Supplemental Compliance Notice Packet

As you prepare for the upcoming open enrollment period, we are pleased to provide you with this compliance packet. This resource is designed to assist you in fulfilling your obligations as a self-insured plan sponsor by outlining and providing the required materials and notices that must be distributed to your employees and their dependents.

This packet contains a variety of notices and disclosures to ensure your plan remains compliant with federal regulations, including ERISA, HIPAA, the ACA, and more.

We recommend that you review all materials in this packet carefully and consult with your legal counsel or benefits advisor to ensure full compliance with all applicable laws. Please reach out to us if you have any questions or require additional support.

HIPAA Special Enrollment Notice

A federal law called HIPAA requires that we notify you of your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons. You have the right to request special enrollment (outside of the plan's annual enrollment period) for yourself and your eligible dependents under the following circumstances.

Loss of Other Coverage (Except Medicaid or a State Children's Health Insurance Program)

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Eligibility Under Medicaid or a State Children's Health Insurance Program

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Medicaid or a State Children's Health Insurance Program

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

Women's Health and Cancer Rights Act (WHCRA) Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

1. All stages of reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, please call your Plan Administrator.

Michelle's Law Notice

Under Michelle's Law, group health plans and health insurers are prohibited from terminating the coverage of a student dependent whose enrollment in a plan requires student status at a post-secondary educational institution, if the student status is lost because of a qualifying Medically Necessary Leave of Absence.

Application Requirements

Michelle's Law applies to a group health plan or related insurance coverage only if the plan or insurer receives written certification by the student dependent's treating physician stating that:

1. The child is suffering from a serious illness or injury, and
2. The Leave of Absence (or other change in enrollment) is Medically Necessary

Definition of Student Dependent

A student dependent is one who, regarding group health plan or health insurance coverage is both:

A dependent child, under the plan's or coverage's terms, of a participant or beneficiary in the plan or coverage Was enrolled in the plan or coverage, on the basis of being a student at a postsecondary educational institution, immediately before the first day of the Medically Necessary Leave of Absence involved.

Newborns and Mother's Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).