DISCLOSURE REQUIREMENTS FOR HEALTH & WELFARE PLANS

Mav 2022

A quick reference tool for common ERISA reporting and disclosure requirements for Health and Welfare plans.

NOTE: many of the due dates in this document have been extended as a result of Covid-19. See the last page for links to the guidance.

ERISAdiagnostics, Inc.

ERISA diagnostics, Inc.

Health & Welfare Plan Reporting and Disclosure Guide

(Plans Subject to Title I of ERISA).

This material is for the sole purpose of providing general information and does not under any circumstances constitute legal advice. You should seek the advice of counsel when applying the requirements to your plans.

This document is intended to be a guide, a quick reference for you as you try to comply with the myriad of regulatory requirements. The last column of the chart will help you as you asses your state of compliance by documenting who is responsible for the various requirements listed

.

Contents

ERISA diagnostics, Inc.

Health & Welfare Plan Reporting and Disclosure Guide
(Plans Subject to Title I of ERISA)

This material is for the sole purpose of providing general information and does not under any circumstances constitute legal advice. You should seek the advice of counsel when applying the requirements to your plans.

What	When	To Whom	Notes
Plan Documents under which the plan is operated	▪ Copies must be furnished no later than 30 days following written request ▪ Made available at principal office and certain other locations.	Participants and beneficiaries	*Plan documents maintained by (indicate whom)* *Plan documents last updated (indicate date)*
Summary Plan Description (SPD)	▪ Within 120 days of plan becoming subject to ERISA ▪ Within 90 days of becoming a participant or beneficiary ▪ Updated SPDs must be distributed every five years if changed or every 10 years if no changes (see our Compliance Cue Card – DOL and Electronic Communication)*	▪ Plan participants ▪ Beneficiaries receiving benefits	*Keep track of when, how and by whom the SPD was distributed.*
Summary of Material Modifications (SMM)	No later than 210 days after the end of the Plan year in which the change is adopted	▪ Plan participants ▪ Beneficiaries receiving benefits	
Summary of material reduction in covered services or benefits	Generally, within 60 days of adoption of material reduction in group health plan services or benefits.	Participants and beneficiaries'	
Form 5500	Required for plans with 100 participants at the beginning of the ERISA plan year. The plan year is defined in the plan document and should not be confused with the policy year. The Form 5500 is due 7 months after the end of the ERISA plan year. A 2 ½ month extension can be obtained by filing Form 5558.	DOL	

ERISA diagnostics, Inc.

Health & Welfare Plan Reporting and Disclosure Guide
(Plans Subject to Title I of ERISA)

This material is for the sole purpose of providing general information and does not under any circumstances constitute legal advice. You should seek the advice of counsel when applying the requirements to your plans.

What	When	To Whom	Notes
Summary Annual Report (SAR)	Within 9 months after the end of the Plan year or 2 months after filing the Form 5500.	Participants and beneficiaries receiving benefits	
Form M-1 (MEWA)	A Multiple Employer Welfare Arrangement (MEWA) must file Form M-1 no later than the March 1 following any calendar year for which a filing is required. More information regarding MEWAs can be found on the DOL website.	DOL	
Form 8928	Form 8928 must be filed by group health plans, plan sponsors or plan administrators who: • fail to provide the required level of pediatric vaccine • fail to comply with certain HIPAA requirements • fail to make comparable Archer medical savings account contributions • fail to make comparable HSA contributions Form 7004 must be filed to obtain the extension. This reporting requirement was effective January 1, 2010. More information regarding Form 8928 can be found at the IRS website.	IRS	
Notices			
CHIPRA	The Notice is required to be provided on an annual basis. The Model CHIP Notice can be found at the DOL website.	Typically included in open enrollment material	

ERISA diagnostics, Inc.

Health & Welfare Plan Reporting and Disclosure Guide
(Plans Subject to Title I of ERISA)

This material is for the sole purpose of providing general information and does not under any circumstances constitute legal advice. You should seek the advice of counsel when applying the requirements to your plans.

