Electronic Disclosures
Plus a little about paper ones, too

Presented by
Carol Taylor, Account Executive & Compliance Officer, Kirby Employee Benefits
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QUESTIONS?

You may ask your question in the questions box at any time. Any questions that we do not answer during the webinar will be posted on the compliance corner webpage in the coming weeks.

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TODAY'S PRESENTER

Carol Taylor

Account Executive & Compliance Officer
Kirby Employee Benefits

Carol has been in the insurance industry for over 29 years in various capacities, ranging from insurance accounting, claims auditing, account management and compliance.

Having read the entire Patient Protection & Affordable Care Act and most of the regulations, Carol has participated in countless seminars, town hall meetings, compliance panels and other educational event meetings both locally and nationally. She is regarded as an industry expert and has been interviewed for multiple newspapers, journals and radio stations. She was chosen to ask the "health care question" at the CNN Republican Presidential Debate held in Tampa, FL in September 2011.

NAHU Roles:

- Former Legislative Council member
- FAHU Legislative Chair
- Compliance Corner
- Professional Development Author & Instructor
- Jacksonville Media & Communications Chair

Barb Gerken

Vice President and Director of Employee Benefit Compliance
First Insurance Group

With 31 years in the group health insurance market, Barb Gerken is the Vice President | Director of Employee Benefit Compliance for First Insurance Group. She joined First Insurance Group in September, 2014. Prior to First Insurance, Barb spent 3 years as the Regional Sales Manager for Cornerstone Broker Insurance Services and 23 years at Anthem Blue Cross and Blue Shield.

Barb is responsible for client compliance with state and federal regulations affecting employee benefit program and business planning to ensure the agency is adapting to the changing Health Insurance landscape.

NAHU Roles

- Legislative Chair of the Ohio Association of Health Underwriters
- Legislative Counsel member,
- Compliance Corner working group member
- Employer Working group member

AGENDA

- Required Notices and Plan Materials
  - Delivery Requirements
  - Delivery Methods
  - ERISA Electronic Delivery Safe Harbor
  - Required Notice Overview

Delivery Requirements

- Plan Administrators have a fiduciary obligation to provide participants, beneficiaries and others with the required plan documents, notices and disclosures. 29 CFR Part 2520.104b-1
- There are three main forms of disclosure requirements:
  - Furnish certain material to all participants covered under the plan.
  - Furnish certain material to individual participants upon their request.
  - Make certain material available to participants for inspection at reasonable times and places.

Required Notices

Pre- Enrollment

- Marketplace Notice
- Summary of Benefits and Coverage
- Special Enrollments Rights
- Children's Health Insurance Program
- Newborns and Mothers Health Protection Act
- Women's Health and Cancer Rights Act
- Genetic Information Non-Discrimination Act
- Wellness – ADA
- Wellness –Reasonable Alternative
- Grandfathered Plan
- Medicare Part D
- Privacy Notice
- Uniformed Services Employment and Reemployment Rights Act

Post-Enrollment

- COBRA General Notice
- Summary Plan Description

* Addressed in regulations

*Special Rules Apply

*Not addressed

Required Notices

Open Enrollment

- Summary of Benefits and Coverage
- Special Enrollments Rights
- Children's Health Insurance Program
- Newborns and Mothers Health Protection Act
- Women's Health and Cancer Rights Act
- Uniformed Services Employment and Reemployment Rights Act
- Genetic Information Non-Discrimination Act
- Wellness – ADA
- Wellness –Reasonable Alternative
- Grandfathered Plan
- Medicare Part D
- Privacy Notice – every 3 years

Event

- Material Modification Notice
- COBRA Qualifying Event
- Qualified Medical Child Support Order
- Medicare Part D
- 1095
- Summary Annual Report

* Addressed in regulations *Special Rules Apply *Not addressed

Delivery Requirements

- Plan Administrators should use measures reasonably calculated to ensure actual receipt.

It is never acceptable to place copies of the material in location frequented by participants (i.e. breakroom, employee kiosk)

- Carriers/Insurers may send notices on behalf of the plan administrator but liability for failure to send notices remains with the plan administrator.

