COMPLIANCE OVERVIEW

Employee Benefit Compliance Chart: Notice and Disclosure Rules

This Compliance Overview summarizes a number of the notice and disclosure requirements that apply to group health plans and employers under federal laws. For example, this overview describes notice and disclosure requirements under:

- ☑ The Affordable Care Act (ACA)
- ☑ COBRA
- ☑ The Consolidated Appropriations Act (CAA)
- ☑ ERISA
- ☑ The Family and Medical Leave Act (FMLA)
- ☑ The Genetic Information Nondiscrimination Act (GINA)
- ☑ HIPAA
- ☑ Medicare Part D
- ☑ Other federal laws, such as the Women's Health and Cancer Rights Act (WHCRA)

Note that COVID-19-related deadline extension relief may be available for some of these notice and disclosure requirements.

LINKS AND RESOURCES

- Department of Labor's (DOL) website regarding compliance assistance for health plans, which includes links to many model forms and notices.
- Internal Revenue Service (IRS) website for tax forms and instructions.
- Center for Medicare and Medicaid Services' (CMS) website regarding Medicare Part D disclosures.
- CMS' Transparency in Coverage webpage.

Required Notices

- Group health plan sponsors must comply with numerous reporting and disclosure requirements.
- Each notice or disclosure has its own timing requirements.
- Although some notice and disclosure requirements apply to all employers, others only apply to certain employers.
- Model forms are available for many required disclosures.

Examples

Some of the main notice and disclosure requirements for group health plans are:

- The summary plan description (SPD)
- COBRA notices
- ACA employee statements
- Medicare Part D notices of creditable coverage
- Form 5500
- Transparency in health care disclosures

Notice and Disclosure Rules

COVID-19-Related Deadline Extensions

Various deadlines, including the time to furnish benefit statements and other notices and disclosures required under ERISA, are extended during the COVID-19 outbreak period (if good faith efforts are made to provide the documents as soon as administratively practicable). The outbreak period began in March 2020, when former President Donald Trump declared a national emergency due to the COVID-19 pandemic, and it will continue until 60 days after the end of the COVID-19 national emergency (or such other date as announced by the federal government).

Under the relief, **these deadline extensions end when the outbreak period is over** or, if earlier, after an individual has been eligible for a specific deadline extension for one year. On Jan. 30, 2023, the Biden administration announced its plan to end the COVID-19 national emergency on **May 11, 2023**. If the national emergency ends on May 11, 2023, the outbreak period will end on **July 10, 2023**. Once the COVID-19 outbreak period ends, health plans can go back to their nonextended deadlines.

LAW	GOVERNS	NOTICE REQUIREMENT	SUMMARY
Affordable Care Act	Group health plans and health insurance issuers	**Statement of grandfathered status**—Plan administrator or issuer must provide on a periodic basis with any participant materials describing plan benefits	To maintain grandfathered plan status, a plan administrator or health issuer must include a statement of grandfathered status in plan materials provided to participants describing the plan's benefits (such as the SPD and open enrollment materials). A model notice is available from the DOL.
		Notice of rescission—Plan administrator or issuer must provide notice of rescission to affected participants at least 30 days before the rescission occurs	Group health plans and health insurance issuers may not rescind coverage once the enrollee is covered, except in cases of fraud or intentional misrepresentation. Plan coverage may not be rescinded without prior notice to the enrollee.
		Notice of patient protections and selection of providers—Plan administrator or issuer must provide notice of patient protections whenever the SPD or similar description of benefits is provided to participants	Group health plans and health insurance issuers that require designation of a participating primary care provider must permit each participant, beneficiary and enrollee to designate any available participating primary care provider (including a pediatrician for children). Group health plans and issuers that provide obstetrical/gynecological care and require a designation of a participating primary care provider may not require preauthorization or referral for obstetrical/gynecological care.

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			This notice is often included in the SPD or insurance certificate provided by the issuer (or otherwise provided with enrollment materials). A model notice is available from the DOL.
		Summary of benefits and coverage (SBC)—Plan administrator and issuer must provide to participants and beneficiaries at the following times: • With any written application materials distributed for enrollment; • If written application materials for enrollment are not provided, no later than when the participant is first eligible to enroll in coverage; • By the first day of coverage, if there was any change to the information that was provided upon application and before the first day of coverage; • To special enrollees, no later than the deadline for providing the SPD; • Upon renewal, if participants and beneficiaries must renew to maintain coverage; and • Upon request.	Group health plans are required to provide a uniform summary of the plan's benefits and coverage to applicants and enrollees. The Departments of Labor, Health and Human Services and the Treasury (Departments) have provided a template for the SBC that plans and issuers must use, as well as additional instructional guidance and sample language for completing the template. The Departments have also provided a uniform glossary of health-coverage-related terms and medical terms for plans and issuers to make available to plan participants and beneficiaries. The template, glossary and other related guidance are available on the DOL's website. The issuer for fully insured plans usually prepares the SBC. If the issuer prepares the SBC, an employer is not also required to prepare an SBC for the health plan, although the employer may need to distribute the SBC prepared by the issuer.
		60-day advance notice of plan changes—Plans and issuers must provide at least 60 days' advance notice of	A health plan or issuer must provide 60 days' advance notice of any material modifications to the plan that are not reflected in the most recent SBC. This notice requirement is limited

