

# Legislative Brief

## Select Employee Benefit Compliance Timelines Regarding Disclosure Notices



The following chart is an overview of some basic reporting and disclosure requirements that apply to group health plans and/or employers. Note that not all reporting and disclosure requirements are reflected in this chart. Users of this chart should refer to the specific federal law at issue for complete information on the necessary reporting and disclosure requirements.

Law	Governs	Notice Requirement	Summary
<b>CHIPRA</b>	Notice requirement applies to employers that maintain group health plans in states that provide premium assistance subsidies under a Medicaid plan or CHIP.	<p><b>Annual Employer CHIP Notice notifying employees of potential state opportunities for premium assistance</b></p> <p>First notice must be sent by the first day of the first plan year beginning after February 4, 2010, or May 1, 2010, whichever is later. For employers with calendar year plans, the notice must be sent by January 1, 2011.</p>	<p>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.</p> <p>For a copy of the model notice, see <a href="http://www.dol.gov/ebsa/pdf/chipmodelnotice.pdf">www.dol.gov/ebsa/pdf/chipmodelnotice.pdf</a></p>
<b>COBRA</b>	Employers that had 20 or more employees on more than 50% of the typical business days during the previous calendar year. Government and church plans are exempt.	<p><b>Initial/General COBRA notice</b> – generally within 90 days of when group health plan coverage begins</p>	<p>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.</p>
		<p><b>Notice to Plan Administrator</b> - 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</p>	<p>Notice of qualifying event must be sent to plan administrator when employer is not plan administrator (e.g., employer has contracted with a third party to administer COBRA).</p>
		<p><b>COBRA election notice</b> – generally 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)</p>	<p>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.</p> <p><b>NOTE:</b> The American Recovery and Reinvestment Act of 2009 (ARRA), as amended, mandates that plans notify certain current and former participants and beneficiaries about the COBRA premium reduction. The DOL has issued model forms which may be used to satisfy these requirements. They may be accessed at <a href="http://www.dol.gov/ebsa/COBRAModelNotice.html">http://www.dol.gov/ebsa/COBRAModelNotice.html</a>.</p>
			Plans subject to the Federal COBRA provisions must provide

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			<p>a <b>General Notice</b> to all qualified beneficiaries (not just covered employees) who experienced a qualifying event at any time from September 1, 2008 through May 31, 2010, regardless of the type of qualifying event, and who have not yet been provided an election notice. The model notice includes information on the premium reduction as well as information required in a COBRA election notice.</p> <p>Note: Individuals who experienced a qualifying event that was a termination of employment from April 1, 2010 through April 14, 2010 may not have been provided proper notice. Those individuals who have not been provided any notice must get the updated General Notice and receive the full 60 days from the date the updated notice is provided to make a COBRA election. Those individuals who have been provided a notice that did not include information related to the most recent extension must also be provided this updated information. Depending on the specific circumstances, either the Supplemental Information Notice or the Notice of Extended Election Period may be used. See below for additional details.</p> <p>Plans subject to continuation coverage provisions under Federal or State law should provide, within 60 days of the date of the termination of employment, a <b>Notice of New Election Period</b> to all individuals who:</p> <ul style="list-style-type: none"> <li>• experienced a qualifying event that was a reduction in hours at any time from September 1, 2008 through May 31, 2010;</li> <li>• subsequently experience a termination of employment at any point from March 2, 2010 through May 31, 2010; and</li> <li>• either did not elect continuation coverage when it was first offered or elected but subsequently discontinued the coverage.</li> </ul> <p>Generally, individuals who have experienced a qualifying event that consists of a reduction of hours and who, from March 2, 2010 through May 31, 2010, experience an involuntary termination of employment must be provided this notice within 60 days of the event. Additionally, CEA provides that for the April 1, 2010 through April 14, 2010 period, the notice requirement attaches to any termination of employment. The Department strongly recommends that notice be provided to individuals who experienced any termination of employment because employers may be subject to civil penalties if it is later determined that the termination was involuntary and notice was not provided.</p> <p>Plans that are subject to continuation coverage provisions under Federal or State law should provide the <b>Supplemental Information Notice</b> to all individuals who elected and maintained continuation coverage based on the following qualifying events:</p>

