Appendix B:
Chart of Required Notices

For group health plans subject to Part 7 of ERISA, required disclosures include:

Type of Disclosure	Applicability	Content Summary	Timing
Notice of special enrollment rights (29 CFR 2590.701-6(c))	All group health plans.	A description of individuals' special enrollment rights.	At or before the time an employee is initially offered the opportunity to enroll in a group health plan.
Wellness program disclosure (§702; 29 CFR 2590.702(f)(2)(v))	For group health plans offering a health contingent wellness program in order to obtain a reward.	◆ The notice must disclose the availability of a reasonable alternative standard (or possibility of waiver of the otherwise applicable standard). ◆ Disclosure must include contact information for obtaining the alternative standard and a statement that recommendations of an individual's personal physician will be accommodated.	◆ In all plan materials that describe the terms of a health contingent wellness program (both activity-only and outcome-based wellness programs). If the plan materials merely mention that a program is available, without describing its terms, this disclosure is not required. ◆ For outcome-based wellness programs, this notice must also be included in any disclosure that an individual did not satisfy an initial outcome-based standard.
Description of rights with respect to hospital stays in connection with childbirth (§711(d); 29 CFR 2520.102-3(u))	Group health plans that provide maternity or newborn infant coverage.	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.	In the SPD (or SMM).

Type of Disclosure	Applicability	Content Summary	Timing
WHCRA enrollment notice (§713(a))	Group health plans that provide coverage for mastectomy benefits.	◆ 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. ◆ A description of any annual deductibles and coinsurance limitations applicable to such coverage.	Upon enrollment in the plan.
WHCRA annual notice (§713(a))	Group health plans that provide coverage for mastectomy benefits.	◆ 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.	Once each year after enrollment in the plan.
Employer Notice regarding Premium Assistance under Medicaid or CHIP (29 CFR 2590.701(f)(3)(B)(i)) * Note, the employer (rather than the group health plan or issuer) is required to provide this notice.	Employers that maintain a group health plan in a state with a CHIP or Medicaid program that provides for premium assistance for group health plan coverage must provide this notice to all employees.	◆ Potential opportunities currently available in the State in which the employee resides for premium assistance under CHIP or Medicaid for health coverage for the employee or the employee's dependents. ◆ Information on how to contact the State in which the employee resides for additional information on premium assistance under these programs. ◆ Description of special enrollment opportunity if eligible for premium assistance under these programs.	May be provided with enrollment packets, open season materials, or the Summary Plan Description.

Type of Disclosure	Applicability	Content Summary	Timing
Michelle's Law Enrollment Notice	All group health plans	Must include a description of the Michelle's law provision for continued coverage during medically necessary leaves of absence.	◆ Notice must be included with any notice regarding a requirement for certification of student status for coverage under the plan. ◆ Note: Under the Affordable Care Act, plans cannot deny or restrict coverage for a child under the age of 26 based on student status.
Mental Health Parity and Addiction Equity Act (MHPAEA) Criteria for Medically Necessary Determination Notice	All group health plans subject to MHPAEA	Notice must provide the criteria for medically necessary determinations with respect to mental health/substance use disorder benefits.	Notice must be provided to any current or potential participant, beneficiary, or contracting provider upon request.
MHPAEA Claims Denial Notice	All group health plans subject to MHPAEA	Notice must provide the reason for any denial of reimbursement or payment for services with respect to mental health/substance use disorder benefits.	Notice must be provided to participants and beneficiaries upon request or as otherwise required by other laws.
MHPAEA Increased Cost Exemption	Group health plans claiming a MHPAEA cost exemption	A group health plan claiming MHPAEA's increased cost exemption must notify plan participants and beneficiaries, the Department of Labor, and the appropriate State agencies of the plan's exemption from the parity requirements.	Notice must be provided if using the cost exemption.
Grandfathered Plan Disclosure/Notice	Group health plans claiming grandfathered status[1]	Notice must disclose that the plan is grandfathered and must include contact information.	Notice must be included in any plan materials describing the benefits or health coverage.

[1] Under the Affordable Care Act, generally, grandfathered plans are plans that were in existence, and in which at least one individual was enrolled, on March 23, 2010. Grandfathered health plans are exempt from many but not all Affordable Care Act market reforms. For further discussion, see the Affordable Care Act section of this publication or visit dol.gov/ebsa.