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		mid-year material modifications in plan terms or coverage that would affect the content of the SBC and are not reflected in the most recent SBC.	to material modifications that do not occur in connection with a renewal or reissuance of coverage. A "material modification" is any change to a plan's coverage that independently, or in connection with other changes taking place at the same time, would be considered by the average plan participant to be an important change in covered benefits or other terms of coverage. A material modification may include: • An enhancement in covered benefits or services or other more generous plan or policy terms (for example, reduced cost-sharing or coverage of previously excluded benefits); or • A material reduction in covered services or benefits or more strict requirements for receiving benefits (for example, a new referral requirement or increased premiums or cost-sharing).
Affordable Care Act (Transparency in Coverage Final Rules)	Non-grandfathered health plans and health insurance issuers	**Public posting of MRFs**—Plans and issuers must disclose detailed pricing information in three separate machine-readable files (MRFs) on a public website. Most employers will rely on their issuers and TPAs (or other service providers) to provide the MRFs. Employers with fully insured health plans should confirm that their issuer will comply by the applicable deadlines and ensure this compliance responsibility is set forth in a written agreement. Similarly,	Federal agencies deferred enforcement of the first and second MRFs related to disclosing in-network and out-of-network data until **July 1, 2022**. Enforcement of the third MRF relating to prescription drugs is **delayed** until further notice. Files must be available on an internet website, and the files must be accessible free of charge, without having to establish a user account, password, or other credentials, and without having to submit any personal identifying information such as a name, email address, or telephone number.

LAW	GOVERNS	NOTICE REQUIREMENT	SUMMARY
		employers with self-insured plans should reach out to their TPAs (or other service providers) to confirm they will be in compliance by the applicable deadlines and update agreements, as necessary, to reflect this responsibility.	
		Price comparison tool—Plans and issuers must make an internet-based price comparison tool available to participants, beneficiaries and enrollees to disclose the personalized price and cost-sharing liability for covered items and services, including prescription drugs. Upon request, plans and issuers must provide this information in paper form. In addition, plans and issuers should be prepared to provide this comparison information over the telephone. Most employers will rely on their issuers or TPAs to develop and maintain the price comparison tool and provide related disclosures in paper or over the phone upon request. Employers with fully insured health plans should confirm that their issuer will comply with the price comparison tool requirements, and	An initial list of 500 shoppable services must be available via the internet based self-service tool for **plan years that begin on or after Jan. 1, 2023**. A list of the remainder of all items and services will be required for **plan years that begin on or after Jan. 1, 2024**. Because the Consolidated Appropriations Act (CAA) created a similar price comparison tool requirement, federal agencies have indicated that they will likely view compliance with the internet-based self-service tool to satisfy the CAA's price comparison tool requirement. However, the CAA also requires plans and issuers to provide cost comparison information over the telephone upon request, which is an additional requirement that plans and issuers must comply with beginning in 2023.

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		ensure this compliance responsibility is reflected in a written agreement. Similarly, employers with self-insured plans should reach out to their TPAs (or other service providers) to confirm they will be in compliance by the deadline and update agreements, as necessary, to reflect this responsibility.	
Affordable Care Act	Employers sponsoring group health plans	**IRS Form W-2**—Aggregate cost of applicable employer-sponsored coverage must be included on employees' Forms W-2. Small employers (those filing **fewer than 250 W-2-Forms**) and employers contributing only to certain plans, such as multiemployer plans or HSAs, are exempt at least until further guidance is issued.	Employers must disclose the aggregate cost of applicable employer-sponsored coverage provided to employees on the employees' W-2 forms. The Form W-2 and Instructions, including a category for reporting the cost of employer-sponsored coverage, are available on the IRS' website. Employers must file Forms W-2 with the Social Security Administration and furnish Forms W-2 to employees by Jan. 31 of each year, unless an extension applies.
Affordable Care Act	All employers subject to the FLSA	**Exchange notice**—The ACA requires employers to provide all new hires with a written notice about the health insurance Exchanges.	Employers must provide all new hires with an Exchange notice that: • Includes information regarding the existence of the Exchange, as well as contact information and a description of the services provided by the Exchange; • Explains how an employee may be eligible for a premium tax credit if the employee purchases a qualified health plan through the Exchange; and • Contains a statement informing the employee that, if the employee purchases a qualified health plan through an Exchange, the employee may lose the employer