Methods of Delivery – Non-Electronic

The regulations provide several delivery methods that meet ERISA standards. The **non-electronic methods** include…

- **hand delivery** at the employee's worksite
- **mail**,
- **insert** in a company publication

Methods of Delivery

Upon Request:

- Hand deliver to the requesting participant or beneficiary
- Mail to an address provided with request.

Available for Review:

- Non-union regulations
  - Made available within 10 days of request
  - Documents must be made available in the principal office of the employer and at each location with at least 50 participants covered under the plan.

Methods of Delivery – Hand Delivery

When hand-delivering notices and other materials at the employee's worksite, it is generally reasonable to assume that it has been shared with any spouses and dependents on the plan.

Exception: A separate COBRA notice is required to be provided to an employee's spouse, regardless of shared addresses.

Methods of Delivery – Hand Delivery

Special Note: Medicare Part D notice – If entities choose to incorporate notice with other plan participant information, the disclosure must be prominent and conspicuous. Must be in at least 14-point font in a separate box, bolded, or offset on the first page of the provided plan participant information.

> ***Sample notice:*** 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 xxxx for more details.

Methods of Delivery – Mail

- First, second and third class mail are all acceptable options of delivery.
  - **second** or **third-class mail** *only if return and forwarding postage is guaranteed* and *address correction is requested*
  - If second or third-class mail is returned with a corrected address, the second mailing requires ***first-class*** delivery.
  - ***Recommendation*** – keep copies of address labels with notes on mailing date.

Methods of Delivery – Mail

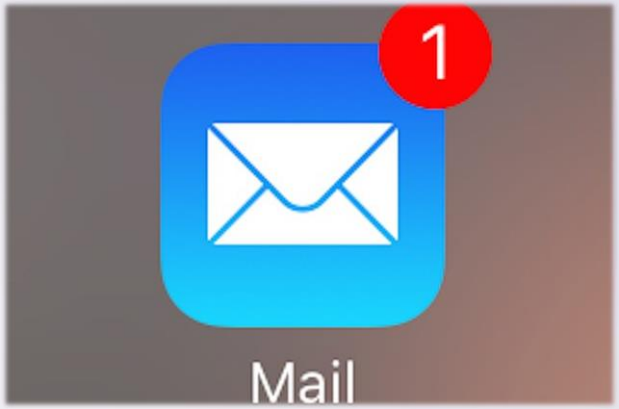
- It is generally reasonable to assume that notices and materials sent via mail have been shared with any spouses and dependents as long as the known address for all is the same as the primary insured.
  - ***Exception:*** A separate COBRA notice is required to be provided to an employee's spouse, regardless of shared addresses.
- A separate notice is required for any dependent with an address different from the primary insured.

Methods of Delivery – Insert in Company Publication

- There are several requirements for delivery of notices included as an insert in a company publication:
  - the distribution list must be comprehensive and up-to-date,
  - a prominent notice must be included on the front page of the publication alerting readers that it contains an insert with important information about rights under the plan which should be read and retained for future reference, and
  - the items must be resent using another reasonable method to anyone not included in the distribution or for whom the distribution failed.

The ERISA Electronic Delivery Safe Harbor

- In 2002, the Department of Labor finalized an electronic distribution safe harbor allowing use of electronic media to satisfy the ERISA requirements for notice and document distribution.
- These methods include:
  - Email distribution
  - Posting on company intranet
  - Provided on dvd, flashdrives



The ERISA Electronic Delivery Safe Harbor

- The regulations cover delivery options to two distinct classes of employees:
  - Employees with ***work-related computer access***; and
  - Participants and beneficiaries who ***consent*** to electronic delivery.

Electronic Delivery Methods – Work-related Access

Work-related computer access only applies when the employee:

- Is able to ***effectively*** access documents furnished in electronic form at any location where employees are reasonably expected to perform their duties; and
- Is expected to have access to the employer's electronic information system as an integral part of those duties.

