Compliance Guide

PAYCHEX

Payroll | Benefits | HR | Insurance

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Welcome to Your Compliance Guide

Thank you for choosing Paychex Insurance Agency as your partner in delivering a comprehensive health care benefits package to your employees. An important part of that package is our online Compliance Guide, created in partnership with ThinkHR, a leading provider of HR information for U.S. insurance brokers and employers. In this guide you'll find important explanations of federal health care-related regulations and your obligations as an employer.

Simply select CTRL+Click to follow the links in the Table of Contents to quickly access the pages that are most applicable to your company's needs. Here are a few important sections to get you started:

- **Calendar** – a high-level overview of important deadlines and responsibilities
- **Glossary of Terms** - become better acquainted with the wording used in notifications
- **Sample Forms and Notices** - view government-issued forms and models for employee notifications

We're confident the Compliance Guide will make the process of understanding and meeting your employer health and benefits obligations as easy and smooth as possible.

Why You Need to Stay Compliant

Employee benefits play an increasingly important role in the lives of employees and their families and have a significant financial and administrative impact on a business organization. Most companies operate in an environment in which an educated workforce has come to expect a comprehensive benefits program. Indeed, the absence of a program, or an inadequate program, can seriously hinder a company's ability to attract and retain good personnel.

With the large investment of time and financial resources in employee benefits and the risk of not keeping up with associated federal regulations, it's more important than ever to understand your obligations as an employer. In this Compliance Guide, we help you identify health benefit notifications requirements and possible penalties your company could incur if you are not compliant with federal regulations.

Checklists of Health Care Related Regulations

Affordable Care Act: Employer Compliance Checklist 2017-2018

The Affordable Care Act (ACA), or federal health care reform, imposes a number of requirements on employers. Whether you are a large or small employer, and whether you do or do not offer health coverage to your workers, some of the ACA's requirements apply to you.

The checklist below highlights ACA provisions that require employer action in 2017 and 2018. To get started, the following definitions will help you determine which requirements apply to your situation:

- **Applicable large employer (ALE):** Employer, including all related employers in the same controlled group, which employed an average of 50 or more full-time and full-time-equivalent employees in the prior calendar year.
- **Full-time employee:** Employee that averages at least 30 hours of service per week (or 130 per month), as determined under one of two allowable measurement methods.
- **Grandfathered plan:** Group health plan that was in existence on March 23, 2010, and since then has not eliminated benefits, decreased the employer's share of coverage cost by more than 5 percent, or increased the employee's deductibles, copays, or coinsurance over certain levels.
- **Group health plan:** Group medical plan (insured or self-funded plan) that provides minimum essential coverage (MEC). Dental- or vision-only plans, and most health flexible spending accounts, employee assistance plans, and fixed indemnity plans are not MEC.
- **Minimum value:** Group health plan's share of total allowed costs is at least 60 percent of such costs and plan includes substantial coverage for physician services and inpatient hospital services. Further, the minimum value plan also is affordable if the employee's cost to enroll for self-only coverage does not exceed 9.69 percent of income (2017) or 9.56 percent of income (2018).

Actions Required
Notices

- q **Employer Notice about Health Insurance Exchanges (Marketplaces):** Provide to all employees within 14 days of hire.
- q **Grandfathered Plan Notice (grandfathered plans only):** Include with materials describing the plan's benefits; e.g., enrollment materials, summary plan description (SPD).
- q **Patient Protection Notice (non-grandfathered plans only):** Provide at enrollment and include in summary plan description (SPD).
- q **Summary of Benefits and Coverage (SBC):** Provide at enrollment and upon request.

Group Health Plan Design

- q **Cost-sharing Limits (non-grandfathered plans only):** Limit the plan's annual out-of-pocket maximum for essential health benefits to no more than $7,150 per person and $14,300 per family (2017 plan year) or $7,350 per person and $14,700 per family (2018 plan year).
- q **Health Flexible Spending Account limit:** Limit the amount of annual elective contributions to no more than $2,600 (2017 plan year) or $2,650 (2018 plan year).

Group Health Plan Fees

- **Patient-Centered Outcomes Research Institute (PCORI):** For self-funded group health plans, count average number of participants for the plan year and pay the corresponding annual fee. For plan years ending in 2017, the fee will be due July 31, 2018.
- **Transitional Reinsurance Program (TRP):** For self-funded plans that provide minimum value, report the plan's average enrollment count by November 15 and pay the corresponding annual fee by the next January 15, or in two installments, by January 15 and November 15. The final year of the program was 2016 with the last payments due in 2017. (Certain self-funded self-administered plans were exempt for 2016; these typically were union trusts.)

Reporting

- **W-2 Reporting of Employee Health Coverage Cost:** Report total cost of each employee's health coverage on Form W-2 (box 12). (Employers that filed fewer than 250 Form W-2s for the prior calendar year are exempt for the current year.)
- **Employer Reporting (IRC § 6056) (ALEs only):** Prepare and distribute Form 1095-C to each person who was a full-time employee for any month in the calendar year to report whether health coverage was offered. File copies of Form 1095-C, along with transmittal Form 1094-C, with the IRS. Forms for each calendar year are due early in the following year.
- **Health Coverage Reporting (IRC § 6055) (self-funded plan sponsors):** Prepare and distribute Form 1095-B to persons covered by the plan for any month in the calendar year, and file copies along with Form 1094-B with the IRS. If plan sponsor also is an ALE, use Forms 1095-C and 1094-C in lieu of Forms 1095-B and 1094-B.

Employer Shared Responsibility (ESR)

The ESR provision – often called the "employer mandate" or "play or pay" – requires ALEs to offer affordable minimum value coverage to full-time employees. The IRS may assess an ESR penalty if at least one full-time employee receives a government subsidy to buy an individual policy through an Exchange due to the ALE's failure to offer coverage.

To avoid the risk of penalties, determine whether each employee meets the ESR definition of full-time employee and, if so, offer coverage on a timely basis. IRS regulations provide guidance for determining full-time status by tracking each employee's hours of services based on specific measurement methods.

Recordkeeping

Employers are advised to maintain detailed documentation of all materials, data, and records used in meeting their requirements under the ACA. Examples include:

- Copies of required notices and description of distribution processes.
- Data used in determining enrollment counts for purposes of PCORI and TRP fees (self-funded plans).
- Data used in preparing statements and IRS forms (1094s, 1095s, W-2s, as applicable) and description of distribution and filing processes. If filing electronically, maintain records of testing protocols.
- If ALE, keep records of employee hours of service and measurement methods for administration of the ESR. Document, by employee, whether the full-time employee definition was met and, if so, document the employer's health coverage offer to the employee. Maintain proof of the plan's status as minimum essential coverage, minimum value coverage and/or affordable coverage, as applicable.

COBRA Checklist
Establishing the COBRA Program and Policy

The Consolidated Omnibus Budget Reconciliation Act (COBRA) amends the Employee Retirement Income Security Act (ERISA), the Internal Revenue Code and the Public Health Service Act to provide continuation of group health coverage that otherwise might be terminated. Employers with 20 or more employees are generally required to offer their employees continuation of coverage through COBRA and can establish a program using the following steps:

1. Determine that your company has/had 20 or more employees and is required to offer continuation of benefits under federal COBRA.
2. Determine which benefits may be continued under COBRA.
3. Determine/outline the qualifying events for continuation coverage and the notifications of these events to the employee, carrier, and/or third-party administrator (TPA).
4. Determine how COBRA will be billed to/paid by the qualified beneficiary and the rates for the coverage.
5. Determine how you will provide the COBRA General Notice of Rights (general notice) to your new employees and new enrollees.
6. Add the COBRA general notice to your summary plan description (SPD) and ensure continuation rights are referenced in your summary of benefits coverage (SBC).
7. Determine how the COBRA recordkeeping and annual reporting requirements will be met.

SPD Checklist
Health and Welfare Benefits Summary Plan Description (SPD) Checklist

The summary plan description (SPD) is the primary vehicle for participants and beneficiaries about their health and welfare plan and how it operates.

The SPD and plan document may be consolidated under one document or they may be separate and distinct from each other; however, the SPD must comply with specific style, format, and content requirements outlined in 29 C.F.R. §§ 2520.102-2 and 2520.102-3. The SPD must be written in a manner calculated to be understood by the average participant and be sufficiently comprehensive to apprise participants and beneficiaries of their benefits, rights, and obligations under the plan.

This checklist is intended to provide a general overview of the content requirements for a compliant health and welfare SPD. While most information may be included in a wrap SPD, other information may be communicated directly in the carrier policies, descriptions, and other materials that are incorporated by reference into the wrap SPD.

Regulatory Reference	SPD Requirement	Date Reviewed
29 CFR § 2520-102.3(a)	The name of the plan (including the name by which the plan is commonly known by plan participants and beneficiaries, if different).	
29 CFR § 2520-102.3(b) (1)-(3)	The name and address of (whichever is applicable): • The employer whose employees are covered under the plan for single employers. • The employee organization that maintains the plan for plans maintained by employee organizations for their members. • The association, committee, joint board of trustees, parent, or most significant employer of a group of employers (all of which contribute to the same plan), or other similar representatives of the parties who established or maintained the plan for: o Collectively-bargained plans. o A plan established or maintained by two or more employers. The SPD should identify participating employers or members of a controlled group pursuant to § 414 of the Internal Revenue Code.	

Regulatory Reference	SPD Requirement	Date Reviewed
29 CFR § 2520-102.3(b)(3) (i)-(ii) – 4(i)-(ii)	A statement that participants and beneficiaries may receive, upon written request to the plan administrator: • A complete list of employers and employee organizations sponsoring the plan. The statement must say that the list is available for examination by participants and beneficiaries. • Information on whether a particular employer or employee organization is a sponsor of the plan and, if so, that sponsor's address.	

Regulatory Reference	SPD Requirement	Date Reviewed
29 CFR § 2520-102.3(c)	The employer identification number (EIN) assigned by the IRS to the plan sponsor.	
29 CFR § 2520-102.3(c)	The plan number.	
29 CFR § 2520-102.3(d)	The type of welfare plan (e.g., group health plan, disability plan, etc.).	
29 CFR § 2520-102.3(e)	The type of administration of the plan (e.g., plan sponsor administration or third-party administration).	
29 CFR § 2520-102.3(f)	The name, business address, and telephone number of the plan administrator.	
29 CFR § 2520-102.3(g)	The name and address of the person designated as agent for service of legal process; a statement that service of legal process may also be made on a plan trustee or the plan administrator.	
29 CFR § 2520-102.3(h)	The name, title, and address of the principal place of business of each trustee of the plan (if applicable).	
29 CFR § 2520-102.3(i)	A statement that the plan is maintained pursuant to one or more collectively bargained agreements (CBA) (if applicable) and that a copy of the CBA may be obtained upon written request to the plan administrator. The statement must also indicate that the CBA is available for examination by participants and beneficiaries.	

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Regulatory Reference	SPD Requirement	Date Reviewed
29 CFR § 2520-102.3(j)(2)(3)	The plan's requirements respecting eligibility and participation for benefits, including: • The conditions pertaining to eligibility to receive benefits (e.g., classes of eligible employees, eligibility for non-employees, waiting periods, minimum number of hours per week, and the effective date of participation). • A description or summary of the benefit(s). A description of the procedures governing qualified medical child support order (QMCSO) determinations or a statement that participants and beneficiaries can obtain a copy of such procedures (without charge) from the plan administrator. • For group health plans, a description of: o Any cost sharing provisions. o Any annual or lifetime caps or other limits on benefits under the plan. o The extent to which preventive services are covered under the plan. o Whether, and under what circumstances, existing and new drugs are covered under the plan. o Whether, and under what circumstances, coverage is provided for medical tests, devices, and procedures. o Provisions governing the use of network providers and the composition of the provider network. (The listing of providers may be furnished as a separate document accompanying the SPD if the SPD contains a statement that provider lists are furnished automatically, without charge, as a separate document.) § Whether, and under what circumstances, coverage is provided for out-of-network services. § Any conditions or limits on the selection of primary care providers or providers of specialty medical care. § Any conditions or limits applicable to obtaining emergency medical care. – Any provisions requiring	

Regulatory Reference	SPD Requirement	Date Reviewed
29 CFR § 2520-102.3(l)	• A statement clearly identifying circumstances that may result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, or recovery (e.g., by exercise of subrogation or reimbursement rights) of any benefits that a participant or beneficiary might otherwise reasonably expect the plan to provide. • A summary of any plan provisions governing the authority of the plan sponsors or others to terminate the plan, amend the plan, or eliminate benefits under the plan and the circumstances, if any, under which the plan may be terminated or benefits may be amended or eliminated. • A summary of any plan provisions governing the benefits, rights, and obligations of participants and beneficiaries under the plan on termination of the plan or amendment or elimination of benefits under the plan. • A summary of any plan provisions governing the allocation and disposition of assets of the plan upon termination. • A summary of any provisions that may result in the imposition of a fee or charge on a participant or beneficiary, or on an individual account thereof, the payment of which is a condition to the receipt of benefits under the plan.	
29 CFR § 2520-102.3(o)	For group health plans subject to COBRA, a description of the rights and obligations of participants and beneficiaries with respect to continuation coverage, including information concerning qualifying events and qualified beneficiaries, premiums, notice and election requirements, procedures, and duration of coverage.	
29 CFR § 2520-102.3(p)	The source of contributions to the plan (e.g., employer, employee, or both) and the method by which the amount of contribution is calculated.	

Regulatory Reference	SPD Requirement	Date Reviewed
29 CFR § 2520-102.3(q)	• The identity of any funding medium used for the accumulation of assets through which benefits are provided. • The identity of any insurance company, trust fund, or any other institution, organization, or entity that maintains a fund on behalf of the plan or through which the plan is funded or benefits are provided, including: o The name and address any insurance carrier/issuer. o Whether and to what extent benefits under the plan are guaranteed under a contract or policy of insurance issued by the carrier/issuer. o The nature of any administrative services (e.g., payment of claims) provided by the carrier/issuer.	
29 CFR § 2520-102.3(r)	The plan year end date/last day of the plan's fiscal year.	

Regulatory Reference	SPD Requirement	Date Reviewed
29 CFR § 2520-102.3(s)	• The procedures governing claims for benefits: • Procedures for obtaining preauthorizations, approvals, or utilization review decisions for group health plans. • Procedures for cling claims, providing notice of benefit determinations, and reviewing denied claims. • Applicable time limits and remedies available under the plan for the redress of claims which are denied in whole or in part. The plan's claims procedures may be furnished as a separate document (that satisfies style and format requirements) if the SPD contains a statement that the plan's claims procedures are furnished automatically, without charge, as a separate document.	
29 CFR § 2520-102.3(t)	A statement of ERISA rights (pursuant to the applicable sections of the model statement included § 2520-102.3(t)(2)).	

Regulatory Reference	SPD Requirement	Date Reviewed
29 CFR § 2520-102.3(u)	A mothers' and newborns' coverage statement in compliance with § 2520-102.3(u)(2) regarding hospital length of stay in connection with childbirth for the mother or newborn child. This should include a description of how federal law and state laws interact and apply if state laws are also applicable.	
29 CFR § 2520-102.2(c)	As applicable, provide participants with an English-language summary plan description that prominently displays a notice, in the non-English language common to these participants, offering them assistance. The assistance provided does not require written materials, but the notice must be provided in the applicable, common, non-English language and must be calculated to provide participants with a reasonable opportunity to become informed about their rights and obligations under the plan. This obligation applies to: • Plans that cover fewer than 100 participants at the beginning of the plan year where 25 percent or more of all plan participants are literate only in the same non-English language. • Plans that cover 100 or more participants at the beginning of the plan year where the lesser of 500 (or more) participants or 10 percent (or more) of all plan participants are literate only in the same non-English language.	

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Regulatory Reference	SPD Requirement	Date Reviewed
Other applicable regulations or laws	Other required or potential provisions (voluntary or best practice provisions) that may be included if applicable: • HIPAA privacy and security provisions. • Women's Health Cancer Rights Act notice. • HIPAA portability provisions (e.g., special enrollment notice). • Mental health parity (MHPA and MHPAEA) disclosure. • Grandfathered health plan status disclosure. • Patient protection disclosure. • Nondiscrimination and accessibility requirements notice (§ 1557). • How insurer refunds (such as dividends, demutualization, and medical loss ratio (MLR) refunds) are allocated to participants. • Reservation of rights for plan administrator to interpret the plan. • Detailed description of the plan's application of the lookback measurement method for determining employee eligibility. • Family and Medical Leave Act (FMLA) and Uniformed Services Employment and Reemployment Rights Act (USERRA) continuation rights.	

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Notice Requirements for Group Health Plans

Plan Documents

Takes Effect:

Plan years and open enrollment periods beginning on or after September 23, 2012.

Applies to:

Grandfathered plans: YES	Nongrandfathered plans: YES	HIPAA-Excepted Benefits: NO
Small Group Market: YES	Large Group Market: YES	Self-Funded Health Plans: YES

Quick Facts:

- The Summary of Benefits and Coverage (SBC) describes a health plan's key features in a standardized format. Required elements include:
  - Uniform standard definitions of medical and health coverage terms;
  - Description of the benefits and any cost-sharing requirements (e.g., deductibles, co-pays);
  - Information about coverage limits or exceptions; and
  - Coverage examples (i.e., cost estimates for hypothetical medical scenarios).
- The SBC is prepared for each plan using templates and instructions provided in federal regulations, then customizing the information to reflect the plan's specific provisions.
- The SBC must be distributed to eligible enrollees at the start of each enrollment period.
- Insurers are responsible for producing the SBCs for insured plans, while SBCs for self-funded plans are the responsibility of the plan sponsor (employer).

Details:

The Affordable Care Act (ACA) requires health plans and insurers to distribute a Summary of Benefits and Coverage (SBC) using a standardized format. It is designed to provide "clear, consistent and comparable information" in plain information focusing on cost-sharing provisions (deductibles, co-pays, co-insurance), exclusions, and coverage examples for hypothetical medical scenarios. A separate SBC is required for each plan. The uniform format is intended to help consumer understand the plan's key features and to compare different plans. See Sample SBC.

Preparing the SBC: The Department of Labor (DOL) provides templates and instructions to assist plans in producing and distributing the SBC. Plans also must make available the Uniform Glossary of insurance and medical terms, which is a same-for-all document posted on a government website. For convenient links to the material, see "Official Guidance" below.

Health insurers are responsible for producing SBCs for insured plans, although they may require the policyholder (employer) to distribute the material. For self-funded plans, the plan sponsor (employer) is responsible for producing and distributing the SBC.

SBCs are not required for plans that are not health plans or that primarily provide excepted benefits. For example, SBCs are not required for the following:

- Health Savings Accounts (HSAs);
- Limited-scope stand-alone dental and/or vision plans;
- Health Flexible Spending Accounts (HFSAs) with little or no employer contribution;
- Fixed-indemnity or specific-disease policies;
- Long-term care, disability, or accident coverage; and
- Retiree-only plans.

A Health Reimbursement Arrangement (HRA) is not an excepted benefit, so an SBC is required. The typical HRA is integrated with a group medical plan and may be included in a single SBC. Employee assistance plans (EAPs) and wellness programs that provide medical services or significant medical benefits also require SBCs, but may be included in the SBC for the group medical plan of which they are a part.

Note that the SBC does not replace other required materials, such as insurance certificates or evidence of coverage (EOC) booklets, or summary plan descriptions (SPDs).

Distributing the SBC: The insurer or employer must distribute the SBC at each of the following times:

- By the first day the participant is eligible to enroll; that is, at initial enrollment and annually at open enrollment;
- Within seven business days of the participant's request; and
- Within 90 calendar days of a special enrollment.

The SBC may be a stand-alone document, or it may be included with the plan's SPD for convenience. If included with an SPD, the SBC content must be intact and prominently displayed (such as immediately after the table of contents).

The SBC must be distributed to all enrolled plan participants (e.g., employees, retirees, COBRA beneficiaries). Separate distribution for dependents is not required, unless the employer knows that they have different addresses. The SBC can be distributed in hard copy or electronically. If provided electronically to enrolled participants, the distribution must comply with the DOL's safe harbor for electronic delivery.

For persons who are eligible but not enrolled at open enrollment, it is sufficient to post the SBC online (in a readily accessible format that can be saved and printed), provided they receive a postcard or ecard notice. The notice must explain that the SBC is available and how to access it and how to request a paper copy free of charge.

Lastly, new hires (or employees newly eligible to enroll) must be given SBCs for all the plans for which they are eligible.

Penalties: Insurers and employers subject to the Public Health Safety Act (PHSA) may be fined up to $1,128 per plan participant for each willful violation. Plans sponsored by private-sector employers are subject to ERISA which may result in fines of up to $110 per participant per day. Additional excise taxes may apply.

Official Guidance:

The federal Departments provide extensive guidance on this topic in the following materials:

- "Summary of Benefits and Coverage and Uniform Glossary; Final Rule" (80 Fed. Reg. 34292; 6/16/2015): click here.
- Templates and Instructions:
  - Summary of Benefits and Coverage (SBC) Template | MS Word Format
  - Sample Completed SBC | MS Word Format
  - Instructions for Completing the SBC - Group Health Plan Coverage
  - Why This Matters language for "Yes" Answers
  - Why This Matters language for "No" Answers
  - HHS Information For Simulating Coverage Examples
  - HHS Coverage Example Calculator and Related Information
- Guidance regarding Uniform Glossary:
  - List of anchors for SBC Uniform Glossary terms
  - Uniform Glossary of Coverage and Medical Terms

Last Reviewed: June 12, 2018

SPD Requirements

The style, format, and content requirements of the SPD are outlined in 29 C.F.R. §§ 2520.102-2 and 2520.102-3. Information required in the SPD includes:

- The plan name.
- The plan sponsor/employer's name and address.
- The plan sponsor's federal Employer Identification Number (EIN).
- The plan administrator's name, address, and phone number.
- Designation of any named fiduciaries, if other than the plan administrator (such as claim fiduciary).
- The plan number for ERISA Form 5500 purposes (501, 502, 503, etc.). **Note:** Each ERISA plan should be assigned a unique number that is not used more than once.
- Type of plan or brief description of benefits (life, medical, dental, disability, etc.).
- The date of the end of the plan year for maintaining plan's fiscal records (note that this may be different than the insurance policy year).
- Each trustee's name, title, and address of principal place of business, if the plan has a trust.
- The name and address of the plan's agent for service of legal process, along with a statement that service may be made on a plan trustee or administrator.
- The type of plan administration (administered by contract, insurer, or sponsor).
- Eligibility terms, such as classes of eligible employees, employment waiting period, and hours per week. and the effective date of participation, such as next day or first of month following satisfaction of eligibility waiting period.
- How insurer refunds (such as dividends, demutualization, and medical loss ratio (MLR) refunds) are allocated to participants.
- Plan sponsor's amendment and termination rights and procedures, and what happens to plan assets, if any, in the event of plan termination.
- Summary of any plan provisions governing the benefits, rights, and obligations of participants under the plan on termination or amendment of plan or elimination of benefits.
- Summary of any plan provisions governing the allocation and disposition of assets upon plan termination.
- Claims procedures, which may be furnished separately in a Certificate of Coverage (COC), provided that the SPD explains that claims procedures are furnished automatically, without charge, in the separate document, and time limits for lawsuits, if the plan imposes them.
- A statement clearly identifying circumstances that may result in loss or denial of benefits (subrogation, Coordination of Benefits, and offset provisions).
- The standard of review for benefit decisions.
- ERISA model statement of participants' rights.
- The sources of plan contributions, whether from employer and/or employee contributions, and the method by which they are calculated.
- Interim Summary of Material Modifications (SMMs) since SPD was adopted or last restated.
- The fact that the employer is a participating employer or a member of a controlled group.
- Whether the plan is maintained pursuant to one or more collective-bargaining agreements, and that a copy of the agreement may be obtained upon request.
- A prominent offer of assistance in a non-English language (depending on the number of participants who are literate in the same non-English language).
- Identity of insurer(s), if any.
- Additional requirements for group health plan SPDs, such as:
  - Detailed description of plan provisions and exclusions (such as co-pays, deductibles, co-insurance, eligible expenses, network provider provisions, prior authorization and utilization review requirements, dollar limits, day limits, visit limits, and the extent to which new drugs, preventive care, and medical tests and devices are covered). A link to network providers should also be provided, and plan limits, exceptions, and restrictions must be conspicuous.