Type of Disclosure	Applicability	Content Summary	Timing
Summary of Benefits and Coverage (SBC) and Uniform Glossary	All group health plans	◆ A template that describes the benefits and coverage under the plan, and a uniform glossary defining statutorily and NAIC recommended terms. ◆ The SBC must include an internet address where an individual can review the Uniform Glossary as well as contact information for obtaining a paper copy. ◆ The required SBC template is available at dol.gov/ebsa/pdf/correctedsbctemplate2.pdf ◆ The Uniform Glossary is available at dol.gov/ebsa/pdf/SBCUniformGlossary.pdf.	◆ SBC must be provided to participants and beneficiaries with enrollment materials and upon renewal or reissuance of coverage. SBC must also be provided to special enrollees no later than the date by which an SPD is required to be provided (90 days from enrollment). ◆ The SBC and a copy of the Uniform Glossary must also be provided upon request within 7 days.
Summary of Benefits and Coverage: Notice of Modification	All group health plans	If a plan makes a material modification in any of the plan terms that would affect the content of the SBC that is not reflected in the most recently provided SBC, the plan must provide notice of such change. This does not apply to changes that occur in connection with a renewal or reissuance.	Notice must be provided no later than 60 days prior to the date on which the modification will become effective.
Notice Regarding Designation of a Primary Care Provider	All non-grandfathered group health plans[2]	If a plan requires a participant or beneficiary to designate a primary care provider, the plan must provide notice of the terms of the plan or coverage regarding designation of a primary care provider and participants' rights to designate any participating primary care provider who is available to accept the participant; with respect to a child, to designate any participating physician who specializes in pediatrics; and that the plan may not require authorization or referral for OB/GYN care by a participating OB/GYN professional.	Notice must be provided with the Summary Plan Description or any other similar description of benefits.

[2] Under the Affordable Care Act, generally, grandfathered plans are plans that were in existence, and in which at least one individual was enrolled, on March 23, 2010. Grandfathered health plans are exempt from many but not all Affordable Care Act market reforms. For further discussion, see the Affordable Care Act section of this publication or visit dol.gov/ebsa.

Type of Disclosure	Applicability	Content Summary	Timing
Internal Claims and Appeals and External Review Notices	All non-grandfathered group health plans	◆ Internal Claims and Appeals: Plans must provide notice of adverse benefit determination and notice of final internal adverse benefit determination. ◆ External Review: ❖ For plans following the independent review organization (IRO) process, the IRO must issue a notice of final external review decision. ❖ For plans following a State process, the state office administering external appeals process for health insurance companies must issue a notice of final external review decision.	◆ For internal claims and appeals, timing of the notices vary based on the type of claim. ◆ For external review the timing of the notice may vary based on the type of claims and whether the state or the federal process applies.
External Review Process Disclosure	All non-grandfathered group health plans	Plans must provide a description of the external review process in or attached to the Summary Plan Description, policy, certificate, or other evidence of coverage provided to participants, beneficiaries, or enrollees.	The description of external review processes must be provided in the Summary Plan Description or other evidence of coverage provided to enrollees.
Employer Notice to Employees of Coverage Options	All employers subject to the Fair Labor Standards Act	◆ Employers subject to the Fair Labor Standards Act must provide a written notice informing the employee of the existence of the Marketplace, the potential availability of a tax credit and that an employee may lose the employer contribution if the employee purchases a qualified health plan. ◆ Model notices are available at dol.gov/ebsa/healthreform/regulations/coverageoptionsnotice.html	Notice must be provided to all new employees.

Preexisting Condition Exclusion Notices and Certificates of Creditable Coverage

For plan years beginning on or after January 1, 2014, plans are no longer required to issue the general notice of preexisting condition exclusion and individual notice of period of preexisting condition exclusion. Plans are also no longer required to issue certificates of creditable coverage after December 31, 2014. These amendments were made because plans are prohibited from imposing preexisting condition exclusions for plan years beginning on or after January 1, 2014. For more information see 79 Fed. Reg. 10296-317 (Feb. 24, 2014)