The safe harbor will not apply to employees whose only access to the employer's network is through a computer kiosk in a common area.

Electronic Delivery Methods - Consent

Written consent is required for any plan participant and beneficiary if work-related computer access is not available.

Consent may be granted electronically or by paper.

Electronic Delivery Methods - Consent

- Prior to providing consent, the participant or beneficiary must be provided with a statement outlining:
  - The types of documents and notices to which the consent will apply;
  - The ability for an individual to withdraw their consent and the means in which the consent can be withdrawn;
  - The policies and procedures for changing their contact information;
  - The right for individuals to request paper copies and any applicable charges;
  - Any hardware/software needs required to access documents.
    - Changes to hardware/software must be communicated at time of change with a requirement to reaffirm consent.

Electronic Delivery Methods - Requirements

Company website postings:

- ***All requirements for electronic delivery requirements must be met.***
- Add a prominent link to the document on the company's main website.
- Provide directions for employees to retrieve any required login credentials.
- Keep notices and documents posted for a reasonable time period.

Electronic Delivery Methods - Requirements

Special Requirements:

Summary of Benefits and Coverage (SBC):

- May be provided electronically through online enrollment system or to individuals requesting online.
    - *Must include option for paper copy*

Electronic Delivery Methods - Requirements

Special Requirements:

Summary of Benefits and Coverage (SBC):

- For employers with any form of paper enrollment:
  - Covered individuals – may be delivered electronically if the electronic distribution safe harbor rules are met.
  - Eligible but not enrolled – may be delivered electronically with the following criteria:
    - Readily accessible format;
    - Paper form is available free of charge; and
    - Notice is sent electronically or paper format advising of availability if posted on intranet.

Electronic Delivery Methods - Requirements

Special Requirements:

- ***COBRA notices:*** must obtain spousal consent to electronic delivery. *It is not sufficient to provide the* notice *to employees and anticipate delivery to spouse.*
- ***Medicare Part D notice***: The employee must be directed to share the notice with any Medicare-eligible dependent covered under the group plan.
- ***1095B/C*** : Requires separate employee consent. Cannot be combined with W-2 consent.