- Information regarding COBRA, HIPAA, and other federal mandates such as Women's Health Cancer Rights Act, pre-existing condition exclusion, special enrollment rules, mental health parity, coverage for adopted children, qualified medical support orders, and minimum hospital stays following childbirth.
- Name and address of health insurer(s), if any.
- Description of the role of health insurers (such as, whether the plan is insured by an insurance company or the insurance company is merely providing administrative services).

Summary of Material Modification

Any change to a plan that materially affects the design or administration must be reported to plan participants in a Summary of Material Modifications (SMM). The SMM must be distributed within 210 days after the end of the plan year in which the modification took place. If the modification is any material reduction in services or benefits, the SMM must be distributed to all plan participants within 60 days of the date the change is made.

A reduction in covered services or benefits generally will include any plan modification or change that:

- Eliminates benefits payable under the plan.
- Reduces benefits payable under the plan.
- Increases premiums, deductibles, co-insurance, co-payments or other amounts to be paid by a participant or beneficiary.
- Reduces the service area covered by a health maintenance organization.
- Establishes new conditions or requirements (e.g., preauthorization requirements) to obtaining services or benefits under the plan.

Modifications to a plan also require updating SPDs and other plan documents. The SMM gives the participants an interim statement of the changes to the plan before a new SPD can be issued.

Grandfathered Plans

Grandfathered health plans are exempt from certain requirements under the Affordable Care Act (ACA). A plan loses its grandfathered plan status if it makes certain changes to reduce its benefits or increase the participant's out-of-pocket costs.

Quick Facts:

A group health plan is grandfathered if it was in existence as of **March 23, 2010** and since then it has not made any of the following changes:

- Eliminate all, or substantially all, benefits to diagnose or treat a particular condition.
- Increase a percentage-based cost-sharing requirement (e.g., increase the participant's co-insurance from 20 percent to 25 percent).
- Increase a deductible or out-of-pocket maximum by an amount that exceeds medical inflation plus 15 percentage points.
- Increase a co-pay by an amount that exceeds medical inflation plus 15 percentage points (or, if greater, $5 plus medical inflation).
- Decrease the employer's share of the coverage cost by more than 5 percentage points.
- Impose annual dollar limits on benefits.

Grandfathered plans are not subject to the following ACA requirements:

- 100 percent coverage for specific preventive care services.
- Nondiscrimination requirements for insured health plans.
- Limits on out-of-pocket maximums.
- Coverage for participants in clinical trials.
- "Small group" insurance reforms (i.e., adjusted community rating; coverage of all "essential health benefits").

Grandfathered plans must notify participants that the plan is grandfathered. Plans that lose grandfathered status immediately become subject to the ACA's requirements for nongrandfathered plans.

Details:

Plans that were in existence on March 23, 2010 were grandfathered under the Affordable Care Act (ACA). The plans may maintain grandfathered status as long as they do not make changes that reduce benefits for participants and/or increase the participant's out-of-pocket costs. Federal regulations set forth six types of changes that result in immediate loss of grandfathered plan status. Plan changes that are not one of the following six prohibited types of changes do not affect the plan's grandfathered status.

- **Eliminating benefits to diagnose or treat a particular condition**. The plan loses grandfathered status if the plan eliminates all, or substantially all, benefits to diagnose or treat a particular condition. For example, terminating or reducing the plan's coverage for diabetes, cystic fibrosis or HIV/AIDS would result in immediate loss of grandfathered plan status.

- **Increasing percentage-based cost-sharing (co-insurance).** Any increase in the participant's required co-insurance is a change resulting in loss of grandfathered status. For instance, if the plan (as of March 23, 2010) paid 90 percent of in-network hospital expenses, the participant's required co-insurance was 10 percent. Any change to reduce the plan's benefit percentage, thus increasing the participant's cost-sharing or co-insurance, is a prohibited change under the grandfathering rules.
- **Increasing deductibles or out-of-pocket maximums.** A significant increase in the plan's deductible or out-of-pocket maximum amounts will cause loss of grandfathered status. However, the plan may increase its deductible(s) and out-of-pocket maximum(s) by a percentage equal to medical inflation plus 15 percentage points without losing grandfathered status. Increases are measured from March 23, 2010 on a cumulative basis and not on an annual basis.
- **Increasing co-pays.** Co-pays typically are fixed-dollar amounts, such as a $25 co-pay per office visit. The plan may increase its fixed-dollar co-pays by no more than the greater of $5 (adjusted annually for inflation) or a percentage equal to medical inflation plus 15 percentage points. The starting point for measuring plan changes always is March 23, 2010. Plans that increase their co-pays in excess of the allowable margins will lose grandfathered status.
- **Reducing Employer Contributions.** A plan does not lose grandfathered status simply because the employee contribution (payroll deduction) increases from year to year. Instead, the grandfathering rules require analyzing the **employer's** contribution toward the plan's cost.

Determine the employer's contribution as a percentage of plan cost (that is, the premium or COBRA rate without admin fee) as of March 23, 2010. Each coverage level or rate tier is analyzed separately. To maintain grandfathered status, the employer's contribution (as a percentage) must not decrease by more than 5 percentage points for any tier of coverage.

For instance, assume that the employer's contribution was 75 percent of the premium for each tier as of March 23, 2010. The carrier's premium rates have increased every year upon renewal. As of January 1, 2014, the employer's contribution is 70 percent of current premium rate for each tier. Although the employees' payroll deductions have increased quite a bit, due to insurance renewal increases and the employer shifting more costs to the employees, these changes have not caused the plan to lose grandfathered status. The employer in this example has not decreased its contribution, as a percentage of plan cost, by more than 5 percentage points as measured from March 23, 2010 to the current date.

- **Imposing Annual Dollar Limits on Benefits.** Plans that did not impose an annual dollar limit on benefits as of March 23, 2010 and later added limits, or plans that reduced the limits after March 23, 2010, lost grandfathered status at the time of the change.

Frequently Asked Questions

Does loss of grandfathered status for one plan affect other plans offered by the same employer?

No. Each benefit package is analyzed separately for grandfathered plan status. For instance, if the employer offers three medical plan options (HMO, PPO and POS), each one's status is determined separately even if all three are provided through a single ERISA plan and/or group insurance contract.

Does a change in carrier cause the plan to lose grandfathered status?

If the carrier change took effect after March 23, 2010 but before November 15, 2010, the plan lost grandfathered status as of the date of the change.

Carrier changes that took effect on or after November 15, 2010 do not affect the plan's grandfathered status as long as the plan had existed in March 2010 and none of the "prohibited" changes had been made. The new carrier will request documentation from the employer to confirm that the plan had maintained grandfathered status.

If the employer contribution structure changes from two tiers to four tiers, does the plan lose grandfathered status?

Employer contributions must be analyzed on a tier-by-tier basis. If a group health plan modifies the tiers of coverage it had on March 23, 2010 (for example, from self-only and family to a multi-tiered structure of self-only, self-plus-one, self-plus-two, and self-plus-three-or-more), the employer contribution for any new tier is tested by comparing it to the contribution rate for the corresponding tier on March 23, 2010.

For instance, if the employer contribution rate for family coverage was 50 percent on March 23, 2010, the employer contribution rate for any new tier of coverage other than self-only (i.e., self-plus-one, self-plus-two, self-plus-three or more) must be within 5 percentage points of 50 percent (i.e., at least 45 percent).

On the other hand, if the plan adds one or more new coverage tiers without eliminating or modifying any previous tiers, and the new coverage tiers cover employees that were not covered previously under the plan, there is no need to analyze the new tiers. For example, if a plan with only a self-only coverage tier added a family coverage tier, the level of employer contribution toward the family coverage would not cause the plan to lose grandfather status.

Do any plan changes other than the five types of prohibited changes affect the plan's grandfathered status?

No. Plan changes do not affect the plan's status as long as the plan does not make any of the specific prohibited changes, measuring from March 23, 2010.

How is medical inflation determined?

Medical inflation is the increase in the overall medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) (unadjusted) published by the U.S. Department of Labor (DOL). To calculate medical inflation for the purposes of the grandfathering rules, the increase in the overall medical care component is computed by subtracting 387.142 (the component published by the DOL for March 2010) from the index amount for any month in the 12 months before the plan change is to take effect and then divide it by 387.142.

To find the CPI-U values, go to the Bureau of Labor Statistics website at www.bls.gov/cpi/tables.htm.

Are there special notice requirements for grandfathered plans?

Yes. Grandfathered plans are required to notify plan participants that the plan considers itself grandfathered. The plan sponsor (employer) or the carrier may provide this notice to participants. The DOL has published a model notice for this purpose, which is available at www.dol.gov/ebsa/grandfatherregmodelnotice.doc.

Important: Failure to provide the grandfathered plan notice to participants will result in loss of grandfathered plan status.

Additionally, the employer or carrier must maintain records documenting the terms of the plan or policy in effect on March 23, 2010, and any other documents necessary to verify, explain, or clarify its status as a grandfathered plan. Documents may include prior and current plan documents, health insurance policies, certificates or contracts, summary plan descriptions, and records of premiums, coverage costs, and employee contribution requirements. Plan participants or state or federal agencies may request to inspect the documents.

Official Guidance:

"Grandfathered Plans …under the Affordable Care Act; Final Rules" (11/18/2015): click here.

Last Reviewed: November 15, 2018

Health Care Reform

Affordable Care Act: 2018 Reporting Requirements for Applicable Large Employers

The Affordable Care Act (ACA) added two employer reporting requirements to the Internal Revenue Code (Code):

- Code § 6056 requires **applicable large employers** (ALEs) to provide an annual statement to each **full-time employee** detailing the employer's health coverage offer (or lack of offer).
- Code § 6055 requires employers (any size) that provide **minimum essential coverage** (MEC) under a **self-funded (uninsured) plan** to provide an annual statement to covered employees and former employees (including information about covered dependents).

The IRS has issued Form 1095-C, ***Employer-Provided Health Insurance Offer and Coverage***, for ALEs to satisfy the requirement under Code § 6056. If the employer self-funds its plan(s), the employer also will use Form 1095-C to satisfy the additional requirement under Code § 6055. Employers providing any Forms 1095-C also must file copies with the IRS using a transmittal form, Form 1094-C, ***Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns***. In addition, the transmittal form requests aggregated information.

GETTING STARTED

Based on 2017 employee records, determine if your organization is an ALE for 2018. If so:

- For each month in 2018, identify which employees are **full-time employees**:
  - Determine whether you offered health coverage to that employee (and children) for that month; and
  - Determine the type of health coverage offered (Minimum essential coverage? Minimum value coverage that is affordable?).

If you self-fund any plan providing minimum essential coverage in 2018, regardless of whether you are an ALE, identify all covered persons (e.g., full-time employees, part-time employees, COBRA, dependents).

REPORTING 2018 INFORMATION FOR AN ALE THAT OFFERS ONLY INSURED PLAN(S) OR NO PLAN

Form 1095-C (Employee Statement)	Form 1094-C (Transmittal to IRS)

Form is required for employees that are full-time employees for any month in 2018.
• Complete Part I:
  • Employer information (name, EIN, address, phone)
  • Employee information (name, SSN, address)
• Complete Part II:
  • Health coverage offer information by month, if any
  • Employee's share of monthly premium for lowest-cost self-only minimum value coverage
  • Safe harbor information, by month
• Leave Part III blank
	• Employer information (name, EIN, address, phone)
	• Information about whether you offered coverage to 95 percent of your full-time employees (and children)
	• Total number of Forms 1095-C you issued to employees
	• Full-time employee counts by month
	• Total employee counts by month
	• Information about members of your aggregated ALE group, if any

REPORTING 2018 INFORMATION FOR AN EMPLOYER THAT PROVIDES A SELF-FUNDED HEALTH PLAN (ASSUMES EMPLOYER ALSO IS AN ALE)	
Form 1095-C (Employee Statement)	**Form 1094-C (Transmittal to IRS)**

Form is required for any employee or former employee covered under the self-funded plan for any month in 2018:
• Complete Part I:
  • Employer information (name, EIN, address, phone)
  • Employee information (name, SSN, address)
• Complete Part II for each employee or former employee:
  • Health coverage offer information by month, if any
  • Employee's share of monthly premium for lowest-cost self-only minimum value coverage
  • Safe harbor information, by month
Note: The items required vary based on the individual full-time employee, non-full-time employee, COBRA, etc.).
• Complete Part III regarding each individual (including dependents) covered under the self-funded plan:
  • Name, and SSN or TIN
  • Months of coverage
	• Employer information (name, EIN, address, phone)
	• Information about whether you offered coverage to 95 percent of your full-time employees (and children)
	• Total number of Forms 1095-C you issued to employees
	• Full-time employee counts by month
	• Total employee counts by month
	• Information about members of your aggregated ALE group, if any

Definitions:

Full-time employee is a common-law employee averaging at least 30 hours of service per week (or 130 per month), as determined under one of two specific measurement methods. An hour of service is each hour for which payment is made or due (e.g., performance of duties, vacation, holidays, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence).

An applicable large employer (ALE) is an employer that had an average of 50 or more full-time employees (including full-time-equivalent employees) in the prior calendar year. For example, an employer's size in 2017 determines whether the employer is an ALE for 2018. Related employers in a controlled group must be counted together.

Minimum essential coverage (MEC) means any employer-sponsored group health plan with medical benefits. "Excepted benefits" (e.g., most types of dental and vision plans, flexible spending accounts (FSAs), employee assistance programs (EAPs), and fixed indemnity plans) are not minimum essential coverage.

Minimum value coverage (MV) means the minimum essential coverage plan's share of total allowed cost of benefits is at least 60 percent of such costs. "Affordable" means the employee's required contribution for self-only coverage does not exceed 9.56 percent (2018) of the employee's income from the employer.

COBRA Notices

Administering the COBRA Program

1. Provide the COBRA general notice to all new employees and/or new enrollees within the first **90 days** of coverage.
2. Provide the employee and/or his or her qualified beneficiaries (dependents) with the Model COBRA Election Notice **within 14 days** if any of the following qualifying events occur:

   Note: This is the timing requirement for a Plan Administrator that is not also the employer. An employer has either 30 days to notify the plan administrator OR if the employer is also the plan administrator, 44 days to notify the employee and dependents.

   - The employee is terminated for reasons other than gross misconduct or experiences a reduction in hours;
   - The employee dies; and/or
   - The employee becomes entitled to Medicare.
3. Notify the health plan or TPA of the qualifying event within 30 days of event.
4. For qualified beneficiaries, upon notification from the employee, provide the employee and/or qualified beneficiaries with the Model COBRA Election Notice **within 14 days** of any of the following qualifying events:

   - Employee divorce;
   - Employee legal separation; and/or
   - An employee's child losing dependent status under the plan.
5. Notify the health plan or TPA of the qualifying event within 60 days of the event.
6. Track when the COBRA election is due — the employee has at least 60 days to elect or decline COBRA coverage.
7. If COBRA is not elected within 60 days, file the information in the appropriate internal files.
8. If COBRA is elected, collect payment for the first month's coverage within 45 days of the COBRA election.
9. After the first month, if COBRA payments are late, provide the qualified beneficiary with the appropriate 30-day grace period notice including a notice of nonpayment.
10. If payment is not received after the 30-day grace period, provide a notice of early termination of COBRA coverage.
11. If late or "short" payment is received, notify the qualified beneficiary in writing and follow steps 8 and 9, if appropriate.
12. Track when COBRA benefits are scheduled to be exhausted.
13. Offer conversion options to the qualified beneficiary 180 days before COBRA benefits are exhausted, if applicable.
14. If a second qualifying event occurs during the COBRA period, extend COBRA rights appropriately with the carrier and notify the qualified beneficiary.

HIPPA Portability and Non-Discrimination Required Notices

HIPAA Portability and Nondiscrimination Requirements

The Health Insurance Portability and Accountability Act (HIPAA) includes provisions of federal law governing health coverage portability, health information privacy and security, administrative simplification, medical savings accounts, and long-term care insurance. This segment of the materials concerns the act's **portability and nondiscrimination requirements**.

The portability provisions of HIPAA, as the name implies, are intended to make it easier for employees to change jobs without the risk of losing their health insurance. It also limits the length of time a health plan can exclude coverage due to a pre-existing medical condition.

HIPAA's portability and nondiscrimination provisions affect group health plan coverage in the following ways:

- By providing certain individuals special enrollment rights in group health coverage when specific events occur, for example, the birth of a child (regardless of any open season).
- By prohibiting discrimination in group health plan eligibility, benefits, and premiums based on specific health factors.
- While HIPAA previously provided for limits with respect to pre-existing condition exclusions, new protections under the Affordable Care Act (ACA) now prohibit pre-existing condition exclusions for plan years that began on or after January 1, 2014.*

*Plan years that began on or after January 1, 2014 are no longer required to issue the general notice of pre-existing condition exclusion and individual notice of period of pre-existing condition exclusion. Plans are also no longer required to issue certificates of creditable coverage after December 31, 2014. For more information, see Pre-Existing Condition Exclusions.

Special Enrollment

The HIPAA rules regarding special enrollment are located at 29 C.F.R. § 2950.701-6. Group health plans are required to provide special enrollment periods during which individuals who previously declined health coverage for themselves and their dependents may be allowed to enroll (regardless of any open enrollment period). In addition to HIPAA special enrollment rights, the Children's Health Insurance Program Reauthorization Act (CHIPRA) added additional special enrollment rights under the Employee Retirement Income Security Act (ERISA).

Special enrollment rights can occur when:

- An individual loses eligibility for coverage under a group health plan or other health insurance coverage (such as an employee and his or her dependents' loss of coverage under the spouse's plan) or when an employer terminates contributions toward health coverage.
- An individual becomes a new dependent through marriage, birth, adoption, or being placed for adoption.
- An individual loses coverage under a state Children's Health Insurance Program (CHIP) or Medicaid program, or becomes eligible to receive premium assistance under those programs for group health plan coverage.

Employees must receive a description of special enrollment rights on or before the date they are first offered the opportunity to enroll in the group health plan. In addition, employers that maintain a group health plan in a state with a CHIP or Medicaid program that provides for premium assistance for group health plan coverage must provide a notice to all employees to inform them of possible opportunities in the state in which they reside.

For more details on special enrollment, see the HIPAA Special Enrollment Rights Chart.

Nondiscrimination Requirements

HIPAA's nondiscrimination rules are located at 29 C.F.R. § 2590.702.

Prohibited Discrimination in Rules for Eligibility

Under HIPAA's nondiscrimination rules, group health plans may not establish any rule for eligibility that discriminate on the basis of a health factor. ***Health factors*** include:

- Health status.
- Medical condition, including both physical and mental illnesses.
- Claims experience.
- Receipt of health care.
- Medical history.
- Genetic information.
- Evidence of insurability (including conditions arising from acts of domestic violence, as well as participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities).
- Disability.
- Any other health status-related factor determined appropriate by the U.S. Department of Health and Human Services (HHS).

Rules for eligibility include, but are not limited to, rules relating to:

- Enrollment.
- The effective date of coverage.
- Waiting (or affiliation) periods.
- Late and special enrollments.
- Eligibility for benefit packages (including rules for individuals to change their selection among benefit packages.
- Benefits (including rules relating to covered benefits, benefit restrictions, and cost-sharing mechanisms such as coinsurance, copayments, and deductibles).
- Continued eligibility and terminating coverage.

Application to Benefits

Under HIPAA's nondiscrimination rules, a group health plan is not required to provide coverage for any particular benefit to any group of similarly situated individuals; however, benefits provided under a group health plan must be uniformly available to all similarly situated individuals. Likewise, any restriction on a benefit or benefits must apply uniformly to all similarly situated individuals and must not be directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. ***Similarly situated individual*** generally refers to an employee who can be compared to another employee because he or she holds a similar job classification, comparable duties, skills, and training, and is subject to the same standards.

Plans may apply different rules regarding eligibility, benefits, premiums, and contributions to individuals who are not similarly situated. A plan may treat distinct groups of employees as not similarly situated if the distinction is based on a bona fide employment-based classification consistent with the employer's usual business practice. Examples include:

- Full-time versus part-time status.
- Different geographic location.
- Membership in a collective-bargaining unit.
- Date of hire.
- Length of service.
- Current employee versus former employee status.
- Different occupations.

In the case of covered persons other than employees, a plan may treat such beneficiaries as not similarly situated if the distinction is based:

- On a bona fide employment-based classification of the participant through whom the beneficiary is receiving coverage.
- On a relationship to the participant (for example, as a spouse or as a dependent child).
- On marital status.
- With respect to children of a participant, on age or student status.
- On any other factor if the factor is not a health factor.

Note: The ACA imposes additional constraints on the ability of plans that provide dependent coverage to exclude or terminate coverage for the children of participants.

The nondiscrimination rules do permit a plan to provide more favorable rules for eligibility for individuals with adverse health factors, such as disability, than for individuals without the adverse health factor. In addition, a plan may charge a higher premium or contribution to individuals with an adverse health factor if the individual would not be eligible for the coverage were it not for the adverse health factor.

The rules also permit plans to provide premium and benefit incentives in connection with a wellness program that meets certain requirements.

Premiums and Contributions

A group health plan may not require an individual, as a condition of enrollment or continued enrollment, to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan based on any health factor that relates to the individual or a dependent.

Discounts, rebates, payments in kind, and any other premium differential mechanisms are taken into account in determining an individual's premium or contribution rate.

Note that this does not prevent a group insurer from underwriting a group as a whole based on the health of the group's participants, provided that it does not charge any particular participant a higher premium than it charges for a similarly situated participant based on health status.

Nonconfinement

A group health plan may not establish a rule for eligibility or set any individual's premium or contribution rate based on whether an individual is confined to a hospital or other health care institution (known as a "nonconfinement clause"). Typically, a nonconfinement clause will deny or delay eligibility for some or all benefits if an individual is confined to a hospital or other health care institution. Nonconfinement clauses may also deny or delay eligibility if an individual cannot perform ordinary life activities.

Actively-at-Work and Continuous Service Provisions

Many group health plans include an "actively-at-work" provision (i.e., a requirement that an employee be actively at work after a waiting period for enrollment in order to have health coverage become effective on that day).

Generally, a group health plan may not establish a rule of eligibility or set any individual's premium or contribution rate based on whether an individual is actively at work, unless absence from work due to any health factor (such as being absent from work on sick leave) is treated, for purposes of the plan or health insurance coverage, as being actively at work.

Exception for the First Day of Work

Notwithstanding the general rule, plans may establish a rule for eligibility that requires an individual to begin work for the employer sponsoring the plan (or, in the case of a multi-employer plan, to begin a job in covered employment) before coverage becomes effective, provided that such a rule for eligibility applies regardless of the reason for the absence.

Source-of-Injury Exclusions

A group health plan may not deny benefits otherwise provided for the treatment of an injury based on the source of that injury. If the injury results from a medical condition or an act of domestic violence, a plan may not deny benefits for the injury if it is an injury the plan would otherwise cover.

For example, a plan may not exclude coverage for self-inflicted injuries (such as injuries resulting from attempted suicide) if the individual's injuries are otherwise covered by the plan and if the injuries are the result of a medical condition (such as depression). A plan **may exclude coverage** for injuries that do not result from a medical condition or domestic violence, such as injuries sustained in high risk activities (for example, bungee jumping). However, the plan could not exclude an individual from **eligibility for coverage** because the individual participates in high risk activities such as bungee jumping.

