ERISA Required Disclosures

Presented by
Carol Taylor, Account Executive & Compliance Officer, Kirby Employee Benefits
Barb Gerken, VP | Director of Employee Benefit Compliance, First Insurance Group

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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.

The information herein should not be construed as legal or tax advice in any way. Regulations, guidance and legal opinions continue to change. The preparer has gathered public information and has attempted to present it in an easily readable and understandable format. Situations vary, technical corrections and future guidance may vary from what is discussed in the presentation.

This is meant for informational content only. The presenter makes no warranty of any kind concerning this information. You should seek the advice of your attorney or tax consultant for additional or specific information.

This presentation is not to be duplicated or distributed.

TODAY'S PRESENTER

Carol Taylor

Account Executive & Compliance Officer
Kirby Employee Benefits

Carol has been in the insurance industry for over 27 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.

Carol is the current Florida Association of Health Underwriters (FAHU) State Legislative Chair and serves on their Board of Directors. She is the former Piedmont Virginia (PVAHU) from 2013 to 2017 and Jacksonville Association of Health Underwriters (JAHU) Legislative Chair as well as serving on the Florida AHU and JAHU Board of Directors from 2010 to September 2013. From July 2013 through June 2017, she served on the National Legislative Council for the National Association of Health Underwriters (NAHU), on various committees and continues to serve on the Compliance Corner Committee.

Barb Gerken

Vice President and Director of Employee Benefit Compliance
First Insurance Group

With 28 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.

She currently serves as Legislative Vice-Chair of NWOAHU, Legislative Vice-Chair of the Ohio Association of Health Underwriters effective 1/1/2017, a member of NAHU Compliance Corner working group effective 7/1/2016 and member of the NAHU Legislative Committee effective 7/1/2017.

AGENDA

- Who is subject to ERISA Regulations?
- Review of Required Notices

ERISA – Who is Subject to It?

- Only exemptions from ERISA are:
  - Governmental plans, such as those sponsored by state, local or public school systems
  - Church plans
- **All** other groups, regardless of size, are required to comply with ERISA

ERISA – Who is Subject to It?

- Benefits that ERISA applies to:
  - Health insurance, which includes medical, dental, vision, HRAs, health FSAs, Rx benefits.
  - Group Life Insurance
  - Disability income/salary continuation plans, unless paid entirely by the employer from general assets
  - Severance pay, funded vacation benefits, apprenticeship/training programs
  - Day care centers, scholarship funds
  - Prepaid Legal Services
  - Could also include an EAP if it provides significant medical care

Other items to consider

- This presentation does not include every notice requirement
  - There may be additional notice requirements based on the size of the group
    - Family & Medical Leave Act (generally, those with 50 or more employees)
    - Non-discrimination notices (employers with 15 or more employees)
- You should check to see if your state has any additional notices or requirements
  - These could also be based on size of the group
    - State Continuation Notices (some require the employer to distribute, some require the carrier to send)
- Notices may be distributed via paper or other means
  - If electronic distribution, they must meet the Dept of Labor Electronic Disclosure requirements

Other items to consider

- Some of the Federal requirements relate to benefits
- States have more benefit related oversight
  - Mental Health – does your State require them to be treated the same as a primary care physician, or a specialist
  - Your State may have more generous rules
    - Example – the Women's Health and Cancer Rights Act, mastectomy procedures have certain requirements
    - Your state may also mandate coverage for a wig

Fines

- Unless otherwise noted, failure to provide notices are subject to fines of $100 per day, per affected beneficiary for ‘reasonable cause’
- If Willful Neglect or other reason (not reasonable cause), then the fines increase
- Fines are **SELF-REPORTED** on IRS Form 8928
- If not reported and the Dept of Labor audits, they will contact the IRS, even higher penalties may be assessed
- Ultimately, it is the plan sponsors responsibility to ensure that the required notices are distributed.

