CRC BENEFITS

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Workplace Benefits
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Notices, Filings, Documents + Testing for Group Benefits

This guide is to help you and your clients with the required federal annual notices distribution to employees, employer filings, plan documents, and nondiscrimination testing for group-sponsored benefit plans. There are several notices that require prominent placement, which are indicated in the table below.

Certain notices and documents may require customization; it is important to ensure the proper information about the plan is inserted into those particular sections of the notices or documents.

LANGUAGE REQUIREMENTS

The ACA requires group health plans and health insurance issuers to provide certain services and notices in a "culturally and linguistically appropriate manner." Specifically, they are required to provide: (1) oral language services (such as a telephone assistance hotline) that include answering questions and providing assistance with filing claims and appeals in any "applicable" non-English language; (2) certain notices in any applicable non-English language, upon request; and (3) in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the plan or issuer (so-called "taglines").

For this purpose, a language is an "applicable" non-English language if at least 10% of the population residing in the participant's or beneficiary's county is literate only in the same non-English language, as determined by the United States Census Bureau. This information can be accessed at: https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/clas-county-data-2023.pdf

Only certain notices are required at this time to be available in non-English languages; however, employers are encouraged to make as many notices and documents available in other languages so that employees may better understand their benefits plans and rights under the law. The notices that must be made available currently are: the Summary of Benefits & Coverages (SBC), the Uniform Glossary, and the model notices for internal claims and appeals, and external review.

*Review—This can be used as a checklist to review which notices, documents, and/or filings apply and can be indicated in the first column. For example, items not applicable to the group may be indicated with N/A, items that apply and are completed may be indicated with a check mark or Y, and items that apply but need to be done may be indicated with an X.

REQUIRED NOTICES

Review*	Disclosure Type	Applicable To	Content	Link to Notice/Template, or Sample Wording	Timing
	Summary of Benefits and Coverages (SBC)	All Group Health Plans (*Provided by Insurance Carrier, ASO/TPA, or employer)*	• Must be prominently placed • This template describes the benefits and coverages under a plan • The SBC must include a web address for the Uniform Glossary (see below) • Contact Information must be included to obtain a paper copy	• Click **here** for more information.	• Provided to enrollees with enrollment materials (new or renewal) • Special period enrollees within 90 days from enrollment • 60 days prior to off-renewal changes • Upon request within 7 days
	Uniform Glossary	All Group Health Plans	• Should be placed after the SBC	• Click **here** for more information.	• Same as the SBC
	Medicare Part D Notice + Disclosure to CMS	All Group Plans Offering Prescription Coverage	• Should be placed after the SBC and Uniform Glossary, must be prominent • Insurance Carriers should provide determination whether the Rx benefits meet or do not meet the Medicare Part D requirements • Notice must be provided to all Medicare-eligible individuals, including spouses and dependents • Updated employee counts should be remitted to the appropriate carriers at least annually.	• Templates are available for both Creditable and Non-Creditable **here**. • Online disclosure is **here**.	• Prior to October 15th each year • When a Medicare-eligible person is eligible to enroll in the group plan (including open enrollment), including those eligible due to disability • Employer online disclosure to CMS no later than 60 days after the start of the plan year, or within 30 days after a change or term in Rx coverage if done mid-plan year
	Premium Assistance under Medicaid or CHIP	Group Health Plans in a state where Medicaid or CHIP programs may provide premium assistance for group health plan coverage	• Opportunities for State assistance under CHIP or Medicaid for health coverage, for the employee, spouse, and/or dependents • How to contact the State for additional information and how to apply	• Click **here** for more information.	• Initial enrollment materials, annual open enrollment information, or the Summary Plan Description (SPD)
	HIPAA Notice of Special Enrollment Rights	All Group Health Plans	• Notification of HIPAA Special Enrollment Rights for certain qualifying events	• Click **here** for more information.	• At or before initial offer of coverage
	Marketplace Notice	All employers subject to the Fair Labor Standards Act	• Information to employees regarding the existence of the Marketplace, potential tax credits, and that employees lose employer contributions if they purchase a Marketplace plan.	• Click **here** for more information.	• Within 14 days of hire, whether eligible for coverage or not

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	HIPAA Notice of Privacy Practices	All Group Health Plans	• Description of individuals' rights with respect to their personal health information and the privacy practices of the plan	• Click **here** for more information. *(See NPP Health Plan Files section which has multiple formats/ languages to use)*	• At or before the initial offer of coverage • Revised notice within 60 days of a material revision • Provide contact information to obtain a copy, including once every three years
	USERRA (Uniformed Services Employment and Reemployment Rights Act)	All Group Health Plans	• Notification for reemployment rights to those who have been absent due to service in the uniformed services, such as active duty, National Guard, and other duties related to service	• Click **here** for more information.	• Posting where employee notices are customarily placed • May include in enrollment materials or other distributions
	GINA (Genetic Information Nondiscrimination Act)	All Employers with 15 or more employees	• Provide information on employer processes regarding requests for genetic information (for example, a wellness plan), or a statement that no genetic information should be provided • Genetic information cannot be used in any employment decisions	• See end note below for sample wording regarding that no genetic information should be provided [i]. • If offering wellness plan that may require notice, seek legal advice for wording	• At or before initial offer of coverage
	Michelle's Law	All Group Health Plans	• Description of continued coverage during medically necessary leaves of absence for students.	• See end note below for sample wording. There is no model notice for this law [ii].	• Within 90 days of initial plan enrollment. • If certification of student status is required for coverage under a plan, a notice must be given with any request for the documentation within one year, or when coverage will terminate. • These provisions are only valid in states where coverage may be extended beyond the age of 25.

