

	<b>Effective for Plan Years Beginning on and/after September 23, 2010</b>
<b>Grandfather Status</b>	Plans must include a statement in any plan material provided to participants and beneficiaries describing benefits under the plan that the plan believes it is grandfathered and contact information for questions and complaints. DOL provided <a href="#">model</a> language.
<b>Rescission</b>	All plans must provide at least 30 days advance written notice to each participant who would be affected by a rescission, whether the rescission applies to the entire group or an individual.
<b>Patient Protection</b>	All non-grandfathered plans must provide notice of the following: <ul style="list-style-type: none"> <li>▪ If a plan requires the designation of a primary care provider, the plan must allow each participant or beneficiary to elect a primary care provide who will accept them, including a pediatrician for a child.</li> <li>▪ A plan also must allow direct access to an in-network ob/gyn for female participants or beneficiaries.</li> </ul> The DOL provided <a href="#">model</a> language.
<b>Lifetime Limits</b>	PPACA prohibits lifetime dollar limits. If an individual was no longer eligible for coverage under the plan because of reaching this limit, the plan must allow the individual into the plan on the first plan year on and after September 23, 2010. The plan must provide this individual notice of the right to reenroll. The DOL provided a <a href="#">model</a> notice. This is a one time notice.
<b>Annual Limits</b>	For plan years beginning before January 1, 2014, a plan may impose restricted annual dollar limits on essential benefits. However, a plan may obtain an annual waiver of the dollar limits if it can show that these restrictions would increase cost or limit access to benefits. If a plan receives a waiver, the plan must provide a notice to all participants that: <ul style="list-style-type: none"> <li>▪ States that the plan or policy does not meet the minimum annual limits for essential benefits and received a waiver of this requirement</li> <li>▪ Includes the dollar amount of the annual limit</li> <li>▪ Describes the plan benefits to which the limits apply</li> <li>▪ States that the waiver is only granted until the last day of the plan year before January 1, 2014</li> <li>▪ Is in 14 point font</li> </ul> For waivers received for plan years on or after February 1, 2011, the notice must be provided as part of any informational or educational materials and included in the SPD. HHS has provided a <a href="#">model</a> notice. Waiver recipients must receive permission to use language that is different from the model notice.

	<p><b>Effective or Plan Years Beginning on and after July 1, 2011 and January 1, 2012</b></p>
<p><b>Claims and Appeals Process</b></p>	<p>PPACA adds additional requirements for claims and appeals procedures that apply to non-grandfathered plans. Although these requirements generally are effective for plan years beginning on and after September 23, 2010, the DOL provided an enforcement grace period for certain provisions for plan years beginning on and after the date noted below.</p> <ul style="list-style-type: none"> <li>▪ Notices must be provided in a culturally and linguistically appropriate manner (1/1/12)</li> <li>▪ Notices to claimants must provide the following additional content:             <ul style="list-style-type: none"> <li>- Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount, and a statement that they the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning are available upon request (1/1/12)</li> <li>- Information to ensure that the reason for the adverse benefit determination or final adverse benefit determination includes the denial code and its meaning and a description of the plan’s standard that was used in denying the claim or final adverse determination (7/1/11)</li> <li>- A description of the internal appeals and external review process (7/1/11)</li> <li>- A description of the availability of and contact information for an applicable office of health insurance consumer assistance or ombudsman as established under PPACA (7/1/11)</li> </ul> </li> <li>▪ If a plan does not strictly adhere to all of the requirement in the interim final regulations, the claimant is deemed to have exhausted the internal claims and appeals process and may initiate any available external review or remedies under ERISA or state law. The strict adherence standard will not apply if the errors were de minimis; non-prejudicial or non-harmful; for good cause or because of matters beyond the plan’s control; in the context of an on-going, good-faith exchange of information; and not a pattern or practice of non-compliance. If a plan asserts the exception, the plan must provide an explanation in response to a written request from the claimant (1/1/12)</li> </ul>
	<p><b>Effective on and after March 23, 2012 (Subject to a delayed applicability date from the Departments)</b></p>
<p><b>Summary of Benefits and Coverage</b></p>	<p>The Secretary of HHS will develop a standard summary of benefits and coverage that group health plans will need to use to describe benefits. The summary must not exceed four pages, be in 12 point font, be presented in “culturally and linguistically” appropriate language, and include the following:</p> <ul style="list-style-type: none"> <li>▪ Uniform definitions of standard insurance terms and medical terms</li> <li>▪ A description of coverage and any cost-sharing (including any deductibles, coinsurance and copayments)</li> <li>▪ Any exceptions, reductions and limitations on coverage</li> <li>▪ Renewability and continuation coverage provisions</li> <li>▪ Coverage facts label illustrating common benefit scenarios, including pregnancy and serious or chronic medical conditions</li> <li>▪ A statement of whether the plan provides minimum essential coverage and has an actuarial value of at least 60 percent (Effective 1/1/14)</li> <li>▪ Contact number to call and an internet address for a copy of the policy (and presumably the SPD for self-funded plans)</li> </ul> <p>If any material modification in any of the terms of the plan coverage is made, and it is not reflected on the most recent SBC, notice of the modification must be provided no later than 60 days before the modification becomes effective.</p>

