Employee Benefit Reporting and Disclosure Requirements

The following chart is a summary of basic federal notice and disclosure compliance requirements that apply to group health plans and/or employers under various employee benefits and employment laws.

Document & Type of Information	Action Required of Employer	Reporting Requirement To Whom & When
Plan Document* Must have a written Plan Document in place for each benefit describing plan's terms and conditions. The documents must include the latest updated SPD, latest Form 5500, trust agreement and other instruments under which the plan is established or operated. Must include ERISA plan numbers.	Employer must **maintain the Plan Document and make it readily available for inspection by DOL at all times.**	Distribution is not required unless a Participant requests a copy, then no later than **30 days** after a written request. Hard copies must be available for examination at the principal office and certain other locations.
Summary Plan Description (SPD) * Primary vehicle for informing participants and beneficiaries about their benefits, rights, and obligations under the Plan and how it operates . Must include N**ewborns' and Mothers' Health Protection Act (NMHPA).** * ***COCs/certificates of coverage from the Insurance Carriers may not meet these requirements.***	The plan administrator/employer must distribute the SPD to all **participants** and **beneficiaries** within the required time period.	All participating employees and beneficiaries receiving benefits must receive a copy of the SPD within **90 days** of being covered by an existing plan or within **120 days** after a new plan is established. Every 5 years if changes are made to SPD information or the Plan is amended. Otherwise, it must be furnished every 10 years.
Summary of Benefits and Coverage (SBC) * A standardized summary of benefits and coverage (SBC) available under each applicable group health plan benefit package (typically, each of the medical coverage options available under the plan). Under current guidance, the SBC may be incorporated into the SPD as long as the SBC is intact and prominently displayed at the beginning of the SPD. However, maintaining the SBC as a standalone document may be preferential because the SBC distribution requirements are broader than SPD distribution requirements.	Employer must distribute to **current and eligible participants and beneficiaries**. The requirement to provide the SBC to a participant's covered dependents will be met if the SBC is provided to participant, unless the plan has knowledge of a dependent's separate address.	The SBC is required to be distributed to participants and beneficiaries: • as part of initial application materials for enrollment (and again by the 1st day of coverage, if there are changes to the information in the SBC between application and enrollment); • as part of annual open enrollment materials, or if no annual open enrollment is held, the SBC must be provided at least 30 days prior to the new plan year (with some flexibility for an insured plan for late insurance policy issuance or renewal); • to special enrollees, within **90 days** of their special enrollment; • at any time upon request, within **7 business days** of the request; and • at least **60 days** prior to the effective date of any mid-year material change to the benefits/ coverage described in the SBC. May be distributed electronically if certain requirements are met (see Q&A10 at http://www.dol.gov/ebsa/pdf/faq-aca8.pdf).

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60-Day Advance Notice of Plan Changes* Notice of material modifications in plan terms or coverage that would affect the content of the summary of benefits and coverage and are not reflected in the most recent summary of benefits and coverage.	Employer must distribute notice to all participants within the required time period.	A health plan or issuer must provide **60 days'** advance notice of any material modifications to the plan that are not related to renewals of coverage.
Summary of Material Modification (SMM)* Describes material (important, significant) changes to a plan (i.e., carrier change, eligibility change, benefit structure change) and changes in the information required to be in the SPD.	Employer must distribute the SMM to all **participants** within the required time period.	All participants must receive within **210 days** after the end of the plan year in which the change occurred. Distribution of updated SPD satisfies this requirement.
Notice of Summary of Material Reduction in Covered Services or Benefits* A Summary of any reduction or elimination of benefits, formulas, methodologies, schedules, or service area, an increase in deductibles, coinsurance, or copays, or establishment of new conditions or requirements (e.g., prior authorization).	Employer must distribute to all **participants** within the required time period.	Within **60 days** after the date of the adoption of the change, or within **90 days** by a system of communication that provides Participants information about their Plan.
IRS Form 5500* Plan financial information and participant counts for each plan where you have 100+ participating employees. Plans with fewer than 100 participants on the 1st day of the Plan Year may be exempt.[1] Former employees covered under COBRA and Severance Pay Plans are also counted. Employees who waive coverage are not counted. (Form 5500 records must be maintained for not less than six years.)	Employer must file the Form 5500 with **DOL** within the required time period.	Employer must file the Form 5500 **electronically** with the U.S. Department of Labor DOL within **7 months** after the end of the Plan Year A 2-1/2 month extension is available by filing a Form 5558.
Schedule A* Insurance policy information (Insurance carriers are required to provide the employer with information necessary to complete this form.)	Employer must file with Form 5500 with **DOL** within the required time period.	Employer must file the Schedule A with Form 5500 **electronically** with the U.S. Department of Labor DOL **within 7 months** after the end of the Plan Year A 2-1/2 month extension is available by filing a Form 5558.

