.102-3(t)(2)); • Eligibility requirements; • Description of plan benefits and how to file a claim for benefits; and • Notices and descriptions required under COBRA, HIPAA, and other health coverage laws.	Each participant covered under the plan (Plan participants and beneficiaries, as well as the U.S. Department of Labor, or DOL, also have the right to obtain a copy of the SPD upon request–see "Plan Documents," below, for requirements.)	Plan administrator (all plans, regardless of size)	Within 90 days after the employee becomes covered under the group plan (New plans have 120 days after becoming subject to ERISA to distribute the SPD.) The SPD must be current within 120 days prior to the date of distribution, and must be accompanied by any summary of material modification or change in information required to be included in the SPD which has not been incorporated into the document being furnished. An updated SPD must be furnished every 5 years if changes are made to SPD information or the plan is amended. Otherwise, it must be furnished every 10 years.
Summary of Material Modifications (SMM) and Summary of Material Reduction in Covered Services or Benefits ***(Click on the SMM link above for model notices)*** ***See also*** "Notice of Modification," *below, for related requirements.*	Describes changes to information required to be included in the SPD and any material modification to the plan (a change that would be considered by an average plan participant to be an important change in covered benefits or other terms of coverage under the plan) Changes that constitute a material reduction in covered services or benefits must be disclosed through either a revised SPD or an SMM **Note:** Under Health Care Reform, a plan may lose "grandfathered" status if it makes certain significant changes.	Each participant covered under the plan (Plan participants and beneficiaries, as well as the DOL, also have the right to obtain a copy of the SMM upon request—see "Plan Documents," below, for requirements.)	Plan administrator (all plans, regardless of size)	Within 60 days of adoption of a material reduction in covered services or benefits (Alternatively, notice of a material reduction may be provided with plan information that is furnished at regular intervals of not more than 90 days, if certain conditions are met.) Material changes that do not result in a reduction in covered services or benefits must be disclosed not later than 210 days after the end of the plan year in which the change is adopted. Timely distribution of a Notice of Modification may satisfy this requirement.

Key Required Notices and Filings

Basic Notice and Filing Requirements (SPD • SMM • Form 5500), *Continued*

In This Section: Summary Plan Description > Summary of Material Modifications > Summary of Material Reduction in Covered Services or Benefits > Form 5500 > Summary Annual Report > Plan Documents

Document	Type of Information	Provide To	Provided By	When Due
Form 5500—Annual Return/Report of Employee Benefit Plan ***(Click on the link above for access to the form and schedules)***	Used to report various kinds of information about a plan, its finances, and its operation (requirements vary depending on the particular type of plan and its size) **Note:** A group health plan with fewer than 100 participants that is either fully insured or self-funded (or a combination of both) is generally not required to file Form 5500.	Filed electronically with the DOL through the ERISA Filing Acceptance System (EFAST2), using either EFAST2-approved vendor software or the IFILE web-based filing system (Even though Form 5500 is filed electronically, the administrator must keep a copy on file, and must make a paper copy available upon request to participants, beneficiaries, and the DOL–see "Plan Documents," below, for requirements.)	Plan administrator (depending on the number of participants covered and plan design, certain plans may be exempt from filing requirements)	Generally by the last day of the 7th calendar month after the end of the plan year (not to exceed 12 months in length) A plan may obtain a one-time extension of time to file (up to 2½ months) by filing Form 5558, *Application for Extension of Time To File Certain Employee Plan Returns*, **with the IRS** on or before the date the Form 5500 would otherwise be due, without extension.
Summary Annual Report (SAR) ***(Model language can be located at 29 C.F.R. § 2520.104b-10(d)(4))***	Narrative summary of the Form 5500 annual financial report	Each plan participant	Plan administrator (plans subject to Form 5500 annual reporting requirements)	Annually within 9 months after the end of the plan year (When an extension of the due date for filing Form 5500 has been granted by the IRS, the SAR must be provided within 2 months after the extended due date.)
Plan Documents ***(Model notice unavailable—plan documents are specific to each plan)***	Instruments under which the plan is established or operated, including the latest updated SPD, any SMMs, the latest Form 5500, and other documents	Participants and beneficiaries (The DOL also has the authority to request any documents relating to an employee benefit plan.)	Plan administrator (all plans, regardless of size)	Copies must be furnished to participants and beneficiaries no later than 30 days after a written request The plan administrator also must make copies available for examination at its principal office.