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			<ul style="list-style-type: none"> <li>• all qualifying events related to a termination of employment that occurred from March 1, 2010 through April 14, 2010 for which notice of the availability of the premium reduction available under ARRA was not given; or</li> <li>• reductions of hours that occurred during the period from September 1, 2008 through May 31, 2010 which were followed by a termination of the employee's employment that occurred on or after March 2, 2010 and by May 31, 2010.</li> </ul> <p>For the first item above, plans must provide this notice to all individuals with a qualifying event related to any termination of employment if they have not already been provided notice of their rights under ARRA. This notice must be provided before the end of the required time period for providing a COBRA election notice. For the second item above, generally, individuals who experience an involuntary termination of employment from March 2, 2010 through May 31, 2010 after experiencing a qualifying event that consists of a reduction of hours must be provided this notice within 60 days of the termination of employment. However, as noted above, CEA requires plans to provide notices to all individuals with qualifying events related to any termination of employment that occurred from April 1, 2010 through April 14, 2010. In those cases, this notice must be provided before the end of the required time period for providing a COBRA election notice. Because employers may be subject to civil penalties if it is later determined that the termination was involuntary, the Department strongly recommends that notice be provided to individuals who experienced any termination of employment.</p> <p>Plans that are subject to continuation coverage provisions under Federal or State law must provide, before the end of the required time period for providing a COBRA election notice, the <b>Notice of Extended Election Period</b> to all individuals who:</p> <ul style="list-style-type: none"> <li>• experienced a qualifying event that was a termination of employment at some time from April 1, 2010 through April 14, 2010;</li> <li>• were provided notice that did not inform them of their rights under ARRA, as amended by CEA; and</li> <li>• either chose not to elect COBRA continuation coverage at that time or elected COBRA but subsequently discontinued that coverage.</li> </ul> <p>Insurance issuers that offer group health insurance coverage that is subject to comparable continuation coverage requirements imposed by State law must provide the <b>Alternative Notice</b> to all qualified beneficiaries, not just covered employees, who have experienced a qualifying event through May 31, 2010. However, because continuation</p>

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			coverage requirements vary among States, this notice should be further modified to reflect the requirements of the applicable State law. Issuers of group health insurance coverage subject to this notice requirement should feel free to use the model Alternative Notice, the model Notice of New Election Period, the model Supplemental Information Notice, the model Notice of Extended Election Period, or the model General Notice (as appropriate).
		<b>Notice of unavailability of COBRA</b> – 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.
		<b>Notice of early termination of COBRA coverage</b> – 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, 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. May be sent with HIPAA certificate of creditable coverage.
		<b>Notice of insufficient payment</b> – Plan must provide reasonable period of time to cure deficiency before terminating COBRA (e.g., 30 day grace period).	Notice to 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.
		<b>Premium change notice</b> – 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.
<b>ERISA</b>	ERISA employee welfare benefit plans, unless exempted	<b>Summary plan descriptions</b> – Automatically to participants within 90 days of becoming covered by the plan and to pension plan beneficiaries	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. Must accurately reflect the plan's contents as of the date not earlier than 120

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		within 90 days after first receiving benefits (though 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.*	days prior to the date the SPD is disclosed.*
		<b>Summary of material modification</b> – automatically to participants and pension plan beneficiaries receiving benefits; not later than 210 days after the end of the plan year in which the change is adopted*; if benefits or services are 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 90 days.	Describes material modification to a plan and changes in the information required to be in the SPD. Distribution of updated SPD satisfies this requirement.*
		<b>Plan documents</b> – copies must be furnished no later than 30 days after a written request. Plan administrator must make copies available at its principal office and certain other locations as specified in regulations.	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.
		<b>Form 5500</b> – generally must be filed 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 <sup>st</sup> of the following year.	Form 5500 filing requirements vary according to type of filer (i.e., 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 Internet site at <a href="http://www.dol.gov/EBSA/5500MAIN.HTML">http://www.dol.gov/EBSA/5500MAIN.HTML</a> and the latest Form 5500 instructions provide information on who is required to file and detailed information on filing.
		<b>Summary annual report</b> – automatically to participants and pension plan beneficiaries receiving benefits within 9 months after end of plan year, or 2 months after due date for filing Form 5500 (with	Narrative summary of the Form 5500 and statement of right to receive annual report. Model notices are found in 29 CFR 2520.104b-10(d).

