Guide to Participant Notices

What	What Groups	Description	Who	When
Distributed Annually				
Notice of Creditable Coverage **"Medicare Part D Creditable Coverage Notice"** **"Medicare Part D Non-Creditable Coverage Notice"** **Include "Required Medicare Language" if notices will be combined with other plan materials**	All group health plans	Group health plan sponsors must provide a notice of creditable or non-creditable prescription drug coverage to Medicare Part D eligible individuals who are covered by, or who apply for, prescription drug coverage under the entity's plan. This notice alerts individuals as to whether or not their prescription drug coverage is at least as good as the Medicare Part D coverage If Medicare D Notices will be combined with other plan materials, special language must be included on the first page that begins plan participant information being provided.	Medicare-eligible employees who are eligible for the plan	Prior to the commencement of the annual coordinated election period for Part D on October 15; Upon enrollment; When drug coverage is terminated or there has been a change to the prescription coverage that affects the creditable status of the plan; and Upon request by plan participants.
CHIPRA Notice **"CHIPRA Notice"**	All group health plans	States may offer eligible low-income children and their families a premium assistance subsidy to help pay for employer-sponsored coverage. If an employer's group health plan covers residents in a state that provides a premium subsidy, the employer must send an annual notice about the available assistance to all employees residing in that state. Employers may use the model notice provided by the DOL as a national notice to meet their obligations under CHIPRA.	All employees, regardless of enrollment or eligibility status	Annually, with open enrollment materials.

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Summary Annual Report **"Sample SAR"†**	Group health plans that file Form 5500	Narrative summary of the Form 5500 and includes a statement of the right to receive the annual report.	Participants covered under the plan.	Within 9 months of the close of the plan year. If an extension of time to file the Form 5500 is obtained, within 2 months after the close of the extension period.

What	What Groups	Description	Who	When
Distributed at Time of Enrollment				
HIPAA Privacy Notice **"Sample HIPAA Privacy Notice"†**	Self-funded plans; Fully-insured plans with access to PHI	HHS requires that participants be provided with a detailed explanation of their privacy rights, the plan's legal duties with respect to PHI, and plan's uses and disclosures of PHI, and how to obtain a copy of the Notice of Privacy Practices	Participants covered under the plan.	Self-funded plans: at enrollment and upon request; Fully-insured plans with access to PHI: upon request.
HIPAA Notice of Special Enrollment Rights **"Notice of special enrollment rights"**	All group health plans	Notice to employees eligible to enroll in a group health plan describing the plan's enrollment rules including the right to enroll within 30 days of the loss of other coverage or of marriage, birth of a child, adoption, or placement for adoption, or within 60 days of a determination of eligibility for a premium assistance subsidy under Medicaid or CHIP.	Employees eligible to enroll.	At or before the time an employee is initially offered opportunity to enroll.
Department of Labor Exchange Notice **"DOL Exchange Notice"** **"DOL Exchange Notice NO HEALTH PLAN"**	All employers subject to the Fair Labor Standards Act	Employers must provide new and existing employees with information about State Exchanges, including information on employee eligibility for coverage under the Exchange.	All employees, regardless of eligibility.	At time of hire.
Initial COBRA Notice **"DOL Model Initial COBRA Notice"**	All group health plans subject to COBRA; some group health plans subject to State Continuation (Includes Missouri)	Notice to covered employees and covered spouses of the right to purchase temporary extension of group health coverage when coverage is lost due to a qualifying event.	Covered employees and covered spouses	When group health plan coverage commences

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Distributed Annually AND at Time of Enrollment				
Women's Health and Cancer Rights Act (WHCRA) **"WHCRA Notice"**	All group health plans that provide medical and surgical benefits for mastectomy	Requires group health plans to provide certain benefits in connection with a mastectomy, requires plans and issuers of group health plans to provide other protections for participants undergoing a mastectomy.	Participants covered under the plan.	Upon enrollment and annually
Summary of Benefits and Coverage **"SBC Template" and "SBC Template Completed"†**	All group health plans, but not to certain "excepted benefits" and retiree-only plans	Uniform summary of the plan's benefits and coverage required under ACA, using the template provided by the DOL, HHS, and Treasury Department.	All applicants, policyholders, and enrollees, and COBRA qualified beneficiaries.	At open enrollment; At initial enrollment; At special enrollment; Upon request
Statement of Grandfathered Status **"Statement of Grandfathered Status"**	Group health plans claiming grandfathered status	To maintain grandfathered plan status, a plan administrator or insurance issuer must include a statement of the plan's grandfathered status in plan materials provided to participants describing the plan's benefits (such as the SPD and open enrollment materials).	Participants and potential enrollees receiving benefit enrollment materials	Must be included in any plan materials describing benefits to participants or beneficiaries