Key Required Notices and Filings

Health Care Reform (ACA)-Required Notices and Filings

In This Section: IRS Forms 1094 & 1095 > Summary of Benefits and Coverage > Notice of Modification > Notice of Rescission of Coverage > Health Insurance Exchange Notice > Disclosure of Grandfathered Status > Notice of Patient Protections > Patient-Centered Outcomes Research Institute (PCORI) Fees > ACA Section 1557 Nondiscrimination Notice & Taglines

Document	Type of Information	Provide To	Provided By	When Due
Forms 1094-C (*Transmittal*) and 1095-C (*Employer-Provided Health Insurance Offer and Coverage*) ***(Click on the links above for the forms)***	Provides information about the health care coverage offered (if any) by an "applicable large employer" (ALE) to report compliance with the employer shared responsibility ("pay or play") provisions	**For ALEs with fully insured plans:** Each employee who was a full-time employee for any month of the calendar year (and who was not in a limited non-assessment period) **For ALEs with self-insured plans:** Any employee who enrolls in the health coverage, whether or not the employee is a full-time employee for any month of the calendar year	Applicable large employers (generally those with **50 or more full-time employees**, including full-time equivalents)	**Form 1095-C** must be furnished to covered individuals/full-time employees by **March 2, 2020** **Forms 1094-C and 1095-C** must generally be filed with the IRS annually, no later than **February 28** (or **March 31**, if filing electronically)
Forms 1094-B (*Transmittal*) and 1095-B (*Health Coverage*) ***(Click on the links above for the forms)***	Used to report information about individuals who are covered by minimum essential coverage	Covered individuals	Self-insuring employers that are not ALEs, and other providers of minimum essential health coverage	**Form 1095-B** must be furnished to covered individuals by **March 2, 2020** **Forms 1094-B and 1095-B** must generally be filed with the IRS annually, by **February 28** (or **March 31**, if filing electronically)

Key Required Notices and Filings

Health Care Reform (ACA)-Required Notices and Filings, *Continued*

In This Section: IRS Forms 1094 & 1095 > Summary of Benefits and Coverage > Notice of Modification > Notice of Rescission of Coverage > Health Insurance Exchange Notice > Disclosure of Grandfathered Status > Notice of Patient Protections > Patient-Centered Outcomes Research Institute (PCORI) Fees > ACA Section 1557 Nondiscrimination Notice & Taglines

Document	Type of Information	Provide To	Provided By	When Due
Summary of Benefits and Coverage (SBC) and Uniform Glossary ***(Click on the link above for model notice)***	A summary of benefits and coverage under the plan, including information on cost-sharing requirements and coverage limitations, as well as definitions of certain coverage-related terms, such as "deductible" and "co-pay"	Plan participants and beneficiaries	Group health plan and health insurance issuer offering group coverage (plans with 2 or more participants who are current employees) **Note:** For insured group coverage, if **either** the issuer or the plan provides the SBC, the requirement is satisfied for **both**; but plans that contract with issuers to provide the SBC must satisfy certain requirements.	Must be provided at specified times during the enrollment process and upon a participant or beneficiary's request, generally as follows: • **Prior to initial enrollment** in the plan; • Upon **renewal** of plan coverage; • **Within 90 days** of special enrollment; and • **Within 7 business days** following receipt of a request (The SBC may be provided together with other summary materials such as an SPD, if the SBC information is intact and prominently displayed at the beginning of the materials and in accordance with the timing requirements for providing an SBC.)
Notice of Modification ***(Model notice unavailable)***	Advance notice of a material change in any plan terms that would affect the content of the SBC and that occurs other than in connection with a renewal or reissuance of coverage **Note:** Certain significant plan changes may cause a loss of "grandfathered" status.	Plan participants and beneficiaries	Group health plan or health insurance issuer offering group coverage (plans with 2 or more participants who are current employees)	No later than 60 days prior to the effective date of the change (Notice provided in a complete and timely manner may also satisfy the requirement to provide a summary of material modifications or SMM.)

Key Required Notices and Filings

Health Care Reform (ACA)-Required Notices and Filings, *Continued*

In This Section: IRS Forms 1094 & 1095 > Summary of Benefits and Coverage > Notice of Modification > Notice of Rescission of Coverage > Health Insurance Exchange Notice > Disclosure of Grandfathered Status > Notice of Patient Protections > Patient-Centered Outcomes Research Institute (PCORI) Fees > ACA Section 1557 Nondiscrimination Notice & Taglines

Document	Type of Information	Provide To	Provided By	When Due
Notice of Rescission of Coverage ***(Model notice unavailable)***	Advance written notice that coverage will be rescinded (declared invalid from the time of enrollment) due to fraud or intentional misrepresentation by a person covered by the plan	Each participant who would be affected	Group health plan or health insurance issuer offering group coverage (plans with 2 or more participants who are current employees)	At least 30 days before the coverage is rescinded
Health Insurance Exchange Notice ***(There is one model notice for employers who offer a health plan to some or all employees, and another model notice for employers who do not offer a plan—click on the link above to access)***	Provides employees with certain information about the existence of Health Insurance Exchanges (also known as Marketplaces), including notice that the employee may lose employer health plan contributions if the employee buys coverage through the Exchange	New employees	All employers covered by the Fair Labor Standards Act	Must be provided to each new employee at the time of hiring, within 14 days of the employee's start date
Disclosure of Grandfathered Status ***(Click on the link above for model notice)***	A statement that the plan believes it is a grandfathered health plan and providing contact information for questions and complaints (required to maintain grandfathered status)	Plan participants and beneficiaries	Grandfathered group health plan (plans with 2 or more participants who are current employees)	In any plan materials provided to a participant or beneficiary describing benefits provided under the plan