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			contribution (if any) to any health benefits plan offered by the employer and that all or a portion of this employer contribution may be excludable for federal income tax purposes. The DOL has provided model Exchange notices for employers to use, which will require some customization.
Affordable Care Act	Applicable large employers (ALEs)	**Code §6056 reporting**—ALEs (employers with at least 50 full-time employees, including full-time equivalents) must file an annual return with the IRS regarding the health coverage, if any, provided to full-time employees. These employers must also provide a related annual statement to employees. The deadlines for these returns and employee statements are as follows: • Section 6056 returns (IRS Forms 1094-C and 1095-C) must be filed with the IRS annually, no later than Feb. 28 (March 31, if filed electronically) of the year after the calendar year to which the return relates. • The employee statements (IRS Form 1095-C) must be provided to full-time employees 30 days from Jan. 31 each year (March 2, 2023 for the 2022 calendar year).	Code section 6056 requires ALEs to report to the IRS information about the health care coverage, if any, they offered to full-time employees. Section 6056 also requires those employers to furnish related statements to employees. According to the IRS, this information reporting is necessary in order to administer the employer shared responsibility "pay or play" rules. The return will give the IRS information about the employer's compliance with the pay or play rules. These rules impose penalties on ALEs that do not offer required coverage to full-time employees and dependents. The employee statements provide information to employees about coverage that was provided in the prior year. The information will be used to determine whether employees can claim a premium tax credit on their tax returns for coverage purchased through an Exchange.

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Affordable Care Act	Non-ALEs with self-insured health plans	**Code §6055 reporting**—Employers that are not ALEs and sponsor self-insured health plans must file an annual return with the IRS regarding the health coverage. These employers must also provide a related annual statement to covered individuals. The deadlines for these returns and statements are as follows: • Section 6055 returns (IRS Forms 1094-B and 1095-B) must be filed with the IRS annually, no later than Feb. 28 (March 31, if filed electronically) of the year after the calendar year in which the coverage is provided. • The statements for covered individuals (IRS Form 1095-B) must be provided 30 days from Jan. 31 each year (March 2, 2023 for the 2022 calendar year).	The ACA requires health insurance issuers, self-insured health plan sponsors, government agencies that administer government-sponsored health insurance programs and any other entity that provides MEC to report information on that coverage to the IRS and covered individuals. This requirement is found in Code section 6055. These reporting requirements are intended to provide the IRS with information necessary to administer certain ACA mandates, such as the shared responsibility penalties for ALEs and the individual mandate. To simplify the reporting process, the IRS allows ALEs with self-insured plans to use a single combined form for reporting the information required under both section 6055 and section 6056.
Americans with Disabilities Act (ADA) – Wellness plan notice	Employers that are subject to the ADA (15 or more employees) and sponsor wellness programs that	**Notice for wellness programs that collect health information**—Employers that sponsor wellness programs that collect health information must provide a notice to participating employees. Although employers are not required to provide the notice at a	Many wellness programs ask employees to answer questions on an HRA or to undergo biometric screenings for risk factors (such as high blood pressure or cholesterol). These inquiries and exams are permitted under the ADA if they are part of a voluntary wellness program. One of the requirements for a voluntary wellness program is that employers must give participating employees a notice that tells them what information will be

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	collect health information	specific time, employees must receive it before providing any health information, and with enough time to decide whether to participate in the program. Waiting until after an employee has completed a health risk assessment (HRA) or medical examination to provide the notice is not permitted.	collected as part of the wellness program, with whom it will be shared and for what purpose, the limits on disclosure and the way information will be kept confidential. The EEOC has provided a sample notice to help employers comply with this ADA requirement.
COBRA ***Note:*** *See COVID-19-related deadline extensions above. IRS Notice 2021-58 clarifies the application of the COBRA deadline extensions for electing COBRA coverage and paying COBRA premiums.*	Employers that had 20 or more employees on more than 50 percent of the typical business days during the previous calendar year Government and church plans are exempt	**Initial/General COBRA notice**—Plan administrator must provide generally within 90 days of when group health plan coverage begins. *See notes at left.*	Notice to covered employees and covered spouses of the right to purchase temporary extension of group health coverage when coverage is lost due to a qualifying event. A model General COBRA Notice is available from the DOL.
		Notice to plan administrator—Employer must notify plan administrator within 30 days of a) qualifying event or b) the date coverage would be lost as a result of the qualifying event, whichever is later.	Notice of certain qualifying events must be sent to plan administrator when employer is not plan administrator (for example, employer has contracted with a third party to administer COBRA). The following qualifying events trigger the employer's notice requirement: (a) employee's termination or reduction in hours; (b) employee's death; (c) employee's Medicare entitlement; and (d) employer's bankruptcy.
		COBRA election notice—Plan administrator must generally provide within 14 days after being notified by the employer or qualified beneficiary of the qualifying event (or 44 days after qualifying event if employer is also plan administrator). *See notes at left.*	Notice to qualified beneficiaries of their right to elect COBRA coverage upon occurrence of qualifying event. Qualified beneficiaries may be covered employees, covered spouses and dependent children. A model COBRA Election Notice is available from the DOL.

