SUMMARY OF REQUIRED NOTICES FOR WELFARE BENEFIT PLANS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA), AFFORDABLE CARE ACT (ACA) AND OTHER LAWS*

*For general informational purposes only; not to be construed as legal advice. Any actions involving the information provided should be coordinated with private legal counsel.

ERISA Required Notices for Welfare Benefit Plans[1]			
Document	**Type of Information**	**To Whom**	**When**
Summary Plan Description (SPD)	An SPD is the primary vehicle for informing participants and beneficiaries about their plan and how it operates. It must be written for the average participant and be sufficiently comprehensive to apprise covered persons of their benefits, rights, and obligations under the plan. It must accurately reflect the plan's contents as of the date not earlier than 120 days prior to the date the SPD is disclosed. See 29 CFR §§ 2520.102-2 and 2520.102-3 for style, format, and content requirements.	Participants. (Also see "Plan Documents" below for persons with the right to obtain an SPD upon request.) See 29 CFR § 2520.102-2(c) for provisions on foreign language assistance when a certain portion of plan participants are literate only in the same non-English language.	The plan administrator must provide SPDs automatically to participants within 90 days of becoming covered by the plan. However, the plan administrator has 120 days after the plan becomes subject to ERISA to distribute SPDs. Updated SPDs must be furnished every 5 years if changes were made to SPD information or the plan is amended. Otherwise SPDs must be furnished every 10 years. See 29 CFR § 2520.104b-2. A model plan document/SPD will be drafted by SBS if requested by the client.
Summary of Material Modification (SMM)	An SMM describes material modifications to a plan and changes in the information required to be in the SPD. Distribution of updated SPDs satisfies this requirement. See 29 CFR § 2520.104b-3.	Participants. (Also see "Plan Documents" below for persons with the right to obtain SMMs upon request.)	The plan administrator must provide SMMs automatically to participants; not later than 210 days after the end of the plan year in which the change is adopted. A model amendment/SMM will be drafted by SBS if requested by the client.
Summary Annual Report (SAR)	An SAR is a narrative summary of the Form 5500 (if applicable). See 29 CFR § 2520.104b-10(d) for prescribed format.	Participants.	The plan administrator must provide SARs automatically to participants within 9 months after end of plan year, or 2 months after due date for filing Form 5500 (with an approved extension).
Notification of Benefit Determination (Claims Notices or "Explanation of Benefits")	Claim Notices or EOBs provide information regarding benefit claim determinations. Adverse benefit determinations must include required disclosures (e.g., the specific reason(s) for the denial of a claim, reference to the specific plan provisions on which the benefit determination is based, and a description of the plan's appeal procedures).	Claimants (participants and beneficiaries or authorized claims representatives).	Claim Notice and EOB requirements vary depending on type of plan and type of benefit claim involved. See 29 CFR § 2560.503-1 for prescribed claims procedures requirements. Will be issued by SBS if claims administration services are elected by the client.

ERISA Required Notices for Welfare Benefit Plans[1]			
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Plan Documents	ERISA requires that every ERISA welfare benefit plan be established and maintained in writing. Copies of certain documents must be furnished upon written request and be available for examination. The documents include the latest updated SPD, latest Form 5500 (if applicable), trust agreement, and other instruments under which the plan is established or operated.	Participants and beneficiaries. Also see 29 CFR § 2520.104a-8 regarding the authority of the Department of Labor (DOL) to request documents.	The plan administrator must furnish copies no later than 30 days after a written request. The plan administrator must make copies available at its principal office and certain other locations as specified in 29 CFR § 2520.104b-1(b). A model plan document/SPD will be drafted by SBS if requested by the client.
Additional ERISA Required Notices for Group Health Plans[2]			
Document	**Type of Information**	**To Whom**	**When**
Summary of Material Reduction in Covered Services or Benefits	A Summary of Material Reduction in Covered Services or Benefits is a summary of group health plan amendments and changes to the information required to be included in an SPD, which constitute a ñmaterial reduction in covered services or benefits.ò See 29 CFR § 2520.104b-3(d)(3) for definitions.	Participants.	The plan administrator generally must provide a Summary of Material Reduction in Covered Services or Benefits within 60 days of the adoption of a material reduction in group health plan services or benefits. See 29 CFR § 2520.104b-3(d)(2) regarding the 90-day alternative rule for furnishing the required information. A model amendment/Summary will be drafted by SBS if requested by the client.
Initial COBRA Notice[3]	The Initial COBRA Notice provides notice of the right to purchase a temporary extension of group health coverage when coverage is lost due to a qualifying event. For more information, see the Employee Benefits Security Administrationôs (EBSAôs) booklet ***An Employer's Guide to Group Health Continuation Coverage Under COBRA***. See 29 CFR § 2590.606-1. The latest Initial COBRA Notice is available at www.dol.gov/ebsa/modelgeneralnotice.doc	Covered employees and covered spouses.	The plan administrator must provide the Initial COBRA Notice when group health plan coverage commences. May be issued by SBS if COBRA administration is elected by the client.