Key Required Notices and Filings

Health Care Reform (ACA)-Required Notices and Filings, *Continued*

In This Section: IRS Forms 1094 & 1095 > Summary of Benefits and Coverage > Notice of Modification > Notice of Rescission of Coverage > Health Insurance Exchange Notice > Disclosure of Grandfathered Status > Notice of Patient Protections > Patient-Centered Outcomes Research Institute (PCORI) Fees > ACA Section 1557 Nondiscrimination Notice & Taglines

Document	Type of Information	Provide To	Provided By	When Due
Notice of Patient Protections ***(Click on the link above for model notice)***	Informs participants of the plan's terms regarding designation of a primary care provider, including the right to choose a primary care provider or a pediatrician, as well as the right to obtain OB/GYN care without prior authorization or referral (if coverage is provided for OB/GYN care under the plan)	Plan participants	Non-grandfathered group health plan that requires or provides for the designation of a participating primary care provider by a participant/ beneficiary (plans with 2 or more participants who are current employees)	Whenever a participant is provided with a summary plan description or other similar description of benefits under the plan
Patient-Centered Outcomes Research Institute (PCORI) Fees	Employers that sponsor certain self-insured health plans are responsible for fees that support research to evaluate and compare health outcomes and the clinical effectiveness of medical treatments, services, and drugs	Filed with the Internal Revenue Service	Plan sponsors of certain self-insured health plans	IRS Form 720 must be filed annually to report and pay the fees no later than July 31st of the calendar year immediately following the last day of the plan year to which a fee applies
ACA Section 1557 Nondiscrimination Notice & Taglines ***(Click on the link above for sample notices and taglines in a variety of languages)***	Informs individuals participating in certain health programs or activities of their civil rights under Section 1557 of the Affordable Care Act, which prohibits discrimination on the basis of race, color, national origin, sex, age, or disability **Note:** The content requirements are modified for small-sized significant communications (such as postcards).	Beneficiaries, enrollees, applicants, and members of the public	Entities administering any health program or activity that receives federal financial assistance (such as hospitals that accept Medicare or doctors who accept Medicaid)	Notices of nondiscrimination and taglines that alert individuals with limited English proficiency to the availability of language assistance services are generally required to be posted in: • Significant publications and communications targeted to beneficiaries, enrollees, applicants, and members of the public; • Conspicuous physical locations where the entity interacts with the public; and • A conspicuous location on the entity's website, accessible from the homepage of such site.

Key Required Notices and Filings

COBRA-Required Notices

In This Section: General Notice of COBRA Rights > Notice of Qualifying Event > COBRA Election Notice > Notice of Unavailability of COBRA Coverage > Notice of Underpayment of COBRA Premium > Notice of Early Termination of COBRA Coverage

Document	Type of Information	Provide To	Provided By	When Due
General Notice of COBRA Rights ***(Click on the link above for model notice)***	Notice of the right to purchase a temporary extension of group health coverage when coverage is lost due to certain qualifying events, as well as other health coverage options that may be available (such as the Health Insurance Marketplace) The following are qualifying events if they cause a loss of coverage: ***For employee/spouse/dependent child:*** • Termination of employment (other than for gross misconduct) • Reduction in hours of employment ***For spouse and dependent child only:*** • Death of covered employee • Covered employee becomes entitled to Medicare • Divorce or legal separation of the covered employee from spouse ***For dependent child only:*** • Loss of dependent child status under the plan rules (Under Health Care Reform, when a plan covers dependents, it generally must continue to make the coverage available until a child reaches age 26.)	Covered employees and their spouses	Plan administrator (group health plans sponsored by employers with 20 or more employees)	Within the first 90 days of coverage **Note**: This requirement may be satisfied by including the general notice in the SPD and giving it to the employee and spouse within the first 90 days of coverage.