Form **8928**
(Rev. May 2016)
Department of the Treasury
Internal Revenue Service

Return of Certain Excise Taxes Under Chapter 43 of the Internal Revenue Code

(Under sections 4980B, 4980D, 4980E, and 4980G)

▶ Information about Form 8928 and its separate instructions is at *www.irs.gov/form8928*.

OMB No. 1545-2146

Filer's tax year beginning , and ending ,

A Name of filer (see instructions)	**B** Filer's employer identification number (EIN)
Number, street, and room or suite no. (If a P.O. box, see instructions)	
City or town, state or province, country, and ZIP or foreign postal code	**E** Plan sponsor's EIN
C Name of plan	**F** Plan year ending (MM/DD/YYYY)
D Name and address of plan sponsor	**G** Plan number

Part I **Tax on Failure To Satisfy Continuation Coverage Requirements Under Section 4980B**

Complete a separate Part I, lines 1 through 6, for failures due to reasonable cause and not to willful neglect, and a separate Part I, lines 12 through 14, for other failures, for each qualifying event for which one or more failures to satisfy continuation coverage requirements that occurred during the reporting period (see instructions).

Section A – Failures Due to Reasonable Cause and Not to Willful Neglect

		For IRS Use Only		
1	Enter the total number of days of noncompliance in the reporting period		1	
2	Enter the number of qualified beneficiaries for which a failure occurred as a result of this qualifying event (2)			
3	If you entered 2 or more on line 2, multiply line 1 by $200. Otherwise, multiply line 1 by $100		3	
4	If the failure was not discovered despite exercising reasonable diligence or was corrected within the correction period and was due to reasonable cause, enter -0- here, and go to line 5. Otherwise, enter the amount from line 3 on line 6 and go to line 7		4	
5	If the failure was not corrected before the date a notice of examination of income tax liability was sent to the employer and the failure continued during the examination period, multiply $2,500 by the number of qualified beneficiaries for whom one or more failures occurred (multiply by $15,000 to the extent the violations were more than de minimis for a qualified beneficiary). If the failures were corrected before the date a notice of examination was sent, enter -0-		5	
6	Enter the smaller of line 3 or line 5		6	
7	If there was more than one qualifying event, add the amounts shown on line 6 of all forms, and enter the total on a single "summary" form. Otherwise, enter the amount from line 6 above		7	
8	Enter the aggregate amount paid or incurred during the preceding tax year for a single employer group health plan or the amount paid or incurred during the current tax year for a multiemployer health plan to provide medical care (8)			
9	Multiply line 8 by 10% (0.10)		9	
10	Amount from section 4980B(c)(4)		10	500,000
11	Enter the smallest of lines 7, 9, or 10. For a third-party administrator, HMO, or insurance company, the amount you enter on this line filed for all plans you administer during the same tax year cannot exceed $2 million; reduce the amount you would otherwise enter on this line to the extent the amount for all plans would exceed this limit		11	

Section B – Failures Due to Willful Neglect or Otherwise Not Due to Reasonable Cause

12	Enter the total number of days of noncompliance in the reporting period		12	
13	Enter the number of qualified beneficiaries for which a failure occurred as a result of this qualifying event (13)			
14	If you entered 2 or more on line 13, multiply line 12 by $200. Otherwise, multiply line 12 by $100.		14	
15	If there was more than one qualifying event, add the amounts shown on line 14 of all forms, and enter the total on a single "summary" form. Otherwise, enter the amount from line 14 above		15	

Section C – Total Tax Due Under Section 4980B

16	Add lines 11 and 15 ▶	126	16	

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?**

  Employees of group health plans
- **When are notices provided?**

  Prior to offering of coverage and at renewal

Special Enrollment Rights

- **Required by?**

  The Health Insurance Portability and Accountability Act (HIPAA)

- **What information is provided?**

  The rights of certain individuals to be afforded special enrollment rights in group health coverage