Electronic Delivery Methods - Requirements

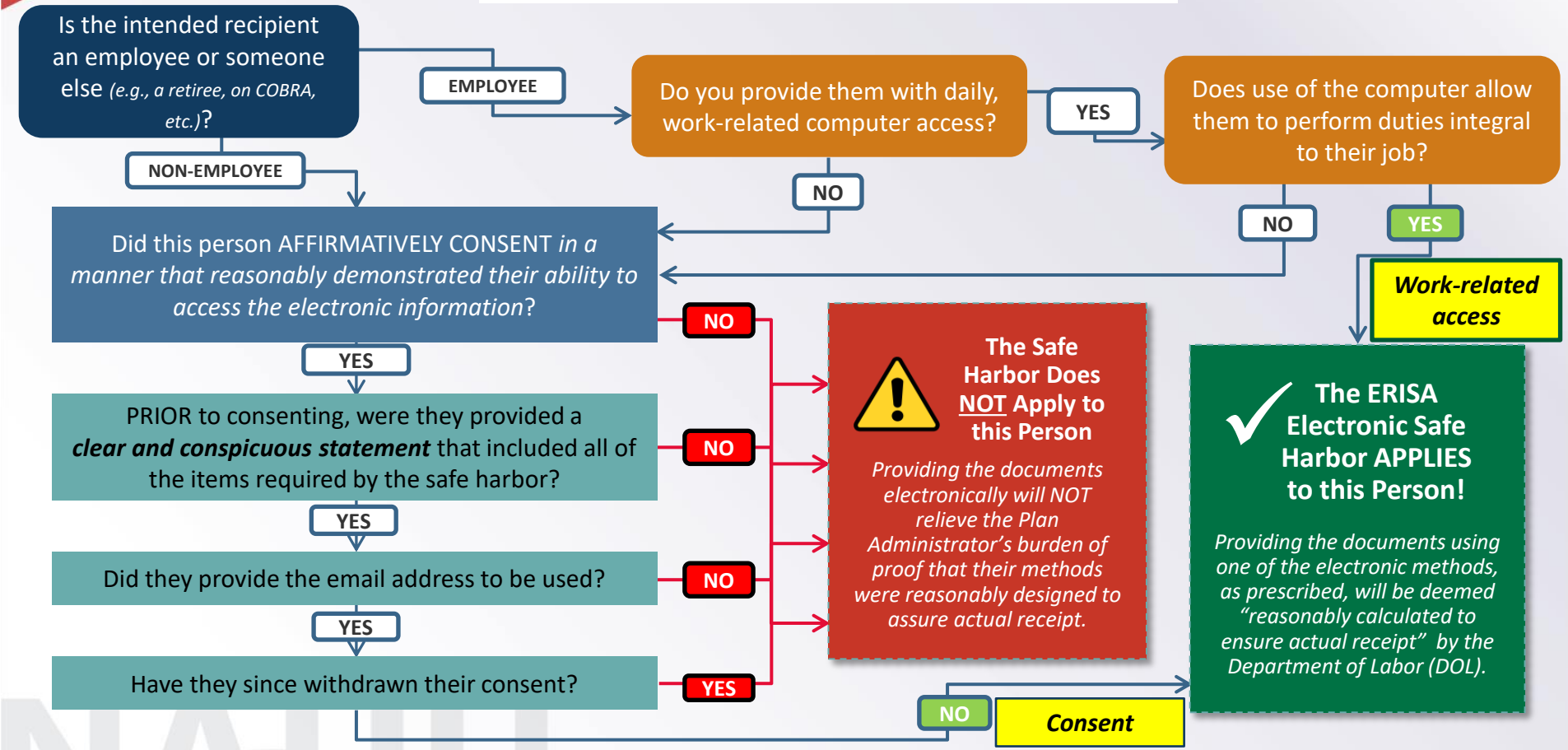
Special Requirements:

- ***HIPAA Privacy notice***:
  - If an employer's group health plan has a website with information regarding the plan services and benefits, the notice of privacy ***must*** be posted on the website.
  - Electronic delivery is acceptable. A paper copy is required for any notice received of failed delivery.

The ERISA Electronic Delivery Safe Harbor

Chart provided courtesy of Tom Seltz, LMC Insurance

WARNING: This safe harbor does not apply to W-2s, 1095s, or HIPAA Breach Notices!



The ERISA Electronic Delivery Safe Harbor

Chart provided courtesy of Tom Seltz, LMC Insurance

RECOMMENDED PROCESS for POSTING DISCLOSURES on INTERNAL WEBSITE PORTALS

1. Obtain **written consent** for electronic delivery *(only needed for those who do not meet work-related computer access standards)*
2. **Post the plan documents, notices and disclosures** on your internal website *(and leave them up for ongoing access)*
3. Send **Notice of Availability** to those covered by the safe harbor *(meaning snail mail/hand deliver to all the others)*
4. **Monitor email account** for bounce-backs, email address changes, withdrawals of consent, requests for paper copies, etc.
5. **Keep record of your actions** for eight years from the time of distribution (in case of an audit, participant lawsuit, etc.)

See 29 CFR Part 2520 for additional information.

Required Notices

Summary Plan Document/Description (SPD)

Required by?

- Employee Retirement Income Security Act (ERISA)

What information is provided?

- Information regarding the benefits available under the group plan, including eligibility requirements, claim filing and appeal instructions, and funding arrangements. The document describes the plan and how it operates.

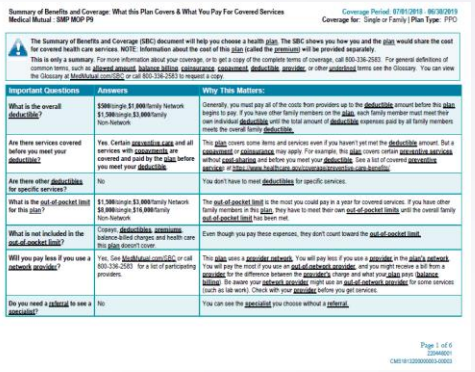
Who is notified?

