Employee Benefits Series

MIA CORP

Health Care Reform

TOP 5 NOTICES

Top 5 Health Care Reform Notices

Grandfathered Plans Only

Document	Type of Information	Provide To	Provided By	Timing of Disclosure
Disclosure of Grandfather Status (Required for a plan to maintain grandfather status)	A statement that the plan believes it is a grandfathered health plan and providing contact information for questions and complaints.	Plan participants and beneficiaries	Group health plan	Whenever a summary of benefits under the plan is provided to participants and beneficiaries

A grandfathered group health plan is a plan in existence as of March 23, 2010—which has covered at least one person continuously from that day forward (not necessarily the same person, but at all times at least one person)—that has not made changes which significantly reduce benefits or increase out-of-pocket costs for individuals covered under the plan.

Non-Grandfathered Plans Only

Document	Type of Information	Provide To	Provided By	Timing of Disclosure
Notice of Patient Protections	Provides notice of applicable patient protections regarding choosing a primary care provider and obtaining access to OB/GYN care without prior authorization.	Plan participants and beneficiaries	Group health plan	Whenever a participant or beneficiary is provided a summary plan description or other similar description of benefits under the plan

Grandfathered and Non-Grandfathered Plans

Document	Type of Information	Provide To	Provided By	Timing of Disclosure
Notice of Waiver from Annual Limit Requirements for Stand-Alone HRAs	Informs eligible participants that the plan has restrictive coverage and includes low annual limits which do not meet the minimum limits set by law for essential health benefits, and that the plan has been granted a temporary waiver from the requirement.	Eligible plan participants	Stand-alone HRAs in effect prior to Sept. 23, 2010, which are automatically exempt for plan years beginning before Jan. 1, 2014	Must be provided to new eligible participants, as well as annually to eligible participants at the start of each plan year for which the waiver applies, as part of plan materials that describe the terms of coverage (such as a summary plan description)

Special Note: *Beginning in 2014, annual dollar limits on coverage of essential health benefits are prohibited for group health plans (including HRAs). HRAs that are "integrated" with other coverage as part of a group health plan that itself has no annual limits will generally be deemed to comply with the requirement to eliminate annual limits, while* ***"stand-alone" HRAs will violate the rules****. FAQs provide guidance on the distinction between integrated and stand-alone HRAs.*

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Grandfathered and Non-Grandfathered Plans (cont'd)				
Document	**Type of Information**	**Provide To**	**Provided By**	**Timing of Disclosure**
Notice Regarding Availability of Health Insurance Exchanges (**Note:** There is one model notice for employers who offer a health plan to some or all employees, and another model notice for employers who do not offer a health plan.)	Provides employees with certain information about the existence of Health Insurance Exchanges (also known as Marketplaces), including notice that the employee may be eligible for a premium tax credit (if applicable) and that the employee may lose employer health plan contributions if the employee buys coverage through the Exchange.	Each current employee and new employees	All employers covered by the Fair Labor Standards Act	Must be provided to each new employee at the time of hiring, within 14 days of the employee's start date
Summary of Benefits and Coverage (SBC) & **Uniform Glossary** and **Notice of Material Modification**	A summary of benefits and coverage under the plan with respect to each benefit package offered for which the participant or beneficiary is eligible, including information on cost-sharing requirements and coverage limitations, as well as definitions of certain coverage-related terms, such as "deductible" and "co-pay." Note: The SBC may be provided in combination with other summary materials (for example, an SPD), if the information is intact and prominently displayed at the beginning of the materials (such as immediately after the Table of Contents in an SPD) and complies with the SBC timing requirements. Templates, instructions and related materials are available from the Center for Consumer Information & Insurance Oversight.	Plan participants and beneficiaries	Group health plan, including its administrator (may be satisfied by the issuer for insured plans, so long as timing and content requirements are satisfied)	The SBC must be provided at specified times during the enrollment process and upon a participant or beneficiary's request, generally as follows: • Prior to initial enrollment in the plan; • Upon renewal of plan coverage; • Within 90 days of special enrollment; and • Within 7 business days following receipt of a request The uniform glossary also must be made available within 7 business days after receipt of a participant or beneficiary's request.
	If any material modification is made in any of the terms of the plan or coverage that would affect the content of the SBC, that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage, the plan or issuer must provide notice of the modification to enrollees **not later than 60 days prior to the date on which such change will become effective**.			

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