Additional ERISA Required Notices for Group Health Plans[2]			
Document	**Type of Information**	**To Whom**	**When**
COBRA Election Notice[3]	The COBRA Election Notice provides notice to ñqualified beneficiariesò of their right to elect COBRA coverage upon the occurrence of a qualifying event. For more information, see EBSAôs booklet ***An Employer's Guide to Group Health Continuation Coverage Under COBRA***. See 29 CFR § 2590.606-4. The latest COBRA Election Notice is available at www.dol.gov/ebsa/modelelectionnotice.doc	Covered employees, covered spouses, and dependent children who are qualified beneficiaries.	The plan administrator must generally provide qualified beneficiaries with this Notice, generally within 14 days after being notified by the employer or qualified beneficiary of the qualifying event. If the employer is also the plan administrator, the plan administrator must provide the Notice not later than 44 days after: the date on which the qualifying event occurred; or if the plan provides that COBRA continuation coverage starts on the date of loss of coverage, the date of loss of coverage due to a qualifying event. Will be issued by SBS if COBRA administration is elected by the client.
Notice of Unavailability of COBRA	The Notice of Unavailability of COBRA provides notice that an individual is not entitled to COBRA coverage. See 29 CFR § 2590.606-4(c).	Individuals who provide notice to the plan administrator of a qualifying event whom the plan administrator determines are not eligible for COBRA coverage.	The plan administrator must provide the Notice of Unavailability of COBRA generally within 14 days after being notified by the individual of the qualifying event. Will be issued by SBS if COBRA administration is elected by the client.
Notice of Early Termination of COBRA Coverage	The Notice of Early Termination of COBRA Coverage provides notice that a qualified beneficiaryôs COBRA coverage will terminate earlier than the maximum period of coverage. See 29 CFR § 2590.606-4(d).	Qualified beneficiaries whose COBRA coverage will terminate earlier than the maximum period of coverage.	The plan administrator must provide the Notice of Early Termination of COBRA Coverage as soon as practicable following the plan administratorôs determination that coverage will terminate. Will be issued by SBS if COBRA administration is elected by the client.

Additional ERISA Required Notices for Group Health Plans[2]			
Document	**Type of Information**	**To Whom**	**When**
Certificate of Creditable Coverage (CCC)[4]	A CCC provides notice from the employeeôs former group health plan documenting prior group health plan creditable coverage. See 29 CFR § 2590.701-5(a)(3)(ii) for information required to be included on the CCC. This notice requirement is expected to be eliminated as of 12/31/2014.	Participants and beneficiaries who lose coverage or who request a certificate.	The plan administration must provide a CCC automatically upon an individual losing group health plan coverage, becoming eligible for COBRA coverage, and when COBRA coverage ceases. A CCC may be requested free of charge anytime prior to losing coverage and within 24 months of losing coverage. Will be issued by SBS if HIPAA administration is elected by the client.
General Notice of Preexisting Condition Exclusion[4]	A General Notice of Preexisting Condition Exclusion describes a group health planôs preexisting condition exclusion and how prior creditable coverage can reduce the preexisting condition exclusion period. See 29 CFR § 2590.701-3(c) for prescribed requirements. For plan years beginning on or after 1/1/2014, the ACA requires that a group health planôs preexisting condition exclusion be eliminated. At that time, this requirement will no longer apply.	Participants.	The plan administrator must provide a General Notice of Preexisting Condition Exclusion as part of any written application materials distributed for enrollment. If the plan does not distribute such materials, the plan administrator must provide a General Notice of Preexisting Condition Exclusion by the earliest date following a request for enrollment that the plan, acting in a reasonable and prompt fashion, can provide the Notice. Will be issued by SBS if HIPAA administration is elected by the client.