- Participants of group plans subject to ERISA (no small group exception)

When are notices provided?

- Within 90 days of enrollment and an update version every 5 years (10 years if there are no changes)

Required Notices



Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 07/01/2018 - 06/30/2019
Coverage for: Single or Family | Plan Type: PPO

Medical Mutual - SMP MOP PP

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 800-336-2583. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at MedMutual.com/SBC or call 800-336-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500/single, $1,000/family Network $1,500/single, $3,000/family Non-Network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Certain preventive care and all services with copayments are covered and paid by the plan before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$1,500/single, $3,000/family Network $8,000/single, $16,000/family Non-Network	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copays, deductibles, premiums, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See MedMutual.com/SBC or call 800-336-2583 for a list of participating providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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Summary of Benefits and Coverage (SBC)

Required by?

- The Affordable Care Act (ACA)

What information is provided?

- Benefits available under the group health plan

Who is notified?

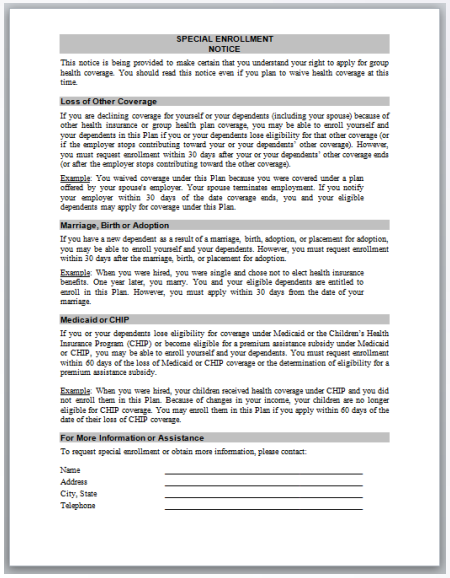
- Participants eligible for group health plans

When are notices provided?

- Prior to offering of coverage and at renewal

Required Notices

Special Enrollments Rights



SPECIAL ENROLLMENT NOTICE

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

Loss of Other Coverage

If you are declining coverage 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 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

Marriage, Birth or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

For More Information or Assistance

To request special enrollment or obtain more information, please contact:

Name _____
Address _____
City, State _____
Telephone _____

Required by?

- The Health Insurance Portability and Accountability Act (HIPAA)

What information is provided?

- The rights of certain individuals to be offered special enrollment right in group health coverage.

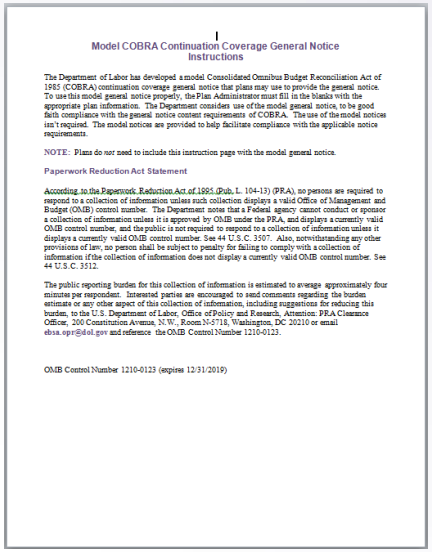
Who is notified?

- Participants of group health plans

When are notices provided?

- Prior to, or at, time of offering of coverage

Required Notices



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)

COBRA General Notice

Required by?

- The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

What information is provided?

- Notice to employee of the potential ability to continue coverage under the employer group health plan.

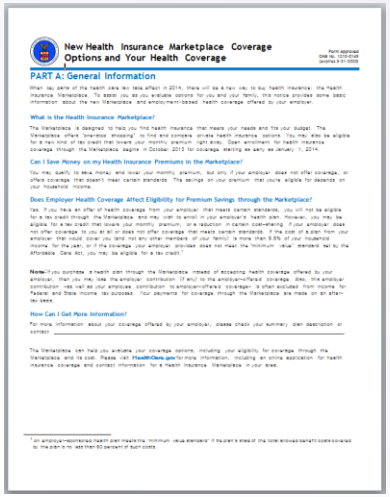
Who is notified?