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	Hospital Stays in Connection with Childbirth	Group health plans that include benefits for maternity or newborn infant coverage	• Statement describing any requirements related to any hospital length of stay in connection with childbirth for a mother or newborn child, in accordance with federal or state laws, as applicable. • If federal or state laws apply in different areas in which the plan operates, a description must contain which law applies in each area.	• Click **here** for more information.	• Details provided In the ERISA SPD or SPD WRAP • Can be included in the SMM

	WHCRA enrollment notice	Group health plans that provide coverage for mastectomy benefits	• For participants/beneficiaries receiving mastectomy-related benefits, a statement that coverage will be provided as determined in consultation with the attending physician for the patient, for:
			  • All stages of reconstruction of the breast where the mastectomy was performed;
			  • Surgery and reconstruction of the other breast to produce a symmetrical appearance;
			  • Prostheses;
			  • Treatment of physical complications of the mastectomy, including lymphedema.
			• Description of copays, deductibles, coinsurance and out-of-pocket limitations applicable to the coverage.
				• Click **here** for more information.	• Initial enrollment in the plan

	WHCRA annual notice	Group health plans that provide coverage for mastectomy benefits	• Same as above, or • Simplified disclosure of the availability of benefits for the four required coverages and how to obtain a detailed description for those.	• Click **here** for more information.	• Annually, at open enrollment or other special enrollment period

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	Designation of a Primary Care Provider	All non-grandfathered group health plans	• If the plan requires a designation of a primary care provider, notice must be given regarding the terms of the plan participants' rights to designate any participating provider who is available to accept the participant • If a child, any participating physician who specializes in pediatrics • Referrals and authorizations may not be required for OB/GYN care by a participating OB/GYN specialist	• Click **here** for more information.	• Details provided In the ERISA SPD or SPD WRAP • May also be provided in other similar descriptions of benefits

	Internal Claims and Appeals and External Review Notices	All non-grandfathered group health plans	• Plans must provide notice of adverse benefit determinations and notice of final internal adverse benefit determinations for the Internal Claims and Appeal provisions
			• External review falls into either the federal or a state process:
			  • For plans following the federal independent review organization (IRO) process, , a notice of final external review decisions must be issued.
			  • For state processes, the state office administering the external appeals process must issue a notice of final external review decisions.
				• Click **here** for more information.	• Language required in the SPD.
					• Notice times will vary based on the type of claim and whetherstate or federal processes apply.

	External Review Process Disclosure	All non-grandfathered group health plans	• Description of the external review process must be provided in the ERISA SPD, policy, certificate of coverage, or other evidence of coverage provided to enrollees, participants, or beneficiaries of the plan.	• Click **here** for more information.	• Details provided in the ERISA SPD or SPD WRAP. • May also be provided in other similar descriptions of benefits.
	Nondiscrimination and Accessibility Statement (§1557)	All group health plans	• Provides notice of nondiscrimination based on multiple factors, as well as language accessibility for disabilities and those whose primary language is not English.	• Click **here** for more information.	• At initial enrollment • Provided annually (open enrollment), or upon request

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	Mental Health Parity and Addiction Equity Act (MHPAEA) Criteria for Medically Necessary Determination Notice	All group health plans subject to MHPAEA	• Provide criteria for medically necessary determinations regarding mental health/substance use disorder benefits.	• Appeal Form **here**.	• Current, potential enrollee, or contracting provider upon request
	MHPAEA Claims Denial Notice	All group health plans subject to MHPAEA	• Reason for denial of claims payment for services for mental health/substance use disorder benefits.	• Appeal Form **here**.	• Upon request, or upon claims denial • As required by other laws
	MHPAEA Increased Cost Exemption	Group health plans claiming a cost exception under MHPAEA	• Notification to plan participants and beneficiaries that the increased cost exemption is being utilized.	• Click **here** for more information.	• At initial enrollment • At renewal or when a change occurs • The DOL must be notified • State agencies may also require notification
	No Surprises Act	All group health plans	• Provides information on surprise billing laws at the state and federal levels.	• Click **here** for more information. • Optional educational piece for consumers **here**.	• Initial enrollment • Open enrollment • Must post notice on plan website • Carriers must include notice of rights and protections on EOBs
	CAA Broker Disclosure	Broker Disclosure to Plan Sponsor for all group health plans described here (medical, dental, vision)	• Agents/Brokers/Consultants who reasonably expect to annually receive at least $1,000 in direct or indirect compensation must disclose their compensation. • Agents/Brokers/Consultants may indicate compensation via a formula versus a dollar amount. For example, if earning 4% commission, or $34 per employee per month, then that formula may be indicated on the disclosure.	• Click **here** for more information.	• Annually, in advance of entering into a contract or agreement for services, unless a multi-year agreement is in place • Potential bonus or other incentive compensation must also be disclosed to the plan sponsor, with a secondary notice disclosed after receipt of any bonus/incentive(s) pro-rated for each applicable client
	HIPAA Business Associate Agreements (BAA)	Agent/Broker and plan sponsor agreement for all health-related benefits coverage (including dental and vision)	• Agents/Brokers must provide an employer with a BAA before a plan sponsor may share Protected Health Information (PHI). • The agreement is to ensure the Agents/Brokers will appropriately safeguard the PHI received and only disclose or use PHI for permissible purposes.	• While there is a model notice on the Department of Health & Human Services website, it is best to review the document with legal counsel **here**.	• A signed agreement by both parties should be received prior to sharing of Protected Health Information. • A revised agreement should be prepared and signed if any law changes occur.

