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2016 WELFARE PLAN COMPLIANCE CALENDAR
UPDATED MAY 1, 2016

ERISA

☐ SUMMARY PLAN DESCRIPTION (SPD)

What:	Who:	When:	How:	Notes:
✓ SPD must clearly state all pertinent terms of plan, including: ✓Eligibility, benefits and exclusions ✓Name, EIN and address of plan sponsor ✓Funding ✓Plan Year ✓COBRA continuation statement ✓Claims procedures ✓ERISA rights ✓Name, title & address of Trustee(s) ✓Agent for service ✓WHCRA ✓HIPAA Special Enrollment Rights	✓ Provided to each participant and each beneficiary covered under the plan, including COBRA, retirees and beneficiaries under a QMSCO (if applicable) ✓ Upon request, to a participant or beneficiary eligible but not covered by the plan	✓ Within 120 days after a plan first becomes subject to ERISA ✓ Within 90 days of the date an individual first becomes a participant in plan ✓ Within 30 days of a participant or beneficiary request ✓ Every 5 years if amended ✓ Every 10 years if no amendments	✓ Hand delivery ✓ U.S. Mail ✓ SPD can be provided to employees with enrollment materials ✓ Electronic delivery (if the plan sponsor meets the requirements for electronic delivery)	✓ Description of *what* is included is partial—full requirements are set out in regulations ✓ Most insurance carriers provide "summary descriptions" that typically **do not** meet the requirements for an SPD ✓ SPD must include offer of assistance in foreign language or must be provided in foreign language if, for large plans (100^{+}), lesser of 500 or 10% of participants, or for small plans, 25% of participants, are literate only in the same non-English foreign language ("Foreign Language Rule")

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2016 WELFARE PLAN COMPLIANCE CALENDAR
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ERISA

☐ SUMMARY OF MATERIAL MODIFICATION (SMM) FOR MATERIAL PLAN CHANGES

What:	Who:	When:	How:	Notes:
✓ Summary of material amendments or modifications summarizing plan changes (other than those materially reducing benefits)	✓ Provided to each participant and each beneficiary, including COBRA, retirees and beneficiaries under a QMSCO (if applicable)	✓ Within 210 days after the close of the plan year in which the change is adopted	✓ Hand delivery ✓ U.S. Mail to all at same household or separately if at different addresses ✓ Electronic delivery (if the plan sponsor meets the requirements for electronic delivery)	✓ Not required if change is incorporated in revised SPD (provided within time limit) ✓ Foreign Language Rule applies

ERISA

☐ NOTICE OF MATERIAL REDUCTION OF BENEFITS

What:	Who:	When:	How:	Notes:
✓ Notice of amendment to plan resulting in a material reduction of any benefit	✓ Provided to each participant and each beneficiary, including COBRA, retirees and beneficiaries under a QMSCO (if applicable)	✓ Within 60 days after adoption of the change	✓ Hand delivery ✓ U.S. Mail to all at same household or separately if at different addresses ✓ Electronic delivery (if the plan sponsor meets the requirements)	✓ Material if reasonable person would believe it to be, includes increase in premiums, co-pays and deductibles, reduction or elimination of network, additional pre-auth. requirements ✓ Foreign Language Rule applies

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ERISA					
☐	***WHCRA Enrollment & Annual Notice***				
	What:	***Who:***	***When:***	***How:***	***Notes:***
	✓ Notice regarding Women's Health and Cancer Rights Act – which requires group health plans, insurance companies and HMOs offering mastectomy coverage to also provide coverage for certain reconstructive surgeries	✓ Provided to each participant and each beneficiary, including COBRA, retirees and beneficiaries under a QMSCO (if applicable)	✓ Upon enrollment and ✓ Annually	✓ Hand delivery ✓ U.S. Mail to all at same household or separately if at different addresses ✓ Electronic delivery (if the plan sponsor meets the requirements for electronic delivery) ✓ Consider including in SPD	✓ Foreign Language Rule should be followed