Wellness Program Rules

On June 3, 2013, a final rule was published regarding the use of incentives in wellness programs. Under the final rule, group health plans may discriminate based on health factors through wellness programs, if such programs are established and maintained in accordance with federal regulations.

All employer-sponsored health promotion and disease prevention programs are considered to be wellness programs, and if they are tied to the employer-sponsored health plan, they must meet the requirements of HIPAA's nondiscrimination provisions.

Types of Wellness Programs

The final rule divides wellness programs into two types:

- Participatory wellness programs.
- Health-contingent wellness programs.

Participatory Wellness Programs

Participatory wellness programs are programs that either do not provide a reward or do not include any conditions for obtaining a reward that are based on an individual satisfying a standard that is related to a health factor. Examples include:

- A program that reimburses employees for all or part of the cost of membership in a fitness center.
- A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.
- A program that provides a reward to employees for attending a monthly, no-cost health education seminar.

Note: These programs are deemed to comply with the HIPAA nondiscrimination rules.

Health-Contingent Wellness Plans

Health-contingent wellness programs require an individual to satisfy a standard related to a health factor to obtain a reward (or require an individual to undertake more than a similarly situated individual based on a health factor in order to obtain the same reward). This standard may be performing or completing an activity relating to a health factor, or it may be attaining or maintaining a specific health outcome.

There are two types of health-contingent wellness programs:

- Activity-only wellness programs.
- Outcome-based wellness programs.

Activity-only wellness programs require an individual to perform or complete an activity related to a health factor in order to obtain a reward. Activity-only wellness programs do not require an individual to attain or maintain a specific health outcome. Examples of activity-only wellness programs include walking, diet, or exercise programs.

Outcome-based wellness programs require an individual to attain or maintain a specific health outcome (such as not smoking or attaining certain results on biometric screenings) in order to obtain a reward.

The reward may be a discount or rebate of premium, waiver of all or part of a cost-sharing mechanism (deductible, co-payment or co-insurance); it may also be the absence of a penalty, such as a surcharge or the reduction of a benefit that would otherwise be provided under the health plan.

These programs must satisfy certain requirements to comply with HIPAA's nondiscrimination rules.

Application of HIPAA Nondiscrimination Rules

Health-contingent wellness programs must meet the following five requirements to satisfy HIPAA nondiscrimination rules:

1. **Limited Reward:** If the reward is tied to a group health plan, the total reward for meeting the wellness standard, combined with any other rewards for health factor-based programs under the same plan, cannot exceed the allowable percentage of the full cost of coverage under that health plan. Full cost of coverage includes the total cost of the employer and employee contribution, including the total cost of family coverage if dependents are allowed to participate in the program. For plan years that began on after January 1, 2014, the allowable percentage cannot exceed 30 percent; however, an additional 20 percent can be added if connected to a program designed to decrease tobacco usage.
2. **Reasonable Design:** The program must be reasonably designed to promote health or prevent disease.
3. **Annual Opportunity to Qualify:** The program must give eligible participants an opportunity to qualify for the full reward at least once a year. If a participant initially declines to participate but joins in the middle of the plan year, the plan is not required to offer the reward until the start of the next plan year.
4. **Uniform Availability:** The full reward must be available to all similarly situated individuals and provide reasonable alternative standards for persons unable to otherwise qualify for the full reward based on a health factor.
5. **Disclosure of Reasonable Alternatives:** Plan materials describing wellness program standards must disclose that a reasonable alternative standard is available to participants for whom it is unreasonably difficult or medically inadvisable to meet the standard required to earn the reward. This disclosure must include contact information for requesting an alternative standard and a statement that the recommendations of the individual's personal physician will be accommodated. This disclosure must also be provided with any notice that the individual failed to satisfy the initial standard of an outcome-based program.

The primary difference between the two types of health contingent wellness programs relates to the rules regarding uniform availability and alternative standards. These rules are summarized next.

Activity-Only Programs

An activity-only program must allow a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom:

- It is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard.
- It is medically inadvisable to attempt to satisfy the otherwise applicable standard.

The program may reasonably require a statement from the individual's physician verifying that the individual meets the "unreasonably difficult" or "medically inadvisable" criteria.

Plans are not required to determine a particular reasonable alternative standard in advance of an individual's request for one; however, a reasonable alternative standard must be furnished by the plan upon the individual's request or the condition for obtaining the reward must be waived. In determining whether a particular alternative standard is reasonable, the following factors should be taken into account:

- If the reasonable alternative standard is completion of an educational program, the plan or issuer must make the educational program available or assist the employee in finding such a program (instead of requiring an individual to find such program unassisted), and may not require an individual to pay for the cost of the program.
- The time commitment required must be reasonable.
- If the reasonable alternative standard is a diet program, the plan is not required to pay for the cost of food but must pay any membership or participation fee. If an individual's personal physician states that a plan standard is not medically appropriate for that individual, the plan must provide a reasonable alternative standard that accommodates the recommendations of the physician.

Outcome-Based Wellness Programs

These programs typically involve an initial screening measurement or test to determine which individuals already meet some specified standards. These may also involve annual repetition of the tests and programs for those individuals who do not meet the standards. Examples of outcome-based wellness programs include a program that tests individuals for specified medical conditions or risk factors (such as high cholesterol, high blood pressure, abnormal BMI, or high glucose level) and provides a reward to employees identified as within a normal or healthy range (or at low risk for certain medical conditions). The program requires employees who are identified as outside the normal or healthy range (or at risk) to take additional steps (such as meeting with a health coach, taking a health or fitness course, adhering to a health improvement action plan, or complying with a health care provider's plan of care) to obtain the same reward.

Reasonable alternative standards for outcome-based programs must meet the following requirements:

- The reasonable alternative standard (or waiver) for obtaining the reward must be available for any individual who does not meet the initial standard based on the measurement, test, or screening.

- The "unreasonably difficult" or "medically inadvisable" standards do not apply to outcome-based programs as a condition of providing a reasonable alternative standard, and no physician's verification can be required. However, if the alternative standard is itself an activity-only program, the same rules that otherwise apply to such programs apply to the alternative standard.
- If the alternative standard is itself an outcome-based program, it must comply with special rules:
  - The reasonable alternative standard cannot be a requirement to meet a different level of the same standard without additional time to comply that takes into account the individual's circumstances. For example, if the initial standard is to achieve a BMI less than 30, the reasonable alternative standard cannot be to achieve a BMI less than 31 on that same date. However, if the initial standard is to achieve a BMI less than 30, a reasonable alternative standard for the individual could be to reduce the individual's BMI by a small amount or small percentage, over a realistic period of time, such as within a year.
  - An individual must be given the opportunity to comply with the recommendations of the individual's personal physician as a second reasonable alternative standard to meeting the reasonable alternative standard defined by the plan, but only if the physician joins in the request. The individual can make a request to involve a personal physician's recommendations at any time and the personal physician can adjust the physician's recommendations at any time, consistent with medical appropriateness. If the physician suggests that an activity-only weight loss program is appropriate, the plan must comply but has a say on which weight loss program should be used.

Wellness programs that do not offer plan-based incentives do not have to comply with the HIPAA wellness rules. This includes programs that have incentives such as cash, gifts, or time off for meeting program goals.

Wellness Programs and the ADA

Employer-sponsored wellness programs that require participants to complete a health risk assessment or participate in a health screening must comply with the Americans with Disabilities Act (ADA). The ADA strictly limits when an employer may make disability-related inquiries of employees or ask them to take medical examinations. However, it permits such activities when they are part of a voluntary wellness program.

In recent years, the Equal Employment Opportunities Commission (EEOC) has sued several employers regarding their employer-sponsored wellness programs. The EEOC has claimed that these plans violated the ADA because employees are penalized in order to induce them to go through medical examinations that are not "job-related or consistent with business necessity."

Special Health Care Notices

Employers sponsoring group health plans must provide certain notices and disclosures to persons eligible for enrollment. Federal law requires providing various notices at different times, such as when the employee first becomes eligible, at each enrollment opportunity, and/or annually. For convenience and to reduce administrative costs, many employers choose to distribute various required notices with their annual open enrollment materials.

The chart below summarizes the health plan notices commonly distributed during open enrollment season. For sample notices and model language, click on the links.

Insured Health Plans: Plans provided through group insurance policies are subject to state insurance laws which may apply in addition to, or in place of, one or more of the federal notice requirements summarized below. In that case, the insurance carrier may prepare and distribute certain notices. Employers are advised to coordinate with the carrier to ensure that all requirements are met.

NOTICE	PURPOSE	MODEL LANGUAGE
Disclosure of Grandfathered Plan Status ***For grandfathered health plans only.***	Discloses that the plan is grandfathered and may not include certain consumer protections that apply to other plans; provides contact information.	For model language, see Grandfathered Plan Notice.
Disclosure of HIPAA Opt-Out ***For certain self-funded non-federal governmental plans only. (This is uncommon.)***	Discloses that the self-funded non-federal governmental plan has opted out of certain federal mandates, such as mental health parity.	For model language, see NFGP HIPAA Opt-Out Notice.
Employer CHIP Notice	Provides information about possible premium assistance for low-income families under a state's Medicaid or Children's Health Insurance Program (CHIP).	The current notice is available at CHIP Notice.
HIPAA Privacy Notice ***For self-funded plans, or insured plans if the employer has access to protected health information.***	Describes ways that the plan may use and disclose individual protected health information, participant's rights, and the plan's duties to protect the information.	For model language, see Model Privacy Notices. **Note:** Notice is required at initial enrollment only. Thereafter, a reminder of notice's availability is required every three years.

NOTICE	PURPOSE	MODEL LANGUAGE
Medicare Part D – Notice of Creditable (or Non-Creditable) Coverage	Informs Medicare-eligible persons as to whether the group health plan's prescription drug coverage is at least as good as (i.e., creditable) as Medicare Part D coverage.	For model notices and instructions, see Creditable Coverage Model Notice Letters and Creditable Coverage. **Note:** Distribute each year before **October 15** (regardless of group health plan's open enrollment dates).

NOTICE	PURPOSE	MODEL LANGUAGE
Newborns' and Mothers' Health Protection Act Notice	Describes required plan benefits for maternity and newborn coverage.	For model language, see page 140 in the DOL Compliance Assistance Manual. **Note:** Separate distribution is not required if notice appears in plan's summary plan description (SPD).
Notice of Patient Protections *For non-grandfathered plans only.*	Describes the plan's patient protections, e.g., designation of primary care provider, OB/GYN care without prior authorization or referral.	For model language, see page 150 in the DOL Compliance Assistance Manual. **Note:** Separate distribution is not required if notice appears in plan's summary plan description (SPD).
Special Enrollment Rights Notice	Describes the plan's special enrollment rules for persons who become newly eligible (due to marriage, birth of child) or who lose coverage under another plan before the next annual enrollment period.	For model language, see page 138 in the DOL Compliance Assistance Manual.
Summary of Benefits and Coverage (SBC) and Uniform Glossary	Provides a short, easy-to-understand summary of the plan's benefits and coverage and a glossary of standard terms.	For templates and instructions for preparing the SBC, see the "for use on or after 04/01/17" section at Guidance on SBCs.

NOTICE	PURPOSE	MODEL LANGUAGE
Wellness Program Disclosures ***For certain wellness programs only.***	One or two notices may be required depending on the wellness program's features: HIPAA notice is required for a health-contingent wellness program that is subject to the alternative standard rule. EEOC notice is required if the wellness program collects participant health information, e.g., health risk assessments, biometric screenings.	For model language under HIPAA, see page 139 of the DOL Compliance Assistance Manual. For a sample EEOC notice, see EEOC Wellness Notice.
Women's Health and Cancer Rights Act Notice	Describes required plan benefits for mastectomy-related services.	For model language, see page 141 (enrollment notice) and page 142 (annual notice) in the DOL Compliance Assistance Manual. **Note:** The enrollment notice is required at initial enrollment only. In following years, either the enrollment notice or the annual notice can be used.

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Form 5500 Annual Reporting Requirements

The content of this article was authored by Stacy Barrow, Partner at Marathas Barrow Weatherhead Lent LLP and Nicole Quinn-Gato, legal editor at ThinkHR.

Consequences for ERISA Plan Document Failures

Failure to timely provide a copy of plan materials to the DOL upon request:

- Up to: $152 Maxed at $1527

DOL may consider the level of "willfulness" in determining the amount of the penalty.
Failure to timely provide a copy of plan materials (including SPDs) to employees upon proper request:

- $110 per day

Penalties are obtained in civil litigation (not automatically assessed).

Consequences for ERISA Plan Document Failures

Other civil exposure:

- Private lawsuits brought by employees
- Breach of fiduciary duty claims

Considerations for self-funded plans:

- Plans should include:
    - Compliant ERISA claims and appeals provisions
- Subrogation provisions

Consequences for Cafeteria Plan Document Failures

No written plan document or employer fails to operate the plan according to its terms:
No written plan document or employer fails to operate the plan according to its terms:

- Employer may be deemed not to have a cafeteria plan
- Employee's elections between taxable and nontaxable benefits may result in gross income to employees
- Payroll tax issues for employers
- Employee relations issues

What is ERISA?

- The Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C.
- Applies to most private employers (including non-profits) and employee organizations (unions) regardless of size
- Common health and welfare benefits subject to ERISA include (but are not limited to):
    - Group health and medical insurance (HMO, PPO, HDHP, EPO)
    - Group dental and vision plans
    - Health flexible spending accounts (health FSAs)
    - Life and accident insurance plans

What is a Cafeteria Plan?

- A cafeteria plan is tax-advantaged, employer-sponsored plan offered pursuant to Section 125 of the Internal Revenue Code (IRS Code)
- Allows employees to make pre-tax contributions to applicable, qualified benefits
- Qualified benefits include (but are not limited to):
    - Group medical, dental, and vision plans
    - Flexible spending accounts (FSAs)-health FSAs and dependent care flexible spending accounts (DCAPs)

Types of Cafeteria Plans

Premium only plans (POP):

- For plans where an employee makes pre-tax contributions for their share of premium costs (ex. Medical plan)
- Does not include health FSAs or dependent care FSAs

Flexible benefit plans:

- Contain additional components, such as health or dependent care FAs, flex credits
- Subject to both ERISA and cafeteria plan document requirements
- Usually incorporate an employer's premium conversion program (pre-tax contribution)

Flex credits:

- Can be part of a flexible benefit plan
- Employer provides employees a specified number of credits to a spend on their benefits and a menu of benefit options
- Usually incorporates an employer's premi9um conversion program

ERISA Requirements:

Plan Document

- ERISA requires that every employee benefit plan be established and maintained pursuant to a written plan document that describes the benefit structure and guides the plan's day-to-day operations
- Must be provided to participants and beneficiaries no later than 30 days after a written request
- The plan document must include certain required details about plan operation and funding policies and procedures, among others

SPD

- ERISA must distribute a summary plan description (SPD) to participants and beneficiaries that informs them about the plan and how it operates
- The SPD must be consistent with the terms of the plan and written in a manner that the average person could understand

SPDs must include all content specified in ERISA regulations

Wrap Documents

- Failure to have an ERISA compliant SPD can result in problems for an employer
- To address these issues, many employers use a wrap document
- A wrap document:
    - Fills the gaps where carrier documents may be lacking
    - Informs employees of all eligibility requirements imposed by the employer
    - Includes all required notices
    - Can reduce employer reporting obligations (Form 5500)

Cafeteria Plan Requirements

Plan Document

- Must have a written plan document that includes all content specified in the IRS code, including participation rule and election periods and requirements, among others.
- Documents must be created and amended prospectively.

SPD

- POP Plans:
    - Not an ERISA benefit
    - No SPD required
- Health FSA:
    - ERISA benefit
    - Must comply with ERISA SPD requirements
    - Health FSA cafeteria plan document often helps define the terms of the ERISA benefit where other plan materials may be lacking in detail
    - Dependent care FSA included in the cafeteria plan document, but general is not subject to ERISA

Health Reimbursement Account (HRA)

- Medical reimbursement accounts (Section 105 of the IRS Code)
- ERISA benefit

Must comply with ERISA SPD requirements

Distribution Requirements

Plan Documents

- DOL ERISA Plans-the latest updated copy must be provided to:
    - Participants and beneficiaries with 30 days of a written request
    - The DOL within 30 days of request

Cafeteria Plans

- Provided to participants and beneficiaries upon request:
    - Health FSAs follow ERISA requirements
    - Disclosure also required for dependent care FSAs

SPDs
The most recent SPD must be provided to:

- The DOL within 30 days of a request
- Participants and beneficiaries:
    - Within 120 days after a plan first becomes subject to ERISA
    - Within 90days after an individual becomes a participant
    - Every 5 years if there have been any changes to the plan during the 5-year period (and a summary of material modification is provided)
    - Every 10 years if there have been no changes to the plan
    - Within 30 days of a plan participant's or beneficiary's request

Distribution requirements

- When substantive information in an SPD changes, the plan sponsor must notify the participants of the changes
- Two Options:
    - Amend and restate the entire plan and distribute the updated SPD to participants; or
    - Prepare a summary of material modifications (SMM) that informs participants of the change
- SMM or amended and restated SPD must be provided to each participant no later than 210 days after the end of the plan yea in which the change is adopted

Electronic distribution requirements

ERISA regulations permit electronic delivery of notices if certain requirements are met:

- Use delivery steps for furnishing documents that are reasonably calculated to result in the actual receipt of the documents
- Use return-receipt or notice of undelivered e-mail features
- Conduct periodic reviews or surveys to confirm receipt
- Take reasonable and appropriate steps to safeguard confidentiality of personal information
- Prepare/furnish notices in a manner consistent with applicable style, format and content requirements
- Make a paper version available on request (at no charge)
- Provide recipients a notice (electronic or paper) describing the significance of the document when it is furnished electronically

Once basic requirements are met, document may be furnished to two classes of protentional recipients:

- **Participants who have the ability to access documents through employer's electronic information system** located where they are reasonably expected to perform duties (no kiosks)
- **Other participants** (retirees and terminated participants with vested benefits, beneficiaries, alternate payees), who must:
    - Affirmatively consent to receive the documents electronically
    - Provide an electronic address
    - Reasonably demonstrate their ability to access documents in electronic form

Electronic distribution requirements apply to other notices required under ERISA and other federal laws impacting employee benefits, including SMMS, COBRA Notices, Marketplace Notices, etc.

Document retention requirements

Cafeteria plans and ERISA

What to keep:

- COBRA Notices
- Corporate resolutions/committee actions related to the plan
- Plan disclosures and communications to participants, such as form 5500s, SARs, SPDs, SMMs, etc.
- Financial reports, audits, and related statements
- Nondiscrimination testing result
- Disputed claim records in the event of future litigation
- Payroll and census data used to determine eligibility and contributions
- Notices of Creditable/Non-creditable coverage (Medicare Part D)

Document Retention Period:

- Basic Rule: Plan documents, SPDs, other documents required by ERISA and/or Secion 125 (annual reports, disclosures, amendments) and any corporate resolutions should be retained for six years after the date of filing, resolution, or amendment:
    - Materials should be preserved in a manner and format that permit ready retrieval
    - Create a paper trail-consider retaining official plan

DOL Audits

Understand the Facts

- Size or type of employer irrelevant
- Geographic area in which an employer is located is irrelevant
- Audits are generated by more than just complaints
    - Every year thousands of ERISA-governed plans are randomly selected for audit by governmental agencies
    - DOL has significantly increased audit enforcement in recent years

How they work

- General, a plan sponsor receives a letter request from the DOL that says:
    - DOL intends to review a “plan” (could be all plans offered or a specific plan)
    - DOL will visit on a certain date unless the plan sponsor provides documentation requested by the time period specified in the letter (usually a very short time period)

What they Audit

- Plan documentation (plan document, SPDs, SMMs, SARs)
- Compliance with electronic distributions rules (if distributing electronically)
- Document retention
- HIPAA privacy
- Cafeteria plans
- Mental Health Parity (MHPA and MHPAEA)
- Compliance with ACA mandates
- Form 5500

Hot Button Issues

- Grandfathered Plans:
  - Disclosure statements regarding grandfathered status
  - Records (including ancillary materials) documenting the terms of the plan on March 23, 2010
  - SPD provisions if the "Age 26/Other Employment Exclusion" is claimed
- Wellness plans (often incorporated in group health plan)
  - Health contingent programs
    - Reward amount-30%/50% requirements
    - Reasonably designed to promote health or prevent disease
    - Participant opportunity to qualify at least once per year
    - Rewards available to all similarly- situated individuals
  - Other ERISA, ADA, and GINA compliance issues

- Mental Health Parity and Addiction Equity Act
  - Big focus on non-quantitative treatment limitations (NQTL):
    - NQTLs are limits on the scope or duration of treatment that are not expressed numerically (ex. Medical management standards)
    - Two new illustrative NQTLs:
      - Network tier design
      - Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage

IRS Enforcement Focus

- Generally, do not engage in enforcement activities for cafeteria plans independently
- May occur in conjunction with other enforcement activities
- May result from information-sharing between agencies

Plan Documentation
- Is there a written plan document?
- Is the plan sponsor operation the plan in accordance with the plan document?

Non-Discrimination Testing
- Testing of all components required at least annually
- Testing required under:
  - Section 125 for cafeteria plans
  - Section 105(h) for health FSAs, HRAs and self-insured medical, dental and vision plans
  - Section 129 for DCAPs
- Tax consequences for highly compensated employees/individuals if testing is failed
- Consequences increase if testing not completed and failures discovered later

Examples of Failing to Operate Cafeteria Plan According to Plan Document

- Pay or reimburse expenses for qualified benefits incurred before the plan was adopted, effective, or amended (whichever is later)
- Offering benefits other than permitted taxable and qualified benefits
- Allowing employees to revoke elections or make new elections inconsistent with election change requirements in the plan document

Key Points

- YOU are responsible for accurate plan documents.
- Failure to timely provide a copy of plan materials to the DOL or employees upon request can result in heavy penalties.

Other consequences include private lawsuits, unhappy employees, and cafeteria plans creating payroll tax issues and amended individual tax filings.

HIPPA Privacy and Security

Guide to Employers

The federal Health Insurance Portability and Accountability Act (HIPAA) covers a wide range of health coverage issues. It includes provisions for portability of coverage, protections for small employers that purchase group insurance, and prohibitions against discrimination based on an individual's health status.

HIPAA also includes a complex set of rules related to the privacy and security of an individual's protected health information (PHI):

- The **Privacy Rule** sets standards for the use and disclosure of PHI as well as standards for the individual's right to understand and control how their information is used. Health plans must establish policies and procedures to protect PHI, ensure its staff is trained on the rules, and provide notices to individuals explaining their privacy rights.
- The **Security Rule** sets security standards to safeguard and protect PHI that is stored or transferred in electronic form. Requirements include physical, technical, and administrative safeguards. In the event of a security breach, the Plan must notify all affected persons, report the breach to the government and, in some cases, notify the media.

The U.S. Department of Health and Human Services (HHS) regulates and enforces the Privacy Rule and Security Rule through its Office for Civil Rights (OCR).

This guide reviews key features of the Privacy Rule and Security Rule ("the Rules") specifically for employers that sponsor group health plans:

- Quick Facts
- The Rules in Brief
- The Employer's Role
- Privacy Notices
- Business Associate Agreements
- HIPAA Authorizations
- Breaches
- Penalties
- Employer Checklist
- Sample Materials

This guide offers general information based on federal regulations and guidance as of September 2017. The guide pertains to employers solely in their role as group health plan sponsors. Employers that also are health care providers, such as hospitals and medical groups, are not addressed. Legal advice is not provided nor intended. Similar to most federal health-related laws, the HIPAA Privacy Rule and Security Rule are extremely complex and all employers are advised to review their unique situation and health plan requirements with experienced legal counsel.

Quick Facts

This guide covers the Rules for group health plans only

The Rules apply to covered entities:

- Health care providers;
- Health care clearinghouses; and
- Health care plans

Employers are not covered entities and the Rules do not apply to employers directly. As group health plan sponsors, however, employers are responsible for their plan's compliance with the Rules.