Additional ERISA Required Notices for Group Health Plans[2]			
Document	**Type of Information**	**To Whom**	**When**
Individual Notice of Period of Preexisting Condition Exclusion[4]	An Individual Notice of Period of Preexisting Condition Exclusion provides notice that a specific preexisting condition exclusion applies to an individual upon consideration of creditable coverage evidence, as well as an explanation of the appeal procedures if the individual disputes the plan's determination. See 29 CFR § 2590.701-3(e) for prescribed requirements. For plan years beginning on or after 1/1/2014, the ACA requires that a group health plan's preexisting condition exclusion be eliminated. At that time, this requirement will no longer apply.	Participants and beneficiaries who demonstrate creditable coverage that is not enough to completely offset the preexisting condition exclusion.	The plan administrator must provide an Individual Notice of Period of Preexisting Condition Exclusion as soon as possible following the determination of creditable coverage. Will be issued by SBS if HIPAA administration is elected by the client.
Notice of Special Enrollment Rights[4]	A Notice of Special Enrollment Rights provides notice 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. A model Notice is provided in the EBSA publication, ***Health Benefits Coverage Under Federal Law***, at www.dol.gov/ebsa/pdf/CAG.pdf	Employees eligible to enroll in a group health plan.	The plan administrator must provide a Notice of Special Enrollment Rights at or before the time an employee is initially offered the opportunity to enroll in the group health plan.
Wellness Program Disclosure[4]	A Wellness Program Disclosure is a notice that must be given by any 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. The Notice must disclose the availability of a reasonable alternative standard (or possibility of waiver of the otherwise applicable standard). Model language is available at www.dol.gov/ebsa/pdf/CAGAppD.pdf	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.	The plan administrator must provide a Wellness Program Disclosure in all plan materials that describe the terms of the wellness program. If the plan materials merely mention that a program is available, without describing its terms, this Disclosure is not required.

Additional ERISA Required Notices for Group Health Plans[2]			
Document	**Type of Information**	**To Whom**	**When**
Women's Health and Cancer Rights Act (WHCRA) Notices[4]	Women's Health and Cancer Rights Act (WHCRA) Notices provide information describing required benefits for mastectomy-related reconstructive surgery, prostheses, and treatment of physical complications of mastectomy. Model Notices are provided in the EBSA publication, ***Health Benefits Coverage Under Federal Law***, at www.dol.gov/ebsa/pdf/CAG.pdf	Participants.	The plan administrator must provide Women's Health and Cancer Rights Act (WHCRA) Notices upon enrollment and annually. Although included in the model plan document/SPD drafted by SBS, must still be provided upon enrollment and annually.
Medical Child Support Order (MCSO) Notice	A Medical Child Support Order (MCSO) Notice provides notification from the plan administrator regarding receipt and qualification determination on a MCSO directing the plan to provide health insurance coverage to a participant's noncustodial children. See ERISA § 609(a)(5)(A) for prescribed requirements.	Participants, any child named in a MCSO, and his or her representative.	The plan administrator, upon receipt of an MCSO, must promptly issue the Notice (including the plan's procedures for determining its qualified status). The plan administrator must also issue a separate Notice as to whether the MCSO is qualified within a reasonable time after its receipt.
National Medical Support (NMS) Notice	A National Medical Support (NMS) Notice is a notice used by state agency responsible for enforcing health care coverage provisions in a MCSO. See ERISA § 609(a)(5) and 29 CFR § 2590.609-2 for prescribed requirements. Depending upon certain conditions, the 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, representatives.	The employer must either send Part A of the NMS Notice to the state agency, or Part B of the Notice to the plan administrator, within 20 days after the date of the Notice or sooner, if reasonable. The plan administrator must promptly notify affected persons of receipt of the Notice and the procedures for determining its qualified status. The plan administrator must within 40-business days after its date or sooner, if reasonable, complete and return Part B to the state agency and must also provide required information to affected persons. Under certain circumstances, the employer may be required to send Part A to the state agency after the plan administrator has processed Part B.