What	When	To Whom	Notes
Initial COBRA notice	Within 90 days of the later of the date plan coverage begins or the first date the plan becomes subject to COBRA. Generally, employers with more than 20 employees are subject to COBRA.	Participants and spouses	
COBRA election notice	▪ Employer must notify plan administrator within 30 days of employee's death, retirement, termination, reduction in hours or date of loss of coverage ▪ Plan administrator must notify employee within 14 days after being notified of the qualifying event Note: if employer and plan administrator are the same, the notice requirement is 44 days.	Plan administrator and affected employee	
COBRA premium insufficiency	Upon insufficient premium.	Affected former participant/beneficiary	
Notice of Unavailability of COBRA	If applicable, within 14 days after the plan administrator receives a notice of a qualifying event.	Affected former participant/beneficiary	
COBRA early termination	As soon as possible following any termination of COBRA coverage that will occur before the maximum period of COBRA coverage.	Affected former participant/beneficiary	
HIPAA Privacy Notice	▪ at the time of enrollment for new enrollees ▪ upon request ▪ within 60 days of a material change to the Notice ▪ no less frequently than once every 3 years.	Participants and new enrollees	

ERISA diagnostics, Inc.

Health & Welfare Plan Reporting and Disclosure Guide
(Plans Subject to Title I of ERISA)

This material is for the sole purpose of providing general information and does not under any circumstances constitute legal advice. You should seek the advice of counsel when applying the requirements to your plans.

What	When	To Whom	Notes
HIPAA notice of special enrollment rights	On or before the time an employee is offered an opportunity to enroll in the group health plan. Effective 4/1/2009, CHIPRA added an additional special enrollment opportunity). Sample Notice can be found DOL website.	Participants	
Breach Notifications for unsecured PHI	Within 60 days of discovery (media notice is also required if breach affects more than 500 residents of a state or jurisdiction).	Each affected individual	
NHMPA (Newborn's Act)	Include in SPD/SMM; SPD/SMM timeframes applicable. Sample Notice can be found DOL website.	Participants	*Included in SPD*
Wellness Program disclosures (potentially two notices)	The Americans with Disabilities Act (ADA) requires an employee health program that includes disability related inquiries or medical examinations, even if included in a health assessment, and collect employee health information to provide a notice to employees. The notice must inform employees of what information will be collected, how it will be used, who will receive it, and what will be done to keep it confidential. The EEOC has published a sample notice to help employers comply with the ADA as well as FAQs. **Notice of reasonable alternative standards.** For group health plans offering a wellness program that requires an individual to satisfy a standard related to a health factor, a notice describing a reasonable alternative must be provided. The DOL has a wellness disclosure which can be found at the DOL website	Employees	

Health & Welfare Plan Reporting and Disclosure Guide
(Plans Subject to Title I of ERISA)

This material is for the sole purpose of providing general information and does not under any circumstances constitute legal advice. You should seek the advice of counsel when applying the requirements to your plans.

What	When	To Whom	Notes
Women's Health and Cancer Rights Act notice (WHCRA)	▪ Upon enrollment ▪ Annually Sample notice can be found at the DOL website	Participants	*Included in new employee orientation kit and annual open enrollment and in SPD*
Medical Child Support Order (MCSO)	▪ Upon receipt of MCSO, administrator must issue notice including procedures for determining qualified status. ▪ Notice regarding qualified status	Affected participant	
National Medical Support Notice (NMS)	▪ Employer must send Part A to the State agency or Part B to the plan administrator within 20 days after the date of the notice or sooner if reasonable. ▪ Administrator must notify affected persons of receipt of the notice and procedures for determining qualified status. ▪ Within 40 business days after its date or sooner, administrator must return Part B to the state agency and provide information to affected persons.	As required	
Medicare Part D Creditable Coverage Notice to participants	▪ Before the beginning of Medicare Part D annual enrollment period ▪ Before an individual is first eligible for Medicare Part D ▪ Before the effective date of coverage for any Medicare eligible individual that joins the plan ▪ Whenever prescription drug coverage ends or changes so that it is no longer creditable or becomes creditable ▪ Upon request Sample Notice may be found at CMS.gov	Affected participants	

ERISA diagnostics, Inc.

