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## **Summary of Required Notices Health Care Reform**

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### **Grandfathered Status**

In order to maintain "grandfathered status" under PPACA, a group health plan must disclose that the plan (coverage) is a "grandfathered health plan" under PPACA. This applies to plan materials given to a participant or beneficiary describing benefits under the plan. This notice must include contact information for questions or complaints. Model language provided by the Department of Labor to satisfy this disclosure requirement is available at <http://www.dol.gov/ebsa/grandfatherregmodelnotice.doc>.

### **Enrollment Opportunity for Dependent Children to Age 26**

A plan must give each child (including those not previously eligible for coverage) the opportunity to enroll for plan coverage. This includes those whose coverage ended or was previously denied coverage because the availability of dependent coverage ended before attainment of age 26. This must occur during a period of not less than 30 days and provide written notice of this enrollment opportunity. The notice and enrollment opportunity must be provided no later than the first day of the first plan year beginning on or after September 23, 2010. Coverage must be made effective no later than the first day of that plan year. The notice may be included with other enrollment materials, provided the statement is prominent. Model language provided by the Department of Labor to comply with the required notice of this enrollment right is available at <http://www.dol.gov/ebsa/depednentsmodelnotice.doc>.

### **No Lifetime Limits and Enrollment Opportunity**

A plan must give written notice to current participants who are not eligible for additional benefits because they previously reached the lifetime limit on benefits. The notice must state that the limit no longer applies and that they are once again eligible for benefits under the plan. Individuals who are not plan participants, or whose coverage ended by reason of reaching a lifetime limit under a plan, must be given an opportunity to enroll in the coverage during a period of not less than 30 days, with coverage effective no later than the first day of the applicable plan year. The notice and enrollment opportunity must be provided no later than the first day of the first plan year beginning on or after September 23, 2010. Model language provided by the Department of Labor is available at <http://www.dol.gov/ebsa/lifetimelimitsmodelnotice.doc>.

## **New Patient Protections**

A group health plan that is not grandfathered for PPACA purposes is required to notify participants of their rights (1) to choose a primary care provider or pediatrician if designation of a primary care physician is required; or (2) obtain in-network obstetrical or gynecological care without prior authorization. The regulations require that the notice must be given whenever the plan provides a participant with a summary plan description or other similar description of benefits under the plan. However, the Department of Labor's model language states that notice must be provided no later than the first day of the first plan year beginning on or after September 23, 2010. Model language provided by the Department of Labor to satisfy this requirement is available at <http://www.dol.gov/ebsa/patientprotectionmodelnotice.doc>.

**Additional notice requirements pending.**

## **Questions**

If you have any questions regarding this release, please contact Russ Kotila at **248.996.1845** or email [russ@jsclarkagency.com](mailto:russ@jsclarkagency.com).

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**MODEL NOTICE FOR EMPLOYEE NOTIFICATION  
OF GRANDFATHERING STATUS**

To maintain status as a grandfathered health plan, a plan or health insurance coverage must include a statement, in any plan materials provided to a participant or beneficiary describing the benefits provided under the plan or health insurance coverage, that the plan or coverage believes it is a grandfathered health plan within the meaning of section 1251 of the Patient Protection and Affordable Care Act and must provide contact information for questions and complaints.

The following model language can be used to satisfy this disclosure requirement:

This [group health plan or health insurance issuer] believes this [plan or coverage] is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information]. [For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.] [For individual market policies and nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at [www.healthreform.gov](http://www.healthreform.gov).]

**MODEL LANGUAGE FOR NOTICE OF OPPORTUNITY  
TO ENROLL DEPENDENTS UP TO AGE 26**

The interim final regulations extending dependent coverage to age 26 provide transitional relief for a child whose coverage ended, or who was denied coverage (or was not eligible for coverage) under a group health plan or health insurance coverage because, under the terms of the plan or coverage, the availability of dependent coverage of children ended before the attainment of age 26. The regulations require a plan or issuer to give such a child an opportunity to enroll that continues for at least 30 days (including written notice of the opportunity to enroll), regardless of whether the plan or coverage offers an open enrollment period and regardless of when any open enrollment period might otherwise occur. This enrollment opportunity (including the written notice) must be provided not later than the first day of the first plan year beginning on or after September 23, 2010. The notice may be included with other enrollment materials that a plan distributes, provided the statement is prominent. Enrollment must be effective as of the first day of the first plan year beginning on or after September 23, 2010.

The following model language can be used to satisfy the notice requirement:

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in [Insert name of group health plan or health insurance coverage]. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to [insert date that is the first day of the first plan year beginning on or after September 23, 2010.] For more information contact the [insert plan administrator or issuer] at [insert contact information].

**MODEL LANGUAGE FOR NOTIFICATION OF  
THE ELIMINATION OF LIFETIME LIMITS**

Plans and issuers are required to give written notice that the lifetime limit on the dollar value of all benefits no longer applies and that an individual, if covered, is once again eligible for benefits under the plan. Additionally, if the individual is not enrolled in the plan or health insurance coverage, or if an enrolled individual is eligible for but not enrolled in any benefit package under the plan or health insurance coverage, then the plan or issuer must also give such an individual an opportunity to enroll that continues for at least 30 days (including written notice of the opportunity to enroll). The notices and enrollment opportunity must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010. For individuals who enroll under this opportunity, coverage must take effect not later than the first day of the first plan year beginning on or after September 23, 2010.

These notices may be provided to an employee on behalf of the employee's dependent. In addition, the notices may be included with other enrollment materials that a plan distributes to employees, provided the statement is prominent. For either notice, if a notice satisfying the requirements is provided to an individual, the obligation to provide the notice with respect to that individual is satisfied for both the plan and the issuer.

The following model language can be used to satisfy the notice requirement:

The lifetime limit on the dollar value of benefits under [Insert name of group health plan or health insurance issuer] no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact the [insert plan administrator or issuer] at [insert contact information].

## **PATIENT PROTECTION MODEL DISCLOSURE**

When applicable, it is important that individuals enrolled in a plan or health insurance coverage know of their rights to (1) choose a primary care provider or a pediatrician when a plan or issuer requires designation of a primary care physician; or (2) obtain obstetrical or gynecological care without prior authorization. Accordingly, the interim final regulations regarding patient protections under section 2719A of the Affordable Care Act require plans and issuers to provide notice to participants of these rights when applicable. 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. This notice must be provided no later than the first day of the first plan year beginning on or after September 23, 2010.

The following model language can be used to satisfy the notice requirement:

**For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries, insert:**

[Name of group health plan or health insurance issuer] generally [requires/allows] the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. [If the plan or health insurance coverage designates a primary care provider automatically, insert: Until you make this designation, [name of group health plan or health insurance issuer] designates one for you.] For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the [plan administrator or issuer] at [insert contact information].

**For plans and issuers that require or allow for the designation of a primary care provider for a child, add:**

For children, you may designate a pediatrician as the primary care provider.

**For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add:**

You do not need prior authorization from [name of group health plan or issuer] or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the [plan administrator or issuer] at [insert contact information].