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ERISA

☐ ***Form 5500 Annual Report***

What:	*Who:*	*When:*	*How:*	*Notes:*
✓ Annual Report (tax return) for the plan	✓ For welfare plans, Form 5500 must be filed if plan has 100 participants or more at beginning of plan year	✓ By last day of the 7th month following last day of plan year ✓ Extension (using Form 5558) for 2.5 months available	✓ On Form 5500, with schedules ✓ Filed electronically with Department of Labor using EFAST 2-approved third party software or IFILE	✓ Church plans and government plans not required to file ✓ Must be provided to participant or beneficiary upon request

ERISA

☐ ***Summary Annual Report-***

What:	*Who:*	*When:*	*How:*	*Notes:*
✓ Summary of information provided on Form 5500	✓ Provided to each participant and each beneficiary, including COBRA, retirees and beneficiaries under a QMSCO (if applicable)	✓ By last day of the 9th month following last day of plan year, or 2 months after extension period ends for Form 5500	✓ Hand delivery ✓ U.S. Mail ✓ Electronic delivery (if the plan sponsor meets the requirements for electronic delivery)	✓ Generally required if Form 5500 is required ✓ Foreign Language Rule applies

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ERISA

☐ *Electronic Delivery Rules*

ERISA regulations permit electronic delivery of notices if certain requirements are met:

Basic Requirements:

- ✓ Delivery steps taken for furnishing documents are reasonably calculated to result in the actual receipt of the documents;
- ✓ Use of return-receipt or notice of undelivered e-mail features;
- ✓ Conduct periodic reviews or surveys to confirm receipt;
- ✓ Reasonable and appropriate steps are taken to safeguard confidentiality of personal information;
- ✓ Electronically delivered documents are prepared/furnished in a manner consistent with the style, format and content requirements applicable to the document;
- ✓ A paper version of the electronic document must be available on request (at no charge); and
- ✓ Each time an electronic document is furnished, a notice (electronic or paper) must be provided to each recipient describing the significance of the document.

Once **basic requirements** are met, documents may be furnished to two classes of potential recipients:

- ✓ Participants who have the ability to access documents through employer's electronic information system located where they are reasonably expected to perform duties
- ✓ Employees working from home or on travel are covered
- ✓ Distribution through a kiosk in a common area in the workplace does not comply with the requirements

- ✓ **Other participants**
- ✓ Retirees and terminated participants with vested benefits, beneficiaries, alternate payees
- ✓ Must affirmatively consent to receive the documents electronically
- ✓ Provide an electronic address
- ✓ Reasonably demonstrate their ability to access documents in electronic form

COBRA

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☐ *Initial Notice*

What:	Who:	When:	How:	Notes:
✓ Initial Notice advising participants of COBRA rights upon a qualifying event ✓ Model notice: http://www.dol.gov/ebsa/modelgeneralnotice.doc	✓ Provided to each participant and each spouse	✓ At enrollment, within 90 days after commencement of coverage, or if earlier, when the plan administrator is requested to furnish a COBRA qualifying event notice	✓ Hand delivery or in SPD (need separate delivery to spouse) ✓ U.S. Mail to all at same household or separately if at different addresses ✓ Electronic delivery (if the plan sponsor meets the requirements for electronic delivery)	✓ Must describe procedure and to designate person or position to whom death, divorce, disability, loss of dependent status is to be reported ✓ Foreign Language Rule has been held not to apply, but it may be best practice

☐ *Qualifying Event Notice & Election Form*

What:	Who:	When:	How:	Notes:
✓ Notice of COBRA rights upon a qualifying event ✓ COBRA election form ✓ Model notice: http://www.dol.gov/ebsa/modelelectionnotice.doc	✓ Provided to each participant and each COBRA qualified beneficiary	✓ Within 44 days of qualifying event	✓ Hand delivery or in SPD (need separate delivery to COBRA qualified beneficiaries), otherwise same as the Initial Notice	✓ DOL has provided model notices ✓ See above re: Foreign Language Rule