DISTRIBUTION OF NOTICES, AS APPLICABLE

Review*	Disclosure Type	Applicable To	Content	Link to Notice/Template, or Sample Wording	Timing
	Grandfathered Plan Notice	All grandfathered health plans	• Disclosure that the plan is claiming grandfathered status Must include contact information for the plan.	• Click **here** for more information.	• Included in plan materials that describe the benefits or health coverage. • Initial enrollment • Open enrollment or when any changes occur.
	COBRA General Notice	All employers subject to COBRA. **Note**: for State Continuation, notices may also be required. Check with your state laws for these requirements.	• Notice of rights to continue coverage under the group plan as contained in federal law. • Generally applies to employers with 20 or more employees. • Updated employee counts should be remitted to the appropriate carriers at least annually.	• Click **here** for more information. • For state continuation, see our guide **here**.	• Within the first 90 days of coverage • May be in enrollment materials
	COBRA Election Notice	All employers subject to COBRA **Note**: For state Continuation, notices may also be required. Check with your state laws for these requirements.	• Election notice for continuation of coverage as contained in federal law. • Generally applies to employers with 20 or more employees.	• Click **here** for more information. • For state continuation, see our guide **here**.	• Employer must notify plan administrator within 30 days. • Plan Administrator must notify the Qualified Beneficiary within 14 days.
	COBRA Notice of Unavailability	All employers subject to COBRA **Note**: for State Continuation, notices may also be required. Check with your state laws for these requirements.	• If the plan determines the request for continuation of coverage is not available under the law, a notice must be sent to the requestor detailing the denial of, and unavailability for, the continuation request.	• No model notice is provided by the DOL. However, if using a COBRA administrator, they will have a notice to use in this situation.	• Plan must notify of the unavailability of coverage within 14 days after the request is received.

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	COBRA Notice of Early Termination	All employers subject to COBRA **Note**: State Continuation, notices may also be required. Check with your state laws for these requirements.	• If continuation is to be discontinued for a valid reason specified under the law, then notice must be sent to the continuant as soon as practicable, with the description of when the coverage will terminate, the reason for the termination, and any right the qualified beneficiary may have under the plan or applicable law.	• No model notice is provided by the DOL. However, if using a COBRA administrator, they will have a notice to use in this situation.	• Plan must notify of the early termination of the coverage as soon as practicable.
	COBRA Notice of Insufficient Payment	All employers subject to COBRA **Note**: State Continuation notices may also be required. Check with your state laws for these requirements.	• Plans may terminate continuation coverage if full payment is not received before the end of a grace period (minimum grace period of 30 days). If the amount of payment is incorrect, but is not significantly less than the amount due, the plan must notify the qualified beneficiary of the incorrect amount and grant a reasonable time period to pay the difference (30 days). While a plan is not required to send monthly premium notices, they must provide notice of early termination due to a failure to make a timely payment.	• No model notice is provided by the DOL. However, if using a COBRA administrator, they will have a notice to use in this situation.	• Plan must notify of the termination of the coverage as soon as practicable.
	Wellness Program Disclosure(s)	Group health plans offering a wellness benefit. **Note:** Where a health-contingent wellness program is offered to obtain a reward, there are additional disclosure requirements, as listed.	• If health-related information is collected, the Nondiscrimination (§1557) notice is required (see information above). • If a health-contingent wellness plan is used, the HIPAA Privacy Notice referenced in the section above must be distributed. • Disclosure of availability for a reasonable alternative standard, or a potential waiver of the applicable standard. • Contact information must be included to obtain the alternative standard, along with a statement that recommendations of the person's personal physician will be accommodated.	• Click **here** for more information.	• Included in plan materials that describe the terms of the wellness program, both for activity-only and outcome-based programs. • Must be included in any disclosure that an individual did not meet the standards provided.