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Schedule C* Service Provider Information Must complete Schedule C if service provider was paid $5,000 or more (Commissions on fully insured plans are not reportable if already reported on Schedule A.)	Employer must file with Form 5500 with **DOL** within the required time period.	Employer must file the Schedule A with Form 5500 **electronically** with the U.S. Department of Labor DOL within **7 months** after the end of the Plan Year A 2-1/2 month extension is available by filing a Form 5558. (Exempt from filing Schedule C if premiums and benefits are paid from general assets of employer, employee contributions are forwarded and insurer refunds are returned within 3 months of receipt, a trust does not hold Plan assets, and, in the case of a self-insured plan, employee contributions are made through a Cafeteria Plan.)
Form M-1 Compliance Information* An attachment to Form 5500 stating: 1. Whether the plan was subject to the Form M-1 filing requirements during the plan year; 2. If subject, a. whether the plan is currently in compliance with Form M-1 filing requirements; b. Provide the Receipt Confirmation Code for the Form M-1. (All welfare benefit plans (whether or not a MEWA) must file M-1 Compliance Information)	Employer must file with Form 5500 with **DOL** within the required time period.	All welfare benefit plans (whether or not a MEWA), Employer must file the Schedule A with Form 5500 **electronically** with the U.S. Department of Labor DOL within **7 months** after the end of the Plan Year A 2-1/2 month extension is available by filing a Form 5558.
Medicare Part D Notice of Creditable or Non-Creditable Prescription Drug Coverage Describes whether prescription drug coverage under the plan constitutes "creditable coverage" under Medicare Part D rules. ((i.e., the coverage is expected to pay on average as much as the standard Medicare prescription drug coverage) This disclosure is required whether the entity's coverage is primary or secondary to Medicare.	Employer must complete **Centers for Medicare and Medicaid Services** (CMS) online Disclosure Form within the required time period. Employer must also provide to each **Medicare Part D eligible individual*** who joins (or seeks to join) the plan during the plan year, prior to his or her prescription drug coverage effective date under the plan. ***This includes disabled or retired participants and COBRA continuees, as well as covered spouses and dependents**. *A single notice may be provided to the individual and his or her spouse and/or dependent(s) covered under the same plan (unless the spouse or dependent is known to reside at a different address).*	**To CMS:** Within **60 days** after the beginning date of the Plan Year, within **30 days** after the termination of the prescription drug plan; and within **30 days** after any change in the creditable coverage status of the prescription drug plan. **To Participant:** Each year, or within the last 12 months **prior to** October 15** (the start of the Medicare annual election period) upon enrollment, change in status of creditable or non-creditable status, upon request, and within 60 days of beginning of each Plan Year **If this notice is distributed to all covered individuals (rather than just Medicare Part D eligible individuals) by this due date, the plan is relieved of the requirement to also distribute the notice to covered individuals who first become eligible for Medicare coverage during the year.*