	<b>2012 Calendar Year Health Care Coverage (Reportable by January 31, 2013)</b>
<b>W-2 Reporting</b>	An employer must report the cost of all applicable employer health care coverage on each employee's Form W-2. Under current guidance, small employers (filed less than 250 forms W-2) and those who contribute to multiemployer plans are excluded.
	<b>Effective March 31, 2013</b>
<b>Explanation of Exchange</b>	At the time of hire (and no later than March 31, 2013 for current employees), an employer must provide each employee with a notice containing the following: <ul style="list-style-type: none"> <li>▪ Information about the existence of the Exchange, including a description of the Exchange services and how an employee may contact the Exchange</li> <li>▪ If the employer contribution is less than 60 percent, that the employee may be eligible for premium tax credits and cost-sharing reductions if purchasing coverage through the Exchange</li> <li>▪ If the employee purchases coverage through the Exchange, the employee will lose the employer contributions and that employer contributions are excludable from income tax</li> </ul>
	<b>Effective for Plan Years Beginning on and after January 1, 2014</b>
<b>Reporting of Health Insurance Coverage</b>	An employer must file a return with the IRS showing: <ul style="list-style-type: none"> <li>▪ The name, address, TIN of the participant and the name and TIN of each other beneficiary</li> <li>▪ The date of coverage</li> <li>▪ The name, address, and employer EIN</li> <li>▪ The portion of the premium paid by the employer</li> </ul> <p>An employer must provide to a participant the following before January 31 of the year following the reporting year:</p> <ul style="list-style-type: none"> <li>▪ The name and address of the employer and a phone number of the contact for the information provided to the participant</li> <li>▪ The information that is required to be on the return to the IRS</li> </ul>
<b>Disclosure of Plan Data and Financials</b>	The Secretary of Labor will update the participant and plan disclosure requirements to be consistent with the standards established by the Secretary of HHS for Exchange plans, relating to the following: <ul style="list-style-type: none"> <li>▪ Claims payment policies and practices</li> <li>▪ Periodic financial disclosures</li> <li>▪ Data on enrollment</li> <li>▪ Data on disenrollment</li> <li>▪ Data on the number of claims that are denied</li> <li>▪ Data on rating practices</li> <li>▪ Information on cost-sharing and payments with respect to any out-of-network coverage</li> <li>▪ Information on enrollee and participant rights</li> <li>▪ Any other information the Secretary of HHS determines appropriate</li> </ul>

	<b>Effective January 1, 2018</b>
<b>Excise Tax Determination</b>	<p>An employer will have to determine whether the following costs for each employee for each year are more than \$10,200 (individual)/ \$27,500 (family):</p> <ul style="list-style-type: none"> <li>▪ Health</li> <li>▪ Employer health FSA contributions and any reimbursements in excess of the employer contributions</li> <li>▪ Employer and employee pre-tax HSA contributions, and</li> <li>▪ HRA contributions</li> </ul> <p>If the cost is above the threshold, the employer is required to determine the excess amount and report the excess amounts to the Secretary of Treasury and each third party administrator or insurer, including the excess amounts attributable to each third party administrator or insurer.</p>
	<b>Unspecified Date</b>
<b>Automatic Enrollment</b>	An employer with more than 200 employees must automatically enroll each new full-time employee and continue such enrollment, unless the employee opts out or changes the coverage. The employer must provide notice of the automatic enrollment and procedures for opting out.