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	Life Insurance Portability/ Conversion Notice	All employers offering Group or Supplemental Life Insurance with a Portability or Conversion Option	• Many Life Insurance plans include a portability and/or Conversion option. • Providing these notices and forms to employees who are leaving, reduces the risks of potential lawsuits stemming from not receiving the notices.	• No model notice is provided by the DOL. However, it is best practice to send out the forms so that those leaving employment can continue their life insurance benefits at their own expense.	• While this is not a required notice, the conversion rights must be included in the Summary Plan Description (SPD) for the Life Insurance offered. The Portability and Conversion notices should be provided by the carrier, in order to make the process easier.
	Medicare Primary/Secondary	Not a Required Notice	• Generally, for groups with fewer than 20 employees, Medicare is Primary and the Group plan offered is Secondary. • Most carriers offset the claims for Medicare paying Primary, even if the person is not enrolled in Medicare. • Updated employee counts should be remitted to the appropriate carriers at least annually.	• See end note for Sample Wording. You should confirm with the carrier whether they will offset for Medicare [iii].	• This is not a required notice, however, given the large number of employers with fewer than 20 employees, this provides much needed education to those eligible for Medicare.
	Notice of Rescission	All group health plans	• Retroactive terminations of benefits is prohibited under the ACA, except in certain circumstances, such as non-payment of premiums, fraud, or misrepresentation. • If a person is enrolled in a plan that is not eligible, their coverage cannot be retroactively terminated. A notice must be sent at least 30 days in advance of the coverage termination.	• No model notice is provided. See the end note for what must be included in the notice [iv].	• Plan must notify at least 30 days in advance of rescission.
	Medical Loss Ratio Rebate (MLR)	All fully insured group health plans receiving a MLR Rebate	• The ACA requires insurance carriers to spend certain percentages of premium amounts received on medical care and quality improvement. • For small group plans, the carrier must spend 80% of the premium amounts on those items. • For large group plans, the carrier must spend 85% of the premium amounts on those items.	• Notice to employees is not required but recommended. • Check out our MLR Rebate Calculator and Guide **here**.	• Carriers must send notification by August 1 each year. • Group must distribute rebate to applicable enrollees within three months of receipt of the funds.

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	Excess Refund for Level-/Self-funded Plans	All Level-/Self-funded plans receiving a refund of excess payments	• ERISA requires amounts attributable to employee contributions to become plan assets, and as such can only be used solely for the benefit of plan participants. • The IRS Tax Code also recognizes the source of the original contribution and requires portions paid by employees to be returned on a pro rata share.	• Notice to employees is not required but recommended. • Check out our MLR Rebate Calculator and Guide **here**.	• Group must distribute refund to applicable enrollees within three months of receipt of the funds.
	Notice of Consent to Receive Plan Documents Electronically	All benefit plans where any electronic delivery method is used for any notice, plan document, etc.	• If all company employees have work-related computer access, the DOL safe harbor does not require authorization from an employee. • However, if all employees do not have work-related computer access, the DOL rules for electronic notices requires that plan beneficiaries give signed, written consent to receive notices or documents in that manner. • Plan beneficiaries may revoke the consent at any time, which must also be signed and written.	• No model language has been provided by the DOL, however, sample language is provided in the end note below [v].	• Consent must be given before any documents or notices can be sent electronically; it is best to be done at hire for that reason. • Merely posting updated information is not enough; an email or other released communication must be sent informing of the new document or notice.
	Family & Medical Leave Act (FMLA) **State Paid Family Leave/ Disability (see your state information for details on the requirements under state laws)**	All employers with 50 or more employees in 20 or more workweeks in the current or previous calendar year	• There are multiple notices that must be provided, each with its own timeframe. • A Guide for Employers is available that details when notices must be given and the process at: https://www.dol.gov/sites/dolgov/files/WHD/legacy/files/employerguide.pdf • The above-referenced guide contains other notice requirements as needed. • More Information can be found **here**. • Employers subject to FMLA (and many subject to state Paid Family Leave and/ or Disability coverage) are generally required to continue the benefits, including employer contributions.	• General Notice (available in English and Spanish) **here**.	• The General Notice should be contained in the Employee Handbook or other written materials about leave and benefits. This notice must be given to each new employee upon hire date.

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	Employer Policies and Procedures regarding Leaves of Absence/ FMLA/State Paid Family Leave/Disability	All employers of all sizes	• It is vital for employers to place their policies for leaves of absence or other benefits in writing. • This can be accomplished in either an employee handbook or within written materials about leave and benefits. • Employers can provide crucial information to an employee such as how to remit their portions of premium contributions while out on leave, what information is needed to return from leave, etc.	• There are no standard or model notices for Employer Handbooks or other written leave and benefit guides.	• Employers should distribute their Employee Handbook or other written guide to leave and benefits upon hire date. • Any changes or updates should also be distributed to employees as they are completed.