Special Note: *Group health plans sponsored by employers with* ***20 or more employees****, including both full- and part-time employees, on more than 50% of typical business days in the prior calendar year are subject to the federal Consolidated Omnibus Budget Reconciliation Act (COBRA). Each part-time employee counts as a fraction of a full-time employee, equal to the number of hours the part-time employee worked divided by the hours an employee must work to be considered full time. Companies that have common ownership interests should contact a knowledgeable attorney for issues related to headcount.*

Many states have enacted what are commonly referred to as "mini-COBRA" laws, which require group health plans to provide continuation of benefits, including plans sponsored by employers with fewer than 20 employees. ***Be sure to review your state's law for applicable "mini-COBRA" requirements.***

Key Required Notices and Filings

COBRA-Required Notices, *Continued*

In This Section: General Notice of COBRA Rights > Notice of Qualifying Event > COBRA Election Notice > Notice of Unavailability of COBRA Coverage > Notice of Underpayment of COBRA Premium > Notice of Early Termination of COBRA Coverage

Document	Type of Information	Provide To	Provided By	When Due
Notice of Qualifying Event ***(Model notice unavailable, but see page 5 of the link above for more information)***	Notice of the occurrence of a qualifying event that is the covered employee's death, termination of employment (other than for gross misconduct), reduction in hours, or entitlement to Medicare **Note:** The employee or one of the qualified beneficiaries is responsible for notifying the plan if the qualifying event is divorce, legal separation, or loss of dependent status under the plan.	Plan administrator	Employer (group health plans sponsored by employers with 20 or more employees)	Within 30 days after the qualifying event **Note:** The plan may not require employees or qualified beneficiaries to provide notice earlier than 60 days from the latest of: • The date the qualifying event occurs; • The date the qualified beneficiary loses (or would lose) coverage under the plan due to the qualifying event; or • The date the qualified beneficiary is informed of the responsibility to notify the plan and the process for doing so.
COBRA Election Notice ***(Click on the link above for model notice)***	Describes the right to COBRA continuation coverage and how to make an election upon the occurrence of a qualifying event, as well as other health coverage options that may be available (including coverage through the Health Insurance Marketplace)	Covered employees, spouses, and dependent children who are qualified beneficiaries	Plan administrator (group health plans sponsored by employers with 20 or more employees)	Generally within 14 days after receiving notice of a qualifying event If the employer is also the plan administrator, the notice must be provided not later than 44 days after the date the qualifying event occurred or the date of loss of coverage due to the qualifying event (if the plan provides that COBRA coverage starts on the date of loss of coverage).

Special Note: *Group health plans sponsored by employers with* ***20 or more employees****, including both full- and part-time employees, on more than 50% of typical business days in the prior calendar year are subject to the federal Consolidated Omnibus Budget Reconciliation Act (COBRA). Each part-time employee counts as a fraction of a full-time employee, equal to the number of hours the part-time employee worked divided by the hours an employee must work to be considered full time. Companies that have common ownership interests should contact a knowledgeable attorney for issues related to headcount.*

Many states have enacted what are commonly referred to as "mini-COBRA" laws, which require group health plans to provide continuation of benefits, including plans sponsored by employers with fewer than 20 employees. ***Be sure to review your state's law for applicable "mini-COBRA" requirements.***

Key Required Notices and Filings

COBRA-Required Notices, *Continued*

In This Section: General Notice of COBRA Rights > Notice of Qualifying Event > COBRA Election Notice > Notice of Unavailability of COBRA Coverage > Notice of Underpayment of COBRA Premium > Notice of Early Termination of COBRA Coverage

Document	Type of Information	Provide To	Provided By	When Due
Notice of Unavailability of COBRA Coverage ***(No model notice provided by the federal government. Sample notice available for general reference purposes only by clicking on the link above.)***	Notice that an individual is not entitled to COBRA continuation coverage or an extension of continuation coverage, which explains the reason the group health plan is denying the request	Individuals who have submitted a notice of qualifying event whom the plan determines are not eligible for COBRA continuation coverage	Plan administrator (group health plans sponsored by employers with 20 or more employees)	Generally within 14 days after receiving notice of a qualifying event
Notice of Underpayment of COBRA Premium ***(No model notice provided by the federal government. Sample notice available for general reference purposes only by clicking on the link above.)***	If the amount of a COBRA premium payment made to the plan is wrong, but is not significantly less than the amount due, the plan must either treat the amount submitted as full payment, or must notify the qualified beneficiary of the deficiency and grant a reasonable period (for this purpose, 30 days is considered reasonable) to pay the difference	Qualified beneficiary who makes timely payment in an amount that is not significantly less than the amount due for a period of COBRA coverage	Employer or plan administrator (group health plans sponsored by employers with 20 or more employees)	A plan must grant a reasonable period of time (no less than 30 days) for payment of a deficiency, where the incorrect amount is not significantly less than the amount due, before taking action to terminate coverage
Notice of Early Termination of COBRA Coverage ***(No model notice provided by the federal government. Sample notice available for general reference purposes only by clicking on the link above.)***	Notice that COBRA coverage will terminate earlier than the maximum period of coverage, which describes the date coverage will terminate, the reason for termination, and any rights to elect alternative coverage	Qualified beneficiaries whose COBRA coverage will terminate earlier than the maximum period of coverage	Plan administrator (group health plans sponsored by employers with 20 or more employees)	As soon as practicable following the administrator's determination that COBRA coverage will terminate