Health & Welfare Plan Reporting and Disclosure Guide
(Plans Subject to Title I of ERISA)

This material is for the sole purpose of providing general information and does not under any circumstances constitute legal advice. You should seek the advice of counsel when applying the requirements to your plans.

What	When	To Whom	Notes
Medicare Part D report to CMS	At a minimum, disclosure to CMS must be made at the following times: ▪ Within 60 days after the beginning date of the plan year for which the entity is providing the disclosure to CMS. ▪ 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	CMS	
Michelle's Law	For group health plans that *cover dependents 26 years of age or older on the basis of student status*, provide notice when medical leave begins or when notice of student status is required.	Participants	
Notice of a Group Health Plan's exemption from the MHPA	A group health plan can claim an exemption from the Mental Health Parity Act requirements if the plan's costs increase one percent or more due to the application of MHPA's requirements. DOL has provided a sample notice. Note: Other disclosures (e.g., criteria for medically necessary determination, claims denial notice) must be provided upon request. Refer to the DOL website for more information.		
Mental Health Parity and Addiction Equity Act (MHPAEA)	MHPAEA generally applies to group health plans and health insurance issuers that provide coverage for either mental health or substance abuse disorders and medical/surgical benefits. The DOL website contains significant guidance. The Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA) should help you assess MHPAEA compliance.		
Individual Coverage HRA (ICHRA)	Applies to employers who offer ICHRAs (new for 2020). The notice must be provided 90 calendar days before the beginning of each plan year to eligible participants. A model notice can be found at the DOL website.	Participants	

This material is for the sole purpose of providing general information and does not under any circumstances constitute legal advice. You should seek the advice of counsel when applying the requirements to your plans.

What	When	To Whom	Notes
Individual Coverage HRA (ICHRA) substantiation	The HRA must establish reasonable procedures to substantiate that participants and dependents covered by the HRA are or will be enrolled in individual health coverage. In addition, the participant must substantiate for each reimbursement request that expenses were incurred. A model notice can be found at the DOL website.		
Health Care Reform			
Grandfather Notice	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. A model notice can be found at the DOL's website.	Participants and beneficiaries receiving benefits	*Indicate whether recent plan changes resulted in loss of grandfather status*
Patient Protection Notice	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. 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, or in the individual market, provides a primary subscriber with a policy, certificate, or contract of health insurance. A patient protection model notice can be found at the DOL's website.	Participant	

ERISA diagnostics, Inc.

Health & Welfare Plan Reporting and Disclosure Guide
(Plans Subject to Title I of ERISA)

This material is for the sole purpose of providing general information and does not under any circumstances constitute legal advice. You should seek the advice of counsel when applying the requirements to your plans.

What	When	To Whom	Notes
Claims and Appeals Model Notices	PPACA requires both an internal and external review process; these rules are applicable for non-grandfathered plans. Model notices can be found at the DOL's website https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/internal-claims-and-appeals	Participant	
Summary of Benefits and Coverages (SBC)	The SBC is a standalone document in addition to the summary plan description and SMMs. Typically provided during open enrollment for current employees; prior to enrollment for new employees; within 7 business days upon request. The latest SBC template, instructions and related materials can be found on the DOL website.	Annually to plan participants and beneficiaries.	
Summary of Material Modification (SMM)	Required if a group health plan or issuer makes any material modification in any of the terms or coverage involved that is not reflected in the most recent Summary of Benefits and Coverage. The plan or issuer must provide a notice of the modification to enrollees not later than 60 days before the modification becomes effective.	Participants and beneficiaries.	
Notice to Employees of Coverage Options (Notice of Exchanges)	The Affordable Care Act requires employers subject to the FLSA to notify employees of the existence of Exchanges as well as other information. The notice must be provided to new employees with 14 days of their start date. Model Notices are available on the DOL website.	New hires.	

This material is for the sole purpose of providing general information and does not under any circumstances constitute legal advice. You should seek the advice of counsel when applying the requirements to your plans.