FILINGS

Review*	Disclosure Type	Applicable To	Content	Link to Notice/Template, or Sample Wording	Timing
	Patient-Centered Outcomes Research Institute Fee (PCORI)	Level-/Self-funded group health plans, Health Reimbursement Arrangements (HRAs), Medical Expense Reimbursement Plans (MERPs), Individual Coverage HRAs (ICHRAs), Qualified Small Employer HRAs (QSEHRAs), and Flexible Spending Accounts (FSAs) with employer contributions	• Self-funded employer plans must submit IRS Form 720 and the applicable fee by July 31st in the year after the plan year ends. • For example: Plans ending in 2025 will not remit the IRS Form 720 and payment until 2026. • A schedule of filing due dates and applicable rates may be found **here**. • Note that there are differing counting methods based on the type of the plan. Information can be found **here**.	• A notice to employees is not required. • IRS Form 720, click **here**. • IRS Form 720 Instructions, click **here**.	• Group must remit form and payment by July 31 in the calendar year after the plan year ends.

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	IRS 1094-B/1095-B (§6055 and §6056)	Level-/Self-funded group health plans, and Individual Coverage HRAs (ICHRAs) that are not offered by an Applicable Large Employer	• Small employers (generally, those with less than 50 Full-Time + Full-Time Equivalents) must report the coverage enrollment annually to the IRS. • Covered employees and any covered family members must be listed on the 1095-B form with the months covered being indicated on the form. • See more information regarding who must file **here**.	• 1094-B Transmittal of Coverage Information, click **here**. • 1095-B Individual Covered Information, click **here**. • Instructions for 1094-B/1095-B, click **here**.	• IRS electronic filing due date for Forms 1094-B and the 1095-Bs is March 31 annually. • Employers are no longer required to distribute the forms if they provide the required notices within the law for employees to request their form, with a 30-day window to receive the form copy. If the employer distributes the forms, they must do so by February 28.
	IRS 1094-C/1095-C (§6055 and §6056)	All Applicable Large Employers (generally 50 or more FT + FTEs), including fully insured, level-/self-funded plans, Individual Coverage HRAs (ICHRAs)	• Applicable Large Employers (ALEs — generally, those with 50 or more Full-Time + Full-Time Equivalents) must report their offer of coverage and enrollment annually to the IRS. • Generally, the reporting must contain a form for all FT employees. Reporting on PT employees is optional, but is highly recommended to include them • If self-funded, then covered employees and any covered family members must be listed on the 1095-C form with the months covered being indicated on the form in Part III. • For information regarding who must file, click **here**.	• 1094-C Transmittal of Coverage Information, click **here**. • 1095-C Individual Covered Information, click **here**. • Instructions for 1094-C/1095-C, click **here**.	• IRS electronic filing due date for Forms 1094-B and the 1095-Bs is March 31 annually. • Employers are no longer required to distribute the forms if they provide the required notices within the law for employees to request their form, with a 30-day window to receive the form copy. If the employer distributes the forms, they must do so by February 28.

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	W-2 Reporting	Employers who release 250 or more W-2s, or who offer Dependent Care Accounts (DCAPs), Health Savings Accounts (HSAs), or Qualified Small Employer HRAs (QSEHRAs)	• Employers releasing 250 or more W-2s for a calendar year must include the value of benefits provided in Box 12 using Code DD of the employee's W-2 (Employers releasing fewer than 250 W-2s are exempt from this filing requirement until the IRS releases guidance). • Employers offering Dependent Care Accounts (DCAPs) must include the amount deducted from an employee's pay in Box 10 of the employee's W-2 • Employer and Employee Health Savings Account (HSAs) contributions must be disclosed in Box 12 of the W-2, indicating Code W. • Employer contributions to a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) are required in Box 12 of the W-2 using Code FF. • Employers that release fewer than 250 W-2s are under an exemption until the IRS releases guidance.	• For more information on W-2 reporting and what must be included, see the IRS table included **here**.	• W-2s must be electronically filed with the IRS and distributed to employees no later than January 31, following the previous calendar tax year.

	Dept of Labor Form 5500	All groups offering retirement plans, no matter the size.
		All groups with 100 or more enrolled employees as of the first day of the plan year.
		All groups where plan assets are held, or if a trust is used (generally, self-funded plans).
			• Form 5500 is an informational filing only. No fees are collected.
			• Information includes plan enrollment, annual premium, compensation paid, and other general data.
			• Insurers should provide a Schedule A or Schedule A information to the plan sponsor.
			• The filing must be done electronically.
			• If previous year Form 5500 filings were not done, the Delinquent Filer Voluntary Compliance Program should be considered.
			  • Delinquent Filer Voluntary Compliance Program
			  • IRS penalty relief for DOL DFVC filers of late annual reports
				• The DOL Form 5500 Series website has links to the current and prior year forms **here**.
				• DOL EFAST2 filing system **here**.
					• DOL Form 5500 must be filed by the end of the seventh month after the plan year ends.
					• For calendar year plan years, the deadline is July 31.
					• Your plan year ends on _____ (month/year), and your filing deadline will be the end of _____ (month/year).