Special Note: *Group health plans sponsored by employers* ***with 20 or more employees****, including both full- and part-time employees, on more than 50% of typical business days in the prior calendar year are subject to the federal Consolidated Omnibus Budget Reconciliation Act (COBRA). Each part-time employee counts as a fraction of a full-time employee, equal to the number of hours the part-time employee worked divided by the hours an employee must work to be considered full time. Companies that have common ownership interests should contact a knowledgeable attorney for issues related to headcount.*

Many states have enacted what are commonly referred to as "mini-COBRA" laws, which require group health plans to provide continuation of benefits, including plans sponsored by employers with fewer than 20 employees. ***Be sure to review your state's law for applicable "mini-COBRA" requirements.***

Key Required Notices and Filings

HIPAA Portability and Nondiscrimination Required Notices **In This Section:** Notice of Special Enrollment Rights > Wellness Program Disclosure				
Document	**Type of Information**	**Provide To**	**Provided By**	**When Due**
Notice of Special Enrollment Rights ***(Click on the link above for model notice)***	Describes the requirement for a group health plan to offer special enrollment to eligible employees and their dependents who experience certain events	Employees eligible to enroll in the group health plan	Group health plans with 2 or more participants who are current employees	At or before the time an employee is initially offered the opportunity to enroll in the group health plan
HIPAA Wellness Program Disclosure ***(Click on the link above for model notice)***	Notice by a group health plan offering a wellness program that requires individuals to meet a standard related to a health factor in order to obtain a reward, which discloses the availability of a reasonable alternative standard to qualify for the reward and states that recommendations of an individual's personal physician will be accommodated	Participants and beneficiaries eligible to participate in a wellness program that requires individuals to meet a standard related to a health factor in order to obtain a reward	Group health plan or health insurance issuer offering a wellness program that requires individuals to meet a standard related to a health factor in order to obtain a reward (plans with 2 or more participants who are current employees)	In all plan materials that describe the terms of a health-contingent wellness program If the plan materials merely mention that a program is available, without describing its terms, this disclosure is not required

Key Required Notices and Filings

Special Health Care Notices

In This Section: Women's Health and Cancer Rights Act Notices > Mental Health Parity and Addiction Equity Act Disclosure > Employer CHIP Notice > Genetic Information Nondiscrimination Act Disclosures > Michelle's Law Notice > Newborns' and Mothers' Health Protection Act Notice > Medical Child Support Order Notices > National Medical Support Notice > ADA Notice Regarding Wellness Program > USERRA Notice > Qualified Small Employer HRA Notice > Individual Coverage HRA Notice

Document	Type of Information	Provide To	Provided By	When Due
Women's Health and Cancer Rights Act (WHCRA) Notices ***(Click on the link above for model notices)***	Describes required benefits for mastectomy-related reconstructive surgery, prostheses, and treatment of the physical complications of a mastectomy	Plan participants and beneficiaries	Group health plan, and insurance company or HMO, providing coverage for medical and surgical benefits with respect to a mastectomy	Upon enrollment in the plan and annually thereafter
Mental Health Parity & Addiction Equity Act (MHPAEA) Disclosure ***(Model notice unavailable)*** **Note:** Under Health Care Reform, most non-grandfathered small group plans are required to cover mental health and substance use disorder services (as one category of "essential health benefits"), at parity with medical and surgical benefits.	Describes criteria for medical necessity determinations made under a group health plan with respect to mental health or substance use disorder benefits (Certain plans that are exempt from the requirements under the MHPAEA based on increased cost may be subject to alternative disclosure rules. Non-grandfathered plans in the small group market that must provide "essential health benefits" that comply with MHPAEA requirements may not qualify for this exemption.)	Any current or potential participant, beneficiary, or contracting provider	Plan administrator of group health plan offering medical/ surgical benefits and mental health or substance use disorder benefits (or health insurance issuer offering such coverage)	Upon request, although other ERISA provisions may require disclosure of information relevant to medical/surgical, mental health, and substance use disorder benefits (e.g., as part of the requirement to disclose plan documents)
Employer CHIP Notice ***(Click on the link above for model notice)***	Informs employees of potential opportunities currently available in the state in which they reside for group health plan premium assistance under Medicaid and the Children's Health Insurance Program (CHIP), as well as the option to purchase coverage through the Health Insurance Marketplace	All employees (regardless of enrollment status)	Employers that provide group health coverage to employees in states with premium assistance through Medicaid or CHIP	Annually before the start of each plan year (may be provided with enrollment packets, open season materials, or the SPD)

Special Health Care Notices, *Continued*

In This Section: Women's Health and Cancer Rights Act Notices > Mental Health Parity and Addiction Equity Act Disclosure > Employer CHIP Notice > Genetic Information Nondiscrimination Act Disclosures > Michelle's Law Notice > Newborns' and Mothers' Health Protection Act Notice> Medical Child Support Order Notices > National Medical Support Notice > ADA Notice Regarding Wellness Program > USERRA Notice > Qualified Small Employer HRA Notice > Individual Coverage HRA Notice