ACA Required Notices			
Document	**Type of Information**	**To Whom**	**When**
Notice of Grandfathered Status	For a grandfathered group health plan to maintain its grandfathered status, a Notice of Grandfathered Status must be included in any plan materials provided to a participant or beneficiary describing the benefits under the plan, that the plan believes it is a grandfathered health plan within the meaning of section 1251 of the ACA. The Notice also must include contact information for questions and complaints. Model language is available at www.dol.gov/ebsa/grandfatherregmodelnotice.doc	Participants and beneficiaries receiving benefits.	The plan administrator must provide the Notice of Grandfathered Status in any materials describing benefits. If applicable, included in the model plan document/SPD drafted by SBS, but also must be provided in any other materials describing plan benefits.
Disclosure of Patient Protections – Choice of Providers	If a non-grandfathered group health plan allows or requires the designation by a participant or beneficiary of a primary care provider, a Disclosure of Patient Protections must be provided. Model language is available at www.dol.gov/ebsa/patientprotectionmodelnotice.doc	Participants.	The plan administrator must furnish the Disclosure of Patient Protections with the SPD or other similar description of benefits. If applicable, included in the model plan document/SPD drafted by SBS, but also must be provided in any other similar descriptions of benefits.
Summary of Benefits and Coverage (SBC) and Uniform Glossary (UG)	The ACA provides for new group health plan disclosure tools, the SBC and UG, to help consumers better compare coverage options available to them in both the individual and group health insurance coverage markets. Generally, the SBC and UG must be provided free of charge. A notice containing the required template for the SBC and UG, as well as instructions and sample language for completing the template are available at www.dol.gov/ebsa/healthreform/	Participants and beneficiaries.	The plan administrator must provide the SBC and UG: annually with open enrollment materials or, if a plan does not offer open enrollment, within 30 days prior to the start of the plan year; prior to enrollment for new enrollees; and within seven business days of a request from a participant or beneficiary. A master SBC will be prepared by SBS if requested by the client.

ACA Required Notices			
Document	**Type of Information**	**To Whom**	**When**
Notice of Material Modification	A Notice of Material Modification is the advance notice of a material modification of group health plan coverage (as defined under ERISA section 102) that must be provided if any of the changes are not reflected in the most recently provided SBC.	Participants and beneficiaries.	The plan administrator must provide the Notice of Material Modification no later than 60 days prior to the date on which such changes will become effective, if they are not reflected in the most recent SBC provided, and occur other than in connection with a renewal or reissuance of coverage. A master updated SBC will be drafted by SBS if requested by the client.
Notice of Rescission	If a rescission (retroactive termination) of group health plan coverage is permitted due to fraud or intentional material misrepresentation, advance written notice must be provided in the form of a Notice of Rescission, and the Notice must include the appeal rights as required by law and as provided in plan benefit documents.	Participants and beneficiaries	The Notice of Rescission must be provided by the plan administrator at least 30 calendar days before coverage may be rescinded. Will be issued by SBS if claims administration services are elected by the client.
Exchange (Marketplace) Notice	Fair Labor Standards Act (FLSA) § 18B, added to the labor statute by the ACA, requires an employer subject to the FLSA (whether or not it offers health coverage) to provide all new employees with a written Exchange (Marketplace) Notice about the health insurance marketplaces and their options for health coverage. The sample Notice for an employer that provides group health coverage is available at www.dol.gov/ebsa/pdf/FLSAwithplans.pdf	Employees whether or not they are enrolled in the employerôs health coverage.	The employer must provide the Exchange (Marketplace) Notice within 14 days of an employeeôs start date. (Current employees should have already received this Notice by 10/1/2013.)