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		Notice of unavailability of COBRA—Plan administrator must provide this notice generally within 14 days after being notified by the individual of the qualifying event (or 44 days after qualifying event if employer is also plan administrator).	Plan administrator must send a notice that an individual is not entitled to COBRA coverage to those individuals who provide notice to the plan administrator of a qualifying event whom the plan administrator determines are not eligible for COBRA coverage.
		Notice of early termination of COBRA coverage—Plan administrator must provide as soon as practicable following the plan administrator's determination that coverage will terminate.	Notice to qualified beneficiaries that COBRA coverage will terminate earlier than the maximum period of coverage. The notice must include the reason for early termination, date of termination and any rights that qualified beneficiary may have to elect alternative group or individual coverage.
		Notice of insufficient payment—Plan administrator must provide reasonable period of time to cure deficiency before terminating COBRA (for example, 30-day grace period).	Plan administrator must notify qualified beneficiary that payment for COBRA was not significantly less than the correct amount before coverage is terminated for nonpayment. A payment is not significantly less than the amount required if the deficiency is no greater than the lesser of $50.00 or 10 percent of the amount the plan requires to be paid.
		Premium change notice—Plan administrator should provide at least one month prior to effective date.	COBRA does not explicitly require advance notice of a premium increase. However, COBRA regulations provide that if a COBRA premium payment is short by an amount that is insignificant, the qualified beneficiary must be provided notice of such underpayment and a reasonable amount of time to make the payment difference. Also, COBRA requires equal coverage and, to some extent, equal treatment between COBRA qualified beneficiaries and similarly situated non-COBRA beneficiaries.

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Consolidated Appropriations Act (CAA) – Transparency Provisions	Group health plans and health insurance issuers	**Surprise billing notice**—For plan years beginning on or after **Jan. 1, 2022**, plans and issuers are required to make publicly available, post on a public website of the plan or issuer, and include on each applicable explanation of benefits a description of the restrictions against balance billing.	The notice must describe, in plain language, the restrictions against balance billing in certain circumstances, including any applicable state law balance billing protections, and information on contacting appropriate state and federal agencies. Insurers can contractually agree to fulfill the disclosure requirement for fully insured plans. Self-insured plans may agree with insurers, TPAs or PBMs to assist in fulfilling these requirements, but the plan must monitor the other party to ensure compliance. A model notice is available for use to satisfy this notice requirement.
		Pharmacy and drug cost reporting—Plans and issuers must report information on plan medical costs and prescription drug spending to federal agencies. Plans and issuers may satisfy their reporting obligations by having third parties, such as issuers, TPAs, or PBMs, submit some or all of the required information on their behalf, provided a plan or issuer enters into a written agreement with the third party that is providing the information on its behalf in accordance with the rules. The agencies expect that it will be rare for group health plans to report the required information on their own, but nothing prohibits them from doing so.	The report was initially required to be provided by Dec. 27, 2021, and by June 1 of each year thereafter. However, federal agencies deferred enforcement of these deadlines, stating that they will not initiate enforcement action against a plan or issuer that submits the required information by Dec. 27, 2022. The agencies then provided a **submission grace period through Jan. 31, 2023**, if a good faith submission of 2020 and 2021 data is made by that date.

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		Gag clause attestations—Plans and issuers must annually submit an attestation of compliance with the prohibition of gag clauses under the CAA's transparency provisions. The CAA prohibits plans and issuers from entering into contracts with health care providers, TPAs or other service providers that would restrict the plan or issuer from providing, accessing or sharing certain information about provider price and quality of deidentified claims.	The first attestation is due by **Dec. 31, 2023**, covering the period beginning Dec. 27, 2020, through the date of attestation. Subsequent attestations, covering the period since the last attestation, are due by Dec. 31 of each following year. If the issuer for a fully insured health plan provides the attestation, the plan does not also need to provide an attestation. Also, employers with self-insured health plans can enter into written agreements with their TPAs to provide the attestation, but the legal responsibility remains with the health plan.
		Accuracy of provider networks—Plans must establish a database on their public websites that contains certain provider directory information, as well as a process to update and verify the accuracy of the information (at least every 90 days) and a protocol for responding to requests about a provider's network participation status.	This requirement is effective for 2022 plan years. However, until further rulemaking is issued to implement the provider directory requirements, plans and issuers are expected to implement these provisions using a **good faith, reasonable interpretation** of the law.
ERISA ***Note:*** *See COVID-19-related deadline extensions above.*	ERISA employee welfare benefit plans, unless exempted	**Summary plan descriptions** - Plan administrator must provide automatically to participants within 90 days of becoming covered by the plan (though a new plan has 120 days after becoming subject to ERISA to distribute	The SPD is the primary vehicle for informing participants and beneficiaries about their plan and how it operates. Must be written for average participant and be sufficiently comprehensive to apprise covered persons of their benefits, rights and obligations under the plan.

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		SPD). Updated SPD must be furnished every 5 years if changes made to SPD information or plan is amended. Otherwise, must furnish every 10 years.	
		Summary of material modification—Plan administrators must provide automatically to participants within 210 days after the end of the plan year in which the change is adopted. If benefits or services are materially reduced, participants must be provided notice within 60 days from adoption. Plan administrators and issuers must provide 60 days' advance notice of any material modification to plan terms or coverage that takes effect mid-plan year and affects the content of the SBC. The 60-day notice can be provided to participants through an updated SBC or by issuing an SMM.	Describes material modifications to a plan and changes in the information required to be in the SPD. Distribution of updated SPD satisfies this requirement.
		Plan documents—Plan administrator must provide copies no later than 30 days after a written request and make copies available at specified locations.	The plan administrator must furnish copies of certain documents upon written request by a participant and/or beneficiary and must have copies available for examination. The documents include the latest updated SPD, latest Form 5500, trust agreement, and other instruments under which the plan is established or operated.

