ERISAPros
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Welfare Benefit Plan Compliance Services

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Reporting and Disclosure Compliance Guide for Welfare Benefit Plans

Document	Type of Information	To Whom	When
Reporting Requirements (to the government)			
Form 5500	Plan financial information and Participant counts (Form 5500 records must be maintained for not less than six years.)	U.S. Department of Labor (DOL) Form 5500 must be filed electronically.	Within seven months after the end of the Plan Year A 2-1/2 month extension is available by filing a Form 5558. (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.)
Schedule A	Insurance policy information	DOL with Form 5500 (Insurance carriers are required to provide the employer with information necessary to complete this form.)	With Form 5500 (Stop-loss policies owned by an employer that pays all premiums for the policies exclusively out of its general assets without employee contributions are not reportable on Schedule A. Employee contributions for coverage made through a Cafeteria Plan are not considered premiums.)
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.)	DOL with Form 5500	With Form 5500 (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.

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Form M-1 Compliance Information (Form M-1 is required to be filed by MEWAs, Multiple Employer Welfare Arrangements)	All welfare benefit plans (whether or not a MEWA) must provide 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.	U.S. Department of Labor (DOL)	With Form 5500, when it is filed.
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. This disclosure is required whether the entity's coverage is primary or secondary to Medicare.	Centers for Medicare and Medicaid Services (CMS) Disclosure to CMS Form	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.

Disclosure Requirements (to Participants)

Document	Type of Information	To Whom	When
Summary Plan Description (SPD)	Primary vehicle for informing participants and beneficiaries about their benefits, rights, and obligations under the Plan and how it operates	Participants and beneficiaries receiving benefits	Within 90 days after becoming 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 Annual Report (SAR)	A narrative summary of Form 5500 information	Participants	Within 9 months after end of plan year, or 2 months after due date for filing Form 5500 with extension.

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Plan Document	Describes the Plan's terms and conditions related to the operation and administration of a Plan.	Participants and beneficiaries*	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 of Material Modification (SMM)	Describes material (important, significant) modifications to a plan and changes in the information required to be in the SPD	Participants	Within 210 days after the end of the plan year in which the change is adopted Distribution of updated SPD satisfies this requirement.

Additional Disclosure Requirements for Group Health Plans

Document	Type of Information	To Whom	When
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)	Participants	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.
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	Participants - (Notice to the covered participant is deemed to provide notice to his or her covered dependents.)	At the time of enrollment for new employees, upon request, within 60 days of a material change to the Notice, and no less frequently than every three years
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	Covered employees and covered spouses*. Model general COBRA notice is available at http://www.dol.gov/ebsa/modelgeneralnotice.doc	Within 90 days after group health plan coverage begins. **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).*

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Document	Type of Information	To Whom	When
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	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
Notice of Unavailability of COBRA	Notice that an individual is not entitled to COBRA coverage.	Individuals who provide notice to the administrator of a qualifying event whom the administrator determines are not eligible for COBRA coverage.	The administrator must provide this notice generally within 14 days after being notified by the individual of the qualifying event.
Notice of Early Termination of COBRA Coverage	Notice that a qualified beneficiary's COBRA coverage will terminate earlier than the maximum period of coverage.	Qualified beneficiaries whose COBRA coverage will terminate earlier than the maximum period of coverage.	As soon as practicable following the administrator's determination that coverage will terminate.
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 Notice for Employers with Health Plans and Notice for Employers without Health Plans	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

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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. May be distributed electronically if certain requirements are met (see Q&A10 at http://www.dol.gov /ebsa/pdf/faq-aca8.pdf). The template for the SBC is available at: http://www.dol.gov/ebsa/pdf correctedsbctemplate2.pdf. Group health plan guidance for drafting the SBC is available at: http://www.dol.gov/ebsa/pdf /SBCInstructionsGroup.pdf. The uniform glossary for use with the SBC is available at: http://www.dol.gov/ebsa/pdf /SBCUniformGlossary.pdf.	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.	During the first open enrollment period beginning on or after September 23, 2012. For plan years beginning on or after September 23, 2012, the SBC is required to be distributed to participants and beneficiaries: • as part of initial application materials for enrollment (and again by the first 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 seven 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.