The extent of the employer's duties depends on whether its group health plan is insured or self-funded and whether the employer has access to protected health information (PHI) for plan administration.

The Rules also apply to **business associates;** i.e., third parties or subcontractors that perform services for the health plan involving the use of PHI. Examples include:

- Third-party administrators, pharmacy benefit managers, and wellness program vendors;
- Legal, actuarial, data aggregation, financial, and other service providers; and
- Brokers and consultants.

An insurer, that is the carrier insuring the health plan, is not a business associate. A health insurer is a covered entity in its own right.

A **health plan** is a plan or program that provides or pays the cost of health care, including insured and self-funded group health plans. So-called "excepted benefits," such as limited-scope dental and vision plans, employee assistance programs (EAPs), and health flexible spending accounts (HFSAs), are not exempt from the Rules.

A narrow exception applies to self-funded self-administered plans with fewer than 50 eligible employees. This is uncommon.

The Rules do not apply to non-health plans or arrangements, such as life or accident insurance, disability income benefits, or workers' compensation. Also, the Rules do not apply to on-site clinics as health plans (although they may be subject to the Rules as health care providers) and do not apply to health savings accounts (HSAs).

Protected health information (PHI) is oral, written, or electronic health information that is:

- Individually identifiable;
- Created, received, stored, or transmitted by the health plan; and
- Related to:
  - An individual's past, present, or future physical or mental health or condition;
  - Providing health care to the individual; or
  - Past, present, or future payment for providing health care to the individual.

The Rules do not apply to **de-identified information**. Information is presumed to be de-identified if 18 specific identifiers (such as names, ID numbers of any kind) are removed and the information cannot be used, alone or in combination with other information, to identify the individual.

Lastly, the Rules do not apply to information, even if individually-identifiable, that does not move through a health plan. Examples include pre-employment screens, sick leave requests, FMLA requests, and return-to-work notes. Although not directly subject to HIPAA, employers nonetheless are advised to safeguard all information as confidential and allow access only to staff with a need to know.

The Rules in Brief

The Rules govern how health plans are allowed to use and disclose PHI. Some uses are permitted without the individual's authorization, either for plan administration purposes or to meet public health and law enforcement needs. Other uses are not permitted unless the individual has given his or her permission by means of a HIPAA Authorization.

Plans must establish and maintain safeguards against unauthorized use or disclosure of PHI, protect against security threats, and ensure compliance by employees that perform functions on the plan's behalf (called the plan's workforce).

The key provisions for health plans are summarized here. The employer sponsoring the health plan may be responsible for a few, or for many, of the provisions depending on the type of plan and administration. We review the different types of employer responsibilities in the next section. This section offers highlights of the rules in general.

The Rules have four basic types of requirements:

- Use and Disclosure Provisions;
- Individual Rights;
- Administrative Safeguards; and
- Security Rule (with respect to electronic PHI)

Use and Disclosure Provisions

Treatment, Payment, and Operations (TPO). The Plan may use and disclose PHI for purposes of treatment, payment, and operations (TPO) without a HIPAA Authorization, provided the Plan:

- Identifies the employees designated to access PHI (i.e., the Plan's workforce);
- Allows only the minimum necessary PHI to be used or disclosed; and
- Ensures that the recipient of the disclosed PHI is entitled to receive it for the stated purpose.

Legal disclosures. The Plan also may disclose PHI without a HIPAA Authorization if required by law. Examples include:

- Disclosures for workers' compensation;
- Court orders and subpoenas;
- Judicial and administrative proceedings; and
- Public health activities.

HIPAA Authorization. The Plan may use and disclose an individual's PHI to the extent the individual has authorized. A valid HIPAA Authorization must meet several criteria. See page 9 for discussion.

Individual Rights

The Rules require the Plan to grant certain rights to individuals. With respect to his or her PHI, each individual may request:

- Copies of PHI for review, either in hard copy or electronically;
- Amendments or changes to PHI;
- Accounting of certain disclosures of PHI;
- Confidential communications; and
- Restrictions.

Administrative Safeguards

The Rules impose extensive administrative requirements which are intended to safeguard PHI. The Plan must:

- Establish written policies and procedures for uses and disclosures and limiting access to PHI;
- Designate a Privacy Officer and Security Officer (most plans also designate a Privacy Contact for routine matters);
- Ensure plan documents, notices of privacy practices, and other materials are compliant;
- Obtain business associate agreements with any third-party administrators, vendors, brokers, or others who will have access to PHI;
- Establish policies for securing information, implementing physical safeguards (such as locked doors and cabinets), and evaluating electronic safeguards; and
- Ensure employees with access to PHI are properly trained on the Plan's policies and procedures.

Security Rule

The Security Rule imposes requirements to protect electronic PHI, which generally is any PHI that is not either handwritten or oral. Even hard copy PHI likely has been created or stored using electronic media.

There are five categories of standards, including administrative, physical, technical, organizational, and documentation requirements. To ensure compliance, the Plan must perform a risk analysis to identify and implement appropriate standards and document the steps its take to meet each standard. The entity's information technology (IT) professionals usually take the lead with these requirements, which are detailed and complex.

The next section reviews how the Rules affect employers that sponsor group health plans. Later sections provide details and sample materials for items that often generate questions from employers: Privacy Notices, Business Associate Agreements, HIPAA Authorizations, and Breach Notifications.

The Employer's Role

The Rules do not apply directly to employers but any employer that sponsors a group health plan is responsible for certain duties on behalf of its plan. The scope of the employer's responsibilities will vary depending on the type of plan and whether the employer has access to PHI.

Employer Type A: (Insured/Hands-Off Approach)

- All plans are insured; that is all coverages are provided through group insurance contracts (including HMO contracts); and
- Employer does not create or receive PHI except for summary health information and/or enrollment forms. (Summary health information contains no individually identifiable information; for example, de-identified claims report. The employer may receive it from the carrier for purposes of obtaining bids or amending or terminating the plan.)

The employer's duties are simple (and should be common practice):

- Refrain from retaliating against plan participant who alleges a violation of the Rules; and
- Do not condition enrollment or eligibility for benefits, treatment, or payment on the individual's waiver of his or her privacy rights.

To continue as Type A, the employer must avoid creating or receiving PHI. For instance, do not assist employees with claim issues. If the employer sends or receives enrollment data electronically, additional duties will apply.

Employer Type B: (Insured/Hands-On Approach)

- Plan is insured; and
- Employer creates or receives PHI that is not merely health summary information or enrollment forms. Examples include managing carve-out plans, certain wellness activities, and assisting with claims issues.

The Plan may disclose PHI to the plan sponsor (employer) provided:

Identify the Workforce and Build a Firewall

The Plan's workforce are specific employees (usually in HR, Benefits, and IT) who perform tasks for the Plan. The workforce may use PHI, if done according to the Rules, but everyone else must be walled off.

- Plan document is amended to allow the plan sponsor to have access to PHI for purposes of plan administration; and
- Plan sponsor certifies that document is amended and agrees to terms and conditions in the amendment (for example limits on uses, description of workforce, firewall).

The Type B employer must comply with numerous Rules. See Employer Checklist on page 13.

Employer Type C: (Self-funded/Hands-On Approach)

Plan is self-funded by the employer. The employer is assumed to have access to PHI since the nature of a self-funded plan is that the employer has final authority for claim decisions.

In this case, the employer is responsible for the Plan's compliance with the Rules. See Employer Checklist on page 13.

On the following pages, we take a closer look at items that often generate questions from employers: Privacy Notices, Business Associate Agreements, HIPAA Authorizations, and Breach Notifications.

Privacy Notices

Health plans are required to distribute a Notice of Privacy Practices (Privacy Notice) to all Plan participants, including covered employees, retirees, and COBRA beneficiaries, that describes:

- The Plan's uses and disclosures of PHI; and
- The individual's rights:
    - To inspect and obtain a copy of his or her PHI;
    - To have the Plan amend PHI;
    - To request restrictions on certain disclosures of PHI;
    - To request confidential communications of PHI; and
    - To receive an accounting of disclosures of PHI made within the prior six years.

Who is Responsible for the Privacy Notice?

The Plan is responsible for maintaining and distributing a Privacy Notice. If the Plan is insured, that means the insurance company. If the employer has access to PHI, other than merely enrollment information for administration purposes, the employer also needs to create and distribute a notice. If, however, the employer's only access to PHI in an insured plan is for administration purposes, the employer does not need to create a notice but must distribute the carrier's notice if a participant requests it.

With respect to self-funded health plans, the employer is responsible for all requirements.

When is the Notice Distributed?

The Privacy Notice must be distributed to Plan participants:

- At the time of his or her initial enrollment in the Plan;
- Upon the individual's request; and
- Within 60 days of a material change in the content of the Notice.

Further, at least once every three years, the Plan must notify participants that the Privacy Notice is available and how to obtain a copy free of charge. The Plan may meet this requirement by distributing either the complete Privacy Notice or a short reminder notice.

How is the Notice Distributed?

Notices must be delivered to the intended recipients. Simply posting the notice on a website or workplace kiosk or bulletin board does not satisfy the distribution requirement.

Electronic distribution is allowed, but the conditions are more restrictive than for other types of benefit notices.

- Notices can be included with other Plan materials, such as the new hire or open enrollment kit. It cannot be part of the same document as a HIPAA authorization.
- The notice can be delivered electronically (by email, for example) but only if the individual has provided his or her consent, including consenting to any hardware or software requirements and acknowledging that his or her consent to receive the notice electronically may be withdrawn at any time.
- If the Plan maintains a website describing services and benefits, the notice must be posted there in addition to distribution to individuals.
- Separate distribution for dependents is not required, unless the Plan knows they have a different address from the employee or if the dependent requests the notice.

Business Associate Agreements (BAAs)

Health plans must receive satisfactory assurances from business associates that PHI will be handled and safeguarded appropriately. To do so, the Plan must enter into a contract, called a business associate agreement (BAA), with each business associate to establish the permitted and required uses and disclosures of PHI. The BAA also must require the business associate to:

- Implement appropriate safeguards (for example, limit access to employees on a need-to-know basis);
- Report to the health plan any known use or disclosure of PHI not permitted by the BAA or any breach of unsecured PHI;
- Ensure that any subcontractors that create, receive, maintain or transmit PHI on behalf of the business associate agree to the same restrictions that apply to the business associate;
- Make PHI available, including for amendment, to individuals as required by the rules;
- Maintain an accounting of disclosures, made during the last six years, and make the accounting available upon request;
- Make its internal practices, books and records relating to use and disclosure of PHI available to the U.S. Department of Health and Human Services (HHS); and
- At termination, the business associate must destroy or return all PHI, if feasible, or extend the limitations on use and disclosure beyond termination of the contract.

Business associates are third parties (for example, TPAs, PBMs, brokers, and others) that use PHI to perform services for the health plan. Insurers, however, are not business associates as they are covered entities in their own right.

A business associate that uses a subcontractor is required to enter into a BAA with its subcontractor.

Note that most TPAs and service providers have developed BAAs for their clients' use. The employer should carefully review all language with its legal counsel before signing. The BAA may include provisions, such as hold harmless or indemnification clauses, not required by HIPAA.

HIPAA Authorizations

Health plans may use and disclose PHI for purposes of treatment, payment, or healthcare operations (TPO events), or if required by law such as for public health or law enforcement. For any other purposes, however, the Plan first must obtain the individual's authorization. This is commonly called a HIPAA Authorization.

A HIPAA Authorization must be written in plain language and contain all of the following:

- Description of the information to be used or disclosed with enough specifics so the Plan knows what information the authorization pertains to;
- Name or other specific identification of the person or classes of persons that are authorized to release the PHI;
- Name or other specific identification of the person or classes of persons that are authorized to receive the PHI;

Blanket or "catch-all" authorizations are not valid. Each authorization must specify the information to be used or disclosed and its purpose.

- Description of the purpose of the requested use or disclosure (at the request of the individual, for example);
- Date or event on which the authorization expires;
- Statement that the individual has a right to revoke the authorization in writing and information about how to make a revocation;
- Explanation of the Plan's ability or inability to condition treatment, payment, enrollment, or eligibility for benefits on the receipt of an authorization; and
- Statement that informs the individual that the information used or disclosed pursuant to the authorization is subject to re-disclosure by the recipient and may no longer be protected by privacy rules.

The authorization must be signed and dated by the individual. Alternatively, the individual's personal representative may sign the authorization provided that the representative indicates his or her authority to act for the individual.

The most common uses of a personal representative are:

- Parent acting on behalf of minor child;
- Guardian acting on behalf of incapacitated adult; and
- Family member acting on behalf of deceased person.

Employee wants help with his claim? OK, but get his signed HIPAA Authorization first.

Breaches

The Rules were expanded several years ago in order to hold health plans and business associates more accountable for maintaining the security of electronic PHI. Information must be kept secure, using administrative, physical, and technological safeguards, and breaches must be investigated.

Further, in the event of a breach or potential breach, the Plan is required to notify all affected individuals and the government. This is called a breach notification. If 500 or more individuals are affected in a single state, the media also must be informed.

What is a breach?

Breach means the unauthorized acquisition, access, use, or disclosure of unsecured PHI in a manner not permitted by the Rules and which compromises the security or privacy of the information.

Unsecured PHI means PHI that is not secured through the use of technology or methodology that makes PHI unusable, unreadable, or indecipherable to unauthorized persons. PHI is secured if:

- It is encrypted consistent with the National Institute of Standards and Technology (NIST) requirements; or
- It is completely destroyed (for example, hard copies are shredded and electronic media is destroyed using NIST guidelines).

The majority of breaches result from the loss or theft of computers, flash drives, or mobile devices with unencrypted data. If the data is encrypted, there is no breach. Encrypt!

What is a breach investigation?

As soon as a breach or potential breach is discovered, the Plan must investigate it and determine whether the PHI was secure (encrypted or properly destroyed). If secured, there is no breach and no further action is needed.

Next, even if not secured, the following three situations are deemed to not be breaches:

- Person receiving the PHI would not reasonably have been able to retain it;
- Acquisition, access, or use of PHI by employees or others acting under the authority of the Plan or a business associate was unintentional; or
- There were certain inadvertent disclosures among people similarly authorized to access PHI at the Plan or a business associate.

If none of the above applies, the Plan's investigation continues by performing a risk assessment. If the assessment determines that there is a low probability that the PHI was compromised, breach notifications are not needed. The risk assessment must, at a minimum, take into account:

- Nature and extent of PHI involved, including the types of identifiers and likelihood of re-identification;
- Identity of unauthorized person(s) who used or received the PHI;
- Whether the PHI was actually acquired or viewed; and
- Extent to which the risk to the PHI has been mitigated.

Inadvertent disclosures of PHI may happen from time to time, but not all disclosers are breaches.

If the incident meets any one of above exclusions, it is not a breach. In that case, the Plan documents the incident but the breach notification requirement is not triggered.

What is a breach notification?

In the event of a breach or potential breach (unless qualifying for an exception above), the Plan must notify HHS. If 500 or more individuals are affected by the breach, the Plan must submit an online report to HHS immediately (and if 500 or more are affected in a single state or jurisdiction, the local media also must be informed). For breaches affecting fewer than 500 individuals, the Plan will submit an online report to HHS in the year following discovery. For details, see HHS Portal to Report Breach of Unsecured PHI.

Regardless of the total number of individuals affected, the Plan must notify each affected person within 60 days of discovery. The notice must include:

- Brief description of what happened, including date of breach and date the breach was discovered;
- General description of the types of PHI (such as birthdates, Social Security or account numbers) but not the actual PHI;
- Information about the Plan's actions to mitigate the harm or prevent other breaches; and
- Description of steps the individual can take to protect against potential harm.

Penalties

HHS through its Office for Civil Rights (OCR) regulates and enforces the Rules. HHS can take direct enforcement action and assess civil monetary penalties against health plan sponsors (insurers and employers) and business associates (third-party administrators, brokers, etc.) for violations.

The current civil penalty amounts are:

- $112 per violation if the person does not know about the violation;
- $1,118 per violation due to reasonable cause;
- $11,182 per violation due to willful neglect that is corrected (generally within 30 days); and
- $55,910 per violation due to willful neglect that is not corrected.

Penalties are subject to an annual cap of $1,677,299 for violations of the same type. The amounts may be adjusted annually for inflation.

Reasonable cause means circumstances that would make it unreasonable, despite the exercise of ordinary business care and prudence, to comply with the provision violated.

Willful neglect means a conscious and intentional failure to comply or a reckless indifference to the obligation to comply.

To determine penalties in a particular case, HHS will investigate the facts and consider a number of mitigating and aggravating factors such as how many individuals were affected, how long the violation continued, and the extent of any harm. HHS also has discretion to resolve matters through corrective action with or without assessing a penalty.

The above are civil penalties. Criminal penalties, including imprisonment, also are possible although such cases usually involve intentional acts to obtain PHI under false pretenses or for personal gain.

Employer Checklist

Employers that sponsor group health plans are responsible for their plan's compliance with the Rules. Depending on the plan type and whether the employer has access to PHI, the employer's responsibilities may include some or all of the following:

- Identify all health plans (for example, medical, dental, vision, health flexible spending account (HFSA), health reimbursement arrangement (HRA), prescription drug).
- Determine the plan's funding method (either insured or self-funded).
- Determine whether employer will create, maintain, receive, or transmit PHI.
- Determine the plan's workforce (employees or job titles that will have access to PHI).
- Create firewall document (non-workforce employees cannot access PHI).
- Identify all business associates with access to PHI. Obtain business associate agreements.
- Designate a Privacy Officer. (Optional: Designate a Privacy Contact for routine matters.)
- Designate a Security Officer.
- Establish policies and procedures for:
    - Uses and disclosures
    - Individual rights
    - Administrative safeguards
    - Handling complaints
- Amend plan document to state that plan uses PHI (including electronic PHI) for plan administrative purposes and that procedures are in place to protect it.
- Create Notice of Privacy Practices (and reminder notice) and implement a distribution process.
- Create HIPAA Authorization forms and establish process for receiving and handling them.
- Identify all locations where PHI is maintained in hard copy or electronically.
- Develop a security policy explaining how electronic PHI is managed and protected.
- Review and address all standards required by Security Rule. Perform risk analysis.
- Create a breach investigation and breach notification process.
- Establish physical safeguards for locations or workstations where PHI is used or stored.
- Conduct workforce training, including new hires as needed, and document it.

Lastly, on periodic basis, review policies and procedures, perform risk analyses (for electronic PHI), and ensure documentation is maintained and up to date.

The Rules are complex and employers are encouraged to work with legal counsel to consider how the requirements apply to each employer's unique situation. Extensive federal guidance is provided at https://www.hhs.gov/hipaa/for-professionals/privacy/index. html.

Medicare Part D Creditable Coverage Notices

Quick Facts

Employers offering group health coverage that includes any prescription drug benefits must complete two notice and disclosure requirements each year:

1. Provide a written notice to all Medicare-eligible plan participants before each October 15 explaining whether the plan's prescription drug coverage is "creditable coverage" (i.e., the coverage is expected to pay on average as much as Medicare's standard prescription drug coverage).
2. Complete the Online Disclosure to CMS Form within the first 60 days of each plan year disclosing whether the plan's prescription drug coverage is "creditable coverage." CMS is the Centers for Medicare and Medicaid Services, a federal agency that collects data and administers various federal programs.

The employer's notice to participants, and disclosure to CMS, must be updated if the plan's credible coverage status changes.

The notice and disclosure requirements apply to all group health plans — insured, self-funded, grandfathered or nongrandfathered — that include prescription drug benefits. There is no exception for small employers.

To assist employers in meeting the notice and disclosure requirements, this commentary provides background, details about preparing and distributing the notice, details about submitting the disclosure, and links to model notices and official CMS guidance.

Caution: This article does not address special issues for employers that receive the Retiree Drug Subsidy (RDS) or employer plans that contract directly with one or more Medicare Part D plans. Employers with either of those arrangements (which are uncommon) should seek the advice of legal counsel regarding the notice and disclosure requirements.

Background

Medicare began offering "Part D" plans — optional prescription drug benefit plans sold by private insurance companies and HMOs — to Medicare beneficiaries many years ago. Persons may enroll for a Part D plan when they first become eligible for Medicare. If they wait too long, however, a "late enrollment" penalty amount is permanently added to the Part D plan premium cost when they do enroll.

There is an exception from the late enrollment penalty for persons who are covered under an employer's group health plan that provides creditable coverage. ***Creditable coverage*** means that the group health plan's drug benefits are actuarially equivalent to, or better than, the standard benefits of a Medicare Part D plan. Individuals can delay enrolling for a Part D plan while they remain covered under an employer's group health plan if the employer's plan is creditable coverage. Medicare will waive the late enrollment premium penalty for individuals who enroll for a Part D plan after their initial eligibility date if they were covered by an employer's creditable plan. To avoid the late enrollment penalty, there cannot be a coverage gap longer than 62 days between the employer's group plan and the Part D plan.

Required Notice to Group Health Plan Participants

To help Medicare-eligible persons make informed decisions about whether and when to enroll for a Medicare Part D drug plan, they need to know if their employer's group health plan provides creditable prescription drug coverage. That is the purpose of the federal law requiring all employers that offer group health coverage including any outpatient prescription drug benefits to provide an annual notice (Employer's Medicare Part D Notice) to all plan participants who also are eligible for Medicare.

This notice requirement applies regardless of the employer's size or whether the group health plan is insured or self-funded, grandfathered or nongrandfathered, or whether the employer's plan is primary or secondary to Medicare. There is no exception for "small" employer plans.

Preparing the Notice

The Centers for Medicare and Medicaid Services (CMS) provides model notices that employers can use to comply with the notice requirement. To begin:

- Determine whether the group health plan's prescription drug coverage is creditable or noncreditable for the upcoming calendar year. If the plan is insured, the carrier/HMO will confirm creditable or noncreditable status. Employers should keep a copy of the written confirmation for their records. For self-funded plans, the plan actuary will determine the plan's status using guidance provided by the CMS.

- Download the appropriate model notice(s) from the CMS website and fill in the blanks and variable items as needed for each group health plan. There are two versions, both available in English and Spanish:
  - Model Creditable Coverage Notice.
  - Model Noncreditable Coverage Notice.
  - Model Creditable Coverage Notice (Spanish).
  - Model Noncreditable Coverage Notice (Spanish).

- Employers that offer multiple group health plans options, such as PPO, HDHP, and HMOs, may use one notice if all options are creditable (or all are noncreditable). In that case, it is advisable to list the names of the various plan options so it is clear. On the other hand, employers that offer a creditable plan and a noncreditable plan, such as a creditable HMO and a noncreditable HDHP, will need to prepare separate notices for the different plan participants.

- Identify the group health plan participants who will receive the Notice of Creditable Coverage or Notice of Noncreditable Coverage, as applicable. Include all group health plan participants who are or may become eligible for Medicare in the next year. Note: "Participants" include covered employees and retirees (and spouses) and COBRA enrollees. Employers often do not know whether a particular participant may be eligible for Medicare due to age or disability. For convenience, many employers decide to distribute their notice to all participants regardless of Medicare status.

- Notices must be distributed at least **annually before October 15**. Medicare holds its Part D enrollment period each year from October 15 to December 7, which is why it is important for group health plan participants to receive their employer's notice before October 15.

- Additionally, the notice(s) must be provided at the following times:
  - When a Medicare-eligible person enrolls in the employer's group health plan (e.g., new hire).
  - When the group health plan coverage changes from creditable to noncreditable coverage (or vice versa).
  - When a plan participant or beneficiary requests the notice(s).

Distributing the Notice(s)

The employer may distribute the notice by first-class mail to the employee's home or work address. The notice should indicate that recipients are responsible for providing the notice to Medicare-eligible family members if enrolled in the group plan. Separate notices for the employee's spouse or family members is not required unless the employer has information that they live at different addresses.