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		Form 5500—Plan administrator generally must file by the last day of the seventh month following the end of the plan year, unless an extension has been granted. For calendar year plans, the deadline is normally July 31 of the following year. Small health plans (less than 100 participants) that are fully insured, unfunded or a combination insured/unfunded, are generally exempt from the Form 5500 filing requirement.	The Form 5500 is the annual return or report for an employee benefit plan. The filing requirements vary according to the type of plan. Certain employee benefit plans are exempt from the annual reporting requirements or are eligible for limited reporting options. The latest Form 5500 instructions provide information on who is required to file and detailed information on filing. These instructions are available on the DOL's website.
		Form M-1—Plan administrator must file with the DOL by March 1 of each year for the previous calendar year. A 60-day automatic extension is available upon request.	Form M-1 is the annual report that must be filed by multiple employer welfare arrangements (MEWAs) and entities claiming exception from MEWA status. In general, a MEWA offers health benefits to the employees of two or more employers. More information about the M-1 filing requirement, and the online filing system, is available on the DOL's website.
		Summary annual report – Plan administrators must provide automatically to participants within 9 months after end of plan year, or 2 months after due date for filing Form 5500 (with approved extension). Plans that are exempt from the annual 5500 filing requirement are not	The summary annual report is a narrative summary of the Form 5500 and includes a statement of the right to receive the annual report. The DOL has a sample SAR for welfare plans.

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		required to provide an SAR. Large, completely unfunded health plans are also generally exempt from the SAR requirement.	
Internal Revenue Code	Group health plans	**IRS Form 8928—Report and Pay Excise Taxes**—Generally must be filed (with the applicable excise tax) by the due date for filing the plan sponsor's or administrator's federal income tax return for the year in which the failure occurred. An automatic extension for filing is available, although the extension does not affect the time to pay the excise tax. There is also limited relief for certain inadvertent failures and "reasonable cause" mistakes that are corrected within 30 days.	The Form 8928 excise tax reporting requirement applies to failures to comply with certain group health plan mandates included in the tax code, such as: • COBRA continuation coverage requirements; • HIPAA's portability, access and renewability and nondiscrimination rules; • Genetic information nondiscrimination requirements; • Mental health parity requirements; and • ACA mandates.
Family and Medical Leave Act (federal FMLA)	Private sector employers with 50 or more employees in 20 or more workweeks in current or preceding calendar year, as well as all public agencies and all public and private elementary and	**General notice**—Must be posted in a location available to both employees and applicants and distributed to employees.	All covered employers are required to post a notice explaining the FMLA, regardless of whether they have eligible employees. In addition to displaying a poster, if a covered employer has any FMLA eligible employees, it must also provide each employee with a general notice about the FMLA in the employer's employee handbook or other written materials about leave and benefits. If no handbook or written leave materials exist, the employer must distribute this general notice to each new employee upon hire. The DOL has a model poster for employers to use.

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	secondary schools	**Notice of eligibility and rights & responsibilities**—Employer must provide written guidance, upon employee notice of need for FMLA leave.	Written guidance must be provided to an employee upon the employee's notice to the employer of the need for FMLA leave. The employer must detail the specific expectations and obligations of the employee, and explain the consequences of the failure to meet these obligations. The DOL has issued a model notice that may be used to satisfy this requirement.
		Designation notice—Employer must notify employee of whether leave has been designated as FMLA leave.	Within five days of receiving sufficient information to grant or deny FMLA leave, the employer must provide a designation notice informing the employee whether the leave is designated as FMLA leave. The DOL has issued a model notice that may be used to satisfy this requirement.
Federal fair employment laws	Employers with 15 or more employees that are subject to federal fair employment laws	**"Know Your Rights: Workplace Discrimination is Illegal" poster**—Employers must post a notice describing federal laws prohibiting job discrimination based on race, color, sex, national origin, religion, age, equal pay, disability or genetic information.	The notice must be posted prominently, where it can be readily seen by employees and applicants for employment. The notice provides information concerning the laws and procedures for filing complaints of violations of the laws. In addition to physically posting the notice, the EEOC encourages employers also to post similar electronic notices on their internal websites in a conspicuous location. The poster is available on the EEOC's website.
Genetic Information Non-discrimination Act (GINA)	Group health plans and health insurance issuers	**Notice of research exception**—To satisfy the research exception, plans or issuers must provide participants with a written request and must file a Notice of Research Exception with the designated federal agency.	Title I of GINA prohibits health plans and health insurance issuers from requiring or requesting that an individual undergo a genetic test, subject to some narrow exceptions. The research exception allows a health plan or issuer to request (but not require) that an individual undergo a genetic test if the information is not used for underwriting and some additional requirements are met. The plan or issuer must:

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			• Make the request in writing to the participant; • Clearly indicate that the test is voluntary and will not impact plan eligibility or contributions; and • Complete a Notice of Research Exception.
Genetic Information Non-discrimination Act (GINA)	Employers in the private sector and state and local governments that employ 15 or more employees	**Request for medical information**—Notice is not generally required; however, model language can be used by an employer lawfully requesting medical information so that any genetic information included with the response will be deemed inadvertent.	Any receipt of genetic information in response to the request for medical information will be deemed inadvertent if the employer's request includes the model (or similar) language. The model language can be found at EEOC Reg. § 1635.8(b)(1)(i)(B)
		Request for genetic information for toxic substance monitoring—Written notice required if genetic information is acquired for toxic substance monitoring.	Employers that want to obtain genetic information of employees in order to monitor the biological effects of exposure to toxic substances in the workplace must provide each affected employee with: • Written notice of the genetic monitoring; and • The individual monitoring results. The employee must authorize the monitoring, unless it is required by law.
		Notice of disclosure—Notice is required for certain permitted disclosures of genetic information.	Employers generally may not disclose an employee's genetic information. Certain exceptions apply to this rule, including disclosure of genetic information in response to a court order or to public health agencies regarding contagious, life-threatening illness. Notice to the employee is required if the employer discloses genetic information for these purposes.

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HIPAA and the ACA—Wellness Programs ***Note:*** *See COVID-19-related deadline extensions above.*	Group health plans and issuers that offer health-contingent wellness programs	**Notice of alternative standard**—Plans and issuers must disclose the availability of an alternative standard in all materials describing the wellness program.	Health-contingent wellness programs, or wellness programs that require individuals to satisfy a standard related to a health factor in order to receive a reward, violate federal nondiscrimination rules unless the program satisfies a number of conditions: • Limit reward to 30 percent of cost of coverage (or 50 percent for health-contingent wellness programs designed to prevent or reduce tobacco use); • Designed to reasonably promote health and prevent disease; • Provide annual opportunity to qualify; • Provide reasonable alternative standard for obtaining the reward for certain individuals; and • Disclose availability of an alternative standard. The disclosure must include contact information for obtaining the alternative and a statement that recommendations of an individual's personal physician will be accommodated. If plan materials merely mention that a wellness program is available, without describing its terms, this disclosure is not required. Sample language is available in the DOL's model notice guide.
HIPAA—Privacy and Security	Covered Entities: Group health plans, health care clearing- houses and health care providers Business Associates: entities that create, receive, maintain or	**Notice of privacy practices**—The plan administrator or insurer must provide the Notice of Privacy Practices when a participant enrolls, upon request and within 60 days of a material revision to the notice. At least once every three years, participants must be notified about the	HHS regulations require that participants be provided with a detailed explanation of their privacy rights, the plan's legal duties with respect to protected health information, the plan's uses and disclosures of protected health information, and how to obtain a copy of the Notice of Privacy Practices. There are special rules for fully insured health plans. If an employer with a fully insured health plan has access to PHI, the plan must have its own privacy notice and provide it upon request. If an employer with a fully insured

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	transmit protected health information (PHI) on behalf of a Covered Entity	availability of the Notice of Privacy Practices.	health plan does not have access to PHI, the plan is not required to maintain or provide a privacy notice. HHS has developed four model privacy notices for health plans—a booklet version, a full-page version, a layered version and a plain text version. These model notices, as well as instructions on how to use them, are available on HHS' website.
		Notice of breach of unsecured PHI—Covered entities and their business associates must provide notification following a breach of unsecured PHI without unreasonable delay and in no case later than 60 days following the discovery of a breach.	Following a breach of unsecured PHI, covered entities must provide notification of the breach to affected individuals, HHS and, in certain circumstances, to the media. If the unsecured PHI is held by a business associate, the business associate must notify the covered entity that a breach has occurred.
HIPAA-Portability	Group health plans and issuers of group health plan insurance coverage, unless exception applies	**Notice of special enrollment rights**—Plan administrators must provide at or before the time an employee is initially offered the opportunity to enroll in the group health plan.	Notice to employees eligible to enroll in a group health plan describing the group health plan's special enrollment rules including the right to enroll within 30 days of the loss of other coverage or of marriage, birth of a child, adoption, or placement for adoption, or within 60 days of the loss of coverage under a Medicaid plan or CHIP, or within 60 days of a determination of eligibility for a premium assistance subsidy under Medicaid or CHIP. This notice is often included in the health plan's SPD or insurance booklet. Model language is available in the DOL's model notice guide.
CHIPRA ***Note:*** *See COVID-19-related deadline*	Employers that maintain group health plans covering employees in	**Annual employer CHIP notice**—If an employer's group health plan covers residents in a state that provides a premium subsidy,	States may offer eligible low-income children and their families a premium assistance subsidy to help pay for employer-sponsored coverage. If an employer's group health plan covers residents in a state that provides a

