Health Plan Notice Matrix:

The what, when, who and how of the dazzling array of select health plan reporting and disclosure obligations

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This matrix summarizes key federal reporting and disclosure obligations imposed upon healthcare plans, primarily healthcare plans subject to ERISA. With limited exceptions it does not endeavor to catalogue health plan reporting and disclosure obligations that may exist under state and local laws. Additionally, the matrix does not include reporting or disclosure obligations related to any state or local paid leave laws. Generally, when a notice obligation falls on a Saturday, Sunday or federal holiday, the notice may be distributed on the next business day.

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Note: For plans subject to ERISA, Department of Labor regulations allow most notices required by ERISA to be furnished as part of other employee communications, such as a newsletter, as long as there is a "prominent" notice on the front of the document advising the reader that the document contains important information about the reader's rights under the plan and ERISA and should be read and retained for future reference. There are specific exceptions to this general rule. Where the notice must be furnished separately, either pursuant to express requirements or as a practical matter (e.g., because the notice is individualized), the manner of distribution is noted in this matrix.

Medicare Part D Reports and Disclosures				
Notice	**Who gets it?**	**When?**	**How?**	**Comments**
Medicare Part D: **Creditable or non-creditable coverage notice to individuals** This is a notice of "creditable" or "non-creditable" prescription drug coverage, basically a comparison of cost of expected claims under the employer's Rx benefit, compared to the standard Medicare Part D benefit.	Each person enrolled in the plan or who is seeking enrollment in the plan, who is also "Medicare eligible," which in this context means *covered* by Parts A or B.	Prior to the Part D annual enrollment period (Oct. 15 – Dec. 7). "Prior to" means within the past 12-months unless there is a material change in the creditable/noncreditable nature of the plan's prescription drug coverage. Prior to the individual's personal seven-month Part D enrollment window (begins three months prior to month in which the individual becomes eligible for Part *B*). Prior to the effective date of coverage in the plan. Upon a material change in the employer's prescription drug benefit (i.e., it becomes, or ceases to be, "creditable"). Upon request.	May be mailed or hand delivered. May be provided electronically to plan participants who can access electronic documents at their regular worksite if they have access to the sponsor's electronic information system on a daily basis as part of their work duties. If this method is chosen, the sponsor must inform the plan participant that the participant is responsible for providing a copy of the electronic disclosure to their Medicare-eligible dependents covered under the group health plan. May be provided electronically to retirees if they consent, and other requirements are met. May be combined with other plan materials, including initial or open enrollment materials, but must be "conspicuous." There must be a text box atop the materials, noting in 14-point font that the packet includes a Medicare Part D notice. A single mailing to the participant's home is adequate notice to a Medicare-enrolled spouse and dependents unless the plan knows such an individual does not reside there.	Applies to ERISA and non-ERISA plans. Actuarial support may or may not be required to attest to creditable coverage. CMS has supplied model notices in English and Spanish. A *personalized* notice of creditable or non-creditable coverage should be supplied upon request. Traditionally, CMS has not enforced this requirement.

Notice	Who gets it?	When?	How?	Comments
Creditable coverage notice to CMS	The Centers for Medicare and Medicaid Services (CMS).	Within 60 days after the **beginning** of the plan year. Within 30 days after termination of a plan providing prescription drug benefits. Within 30 days after any change in the creditable nature of the prescription drug coverage under a health plan.	Notice is made electronically, through completion of an online disclosure form.	Applies to ERISA and non-ERISA plans. Early guidance said "plan year" meant the contract year or ERISA plan year; recent HHS comments suggest it might now be the ERISA plan year. Either approach likely remains acceptable. CMS disclosure is not required for retirees where the employer receives the retiree subsidy or contracts directly with a Part D plan for its retirees.

HIPAA Reports and Disclosures				
Notice	**Who gets it?**	**When?**	**How?**	**Comments**
HIPAA Reports and Disclosures: **Privacy notice** Notice of the plan's privacy practices with respect to "protected health information" (PHI). Covered entities, such as health plans and insurers, are required to supply a privacy notice to enrollees.	All enrolled individuals. However, delivery to the enrolled participant (employee or retiree) is deemed to be delivery to all of their dependents. However, if a dependent asks for a copy of the notice, the plan must supply it.	Upon initial enrollment and upon request. The notice must be reissued within 60 days after a material change to its contents. In any event, the responsible party must notify covered individuals every three years that the notice exists, and how they may obtain a copy. Best practice is probably to include the notice in initial and annual enrollment packets.	If the plan is fully insured the carrier has the obligation to send the notice, unless the plan sponsor is "hands on" the plan's PHI, in which case the insurer's obligations remain but the sponsor also has an obligation to maintain a notice and provide it upon request. If the plan is self-funded, the sponsor has the obligation as a practical matter. The employer may contract with a vendor to provide the notice, but the employer retains the responsibility. The notice must be delivered to the participant (posting is not adequate), but not necessarily in a separate document. However, the notice is sufficiently large that it's probably best furnished as a separate document. The notice may also be distributed via email if the participant has agreed to accept it that way. Some employers also post the notice on their website, where employee benefits are discussed.	Applies to ERISA and non-ERISA plans. Lockton maintains a model notice. Contact your Lockton account service team.
Privacy notice reminder This is a reminder of the plan's privacy notice, reminding participants that the plan has a privacy notice, and that it is available for review.	All enrolled individuals. However, delivery to the enrolled participant (employee or retiree) is deemed to be delivery to all of their dependents.	Every three years. However, if the privacy notice is provided regularly, such as in each initial and annual enrollment packet, or reproduced in the SPD, arguably this notice obligation is moot.	Likely in accordance with the same manner in which the actual privacy notice is provided.	Applies to ERISA and non-ERISA plans. Lockton maintains a model notice. Contact your Lockton account service team.

Notice	Who gets it?	When?	How?	Comments
Notice of privacy or security breach A notice by plans subject to HIPAA privacy and security standards, to HHS and affected individuals, regarding a breach of "unsecured" protected health information (PHI). Note: Business associates are also subject to a notice requirement to the plan.	Department of Health and Human Services, affected individuals and, in some instances, local media outlets.	To each affected individual: As soon as reasonably possible (and in no case later than 60 days) following the discovery of a breach.* To HHS: The plan must maintain a log or other documentation of the breach(es) and submit it to HHS annually, no later than 60 days after the end of the calendar year in which the breach is discovered. For breaches affecting 500+ individuals, notice must be supplied to HHS immediately. To local media outlets: Notice is required to prominent media outlets if the breach affects 500+ residents. *Turning a blind eye will not help the plan as it will be deemed to have knowledge of a breach if, exercising reasonable diligence, it would have discovered it.	To affected individuals: By first class mail, or email if preferred by the individual. To HHS: Electronically; HHS has posted on its website an online form and instructions for reporting breaches of unsecured PHI.	Applies to all plans subject to HIPAA privacy and security. A breach is defined as any impermissible acquisition, access, use, or disclosure of PHI unless the plan demonstrates that there is a low probability that the PHI has been compromised. Plans are required to perform a formal risk assessment for each breach. PHI that is encrypted is less likely to be "breached." The notice to affected individuals should describe the circumstances of the breach (including the date of the breach and the date of discovery), the information disclosed, steps the affected individuals should take to minimize the potential harm, contact information for additional details, and action taken by the health plan to mitigate any harm. PHI *security* breaches require consultation with legal counsel.
Special enrollment notice This is a notice apprising eligible employees and their dependents of their right to enroll immediately if they lose other coverage due to a special enrollment event.	Eligible employees	At or before the time the employee is first offered an opportunity to enroll.	The notice language should be included in enrollment forms or as a special notice. It should be provided in writing. Electronic notice is permitted. Best practice is to comply with the DOL's comprehensive regulations for the provision of electronic notices.	Applies to ERISA and non-ERISA plans. An explanation of a plan's special enrollment rights should also be in the SPD. Note that CHIPRA added two new HIPAA special enrollment events. Lockton maintains a model notice.