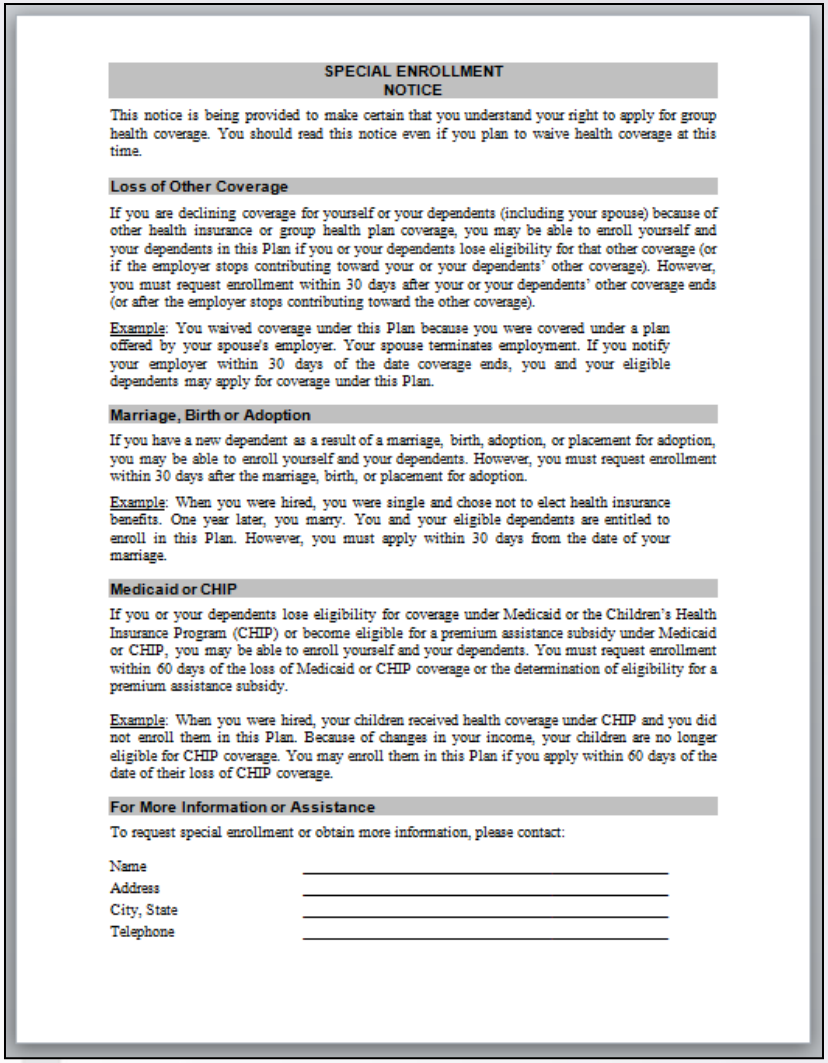
- **Who is notified?**

  Employees of group health plans

- **When are notices provided?**

  Prior to or at time of offering of coverage

Special Enrollment 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 _____

COBRA General Notice

- **Required by?**

  The Consolidate 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

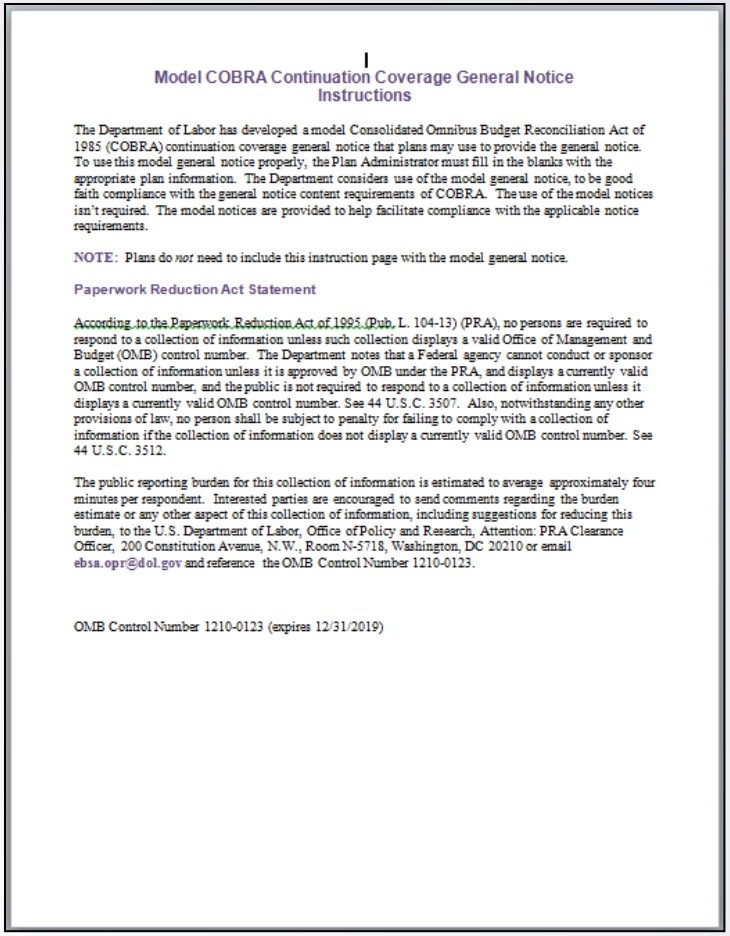
- **Who is notified?**

  Employees and spouses of group health plans

- **When are notices provided?**

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