Document	Type of Information	Provide To	Provided By	When Due
Genetic Information Nondiscrimination Act (GINA) Disclosures ***(The link above contains model "warning" language from the federal government, as well as a sample general disclosure, which may be used for general reference purposes only.)***	Informs health care providers not to collect genetic information, including family medical history, as part of an employment-related medical examination An additional "warning" not to provide genetic information may be required when requesting medical information (**Note:** This warning may be in writing or oral, if the employer typically does not make such requests in writing.)	Entities from whom requests for health-related information are made	Employers with 15 or more employees	Whenever an applicant or employee is sent for a medical examination The additional "warning" is required when requests for health-related information are made (e.g., to support an employee's request for reasonable accommodation or a request for sick leave), but only if the request for medical documentation is made in a way that is likely to result in receipt of genetic information.
Michelle's Law Notice ***(No model notice provided by the federal government. Sample notice available by clicking on the link above for general reference purposes only.)***	Describes the right of a dependent child who has lost student status for purposes of coverage, as a result of a medically necessary leave of absence from a post-secondary educational institution, to continued coverage during the leave of absence for up to one year, or until coverage would otherwise terminate (whichever is earlier)	Plan participants	Group health plans that base eligibility for coverage on student status, and the health insurance issuer providing group coverage	With any notice regarding a requirement for certification of student status for coverage under the plan **Note:** Under Health Care Reform, group health plans and issuers are generally required to provide dependent coverage to age 26, regardless of student status of the dependent. Nonetheless, in some circumstances, such as where a plan provides dependent coverage beyond age 26, Michelle's Law may apply.
Newborns' and Mothers' Health Protection Act Notice ***(Click on the link above for model notice)***	Statement describing applicable requirements under federal and/or state law relating to any hospital length of stay in connection with childbirth for a mother or newborn	Plan participants	Group health plans that provide maternity or newborn infant coverage	Must be included in the SPD

Key Required Notices and Filings

Special Health Care Notices, *Continued*

In This Section: Women's Health and Cancer Rights Act Notices > Mental Health Parity and Addiction Equity Act Disclosure > Employer CHIP Notice > Genetic Information Nondiscrimination Act Disclosures > Michelle's Law Notice > Newborns' and Mothers' Health Protection Act Notice > Medical Child Support Order Notices > National Medical Support Notice > ADA Notice Regarding Wellness Program > USERRA Notice > Qualified Small Employer HRA Notice > Individual Coverage HRA Notice

Document	Type of Information	Provide To	Provided By	When Due
Medical Child Support Order (MCSO) Notices ***(Model notices unavailable)***	Notification regarding receipt of an MCSO directing the plan to provide health insurance coverage to a participant's noncustodial children (including the plan's procedures for determining qualified status), and a separate notice as to whether the MCSO is qualified	Participants, any child named in an MCSO, and the child's representative	Plan administrator (all group health plans)	**Notice of Receipt of MCSO**: Promptly upon receipt of the MCSO **Notice of Qualification Determination**: Within a reasonable time after receipt of the MCSO
National Medical Support (NMS) Notice ***(Click on the link above to download form and instructions)***	Notice used by state child support enforcement agencies responsible for enforcing health care coverage provisions in an MCSO **Note:** Depending upon certain conditions, an employer must complete and return Part A of the NMS 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 MCSO.	State agencies, employers, plan administrators, participants, custodial parents, children, and representatives	Employer and plan administrator (all group health plans)	Employer must either send Part A to the state agency, or Part B to the plan administrator, within 20 days after the date of the notice or sooner, if reasonable **Note(s):** Plan administrator must promptly notify affected persons of receipt of the notice and the procedures for determining qualified status. Plan administrator must within 40 business days complete and return Part B to the state agency and also provide required information to affected persons. In certain instances, the employer may be required to send Part A to the state agency after the plan administrator has processed Part B.

Key Required Notices and Filings

Special Health Care Notices, *Continued*

In This Section: Women's Health and Cancer Rights Act Notices > Mental Health Parity and Addiction Equity Act Disclosure > Employer CHIP Notice > Genetic Information Nondiscrimination Act Disclosures > Michelle's Law Notice > Newborns' and Mothers' Health Protection Act Notice> Medical Child Support Order Notices > National Medical Support Notice > ADA Notice Regarding Wellness Program > USERRA Notice > Qualified Small Employer HRA Notice > Individual Coverage HRA Notice