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extensions above.	states that provide premium assistance subsidies under a Medicaid plan or CHIP	the employer must send an annual notice about the available assistance to all employees residing in that state.	premium subsidy, the employer must send an annual notice about the available assistance to all employees residing in that state. Employers may use the model notice provided by the DOL to meet their obligations under CHIPRA.
Individual Coverage HRA (ICHRA)	Employers that sponsor ICHRAs for specific classes of employees (or all employees)	**ICHRA notice**—Employers with ICHRAs must provide a notice to eligible participants regarding the ICHRA. In general, this notice must be provided at least 90 days before the beginning of each plan year.	Employers of all sizes may implement an ICHRA to reimburse their eligible employees for insurance policies purchased in the individual market or Medicare premiums. Employers with ICHRAs must provide written notice to eligible participants including, among other things, the following information: • A description of the terms of the ICHRA; • A statement of the participant's right to opt out of and waive future reimbursement under the ICHRA; and • A description of the premium tax credit eligibility consequences for a participant who accepts the ICHRA. A model notice is available for employers to use to satisfy this notice requirement.
Medicare Part D	Group health plan sponsors that provide prescription drug coverage, except entities that contract with or become a Part D plan	**Disclosure notices for creditable or non-creditable coverage**—At a minimum, must be provided by the plan sponsor at the following times: 1) Prior to the Medicare Part D Annual Coordinated Election Period—Oct. 15 through Dec. 7 of each year; 2) Prior to an individual's Initial Enrollment Period for Part D;	Group health plan sponsors — or entities that offer prescription drug coverage on a group basis to active and retired employees and to Medicare Part D eligible individuals — must provide, or arrange to provide, a notice of creditable or non-creditable prescription drug coverage to Medicare Part D eligible individuals who are covered by, or who apply for, prescription drug coverage under the entity's plan. This creditable coverage notice alerts the individuals as to whether or not their prescription drug coverage is at least as good as the Medicare Part D coverage. Model forms are available from CMS.

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		3) Prior to the effective date of coverage for any Medicare eligible individual that joins the plan; 4) Whenever prescription drug coverage ends or changes so that it is no longer creditable or becomes creditable; and 5) Upon request by a Medicare Part D eligible individual. *If the plan sponsor provides notice to all participants annually, CMS will consider 1 & 2 above to be met. "Prior to" means in the prior 12 months.	
		Disclosure to CMS—Plan sponsor must make on an annual basis (60 days after the beginning of the plan year) and upon any change that affects creditable coverage status (within 30 days of the change)	Employers must disclose to CMS whether the coverage is creditable. An entity is required to provide the Disclosure Notice through completion of the Disclosure Notice form, unless specifically exempt as outlined in related CMS guidance. This is the sole method for compliance with the disclosure requirement.
Medicare Part D-Retiree Drug Subsidy	Employers with group health plans that cover retirees who are entitled to enroll in Part D but who elect not to do so	**Retiree drug subsidy application**—At least 90 days before the beginning of each plan year, plan sponsors must apply for retiree drug subsidy, unless CMS approves request for extension.	An employer who wishes to sponsor a prescription drug plan with retiree prescription drug coverage that is at least as good as Part D coverage may apply for the retiree drug subsidy, which is exempt from federal income tax. The subsidy is available to employers with group health plans that cover retirees who are entitled to enroll in Part D but who elect not to do so.

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Mental Health Parity and Addiction Equity Act (MHPAEA) ***Note:*** *See COVID-19-related deadline extensions above.*	Group health plans (of employers with over 50 employees) offering mental health and substance use disorder benefits	**Notice of cost exemption**—Group health plans claiming the increased cost exemption must promptly notify the appropriate federal and state agencies, plan participants and beneficiaries. Notice must also be provided upon request.	The cost exemption will apply to a group health plan if its cost increase exceeds 2 percent in the first plan year and 1 percent in a subsequent year. If the 2-percent or 1-percent increased cost is incurred, the plan is exempt for the plan year following the year the cost was incurred. Thus, the exemption lasts one year and then the plan is required to comply again. A group health plan or health insurance issuer must promptly notify the Secretaries of the DOL, HHS and the Treasury, the appropriate state agencies, and participants and beneficiaries in the plan of such election. A notification to the Secretaries must include: • A description of the number of covered lives under the plan (or coverage) involved at the time of the notification, and as applicable, at the time of any prior election of the cost-exemption by such plan (or coverage); • For both the plan year upon which a cost exemption is sought and the year prior, a description of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan; and • For both the plan year upon which a cost exemption is sought and the year prior, the actual total costs of coverage with respect to mental health and substance use disorder benefits under the plan.
		Notice of criteria for medically necessary determination—Plan administrators and health insurance issuers must	The plan administrator or the health insurance issuer must disclose the criteria for medical necessity determinations with respect to MH/SUD benefits to any current or potential participant, beneficiary or contracting provider

