Health Care Reform ALERT
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New Health Plan Notices Required Under Health Care Reform

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The National Health Care Reform Law (commonly known as "PPACA") introduced a number of new notices that health plans must provide to plan participants. Some of these notices are meant to notify participants and other interested individuals of changes to their benefits under the plan, and of special enrollment opportunities related to the changes. Other notices are required in specific circumstances such as a rescission of coverage or the denial of a claim for benefits. The chart below describes these new PPACA notices in detail.

PPACA Notice	From Whom?	To Whom?	When?	How?
Dependent coverage until age 26—PPACA special enrollment notice — see model notice at http://www.dol.gov/ebsa/.	Group health plans and health insurance issuers providing dependent coverage.	Employees eligible to participate in the plan.	Not later than the first day of the first plan year beginning on or after September 23, 2010. ONE TIME notice.	May be included with other enrollment materials that a plan distributes, provided the statement is prominent.
Elimination of Lifetime Limits—PPACA special enrollment notice—see model notice at http://www.dol.gov/ebsa/.	Group health plans and health insurance issuers.	Individuals who reached a lifetime limit under a plan or health insurance coverage prior to the effective date and are otherwise still eligible under the plan or health insurance coverage.	Not later than the first day of the first plan year beginning on or after September 23, 2010. ONE TIME notice.	May be included with other enrollment materials that a plan distributes to employees, provided the statement is prominent.
Grandfathered plan statement—see model statement at http://www.dol.gov/ebsa/. See also distribution guidance in Employee Benefits Security Administration's (EBSA) FAQs About the Affordable Care Act Implementation, Part IV.	Grandfathered group health plans and health insurance issuers.	Statement must appear in any plan materials provided to a participant or beneficiary describing the benefits provided under the plan or health insurance coverage.	Notice requirement appeared in regulations which were effective June 14, 2010. Include so long as the plan wishes to maintain grandfathering.	Language must be included whenever a summary of the benefits under the plan is provided to participants and beneficiaries. Include in summary plan descriptions upon initial eligibility to receive benefits

				under the plan or coverage, during an open enrollment period, or upon other opportunities to enroll in, renew, or change coverage. Also include in other communications in which disclosure of grandfather status would be appropriate and consistent with the goal of providing participants and beneficiaries the information necessary to understand and make informed choices regarding health coverage.
Patient protections—notice regarding right to select primary care providers—see model notice at http://www.dol.gov/ebsa/.	Non-grandfathered group health plans and health insurance issuers.	Plan participants.	According to model notice: no later than the first day of the first plan year beginning on or after September 23, 2010. According to regulations: whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits.	The notice must be provided whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits under the plan or health insurance coverage.
Rescissions—PPACA advance notice requirement.	Group health plan or a health insurance issuer offering group or individual health insurance coverage.	To each participant who would be affected by the rescission.	At least 30 calendar days advance notice to an individual before coverage may be rescinded.	No further information as of the date of this Alert.
Claims Procedures—new PPACA rules enhance existing Employee Retirement Income Security Act (ERISA) claims requirements.	Non-grandfathered group health plans and health insurance issuers.	Participants and beneficiaries.	New rules are effective for non-grandfathered plans for plan years beginning on or after September 23, 2010. However, the Department of Labor (DOL) has indicated that an enforcement grace period is in effect until	Key enhancements: Urgent care claims must now be decided in writing within 24 hours (formerly, 72 hours). External review must now be provided through Independent Review Organization

			July 1, 2011.	(IRO). If external review is requested: • Initial written response required within five days of request. • IRO response required within 45 days (72 hours if expedited review requested). Notices of available internal claims and appeals and external review processes must be provided in a culturally and linguistically appropriate manner.
W-2 Form—aggregate cost of major medical coverage must be included on W-2.	W-2 issuers.	Employees receiving W-2.	Generally effective for the 2012 W-2 (i.e. the W-2 issued in 2013). However, if any employee terminates in 2012 and requests a W-2, the aggregate cost of coverage must be included.	No further information as of the date of this Alert.
PPACA uniform summary of coverage.	A health insurance issuer (including a group health plan that is not a self-insured plan) offering health insurance coverage within the United States; or in the case of a self-insured group health plan, the plan sponsor or plan administrator.	Enrollees.	No later than March 23, 2012. 60 days prior to any material modification in benefits.	Model disclosures to be developed; no further information as of the date of this Alert.

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