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Notification of Benefit Determination (claims notices or "explanation of benefits")	Information regarding benefit claim determinations Adverse benefit determinations must include required disclosures (e.g., the specific reason(s) for the denial of a claim, reference to the specific plan provisions on which the benefit determination is based, and a description of the plan's appeal procedures).	Claimants (participants and beneficiaries or authorized claims representatives)	Requirements vary depending on type of plan and type of benefit claim involved.
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	All employees, whether or not a Participant who reside in a state in which medical premium assistance is available Model Notice & List of States	At the time of initial enrollment and on the first day of each Plan Year thereafter
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	Participants Model initial and annual notices are available at http://www.dol.gov/ebsa/pdf/cagappc.pdf (pages 109 and 110)	Upon enrollment and annually thereafter
Newborns' Act Disclosure	A description of the requirements for a hospital length of stay in connection with childbirth under federal or state law, as applicable (model language is provided at http://www.dol.gov/ebsa/pdf/cagappc.pdf (on page 108))	All Participants and Beneficiaries	Must be included in SPD. See SPD distribution requirements above.

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HIPAA Certificate of Creditable Coverage	A notice from employee's former group health plan documenting prior group health plan creditable coverage	Participants and beneficiaries who lose coverage or who request a certificate	Automatically upon losing group health plan coverage, becoming eligible for COBRA coverage, and when COBRA coverage ceases A certificate may be requested free of charge anytime prior to losing coverage and within 24 months of losing coverage.
General Notice of Preexisting Condition Exclusion	A notice describing a group health plan's pre-existing condition exclusion and how prior creditable coverage can reduce the preexisting condition exclusion period.	Participants - A model notice is available at http://www.dol.gov/ebsa/pdf/cagappc.pdf (beginning on page 99).	Must be provided as part of any written application materials distributed for enrollment. If the plan does not distribute such materials, by the earliest date following a request for enrollment in a plan.
Individual Notice of Period of Preexisting Condition Exclusion	A notice that a specific "PEC" period applies to an individual upon consideration of creditable coverage evidence and an explanation of appeal procedures if the individual disputes the plan's determination	Participants and Beneficiaries	As soon as possible following the determination of creditable coverage
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 becoming eligible for premium assistance under Medicaid or CHIP	Employees eligible to enroll in a group health plan Model language is available at http://www.dol.gov/ebsa/pdf/cagappc.pdf (on page 102), although it must be revised to include a description of the Medicaid- and CHIP-related special enrollment events.	At or before the time an employee is initially offered the opportunity to enroll in the group health plan

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Medicare Part D Notice of Creditable or Non-Creditable Prescription Drug Coverage	Describes to Medicare Part D eligible individuals whether their 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 notice will help eligible individuals determine whether to enroll in Part D coverage during the annual Medicare Part D election period (October 15 to December 7) or during their initial Medicare Part D enrollment period. The current model notices are available at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Model-Notice-Letters.html	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).*	Each year, 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.* ***Guidance clarifies that "prior to" means a notice must have been provided within the last 12 months.*
Grandfathered Plan Status Disclosure	Notice must state that the Plan is grandfathered & list contact information for questions and complaints A model notice is available at http://www.dol.gov/ebsa/grandfatherregmodelnotice.doc	Participants in Grandfathered Plans	Whenever a summary of the benefits of the plan is provided to participants and beneficiaries. For example, SPDs upon initial eligibility, during an open enrollment period, or upon other opportunities to enroll in, renew, or change coverage.
Patient Protections Notice	A non-grandfathered group health plan must describe to covered individuals their rights to (1) choose a primary care provider or a pediatrician (when the plan requires designation of a primary care physician), and/or (2) obtain gynecological or obstetrical care without prior authorization.	Participants and Beneficiaries A model notice is available at http://www.dol.gov/ebsa/patientprotectionmodelnotice.doc	Include (if applicable) whenever an SPD or other description of benefits is provided.