The notice is intended to be a stand-alone document. It may be distributed at the same time as other plan materials, but it should be a separate document. If the notice is incorporated with other material (such as stapled items or in a booklet format), the notice must appear in 14 point font, be bolded, offset, or boxed, and placed on the first page. Alternatively, you can put a reference (in 14 point font, either bolded, offset, or boxed) on the first page telling the reader where to find the notice within the material. In that case, CMS suggests the following text for the first page:

"If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page XX for more details."

Email distribution is allowed, but only for employees who have regular access to email as an integral part of their job duties. Employees also must have access to a printer and be notified that a hard copy of the notice is available at no cost upon request.

Required Disclosure to CMS

Separate from the participant notice requirement, employers also must disclose to CMS whether their group health plan's prescription drug benefits provide creditable or noncreditable coverage. The plan sponsor (employer) must submit its annual disclosure to CMS within **60 days of the start of each plan year**. For instance, for calendar-year group health plans, the employer must comply with this disclosure requirement by March 1 (or February 29 if leap year).

Disclosure to CMS also is required within 30 days of termination of the prescription drug coverage and within 30 days of a change in the plan's status as creditable coverage or noncreditable coverage.

The CMS online tool is the only method allowed for completing the required disclosure. Click on the link, then follow the prompts to respond to a series of questions regarding the plan. The link is the same regardless of whether the employer's plan provides creditable or noncreditable coverage. The entire process usually takes only 5 or 10 minutes to complete.

Needed Information

The employer will need to gather the following information in order to complete the online disclosure to CMS:

- Information about the plan sponsor (employer): Name, address, phone number, and federal Employer Identification Number (EIN).
- Number of prescription drug options offered (e.g., if employer offers two plan options with different benefit levels, the number is "2").
- Creditable/Noncreditable Offer: Indicate whether all options are creditable or noncreditable or whether some are creditable and others are noncreditable.
- Plan year beginning and ending dates.

- Estimated number of plan participants eligible for Medicare (and how many are participants in the employer's retiree health plan, if any).
- Date that the plan's Notice of Creditable (or Noncreditable) Coverage was provided to participants.
- Name, title, and email address of the employer's authorized individual completing the disclosure.

Employers are advised to print a copy of the completed disclosure for their records.

Official Guidance

CMS provides official guidance regarding the notice and disclosure requirements on its website. Information includes model notices, instructions for preparing and distributing the notices to participants, and directions for submitting the plan's annual disclosure to CMS.

Last Reviewed: June 24, 2015

Disability Benefits

Introduction

Disability benefits are payments that guarantee income when an employee cannot work because of sickness (physical or mental) or accident. The length and cause of the disability are two key factors in determining the form of disability benefit that may apply. Disability periods may be temporary or permanent and may result from an on-the-job accident (typically paid from a workers' compensation plan) or illness or may be completely unrelated to work.

Overview

Types of Disability

Short-Term Disability

A ***short-term disability*** is usually defined as an employee's inability to perform the duties of the employee's current position. Paid sick leave and short-term disability plans protect employees against loss of income during temporary absences from work due to illness or accident. Sick leave is provided to most full-time employees, and sickness and accident insurance to a significant but smaller number of full-time employees. Some employees have both sick leave and short-term disability plans, with the two benefits coordinated. The duration of short-term disability benefits typically ranges from 13 to 52 weeks, although most employees are covered for up to 26 weeks. Short-term disability plans usually specify when successive periods of disability are considered to be separate disabilities and when they are considered to be a continuous disability.

Often, paid sick leave is available to the employee without any waiting period, and it may be used during the interim before sickness and accident insurance payments begin. Under most sickness and accident insurance plans, the disability must exist for at least one week before an employee becomes eligible for benefits. This waiting period is intended to control plan costs and simplify plan administration.

Sick leave usually provides 100 percent of an employee's normal earnings, and the plan frequently specifies a maximum number of covered days each year that are permitted for paid sick leave (for example 13 days). Since 2011, the state of Connecticut requires paid sick leave to accrue at one hour per 40 hours worked, if an employer employs more than 49 people in Connecticut. Effective July 1, 2015 the state of California requires certain employers with at least one employee to provide paid sick leave. Additionally, effective July 1, 2015, the state of Massachusetts requires up to 40 hours of paid sick leave per individual annually if there are more than 10 employees. Other plans provide sick leave benefits (for example 30 days) per illness instead of per year. When used in conjunction with sick leave plans, sickness and accident plans provide benefits after sick leave benefits are exhausted.

The level of sickness and accident benefits for short-term disability may be expressed as a dollar amount or as a percentage of employee earnings. The level and duration of benefits may increase with service. Generally, benefits replace between one-half and two-thirds of a person's predisability gross weekly income. It is often thought that a higher replacement rate would create a disincentive for employees to return to work.

Employers generally pay for short-term disability plans. These plans may be financed under the following:

- A group insurance contract with a private insurance carrier.
- An employer self-insurance arrangement.
- An employer-established employee benefit trust fund.
- General corporate assets (such as for a sick leave plan).

Long-Term Disability

In most long-term plans, disability for the first two years is defined somewhat differently from disability under short-term plans (for example, an employee's inability to perform the duties of the employee's occupation vs. the duties of the current position). If the disability continues for more than two years, the definition of disability usually changes to the inability to perform any occupation that the person is reasonably suited to do by training, education, and experience.

Private sources of long-term disability benefits include the following:

- Disability provisions under long-term disability plans.
- Group life insurance.
- Employment-based pension plans.
- Other insurance arrangements (such as individual insurance protection).

Like short-term benefits, long-term disability benefits are integrated with benefits from other sources to produce reasonable replacement rates and to control costs.

Long-term benefits generally begin after short-term disability benefits (such as sick leave, and illness or accident insurance) expire. Most plans provide benefits for the length of a disability up to a specified age (for example age 65, when Social Security and employment-based retirement benefits usually begin).

Typically, long-term disability plans pay benefits amounting to approximately 60 percent of a person's predisability monthly pay. However, some plans provide as much as 70 percent of predisability pay. Additionally, some plans contain a provision stating that private-sector long-term disability benefits plus Social Security disability benefits cannot exceed a stated amount (for example 75 percent of predisability salary). Most plans set a limit on monthly payments. The cost of long-term disability benefits may be financed by the following:

- Employer contributions.
- Employee contributions.
- Employer/employee cost sharing.

Similar to short-term disability plans, long-term plans usually specify when successive periods of disability are considered to be separate disabilities and when they are considered to be a continuous disability. In addition, some long-term plans provide for continued payment of at least some disability benefits when long-term disabled persons engage in rehabilitative employment.

Disability Benefit Options

The following choices are available to employers that decide to offer disability benefits:

- Paid sick leave benefits.
- Short-term disability insurance.
- Long-term disability insurance.

There are other state- or federally-mandated programs for employees who become disabled. They are not benefit programs in that employers are not required to purchase them as they would a conventional benefit plan; however, employers may be required to pay for them, administer them in part, and provide employees with information about them. These benefits include the following:

- Workers' compensation.
- State-run temporary disability programs.
- Federal Social Security disability benefits.

Paid Sick Leave Benefits

Paid sick leave benefits are discussed in detail in the material on Employee Leave.

Disability Insurance

More employers are beginning to recognize the value of disability insurance as a benefit. These products offer peace of mind, because if an employee suffers a disabling illness or accident, the employee can focus on recovery knowing their financial stability is protected. By providing competitive benefits to employees, employers can attract and keep employees while increasing productivity, as well as the overall health and well-being of the workforce.

Since disability protection is something employees need and want, it is sensible for employers to provide the coverage. Beyond the needs of employees, these benefits offer important advantages to employers. The hidden or indirect costs of disability — such as salaries for replacement employees or the value of lost productivity — are an expensive problem for businesses.

Disability insurance is both a benefit and a health and productivity tool. The rehabilitation and management tools built into a group disability plan can yield substantial savings to employers, particularly in large organizations. Such programs help employees return to productivity, relieving huge direct and hidden costs of disability.

Disability insurance coverage can be paid for in the following ways:

- Fully paid by the employer.
- Cost-shared with employees.
- Offered as an employee-paid, voluntary benefit.

In many cases, employers fund a basic plan to protect employees, and employees may then add supplemental coverage to better address their individual financial circumstances.

Types of Disability Policies

Short-Term Disability Policies

Short-term disability policies are private policies that employers may purchase for employees. Short-term disability insurance is designed to provide income to employees who become disabled due to sickness or an accident and are unable to work after an initial waiting period (generally one to seven days). Short-term benefits are usually expressed in terms of the maximum number of weeks that the plan will pay (the industry standard is 26 weeks). Government statistics show that these benefits typically replace about 50 percent to 67 percent of an employee's income.

Benefits Period

Benefits payment is usually expressed in terms of a maximum number of weeks (13, 26, or 52) of benefits for a single period of disability. While statistics show that most short-term disabilities last far less than 13 weeks, 26 weeks is the most common limitation on disability policies.

Waiting Period

Generally, an employee will be required to satisfy a waiting period before disability benefit payments will begin. During the waiting period, employees are likely to use sick leave, vacation, or personal leave, if those benefits are offered. If an employee is collecting disability benefits and the duration of the disability exceeded the limits of the short-term policy, either of the following would happen:

- The employee might begin collecting under a long-term disability plan (if one is offered by the employer).
- Benefits would terminate.

Long-Term Disability Policies

Long-term disability policies take up where short-term policies leave off, covering employees who become disabled and unable to work for longer periods of time (generally six months or longer).

Benefits Period

Long-term disability insurance typically provides 50 to 60 percent of pay to disabled employees, which continues to retirement age or for a specified number of months, depending on the employee's age at the time of disability. In most plans, benefits are paid for the duration of the disability up to the age of 65. Benefits are usually computed as a percentage of the employee's basic compensation prior to the disability. There is usually a maximum dollar amount per week or month.

What Counts as Disabled

Long-term disability insurance plans generally define ***disability*** in one of the following two ways:

- The inability to perform the tasks of one's own occupation.
- The inability to perform the tasks of any occupation at all.

A plan may use both definitions of disability for separate periods of time. For example, for the first 24 months of a disability, disability may be defined as an inability to perform the employee's regular job. However, after that it may mean an inability to perform any job that the employee is qualified to perform.

An employee does not have to be permanently disabled to receive benefits; however, most plans require that the employee must have been a regular, full-time employee for at least a year to be eligible.

Insurance Plan Terms

This section explains some of the terms that employers need to be aware of when making plan choices.

Own Occupation or Any Occupation

Long-term disability plans provide income when an employee is unable to work in the employee's ***own occupation*** or to work in ***any occupation*** for which the person is suited by education, training, and experience. Some plans have the more restrictive own occupation standard for an initial period — usually two years. During this time, the plan pays benefits if the person cannot perform the essential work functions of the job in which the person was employed when becoming disabled. That two-year period is customarily followed by the broader any occupation standard. Under this standard, a plan would continue to pay benefits only if the person were unable to perform any job functions for which the individual might be qualified based on education, experience, and training.

Income Replacement

Plans typically replace 50 to 60 percent of income known as ***income replacement***. Plans are structured to balance financial assistance in a time of great need with incentives to return to work.

Waiting or Elimination Period

With a ***waiting*** or ***elimination period***, benefits in a long-term disability plan usually start 30 to 180 days after the disability occurs. Employers should coordinate coverage so that once any sick pay and short-term disability benefits have been exhausted, long-term disability benefits begin immediately.

Residual or Partial Disability

Residual or ***partial disability*** benefits assist when an employee experiences a disability and then returns to work part time. The partial payments offset earnings lost while the employee makes a transition back to a full-time schedule.

Rehabilitation

Employers should be familiar with the rehabilitation and disability case management capabilities the insurance carrier offers. ***Rehabilitation*** management considers how successful the carrier has been in assisting employees as they return to productive work. In addition, employers should look into how well these rehabilitation and management resources coordinate with services the company provides on its own or through other benefits service providers. Easy integration for seamless administration is key to program success.

Ease of Use

It is beneficial when employers and employees have plenty of ***ease of use*** (easy, timely ways to get information).

Large employers often value online access or other simple methods to obtain facts about their short-and long-term disability experience, such as knowing how many employees are out, how long employees are out on average, and at which locations.

Employers of any size often find value in receiving help with the Family and Medical Leave Act (FMLA), Americans with Disabilities Act (ADA), and other regulations. Disability insurance plans are a potential tool for making FMLA notification in a timely, accurate way.

From the employee perspective, plans often work best when there are multiple ways to get information — mail, fax, phone, or online. The easier it is for employees to access information they need — such as status of a benefit check — the easier it will be for the employer's human resource or benefits area.

Customization

It is essential for short- and long-term disability insurance providers to offer ***customization*** (customize a plan towards a company's existing benefits and information systems). This is particularly true for large organizations of 2,000 or more employees that may already have some form of disability insurance and are making a change or addition to the current program. Consider how well the plan will work with and transfer information from prior plans. Employers should also check if the plan offers provisions that solve problems specific to the employer's organization.

Coordination and Integration

The best plans offer ***coordination and integration*** (coordinate the short- and long-term benefit processes, and also coordinate with other health and welfare benefits the employee may need to access, for example workers' compensation). How tightly the different benefits need to coordinate or integrate depends on the size and nature of the organization. Larger companies likely will have more benefit programs to coordinate and greater potential gains from active management of those programs because they will have more claim situations. Smaller companies, especially those with little or no human resource staffing, primarily need a quality plan that works well at all junctures in the process — communicating the benefit to the employee, serving the employee as a customer, and integrating easily with other benefits.

Another alternative in coordinating benefits is for an employer to supplement group disability insurance with individual disability income insurance. Group disability insurance is a very valuable benefit, but may leave a gap in coverage for some individuals (such as those who are highly compensated). Supplemental individual disability income insurance can be customized to help fill any gaps in coverage. The employer chooses if the individual policies are employer-or employee-paid. (Contact the insurance representative or financial professional for more information.)

Federal Social Security Disability Benefits

The federal government provides disability benefits under the following two programs, which are collectively referred to as Social Security disability benefits:

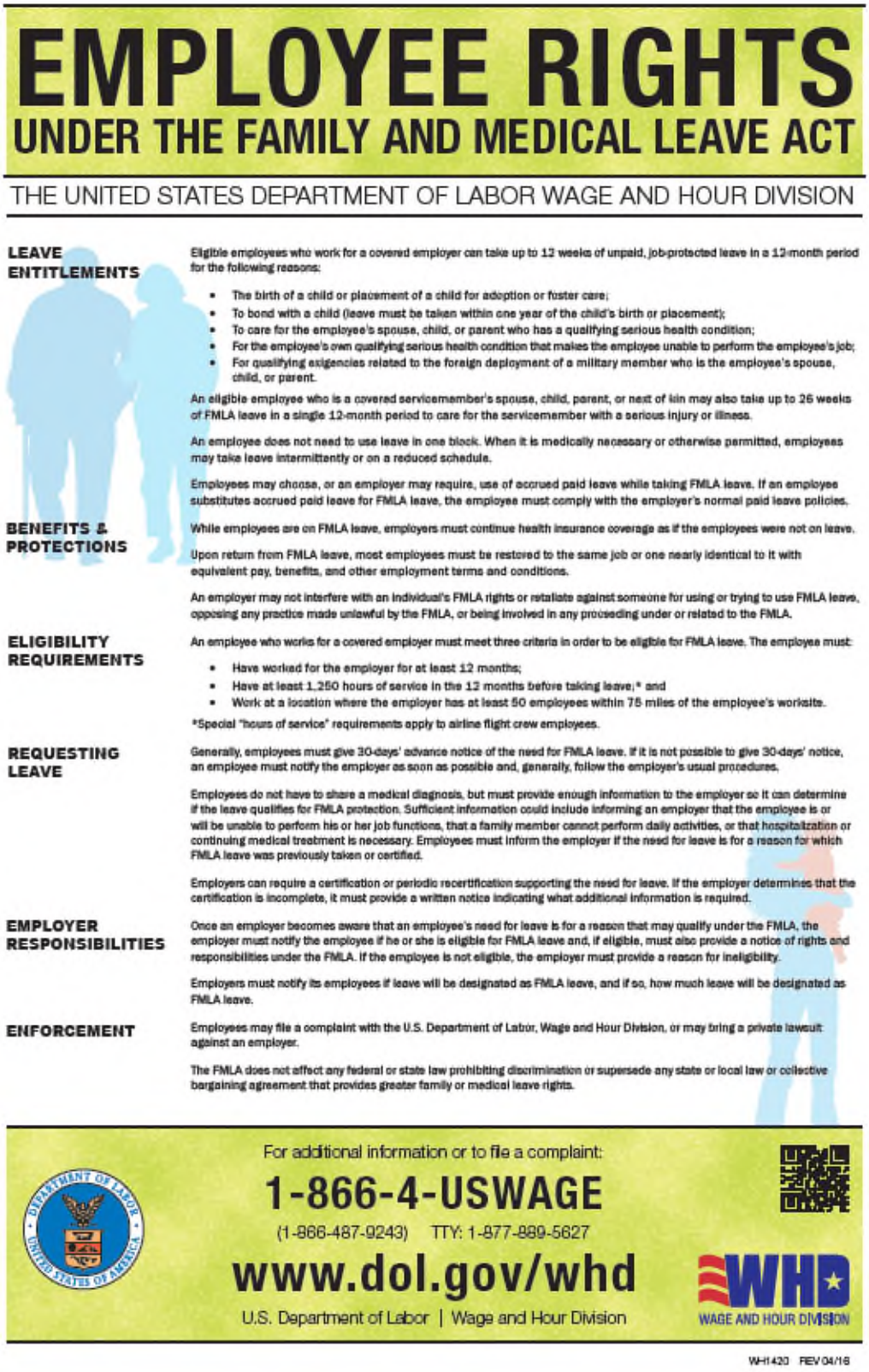
- The Supplemental Security Income program (SSI), authorized under Title XVI of the Social Security Act.
- The SSDI benefits program (SSDI), authorized under Title II of the Social Security Act.

SSI provides benefits to disabled individuals whose income and assets fall below a specified level. SSI may provide monthly disability income for those who meet Social Security rules for disability and who have limited income and resources.

SSDI provides benefits to disabled employees, dependents, and surviving spouses and is a wage replacement income for those who pay FICA taxes when they have a disability meeting Social Security disability rules. In addition, the following points are true of the SSDI program:

- It provides a variety of benefits to family members when a primary wage earner in the family becomes disabled or dies.
- It is financed with Social Security taxes paid by employees, employers, and self-employed persons.
- Its benefits are payable to disabled employees, widows, widowers, and children or adults disabled since childhood who are otherwise eligible.

FMLA Notices



EMPLOYEE RIGHTS
UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION

LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within one year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

WAGE AND HOUR DIVISION

WH1420 REV 04/16

Benefit Notices for New Hires

Employers with Fewer than 20 Employees

Employers sponsoring group health plans are required by federal law to provide certain notices and disclosures to persons when they first become eligible for enrollment. These materials often are referred to as “new hire benefit notices” or “initial enrollment benefit notices.”

To get started, see the list of notices contained in this package along with guidance about which notices to include for your plan. Then just copy the notices you need and customize them with your plan’s information. ***For convenience, variables and fill-in items are highlighted in red.***

Insured Health Plans: Plans provided through group insurance policies are subject to state insurance laws that may apply in addition to, or in place of, one or more of the federal notices in this package. In that case, the insurance carrier provides the applicable notice(s) which may be distributed with enrollment materials or included in the carrier’s evidence of coverage (EOC) booklet. Employers are advised to coordinate with the carrier to ensure that all requirements are met under both federal and state law.

HIPAA Privacy Notices: Employers who sponsor one or more group health plans that are subject to Privacy and Security Rules under the Health Insurance Portability and Accountability Act (HIPAA) may be responsible for their plan’s compliance with the rules, including the requirement to prepare and distribute a Notice of Privacy Practices (Privacy Notice) to plan participants. The requirements vary widely, depending on whether the plan is insured or self-funded, the extent to which the employer has access to personal health information (PHI), the use of electronic media, and other factors. Due to these variables, Privacy Notices are outside the information provided here, and employers are advised to review their plan or plans with legal counsel offering expertise in HIPAA.

Multi-Employer Plans, Multiple Employer Welfare Arrangements, and Association Health Plans: This material is designed for use by ***single-employer plans only***. Do not use for multi-employer plans (e.g., union trusts), multiple employer welfare arrangements (MEWAs), or association health plans.

Entities Subject to § 1557 of the Affordable Care Act (ACA): Certain health programs that receive federal financial assistance may be subject to additional notice requirements under § 1557 of the ACA which are outside the scope of these materials. Employers who may be affected are advised to review the matter with legal counsel.

Notice	When to Use the Notice
Disclosure of Grandfathered Plan Status	Use this notice only for a group health plan that maintains grandfathered plan status, as defined by the Affordable Care Act (ACA). If using, fill in plan name and other information where indicated to create final copy.
Disclosure of HIPAA Opt-Out	Use this notice only for a self-funded nonfederal governmental plan that has opted out of certain federal benefit mandates, such as mental health parity. ***This is uncommon.*** If using, fill in plan name and other information where indicated to create final copy.
Employer CHIP Notice	Use this notice if group health coverage is offered to persons who live in any one of the states listed in the notice. For convenience, this notice may be distributed to all persons eligible for group health coverage, regardless of location. If used, do not attach this notice to other notices. It should stand alone so recipients understand its significance.
Employer Exchange Notice	**REQUIRED notice to all new employees**, regardless of eligibility for any employer-sponsored benefits. Distribute within 14 days of hire. Use first template for employers who offer group health coverage to at least some employees, or use second template for employers who do not offer group health coverage to any employees, as appropriate, then fill in employer and coverage information where indicated to create final copy.
General Notice of USERRA Rights	This notice is OPTIONAL. Although employers are required to display this USERRA Notice (as a poster) in the workplace, they are not required to distribute it to employees.
Medicare Part D Notice of Creditable Coverage	Use this notice only if the group health plan's prescription drug coverage is creditable (i.e., equal or superior to Medicare Part D). Although it is only necessary to provide this notice to Medicare eligible persons, most employers distribute the notice to all plan participants regardless of Medicare status. If using, complete variable items with appropriate text. This notice must stand alone; e.g., if distributed with other material in the same envelope, this notice should be either on top or loose. **Note:** If multiple plans are offered, and at least one plan is creditable, include this notice and identify the creditable plan.
Medicare Part D Notice of Non-Creditable Coverage	Use this notice only if the group health plan's prescription drug coverage is non-creditable (i.e., is not equal nor superior to Medicare Part D). Although it is only necessary to provide this notice to Medicare-eligible persons, most employers distribute the notice to all plan participants regardless of Medicare status. If using, complete the variable items with appropriate text. This notice must stand alone; e.g., if distributed with other material in the same envelope, this notice should be either on top or loose. **Note:** If multiple plans are offered, and at least one plan is non-creditable, include this notice and identify the creditable plan.