Notice	Who gets it	When?	How?	Comments
Alternative standard available under activity- or outcomes-based wellness program See entries under "Health Reform: Wellness programs" and "Miscellaneous Reports and Disclosures — EEOC."				

COBRA Disclosures				
Notice	**Who gets it?**	**When?**	**How?**	**Comments**
COBRA Disclosures: **General notice** This is a general explanation of COBRA rights. The plan's summary plan description should reflect COBRA contact points and procedures for notices to the plan.	Participants and, if married, the covered spouse. Remember to provide to health FSA and HRA participants and beneficiaries. Qualified small employer HRAs are exempt from COBRA, so this notice is not required.	Within 90 days after coverage under the plan begins. If the employee moves to a different plan at open enrollment, the plan must issue new general notice (but not if the move is simply from option to option within the same plan). If the employee is enrolled and then adds a spouse, the spouse must receive the general notice within 90 days after enrollment.	By first-class (or better) mail addressed to employee and, if spouse is covered, to spouse or "family." Hand delivery to the employee is adequate for the employee, but is not deemed to be delivery to the spouse. Preferred approach is first-class (or better) mailing to the employee's address. If the plan knows covered dependents live elsewhere, it should send separate notices to the appropriate addresses. Electronic notice is permitted. Best practice is to follow the DOL's comprehensive regulations for the provision of electronic notices.	Applies to ERISA and non-ERISA plans, except church plans. The DOL has supplied model notices in English and Spanish. Contact your Lockton account service team. The plan is required to send the notice by means "reasonably calculated" to be received, but is not required to guarantee receipt. Failure to provide the COBRA general notice to plan participants and beneficiaries could result in a fine of $110/day with no maximum.
Election notice This is an explanation of rights to COBRA coverage, duration of coverage, payment, notice obligations, etc. provided after a covered individual loses eligibility due to certain events.	Any employee, retiree or dependent that loses coverage on account of a COBRA qualifying event. Supply to health FSA and HRA participants and beneficiaries upon a qualifying event. Notice to health FSA participant is required only if the participant is in a positive account position at the time of the qualifying event (i.e., money contributed is more than money reimbursed to that point in the plan year). Qualified small employer HRAs are exempt from COBRA, so this notice is not required.	After a qualifying event. If the event is the employee's death, termination of employment, reduction in hours or Medicare entitlement, or the employer's bankruptcy, the employer must supply notice to the plan administrator within 30 days after the qualifying event, 44 days if the employer is also the plan administrator (this is typical for self-funded plans). For other qualifying events (e.g., divorce, legal separation, child aging out), within 14 days after receiving notice of the qualifying event.	Must be in writing. First-class (or better) mail addressed to qualified beneficiaries is preferred. Hand delivery to the employee is adequate for the employee, but is not deemed to be delivery to the spouse. If the employee and spouse are both beneficiaries, address the notice to both or to the employee "and family." If the employee and children are beneficiaries, address the notice to the employee "and family." The plan may send one notice to all beneficiaries if they reside at the same address. If not, the plan must send separate notices to separate addresses.	Applies to ERISA and non-ERISA plans, except church plans. The DOL has supplied a model notice in English and Spanish. Contact your Lockton account service team. The plan is required to send the notice by means "reasonably calculated" to be received, but is not required to guarantee receipt. Failure to notify participants and beneficiaries of their COBRA rights within 14 days of notice of a qualifying event could result in a fine of $110/day with no maximum.

Notice	Who gets it?	When?	How?	Comments
Notice of unavailability of COBRA coverage This is a notice intended to apprise employees and dependents that COBRA coverage is not available.	All persons who are expecting to receive COBRA but COBRA is unavailable, e.g., because no qualifying event has in fact occurred, because notice from the employee was not timely, etc. Qualified small employer HRAs are exempt from COBRA, and therefore this notice is not required with respect to such an HRA.	Within 14 days after an individual requests COBRA coverage (or provides notice of an event such as divorce, legal separation or child's emancipation that would have been a qualifying event but for some other reason), but no COBRA coverage is available. For example, perhaps a spouse lost coverage due to divorce but failed to notify the plan within 60 days.	In writing. The plan may send one notice to all beneficiaries if they reside at same address. If not, the plan must send separate notices to separate addresses. If sent to the employee and spouse, the notice should be addressed to both. The notice should go to the individual expecting to receive COBRA, not necessarily the individual who provided notice of the event.	Applies to ERISA and non-ERISA plans, except church plans. There is no DOL model notice. Lockton maintains a model notice. Contact your Lockton account service team. The plan is required to send the notice by means "reasonably calculated" to be received, but is not required to guarantee receipt.
Notice of early termination of COBRA coverage This is a notice that COBRA coverage is terminating early (this notice is not required when COBRA coverage is exhausted).	COBRA qualified beneficiaries whose COBRA coverage will terminate early. Qualified small employer HRAs are exempt from COBRA, and therefore this notice is not required with respect to such an HRA.	As soon as practicable after the plan administrator determines that COBRA coverage will be terminated prematurely.	In writing. The plan may send one notice to all beneficiaries if they reside at same address. If not, the plan must send separate notices to separate addresses. If sent to the employee and spouse, the notice should be addressed to both.	Applies to ERISA and non-ERISA plans, except church plans. There is not a DOL model notice. Lockton maintains a model notice. Contact your Lockton account service team. The plan is required to send the notice by means "reasonably calculated" to be received, but is not required to guarantee receipt.
Notice of insignificant COBRA premium shortfall This is a notice that the COBRA qualified beneficiary underpaid a COBRA premium by an insignificant amount.	COBRA qualified beneficiaries who underpay a COBRA premium by an insignificant amount. An insignificant amount is the lesser of $50 or 10% of the premium due.	Immediately when partial payment is received. Provide a reasonable grace period (e.g., 30 days) to cure the underpayment. The notice is not necessary if the plan is willing to accept the partial payment as payment in full.	In writing. There is no DOL model notice.	Applies to ERISA and non-ERISA plans, except church plans. If an individual underpays a COBRA premium by an insignificant amount, the plan must send a notice of underpayment — and supply an opportunity to cure the deficiency — before terminating COBRA coverage.

Affordable Care Act Reports and Disclosures				
Notice	**Who gets it**	**When?**	**How?**	**Comments**
Affordable Care Act Reports and Disclosures: **Notice of grandfathered status** This is a notice apprising participants and beneficiaries of the plan's intent to retain grandfathered status under the ACA, with respect to one or more coverage options. This notice applies only to plans that intend to retain grandfathered status into the ensuing plan year.	The participant (e.g., the employee) who receives other plan materials.	Presumably, not later than the first day of the plan year.	The notice should be included in plan materials supplied to participants. Most sponsors will include this in open enrollment materials. Electronic notice should be acceptable, subject to compliance with comprehensive federal regulations for the provision of electronic notices.	Applies to ERISA and non-ERISA plans (grandfathered plans only). There does not appear to be any special notice required if a plan *loses* grandfather status. In that event, of course, the plan should be amended to reflect the new mandates that apply to it. ACA benefit mandates do not apply to HIPAA "excepted benefits"[1] maintained by non-governmental employers (federal authorities will not enforce the mandates against excepted benefits maintained by governmental employers). Thus, grandfather status is irrelevant with respect to these benefits. The DOL has supplied model notices in English and Spanish. Contact your Lockton account service team. *This notice is moot, of course, after the plan loses grandfathered status. Failure to comply with ACA benefit mandates may result in a fine of $100/day per individual with no maximum.*

[1]HIPAA "excepted benefits" include retiree-only plans, most dental and vision coverage, and most health flexible spending accounts.