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Summary Annual Report (SAR) * An annual statement in narrative form that summarizes the latest annual report (Form 5500) for the plan.	Employer must distribute the SAR to all **participants** in any plan that files Form 5500 within the required time period.	Employees must receive the SAR **within 9 months** after end of Plan Year, **or 2 months** after due date for filing Form 5500 with extension.
HIPAA Notice of Privacy Practices* Notice of how a covered entity may use and disclose PHI (protected health information) about the individual, as well as his or her rights and the covered entity's obligations with respect to that information.	Employer or insurer must distribute to all **participants** within the required time period. - (Notice to the covered participant is deemed to provide notice to his or her covered dependents.)	At the time of **enrollmen**t for new employees, upon request, within **60 days** of a material change to the Notice, and no less frequently than **every three years.**
Notice of Exchanges* Information about health care coverage options through the health Exchanges, including: • services provided • eligibility for tax credit • minimum value • loss of tax-free employer contribution	Employer must distribute to **ALL employees** regardless of their full-time or part-time status and regardless of whether they are enrolled in the plan. Separate notices for dependents or other individuals who are or may become eligible for coverage are not required.	Within **14 days** of employee's start date.
Notice regarding Premium Assistance under Medicaid or Children's Health Insurance Program Reauthorization Act (CHIPRA) * Employee notification about any premium assistance program subsidy under Medicaid or CHIP available in the state where the employee resides.	Employer must distribute to **All employees**, whether or not a Participant who reside in a state in which medical premium assistance is available	At the time of **initial enrollment** and on the **first day** of each Plan Year thereafter.
Notice of Special Enrollment Rights under HIPAA and CHIPRA* A notice describing the group health plan's special enrollment rules, including the right to a special enrollment within 30 days of the loss of other coverage, gaining a new dependent through marriage, birth, adoption or placement for adoption, or within 60 days of the loss of coverage under a Medicaid plan or CHIP, or within 60 days of becoming eligible for premium assistance under Medicaid or CHIP.	Employer must distribute to **ALL employees** eligible to enroll in a group health plan	At or before the time an employee is initially offered the opportunity to enroll in the group health plan
Women's Health and Cancer Rights Act (WHCRA) Notice* Describes required benefits for mastectomy- related reconstructive surgery, prostheses, and treatment of physical complications of mastectomy.	Employer must distribute to ALL **participants**	Upon enrollment and **annually** thereafter.

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IRS 6056--Form 1095-C Employer Provided Health Insurance Offer and Coverage for Employers with 50+ employees. Reports information about health insurance coverage offered and any safe harbors or other relief available to the employer, or reports that no offer of coverage was made. Helps the IRS determine if your organization potentially owes an employer shared responsibility payment to the IRS. Helps the IRS determine whether your full-time employees and their dependents are eligible for the premium tax credit.	Employer must distribute to all full time employees and must file with IRS.	Provided to full-time employees by 1/31 to use when filing their tax returns. Provided to IRS by 2/28 (3/31 if done electronically). In 2016, for the 2015 plan year, these dates were delayed. The 1095 to employees is due 3/31/16. Provided to the IRS by 5/31/16 (6/30/16 if done electronically.)
IRS 6056--Form 1094-C Transmittal of Employer Provided Health Insurance Offer and Coverage Information Returns Provides a summary to the IRS of aggregate employer-level data. Helps the IRS determine whether an employer is subject to an employer shared responsibility payment and the proposed payment amount.	Employer must file with IRS.	Provided to IRS by 2/28 (3/31 if done electronically). In 2016, for the 2015 plan year, these dates were delayed. The 1095 to the IRS is due 5/31/16 (6/30/16 if done electronically.)
Family and Medical Leave Act (federal FMLA) Entitles eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons with continuation of group health coverage under the same terms and conditions as if the employee had not taken leave. Applicable to all private sector employers with 50 or more employees in 20 or more workweeks in current or preceding calendar year, as well as all public agencies and all public and private elementary and secondary schools.	All covered employers are required to post a **General Notice** explaining the FMLA, including the family military leave amendments, regardless of whether they have eligible employees.	If written guidance regarding employee benefits or leave rights exists, such as in an employee handbook or benefits guide, then FMLA information regarding entitlements and obligations must be included in it as well.