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	Dept of Labor Form M-1	All Multiple Employer Welfare Arrangements (MEWAs). **IMPORTANT NOTE:** Under federal guidance, if a plan allows any non-employee (for example, a subcontractor receiving a 1099) to be eligible or enroll in the plan, under federal guidance, the plan is defined as MEWA and must file Form M-1.	• The Form M-1 contains plan entity general information, including contact information, agent or promoter information, actuary contact information, TPA, stop loss coverage, and other compliance information. • No fees are collected for this filing. • Certain entities operating a MEWA may require audited plan financial statements.	• The DOL Form M-1 web page contains information and a place to login **here**.	• The MEWA must file the M-1 30 days prior to beginning to operate in a state. • The MEWA must file within 30 days for expansion into any other state if a merger with another MEWA occurs, the number of employees currently covered grows to at least 50% greater than the previous year; or if a material change occurs as listed in the instructions. • In addition, there is an annual reporting requirement.
	CAA RxDC Reporting	All employers offering coverage with Prescription Coverage	• The RxDC reporting is comprehensive, covering prescription costs, yearly change in drug pricing comparison, the top 50 frequent brand-name drugs prescribed, the 50 most costly drugs, information on Rx rebates, medical claims spending by category, and other plan information. • Generally, most insurance carriers will submit a complete filing to CMS as required, as long as the employer has responded to any survey or information request from the plan sponsor (employer group). • If the carrier does not receive the requested information by their internal deadline, then the employer (plan sponsor) is required to file both the P2 and D1 template files with CMS on their HIOS system.	• You can access the CRC Benefits guide **here**. • The template files can be downloaded **here**. • The step-by-step instructions are available **here**. • Other resources are available on the CMS website here.	• The annual filing deadline is June 1st for the prior calendar year information.

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	CAA Gag Clause Prohibition Compliance Attestation (GCPCA)	All employers offering health insurance benefits	• The Gag Clause Prohibition Compliance Attestation (GCPCA) is a government-required disclosure by carriers and plan sponsors to ensure medical carriers, PBMs, TPAs, or other vendor contracts do not restrict the release of certain information, such as network-contracted rates, service codes, or other claim-related information. • The filing is done through the CMS HIOS system.	• Check out our guide **here**. • The HIOS user manual can be found **here**. • The HIOS instruction manual can be found here.	• The filing is due by December 31st annually. • The reporting period is for one year, based on the previous time frame of reporting. For example, if the previous filing was submitted on December 1st in the prior year, the current attestation will cover the period from December 1st of the prior year to December 1st of the current year.
	CAA Transparency in Coverage (TiC Rule)	For fully insured contracts, the insurance carrier is required to post For self-funded contracts, the plan sponsor is required to post, unless they have an agreement with their administrator	• The Transparency in Coverage (TiC) requires publicly posted machine-readable files with both in- and out-of-network pricing for medical procedures. • There must also be an online price comparison tool to get cost-sharing estimates based on services in their area. • The goal is to promote pricing transparency amongst the providers in an area to enable informed healthcare decisions.	There is no model notice for this disclosure; the files posted must be machine-readable, which is typically in a .json format. Information can be found **here**.	• Monthly updates are required to meet the guidelines. • The information should be posted on the website for the plan. If there is no plan website, then the employer should consider adding it to their general website, on its own page.

OTHER REQUIRED PLAN DOCUMENTS, NONDISCRIMINATION TESTING

Review*	Disclosure Type	Applicable To	Content	Link to Notice/Template, or Sample Wording	Timing
	ERISA Summary Plan Description (SPD) or WRAP	All benefit plans offered by employers, including retirement plans, that are subject to ERISA. Generally, only governmental plans and church plans are exempt from ERISA.	• ERISA requires general information to be provided to participants and beneficiaries of employee benefit plans. • The SPD or WRAP should include details such as the plan structure, eligibility requirements, claims procedures, procedures for appeals or disputes, ensuring enrollees understand their rights and responsibilities. • Under ERISA, health and welfare benefit plans should be assigned a three-digit plan number, starting with 501.	• These documents are legal in nature and should be obtained from a reputable vendor or legal counsel.	• New employees and enrolled beneficiaries must receive a copy of the SPD/WRAP within 90 days after enrolling in any benefits. • The plan sponsor must distribute an updated SPD every five years in the event of any changes. • Must be distributed at least every 10 years, if no changes are made.
	Summary of Material Modifications (SMMs)	All benefit plans offered by employers, including retirement plans, that are subject to ERISA. Generally, only governmental plans and church plans are exempt from ERISA.	• A plain language document written in a manner that the average participant can understand, a summary of material modifications or changes in the terms of a plan offered must be provided in a Summary of Material Modifications.	• The DOL has not released a model notice for the SMM. More information can be obtained **here**.	• The SMM must be furnished within 210 days after the end of the plan year in which the modification was made. • If there are material reductions in benefits, the SMM must be furnished within 60 days. • If an updated SPD is released, the distribution of the revised SPD meets the SMM obligations.
	Summary Annual Reports (SARs)	All benefit plans are required to file a DOL Form 5500.	• The SAR is a summary of the DOL Form 5500 in a narrative format, versus the form format.	• The model form for the SAR is located **here**.	• Within 9 months after the end of the plan year, or 2 months after the due date for filing Form 5500, where an approved extension is filed.