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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. A model notice is available at http://www.dol.gov/ebsa/pdf/cagappc.pdf (beginning on page 107).	Participants and beneficiaries eligible to participate in the wellness program	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.)
Notice of Waiver from Annual Limit Requirement	Any limited benefit group health plan (or "mini-med" plan) that has received a waiver from compliance with the Affordable Care Act restrictions on annual limits on essential health benefits must disclose the plan's receipt of the waiver and describe that the plan does not meet the minimum annual limit. The most current version of the model notice, along with related guidance, is available at http://cciio.cms.gov/resources/files/06162011_annual_limit_guidance_2011-2012_final.pdf	Current and eligible participants in the applicable Plan	As part of any informational or educational materials about the plan, including the SPD. Notice must be provided in **bold 14-point type**, and must otherwise be prominently displayed.
Medical Child Support Order (MCSO) Notice **and** **Qualified Medical Child Support Order (QMCSO)**	A notice from the Plan Administrator regarding the receipt and qualification determination of a MCSO, directing the plan to provide health insurance coverage to a participant's noncustodial children. If the Plan Administrator determines that the MCSO meets all the qualifications, it is deemed to be a QMCSO. FAQs about MCSOs and QMCSOs http://www.dol.gov/ebsa/publications/qmcso.html	Participants, any child named in an MCSO or a QMCSO, and his or her representative.	The Administrator, upon receipt of MCSO must promptly issue notice (including plan's procedures for determining its qualified status). Within a reasonable time after its receipt, the Administrator must also issue separate notice as to whether the MCSO is qualified, i.e., a QMCSO.

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National Medical Support Notice (NMSN)	A notice used by state child support enforcement agencies that enforce health care coverage provisions in a MCSO. A QMCSO which enforces state Medicaid laws must be in the form of a NMSN. If the NMSN is appropriately completed by the child support agency, it is deemed to be a valid QMCSO. FAQs about National Medical Support Notices And The Role Of State Child Support Enforcement Agencies (See Q2-1) http://www.dol.gov/ebsa/publications/qmcso.html	State agencies, employers, plan administrators, participants, custodial parents, and children's representatives	Employer must send either 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. The Plan Administrator must promptly notify affected persons of receipt of the notice and the procedures for determining its qualified status. The Plan Administrator must, within 40 business days after its date or sooner, if reasonable, complete and return Part B to the state agency and provide required information to affected persons. Under certain circumstances, the employer may be required to send Part A to the state agency after the Plan Administrator has processed Part B.

[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.)

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How and When Should an SPD and Other ERISA Documents be Delivered?

The Plan Administrator/employer is responsible for preparing the SPD and ***affirmatively delivering*** it to certain persons, e.g.:

- covered employees
- terminated COBRA Participants
- parents or guardians of children covered under a qualified medical support order
- dependants of a deceased participant
- Representatives or guardians of incapacitated persons

Unless requested, an SPD does not need to be provided separately to dependants of a covered employee or to employees who are not covered, although it is a good idea to do so.

Determining whether an SPD was furnished to a Participant or Beneficiary is important. An employer should be prepared to prove that it furnished one in a way ***"reasonably calculated to ensure actual receipt,"*** using a method ***"likely to result in full distribution."*** Acceptable methods of delivery include first-class mail, hand-delivery, and electronically, if the employees have access to computers in the workplace and can print a copy easily.

DOL regulations are quite clear that merely placing copies of the SPD in a break room or posting the SPD on an employer's website or intranet does not necessarily satisfy this requirement because it was not affirmatively delivered to the Participant.

Electronic Distribution of ERISA Documents

Requirements for employees with work-related computer access—Definition of work-related computer access: The employee has the ability to access documents at any location where they reasonably could be expected to perform employment duties. In addition, access to the employer's electronic information system must be an integral part of their employment duties.

- Electronic materials must be prepared and furnished in accordance with otherwise applicable requirements (e.g., timing and format requirements for SPDs as outlined under ERISA.)
- A notice must be provided to each recipient, at the time that the electronic document is furnished, detailing the significance of the document.
- The notice must advise the participant of their rights to have the opportunity, at their work site, to access documents furnished electronically and to request and receive (free of charge) paper copies of any documents received electronically.
- The employer must take necessary measures to ensure the electronic transmittal will result in actual receipt of information by the participants (i.e. return-receipt.)
- If the disclosure includes personal information relating to an individual's accounts and benefits, the plan must take reasonable and appropriate steps to safeguard the confidentiality of the information.

Additional requirements for non-employees or employees with non-work related computer access—

- Affirmative consent for electronic disclosure must be obtained from the individual. Before consent can be obtained, a pre-consent statement must be furnished that explains:
    - The types of documents that will be provided electronically;

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- The individual's right to withdraw consent at any time without charge;
- The procedures for withdrawing consent and updating information (e.g. updating the address for receiving electronic disclosure);
- The right to request a paper version and its cost (if any); and
- The hardware and software requirements needed to access the electronic document.