Notice	When to Use the Notice
Newborns' and Mothers' Health Protection Act Notice	Use this notice for a group medical plan that includes maternity and newborn coverage. Separate distribution is not required if the information in the notice already appears in the plan's SPD.
Notice of Patient Protections	Use this notice for nongrandfathered health plans that allow or require members to designate primary care physicians (PCPs) and/or require preauthorization or referral for other care. If using, fill in plan name and other information where indicated to create final copy. Separate distribution is not required if the information already appears in the plan's SPD.
Notice of Special Enrollment Rights	Use this notice for all group health plans (other than "excepted benefits" such as a stand-alone dental or vision plan, or health FSA, that has not adopted HIPAA's special enrollment rules). Fill in plan name and other information where indicated to create final copy.
Wellness Program Disclosure (ADA)	Use this notice for a wellness program that is subject to the Americans with Disabilities Act (ADA) regarding programs that request health information. If using, fill in plan name and other information where indicated to create final copy.
Wellness Program (GINA General Disclosure)	Use this notice for a wellness program that requests any health information. Employers are prohibited from requesting or requiring genetic information. By providing this notice, any receipt of genetic information generally will be deemed inadvertent and not a violation of the prohibition.
Wellness Program Disclosure (HIPAA)	Use this notice for a wellness program that is subject to HIPAA's notice requirement regarding reasonable alternative standards to earn a program incentive. If using, fill in plan name and other information where indicated to create final copy.
Women's Health and Cancer Rights Act Notice	Use this notice for group medical plans that cover mastectomies. Note that this is the long notice; a shorter notice is allowed for repeated annual distribution, but most employers prefer using the long form for both initial and annual distribution. If using, fill in plan name and other information where indicated to create final copy

Employers with 20 - 49 Employees

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Employer CHIP Notice	Use this notice if group health coverage is offered to persons who live in any one of the states listed in the notice. For convenience, this notice may be distributed to all persons eligible for group health coverage, regardless of location. If used, do not attach this notice to other notices. It should stand alone so recipients understand its significance.
Employer Exchange Notice	**REQUIRED notice to all new employees**, regardless of eligibility for any employer-sponsored benefits. Distribute within 14 days of hire. Use first template for employers who offer group health coverage to at least some employees, or use second template for employers who do not offer group health coverage to any employees, as appropriate, then fill in employer and coverage information where indicated to create final copy.
General Notice of COBRA Rights	Use this notice for new group health plan enrollees. Complete variable items with appropriate text. **Caution:** Most employers use an outside COBRA administrator. In that case, consult with vendor to determine whether to use this template or the vendor's customized notice.
General Notice of USERRA Rights	This notice is OPTIONAL. Although employers are required to display this USERRA notice (as a poster) in the workplace, they are not required to distribute it to employees.
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Wellness Program (GINA General Disclosure)	Use this notice for a wellness program that requests any health information. Employers are prohibited from requesting or requiring genetic information. By providing this notice, any receipt of genetic information generally will be deemed inadvertent and not a violation of the prohibition.
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Employers with 50+ Employees

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General Notice of COBRA Rights	Use this notice for new group health plan enrollees. Complete variable items with appropriate text. **Caution:** Most employers use an outside COBRA administrator. In that case, consult with vendor to determine whether to use this template or the vendor's customized notice.
General Notice of FMLA Rights	Requirement to provide this notice can be met either by distributing it to FMLA-eligible employees, or by simply including the text in employee handbooks. In either case, the employer must display this FMLA Notice (as a poster) in the workplace.
General Notice of USERRA Rights	This notice is OPTIONAL. Although employers are required to display this USERRA notice (as a poster) in the workplace, they are not required to distribute it to employees.
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The Employee Retirement Income Security Act (ERISA)

The Employee Retirement Income Security Act of 1974 (ERISA) is located at 29 U.S.C. § 1001 et seq. with corresponding regulations at 29 C.F.R. Part 2509 et seq. ERISA is a federal law that sets standards of protection for individuals in most voluntarily established, private-sector employee benefit plans.

Purpose of ERISA

ERISA was intended to:

- Protect the rights of employees and beneficiaries in employee benefit plans.
- Require employers and their representatives to meet certain standards of conduct.
- Require employer reporting to the federal government and disclosures to participants.

ERISA is a labor statute and a tax statute that applies to private employers of all sizes. It allows for the delivery of both pension and welfare benefits with preferred tax treatment. Most of ERISA's significant regulations only apply to pension and profit sharing plans. The law:

- Requires plans to provide participants with plan information, including important facts about plan features and funding.
- Sets minimum standards for participation, vesting, benefit accrual, and funding.
- Rejects prohibited discrimination against or interference with an employee concerning entitlement to benefits.
- Provides fiduciary responsibilities for those who manage and control plan assets.
- Requires plans to establish claims and appeals processes for eligible participants to receive benefits.
- Sets standards for benefit plans to qualify for favorable tax treatment.
- Gives participants the right to sue for benefits and breaches of fiduciary duty.
- If a defined benefit plan is terminated, guarantees payment of certain benefits through a federally chartered corporation, the Pension Benefit Guaranty Corporation (PBGC).

ERISA **does not** require any employer to establish a plan; however, employers who establish plans must meet certain minimum standards.

The administration of ERISA is divided among the U.S. Department of Labor, the Internal Revenue Service (IRS), and the Pension Benefit Guaranty Corporation (PBGC). Title I of ERISA, which contains rules for reporting and disclosure, vesting, participation, funding, fiduciary conduct, and civil enforcement, is administered by the U.S. Department of Labor. Title II of ERISA, which amended the Internal Revenue Code to parallel many of the Title I rules, is administered by the IRS. Title III is concerned with jurisdictional matters and with coordination of enforcement and regulatory activities by the U.S. Department of Labor and the IRS. Title IV covers the insurance of defined benefit pension plans and is administered by the PBGC.

Coverage

ERISA applies to most private employers, including for-profit and nonprofit organizations, regardless of size. ERISA generally applies to all benefit plans sponsored by private employers or employee organizations (e.g., labor unions), including self-insured and fully insured plans, so long as the plan is providing retirement benefits, health care, or other ERISA-listed benefits.

The following plans are subject to ERISA:

- Defined benefit pension plans.
- Defined contribution pension plans.
- Group health and medical insurance (PPO, HDHP, HMO, POS, etc.).
- Dental and vision plans.
- Health Flexible Spending Accounts (FSAs).
- Health Reimbursement Accounts (HRAs).
- Prescription drug plans.
- Disability plans.
- Life and accident insurance plans.
- Wellness programs*.
- Employee Assistance Programs (EAPs)*.

*Wellness programs and EAPs are covered by ERISA if they provide medical care.

Exemptions

As a general rule, ERISA does not cover group health plans established or maintained by governmental entities, churches for their employees, or plans which are maintained solely to comply with applicable workers' compensation, unemployment, or disability laws. In addition, ERISA does not cover plans maintained outside the United States primarily for the benefit of nonresident aliens, or unfunded excess benefit plans.

The following plans are not covered by ERISA:

- Government plans (federal, state, city, school district, etc.).
- Church plans (unless the plan elects to be covered under ERISA).
- Workers' compensation, unemployment insurance, or statutory disability benefit plans.
- Health Savings Accounts (HSAs).
- Section 125 premium-only plans.
- Plans maintained outside the U.S. for nonresident alien employees.
- Voluntary plans.
- Benefits funded through payroll practice.

Voluntary Plan Safe Harbor

Certain voluntary insurance plans may be exempt from ERISA. To be considered exempt under ERISA's voluntary plan safe harbor, all of the following requirements must be met:

- The plan must be completely voluntary.
- The plan must not allow employer contributions.
- The plan must not allow the employer to endorse the plan.
- The plan must not allow the employer to receive any consideration (other than reimbursement of administrative expenses).

Payroll Practice Exception

Under the payroll practice exception, certain benefits payments are exempt from ERISA if they are paid solely out of the employer's general assets. These benefits include overtime pay, unfunded sick pay, paid medical leave, and income replacement benefits, including short-term disability or salary continuation plans.

ERISA Requirements

ERISA sets uniform minimum standards to ensure that employee benefit plans are established and maintained in a fair and financially sound manner. Additionally, employers have an obligation to provide promised benefits and satisfy ERISA's requirements for managing and administering private retirement and welfare plans.

Title I of ERISA requires persons and entities that manage and control plan funds to:

- Manage plans for the exclusive benefit of participants and beneficiaries.
- Carry out their duties in a prudent manner and refrain from conflict of interest transactions expressly prohibited by law.
- Comply with limitations on certain plans' investments in employer securities and properties.
- Fund benefits in accordance with the law and plan rules.
- Report and disclose information on the operations and financial condition of plans to the government and participants.
- Provide documents required in the conduct of investigations to ensure compliance with the law.

Plans covered by ERISA are subject to some or all of the following requirements:

- Written Plan Documents.
- Summary Plan Description (SPD).
- Summary of Material Modification (SMM).
- Form 5500.
- Form 5500-SF.
- Summary of Annual Report (SAR).
- Fiduciary Standards.
- Prohibited Transactions and Exceptions.

Written Plan Documents

The administrator of an employee benefit plan is the individual or entity specifically designated in the plan documents as the administrator. If the plan documents do not designate an administrator, the administrator is the employer maintaining the plan, or, in the case of a plan maintained by more than one employer, the association, committee, joint board of trustees, or similar group representing the parties maintaining the plan.

ERISA requires plan administrators to provide plan participants notification in writing of the most important facts about their retirement and health benefit plans including plan rules, financial information, and documents on the operation and management of the plan. Some of these facts must be provided to participants regularly and automatically by the plan administrator, while others are available upon request, free-of-charge or for copying fees. The request should be made in writing.

Warning: A Certificate of Coverage (COC) is a document provided by the insurance company that describes a covered person's coverage benefits, limitations, and exclusions. These documents may not meet the requirements of ERISA for plan documents.

Options for plan documents include:

- Wrap-Around Plan Document creating a combined plan for all insured benefits incorporating the COC as part of the SPD. A Wrap Document is a document that "wraps" around the insurance policy, certificate, or booklet so that the plan sponsor complies with ERISA. The plan benefits continue to be governed by the insurance policy, certificate, or booklet, but the Wrap Document supplements that information so that the combined documents comply with ERISA.
- Individual Plan with separate Plan Document and separate SPD for each benefit.
- Umbrella Plan combining all welfare benefits into a single plan with separately bundled or individual SPDs.

Summary Plan Description (SPD)

The Summary Plan Description (SPD) is the primary vehicle for informing participants and beneficiaries about their plan and how it operates. The SPD and Plan Document may be consolidated under one document or they may be separate and distinct from each other. Additionally, the SPD must be written for the average participant and be sufficiently comprehensive to apprise covered persons of their benefits, rights, and obligations under the plan.

Form 5500

The Department of Labor, Internal Revenue Service, and the Pension Benefit Guaranty Corporation jointly developed the Form 5500 Series so employee benefit plans could utilize the forms to satisfy annual reporting requirements under Title I and Title IV of ERISA and under the Internal Revenue Code. Certain plans are also required to submit an accountant's report. Plan sponsors must generally file the forms on the last day of the seventh month after their plan year ends. Form 5558 may be used to request a two and one-half month extension of the Form 5500 filing due date.

All Form 5500 ***Annual Return/Report of Employee Benefit Plan***, all Form 5500-SF ***Short Form Annual Return/Report of Small Employee Benefit Plan***, and any required schedules and attachments, must be completed and filed electronically using EFAST2-approved third-party software or using IFILE.

Plan administrators should review the ***Reporting and Disclosure Guide***, published by the Department of Labor, for more detailed information regarding filing Form 5500.

Summary Annual Report

Defined contribution retirement plan and welfare plan administrators must annually provide a Summary Annual Report (SAR), which is a narrative summary of the Form 5500 to participants and beneficiaries.

Fiduciary Standards

Part 4 of Title I sets forth standards and rules for the conduct of plan fiduciaries. Persons who exercise discretionary authority or control over management of a plan or disposition of its assets are ***fiduciaries*** for purposes of Title I of ERISA. Fiduciary status is based on the functions performed for the plan, not just a person's title.

A plan's fiduciaries ordinarily include the trustee, any investment advisers, all individuals exercising discretion in the administration of the plan, all members of a plan's administrative committee (if it has such a committee), and those who select committee officials. Attorneys, accountants, and actuaries generally are not fiduciaries when acting solely in their professional capacities. The key to determining whether an individual or an entity is a fiduciary is whether they are exercising discretion or control over the plan.

Fiduciaries are required to discharge their duties solely in the interest of plan participants and beneficiaries and for the exclusive purpose of providing benefits and defraying reasonable expenses of administering the plan. In discharging their duties, fiduciaries must act prudently and in accordance with documents governing the plan, to the extent such documents are consistent with ERISA.

Section 404(a)(1)(B) of ERISA contains what may be referred to as the "Prudent Expert Standard." Requiring the fiduciary act with the prudence of one "familiar with such matters" creates a distinction from the general prudent person standard. When selecting advisors, employers must demonstrate due diligence in establishing that such advisors meet this standard.

The Department of Labor has taken the position that there is a class of activities which relates to the formation, rather than the management, of plans. These activities, generally referred to as ***settlor functions***, include decisions relating to the formation, design and termination of plans and, except in the context of multi-employer plans, generally are not activities subject to Title I of ERISA. The Department of Labor also has taken the position that, while expenses attendant to settlor activities do not constitute reasonable plan expenses, expenses incurred in connection with the implementation of settlor decisions may constitute reasonable expenses of the plan.

Settlor functions are different from fiduciary functions. An employer, or the management of a sponsoring entity, engages in necessary settlor functions when establishing a plan, choosing plan design, and amending or terminating a plan. Such business decisions do impact an employee benefits plan; nonetheless, these settlor functions are not governed by the fiduciary duty provisions of ERISA.

Prohibited Transaction Exemption Procedures

In order to avoid confusion over dual jurisdiction between the Department of Labor and IRS, Reorganization Plan No. 4 of 1978 transferred the authority to grant exemptions from the prohibited transaction provisions under the Internal Revenue Code to the Department of Labor. As a result, the Department of Labor has the exclusive authority to issue prohibited transaction exemptions (PTEs) involving plans that are:

- Covered solely under Title I of ERISA (welfare benefit plans such as group health plans).
- Covered solely under Title II of ERISA (plans without employees such as nonemployer sponsored IRAs and Keoghs).
- Covered under both Titles I and II of ERISA (pension and individual account plans such as 401(k) plans).

Prohibited Transactions

Prohibited transaction provisions prohibit fiduciaries from causing a plan to engage in certain types of transactions with persons referred to as "parties in interest" under Title I of ERISA or "disqualified persons" under the Internal Revenue Code. The purpose of the prohibited transaction rules is to prevent dealings with parties who may be in a position to exercise improper influence over plan assets, and to prevent plan fiduciaries from taking actions with respect to a plan which involves self-dealing and conflicts of interest.

There are two categories of prohibited transactions. The first category deals with transactions between the plan and a party in interest with respect to the plan. Specifically, for these transactions a plan fiduciary may not cause a plan to enter into a transaction which directly or indirectly constitutes any of the following:

- A sale, exchange, or leasing of property.
- A loan or other extension of credit.
- A provision of goods, services, or facilities.
- A transfer or use of the income or the assets of the plan.
- An acquisition and holding of employer securities or employer real property that does not meet certain conditions.

The second category of prohibited transactions describes situations involving fiduciary self-dealing and conflicts of interest. For example, a violation may occur where a plan fiduciary causes a plan to engage in transactions that may benefit that plan fiduciary or a person or entity in which the fiduciary has a financial interest. This second category also applies where a fiduciary acts on behalf of a party or represents a party whose interests are adverse to the interests of the plan.

Party in Interest/Disqualified Person

Parties in interest/disqualified persons are individuals or entities that have defined relationships to a plan. They include a person providing services to the plan (such as attorneys, accountants, or third-party administrators), an employer or union whose employees or members participate in the plan, and plan fiduciaries.

It is important to note that there are some differences between these two terms under ERISA and the Internal Revenue Code. For example, the definition of "party in interest" in ERISA includes, among other categories, employees of a plan sponsor, while the corresponding term in the Internal Revenue Code — "disqualified person" — includes only certain highly-compensated employees.

Exemptions

There are a number of exemptions allowing plans to conduct transactions necessary for plan operation, but that are otherwise prohibited. Exemptions may be categorized as **statutory exemptions** or **administrative exemptions**.

A statutory exemption may be relied upon provided that the conditions of the exemption are met. One exemption in the law allows a plan to hire a service provider as long as the services are necessary to operate the plan and the contract or arrangement under which the services are provided and the compensation paid for those services is reasonable. The law provides exemptions for many plan dealings with banks, insurance companies, and other financial institutions that are essential to the ongoing operations of the plan. Another exemption permits plans to offer loans to participants. To the extent that a transaction is permitted by a statutory exemption, the parties would not need to request an administrative exemption for the same transaction from the Department of Labor.

The department may grant additional exemptions. The exemptions issued by the department can involve transactions available to a class of plans or to one specific plan.

The Department of Labor has the authority to grant administrative exemptions from the prohibited transaction provisions of ERISA and the Internal Revenue Code for a class of transactions or for individual transactions. In order to grant an administrative exemption, the department must make three determinations:

1. The exemption must be administratively feasible;
2. In the interest of the plan and its participants and beneficiaries; and
3. Protective of the rights of plan participants and beneficiaries.

Prior to granting an exemption, the department must publish a notice of proposed exemption in the Federal Register so that interested persons are given the opportunity to comment on the proposal. If the transaction involves potential fiduciary self-dealing or conflicts of interest, an opportunity for a public hearing also must be provided. The exemption procedures are designed to ensure that the department is provided with all the relevant materials that are necessary to accurately and promptly decide whether or not an exemption should be proposed.

A class exemption may provide exemptive relief from the prohibited transaction provisions in ERISA or the Internal Revenue Code, or both, to an identified class of entities or individuals who engage in the transaction(s) described in the exemption and who also satisfy the conditions contained in the exemption.

In 1996, the department published a class exemption PTE 96-62, commonly referred to as EXPRO. The EXPRO exemption is available for a class of prospective transactions which meet the conditions contained in PTE 96-62 as well as the authorization requirements described therein. If the conditions and authorization procedures are met, an applicant may be able to obtain individual prohibited transaction relief on an expedited basis.

Individual exemptions involve case-by-case determinations as to whether the specific facts represented by an applicant concerning a specific transaction (as well as the conditions applicable to such a transaction) support a finding by the department that the requirements for relief from the prohibited transaction provisions of ERISA and the Internal Revenue Code have been satisfied. Unlike a class exemption, an individual exemption may be relied upon only by the specific parties in interest named or otherwise identified in the exemption. Parties in interest or disqualified persons that are unable to meet the conditions of a class exemption also may request an individual exemption. Guidance on exemptions is available on EBSA's website.

Disclosure and Reporting Requirements

ERISA notice requirements are outlined at 29 U.S.C. § 1021.

Both pension and welfare benefit plans are required to meet extensive disclosure and reporting requirements under ERISA. Plan administrators should review the ***Reporting and Disclosure Guide*** for more detailed information regarding current reporting requirements.

Posting Requirements

ERISA has no posting requirements.

Airline Requirements

Section 107 of ERISA (29 U.S.C. § 1027) requires anyone who files an employee benefit plan report (i.e., Form 5500) to maintain sufficient records to support all information included on the report for at least six years from the date the report is filed. Plan sponsors must generally file Form 5500 on the last day of the seventh month after their plan year ends. Typically, employers with less than 100 participants in a welfare plan at the beginning of the year do not file Form 5500 for the welfare plan for that year.

However, Section 209 of ERISA (29 U.S.C. § 1059) contains a much broader and open-ended recordkeeping requirement. Section 209 requires employers to maintain all records necessary to determine benefits that are or may become due to each employee.

Records that should be maintained include, but are not limited to, the following:

- Plan documents, including amendments.
- IRS determination letters.
- SPDs and SMMs.
- Participant benefit statements.
- Company resolutions declaring match and/or profit sharing contributions.
- Participant notices.
- Form 5500 (including all required schedules and attachments).
- Actuarial statements and valuations.
- Age and service records that are used to determine waiting periods, eligibility, vesting, breaks in service, and benefits.
- Payroll records.

Enforcement

The administration of ERISA is divided among the U.S. Department of Labor, the Internal Revenue Service of the Department of the Treasury (IRS), and the Pension Benefit Guaranty Corporation (PBGC). Title I of ERISA, which contains rules for reporting and disclosure, vesting, participation, funding, fiduciary conduct, and civil enforcement, is administered by the U.S. Department of Labor. Title II of ERISA, which amended the Internal Revenue Code to parallel many of the Title I rules, is administered by the IRS. Title III is concerned with jurisdictional matters and with coordination of enforcement and regulatory activities by the U.S. Department of Labor and the IRS. Title IV covers the insurance of defined benefit pension plans and is administered by the PBGC.

ERISA confers substantial law enforcement responsibilities on the Department of Labor. The department has the authority to bring a civil action to correct violations of the law, provides investigative authority to determine whether any person has violated Title I (Protection of Employee Rights), and imposes criminal penalties on any person who willfully violates any provision of Part 1 of Title I.

The Employee Benefits Security Administration (EBSA) has the authority to assess civil penalties for reporting violations. A penalty of up to $2,063 per day may be assessed against plan administrators who fail or refuse to comply with annual reporting requirements. Section 502(i) gives the agency authority to assess civil penalties against parties in interest who engage in prohibited transactions with welfare and nonqualified retirement plans. The penalty can range from 5 – 100 percent of the amount involved in a transaction.

A parallel provision of the Internal Revenue Code directly imposes an excise tax against disqualified persons, including employee benefit plan sponsors and service providers, who engage in prohibited transactions with tax-qualified retirement plans.

Finally, § 502(l) requires the Department of Labor to assess mandatory civil penalties equal to 20 percent of any amount recovered with respect to fiduciary breaches resulting from either a settlement agreement with the Department of Labor or a court order as the result of a lawsuit by the Department of Labor.

Interaction with Other Laws

Part 5 of Title I states that the provisions of ERISA Titles I and IV supersede state and local laws which "relate to" an employee benefit plan. ERISA, however, does not pre-empt certain state and local laws, including state insurance regulation of multiple employer welfare arrangements (MEWAs). MEWAs generally constitute employee welfare benefit plans or other arrangements providing welfare benefits to employees of more than one employer, not pursuant to a collective-bargaining agreement.

In addition, ERISA's general prohibitions against assignment or alienation of retirement benefits do not apply to qualified domestic relations orders. Plan administrators must comply with the terms of qualifying orders made pursuant to state domestic relations laws that award all or part of a participant's benefit in the form of child support, alimony, or marital property rights to an alternative payee (spouse, former spouse, child, or other dependent). Finally, group health plans covered by ERISA must provide benefits in accordance with the requirements of qualified medical child support orders issued under state domestic relations laws.

Important legislation has amended ERISA and increased the responsibilities of the Department of Labor's Employee Benefits Security Administration (EBSA). For example, the Retirement Equity Act of 1984 reduced the maximum age that an employer may require for participation in a retirement plan, lengthened the period of time a participant could be absent from work without losing credit towards the plan's vesting rules for pre-break years of service, and created spousal rights to retirement benefits through qualified domestic relations orders (QDROs) in the event of divorce, and through pre-retirement survivor annuities.

The Omnibus Budget Reconciliation Act of 1986 eliminated the ability of employers to limit participation in their retirement plans for new employees who are close to retirement and the ability to freeze benefits for participants over age 65.

The Omnibus Budget Reconciliation Act of 1989 requires the Secretary of Labor to assess a civil penalty equal to 20 percent of any amount recovered for violations of fiduciary responsibility.

The Pension Protection Act of 2006 made many changes to ERISA, including expanding the availability of fiduciary investment advice to participants in 401(k)-type plans and individual retirement accounts (IRAs), removing impediments to automatic enrollment through qualified default investment alternatives, and increasing the transparency of pension plan funding through new notice requirements.

The Department of Labor's responsibilities under ERISA have also been expanded by health care legislation. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) added a new Part 6 to Title I of ERISA, which provides for the continuation of health care coverage for employees and their beneficiaries (for a limited period of time) if certain events would otherwise result in a reduction in benefits.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) added a new Part 7 to Title I of ERISA aimed at making health care coverage more portable and secure for employees, and gave the Department of Labor broad additional responsibilities with respect to private health plans.

These responsibilities were increased further with the enactment of the Newborns' and Mothers' Health Protection Act of 1996, the Mental Health Parity Act of 1996, the Women's Health and Cancer Rights Act of 1998, the Genetic Information Nondiscrimination Act of 2008, the Mental Health Parity and Addiction Equity Act of 2008, and the Children's Health Insurance Program Reauthorization Act.