Notice	Who gets it?	When?	How?	Comments
Notice of right to designate primary care provider & no obligation for preauthorization for OB-GYN care This is a notice apprising participants in network plans of their right to designate a PCP, including their right to designate a pediatrician as their child's PCP, and of their right to obtain OB-GYN care without preauthorization or referral.	Any participant in a plan that requires designation of a primary care provider or that provides coverage for OB-GYN care and requires designation of a primary care provider.	Notice is provided when the plan issues summary plan descriptions or similar summaries. The notice should be included in the summaries.	In writing, as part of (or with) any summary plan description or similar plan summary. Electronic distribution is likely permitted in accordance with comprehensive federal regulations for the provision of electronic notices.	Applies to ERISA and non-ERISA plans (non-grandfathered plans only). Neither this notice obligation nor the underlying mandate applies to HIPAA "excepted benefits" maintained by non-governmental employers. Federal authorities say they will not enforce the requirement against excepted benefits maintained by governmental employers. The DOL has supplied model notices in English and Spanish. Contact your Lockton account service team.
Wellness programs — alternative standard available under activity- or outcomes-based wellness programs Activity- and outcomes-based wellness programs must disclose the availability of a reasonable alternative standard if the program provides a reward for satisfying a standard related to a health factor. See also the entries under, "Miscellaneous Reports and Disclosures — EEOC."	Participants (covered employees/retirees), COBRA and other beneficiaries receiving benefits, and alternate recipients, to the extent they're eligible for wellness program participation.	A specific time period is not addressed in the final regulations or their codification in the healthcare reform statute; however, such disclosure must be included in all plan materials describing the terms of the program. Communications that refer to the wellness program but do not provide details about it (such as the Summary of Benefits and Coverage) are not required to provide this disclosure.	A specific method for distribution is not addressed in the final regulations; however, such disclosure must be included in all plan materials describing the terms of the program (written or online).	Applies to ERISA and non-ERISA plans. The final regulations include model language that can be used to satisfy the disclosure requirement. Plan materials are not required to describe a specific reasonable alternative standard, only the availability of one. The plan may, and in some cases must, accept the recommendations of the individual's physician as the appropriate alternative standard.

Notice	Who gets it?	When?	How?	Comments
Report on wellness programs & quality/safety measures Plans must report information on programs to enhance wellness.	The federal government.	Timing TBD. Will be addressed in pending regulations.	Presumably, electronically via a web portal. Federal authorities will issue a model report form.	Applies to ERISA and non-ERISA plans (non-grandfathered plans only). This is an ACA-imposed requirement that has never been implemented.
Disclosure regarding insurance exchanges The ACA requires employers subject to the Fair Labor Standards Act to notify employees and others of the impending availability of coverage through an insurance exchange.	Employees, including part-time employees, and employees not eligible for or enrolled in the employer's health plan.	Within 14 days of hire. Note: This is *not* an annual notice requirement.	Hand delivered, supplied by first class mail, or, if sent electronically, best practice is to comply with DOL standards for electronic delivery of other required notices.	The employer, not the plan, has this obligation under the Fair Labor Standards Act. Best practice is to not include this notice in a benefits guide or newsletter because *all* employees must receive the notice There is no express penalty for failure to provide the notice.
Report of minimum essential coverage (section 6055 reporting) The ACA requires employers and insurers to report minimum essential coverage supplied to "primary insureds" and their dependents.	Each "primary insured" (e.g., employee, retiree, COBRA beneficiary, etc.) who had coverage for at least a day during the prior calendar year; copy to the IRS. Some states now impose their own individual mandates and require employers with employees residing in those states to transmit to the state the federal coverage reporting form or similar form prepared for the employee. See *State and Local Notices* later in this grid.	**To the primary insured:** March 2 following the calendar year in which the coverage was provided. The extended deadline has been made permanent and is March 2. **To the IRS:** Last day of February following the calendar year in which the coverage was provided or, if filed electronically, March 31 following the year in which coverage was provided. See the Instructions to IRS Form 1094-C/1095-C for information about when employers must file electronically. **To various state authorities:** See *State and Local Notices* later in this grid.	**Self-insured coverage:** Form 1095-C from the employer; a copy of all Forms 1095-C issued by the employer to primary insureds are transmitted to the IRS (and certain state authorities) with a Form 1094-C. **Insured coverage**: The insurer issues Form 1095-B to the primary insureds, copies to the IRS (and certain state authorities) with Form 1094-B. Electronic filing to the IRS is required for those who file at least 10 returns under Code § 6055.	These forms also indicate, by month, coverage of specific dependents (identified by SSN or date of birth). Where a self-insured coverage is provided to individuals who were non-employees throughout the year (such as retirees, partners, outside directors and COBRA beneficiaries) the coverage may be reported on either Form 1095-B or Form 1095-C. Notice to these individuals may be excused, except upon request, if proper notice is provided. See the Instructions to IRS Form 1094-C/1095-C.

Notice	Who gets it?	When?	How?	Comments
Report demonstrating compliance with the employer mandate (section 6056 reporting) The ACA requires employers subject to the "play or pay" mandate to report information on the medical insurance (if any) offered to their full-time employees (employees working on average at least 30-hours per week), to demonstrate compliance with the mandate.	Each individual who, for at least a month in the prior calendar year, was an ACA full-time employee of an employer subject to the employer mandate; copy to the IRS.	**To the full-time employee:** March 2 following the year to which the report relates. The extended deadline has been made permanent and is March 2. **To the IRS:** Last day of February following the year to which the report relates or, if filed electronically, March 31 following the year to which the report relates. See the Instructions to IRS Form 1094-C/1095-C for information about when employers must file electronically.	On Form 1095-C from the employer; a copy of all Forms 1095-C issued by the employer are transmitted to the IRS with a Form 1094-C. Electronic filing to the IRS is required for those who file at least 10 returns under Code § 6055.	A self-insured employer satisfies section 6055 and 6056 reporting with respect to a full-time employee on the same Form 1095-C; Part I identifies the employer and the employee, Part II accomplishes Section 6056 reporting and, if the employee had self-insured coverage during the prior year, Part III reflects the months of coverage. An employer providing insured coverage to a full-time employee does not complete Part III.
Notice of retroactive coverage cancellation (i.e., "rescission") As a general rule, the ACA permits plans to cancel coverage for an individual or group retroactively only in the case of fraud or material misrepresentation, as prohibited by the plan, and only after 30-days' notice. *There are exceptions for certain retroactive cancellations due to administrative delays and errors where the participant hasn't paid any required premium for the period for which coverage would be cancelled retroactively.*	The affected participant who is losing coverage *retroactively* for reasons other than, for example, nonpayment of premium, or short-term delays in administrative processing of dis-enrollments. Presumably, if the affected individual is a dependent, notice to the participant is considered notice to the dependent. The regulations require notice to "the participant" (i.e., the covered employee).	Notice of rescission must be provided no fewer than 30 days prior to the date coverage is cancelled.	In writing. Electronic distribution is likely permitted in accordance with comprehensive federal regulations for the provision of electronic notices. Retroactive cancellation of coverage is, with respect to non-grandfathered plans, an "adverse benefit determination" subject to enhanced disclosure obligations under new guidelines for processing claims appeals. It appears notice of retroactive coverage cancellation must meet the same standards that apply to explanations of benefits.	Applies to ERISA and non-ERISA plans (grandfathered and non-grandfathered plans). Coverage rescissions under non-grandfathered plans are subject to expanded appeal rights, a fact which probably explains in part the 30-day advance notice requirement (i.e., the desire to allow the member time to appeal). Neither the prohibition on rescissions (except in cases of fraud) nor, therefore, this notice obligation applies to HIPAA "excepted benefits"[1] maintained by non-governmental employers. Federal authorities will not enforce the requirement against excepted benefits maintained by governmental employers.