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		approved extension)*	
<b>Family and Medical Leave Act (federal FMLA)</b>	Covered employers (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 local educational agencies)	Post <b>notice</b> in a location available to both employees and applicants  <b>Written guidance</b> , if it exists  <b>Written guidance</b> , upon employee notice of need for FMLA leave	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.  Written guidance must be provided to an employee upon the employee's notice to the employer of the need for FMLA leave (i.e., eligibility notice, and rights and responsibilities notice). The employer must detail the specific expectations and obligations of the employee, and explain the consequences of the failure to meet these obligations. After the employer has sufficient information, it must provide a designation notice informing the employee whether the leave is designated as FMLA leave.  The DOL has issued optional forms which may be used to satisfy these notice requirements. They can be accessed at <a href="http://www.dol.gov/esa/whd/fmla/finalrule.htm">http://www.dol.gov/esa/whd/fmla/finalrule.htm</a>
<b>Genetic Information Non-discrimination Act (GINA) – Employment Provisions</b>  <b>EFFECTIVE NOVEMBER 21, 2009</b>	Employers in the private sector and state and local governments that employ 15 or more employees	No general notice requirements  <b>Individual notice</b> required if genetic information used for toxic substance monitoring or for certain disclosures of genetic information.	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 written notice to each affected employee of the genetic monitoring. The employee must authorize the monitoring, unless it is required by law. Additional requirements apply to genetic monitoring.  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.
<b>HIPAA-Wellness Programs</b>	Group Health Plans and Insurers that offer Wellness Programs which condition a reward based on outcome.	Plan years beginning on or after July 1, 2007 - <b>plans must disclose</b> the availability of an alternative standard in all materials describing the wellness program.	Wellness programs which offer a reward conditioned upon an individual's ability to meet a standard that is related to a health factor will violate HIPAA nondiscrimination rules unless the program satisfies a number of conditions: <ul style="list-style-type: none"> <li>• Limit reward to 20% of cost of coverage;</li> <li>• Design to reasonably promote health and prevent disease;</li> <li>• Provide annual opportunity to qualify;</li> <li>• Provide reasonable alternative standard for obtaining the reward for certain individuals; and</li> <li>• Disclose availability of an alternative standard.</li> </ul> <p>The regulations provide safe harbor language for this disclosure.</p>

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<b>HIPAA-Privacy and Security</b>	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: service providers to Covered Entities that use protected health information (PHI)	<b>Notice of Privacy Practices</b> – the plan administrator of covered entities must comply by April 14, 2003 and every 3 years thereafter for large plans; small plans have until April 14, 2004 and every 3 years thereafter; must also comply at enrollment and within 60 days of a material revision to the notice.	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.
		<b>Notice of Breach of Unsecured PHI</b> – HIPAA 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, the Department of Health and Human Services, and, in certain circumstances, to the media. In addition, business associates must notify covered entities that a breach has occurred.
<b>HIPAA-Portability</b>	Group health plans and issuers of group health plan insurance coverage, unless exception applies	<b>Certificate of Creditable Coverage</b> - Automatically upon losing group health plan coverage, becoming 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 employee’s former group health plan to participants and beneficiaries who lose coverage, documenting prior group health plan creditable coverage and length of time covered.
		<b>General notice of preexisting condition exclusion</b> – must be provided 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.

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		<p><b>Individual notice of period of preexisting condition exclusion</b> – as soon as possible following the determination of creditable coverage.*</p>	<p>Notice to participants and beneficiaries, who demonstrate creditable coverage that is not enough to completely offset the preexisting condition exclusion, that a specific preexisting condition exclusion period applies to an individual upon consideration of creditable coverage evidence and an explanation of appeal procedures if the individual disputes the plan’s determination.</p>
		<p><b>Notice of special enrollment rights</b> – at or before the time an employee is initially offered the opportunity to enroll in the group health plan.*</p>	<p>Notice to employees eligible to enroll in a group health plan describing the group health plan’s special enrollment rules including the right to special 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.</p>
<b>Medicare Part D</b>	Group health plan sponsors that provide prescription drug coverage, except entities that contract with or become a Part D plan	<p>At a minimum, <b>Disclosure Notices for creditable or non-creditable coverage</b> must be provided by the plan at the following times:</p> <ol style="list-style-type: none"> <li>1) <u>Prior to</u> the Medicare Part D Annual Coordinated Election Period – beginning November 15<sup>th</sup> through December 31<sup>st</sup> of each year;</li> <li>2) Prior to an individual’s Initial Enrollment Period for Part D;</li> <li>3) Prior to the effective date of coverage for any Medicare eligible individual that joins the plan;</li> <li>4) Whenever prescription drug coverage ends or changes so that it is no longer creditable or becomes creditable; and</li> <li>5) Upon a beneficiary’s request.</li> </ol>	<p>Group health plans — 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 individuals who 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.</p>
		<p><b>Disclosure to CMS</b> made on 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)</p>	<p>Employers must disclose to the Centers for Medicare and Medicaid Services (CMS) whether the coverage is creditable. An entity is required to provide the Disclosure Notice through completion of the Disclosure Notice form on the CMS Creditable Coverage Disclosure Web Page at <a href="https://www.cms.hhs.gov/CreditableCoverage/45_CCDisclosureForm.asp">https://www.cms.hhs.gov/CreditableCoverage/45_CCDisclosureForm.asp</a> unless specifically exempt as outlined in related CMS guidance. This is the sole method for compliance with the disclosure requirement.</p>