COBRA General Notice



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)

Marketplace Notice

- **Required by?**

  The Affordable Care Act (ACA)

- **What information is provided?**

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

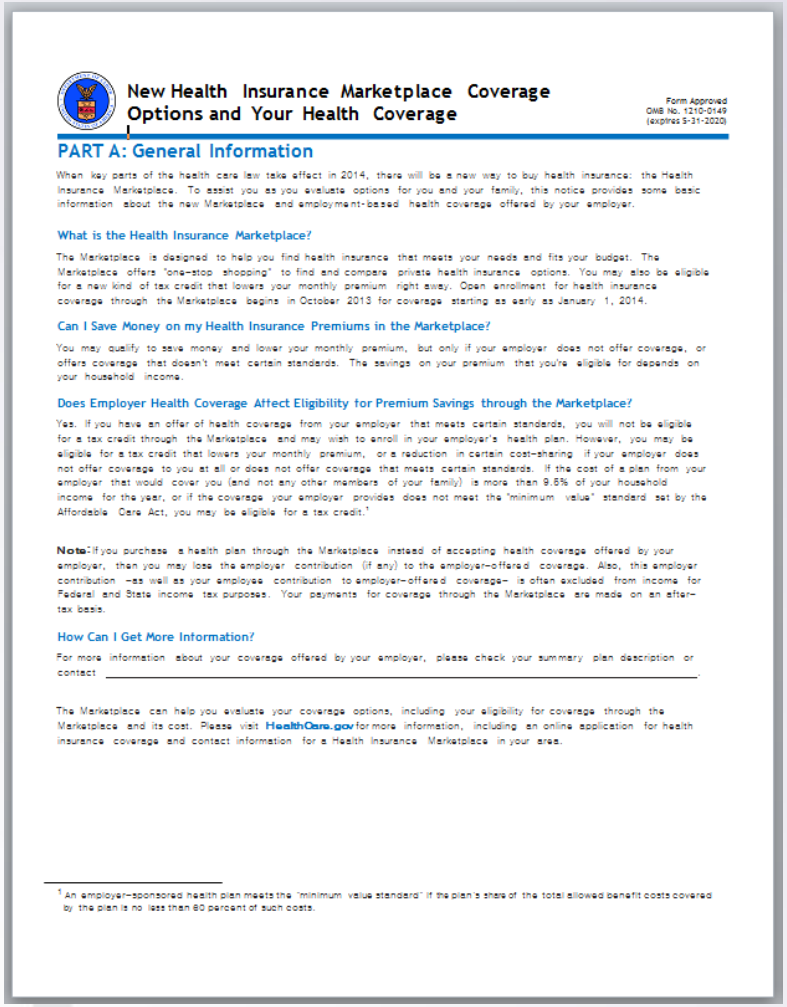
- **Who is notified?**

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

- **When are notices provided?**

  Within 14 days of hire

Marketplace Notice



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 9-31-2020)

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.