Notice	Who gets it?	When?	How?	Comments?
Notice of retroactive coverage cancellation, continued				The DOL has supplied model notices for use in the claims and appeals context in English and Spanish. Contact your Lockton account service team. Also see the separate discussion below regarding the claims and appeals notice obligations under the ACA.
W-2 reporting of healthcare plan values The ACA requires most plan sponsors to report the values of certain health coverages.	Employees and the IRS. There is no obligation to issue a W-2 showing health coverage values to an individual who would not otherwise be entitled to a W-2, such as former employees, spouses and dependents on COBRA, retirees, etc.	The W-2 is due by the deadline for submitting W-2 data to IRS and furnishing a copy to individuals (generally, Jan. 31 following the end of the reporting year).	The Form W-2 is typically transmitted electronically to the IRS, in writing to employees, although employees may consent to receiving the W-2 electronically.	Applies to employer sponsors of grandfathered and non-grandfathered plans. The W-2 reporting is merely informational. The obligation applies with respect to reportable coverage whether taxable or nontaxable. The value of many forms of ancillary coverage are exempt. See the Instructions to Form W-2. Insured plans will report the premium cost; self-insured will typically use the COBRA rate (minus the 2%).

Notice	Who gets it?	When?	How?	Comments?
Patient-centered outcomes research institute (PCORI) tax submission Insurers and self-insured plan sponsors owe a tax, based on the number of covered lives under the plan, to fund comparative effectiveness research.	The Internal Revenue Service.	By July 31 following each plan year. See this IRS table of due dates and amounts.	On IRS Form 720. The IRS has authorized several methods plan sponsors may use for computing the number of covered lives. Your Lockton account service team can provide white papers on this topic.	Applies to insurers and sponsors of self-insured plans. The tax is adjusted for inflation annually. Click here for a description of the adjusted amounts. The fee does not apply to "excepted benefits" such as most dental and vision coverage, most health FSAs, on-site clinics, long-term care, critical illness and most indemnity policies. EAPs, disease management and wellness programs not supplying significant benefits are exempt, as are stop-loss contracts. There is no exception for COBRA coverage, retiree-only plans or for governmental plans. However, most expatriate coverage is exempt, and the plan does not count individuals (and their dependents) whose addresses are outside the U.S. The fee does not apply to separate health reimbursement arrangements (HRAs) where the HRA and the medical plan are self-insured and have the same plan year. Where the medical plan is insured or the HRA has a different plan year, the HRA sponsor owes the fee for the HRA, but bases the amount due solely on the number of covered employees and retirees.

Notice	Who gets it?	When?	How?	Comments?
Summary of benefits and coverage (SBC) The ACA requires insurance carriers and plan sponsors to furnish "plain English" summaries of health plan benefits.	Eligible and enrolled employees, including former employees. Notice to the employee will be deemed notice to dependents unless the plan is aware that not all dependents reside at the same address.	**Initial enrollments**: By the time written enrollment materials are provided; if none, not later than the first day the individual may enroll. If re-enrollment is *automatic*, the SBC must be furnished no later than 30 days prior to the first day of the new plan year. **Special enrollment**: Not later than 90 days *after* the special enrollment. **Midyear material plan change:** Not later than 60 days *prior* to the effective date of the change. **Upon request:** As soon as practicable, but not later than seven business days after the request.	In writing or electronically. Electronic distribution is permitted in connection with online enrollment or online renewal of coverage. Otherwise, electronic distribution is permitted in accordance with comprehensive federal regulations for the provision of electronic notices.	Applies to ERISA and non-ERISA plans. Applies to grandfathered and non-grandfathered plans. Summaries must be "culturally and linguistically appropriate." See discussion above. The requirement does not apply to HIPAA "excepted benefits "[1] maintained by non-governmental employers. Presumably, federal authorities will not enforce the requirement against excepted benefits maintained by governmental employers. The federal agencies have issued final regulations and a model SBC and accompanying glossary of terms and instructions. Failure to provide summary of benefits and coverage (SBC) may result in a fine.

Claims and appeals under the Affordable Care Act

ERISA plans are subject to a variety of rules regarding the time within which health plan claims and appeals must be decided, and information they must supply upon an adverse benefit determination. We have not endeavored to describe those detailed rules here. However, we describe below the new claims and appeals rules that apply under healthcare reform. Generally, the ACA's claims and appeals rules start with ERISA's claims and appeals rules, bolster them in several ways, and then apply them to ERISA *and non-ERISA plans*, but only once the plans lose grandfathered status.

Notice	Who gets it?	When?	How?	Comments
Claims and appeals under the Affordable Care Act: **Claims & appeals/notice of external review process** The ACA requires group health plans to issue a notice describing the new external review process under state or federal procedures, as applicable.	All plan participants.	This obligation began as of the first day of the plan year beginning on or after Sept. 23, 2010.	ERISA plans must include language in the SPD describing the claims and appeals process including external review.	Applies to ERISA and non-ERISA plans (non-grandfathered plans only).
Claims & appeals/notice of adverse benefit determination (e.g., full or partial denial of claims, similar coverage or benefit determinations, etc.) A group health plan must provide a written notice of an adverse benefit determination for initial claim denials.	The claimant or the claimant's authorized representative.	**Urgent care claims:** 72 hours **Pre-service claims:** 15 days **Post-service claims:** 30 days **Concurrent care claims:** 24 hours for urgent concurrent care claims; in other cases, the above 15- or 30-day periods apply.	In writing, using measures reasonably calculated to ensure actual receipt. Notification for urgent care claims may be provided orally, but written notice must follow within 3 days. Electronic notice is permitted, subject to compliance with the DOL's comprehensive regulations for the provision of electronic notices. The DOL has supplied model notices in English and Spanish. Contact your Lockton account service team.	Applies to ERISA and non-ERISA plans (non-grandfathered plans only). ERISA group plans must comply with current DOL claims regulations, except to the extent modified by applicable provisions of the ACA. The ACA requires the notice be provided in a "culturally and linguistically appropriate" manner and include several additional disclosures. Specifically, if 10% or more of a county's residents are literate in a non-English language, an EOB supplied to an enrollee residing in that county must include a statement offering language assistance. The statement must be in the relevant non-English language (limited to Spanish, Chinese, Tagalog or Navajo).

Notice	Who gets it?	When?	How?	Comments
Claims & appeals/notice of final internal adverse benefit determination (e.g., notice of plan's internal decision on a claim appeal) A group health plan must provide written notice for an adverse benefit determination that has been upheld by the plan at completion of the plan's internal appeals procedures, or with respect to which the internal appeals procedures have been exhausted.	The claimant or the claimant's authorized representative.	**Urgent care claims:** 72 hours **Pre-service claims:** 30 days **Post-service claims:** 60 days **Concurrent care claims:** 72 hours for urgent care claims; in other cases, before treatment ends or is reduced, where the adverse benefit determination is a plan decision to reduce or terminate concurrent care early.	In writing, using measures reasonably calculated to ensure actual receipt. Electronic notice is permitted, subject to compliance with the DOL's comprehensive regulations for the provision of electronic notices. The DOL has supplied model notices in English and Spanish. Contact your Lockton account service team.	Applies to ERISA and non-ERISA plans (non-grandfathered plans only). ERISA group plans must comply with the current DOL claims regulations, except to the extent modified by applicable provisions of the ACA. The ACA requires the notice be provided in a "culturally and linguistically appropriate" manner and include additional disclosures. See the discussion on this standard, above.