- Employees and spouses covered under the group health plan

When are notices provided?

- 90 days from the date the employee or spouse becomes eligible under the plan

Required Notices



New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

What is the Health Insurance Marketplace?

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

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

How Can I Get More Information?

Marketplace/Exchange Notice

Required by?

- The Affordable Care Act (ACA)

What information is provided?

- Notice to employee of the availability of coverage through the federal marketplace

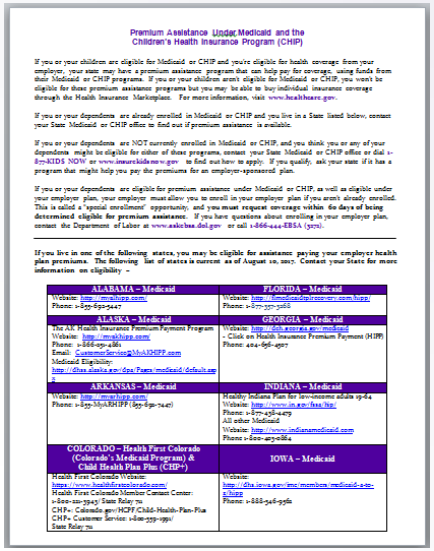
Who is notified?

- All employees of employers subject to the Fair Labors Standard Act (FLSA)

When are notices provided?

- Within 14 days of hire

Required Notices



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 August 10, 2017. 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: 1-800-457-8282
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/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562

Children's Health Insurance Program

Required by?

- Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

What information is provided?

- Potential opportunities for premium assistance for dependent children.

Who is notified?

- Participants of group health plans in state that provide premium assistance subsidies under a Medicaid or CHIP plan

When are notices provided?

- Prior to, or at, time of offering of coverage AND at open enrollment

Required Notices

Newborns' Act Disclosure

Required by?

- Newborns' and Mothers' Health Protection Act (NMHPA)

What information is provided?

- The length of stay required by health plans in connection with childbirth.

Who is notified?

- Participants of group health plans

When are notices provided?

- Prior to, or at, time of offering of coverage AND at open enrollment

Required Notices

Newborns' Act Disclosure

Required Language

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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Required Notices

Women's Health and Cancer Rights Act (WHCRA) Disclosure

Required by?

- Women's Health and Cancer Rights Act (WHCRA) of 1998

What information is provided?

- The coverage available to women undergoing a mastectomy.

Who is notified?

- Participants of group health plans offering coverage for a mastectomy

When are notices provided?

- Prior to, or at, time of offering of coverage AND at open enrollment

Required Notices

Women's Health and Cancer Rights Act (WHCRA) Disclosure

Required Language

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, this plan provides coverage for:

1. All stages of reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.

Contact your plan administrator (insert contact information) for more information.

Required Notices

Genetic Information Non-Discrimination Act (GINA) Disclosure

Required by?

- Genetic Information Non-Discrimination Act (GINA) of 2008

What information is provided?

- Prohibits employer from using employee and/or dependent genetic information to alter employment or benefits.

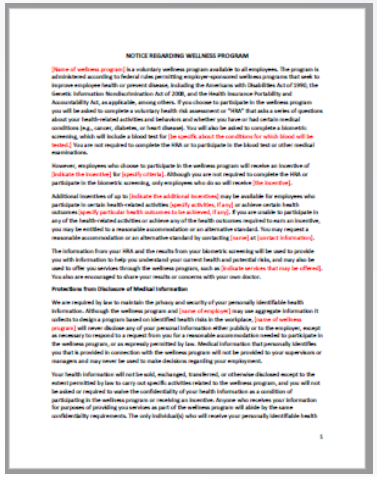
Who is notified?

- Participants of group health plans

When are notices provided?