Children's Health Insurance Program (CHIP)

- **Required by?**

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

- **What information is provided?**

  Potential opportunities for premium assistance for dependent children.

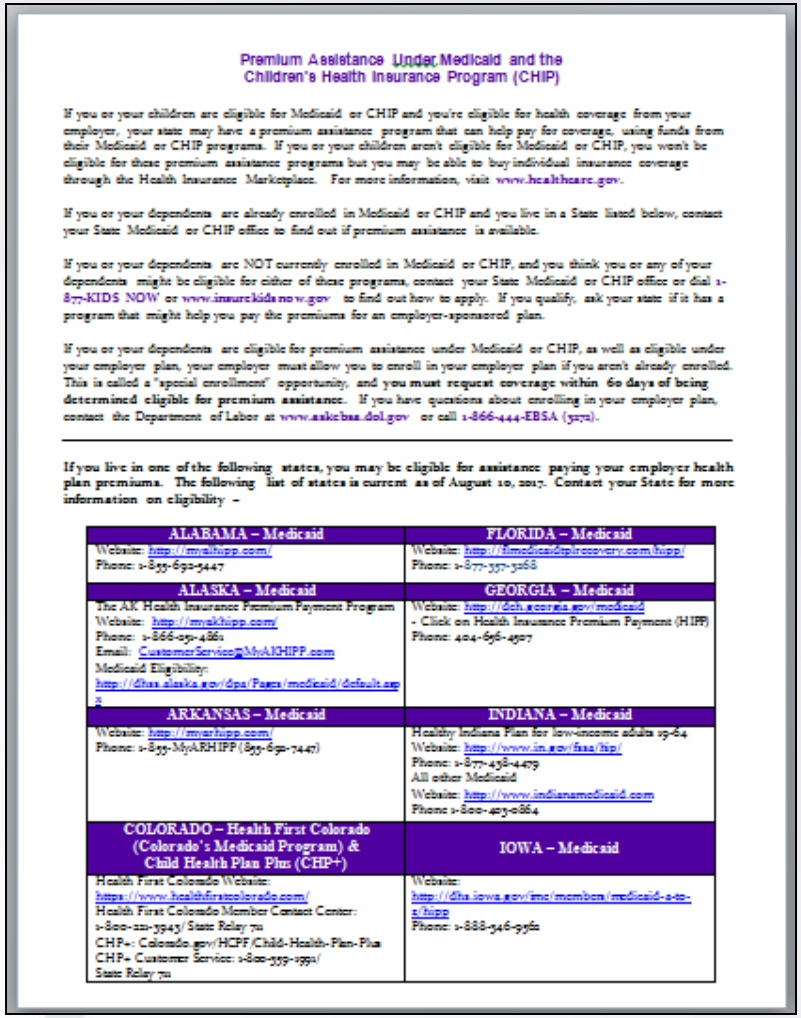
- **Who is notified?**

  Employees of group health plans in states that provide premium assistance subsidies under a Medicaid plan or CHIP

- **When are notices provided?**

  Prior to or at time of offering of coverage and at open enrollment

Children's Health Insurance Program (CHIP)



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 1-800-403-0864
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/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562

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?**

  Employees of group health plans

- **When are notices provided?**

  Prior to or at time of offering of coverage and at open enrollment

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).

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?**

  Employees 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

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.

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?**

  Employees of group health plans

- **When are notices provided?**

  Prior to or at time of offering of coverage and at open enrollment

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.