- The regulations permit the pre-consent statement to be provided electronically if the employer has a current and reliable e-mail address.
- If system hardware or software requirements change, a revised statement must be provided and renewed consent from each individual must be obtained.
- If the documents are to be provided via the Internet, the affirmative consent must be given in a manner that reasonably demonstrates the individual's ability to access the information in electronic form, and the individual must have provided an address for the receipt of electronically furnished documents.
- The Employer must keep track of individual electronic delivery addresses, individual consents and the actual receipt of e-mailed documents by recipients.
- The 5 steps outlined above under "Requirements for employees with work-related computer access" must also be followed.

Miscellaneous Terminology

Certificate/Evidence of Coverage (Certificate/Evidence of Insurance, Certificate Booklet, or just "Cert")—a booklet describing the terms of the insurance coverage that are provided to Participants are Certificates of Insurance

Claim Fiduciary—is a Named Fiduciary having the authority and responsibility to adjudicate claims in accordance with the provisions of the Plan. For insured plans, the carrier is typically the Claim Fiduciary. However, for self-insured plans, the Plan Sponsor/Administrator can name itself or an independent third party as the Claim Fiduciary.

Employer Sponsored—means: 1) the employer contributes to the cost, 2) participation in the coverage is not voluntary, OR 3) the employer endorses or recommends the Plan.

Fidelity Bond—covers anyone who handles Plan assets and insures against a fiduciary's fraud or dishonesty. A bond may not be needed for an Unfunded Plan that accepts employee contributions that are not segregated from the employer's general assets.

Fiduciary Liability Insurance—indemnifies fiduciaries for errors in Plan administration, whether or not they are a Named Fiduciary.

Master Contract—an insurance policy issued to an employer, which provides group insurance benefits to its employees. It usually contains the same information as the Certificate of Coverage, but also has information specifically relating to the employer, such as a grace period for payment of premiums, the Policy Year, and premium rates.

Named Fiduciary—a person or an entity named in the Plan having the duty to operate it prudently and in the best interests of its Participants.

Other Fiduciaries—anyone (even an employee, whether or not (s)he is a Named Fiduciary) who performs functions, such as exercising discretionary responsibility, authority, or control over Plan management decisions, disposition of Plan assets, or rendering investment advice.

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Plan Sponsor—the sponsoring employer

Plan Administrator—is typically the employer/Plan Sponsor, unless another party is designated. The Plan Administrator is directly responsible for Plan compliance. Note—the term "Plan Administrator" is usually not a TPA or an insurance company.

Participants and Beneficiaries—employees, former employees, their dependants and beneficiaries who are eligible to benefit from an ERISA plan.

Plan Number—a three digit number assigned by the Plan Administrator for Reporting on Form 5500.

Plan Year—any twelve month period chosen by the Administrator for Reporting purposes. Note—this is not necessarily the same as the policy year of underlying insurance contracts.

Summary of Benefits (Benefit Summary)—a short (1 to 4 pages) handout summarizing and highlighting the features of coverage contained in the Certificate of Coverage, e.g., deductibles, copays, coinsurance, exclusions, etc.

Third Party Administrator (TPA)—administers Plan and adjudicates claims. A TPA is usually not the Plan Administrator.

Welfare Benefit Plan—a program established by an employer or an employee organization that provides for its Participants or their Beneficiaries: medical, surgical, or hospital care or benefits; benefits in the event of sickness, accident, disability, death or unemployment; vacation benefits, apprenticeship or other training programs; day care centers; scholarship funds; or prepaid legal services. It may be self-insured, partially self-insured, or fully insured.

IMPORTANT NOTICE

This chart provides only general guidance, and not all rules and requirements are reflected in this guide. For example, the guide, as a general matter, does not focus on disclosures required by the Internal Revenue Code or the provisions of ERISA for which the Treasury Department and Internal Revenue Service have regulatory and interpretive authority. Refer to specific Form 5500 Instructions and the Code of Federal Regulations for complete, accurate, and up to date information on Reporting and Disclosure requirements. Information in ERISA *Pros*' publications is provided as a general informational source. Information and articles are general in nature and are not intended to constitute legal or tax advice in any particular matter. Transmission of this information does not create an attorney-client relationship. ERISA *Pros*, LLC is not a law firm and does not provide legal or tax advice. ERISA Pros does not warrant and is not responsible for errors or omissions in the content on its website or in its publications.

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