	Plan Documents	All benefit plans offered by employers	• Upon written request, a plan sponsor/administrator must provide copies of documents pertaining to the plans offered.
			• These documents include:
			  • Summary Plan Description (SPD)
			  • The latest Form 5500
			  • Any trust agreements, if applicable
			  • Any other documents that detail how the plan is established or operated
				• See above and below for links or information based on the document(s) requested.	• In addition to the regular distribution requirements, a plan must provide copies of any documents within 30 days after a written request.
					• Document copies should be available at the principal office of the plan administrator.

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	Qualified Medical Child Support Orders (QMCSOs)	All employers offering group health plans (may also include dental and/or vision)	• A judgment, decree, or order made by a court, based on state domestic relations laws, requiring coverage for child support or health benefit coverage for a child of an employee.	• Each state and/or municipality may have a different format for its QMCSO. • More information can be found **here**.	• It requires employers and insurers to enroll a child in the parents' health insurance without regard to open enrollment restrictions. • The support order should be reviewed carefully, as many require a report to be returned to the ordering entity.
	ERISA Fiduciary Duties	All employers offering benefit plans	• Plan fiduciaries, generally the decision makers for benefit offerings, must act solely in the best interest of plan participants and beneficiaries. • There are requirements to act prudently, follow the terms of the plan documents, and avoid conflicts of interest. • Fiduciaries who do not follow the requirements may be held personally liable.	• Information can be reviewed **here**. • Additional resources can be found **here**. • A self-compliance checklist can be obtained **here**.	• There are no notice distribution requirements for this specific item. Fiduciaries should ensure that all decisions are properly documented and that documents are retained as required.

	§125 Plan Document (FSA/ DCAP or Premium Only Plan) + Nondiscrimination Testing	All employers offering pre-tax deductions for premiums, FSAs/ DCAPs, and/or HSAs	• A written SPD and Plan Document are required to establish and maintain a §125 plan.
			• The benefits, eligibility, procedures for making elections and/or waiving the program, a statement that elections are irrevocable for the 12-month period (unless a qualifying life event occurs), along with other requirements, must be distributed to employees.
			• **Nondiscrimination Testing:**
			  • Must be performed annually to ensure that highly compensated individuals (HCIs) are not disproportionately benefiting from the plan.
			  • Testing failures result in the loss of tax benefits for HCIs, making their contributions to the plan taxable.
					• New employees and enrolled beneficiaries must receive a copy of the SPD/WRAP within 90 days after enrolling in any benefits.
					• The plan sponsor must distribute an updated SPD every five years in the event of any changes.
					• Must be distributed at least every 10 years, if no changes are made.
					• Any amendments must be adopted prior to the effective date; retroactive changes are prohibited.

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	§129 Nondiscrimination Testing for Dependent Care Account Plans (DCAPs/ DCFSAs)	All employers offering Dependent Care Account Plans	• Nondiscrimination testing must be performed annually to ensure that highly compensated individuals (HCIs) are not disproportionately benefiting from the plan. • Testing failures result in the loss of tax benefits for HCIs, making their contributions to the plan taxable.		• There are no notice distribution requirements under the testing.
	§105(h) Nondiscrimination Testing for Self-funded plans	All employers offering level-/self-funded plans, including HRAs, MERPs, and ICHRAs	• Nondiscrimination testing must be performed annually to ensure that highly compensated individuals (HCIs) are not disproportionately benefiting from the plan. • Testing failures result in the loss of tax benefits for HCIs, making their contributions to the plan taxable.	• The plan administrator, carrier, TPA, tax advisor, or legal counsel should assist with performing the annual testing.	• There are no notice distribution requirements under the testing.
	§79 Nondiscrimination Testing	All Group Term Life Plans	• Nondiscrimination testing must be performed annually to ensure that highly compensated individuals (HCIs) are not disproportionately benefiting from the plan. • Testing failures result in the loss of tax benefits for HCIs, making their contributions to the plan taxable.	• The plan administrator, carrier, tax advisor, or legal counsel should assist with performing the annual testing.	• There are no notice distribution requirements under the testing.
	Health Reimbursement Arrangement/Medical Expense Reimbursement Plan (HRA/MERP) Document	All group health plans offering an HRA or MERP Arrangement	• A Summary Plan Description (SPD) must be adopted by an employer in order to implement an HRA/MERP. • A Summary of Benefits & Coverages (SBC) detailing the benefits covered under the HRA/MERP should be distributed to plan enrollees.	• SBC Model Template can be found **here**.	**SPD:** • Employers should sign and adopt the plan prior to the effective date of coverage. **Notice to Employees (SBC):** • Provided to enrollees with enrollment materials (new or renewal) • Special period enrollees within 90 days from enrollment • 60 days prior to off-renewal changes • Upon request within 7 days