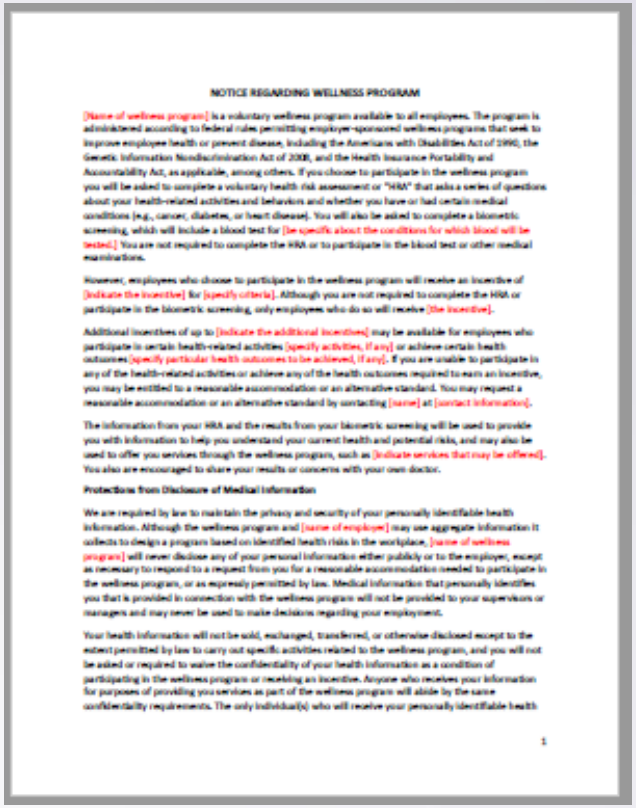
- **Who is notified?**

  Employees 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

Wellness Program – ADA Disclosure



NOTICE REGARDING WELLNESS PROGRAM

[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 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

1

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?**

  Employees 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

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."