Notice	Who gets it?	When?	How?	Comments
Claims & appeals/ preliminary notice regarding request for external review Plans must provide notice to individuals filing for an external review of a claim, with the notice addressing whether the individual's claim is eligible for external review.	The claimant or the claimant's authorized representative.	Within one business day following completion of the preliminary review. The plan has five business days following the date of receipt of the external review request to complete the preliminary review.	In writing.	Applies to ERISA and non-ERISA plans (non-grandfathered self-insured plans subject to the federal external review process). If the claimant's request for external review is complete, but not eligible for external review, the notification must include the reasons for its ineligibility, and contact information for the EBSA. If the request is not complete, the notification must describe the information or materials needed to make the request complete and the plan must allow a claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.
Claims & appeals/notice of final external review decision The ACA requires an external review process following exhaustion of internal appeals. An independent review organization (IRO) or a state external review examiner must provide a notice of its final decision.	**Federal process:** An IRO must provide notice to the claimant or authorized representative and the plan. **State process:** An external review examiner must provide notice to the claimant or authorized representative and the insurance company.	**External review:** Within 45 days of receipt of the request for the external review. **Expedited external review:** As expeditiously as the claimant's medical condition may require, but in no event more than 72 hours after receipt of the request for an expedited external review.	**External review:** In writing. Unclear how the notice may be distributed "in writing." **Expedited external review:** May be provided in an electronic form, but a follow-up written notice must be provided within 48 hours from the initial notice.	Applies to ERISA & non-ERISA plans (non-grandfathered plans only). The primary focus here is on self-funded plans subject to the external review process. The external review obligation for fully insured plans lies with the carriers and is subject to applicable state review guidelines, as they may be supplemented by federal standards. In the case of self-insured plans, the plan sponsor will want to ensure that the IRO is properly and timely handling this notice. The DOL has supplied model notices in English and Spanish. Contact your Lockton account service team.

Miscellaneous Reports and Disclosures				
Notice	**Who gets it?**	**When?**	**How?**	**Comments**
Miscellaneous Reports and Disclosures: **Women's Cancer Rights Act notice** This is a general explanation of the plan's coverage of breast reconstruction and prostheses following mastectomy.	Participants (covered employees/retirees), COBRA, and other beneficiaries receiving benefits, and alternate recipients.	At enrollment and annually (prior to the beginning of the plan year) thereafter.	In writing. Notice may be a separate document or included in the SPD (as long as furnished timely). A separate notice included in the annual enrollment packet is appropriate and typical, but must be "prominent." Electronic notice is permitted, subject to the DOL's comprehensive regulations for the provision of electronic notices.	Applies to ERISA and non-ERISA plans. State and local self-insured governmental plans may opt out. Lockton maintains a model notice. Contact your Lockton account service team.
Michelle's Law notice This is a notice summarizing the availability of continued pre-COBRA coverage for ill college students.	Participants, COBRA beneficiaries and alternate recipients under a QMCSO (presumably; guidance not yet issued).	Notice is only required if the plan requires certification of student status in order to cover a college-age dependent child. Such notice must include a description of the continued coverage available to ill college students, under Michelle's Law.	Apparently, with any notice (supplied by the plan) concerning a requirement to certify student status as a prerequisite to coverage of a college-age dependent child.	Applies to ERISA and non-ERISA plans. State and local self-insured governmental plans may opt-out. Does not apply to "excepted benefits" such as most dental and vision coverage, most health FSAs, on-site clinics, long-term care, critical illness and most indemnity policies. Due to the ACA, this notice appears to have continuing relevance only for plans that impose a "full-time student" requirement below age 26 for children who are not natural, step, adopted, or foster children, and/or continue coverage to students beyond age 26.
USERRA notice This is a notice of employees' rights and obligations under the Uniformed Services Employment and Reemployment Rights Act.	Employees.	If notice is not already posted, it should be posted immediately.	Notice may be posted where labor relations notices are posted	Applies to all employers. The DOL has provided a model notice.

Notice	Who gets it?	When?	How?	Comments
Notice of premium assistance under Medicaid or the Children's Health Insurance Program (CHIP) This is a notice informing employees of potential opportunities currently available, in the state in which the employee resides, for group health plan premiums assistance under Medicaid and CHIP.	Every employee, regardless of enrollment status, residing in a state which offers premium assistance under Medicaid or CHIP, if the employer provides healthcare coverage to individuals in that state. Currently, about 40 states offer such assistance.	Annually. Best practice would be to also provide the notice to newly hired employees, as they or dependents might qualify for assistance under Medicaid or CHIP.	In writing. May be furnished with enrollment packets, other plan materials, or SPDs. **Regulations require the notice to be a separate document,** even if offered with enrollment materials. May be hand-delivered or delivered via first-class mail. Electronic distribution is permitted in accordance with the DOL's comprehensive regulations for the provision of electronic notices.	Applies to ERISA and non-ERISA plans. The DOL has provided a model notice on its website. Contact your Lockton account service team. This notice is updated annually to reflect any changes in the number of states offering premium assistance programs. Failure to comply with Medicaid/CHIP notice requirement may result in a fine.
Notice of cancellation of coverage during FMLA leave (for nonpayment) This is a notice that the employer is canceling an employee's coverage during FMLA leave for nonpayment of premium when payment is more than 30 days late.	The covered employee who is on FMLA leave.	The notice is provided once the employee's premium payment is more than 30 days late and must be supplied at least 15 days prior to the date coverage will cease.	In writing, by mail (preferably first-class) to the covered employee.	Applies to all employers subject to the FMLA. The notice must provide that coverage will terminate upon a specified date that is at least 15 days after the date of the notice, if payment is not received. Once proper notice is supplied, coverage may be cancelled retroactively to the date when the unpaid premium was due **only** if the employer has an established policy to that effect. Else, coverage continues through the 30-day grace period.

Notice	Who gets it?	When?	How?	Comments
Notice of comparable contributions to health savings accounts This is a notice, by employers whose HSA contributions are subject to the "comparability" rules, to employees who failed to establish an HSA by year's end, or who did so but failed to tell the employer. The notice advises such employees of the availability of comparable employer contributions to their HSAs.	Employees who are eligible to make HSA contributions, where the employer makes its own contributions to employees' HSAs and is required to make "comparable" contributions to the HSAs of comparable employees. To benefit from the comparable contributions, the employee must establish an HSA and notify the employer by the end of February following the year for which the employer must make comparable contributions.	Annually, no earlier than 90 days before the first HSA employer contribution for that calendar year (if the contribution is subject to the comparability rules) and no later than Jan. 15 of the following calendar year. If subject to these rules, the employer must make the comparable contributions for the prior year, with interest, by April 15 of the following year.	In writing, or electronically in accordance with IRS guidelines. The IRS has supplied a model notice.	Applies to all employers making HSA contributions subject to the comparability rules. Employers who make contributions to employees' HSA are subject to the comparability rules ***unless*** they allow employees to make their own pre-tax contributions to their respective HSAs, through the employer's section 125 cafeteria plan. ***Most employers satisfy this exception.***
EEOC notice under ADA for employees participating in wellness programs This is a notice required under the Americans with Disabilities Act for employees participating in wellness programs involving medical examinations or disability-related inquiries.	Employees participating in wellness programs involving medical examinations (e.g., biometrics) or disability-related inquiries (e.g., health risk questionnaires).	Prior to the employees' participation.	May be provided via hand delivery, mail or electronically. Most programs will supply the notice as part of registration for biometrics, or as part of a log-in process for an online health risk questionnaire.	The EEOC has offered a model notice.
EEOC authorization under GINA for spouse's participation in wellness programs This is an authorization required under GINA when an employer's wellness program offers an incentive for a spouse's participation in a health risk assessment or biometric screening.	Spouses participating in a wellness program involving collection of family medical history, where the employee is offered an incentive for the spouse's participation.	Prior to the spouse's participation.	May be provided via hand delivery, mail or electronically. Most programs will supply the notice as part of registration for biometrics, or as part of a log-in process for an online health risk questionnaire.	There is no model authorization provided by the EEOC. Lockton has prepared a model authorization. Most wellness vendors will have their own model form. Failure to comply with GINA notice requirement may result in a fine.