Other Required Notices			
Document	**Type of Information**	**To Whom**	**When**
Notice of Privacy Practices (NPP)	Participants must be provided with an NPP describing how the group health plan may use and share covered individualsô health information and how they can exercise their health privacy rights. The plan cannot use or disclose information in a way that is inconsistent with its NPP. NPP instructions and models are available at www.hhs.gov/ocr/privacy/hipaa/modelnotices.html	Participants.	The plan administrator must provide the NPP at enrollment and generally when there is a material change to the NPP. Every three years the plan administrator must notify covered individuals that an NPP is available and how to obtain it.
Breach Notification	A Breach Notification must generally be provided if there is an unauthorized acquisition, access, use, or disclosure of unsecured protected health information.	Affected individuals, the Department of Health and Human Services (HHS) and prominent media outlets, if the breach involves more than 500 individuals. Annually to HHS for breaches involving fewer than 500 individuals.	The plan administrator must provide the Breach Notification no later than 60 days after the date of the discovery of the breach.
Notice of Creditable Coverage Letter	In general, group health plans that offer prescription drug coverage on a group basis to active and retired employees and beneficiaries who are Medicare-eligible must disclose, through a letter, whether such coverage is creditable. Model Notice letters are available at www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Model-Notice-Letters.html	Medicare-eligible participants and beneficiaries covered by the prescription drug plan.	The plan sponsor must provide the Notice: before October 15 each year; before an individualôs initial enrollment period for Medicare Part D; before the effective date of coverage for any Medicare-eligible individual that joins the plan; whenever prescription drug coverage ends or changes so that it is no longer creditable or becomes creditable; and upon request. The complete guidelines regarding creditable coverage determinations, creditable coverage notifications and disclosures are available from the Centers for Medicare & Medicaid Services (CMS) at www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/index.html?redirect=/CreditableCoverage/

Other Required Notices			
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Creditable Coverage Disclosure to CMS	Group health plans that offer prescription drug coverage on a group basis to active and retired employees and beneficiaries who are Medicare-eligible must share the creditable coverage status of the coverage with CMS.	To CMS by completing an online notice. Instructions are available at www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosure.html	The plan sponsor must provide the Creditable Coverage Disclosure: within 60 days after the beginning date of the plan year for which the plan sponsor is providing the Disclosure to CMS; within 30 days after the termination of the prescription drug plan; and within 30 days after any change in the creditable coverage status of the prescription drug plan.
CHIPRA Notice	Employers that maintain a group health plan in a state that provides premium assistance under Medicaid or the Childrenôs Health Insurance Program must notify all employees of potential opportunities for premium assistance in the state in which the employee resides. A CHIPRA model notice is available at www.dol.gov/ebsa/chipmodelnotice.doc	Participants and beneficiaries.	The employer must provide the CHIPRA Notice annually, by the first day of the plan year.

[1] Please refer to the DOLôs regulations and other guidance for information on the extent to which charges may be assessed to cover the cost of furnishing particular information, statements, or documents to participants and beneficiaries required under Title I of ERISA. See, e.g., 29 CFR § 2520.104b-30.

[2] The term ñgroup health planò means an employee welfare benefit plan to the extent that the plan provides medical care to employees or their dependents directly or through insurance, reimbursement or otherwise.

[3] COBRA generally applies to group health plans of employers who employed 20 or more employees during the prior calendar year. Provisions of COBRA covering state and local government plans are administered by the Department of Health and Human Services. Provisions of COBRA covering state and local government plans are administered by the Department of Health and Human Services. COBRA does not apply to plans sponsored by certain church-related organizations.

[4] For more information, see EBSAôs ***Compliance Assistance Guide: Health Benefits Coverage Under Federal Law***.