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Genetic Information Nondiscrimination Act (GINA) Federal law that prohibits discrimination in health coverage and employment based on genetic information. Employers in the private sector and state and local governments that employ 15 or more employees.	All covered employers are required to post a **General Notice** explaining GINA in a conspicuous place.	
Uniformed Services Employment And Reemployment Rights Act (USERRA) DOL regulations that protect the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System.	Employers must provide USERRA Notice by posting where other employee notices are customarily posted, or provide to employees by alternate means.	
Wellness Program Disclosure* A notice that describes the terms of the wellness program, if offered, that requires individuals to meet a standard related to a health factor in order to obtain a reward. It must disclose the availability of a reasonable alternative standard or the possibility of a waiver.	Employer must distribute to **ALL participants and beneficiaries** eligible to participate in the wellness program employees	Anytime a description of the Wellness Program is distributed. (If the plan materials merely mention that a program is available, without describing its terms, this disclosure is not required.)
Initial (General) COBRA Notice* Notice of the right to purchase a temporary extension of group health coverage when coverage is lost due to a qualifying event. Applicable to employers that have 20 or more employees on more than 50% of the typical business days during the previous calendar year. Government and church plans are exempt.	Employer must distribute to all covered **employees and covered spouses** within the required time period. **A single notice may be mailed to the employee's home, addressed to both the employee and spouse (if the spouse is known to reside at that address).*	Employers must provide within **90 days** after group health plan coverage begins.
COBRA Election Notice* Notice to "qualified beneficiaries" of their right to elect COBRA coverage upon occurrence of qualifying event: employee's death, retirement, termination, reduction in hours or loss of coverage.	Employer must distribute to **all** covered **employees, spouses, and dependent children** who are qualified beneficiaries.	Employer must notify plan administrator within **30 days** of qualifying event. Plan administrator must notify employee within **14 days** after being notified by the employer of the qualifying event. If the employer is also the plan administrator, the administrator must provide the notice not later than **44 days** after: the date on which the qualifying event occurred or date loss of coverage if plan provides that COBRA starts on date of loss of coverage.

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Notice of patient protections and selections of providers* Group health plans and health insurance issuers that require designation of a participating primary care provider must permit each participant, beneficiary and enrollee to designate any available participating primary care provider (including a pediatrician for children). Group health plans and issuers that provide obstetrical/gynecological care and require a designation of a participating primary care provider may not require preauthorization or referral for obstetrical/gynecological care.	Plan administrator or issuer must provide notice to participant.	Must notify participant of new patient protections whenever the **SPD** or similar description of benefits is provided to a participant. The first notice should be provided no later than the **first day** of the first plan year.
PCORI (Patient-Centered Outcomes Research Institute) (Applicable to Self-funded/Self-Insured employers only) A fee under the Affordable Care Act applies on a plan year basis to self-funded (self-insured) plans. The amount of the fee is adjusted annually. Plan and policy years ending on or after Oct. 1, 2012 and before Oct. 1, 2019.	Self-insured employers must file IRS form 720.	Self-insured employers must submit the fee by July 31 of the year immediately following the last day of the plan/policy year.
Reinsurance Fee (Applicable to Self-funded/Self-Insured employers only) One of several new fees adjusted annually, intended to help fund implementation of the Patient Protection and Affordable Care Act (PPACA). Annual fee paid by employers on self-funded (self-insured) health plans. Calendar years 2014, 2015 and 2016.	Self-insured employers must register and report annual enrollment count to CMS.	Self-insured employers report annual enrollment count (based on the first 9 months of the year) to CMS by Nov. 15 of the benefit year, beginning on Nov. 15, 2014. Within 30 days of submission of the annual enrollment count or by Dec. 15, whichever is later, the Department of Health and Human Services (HHS) will notify the contributing entity of the Reinsurance Fee to be paid for the applicable benefit year. Payment is due within 30 days of the date of this notification.

[1]Exempt if 1) contributions by participants are forwarded by the employer within 3 months of receipt, 2) in the case of an insured plan, refunds to which contributing participants are entitled (e.g.,MLR rebates) are returned to them within 3 months of receipt by the employer, and 3) contributing participants are informed upon entry into the plan of the plan provisions concerning the allocation of refunds. (Note: the <100 small plan exemption does not exempt the employer from the requirement to furnish SPDs to participants and beneficiaries.)

*Some of the items specifically asked for in DOL audit letter