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

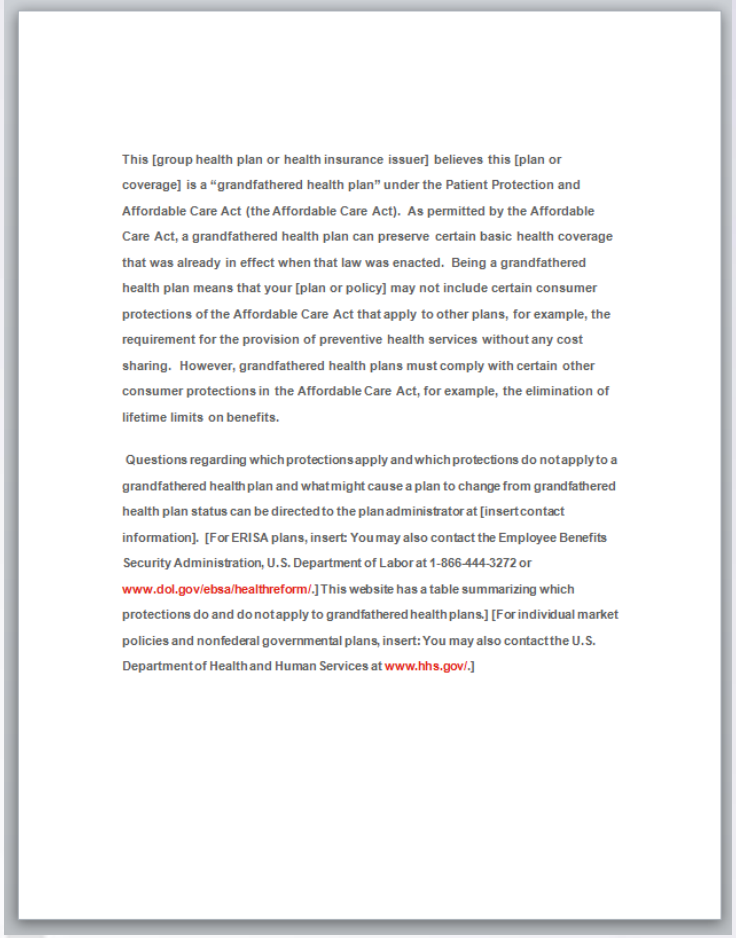
- **Who is notified?**

  Employees 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

Grandfathered Plan Disclosure



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?**

  Employees 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

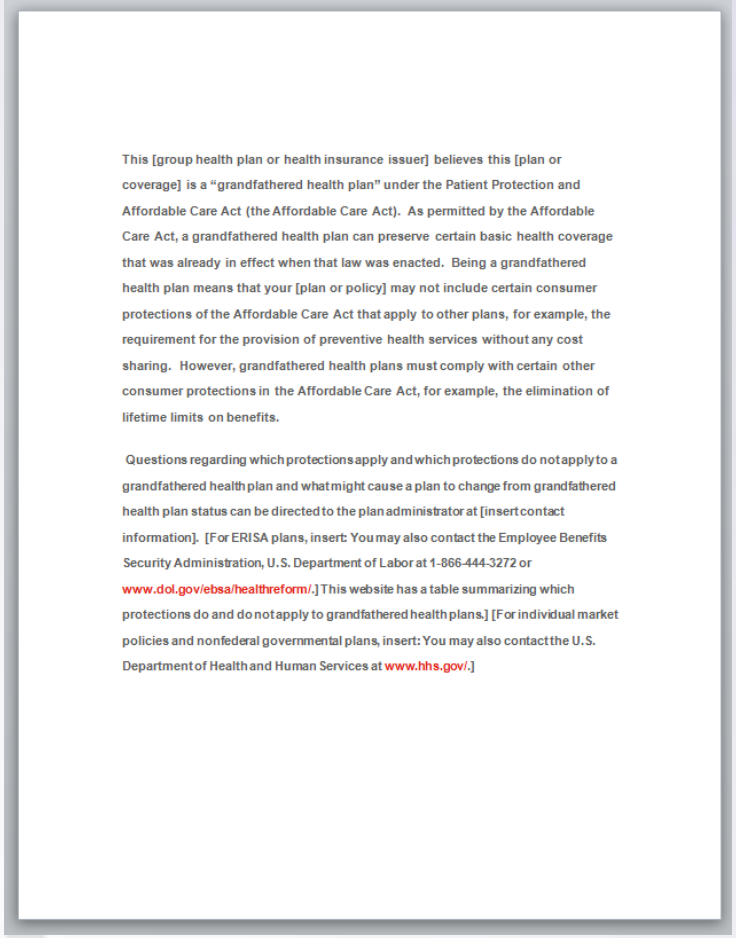
- **How to notify?**

  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.

Material Modification Notice



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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