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☐ NOTICE OF UNAVAILABILITY OF COVERAGE

What:	Who:	When:	How:	Notes:
✓ Notice advises otherwise eligible employees and dependents that COBRA is not available	✓ Provided to each participant and each beneficiary who would be otherwise eligible for coverage	✓ Within 44 days of the event that would otherwise be a qualifying event	✓ Hand delivery or in SPD (need separate delivery to each beneficiary) ✓ U.S. Mail to all at same household or separately if at different addresses ✓ Electronic delivery (if the plan sponsor meets the requirements for electronic delivery)	✓ Foreign language rule has been held not to apply, but it may be best practice

☐ NOTICE OF COBRA COVERAGE EARLY TERMINATION

What:	Who:	When:	How:	Notes:
✓ Notice that COBRA coverage will terminate early ✓ Not required if COBRA coverage is exhausted	✓ COBRA qualified beneficiaries whose COBRA coverage will terminate early	✓ As soon as practicable after determination that COBRA coverage will end early	✓ Hand delivery or in SPD (need separate mailing to other beneficiaries), otherwise same above	✓ Foreign language rule has been held not to apply, but it may be best practice

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MEDICARE

☐ *Medicare Part D Creditable Coverage Notice*

What:	*Who:*	*When:*	*How:*	*Notes:*
✓ Notice advising whether group health plan prescription drug coverage constitutes (or does not constitute) creditable coverage for purposes of Medicare Part D	✓ Each participant and dependent who is "Medicare Eligible" **NOTE**: Plan sponsor not required to track separate events if notice is provided to all participants (not just Medicare Eligible) prior to October 15 each year	✓ Prior to the Part D annual enrollment period (10/15-12/7) ✓ Prior to the individual's personal 7-month Part D enrollment window (begins 3 months prior to month in which the individual becomes eligible for Part B) ✓ Prior to effective date of coverage in the plan ✓ Upon material change in prescription benefit (causing it to become, or ceasing to be, "creditable"), and ✓ Upon request	✓ May be mailed or hand-delivered ✓ Posting is not adequate ✓ Notice may be provided electronically to Medicare-eligible individuals who have adequate means to access electronic information. Individuals must consent to electronic notice, after appropriate disclosure ✓ May be combined with other plan-related materials, including initial or open enrollment materials, but must be conspicuous (at least 14-pt font in a separate box, bolded, or offset on the first page) ✓ Single mailing to home is adequate, unless sponsor knows dependent does not reside there ✓ *Personalized* notice of creditable or non-creditable coverage must be supplied upon request, and *may* also be supplied in lieu of the model generic notices of creditable or non-creditable coverage	✓ Actuarial support may or may not be required to attest to creditable coverage ✓ Safe harbor determination may be available, see http://www.cms.hhs.gov/creditablecoverage ✓ Creditable coverage forms are available at http://www.cms.hhs.gov/creditablecoverage

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MEDICARE

☐ *Medicare Part D Creditable Coverage Notice to CMS*

What:	Who:	When:	How:	Notes:
✓ Notice to CMS as to whether prescription coverage is creditable or not	✓ CMS	✓ Within 60 days after beginning of plan year ✓ Within 30 days of termination or material change to prescription drug benefit	✓ On-line at http://www.cms.hhs.gov/creditablecoverage	✓ Separate notices may be required for different plans ✓ Instruction manual available online: http://www.cms.gov

☐ *Medicare Part D Retiree Subsidy*

What:	Who:	When:	How:	Notes:
✓ Employers or unions that offer retirees prescription drug benefits may apply for retiree drug subsidy	✓ CMS	✓ Within 90 prior to beginning of plan year ✓ 30 day extension may be available, if requested and approved prior to deadline	✓ Application and valid retiree list at http://rds.cms.hhs.gov/how_to/start_application.htm ✓ If new plan sponsor, visit http://rds.cms.hhs.gov/how_to/new_psid.htm#what first	