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<b>Medicare Part D-Retiree Drug Subsidy</b>	Employers with group health plans that cover retirees who are entitled to enroll in Part D but who elect not to do so	At least 90 days before the beginning of each plan year, <b>plan sponsors must apply for retiree drug subsidy</b> , unless CMS approves request for extension.  Medicare beneficiaries must be notified that plan's coverage is creditable.	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. Each Plan Sponsor that seeks the retiree drug subsidy must electronically complete the application through the RDS Center at <a href="http://rds.cms.hhs.gov">http://rds.cms.hhs.gov</a> .
<b>Mental Health Parity Act (MHPA)/ Mental Health Parity and Addiction Equity Act (MHPAEA)</b>  <b>MHPA – EFFECTIVE FOR PLAN YEARS BEGINNING BEFORE OCTOBER 4, 2009</b>  <b>MHPAEA – EFFECTIVE FOR PLAN YEARS BEGINNING ON OR AFTER OCTOBER 4, 2009</b>	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	<b>MHPA</b> - 30 days before the exemption becomes effective - group health plans covered under ERISA claiming the increased cost exemption must <b>notify the DOL, plan participants and beneficiaries</b>  Upon written request  <b>MHPAEA</b> – group health plans claiming the increased cost exemption must <b>promptly notify the appropriate federal and state agencies, plan participants and beneficiaries</b>  Upon request	<b>MHPA</b> - The mental health parity requirements do not have to be met by any group health plan whose costs increase 1% or more due to the application of the MHPA's requirements. The increased cost exemption must be based on actual claims data, not on an increase in insurance premiums. The plan must implement the provisions of the MHPA for at least 6 months and the calculation of the 1% cost exemption must be based on at least 6 months of actual claims data with parity in place.  Upon written request – A summary of the aggregate data and the computation supporting the increased cost exemption must be made available to plan participants and beneficiaries free of charge upon written request.  <b>MHPAEA</b> – The cost exemption will apply to a group health plan if its cost increase exceeds 2% in the first plan year and 1% in each subsequent year. Cost-increase determinations must be made and certified in a written actuarial report. The plan must comply with the parity requirements for the first 6 months of the plan year involved. The written report and underlying documentation must be maintained for 6 years following the notification to elect the cost exemption.  A group health plan or health insurance issuer shall 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 shall include-- <ul style="list-style-type: none"> <li>• 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);</li> <li>• 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</li> <li>• 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.</li> </ul> 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

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			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.
<b>Michelle's Law</b>  <b>EFFECTIVE FOR PLAN YEARS BEGINNING ON OR AFTER OCTOBER 9, 2009</b>	Employer-sponsored group health plans	<b>Michelle's Law Notice</b> included 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.
<b>Newborns' and Mothers' Health Protection Act (NMHPA)</b>	Group health plans that provide maternity or newborn infant coverage	<b>Statement</b> 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.
<b>Qualified Medical Child Support Orders</b>	Plan administrators of group health plans and state child support enforcement agencies	<b>Medical child support order notice</b> - upon receipt of medical child support order, plan administrator must promptly <b>issue notice</b> , including plan's procedures for determining its qualified status. Within a reasonable time after its receipt, plan administrator must also issue <b>separate notice</b> as to whether the medical child support order is qualified.	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.
		<b>National Medical Support notice</b> - 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	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.*

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		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.*	
<b>Uniformed Services Employment and Reemployment Rights Act (USERRA)</b>	All public and private employers, regardless of size	Provide <b>notice</b> 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.
<b>Women's Health and Cancer Rights Act (WHCRA)</b>	Group health plans that provide coverage for mastectomy benefits	Provide <b>notice</b> upon enrollment in the plan and annually thereafter	<p>The DOL has published sample language for both the enrollment notice and the annual notice.</p> <p>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 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.</p> <p>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.</p>

\*Source: "Reporting and Disclosure Guide for Employee Benefit Plans," U.S. Dept. of Labor, EBSA, reprinted October 2008

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