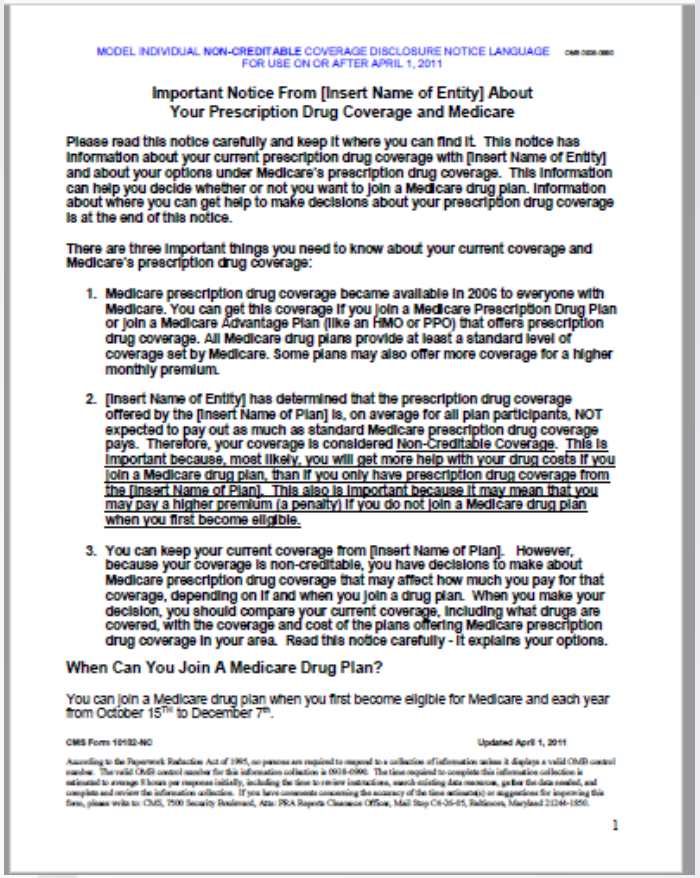
- **Who is notified?**

  Employees and dependents 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

Medicare Creditable Coverage Notice



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.

CMS 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 9 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.

1

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

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 plans

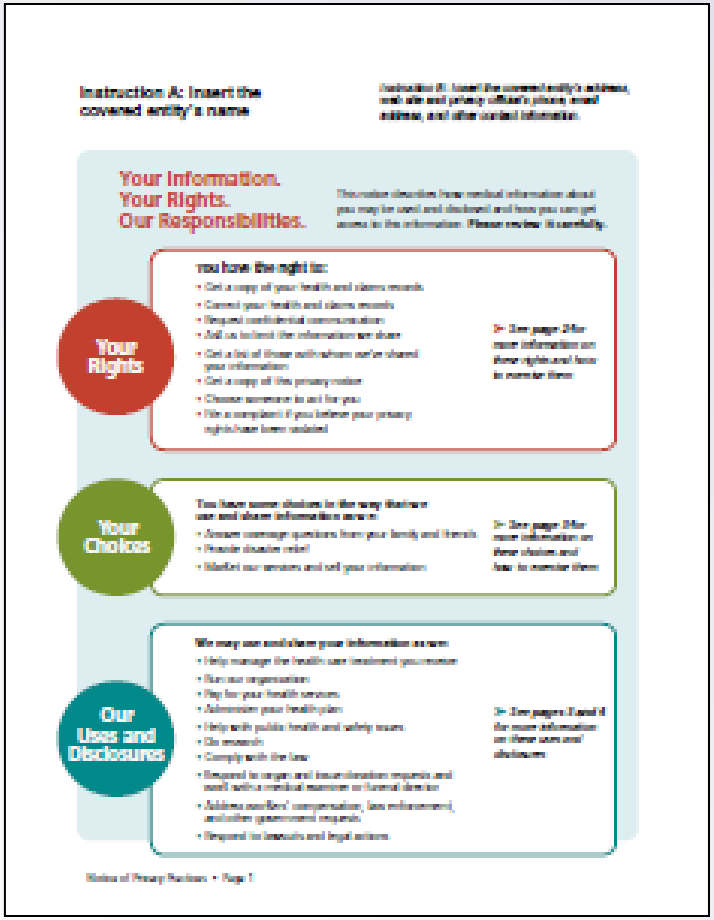
- **Who is notified?**

  Employees 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

Privacy Notice



Instruction A: Insert the covered entity's name

Instruction B: Insert the covered entity's address, web site and privacy official's phone, email address, and other contact information.

Your Information.
Your Rights.
Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights:

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

> See page 2 for more information on these rights and how to exercise them

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

> See page 2 for more information on these choices and how to exercise them

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

> See pages 3 and 4 for more information on these uses and disclosures

Notice of Privacy Practices • Page 1

RESOURCES

Department of Labor (DOL) Self-Compliance Tool:
https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/cagappa.pdf

Newborns' Act:
https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/nmhpa

Privacy Notice:
https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/model-notices-privacy-practices/index.html

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.

THANK YOU FOR ATTENDING

Compliance Corner Resources

- The new *Compliance Cornered* Blog
- Archived, topical webinars
- Resource pages, documents, and FAQs
- Ask a question to legislative@nahu.org