What	When	To Whom	Notes
Rescission Notice	A 30-day advance notice must be provided to a participant if coverage is cancelled retroactively due to fraud or intentional misrepresentation.	Participants and beneficiaries.	
ACA §1557 Nondiscrimination Notice	Applies to any health program or activity which receive Federal financial assistance. FAQs can be found at the HHS website. A model notice is available. Consult counsel if you believe it applies to your organization.		
PCORI Comparative Effectiveness Research fee	The Affordable Care Act established the Patient-Centered Outcomes Research Institute funded by the Patient-Centered Outcomes Research Trust Fund. The Trust Fund is to be funded in part by fees to be paid by issuers of health insurance policies and sponsors of self-insured health plans. Form 720 - Quarterly Federal Excise Tax Return must be filed annually by the July 31 of the calendar year immediately following the last of policy/plan year to which fees apply. FAQs can be found on the IRS website.	Filed with government by the insurer in the case of insured plans or the employer in the case of self-insured plans.	

This material is for the sole purpose of providing general information and does not under any circumstances constitute legal advice. You should seek the advice of counsel when applying the requirements to your plans.

What	When	To Whom	Notes
1095-B &1094-B ACA §6055 Minimum Essential Coverage Information Reporting	Enables the individual to prove and the IRS to verify the existence of individual coverage. Proposed regulations issued December 6, 2021 would permanently extend the due date for furnishing statements to individuals to March 2 but retained the due date for filing with the IRS. (February 28 if filed on paper or March 31 if filed electronically). Good faith relief no longer applies. For a quick reference, see our compliance cue card.	Provided to participants by insurance company in the case of insured plans; employer in the case of self-insured plans	
1095-C & 1094-C ACA §6056 Health Insurance Coverage Reporting by Applicable Large Employers (ALE)	Requires insurers, employers with self-insured plans and others to report health coverage information including the availability of minimum value health coverage. Proposed regulations issued December 6, 2021 would permanently extend the due date for furnishing statements to individuals to March 2 but retained the due date for filing with the IRS. (February 28 if filed on paper or March 31 if filed electronically). Good faith relief no longer applies. Four a quick reference, see our compliance cue card.	Provided to participants by the Applicable Large Employer	
Space reserved for future guidance			

This material is for the sole purpose of providing general information and does not under any circumstances constitute legal advice. You should seek the advice of counsel when applying the requirements to your plans.

Consolidated Appropriations Act - NOTE we strongly recommend that you consult with counsel, your provider and refer frequently to government websites for potential updates https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs http://www.cms.gov/cciio/resources/fact-sheets-and-faqs/index.html			
What	**When**	**To Whom**	**Notes**
Pharmacy Benefits and Drug Costs	Extensive information regarding Pharmacy benefits and costs. Filing due date is the June 1 however Initial filing dates extended to December 27, 2022 for both the 2020 and 2021 plan years. See https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf	Provided by plans and issuers to the government.	

This material is for the sole purpose of providing general information and does not under any circumstances constitute legal advice. You should seek the advice of counsel when applying the requirements to your plans.

No Surprises Act – We have not included all the requirements of the No Surprises Act. NOTE we strongly recommend that you consult with counsel, your provider and refer frequently to government websites for potential updates https://www.cms.gov/nosurprises/policies-and-resources/overview-of-rules-fact-sheets https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act			
Who	**What**	**To Whom**	**Notes**
Transparency in Coverage (TiC)	The Transparency in Coverage Final Rules (the TiC Final Rules) require non-grandfathered group health plans and health insurance issuers offering non-grandfathered coverage in the group and individual markets to disclose on a public website information regarding in-network provider rates for covered items and services, out-of-network allowed amounts and billed charges for covered items and services, and negotiated rates and historical net prices for covered prescription drugs in three separate machine-readable files. The machine-readable file requirements of the TiC Final Rules are applicable for plan years (in the individual market, policy years) beginning on or after January 1, 2022. Enforcement deferred to July 1, 2022.	Posted on Public Website	
Price Comparison Tools	The TiC Final Rules require plans and issuers to make price comparison information available to participants, beneficiaries, and enrollees through an internet-based self-service tool and in paper form, upon request. This information must be available for plan years (in the individual market, policy years) beginning on or after January 1, 2023, with respect to the 500 items and services identified by the Departments in Table 1 in the preamble to the TiC Final Rules,[5] and with respect to all covered items and services, for plan or policy years beginning on or after January 1, 2024.	Available to participants, beneficiaries and enrollees through an internet-based self-service tool and in paper upon request.	