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		disclose the criteria for medically necessary determinations with respect to mental health/substance use disorder (MH/SUD) benefits.	upon request and the reason for any denial of reimbursement or payment for services with respect to MH/SUD benefits to the participant or beneficiary.
		Comparative analyses of NQTLs used—Plan administrators and health insurance issuers must conduct comparative analyses of the nonquantitative treatment limitations (NQTLs) used for medical and surgical benefits as compared to mental health and substance use disorder (MH/SUD) benefits. As of Feb. 10, 2021, the comparative analyses, and certain other information, must be made available upon request to applicable agencies.	FAQs address the following: • When plans and issuers must make their NQTL comparative analyses available; • What information plans and issuers must make available; • Reasons why documentation of comparative analyses of NQTLs might be insufficient; • What types of documentation should be made available; and • What actions the Departments might take for noncompliance.
Michelle's Law ***Note:*** *See COVID-19-related deadline extensions above.*	Employer-sponsored group health plans	**Michelle's law notice**—Plan administrators and group health plan insurers must include with any notice regarding a requirement for certification of student status.*	If a group health plan (or insurance issuer providing coverage for the plan) requires a certification of student status for coverage under the plan, it must send a Michelle's Law Notice along with any notice regarding the certification requirement. The Michelle's Law Notice must be written in language understandable to a typical plan participant and must describe the terms of the continuation coverage available under Michelle's Law during medically necessary leaves of absence. *Under the ACA, group health plans are required to cover dependent children up to age 26, regardless of student status. The ACA's

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			coverage mandate for adult children limits the impact of Michelle's Law. However, group health plans that extend coverage past the age of 26 for adult children who are students will still be subject to the requirements of Michelle's Law.
Newborns' and Mothers' Health Protection Act (NMHPA) ***Note:*** *See COVID-19-related deadline extensions above.*	Group health plans that provide maternity or newborn infant coverage	**NMHPA notice**—Plan administrators must include a statement within the SPD (or SMM) timeframe.	The plan's SPD must include a statement describing any requirements under federal or state law applicable to the plan, and any health insurance coverage offered under the plan, relating to any hospital length of stay in connection with childbirth for a mother or newborn child. If the federal law applies in some areas in which the plan operates and state law applies in other areas, the SPD should describe the different areas and the federal or state requirements applicable in each. Model language is available in the DOL's model notice guide.
Qualified Medical Child Support Orders ***Note:*** *See COVID-19-related deadline extensions above.*	Plan administrators of group health plans and state child support enforcement agencies	**Medical child support order notice**—Upon receipt of medical child support order, plan administrator must promptly issue notice, including plan's procedures for determining its qualified status. Within a reasonable time after its receipt, plan administrator must also issue separate notice as to whether the medical child support order is qualified.	This is a notification from the plan administrator regarding receipt and qualification determination on a medical child support order directing the plan to provide health insurance coverage to a participant's noncustodial children.
		National medical support notice—Within 20 days after the date of notice or sooner, if reasonable, employer must either send Part A to State agency, or Part B to plan	Notice used by State agency responsible for enforcing health care coverage provisions in a medical child support order. Depending upon certain conditions, employer must complete and return Part A of the National Medical Support notice to the State agency or transfer

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		administrator. Plan administrator must promptly notify affected persons of receipt of notice and procedures for determining its qualified status. Plan administrator must within 40-business days after its date or sooner, if reasonable, complete and return Part B to State agency and must also provide required information to affected persons. Under certain circumstances, employer may be required to send Part A to State agency after plan administrator has processed Part B.	Part B of the notice to the plan administrator for a determination on whether the notice is a qualified medical child support order.
Qualified Small Employer HRA (QSEHRA) ***Note:*** *See COVID-19-related deadline extensions above.*	Non-ALEs that do not maintain a group health plan for their employees	**QSEHRA notice**—An employer funding a QSEHRA for any year must provide a written notice to each eligible employee. This notice must be provided within 90 days of the beginning of the year. For employees who become eligible to participate in the QSEHRA during the year, the notice must be provided by the date on which the employee becomes eligible to participate.	The notice must include the following information: • The employee's maximum benefit under the QSEHRA for the year; • A statement that, if the employee is applying for advance payment of the premium assistance tax credit, the employee should provide the Exchange with information about the QSEHRA's maximum benefit; and • A statement that, if the employee is not covered under minimum essential coverage for any month, reimbursements under the QSEHRA may be includible in gross income.
Uniformed Services Employment and Reemployment	All public and private employers, regardless of size	**USERRA notice**—Employers must provide notice by posting where other employee notices are customarily posted, or	Employers must provide notice of rights, benefits and obligations of persons entitled to USERRA and of employers.

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Rights Act (USERRA)		provide to employees by alternate means.	
Women's Health and Cancer Rights Act (WHCRA) ***Note:*** *See COVID-19-related deadline extensions above.*	Group health plans that provide coverage for mastectomy benefits	**WHCRA notice**—Plan administrators and issuers must provide notice upon enrollment in the plan and annually thereafter.	Enrollment notice should include a statement that for participants and beneficiaries who are receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications of the mastectomy, including lymphedema. Notice should also include a description of any deductibles and coinsurance limitations applicable to such coverage. Annual notice should include a copy of the WHCRA enrollment notice, or a simplified disclosure providing notice of the availability of benefits for the four required coverages and information on how to obtain a detailed description. Model language is available in the DOL's model notice guide.