- Prior to, or at, time of offering of coverage AND at open enrollment

Required Notices



NOTICE REGARDING WELLNESS PROGRAM

[Name of wellness program] has 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 complete a 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 HRA or to participate in the blood test 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 HRA or participate in the biometric screening, only employees who do so will receive [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 [name] at [contact information].

The information from your HRA and the results from your biometric screening 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 [name of employer] may use aggregate information it collects to design a program based on identified health risks in the workplace, [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

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Wellness Program – ADA Disclosure

Required by?

- Americans with Disabilities Act (ADA) *effective January 2017*

What information is provided?

- Information on what health information will be collected through a wellness program, how will it be used, who will receive it and what will be done to keep it confidential.

Who is notified?

- Participants offered employer-sponsored wellness programs that collect employee health information

When are notices provided?

- Prior to, or at, time of offering of coverage AND at open enrollment

Required Notices

Wellness Program – Reasonable Alternative Disclosure

Required by?

- The Affordable Care Act (ACA)

What information is provided?

- The availability of a reasonable alternative for individuals unable to satisfy the requirements of a wellness program due to medical conditions.

Who is notified?

- Participants offered rewards for participating in employer-sponsored wellness programs

When are notices provided?

- Prior to, or at, time of offering of coverage AND at open enrollment

Required Notices

Wellness Program – Reasonable Alternative Disclosure

Required Language

"If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call us at [insert telephone number] and we will work with you to develop another way to qualify for the reward."

Required Notices

This [group health plan or health insurance issuer] believes this [plan or coverage] 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 or policy] 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 plan administrator at [insert contact information]. [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 individual market policies and nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at www.hhs.gov.]

Grandfathered Plan Disclosure

Required by?

- The Affordable Care Act (ACA)

What information is provided?

- Notification that the grandfathered plan may not provide the consumer protection and benefits available in ACA compliant plans.

Who is notified?

- Participants of group health plans in place since March 23, 2010

When are notices provided?

- Prior to, or at, time of offering of coverage AND at open enrollment

Required Notices

This [group health plan or health insurance issuer] believes this [plan or coverage] 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 or policy] 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.

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Summary of Material Modification (SMM) Notice

Required by?

- ERISA

What information is provided?

- Any change in the group benefit plan that materially affects the benefit or cost.

Who is notified?

- Plan participants affected by the change.

When are notices provided?

- Within 210 days after the end of the plan year in which a material modification is made. If the modification is a reduction in benefits, the SMM must be distributed within 60 days of the adoption date.

Required Notices

This [group health plan or health insurance issuer] believes this [plan or coverage] 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 or policy] 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 plan administrator at [insert contact information]. [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 individual market policies and nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at www.hhs.gov.].

Material Modification Notice

Required by?

- The Affordable Care Act (ACA)

What information is provided?

- Notice to the employee that a material change is being made to the employer group health plan outside of the renewal date.

Who is notified?

- Participants of group health plans making changes outside of renewal

When are notices provided?

- 60 days prior to the effective date of the change

****Material Modification Notice is not required if changes are made at renewal ****

Required Notices

This [group health plan or health insurance issuer] believes this [plan or coverage] 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 or policy] 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 plan administrator at [insert contact information]. [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 individual market policies and nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at www.hhs.gov/.]

Material Modification Notice (continued)

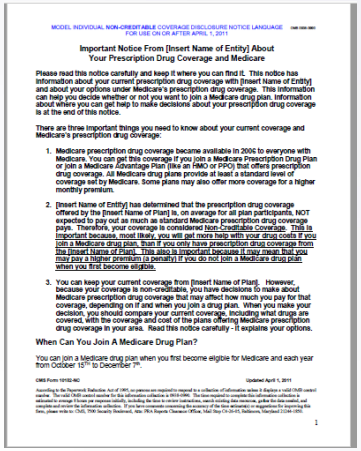
How to notify?

- Can be met by providing an updated Summary of Benefits and Coverage (SBC) or a notice outlining the changes

Penalties?

- $1,000 for each failure.