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Event or Program-Specific Disclosures				
Wellness Program Notice **"Model Wellness Program Disclosure"**	Wellness programs that condition a reward or penalty on achieving a standard that is related to a health factor	Wellness programs which offer a reward conditioned upon an individual's ability to meet that is related to a health factor will violate HIPAA's nondiscrimination rules unless the program discloses the availability of an alternative standard.	Participants who may be eligible for the reward/penalty	All materials describing the wellness program must include disclosure of the availability of an alternative standard.
COBRA Election Notice **"DOL Model Election Notice"**	All group health plans subject to COBRA; some group health plans subject to State Continuation (Includes Missouri)	Notice to qualified beneficiaries of their right to elect COBRA coverage upon occurrence of qualifying event.	Covered employees, covered spouses, and dependent children	Within 44 days of qualifying event.
Notice of Unavailability of COBRA Coverage **"Sample Notice of Unavailability of COBRA"**	All group health plans subject to COBRA; some group health plans subject to State Continuation (Includes Missouri)	If an individual provides notice to the plan administrator of a qualifying event and the plan determines that the individual is not entitled to COBRA coverage, the plan administrator must send the individual the Notice of Unavailability of COBRA Coverage.	Individual attempting to elect COBRA.	Within 14 days after the plan administrator has received notice of a qualifying event.
Notice of Early Termination of COBRA Coverage **"Sample Notice of Termination of COBRA"**	All group health plans subject to COBRA; some group health plans subject to State Continuation (Includes Missouri)	Notice to qualified beneficiaries that COBRA coverage will terminate earlier than the maximum period of coverage. Must include reason for early termination, date of termination, and any rights that qualified beneficiary may have to elect alternative group or individual coverage, such as a conversion right.	Qualified beneficiaries whose COBRA coverage terminates	As soon as practicable following decision to terminate COBRA coverage
Notice of Insufficient Payment **"Sample Notice of Insufficient Premium Payment"**	All group health plans subject to COBRA; some group health plans subject to State Continuation (Includes Missouri)	Plan administrator must notify qualified beneficiaries that payment for COBRA was significantly less than the correct amount before coverage is terminated for nonpayment. A payment is significantly less than the amount required if the deficiency is greater than the lesser of $50 or 10% of the amount the plan requires to be paid	Qualified beneficiary making the insufficient payment	As soon as practicable
Qualified Medical Child Support Orders (QMCSO) or	Group health plans subject to ERISA	Notification from the plan administrator regarding receipt and qualification determination on a medical child support	Agency or entity issuing the medical child support order.	Upon receipt of a medical child support order. Within a

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National Medical Support Notices (NMSN) **"Sample Letter Accepting QMCSO" and "Sample Letter Rejecting QMCSO"**		order directing the plan to provide health insurance coverage to a participant's noncustodial children.		reasonable time after receipt, plan administrator must issue separate notice as to whether the medical child support order is qualified
Notice of Rescission **"Sample Notice of Rescission"**	All group health plans	Group health plans and health insurance issuers may not rescind coverage once the enrollee is covered except in cases of fraud or intentional misrepresentation. Plan coverage may not be rescinded without prior notice to the enrollee.	Each participant who would be affected by a coverage rescission	Notice must be given at least 30 days before the rescission occurs.

What	What Groups	Description	Who	When
Notices Included in the SPD or Plan Document				
Patient Protections Notice **"Patient Protections Model Notice"**	Non-grandfathered plans that require designation of a primary care physician	Group health plans that require designation of a primary care provider must provide a notice to each participant describing the plan's requirements regarding designation of a primary care provider and certain other rights of the participant or beneficiary.	Covered employees, COBRA qualified beneficiaries, retirees (not covered spouses and children)	Within 90 days for newly covered participants; Within 120 days for new plans; Every 5 years if material changes made to SPD; Every 10 years if no material changes made to SPD.
Newborns' and Mothers' Health Protection Act (NMHPA) **"NMHPA Sample Language"**	All employer-provided group health plans	The plan's SPD must include a statement describing any requirements under federal or state law applicable to the plan, and any health insurance covered under the plan, relating to any hospital length of stay in connection with childbirth for a mother or newborn child.	Covered employees, COBRA qualified beneficiaries, retirees (not covered spouses and children)	Within 90 days for newly covered participants; Within 120 days for new plans; Every 5 years if material changes made to SPD; Every 10 years if no material changes made to SPD.
Notice of Appeals Process **Check with carrier/TPA**	Fully-insured plans may generally rely on insurer. Self-insured plans will need to work with TPA to ensure adequate disclosures are in the SPD. Grandfathered plans do not need to comply.	Notices relating to internal claims and appeals and external review	Covered employees, COBRA qualified beneficiaries, retirees (not covered spouses and children)	Within 90 days for newly covered participants; Within 120 days for new plans; Every 5 years if material changes made to SPD; Every 10 years if no material changes made to SPD.

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