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	Individual Coverage Health Reimbursement Arrangement (ICHRA)	All groups offering an ICHRA	• Inform employees of the availability of an ICHRA from their employer and the terms and conditions of the plan, including the right to opt out.	• Click **here** for more information.	• Notice must be given at least 90 days before the beginning of each plan year. • For any employee not eligible at that time, notice should be provided by the date the employee becomes eligible at the beginning of the plan year.
	Benchmark Plan Selection	All group health plans that are level-/self-funded or offered by an Applicable Large Employer (ALE)	• One of the three Federal Employees Health Benefit Programs (FEHBP) options or a state filed Benchmark plan with CMS must be chosen by an employer offering self-funded plans, or is an ALE, to ensure the plan imposes no annual or lifetime dollar limits on any Essential Health Benefits (EHBs). The requirement applies to both in-network and out-of-network benefits.	• All filed state Benchmark plans can be found **here**.	• No notice to employees is needed, as the adopted Benchmark or FEHBP benefits would be included in the plan documents (SBCs and SPD). See the requirements for the SBCs and the SPD in the above sections.

END NOTES

[i] The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to any requests for medical information, if applicable. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

[ii] Michelle's Law is a federal law that requires certain group health plans to continue eligibility for adult dependent children who are students attending a post-secondary school, where the children would otherwise cease to be considered eligible students due to a medically necessary leave of absence from school. In such a case, the Plan must continue to treat the child as eligible up to the earlier of:

- The date that is one year following the date the medically necessary leave of absence began; or the date coverage would otherwise terminate under the Plan.

For the protections of Michelle's Law to apply, the child must:

- Be a dependent child, under the terms of the Plan, of a participant or beneficiary; and
- Have been enrolled in the Plan, and as a student at a post-secondary educational institution, immediately preceding the first day of the medically necessary leave of absence.

"Medically necessary leave of absence" means any change in enrollment at the post-secondary school that begins while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of coverage under the Plan.

If you believe your child is eligible for this continued eligibility, you must provide to the Plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact the Plan Administrator.

[iii] If you, or a dependent, are entitled to Medicare and have not elected Part A and Part B, the medical plan offered through <CARRIER NAME> will pay/will not pay secondary to Medicare, even if you are not enrolled in Medicare. This may also be called Medicare Estimation. In the event you are not enrolled in Medicare Part A and Part B, the medical plan will subtract from any services charged the amount that Medicare would have paid and then apply the benefits under the plan. In these circumstances, you will be responsible to pay the providers for the costs not covered under the plan.

[iv] Rescission notices must include the date of the notice, information about the insurance company and/or plan sponsor, information about the insured including plan or policy details, a clear statement that coverage will be rescinded, the retroactive date of the rescission, a detailed explanation of the reason for the rescission citing the specific instance of fraud or misrepresentation, a statement of the amount of premiums to be refunded based on the rescission date, information on how to appeal the decision and contact information for questions.

[v] Initial notice for affirmative consent

TO: [Participant/Beneficiary Name]

FROM: [Plan Administrator/Employer]

RE: Notice and Consent to Electronic Delivery of ERISA Documents

This notice serves to inform you of your right to receive certain plan documents electronically. We are seeking your affirmative consent to receive documents, such as the Summary Plan Description, Summaries of Material Modifications, and Summary Annual Reports, through electronic delivery. Please read this notice carefully.

Information for your consent:

Documents: By consenting, you agree to receive the following documents electronically: [List specific documents, e.g., Summary Plan Description (SPD), Summary of Material Modifications (SMM), Summary Annual Report (SAR)].

Right to withdraw consent: You have the right to withdraw your consent to electronic delivery at any time, free of charge. You may also request a paper copy of any document furnished electronically.

How to withdraw consent: To withdraw your consent or request a paper copy of a document, please contact [HR@company.com] or call [444-444-4444].

Hardware and software requirements: To access the electronic documents, you must have the following: [e.g., A computer with internet access, an email account, and Adobe Acrobat Reader].

Contact information updates: It is your responsibility to keep your electronic contact information up to date. To update your email address, please visit [company intranet/portal] or contact [HR department].

By providing your consent, you confirm that you have access to the necessary hardware and software to receive and retain documents in the specified electronic format.

Electronic consent confirmation: Consent is given to the electronic delivery of plan documents. Signature and Date required.

CHECKLIST REVIEW SUMMARY

This checklist serves as a review of compliance-related items relevant to the client's operations, documentation, or procedures. Each item has been assessed for its status and categorized accordingly. The review is intended to identify areas of strength, note items that are not applicable, and highlight any areas requiring further attention or corrective action.

Client Name:

Review Date:

Reviewer Name:

Client Signature:

Date:

This checklist and review is not intended to be exhaustive and is provided for educational and informational purposes only. This document does not constitute legal or tax advice. Clients are encouraged to consult with qualified legal counsel and/or a licensed tax advisor regarding any specific concerns or decisions.

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