Required Notices



MODEL INDIVIDUAL NON-CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE
FOR USE ON OR AFTER APRIL 1, 2011

Important Notice From [Insert Name of Entity] About Your Prescription Drug Coverage and 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 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 Plan]. This also 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.
3. You can keep your current coverage from [Insert Name of 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.

OMB Form 10182-NC Updated April 1, 2011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 10 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Medicare Creditable Coverage Notice

Required by?

- Medicare Part D Legislation

What information is provided?

- Whether or not the employer plan is expected to pay out as much as the standard Medicare prescription drug coverage.

Who is notified?

- Participants of group health plans who are eligible for Medicare

When are notices provided?

- Prior to, or at, time of offering of coverage and annually by October 15

Required Notices

Medicare Creditable Coverage Notice

- Employers are also required to disclose the creditable status of the plan to the Centers for Medicare and Medicaid Services (CMS)

  https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html

- Notify CMS within 60 days after the renewal if no changes are made to the plan
- Notify CMS within 30 days after the renewal if there is a change in the creditable status of the plan

Required Notices

Privacy Notice

Required by?

- The Health Insurance Portability and Accountability Act (HIPAA)

What information is provided?

- Explanation of individual rights with respect to their personal health information and privacy of health plan.

Who is notified?

- Participants of group health plans

When are notices provided?

- Prior to, or at, time of offering of coverage, full notice every 3 years and annual notice of availability of policy at open enrollment

Required Notices

Summary Annual Report

Required by?

- Employee Retirement Income Security Act (ERISA)

What information is provided?

- Summary of the Form 5500 information with notice of filing.

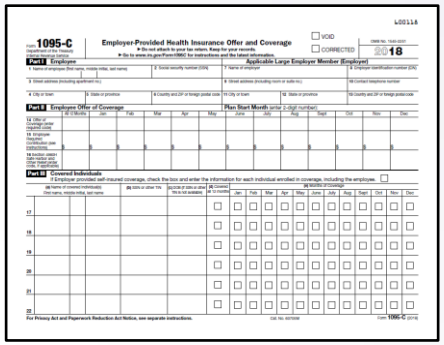
Who is notified?

- Participants in employer group plans subject to the 5500 filing requirements. In general, plans with fewer than 100 participants are not required to file.

When are notices provided?

- Within 9 months after the end of the plan year.

Required Notices



1095B/C

Required by?

- The Affordable Care Act (ACA)

What information is provided?

- Information regarding the offer of coverage under a group health plan, employee contributions and employee elections for coverage.

Who is notified?

- Applicable Large Employers (ALE) and small, self-funded employers.

When are notices provided?

- Determined annually by the IRS but traditionally at the end of February.

Required Notices

Qualified Medical Child Support Order (QMCSO)

Required by?

- Employee Retirement Income Security Act (ERISA)

What information is provided?

- A court or agency requirement for a parent-employee who is divorced, separated, or never married to provide group health plan benefits to a child. The order must be qualified by the employer.

Who is notified?

- The employee/plan participant and the child/representative.

When are notices provided?

- Within a reasonable time after receiving the order. What is a reasonable period will depend on the circumstances.

Required Notices

Uniformed Services Employment and Reemployment Act (USSERA) Notice

YOUR RIGHTS UNDER USERRA

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.

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.

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.

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 don't 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.

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 website 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.

VETS U.S. Department of Labor 1-866-487-2365 | U.S. Department of Justice | Office of Special Counsel | ESGR 1-800-336-4590

Publication Date — April 2017

Required by?

- Uniformed Services Employment and Reemployment Act (USSERA)

What information is provided?

- The right for an employee to continue coverage under the group health plan during active military service OR the right to be reinstated when returning from active military service without a waiting period.

Who is notified?

- An employee leaving employment for active military service.

When are notices provided?

- Can be satisfied by displaying a USERRA notice poster

RESOURCES

ERISA Rules and Regulations for Reporting and Disclosure:
https://www.law.cornell.edu/cfr/text/29/2520.104b-1

QUESTIONS?

You may ask your question
in the questions box at any time.
Any questions that we do not answer during the webinar will be posted on the compliance corner webpage in the coming weeks.