Notice	Who gets it?	When?	How?	Comments
Notice of qualifying small employer health reimbursement arrangement (QSEHRA)	All employees eligible to participate in the QSEHRA, regardless of enrollment status.	Annually, at least 90 days before beginning of the "year," and, for initial enrollment, the first date the employee is eligible to participate in QSEHRA.	In writing. Electronic distribution is permitted in accordance with the DOL's comprehensive regulations for the provision of electronic notices.	Applies to small employers ***not subject to the ACA employer mandate*** and who sponsor a QSEHRA that reimburses employees for medical insurance premiums on a tax-free basis. The notice must: • Describe the employee's benefit under the QSEHRA. • Include a statement that the employee should give the information about their QSEHRA benefit to any health insurance marketplace through which the employee qualifies for ACA subsidies to defray the cost of the insurance. • Include statement that if the employee is not covered by minimum essential coverage, they may be subject to ACA individual mandate penalties and may have to include the QSEHRA benefit in their taxable income. A model notice is available.

Notice	Who gets it?	When?	How?	Comments
Notice of individual coverage health reimbursement arrangement (ICHRA)	All employees eligible to participate in the ICHRA, regardless of enrollment status.	Annually, at least 90 days before beginning of the plan year and, for initial enrollment, the first date the employee is eligible to participate in ICHRA. If the employer first establishes a calendar year ICHRA within 120 days prior to the beginning of the first plan year, the notice is due not later than the date the ICHRA takes effect for the employee.	In writing. Electronic distribution is permitted in accordance with the DOL's comprehensive regulations for the provision of electronic notices.	Employers who sponsor an ICHRA that reimburses employees for premium expenses for individual health insurance policies or Medicare premiums in lieu of offering group medical insurance must provide eligible employees notice about the ICHRA, the benefits provided by the IHCRA, its conditions, and the effect of the ICHRA coverage on the ability of the employee to qualify for federal subsidies in an individual market health insurance exchange, or marketplace. A model notice is available.
Notice of excepted benefit health reimbursement arrangement (EBHRA)	Employees of non-federal government employers who are eligible to participate in the EBHRA regardless of enrollment status.	This notice must be provided annually no later than 90 days after the first day of the EBHRA plan year, or if a participant is not eligible to participate at the beginning of the plan year, no later than 90 days after the employee becomes a participant in the EBHRA.	In writing. Electronic distribution is permitted in accordance with the DOL's comprehensive regulations for the provision of electronic notices.	The notice requirement applies only to non-federal government plan sponsors. Employers may offer EBHRAs as an added benefit. While limited, they are not required to be "integrated" with employers' major medical plans like regular HRAs. EBHRAs also qualify as "excepted benefits" and are not subject to the PHSA mandates under the ACA (e.g., prohibitions on annual and lifetime limits, required preventive coverage, required coverage of dependents to age 26, etc). Additionally, excepted benefits are not subject to HIPAA's portability requirements (e.g., special enrollment and nondiscrimination). However, unless meeting a separate exception, EBHRAs are subject to other federal laws including ERISA (along with its various plan documents, SPD, Form 5500, notice, and claims procedure requirements),

Notice	Who gets it?	When?	How?	Comments
				HIPAA privacy, COBRA, Code 105(h) nondiscrimination, and others.
W-2 reporting of imputed taxable income	Employees and the IRS.	By Jan. 31.	Reported on W-2s mailed to employees and submitted to the IRS.	This is an employer obligation. Imputed income can arise under healthcare plans where coverage is provided to non-dependents, such as non-dependent domestic partners and/or their children, or to an employee's non-dependent adult children beyond the year in which the children attain age 26. Note that imputed income can also arise under group-term life plans and some LTD programs. State income taxation may vary from federal taxation, depending on the circumstance.

Notice	Who gets it?	When?	How?	Comments
Newborns' and Mothers' Health Protection Act notice This is a notice that must be included in the plan's SPD describing any coverage offered and applicable requirements under Federal or State law applicable to the plan relating to hospital length of stays provided in connection with childbirth for the mother or newborn child	Anyone who receives the SPD. SPDs (including the Newborns' Act notice) must be distributed to all plan participants including covered employees/retirees, COBRA participants, and other beneficiaries receiving benefits, and alternate recipients. If SPDs are distributed electronically, this notice may also be distributed electronically as part of the SPD.	Must be included in the plan's SPD.as part of the SPD.	Must be included in the plan's SPD. Lockton maintains a model notice. Contact your Lockton account service team.	Applies to ERISA and non-ERISA group health plans that provide benefits for hospital stays following childbirth. State and local self-insured governmental plans may opt out.

Standard ERISA Reports and Disclosures				
Notice	**Who gets it?**	**When?**	**How?**	**Comments**
Standard ERISA Reports and Disclosures: **Annual report (form 5500)**	The Department of Labor.	Within seven months after the close of the plan year (an automatic two and a half month extension is available for the asking).	On a Form 5500, with appropriate schedules attached.	Applies to ERISA plans only. Exemptions apply to unfunded or insured welfare plans that have fewer than one hundred participants at the beginning of the plan year. Failure to file Form 5500 may result in a fine.
Summary annual report This is a summary of pertinent information from the plan's Form 5500 filing.	Participants (employees and retirees) in the health plan, COBRA and other beneficiaries receiving benefits, and alternate recipients under QMCSOs.	Within nine months after end of the plan year or, if later, two months after the extended deadline for filing the plan's Form 5500.	In writing. Electronic notice is permitted, subject to compliance with the DOL's comprehensive regulations for the provision of electronic notices.	Applies to ERISA plans only, even if the plan filed a Form 5500. The SAR requirement does not apply to plans that pay benefits exclusively from the employer's general assets (e.g., no trust, no insurance contract, participant contributions are made through a Section 125 plan, etc.). Failure to provide participants and beneficiaries with required plan documents upon request may result in a $110/day fine with no maximum. Failure to furnish plan documents to the DOL upon request may result in a fine.
Plan documents Plan and related documents such as insurance contracts, trust agreements, etc.	Participants (employees and retirees), beneficiaries, COBRA beneficiaries, and alternate recipients, upon written request.	Within 30 days after receipt of the written request.	In writing. The plan may make a reasonable charge for copying, not to exceed 25 cents per page.	Applies to ERISA plans only. Failure to provide participants and beneficiaries with required plan documents upon request may result in a $110/day fine with no maximum. Failure to furnish plan documents to the DOL upon request may result in a fine.

Notice	Who gets it?	When?	How?	Comments
Summary plan description This is a plain summary of the plan's key provisions.	Participants (employees and retirees), COBRA beneficiaries, and alternate recipients under a QMCSO.	Within 90 days after coverage begins or, for a new plan, within 120 days after the plan begins. Within 30 days upon written request.	In writing. May be hand delivered or mailed. Electronic SPDs are permitted, subject to the DOL's comprehensive regulations for the provision of electronic notices.	Applies to ERISA plans only. DOL regulations describe the required contents of an SPD. Must restate the SPD every five years (10 years if no changes). Note the differences between the SPD obligation, and the obligation (under the ACA) to furnish a Summary of Benefits and Coverage (SBC). Failure to provide participants and beneficiaries with required plan documents upon request may result in a $110/day fine with no maximum. Failure to furnish plan documents to the DOL upon request may result in a fine.