The 2010 passage of the Patient Protection and Affordable Care Act (ACA) brought widespread health care reform. In addition to the ACA's market reform provisions, significant changes impacted dependent coverage, lifetime and annual benefit limits, coverage of preventative services, elimination of pre-existing condition exclusions, disclosures to plan participants, claims procedures and external review, and many other areas. The ACA also provided EBSA with additional enforcement authority to protect workers and employers whose health benefits are provided MEWAs.

Calendar - Timeline of Benefit Notices

DUE DATE	BENEFIT NOTICE	EXPLANATION	TO WHOM NOTICE GIVEN
NOTICE DUE UPON HIRE			
No later than 14 days after the employee's hire date	**Notice Regarding Availability of Health Insurance Marketplace Coverage Options (a.k.a. per Chicago Manual Employer Exchange Notice)**	Informs employee of the existence of the Marketplace (Exchange), its services, and how to contact the Marketplace for assistance **Model Notice** for employers who offer a health plan to some or all employees **Model Notice** for employers who do not offer a health plan For more information, see **Technical Release 2013-02**	All new employees
NOTICES DUE BY A CERTAIN DATE			
Prior to October 15 each year Prior to an individual's initial enrollment period for Part D Prior to the date of enrolling in the employer's plan and upon any change that affects whether the coverage is "creditable"	**Medicare Part D – Notice of Creditable (or Non-Creditable) Coverage Disclosure Notice**	Informs Medicare-eligible participants as to whether the group plan's prescription drug coverage is creditable For model notices and instructions, see **Creditable Coverage Model Notice Letters** and **Creditable Coverage**	Medicare-eligible plan participants (e.g., employees, dependents, COBRA enrollees, and retirees participating in employer's group health plan)
Generally within 9 months after the end of each plan year ERISA plans only	**Summary Annual Report**	Summary of the plan's Form 5500 report, if any	Plan participants and beneficiaries

June 2018

DUE DATE	BENEFIT NOTICE	EXPLANATION	TO WHOM NOTICE GIVEN
NOTICES DUE WHEN ENROLLMENT IS OFFERED			
With enrollment materials and upon renewal of coverage Within 90 days of special enrollment No later than 7 business days following request	**Summary of Benefits and Coverage (SBC) and Uniform Glossary**	A short, easy-to-understand summary of the plan's benefits and coverage, and a uniform glossary of standard terms For more information, see section on **Summary of Benefits and Uniform Glossary**	Persons eligible to enroll
At or before each enrollment period	**Notice of Special Enrollment Rights**	Describes the plan's special enrollment rules For model language, see page 138 in the **DOL Compliance Assistance** Manual	Persons eligible to enroll
With any materials describing the plan's benefits Grandfathered plans only	**Disclosure of Grandfathered Plan Status**	Statement that the plan is grandfathered and contact information **Model Notice**	Persons eligible to enroll
At enrollment and annually	**Women's Health and Cancer Rights Act (WHCRA) Notices**	Describes required plan benefits for mastectomy-related services For model language, see pages 141 and 142 in the **DOL Compliance Assistance** Manual	Persons eligible to enroll
At enrollment and annually	**Employer CHIP Notice**	Provides information about possible premium assistance under a state's Medicaid or Children's Health Insurance Program **Model CHIP Notice**	All eligible employees

June 2018

DUE DATE	BENEFIT NOTICE	EXPLANATION	TO WHOM NOTICE GIVEN
NOTICES DUE WHEN ENROLLMENT IS MADE			
Upon enrollment in the plan (Also provide notice, or reminder that notice is available, at least once every 3 years)	**HIPAA Notice of Privacy Practices for Protected Health Information**	Describes ways that the plan may use and disclose individual protected health information, employee's rights, and the plan's duties to protect that information **Model Notices of Privacy Practices**	Plan participants and beneficiaries
Within 90 days after health coverage begins	**General Notice of COBRA Rights**	Explains right to purchase temporary extension of group health coverage when coverage is lost due to a qualifying event **Model General Notice**	Plan participants and beneficiaries
With materials describing the terms of a wellness program	**Wellness Program Disclosure**	One or two notices may be required, depending on the wellness program's features: • HIPAA notice is required for a health-contingent wellness program that is subject to the alternative standard rule. • EEOC notice is required if the wellness program collects participant health information, e.g., health risk assessments, biometric screenings.	Eligible participants
Within 30 days of participant's written request ERISA plans only	**Plan Document**	Documents, including latest updated SPD, contracts and other instruments, under which the plan is established and operated	Plan participant or beneficiary making the request
Within 90 days of becoming covered ERISA plans only	**Summary Plan Description (SPD)**	Describes the plan and how it operates and explains the participant's rights and responsibilities under ERISA	Plan participants and beneficiaries
When participants receive an SPD or other benefits summaries Nongrandfathered plans	**Notice of Patient Protections** May include in SPD	Describes plan's patient protection provisions, e.g., designation of a primary care provider, OB/GYN care without prior authorization	Plan participants and beneficiaries

DUE DATE	BENEFIT NOTICE	EXPLANATION	TO WHOM NOTICE GIVEN
NOTICES DUE UPON CERTAIN EVENTS (in connection with plan changes)			
No later than 60 days before change affecting SBC content	**Notice of Modification (of SBC)**	Advance notice of material changes in the plan that affect the content of the SBC	Plan participants and beneficiaries
Within 60 days of adoption of material reduction in group health benefits or services ERISA plans only	**Summary of Material Reduction (SMR)** (Updated SPD can be provided in lieu of SMR)	Describes changes in group health benefits or services that constitute a material reduction and changes in the SPD's content	Plan participants and beneficiaries
Within 210 days after the end of the plan year in which the material modification is adopted ERISA plans only	**Summary of Material Modification (SMM)** (Updated SPD can be provided in lieu of SMM)	Describes material modifications to a plan and changes in the SPD's content	Plan participants and beneficiaries
At least 30 days before rescission of coverage	**Notice of Rescission of Coverage**	Advance written notice of rescission (which may be retroactive), including date of, and reason for, rescission	Affected participants and beneficiaries
Upon request for certification of student status For plans offering coverage for students age 26 and older	**Michelle's Law Enrollment Notice**	Describes child's right to continue coverage during medically necessary leave of absence from postsecondary educational institution	Plan participants
NOTICES DUE UPON CERTAIN EVENTS (in connection with federal COBRA)			
Within 30 days of a covered dependent losing coverage (e.g., due to divorce, child attaining limiting age)	**Notice of Qualifying Event**	Notice of covered dependent's loss of eligibility if a qualifying event that triggers COBRA	Plan administrator
Within 14 days after receiving notice of COBRA qualifying event or within 44 days of the qualifying event if the employer is also the plan administrator	**COBRA Election Notice**	Describes right to COBRA continuation coverage, along with election form and cost information **Model Election Notice**	Qualified beneficiaries
Within 14 days after receiving notice of a qualifying event	**Notice of Unavailability of COBRA Coverage**	Notice that the individual is not entitled to COBRA with reasons for denial	Individuals not qualified for COBRA
No less than 30 days after COBRA payment deficiency	**Notice of Underpayment of COBRA Premium**	Used when COBRA participant makes a timely but incorrect amount of payment for the COBRA premium	Participant making the underpayment

DUE DATE	BENEFIT NOTICE	EXPLANATION	TO WHOM NOTICE GIVEN
NOTICES DUE UPON CERTAIN EVENTS (in connection with federal COBRA, continued)			
As soon as practicable following determination that COBRA will terminate	**Notice of Early Termination of COBRA Coverage**	Provides notice that COBRA will terminate earlier than the maximum period of coverage, including date of, and reason for, termination as well as alternative coverage options	Qualified beneficiaries whose COBRA will terminate earlier than the maximum period of coverage
NOTICES DUE UPON CERTAIN EVENTS (other)			
Varies, depending on the type of benefit claim involved	**Notice of Benefit Determination (Claim Notice or "Explanation of Benefits")**	Information regarding benefit claim determinations Additional information based upon adverse decisions and/or appeals	Claimants
Promptly upon receipt of the medical child support order	**Medical Child Support Order (MCSO) Notice**	Notification regarding receipt of a support order and description of the plan's procedures for determining its qualified status	Participants, any child named in the order and the child's representative
No later than 20 days of the date of the notice, send Part A to the state agency or Part B to the plan administrator Must also notify affected persons of receipt as soon as is practicable Plan administrators must complete and return Part B to the state agency and affected persons within 40 business days	**National Medical Support (NMS) Notice**	**Notice used by state child support enforcement agencies directing the employer's plan to enroll the child**	State agencies, employers, plan administrators, participants, custodial parents, child representatives
Upon request	**Mental Health Parity & Addiction Equity Act Disclosure**	**Describes criteria for determining medical necessity for mental health or substance use disorder benefits**	Current or potential participants, beneficiaries, or contracting healthcare providers
For Affected Individuals: No later than 60 calendar days after discovery of breach For Annual Report: If breach affects fewer than 500 individuals, no later than 60 days after the end of the calendar year in which the breaches occurred. If breach affects more than 500 individuals, no later than 60 calendar days after discovery	**HIPAA Notice of Breach of Unsecured Protected Health Information**	Provides information related to the discovery of a breach of unsecured protected health information with steps individuals should take to protect themselves and what the administrator is doing to fix the situation	Affected individuals, U.S. Department of Health and Human Services (and media outlets for large breaches affecting more than 500 residents of a state or jurisdiction)

Sample Forms and Notices

Employers and their advisors are cautioned that sample materials cannot be used without careful review and customization for their group health plan's procedures and requirements. The samples are provided for the most common items and do not include all the materials that the employer may need. Employers are encouraged to work with legal counsel offering expertise in the Rules.

The following Sample Forms and Notices apply to federal requirements only. There may be additional state level forms and notices that apply. Please use the government provided-links for the most up to date information.

DISCLOSURE OF GRANDFATHERED PLAN STATUS

This [insert group health plan name] believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted.

Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans; for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the. [For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.] [For nonfederal governmental employer plans, insert: You may also contact the Department of Health and Human Services.]

DISCLOSURE TO ENROLLEES REGARDING HIPAA OPT-OUT

Group health plans sponsored by State and local governmental employers must generally comply with Federal law requirements in title XXVII of the Public Health Service Act. However, these employers are permitted to elect to exempt a plan from the requirements listed below for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. We have elected to exempt the plan from [insert “all” or specify which of the following apply] of the following requirements:

1. Protection against limiting hospital stays in connection with the birth of a child to less than 48 hours for a vaginal delivery, and 96 hours for a cesarean section.
2. Protections against having benefits for mental health and substance use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the plan.
3. Certain requirements to provide benefits for breast reconstruction after a mastectomy.
4. Continued coverage for up to one year for a dependent child who is covered as a dependent under the plan solely based on student status, who takes a medically necessary leave of absence from a postsecondary educational institution.

The exemption from these Federal requirements will be in effect for the [insert “plan year” or “period of plan coverage”] beginning [insert beginning date] and ending [insert specific ending date]. The election may be renewed for subsequent plan years.

Per the Genetic Information Nondiscrimination Act (GINA), the opt-out does not prevent HIPAA’s portability and nondiscrimination requirements from applying to genetic information. Further, the opt-out does not apply to GINA’s restrictions on requesting, requiring, collecting and using genetic information.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2018. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075

MONTANA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: The Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact _____

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)	
5. Employer address	6. Employer phone number	
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)	12. Email address	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☐ Some employees. Eligible employees are:
- With respect to dependents:
  - ☐ We do offer coverage. Eligible dependents are:
  - ☐ We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

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What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name		4. Employer Identification Number (EIN)
5. Employer address		6. Employer phone number
7. City	8. State	9. ZIP code
10. Who can we contact about employee health cove rage at this job?		
11. Phone number (if different from above)	12. Email address	

You are not eligible for health insurance coverage through this employer. You and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.

GENERAL NOTICE OF USERRA RIGHTS

Your Rights Under USERRA

A. The Uniformed Services Employment and Reemployment Rights Act

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

B. Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

C. Right To Be Free From Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service; then an employer may not deny you
  - Initial employment;
  - Reemployment;
  - Retention in employment;
  - Promotion; or
  - Any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

D. Health Insurance Protection

- If you leave your job to perform military service, you have the right to elect to continue your existing employer based health plan coverage for you and your dependents for up to 24 months while in the military.

- Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

E. Enforcement

- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at ***http://www.dol.gov/vets.*** An interactive online USERRA Advisor can be viewed at ***http://www.dol.gov/elaws/userra.htm.***

- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.

- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address: ***http://www.dol.gov/vets/programs/userra/poster.htm***. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees. U.S. Department of Labor, Veterans' Employment and Training Service, 1-866-487-2365.

[This Notice for Plan that Provides Creditable Coverage]

Important Notice from [Insert Name of Entity] About Your Prescription Drug Coverage and Medicare

This Notice Applies to You (or Dependent) ONLY if such person is (1) enrolled in a group medical plan offered by [insert name of entity] AND (2) eligible for Medicare.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with [insert name of entity] and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.
There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **[Insert name of entity] has determined that the prescription drug coverage offered by the [insert group health plan name] is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current [insert name of entity] coverage [insert "will" or "will not"] be affected. [Insert an explanation of the prescription drug coverage plan provisions/options under the particular entity's plan that Medicare eligible individual have available to them when they become eligible for Medicare Part D (e.g., they can keep this coverage if they elect Part D and this plan will coordinate with Plan D coverage; for those individuals who elect Part D coverage, coverage under the entity's plan will end for the individual and all covered dependents, etc. See pages 7-9 of the CMS Disclosure of Creditable Coverage to Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.]

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents [insert "will" or "may not"] be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with [insert name of entity] and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage …

Contact the person listed below for further information at [insert telephone number]. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through [insert name of entity] changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: [Insert MM/DD/YY]
Name of Entity/Sender: [Insert Name of Entity]
Contact--Position/Office: [Insert Position/Office]
Address: [Insert Street Address, City, State & Zip Code of Entity]
Phone Number: [Insert Entity Phone Number]

[This Notice for Plan that Provides Non-Creditable Coverage]

Important Notice from [Insert Name of Entity] About Your Prescription Drug Coverage and Medicare

This Notice Applies to You (or Dependent) ONLY if such person is (1) enrolled in a group medical plan offered by [insert name of entity] AND (2) eligible for Medicare.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with [insert name of entity] and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **[Insert name of entity] has determined that the prescription drug coverage offered by the [insert name of group health plan] is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the [insert name of group health plan]. This also**

3. **is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.**

4. **You can keep your current coverage from [insert name of group health plan]. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you decide to drop your current coverage with [insert name of entity] since it is employer group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however, you also may pay a higher premium (a penalty) because you did not have creditable coverage under [insert name of group health plan].

[Insert if previous coverage provided by the entity was creditable coverage: Since you are losing creditable prescription drug coverage under your current plan, you are also eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.]

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Since the coverage under [insert name of group health plan] is not creditable, depending on how long you go without creditable prescription drug coverage, you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

What Happens to Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current [insert name of entity] coverage [insert "may" or "will not"] be affected. [Insert an explanation of the prescription drug coverage plan provisions/options under the particular entity's plan that Medicare eligible individuals have available to them when they become eligible for Medicare Part D (e.g., they can keep this coverage if they elect part D and this plan will coordinate with Part D coverage; for those individuals who elect Part D coverage, coverage under the entity's plan will end for the individual and all covered dependents, etc.). See pages 9 - 11 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.]

If you do decide to join a Medicare drug plan and drop your current [insert name of entity] coverage, be aware that you and your dependents [insert "will" or "will not"] be able to get this coverage back.

For More Information About This Notice or Your Current Prescription Drug Coverage …

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through [insert name of entity] changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date:	[Insert MM/DD/YY]
Name of Entity/Sender:	[Insert Name of Entity]
Contact--Position/Office:	[Insert Position/Office]
Address:	[Insert Street Address, City, State & Zip Code of Entity]
Phone Number:	[Insert Entity Phone Number]

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE OF PATIENT PROTECTIONS

For plans and insurers that require or allow for the designation of primary care providers by participants or beneficiaries, insert:

[Insert name of group health plan] generally [insert "requires" or "allows," as applicable] the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. [If the plan or health insurance coverage designates a primary care provider automatically, insert: Until you make this designation, [insert name of group health plan] designates one for you.] For information on how to select a primary care provider, and for a list of the participating primary care providers, contact [insert name, title, telephone number, and any additional contact information of the appropriate plan representative].

For plans and issuers that require or allow for the designation of a primary care provider for a child, add:

For children, you may designate a pediatrician as the primary care provider.

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add:

You do not need prior authorization from [insert name of group health plan or insurer] or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact [insert name, title, telephone number, and any additional contact information of the appropriate plan representative].

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within [insert "30 days" or any longer period that applies under the plan] after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within [insert "30 days" or any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption.

If you are declining enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within [insert "60 days" or any longer period that applies under the plan] after your or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. However, you must request enrollment within [insert "60 days" or any longer period that applies under the plan] after you or your dependents become eligible for the premium assistance.

To request special enrollment or obtain more information, contact [insert name, title, telephone number, and any additional contact information of the appropriate plan representative].

WELLNESS PROGRAM DISCLOSURE (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

NOTICE REGARDING WELLNESS PROGRAM (ADA)

[Insert name of wellness program] is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to [insert brief description, such as voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for [be specific about the conditions for which blood will be tested]. You are not required to complete the inquiries or to participate in tests or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of [indicate the incentive] for [specify criteria]. Although you are not required to complete the inquiries or participate in the screenings, only employees who do so will receive [indicate the incentive].

Additional incentives of up to [indicate the additional incentives] may be available for employees who participate in certain health-related activities [specify activities, if any] or achieve certain health outcomes [specify particular health outcomes to be achieved, if any]. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting [insert name, title, telephone number, and any additional contact information of the appropriate plan representative].

The information from your inquiries and results from your screenings will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as [indicate services that may be offered]. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and [insert name of employer] may use aggregate information it collects to design a program based on identified health risks in the workplace, [insert name of wellness program] will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) [indicate who will receive information such as "a registered nurse," "a doctor," or "a health coach"] in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. [Specify any other or additional confidentiality protections if applicable.]

Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact [insert name, title, telephone number, and any additional contact information of the appropriate plan representative].

WELLNESS PROGRAM DISCLOSURE (HIPAA)

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at [insert name, title, telephone number, and any additional contact information of the appropriate plan representative] and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals 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.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: [insert brief description of deductibles and coinsurance applicable to these benefits].

If you would like more information on WHCRA benefits, contact [insert name, title, telephone number, and any additional contact information of the appropriate plan representative].

Model COBRA Continuation Coverage Election Notice Instructions

The Department of Labor has developed a model Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation coverage election notice that the Plan may use to provide the election notice. To use this model election notice properly, the Plan Administrator must fill in the blanks with the appropriate plan information. The Department considers use of the model election notice to be good faith compliance with the election notice content requirements of COBRA. The use of the model notices isn't required. The model notices are provided to help facilitate compliance with the applicable notice requirements.

NOTE: Plans do ***not*** need to include this instruction page with the model election notice.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately four minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0123.

OMB Control Number 1210-0123 (expires 12/31/2019)]

Model COBRA Continuation Coverage Election Notice
(For use by single-employer group health plans)

IMPORTANT INFORMATION: COBRA Continuation Coverage and other Health Coverage Alternatives

[***Enter date of notice***]

Dear: [***Identify the qualified beneficiary(ies), by name or status***]

This notice has important information about your right to continue your health care coverage in the [*enter name of group health plan*] (the Plan), as well as other health coverage options that may be available to you, including coverage through the Health Insurance Marketplace at www.HealthCare.gov or call 1-800-318-2596**. You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage.** Please read the information in this notice very carefully before you make your decision. If you choose to elect COBRA continuation coverage, you should use the election form provided later in this notice.

Why am I getting this notice?

You're getting this notice because your coverage under the Plan will end on [***enter date***] due to [***check appropriate box***]:

- £ End of employment
- £ Death of employee
- £ Entitlement to Medicare
- £ Reduction in hours of employment
- £ Divorce or legal separation
- £ Loss of dependent child status

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage through COBRA continuation coverage when there's a "qualifying event" that would result in a loss of coverage under an employer's plan.

What's COBRA continuation coverage?

COBRA continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries who aren't getting continuation coverage. Each "qualified beneficiary" (described below) who elects COBRA continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan.

Who are the qualified beneficiaries?

Each person ("qualified beneficiary") in the category(ies) checked below can elect COBRA continuation coverage:

- £ ***Employee or former employee***
- £ ***Spouse or former spouse***
- £ ***Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage***
- £ ***Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan***

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

If I elect COBRA continuation coverage, when will my coverage begin and how long will the coverage last?

If elected, COBRA continuation coverage will begin on [***enter date***] and can last until [***enter date***]***.***

[***Add, if appropriate:*** You may elect any of the following options for COBRA continuation coverage: [***list available coverage options***].

Continuation coverage may end before the date noted above in certain circumstances, like failure to pay premiums, fraud, or the individual becomes covered under another group health plan.

Article I. Can I extend the length of COBRA continuation coverage?

If you elect continuation coverage, you may be able to extend the length of continuation coverage if a qualified beneficiary is disabled, or if a second qualifying event occurs. You must notify [***enter name of party responsible for COBRA administration***] of a disability or a second qualifying event within a certain time period to extend the period of continuation coverage. If you don't provide notice of a disability or second qualifying event within the required time period, it will affect your right to extend the period of continuation coverage.

For more information about extending the length of COBRA continuation coverage visit http://www.dol.gov/ebsa/publications/cobraemployee.html.

How much does COBRA continuation coverage cost?

COBRA continuation coverage will cost: [***enter amount each qualified beneficiary will be required to pay for each option per month of coverage and any other permitted coverage periods.***]

Other coverage options may cost less. If you choose to elect continuation coverage, you don't have to send any payment with the Election Form. Additional information about payment will be provided to you after the election form is received by the Plan. Important information about paying your premium can be found at the end of this notice.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You can learn more about the Marketplace below.

What is the Health Insurance Marketplace?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

When can I enroll in Marketplace coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. **After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

Can I enroll in another group health plan?

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

What factors should I consider when choosing coverage options?

When considering your options for health coverage, you may want to think about:

- Premiums: Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- Provider Networks: If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- Drug Formularies: If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- Severance payments: If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.
- Service Areas: Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

For more information

This notice doesn't fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator.

If you have questions about the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, contact [***enter name of party responsible for COBRA administration for the Plan, with telephone number and address***].

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at http://www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

To protect your and your family's rights, keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy of any notices you send to the Plan Administrator.

COBRA Continuation Coverage Election Form

Instructions: To elect COBRA continuation coverage, complete this Election Form and return it to us. Under federal law, you have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan.

Send completed Election Form to: [*Enter Name and Address*]

This Election Form must be completed and returned by mail [*or describe other means of submission and due date*]. If mailed, it must be post-marked no later than [*enter date*].

If you don't submit a completed Election Form by the due date shown above, you'll lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you submit a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you submit the completed Election Form.

I (We) elect COBRA continuation coverage in the [***enter name of plan***] (the Plan) listed below:

Name Date of Birth
Relationship to Employee SSN (or other identifier)

a. _____

[***Add if appropriate:*** Coverage option elected: _____]

b. _____

[***Add if appropriate:*** Coverage option elected: _____]

c. _____

[***Add if appropriate:*** Coverage option elected: _____]

_____ _____
Signature Date

_____ _____
Print Name Relationship to individual(s) listed above

_____

_____

_____ _____
Print Address Telephone number

Important Information About Payment

First payment for continuation coverage

You must make your first payment for continuation coverage no later than 45 days after the date of your election (this is the date the Election Notice is postmarked). If you don't make your first payment in full no later than 45 days after the date of your election, you'll lose all continuation coverage rights under the Plan. You're responsible for making sure that the amount of your first payment is correct. You may contact [***enter appropriate contact information, e.g., the Plan Administrator or other party responsible for COBRA administration under the Plan***] to confirm the correct amount of your first payment.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you'll have to make periodic payments for each coverage period that follows. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due [***enter due day for each monthly payment***] for that coverage period. [***If Plan offers other payment schedules, enter with appropriate dates:*** You may instead make payments for continuation coverage for the following coverage periods, due on the following dates:]. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan [***select one:*** will ***or*** will not] send periodic notices of payments due for these coverage periods.