This material is for the sole purpose of providing general information and does not under any circumstances constitute legal advice. You should seek the advice of counsel when applying the requirements to your plans.

Model Notice Regarding Patient Protections Against Surprise Billing	For plan years beginning on or after January 1, 2022, each group health plan and health insurance issuer offering group health insurance coverage shall make publicly available, post on a public website of such plan or issuer, and include on each explanation of benefits for an item or service with respect to which the requirements under ERISA section 716 applies https://www.cms.gov/httpswwwcmsgovregulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10780	Public website and included in explanation of benefits.	
Air Ambulance Reporting	Claims data related to air ambulance services with respect to a group health plan to be furnished by the service provider. ERISA Section 723	To the government; awaiting further guidance	
Continuation of Care	"Continuing Care" patient must be notified if the contract with the provider or facility terminates.	Continuing care patients	
ID cards	ERISA Section 716(e) A group health plan or a health insurance issuer offering group health insurance coverage and providing or covering any benefit with respect to items or services shall include, in clear writing, on any physical or electronic plan or insurance identification card issued to the participants or beneficiaries in the plan or coverage the following: Any deductible applicable to such plan or coverage: any out-of-pocket maximum limitation applicable to such plan or coverage; a telephone number and Internet website address through which such individual may seek consumer assistance information, such as information related to hospitals and urgent care facilities that have in effect a contractual relationship with such plan or coverage for furnishing items and services under such plan or coverage	Participants	

*The DOL issued another safe harbor for electronic communication; we will be preparing a Compliance Cue Card soon!

ERISA diagnostics, Inc.

Health & Welfare Plan Reporting and Disclosure Guide
(Plans Subject to Title I of ERISA).

This material is for the sole purpose of providing general information and does not under any circumstances constitute legal advice. You should seek the advice of counsel when applying the requirements to your plans.

ERISAdiagnostics, Inc. believes that it is crucial to apply a risk management process to your employee benefit programs. The risk management rocess is just that, a process that begins by asking some basic questions:

- Do you have plan documents and summary plan descriptions for your ERISA plans?
- Are they up to date? Do they satisfy DOL requirements?
- Do you have contracts in place with your plan providers? (TPA's, recordkeepers, etc.)
- Are the terms of plans followed in operation?
- Do the key players understand and fulfill their roles?

ERISAdiagnostics, Inc. can help you with your benefit compliance challenges, allowing you more time to focus on your business. Our ERISA experience is extensive and in-depth at the corporate level, as well as with the Big 5 national accounting firms, consulting firms, law firms, and government agencies.

We hope you find this guide helpful!

Mary B. Andersen, CEBS, ERPA, QPA
maryandersen@erisadiagnostics.com
610-524-5351

ERISA diagnostics, Inc.

Health & Welfare Plan Reporting and Disclosure Guide
(Plans Subject to Title I of ERISA).

This material is for the sole purpose of providing general information and does not under any circumstances constitute legal advice. You should seek the advice of counsel when applying the requirements to your plans.

Changes to the due dates in this guide due to COVID-19

Many of the dates for various notices, filings, claims procedures have been changed by Covid-19.

The DOL has established a website page "Response to COVID-19" which can be accessed at this link https://www.dol.gov/agencies/ebsa/coronavirus

The IRS has established a website page "Coronavirus Tax Relief for Health Plans and Retirement Plans" which can be accessed at this link https://www.irs.gov/coronavirus/coronavirus-tax-relief-for-health-plans-and-retirement-plans

We recommend that you check the government websites frequently in case there are more changes.