Notice	Who gets it?	When?	How?	Comments
Summary of material reduction in benefits (SMR) This is a notice of amendments that effect a material reduction in benefits	Participants (employees and retirees), COBRA and other beneficiaries receiving benefits, and alternate recipients under QMCSOs.	Within 60 days after adoption of the change. Note: "adoption" means when the employer formally approves the change.	In writing. Electronic notice is permitted, subject to compliance with the DOL's comprehensive regulations for the provision of electronic notices.	Applies to ERISA plans only. A reduction is "material" if a typical participant would reasonably consider it as such. This can include elimination of benefits and networks, reduction in service area, increase in premiums, deductibles, co-pays and coinsurance, additional pre-authorization requirements, etc. Note that changes to the information required to be contained in a summary of benefits and coverage (SBC) must be provided *earlier* than this deadline. A plan may satisfy this SMR obligation with the same document it uses to satisfy the "summary of the change to SBC information." Failure to provide participants and beneficiaries with required plan documents upon request may result in a $110/day fine with no maximum. Failure to furnish plan documents to the DOL upon request may result in a fine.
Summary of material modification (SMM) This is a description of material plan amendments, other than amendments making material reduction in benefits.	Participants (employees and retirees), COBRA and other beneficiaries receiving benefits, and alternate recipients under QMCSOs.	Within 210 days after the close of the year in which the change is adopted.	In writing. Electronic notice is permitted, subject to compliance with the DOL's comprehensive regulations for the provision of electronic notices.	Applies to ERISA plans only. Compare this disclosure obligation with the accelerated due dates for summaries of material reductions in benefits (SMRs), and for updated summaries of benefits and coverage (SBCs). Failure to provide participants and beneficiaries with required plan documents upon request may

				result in a $110/day fine with no maximum. Failure to furnish plan documents to the DOL upon request may result in a fine.

Notice	Who gets it?	When?	How?	Comments
Form M-1 (MEWAs) Multiple employer health plans only.	The Department of Labor.	Not less than 30 days prior to the MEWA's origination. Thereafter, each March 1 (but see exception, below). In addition, within 30 days after: the MEWA begins operating in an additional state; a participant increase of 50% or more; a merger with another MEWA; or after a material change in the financial or custodial information reported in Part II of the Form M-1. An annual report (March 1) is not required if between Oct. 1 and Dec. 1 of the prior year the MEWA experienced an origination or special filing event and timely filed the M-1. An automatic 60-day extension of time is available by filling out certain initial portions of the Form, as described in the instructions. There is no delinquent filer program for late M-1 filings.	On a Form M-1. Filing must be done online.	Applies to MEWAs that are ERISA plans at the MEWA level, or to MEWAs that instead constitute individual ERISA plans at the participating employer level. If the participating employers do not control the plan design and administration, each employer might need to file a separate Form 5500 for its respective slice of the larger MEWA. Filing is only required of healthcare plans that are MEWAs. Some MEWAs are exempt from filing, including: • Most health insurers • MEWAs not subject to ERISA (i.e., governmental or church plans) • MEWAs with at least 25% common ownership of participating employers, or where the non-employees whose coverage gives rise to MEWA status amount to 1% or less of the total covered employees (this does not mean the arrangement is not a MEWA; it merely excuses the M-1 filing). • Temporary MEWAs arising from an acquisition, if MEWA status doesn't extend past the end of the plan year following the plan year in which the event occurs. Failure to file Form M-1 may

				result in a fine of $1,746/day per plan with no maximum

Transparency-related Reports and Disclosures				
Notice	**Who gets it?**	**When?**	**How?**	**Comments?**
Transparency-related Reports and Disclosures: **Surprise billing notice** The Consolidated Appropriations Act (CAA) requires plans to include a surprise billing notice in certain explanations of benefits (EOBs), to post a similar notice on a website maintained by the plan, and to otherwise make the notice available.	With respect to the notice included with an EOB, a plan enrollee who incurs a claim subject to surprise billing protection, i.e., out-of-network (OON) emergency room care, OON air ambulance transport, and treatment by an OON provider at an in-network facility. All employees, via posting, with respect to the notice to be posted on the plan's website.	The requirement applies for plan years beginning after 2021. The notice enclosed with an EOB must, of course, be provided within the time frame for supplying the EOB.	With the EOB, for EOBs reflecting adjudication of claims subject to federal surprise billing requirements. Also, posting on the plan's (or presumably, insurer's or TPA's) website.	Applies to ERISA and non-ERISA plans, whether grandfathered or non-grandfathered. Does not apply to excepted benefits. The DOL has issued a model notice.
Plan ID cards reflecting cost-sharing information The CAA requires that plans reflect the plan's deductible, out-of-pocket maximum and contact information for more information on any physical or electronic ID card.	Plan enrollees.	The requirement applies for plan years beginning after 2021.	On any physical or electronic plan ID card.	Applies to ERISA and non-ERISA plans, whether grandfathered or non-grandfathered. Does not apply to excepted benefits.
Medical plan cost reporting The CAA requires plans to provide a report reflecting a variety of plan cost-related information, particularly regarding prescription drugs.	The Department of Labor	For reference years 2022 and later, the reporting is due the following June 1, annually. The first reports reflecting 2020 and 2021 plan information due Jan. 31, 2023 (with CMS provided grace period from Dec. 27, 2022).	Reporting is completed electronically through the CMS Enterprise Portal. If the employer plan sponsor is reporting any part of the costs, the employer will need to establish a HIOS account. However, third party administrators and/or pharmacy benefit managers contracted with the group health plan will assist and/or submit filings on behalf of the group health plan.	Applies to ERISA and non-ERISA plans, whether grandfathered or non-grandfathered. Does not apply to excepted benefits.

Notice	Who gets it?	When?	How?	Comments?
Continuity of care notice The CAA requires a plan to provide a "continuing care patient" with a notice when the treating provider loses in-network status.	"Continuing care patients," defined as individuals undergoing a course of treatment for a serious and complex condition; undergoing a course of institutional or inpatient care; scheduled to undergo nonelective surgery or post-operative care from the provider; are pregnant and undergoing treatment; or are terminally ill.	The requirement applies for plan years beginning on or after Jan. 1, 2022.	Notice must be provided on a "timely basis" although the specific time period has not been defined. The agencies have stated in guidance that plans are to use a good faith, reasonable interpretation of the requirement, pending the issuance of further guidance.	Applies to ERISA and non-ERISA plans, whether grandfathered or non-grandfathered. Does not apply to excepted benefits. The notice is triggered when a treating provider has a change in network status, or the plan is terminating the network relationship. The plan must provide the option for the individual to continue receiving care with the medical provider at the in-network rate for an additional 90 days.
Price comparison tool The Transparency in Coverage (TiC) final rules requires a plan to disclose cost-sharing information to a participant or beneficiary.	Plan participants, beneficiaries and/or their authorized representative.	An initial list of 500 shoppable services must be available on the price comparison tool for plan years that begin on or after January 1, 2023. The list will be updated quarterly. The remainder of all items and services must be available through the tool for plan years that begin on or after January 1, 2024.	Plans are required to make cost-sharing information available on an Internet-based self-service tool and, if requested, on paper and by telephone.	Applies to ERISA and non-ERISA plans, whether grandfathered or non-grandfathered. Does not apply to excepted benefits. The price comparison tool allows an individual enrolled under the plan to compare the amount of cost-sharing that the individual would be responsible for paying under the plan with respect to the furnishing of a specific item or service by a provider. The price comparison information is to be provided with respect to a particular plan year and geographic region and with respect to participating providers under the plan.
Machine-readable files The Transparency in Coverage (TiC) final rules requires health plans and issuers to publicly disclose price information in machine-readable files.	Public disclosure	The requirement went into effect on July 1, 2022. The files are update monthly.	Post machine readable files on the plan's public website. If the plan does not have a public website, the service provider (such as a TPA) may post the files on its	Applies to non-grandfathered insured and self-funded group health plans. Does not apply to excepted benefits.

			public website on behalf of the plan.	The disclosures must show negotiated rates for covered items and services between the plan or insurer and in-network providers, as well as historical payments to, and billed charges from, out-of-network providers. A separate machine-readable file must set forth prescription drug information. This portion of the TiC regulations is put on hold.
Gag clause prohibition compliance attestation (GCPCA) Under the Transparency provision of the CAA, plans and issuers must annually submit to CMS an attestation that the plan or issuer is in compliance with the gag clause prohibition.	CMS	The first gag clause prohibition attestation is due no later than December 31, 2023, covering the period beginning December 27, 2020, or the effective date of the group health plan coverage (if later), through the date of attestation. Subsequent attestations, covering the period since the last preceding attestation, are due by December 31 of each year thereafter.	Attestations are collected by CMS via the online portal.	The gag clause prohibition generally prohibits plans and issuers from entering into an agreement with a health care provider, network or association of providers, third-party administrator (TPA), or other service provider offering access to a network of providers that would directly or indirectly restrict a plan from providing, accessing, or sharing certain information related to cost or quality of care or de-indetified claims and encounter information.