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you'll be given a grace period of 30 days after the first day of the coverage period [***or enter longer period permitted by Plan***] to make each periodic payment. You'll get continuation coverage for each coverage period as long as payment for that coverage period is made before the end of the grace period. [***If Plan suspends coverage during grace period for nonpayment, enter and modify as necessary:*** If you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.]

If you don't make a periodic payment before the end of the grace period for that coverage period, you'll lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be sent to:

[***enter appropriate payment address***]

Model COBRA Continuation Coverage General Notice Instructions

The Department of Labor has developed a model Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation coverage general notice that plans may use to provide the general notice. To use this model general notice properly, the Plan Administrator must fill in the blanks with the appropriate plan information. The Department considers use of the model general notice, to be good faith compliance with the general notice content requirements of COBRA. The use of the model notices isn't required. The model notices are provided to help facilitate compliance with the applicable notice requirements.

NOTE: Plans do ***not*** need to include this instruction page with the model general notice.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately four minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0123.

OMB Control Number 1210-0123 (expires 12/31/2019)

Sample

[Words or phrases contained in brackets are intended as either optional language or as instructions to the user.]

Notice of Privacy Practices

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

[Insert name of group health plan(s)] (the "Plan") provides health benefits to eligible employees of [insert employer's name] ("we"), and their eligible dependents. The Plan creates, receives, uses, maintains, and discloses health information about Plan participants ("you"). The Plan has adopted policies to safeguard the privacy of your health information and comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This Notice is effective [insert effective date] and remains in effect until we change or replace it.

This Notice describes how your protected health information (PHI) may be used or disclosed to carry out treatment, payment, or healthcare operations, or for any other purposes that are permitted or required by law. It also describes the Plan's responsibilities and your rights with respect to your PHI.

Generally, PHI is health information, including demographic information, collected from you or created or received by a healthcare provider, a healthcare clearinghouse, a health plan, or your employer on behalf of a group health plan, from which it is possible to individually identify you and that relates to:

- your past, present, or future physical or mental health or condition;
- the provision of healthcare to you; or
- the past, present, or future payment for the provision of healthcare to you.

The Plan's Responsibilities

The Plan is required by law to:

- Ensure that health information that identifies you is kept private, except as such information is required or permitted to be disclosed bylaw;
- Describe the Plan's responsibilities and privacy practices with respect to your PHI;
- Abide by the terms of this Notice as currently in effect; and
- Inform you in the event of a breach of your unsecured PHI.

[*If you are covered by an insured health option under the Plan, you will also receive a separate notice from the insurance company or HMO.*]

How the Plan May Use and Disclose Your Information

The Plan and its business associates, which are service providers that assist us in administering the Plan or providing Plan services to you, use and disclose PHI in the ways described below. For purposes of this Notice, "the Plan" includes its business associates. We will not use or share your information other than as described in this Notice.

In order to administer your Plan coverage effectively, the Plan is permitted by law to use and disclose your PHI in certain ways without your authorization. The following list describes the ways that the Plan is legally allowed or required to use and disclose your PHI without your prior written authorization:

- **For treatment.** To ensure that you receive appropriate treatment and care, the Plan may use and disclose your PHI to coordinate care between the Plan and your provider. For example, we may disclose your PHI to healthcare providers for their treatment activities.

- **For payment.** To ensure that claims are paid accurately and you receive the correct benefits, the Plan may use and disclose your PHI to determine plan eligibility and responsibility for coverage and benefits. For example, the Plan may use and disclose your PHI when it confers with other health plans to resolve a coordination of benefits issue. The Plan may also use your PHI for utilization review activities.
- **For healthcare operations.** To ensure quality and efficient plan operations, the Plan may use and disclose your PHI in several ways, including plan administration, quality assessment and improvement, vendor review and for health care fraud and abuse detection and compliance. [Insert examples of how the Plan uses PHI for its operations, such as: For example, the Plan may use and disclose your PHI to assist in the evaluation of a vendor who supports the Plan for underwriting and related purposes. Another example includes the disclosure of your PHI to vendors to support our wellness initiatives.] The Plan is not allowed to use genetic information to decide whether to give you coverage or the price of that coverage.
- **Disclosures to the plan sponsor.** For the purpose of administration, the Plan may disclose PHI to certain employees of the Plan Sponsor ([insert employer name]). However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without your specific authorization.

Other Permitted Uses and Disclosures

Federal regulations allow us to use and disclose your PHI, without your authorization, for several additional purposes, in accordance with federal and state law:

- To a coroner or medical examiner;
- To cadaveric organ, eye or tissue donation programs;
- For research purposes, as long as certain privacy-related standards are satisfied;
  - Public health;
  - Reporting and notification of abuse, neglect or domestic violence;
  - Oversight activities of a health oversight agency;
  - Judicial and administrative proceedings;
  - Law enforcement;
  - To avert a serious threat to health or safety;
  - Specialized government functions (for example, military and veterans' activities, national security and intelligence, federal protective services, medical suitability determinations, correctional institutions and other law enforcement custodial situations);
  - Workers' compensation or similar programs established by law that provide benefits for work-related injuries or illness; and
  - Other purposes required by law, provided that the use or disclosure is limited to the relevant requirements of such law.

Also, for health and safety, and when consistent with applicable law and standards of ethical conduct, the Plan may disclose your PHI if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or the health and safety of others.

Uses and Disclosures that You May Authorize

The following uses and disclosures will only be made with your written authorization:

- Uses and disclosures for marketing purposes;
- Uses and disclosures that constitute a sale of PHI;
- Most uses and disclosures of psychotherapy notes; and
- Other uses and disclosures not otherwise described in this Notice.

You may revoke your authorization in writing at any time by contacting us. (See "How to Contact Us" below.) Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon your written authorization and prior to receiving your revocation. We also may continue to use and disclose your PHI after revocation if the authorization was obtained as a condition of securing insurance and other law provides us with the right to contest a claim under the policy or the policy itself.

Finally, if applicable state law provides you greater rights or protections concerning your PHI, we will follow such laws. **Your Rights**

You have certain rights regarding access to, and the use and disclosure of your PHI as described below. To exercise any of these rights, contact us. (See "How to Contact Us" below.) Specifically, you have the right to:

- **Inspect and copy.** You have the right to inspect your PHI. Any request for access to your health information should be sent to us in writing. (See "How to Contact Us" below.) If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request if the information can be readily produced in that form and format. If the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. We may deny your request in writing in certain, very limited circumstances. We may charge a reasonable, cost-based fee. If you are denied access, you may request that the denial be reviewed by submitting a written request to us.
- **Amend.** You have the right to request to amend your PHI if you think it is incorrect or incomplete. You must provide the request and your reason(s) for the request in writing to us. (See "How to Contact Us" below.) You will be notified in writing if your request is denied. If your request is denied, you have the right to submit a written statement disagreeing with the denial, which
- **Receive an accounting of disclosures.** You have the right to request a list of certain disclosures of your PHI that the Plan or our business associates have made. We will include all of the disclosures except for those about treatment, payment, health care operations and certain other disclosures (such as any you have asked us to make). Your request must be made in writing and state the time period of the request, which may not be longer than six years prior to your request. The first request within a 12-month period will be provided to you free of charge, and any additional requests within this time period may be subject to a reasonable, cost-based fee. The Plan will notify you prior to charging a fee, and you may choose to withdraw or modify your request at that time before any costs are incurred.
- **Be notified of a breach.** You have the right to be notified in the event that the Plan (or a business associate) discovers a breach of unsecured PHI.
- **Personal representatives.** You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. The Plan retains discretion to deny a personal representative access to your PHI to the extent permissible under applicable law.
- **Obtain a copy of this Notice.** You have a right to receive a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time, even if you have previously agreed to receive the Notice electronically.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the U.S. Department of Health and Human Services. To file a complaint with the Plan, see "How to Contact Us" below. All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with the Plan. **How to Contact Us**

The Plan has designated [insert name or title of Privacy Contact] as its contact person for all issues regarding the Plan's privacy practices and your privacy rights at [insert employer name, address, telephone number].

Sample

[Words or phrases contained in brackets are intended as either optional language or as instructions to the user.]

Reminder of Availability of Notice of Privacy Practices

The Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the [insert name of group health plan(s)] (the "Plan") to periodically send a reminder to participants about the availability of the Plan's Notice of Privacy Practices ("Privacy Notice") and how to obtain that notice. The Privacy Notice explains participants' rights and the Plan's legal duties with respect to protected health information (PHI) and how the Plan may use and disclose PHI.

To obtain a copy of the Privacy Notice, contact [insert employer name, address, telephone number], Attn: Privacy Contact. [You may also view the Privacy Notice online at [insert website address].]

You may also contact the Privacy Contact at [insert employer name, address] or call [insert telephone number] for more information on the Plan's privacy policies or your rights under HIPAA.

Sample

[Words or phrases contained in brackets are intended as either optional language or as instructions to the user.]

Business Associate Agreement (BAA)

Definitions

The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required by Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

(a) Business Associate. "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean [Insert Name of Business Associate].

(b) Covered Entity. "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean [Insert Name of Group Health Plan].

(c) HIPAA Rules. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

Obligations and Activities of Business Associate

Business Associate agrees to:

(a) Not use or disclose protected health information other than as permitted or required by the Agreement or as required by law;

(b) Use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of protected health information other than as provided for by the Agreement;

( ) Report to covered entity any use or disclosure of protected health information not provided for by the Agreement of which it becomes aware, including breaches of unsecured protected health information as required at 45 CFR 164.410, and any security incident of which it becomes aware;
[The parties may wish to add additional specificity regarding the breach notification obligations of the business associate, such as a stricter timeframe for the business associate to report a potential breach to the covered entity and/or whether the business associate will handle breach notifications to individuals, the HHS Office for Civil Rights (OCR), and potentially the media, on behalf of the covered entity.]

(c) In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the business associate agree to the same restrictions, conditions, and requirements that apply to the business associate with respect to such information;

(d) Make available protected health information in a designated record set to the [Choose either "covered entity" or "individual or the individual's designee"] as necessary to satisfy covered entity's obligations under 45 CFR 164.524;
[The parties may wish to add additional specificity regarding how the business associate will respond to a request for access that the business associate receives directly from the individual (such as whether and in what time and manner a business associate is to provide the requested access or whether the business associate will forward the individual's request to the covered entity to fulfill) and the timeframe for the business associate to provide the information to the covered entity.]

(e) Make any amendment(s) to protected health information in a designated record set as directed or agreed to by the covered entity pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy covered entity's obligations under 45 CFR 164.526;
[The parties may wish to add additional specificity regarding how the business associate will respond to a request for amendment that the business associate receives directly from the individual (such as whether and in what time and manner a business associate is to act on the request for amendment or whether the business associate will forward the individual's request to the covered entity) and the timeframe for the business associate to incorporate any amendments to the information in the designated record set.]

(g) Maintain and make available the information required to provide an accounting of disclosures to the [Choose either "covered entity" or "individual"] as necessary to satisfy covered entity's obligations under 45 CFR 164.528;
[The parties may wish to add additional specificity regarding how the business associate will respond to a request for an accounting of disclosures that the business associate receives directly from the individual (such as whether and in what time and manner the business associate is to provide the accounting of disclosures to the individual or whether the business associate will forward the request to the covered entity) and the timeframe for the business associate to provide information to the covered entity.]

(h) To the extent the business associate is to carry out one or more of covered entity's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the covered entity in the performance of such obligation(s); and

(i) Make its internal practices, books, and records available to the Secretary for purposes of determining compliance with the HIPAA Rules. **Permitted Uses and Disclosures by Business Associate**

(a) Business associate may only use or disclose protected health information
[Option 1 – Provide a specific list of permissible purposes.]

[Option 2 – Reference an underlying service agreement, such as "as necessary to perform the services set forth in Service Agreement."]

[In addition to other permissible purposes, the parties should specify whether the business associate is authorized to use protected health information to de-identify the information in accordance with 45 CFR 164.514(a)-(c). The parties also may wish to specify the manner in which the business associate will de-identify the information and the permitted uses and disclosures by the business associate of the de-identified information.]

(b) Business associate may use or disclose protected health information as required by law.

(c) Business associate agrees to make uses and disclosures and requests for protected health information
[Option 1] consistent with covered entity's minimum necessary policies and procedures.

(d) Business associate may not use or disclose protected health information in a manner that would violate Subpart E of 45 CFR Part 164 if done by covered entity [if the Agreement permits the business associate to use or disclose protected health information for its own management and administration and legal responsibilities or for data aggregation services as set forth in optional provisions (e), (f), or (g) below, then add ", except for the specific uses and disclosures set forth below."]

(e) [Optional] Business associate may use protected health information for the proper management and administration of the business associate or to carry out the legal responsibilities of the business associate.

(f) [Optional] Business associate may disclose protected health information for the proper management and administration of business associate or to carry out the legal responsibilities of the business associate, provided the disclosures are required by law, or business associate obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies business associate of any instances of which it is aware in which the confidentiality of the information has been breached.

(g) [Optional] Business associate may provide data aggregation services relating to the health care operations of the covered entity. **Provisions for Covered Entity to Inform Business Associate of Privacy Practices and Restrictions**

(a) [Optional] Covered entity shall notify business associate of any limitation(s) in the notice of privacy practices of covered entity under 45 CFR 164.520, to the extent that such limitation may affect business associate's use or disclosure of protected health information.

(b) [Optional] Covered entity shall notify business associate of any changes in, or revocation of, the permission by an individual to use or disclose his or her protected health information, to the extent that such changes may affect business associate's use or disclosure of protected health information.

(c) [Optional] Covered entity shall notify business associate of any restriction on the use or disclosure of protected health information that covered entity has agreed to or is required to abide by under 45 CFR 164.522, to the extent that such restriction may affect business associate's use or disclosure of protected health information.

Permissible Requests by Covered Entity

[Optional] Covered entity shall not request business associate to use or disclose protected health information in any manner that would not be permissible under Subpart E of 45 CFR Part 164 if done by covered entity. [Include an exception if the business associate will use or disclose protected health information for, and the agreement includes provisions for, data aggregation or management and administration and legal responsibilities of the business associate.]

Term and Termination

(a) **Term.** The Term of this Agreement shall be effective as of [Insert effective date], and shall terminate on [Insert termination date or event] or on the date covered entity terminates for cause as authorized in paragraph (b) of this Section, whichever is sooner.

(b) **Termination for Cause.** Business associate authorizes termination of this Agreement by covered entity, if covered entity determines business associate has violated a material term of the Agreement [and business associate has not cured the breach or ended the violation within the time specified by covered entity]. [Bracketed language may be added if the covered entity wishes to provide the business associate with an opportunity to cure a violation or breach of the contract before termination for cause.]

(c) **Obligations of Business Associate Upon Termination.**

[Option 1 – if the business associate is to return or destroy all protected health information upon termination of the agreement]

Upon termination of this Agreement for any reason, business associate shall return to covered entity [or, if agreed to by covered entity, destroy] all protected health information received from covered entity, or created, maintained, or received by business associate on behalf of covered entity, that the business associate still maintains in any form. Business associate shall retain no copies of the protected health information.

[Option 2—if the agreement authorizes the business associate to use or disclose protected health information for its own management and administration or to carry out its legal responsibilities and the business associate needs to retain protected health

Upon termination of this Agreement for any reason, business associate, with respect to protected health information received from covered entity, or created, maintained, or received by business associate on behalf of covered entity, shall:

1. Retain only that protected health information which is necessary for business associate to continue its proper management and administration or to carry out its legal responsibilities;
2. Return to covered entity [or, if agreed to by covered entity, destroy] the remaining protected health information that the business associate still maintains in any form;
0. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information to prevent use or disclosure of the protected health information, other than as provided for in this Section, for as long as business associate retains the protected health information;
1. Not use or disclose the protected health information retained by business associate other than for the purposes for which such protected health information was retained and subject to the same conditions set out at [Insert section number related to paragraphs (e) and (f) above under "Permitted Uses and Disclosures By Business Associate"] which applied prior to termination; and
3. Return to covered entity [or, if agreed to by covered entity, destroy] the protected health information retained by business associate when it is no longer needed by business associate for its proper management and administration or to carry out its legal responsibilities.

[The agreement also could provide that the business associate will transmit the protected health information to another business associate of the covered entity at termination, and/or could add terms regarding a business associate's obligations to obtain or ensure the destruction of protected health information created, received, or maintained by subcontractors.]

(d) **Survival.** The obligations of business associate under this Section shall survive the termination of this Agreement.

Miscellaneous [Optional]

(a) [Optional] Regulatory References. A reference in this Agreement to a section in the HIPAA Rules means the section as in effect or as amended.

(b) [Optional] Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for compliance with the requirements of the HIPAA Rules and any other applicable law.

(c) [Optional] Interpretation. Any ambiguity in this Agreement shall be interpreted to permit compliance with the HIPAA Rules.

Group Health Plan (Covered Entity):		**Business Associate:**	
By:	_____	By:	_____
Print Name:	_____	Print Name:	_____
Title:	_____	Title:	_____
Date:	_____	Date:	_____

Sample

Authorization to Disclose Protected Health Information (PHI)

In accordance with the Health Insurance Portability and Accountability Act (HIPAA)

I hereby authorize the Plan:

To disclose _____

(description of health information to be disclosed (such as insurance claim information, treatment information))

to _____

(name or title of person or entity to receive information (name of health care provider, for example))

for the purpose of _____

(description of all purposes for the disclosure (for example, to recover overpayment from health care provider))

I understand that I may refuse to provide this authorization and that my eligibility for Plan benefits, or ability to obtain treatment or payment, will not be affected by my refusal.

I understand that I may revoke this authorization at any time in writing by sending a written request to the Plan's Privacy Contact. Revoking this authorization, however, will not have any effect on the Plan's use or disclosure of my Protected Health Information (PHI) before the Plan received the revocation.

I understand that if Protected Health Information (PHI) about me is disclosed to a person or organization that is not required to comply with federal privacy regulations, the information may be re-disclosed and no longer protected by the federal privacy regulations.

This authorization expires upon _____

(date or event)

_____ _____

Signature of Plan Participant (or Representative) Date

_____ _____

Print Name of Plan Participant Print Name of Representative *(if applicable)*

_____

Relationship of Representative to Plan Participant *(if applicable)*

[Name of Group Health Plan]

[ATTN: Privacy Contact]

[mailing address and telephone number]

Sample

[Words or phrases contained in brackets are intended as either optional language or as instructions to the user.]

Breach Notification to Individual

[Date]

[Name]
[Address]

Subject: Breach of Unsecured Protected Health Information

Dear :

On behalf of the [insert name of group health plan(s)] ("the Plan"), we are notifying you of a breach or potential breach of your Protected Health Information (PHI). PHI is individually identifiable health information that is created, received, stored, or transmitted by a covered entity (such as the Plan) and relates to the past, present, or future physical or mental health of the individual or information relating to the provision of care or payment for that care.

To the best of our knowledge:

- The breach occurred on or about_____. It was discovered on
- The information that may have been disclosed improperly includes _____

We are investigating the circumstances surrounding this breach or potential breach. [Describe the investigative steps being taken and actions being put in place to protect against future breaches and to mitigate harm, and suggest actions the individual can consider to help protect him/herself.]

We are working diligently to correct the situation and mitigate any potential harm.

If you have any questions regarding this notice or the Plan's privacy practices, please contact:

[Name of Group Health Plan]
[Name of Plan Sponsor (Employer)]
ATTN: Privacy Contact
[Address and Telephone Number]

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Underlined text indicates a term defined in this Glossary.
- See page 6 for an example showing how deductibles, coinsurance and out-of-pocket limits work together in a real life situation.
- For a more expansive list of terms please visit the Healthcare.gov website, https://www.healthcare.gov/glossary/

Allowed Amount
This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense", "payment allowance", or "negotiated rate".

Appeal
A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing
When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not bill you for covered services.

Coinsurance
Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance ***plus*** any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)

Claim
A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

Complications of Pregnancy
Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

Copayment
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cost Sharing
Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn't cover usually aren't considered cost sharing.

Cost-sharing Reductions
Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible.)

Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation

Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care / Emergency Services

Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

Excluded Services

Health care services that your plan doesn't pay for or cover.

Formulary

A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost sharing amounts will apply to each tier.

Grievance

A complaint that you communicate to your health insurer or plan.

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a "policy" or "plan".

Home Health Care

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers. Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

Individual Responsibility Requirement

Sometimes called the "individual mandate", the duty you may have to be enrolled in health coverage that provides minimum essential coverage. If you don't have minimum essential coverage, you may have to pay a penalty when you file your federal income tax return unless you qualify for a health coverage exemption.

In-network Coinsurance

Your share (for example, 20%) of the allowed amount for covered healthcare services. Your share is usually lower for in-network covered services.

In-network Copayment

A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

Marketplace

A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an "Exchange". The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP). Available online, by phone, and in-person.

Maximum Out-of-pocket Limit

Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

Medically Necessary

Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

Minimum Essential Coverage

Health coverage that will meet the individual responsibility requirement. Minimum essential coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage.

Minimum Value Standard

A basic standard to measure the percent of permitted costs the plan covers. If you're offered an employer plan that pays for at least 60% of the total allowed costs of benefits, the plan offers minimum value and you may not qualify for premium tax credits and cost sharing reductions to buy a plan from the Marketplace.

Network

The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Network Provider (Preferred Provider)

A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."

Orthotics and Prosthetics

Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.

Out-of-network Coinsurance

Your share (for example, 40%) of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network copayments usually are you more than in-network coinsurance.

Out-of-network Copayment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract

Out-of-pocket Limit The most you ***could*** pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

Out-of-network Provider (Non-Preferred Provider)
A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-participating" instead of "out-of-network provider".

Physician Services
Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan
Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan", "policy", "health insurance policy" or "health insurance".

Preauthorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Premium
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

Premium Tax Credits
Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

Prescription Drug Coverage
Coverage under a plan that helps pay for prescription drugs. If the plan's formulary uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in cost sharing will be different for each "tier" of covered prescription drugs.

Prescription Drugs
Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)
Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician
A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider
A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of health care services.

Provider
An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Referral
A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for

Rehabilitation Services
Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Skilled Nursing Care
Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is ***not*** the same as "skilled care services", which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Screening
A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Specialist
A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug
A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

Paychex Services

The following are the Paychex Insurance Agency services available to help you manage your compliance needs.

*Please speak to your Account Manager to discuss which of these services are already part of your account and which can be purchased.

Service	Description
Balance Care	Help your employees resolve health-care-related questions and problems while reducing your time spent researching them
MLR- rebate support	If you receive notice of a coming rebate, we will work with you to help ensure prompt and appropriate handling of the rebate, based on your group's circumstances.
Marketplace notifications	Paychex will assist employers with Marketplace Notifications.
SPD/ERISA Wrap	Wrap and Plan Document Preparation. Our compliance experts help keep your business from breaking the law and incurring stiff ERISA penalties.
POP	A POP allows businesses to save social security (FICA), federal income taxes, federal unemployment taxes (FUTA), and, generally, state income taxes* on the money employees contribute to their premiums. Employer tax savings can average 7 to 10 percent of employees' contributions.
COBRA	A full range of COBRA and State Continuation services.
ESR	Reporting is available for Paychex payroll clients to estimate the number of full-time employees (including full-time equivalents) and provide information that will help determine which full-time employees may subject you to a penalty if they are not offered qualified and affordable coverage.
5500 Filings	We can monitor your plan and track the number of participants enrolled during each plan year. Your account manager will partner with our preferred third-party vendor that will assist in the preparation of the Form 5500.

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