Document	Type of Information	Provide To	Provided By	When Due
ADA Notice Regarding Wellness Program ***(Click on the link above for sample notice)***	Informs employees offered participation in a wellness program what employee health information will be collected, how it will be used, who will receive it, and what will be done to keep it confidential	All employees offered participation in a wellness program that collects employee health information	Employers with 15 or more employees that offer a wellness program that collects employee health information	Employees must receive the notice before providing any health information, and with enough time to decide whether to participate in the program **Note:** If employers already provide a notice that informs participants what information will be collected, who will receive it, how it will be used, and how it will be kept confidential, this notice is generally not required.
Uniformed Services Employment and Reemployment Rights Act (USERRA) Notice ***(Click on the link above for model notice)***	Provides individuals with notice of the rights, benefits, and obligations of employees and employers under the law	Employees covered by USERRA	All employers	May be posted where employers customarily place notices for employees
Qualified Small Employer HRA (QSEHRA) Notice ***(No model notice provided by federal government. Sample notice above for general reference purposes only.)***	Provides eligible employees with information regarding their permitted benefit under a QSEHRA, along with information regarding Health Insurance Marketplace and individual mandate requirements	Eligible employees	Employers with fewer than 50 full-time employees in the preceding calendar year, that do not offer a group health plan, and that fund a QSEHRA	Generally no later than 90 days before the beginning of the year in which the QSEHRA is funded
Individual Coverage HRA Notice (for plan years beginning in 2020) ***(Click on the link above for model notice)***	Provides eligible employees with information regarding the HRA's terms and its interaction with the premium tax credit	Eligible employees that are not offered traditional group health plan coverage	Employers offering an Individual Coverage HRA as an alternative to traditional group health coverage	Generally no later than 90 days before the beginning of the Individual Coverage HRA plan year

Key Required Notices and Filings

Notices Related to Benefit Claims **In This Section:** Notice of Benefit Determination > Notice of Adverse Benefit Determination and Final Internal Adverse Benefit Determination				
Document	**Type of Information**	**Provide To**	**Provided By**	**When Due**
Notice of Benefit Determination ***(Model notice unavailable, but click here for an example from the Centers for Medicare & Medicaid Services)*** (also called claims notice or "explanation of benefits")	Information regarding benefit claim determinations Adverse benefit determinations must include certain information, including the specific reason(s) for the denial, reference to the specific plan provisions on which the decision is based, and a description of the plan's appeal procedures	Participants and beneficiaries (or their authorized representatives)	Plan administrator (all plans, regardless of size)	Requirements vary depending on the type of benefit claim involved (e.g., urgent care, pre-service or "prior authorization," or post-service claims)
Notice of Adverse Benefit Determination and Notice of Final Internal Adverse Benefit Determination ***(Click on the links above for model notices)***	In addition to required disclosures described under "Notice of Benefit Determination," above, non-grandfathered plans must include additional information in each notice of adverse benefit determination. When a claim is denied, the claimant may request that the plan reconsider its decision—this review is called an "internal appeal." If the plan continues to deny the service or payment, the claimant must be provided a written decision (called the "final internal adverse benefit determination") which includes information on how to request an external review and other disclosures.	Participants and beneficiaries (or their authorized representatives)	Plan administrator (non-grandfathered group health plans)	Requirements vary depending on the type of benefit claim involved and the stage of review Decisions on internal appeals generally must be provided within: • 72 hours for denials of claims for urgent care; • 30 days for denials of non-urgent care not yet received ("prior authorization claims"); and • 60 days for denials of services already received by the individual ("post-service claims").

Key Required Notices and Filings

HIPAA Privacy and Security-Related Notices

In This Section: Notice of Privacy Practices > Notice of Breach of Unsecured Protected Health Information

Document	Type of Information	Provide To	Provided By	When Due
Notice of Privacy Practices ***(Click on the link above to download model notices in 4 different formats)*** **Note:** Fully insured group plans that do not create or receive PHI—other than summary health information and enrollment information–are **not** required to develop this notice.	Describes how a covered entity, including a group health plan, may use and disclose an individual's protected health information (PHI), and the individual's rights and the plan's legal duties with respect to that information	Individuals enrolled in group health plan coverage	Covered entities, including group health plans, unless a specific exception applies	Fully insured group plans that create or receive PHI in addition to summary health information and enrollment information must maintain a notice and provide it to any person upon request. Other health plans must provide the notice as follows: **To new enrollees**: At the time of enrollment **To individuals covered by the plan**: Within 60 days of a material revision to the policy (special rules apply for website notice postings) A health plan also must notify individuals covered by the plan of the availability of, and how to obtain, the notice at least once every 3 years, and make it available to any person who asks for it.
Notice of Breach of Unsecured Protected Health Information ***(Model notice unavailable)***	Provides certain information related to the discovery of a breach of unsecured protected health information, including: • A description of the breach; • The types of information that were involved in the breach; • Steps affected individuals should take to protect themselves from potential harm; • A brief description of what the covered entity is doing to investigate, mitigate the harm, and prevent further breaches; and • Contact information for the covered entity.	Affected individuals, the U.S. Department of Health and Human Services, and (for a breach affecting more than 500 residents of a state or jurisdiction) prominent media outlets	Covered entities, including group health plans (business associates also have certain responsibilities for providing notice of a breach)	**To affected individuals**: No later than 60 calendar days after the discovery of a breach **To HHS Secretary (submitted electronically)**: *Breaches affecting fewer than 500 individuals*–no later than 60 days after the end of the calendar year in which the breaches were discovered *Breaches affecting 500 or more individuals*–no later than 60 calendar days after discovery **To media (breaches affecting more than 500 residents of a state or jurisdiction)**: No later than 60 calendar days after discovery of a breach