Select State and Local Reports and Disclosures				
Notice	**Who gets it?**	**When?**	**How?**	**Comments**
Select State and Local Reports and Disclosures: **California notice regarding midyear FSA claim submission deadline**	California residents participating in a flexible spending account (health, dependent care or adoption assistance).	The law does not specify a due date, but presumably the notice should be supplied at such times so that participants are aware of a deadline to submit claims prior to the close of the plan year.	The notice must be provided in two different forms, one of which may be electronic, such as written form, postal mail, electronic mail, text message or in person.	The notice requirement applies to employers with respect to employees in California, enrolled in an FSA (health, dependent care or adoption assistance) that imposes a deadline to withdraw funds from the FSA that is prior to the end of the plan year. For instance, if an FSA requires participants who terminate employment before the end of the plan year to submit claims within 90-days of employment termination, as opposed to the end of the plan year, notice of that deadline must be provided.
California individual mandate reporting State law requires employers with employees residing in California to submit copies of their Forms 1095-C and 1094-C to the state.	State of California Franchise Tax Board. The state law requires primary enrollees in California also receive a 1095-C (from self-insured employers) or 1095-B (from the insurer, for an insured plan), but this simply mirrors the federal obligation.	The state law requires forms be provided to California residents by Jan. 31 and filed with the state by March 31. These deadlines are often extended, to track deferred deadlines announced by the IRS, or for other reasons.	Electronically to the state if submitting at least 250 of the same forms.	Requirement applies to any employer or insurer providing medical coverage to California residents. It appears those employers with employees who reside in California must automatically furnish a Form 1095-C to a primary insured who in the prior year had self-insured coverage under the employer plan even if the individual was not an ACA full-time employee of the employer at any time during the year, this differs from IRS requirements. See Lockton's *States with Individual Health Insurance Mandates* grid.

Notice	Who gets it?	When?	How?	Comments
Commuter benefit notices	See Lockton's *Commuter Benefit Mandates* grid for details related to state and local commuter benefit notice requirements.			
District of Columbia individual mandate reporting The District requires employers with employees residing in the District to submit copies of their Forms 1095-C and 1094-C to the District.	District taxing authorities.	The state law requires forms be filed with the state 30 days after the federal filing deadline required by the IRS, including any delay.	Electronically, to MyTax.DC.gov.	The reporting requirements applies to employers that cover at least 50 full-time employees and cover at least one employee who was a DC resident (based on home mailing address or if DC taxes are withheld from wages). See Lockton's *States with Individual Health Insurance Mandates* grid.
Illinois notice comparing employer's group medical benefits with the state's essential health benefits (EHBs) Illinois law requires employers with employees in Illinois to supply a notice to all employees (in Illinois), comparing the employer's group medical plan benefits with the state's EHB package.	All employees eligible for the employer's medical plan.	Upon hire and annually thereafter.	In writing, via email or website posting.	The Illinois Department of Insurance will supply additional details on how to satisfy this requirement. The statute merely says the employer will provide a written list of the covered benefits included in the group medical plan in a format that easily compares those benefits with the EHBs required of individual health insurance coverage regulated by the state. ERISA likely preempts this requirement, as to ERISA employers.
Massachusetts Form 1099-HC	Employees in Massachusetts who had creditable coverage under the employer's plan during the calendar year; and the Massachusetts Department of Revenue.	By Jan. 31.	By mail or hand delivery to employees; by electronic file to the Department of Revenue. The employer has the obligation; but if the plan is insured and the contract was issued or delivered in MA, the carrier has the obligation.	An employer obligation. The obligation may be preempted by ERISA, but to our knowledge there has not been a challenge lodged against the requirement. Penalties of $50 per form, up to $50,000 maximum, apply for failure to comply. Forms should also be provided to retirees and COBRA beneficiaries. See Lockton's *States with Individual Health Insurance Mandates* grid.

Notice	Who gets it?	When?	How?	Comments
Massachusetts health insurance responsibility disclosure (HIRD)	Massachusetts Department of Revenue.	Between Nov. 15 and Dec. 15 each year. Details here.	The HIRD form is filed electronically through the Massachusetts Department of Revenue web portal, MassTaxConnect.	Applies to any employer that reported six or more employees (includes all employment categories) in any Massachusetts unemployment wage report during the past 12 months. The employer must file the health insurance reporting disclosure (HIRD) form with Massachusetts tax authorities.
New Jersey individual mandate reporting State law requires employers with employees residing in New Jersey to submit copies of their Forms 1095-C and 1094-C to the state.	New Jersey Division of Revenue and Enterprise Services. The state law requires primary enrollees in New Jersey also receive a 1095-C (from self-insured employers) or 1095-B (from the insurer, for an insured plan), but this simply mirrors the federal obligation.	The state law requires the filing by Feb. 15 following the reporting year. This deadline is likely to be deferred to track IRS filing deadlines. Notice to enrollees will follow IRS requirements.	Electronically to the state. Notice to enrollees will follow IRS requirements.	The reporting requirement applies to all employers providing coverage to an individual who is a resident in New Jersey. See Lockton's *States with Individual Health Insurance Mandates* grid.
Rhode Island individual mandate reporting State law requires employers with employees residing in Rhode Island to submit copies of their Forms 1095-C and 1094-C to the state.	Rhode Island Division of Taxation. The state law requires primary enrollees in Rhode Island receive a 1095-C (from self-insured employers) or 1095-B (from the insurer, for an insured plan), but this simply mirrors the federal obligation.	The state law requires forms to be provided to Rhode Island residents by March 2 and to the state taxing authorities by March 31 following the reporting year. Notice to enrollees following IRS requirements related to timing will suffice for Rhode Island requirements.	Electronically to the state. Notice to enrollees will follow IRS requirements.	The reporting requirement applies to every applicable entity that provides minimum essential coverage to an individual resident of Rhode Island. See Lockton's *States with Individual Health Insurance Mandates* grid.
San Francisco Healthcare Security Ordinance (reports) The city's healthcare security ordinance requires an annual filing from covered employers.	The annual report is filed with the Office of Labor Standards Enforcement.	The annual report is filed by April 30 of each year.	The annual report may be completed and submitted online.	Covered employers must maintain signed copies of an official employer waiver forms issued by the HCSO for every employee who waives their right to healthcare expenditures from the employer. Waiver forms must be kept for a period of four years from the date the employee signs the form.

Notice	Who gets it?	When?	How?	Comments
San Francisco Healthcare Security Ordinance (disclosure of employee healthcare payment)	Employees on whose behalf the employer makes healthcare contributions to the city, on behalf of covered employees, to satisfy the employer's HCSO healthcare expenditure requirement.	Within 15 days after the first payment to San Francisco. The notice to a given employee is required only once.	The notice may be delivered by mail, by email, or in person. The payment confirmation may be downloaded from the city's Office of Labor Standards Enforcement (OLSE) website.	An employer obligation. The payment confirmation may be downloaded from the city's Office of Labor Standards Enforcement (OLSE) website. See Lockton's *Employer's Guide to the San Francisco Health Care Security Ordinance*.
San Francisco Healthcare Security Ordinance (notice of employee rights)	Employees in San Francisco.	If notice is not already posted, it should be posted immediately.	Notice may be posted.	Applies to businesses with 20 or more employees (and nonprofit organizations with 50 or more employees) who are subject to the San Francisco healthcare security ordinance.