Key Required Notices and Filings

Medicare Part D Creditable Coverage Notices

In This Section: Medicare Part D Creditable and Non-Creditable Coverage Disclosure Notices

Document	Type of Information	Provide To	Provided By	When Due
Medicare Part D– Creditable Coverage Disclosure Notice or Non-Creditable Coverage Disclosure Notice ***(Click on the links above for model notices)***	Notifies Medicare-eligible individuals as to whether the plan's prescription drug coverage is creditable coverage, meaning the coverage is expected to pay, on average, as much as the standard Medicare prescription drug coverage **Note:** Individuals who do not maintain creditable coverage for 63 days or longer following their initial enrollment period for Medicare Part D may be required to pay a late enrollment penalty. Accordingly, this information is essential to the decision to enroll in a Medicare Part D prescription drug plan.	• Medicare-eligible active employees and their dependents • Medicare-eligible COBRA individuals and their dependents • Medicare-eligible disabled individuals covered under the prescription drug plan • Any retirees and their dependents	Employers who sponsor group health plans that offer prescription drug coverage to Medicare-eligible individuals	• Prior to the annual enrollment period for Medicare Part D that begins on Oct. 15th • Prior to an individual's initial enrollment period for Medicare Part D • Prior to the effective date of enrolling in the employer's prescription drug plan and upon any change that affects whether the coverage is creditable • Upon request by the individual Online disclosure to the Centers for Medicare & Medicaid Services is also required annually, no later than 60 days from the beginning of a plan year, within 30 days after termination of a prescription drug plan, or within 30 days after any change in creditable coverage status.

Family and Medical Leave Act (FMLA) Notices

In This Section: General FMLA Notice > Notice of FMLA Eligibility & Rights and Responsibilities > FMLA Designation Notice

Document	Type of Information	Provide To	Provided By	When Due
General FMLA Notice ***(Click on the link above for model notice)***	Summarizes the major provisions of the FMLA and informs employees of how to file a complaint	All employees	Covered employers (generally those with **50 or more** employees)	Must be posted prominently where it can be readily seen by employees and applicants, even if no employees are eligible for FMLA leave If an employer has any FMLA-eligible employees, the notice must also be provided in employee handbooks or other written guidance concerning employee benefits or leave rights (if such written materials exist), or by distributing a copy to each new employee upon hiring.

Key Required Notices and Filings

Family and Medical Leave Act (FMLA) Notices, *Continued* **In This Section:** General FMLA Notice > Notice of FMLA Eligibility & Rights and Responsibilities > FMLA Designation Notice				
Document	**Type of Information**	**Provide To**	**Provided By**	**When Due**
Notice of FMLA Eligibility & Rights & Responsibilities ***(Click on the link above for model notice)***	Provides notice of an employee's eligibility to take FMLA leave, details the specific expectations and obligations of the employee, and explains any consequences of a failure to meet these obligations	Employees requesting or qualifying for FMLA leave	Covered employers (generally those with **50 or more** employees)	Generally within 5 business days of the employee requesting FMLA leave (or when the employer acquires knowledge that an employee's leave may be for an FMLA-qualifying reason) **Note:** Written notice of any change in the employee's eligibility status, or the specific information provided by the notice of rights and responsibilities, is also required (generally within 5 business days).
FMLA Designation Notice ***(Click on the link above for model notice)***	Notifies the employee about whether leave will be designated and counted as FMLA leave	Employees requesting or qualifying for FMLA leave	Covered employers (generally those with **50 or more** employees)	Generally within 5 business days after the employer has enough information to determine whether the leave is being taken for an FMLA-qualifying reason (if leave is not designated as FMLA-qualifying, the notice may be in the form of a simple written statement) **Note**: Written notice of any change to the information provided in the designation notice is also required, within 5 business days of receipt of the employee's first notice of the need for leave subsequent to any change.

Please Note: *This calendar provides information on key required notices and filings for group health plans under federal law. The information is subject to change and should be used for general reference purposes only. In addition, certain requirements may depend on a number of factors, including the number of employees in your organization and the type of benefits offered under your health plan. Your plan may also be subject to other requirements that are not included in this calendar, such as certain reporting and disclosure required under state law. Employers who have questions are encouraged to consult with their plan administrators, the U.S. Employee Benefits Security Administration (1-866-444-3272), the Internal Revenue Service (1-800-829-4933), or a knowledgeable employment law attorney for further guidance.*

Key Required Notices and Filings

Provided by:

NP Benefit Services

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