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HIPAA

☐ ***HIPAA Privacy Notice (NPP)***

What:	Who:	When:	How:	Notes:
✓ Notice of group health plan privacy practices ✓ **NOTE**: Changes required by Omnibus Final Rule trigger redistribution of NPP. If plan currently posts NPP on web site: (i) must prominently post material change or revised NPP on web site by September 23, 2013; and (ii) provide the revised NPP or information about material change and how to obtain revised NPP in next annual mailing to individuals covered by the plan. If no web site, plan required to provide the revised NPP, or information about the material change and how to obtain the revised NPP, within 60 days of the material revision.	✓ All participants and beneficiaries ✓ If dependent requests a separate copy, the plan must provide	✓ At enrollment ✓ Upon request ✓ NPP must be re-issued within 60 days after a material change to its contents ✓ Participants must be notified every three years that the notice exists, and how they may obtain a copy	✓ Delivery to the enrolled participant (employee or retiree) is deemed to be delivery to all of his or her dependents ✓ The notice must be delivered to the participant (posting is not adequate), but not necessarily in a separate notice ✓ The notice may also be distributed via email if the participant has agreed	✓ If fully insured, insurer typically provides ✓ **NOTE**: Fully insured plans may have limited obligations under HIPAA's Privacy rule, depending on the amount of protected health information (PHI) the plan receives

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HIPAA

☐ HIPAA SPECIAL ENROLLMENT RIGHTS

What:	Who:	When:	How:	Notes:
✓ Notice to all employees who are eligible for coverage ✓ Must that if they (or spouse or dependents) don't accept coverage because they (their spouse or dependents) have coverage elsewhere, may enroll if coverage is lost, but must do so within 30 days of lost coverage ✓ Must also explain that new dependents through birth, marriage, adoption, placement for adoption may be added, but must be added within 30 days of birth, marriage, adoption or placement ✓ Must also state whether the plan requires an employee declining coverage to state in writing whether they are declining due to other health coverage	✓ Provided to each employee who is otherwise eligible for coverage, whether or not they decline coverage.	✓ Upon first being eligible or at time of open enrollment	✓ Hand delivery ✓ U.S. Mail ✓ Electronic delivery (if the plan sponsor meets the requirements for electronic delivery) ✓ Typically included in orientation materials and annual enrollment materials	✓ Employees and their families may enroll within 60 days of losing eligibility for Medicaid or becoming eligible for premium assistance under Medicaid

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CHIPRA				
☐ ***CHIPRA Notice***				
What:	**Who:**	**When:**	**How:**	**Notes:**
✓ Employers offering group health plan coverage in states that provide subsidized premiums must notify employees residing in such states of potential premium assistance under Medicaid and CHIP	✓ Provided to each employee whose state provides premium assistance, if the employer offers coverage in that state	✓ Annually, by the start of each plan year	✓ Hand delivery ✓ U.S. Mail ✓ Electronic delivery (if the plan sponsor meets the requirements for electronic delivery) ✓ Typically included in orientation materials and annual enrollment materials, but notice must appear separately and in a manner which ensures that an employee who may be eligible for premium assistance could reasonably be expected to appreciate its significance.	Link to model notice: http://www.dol.gov/ebsa/chipmodelnotice.doc Consider including in new hire packet

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GINA

☐ GENETIC INFORMATION NONDISCRIMINATION ACT

What:	Who:	When:	How:	Notes:
✓ GINA prohibits discrimination by group health plans, health insurance issuers and employers against an individual based on the individual's genetic information	✓ Employers are required to post a notice explaining GINA ("EEO is the Law" poster)	✓ Final regulations effective January 10, 2011	✓ "Genetic information" includes genetic testing, and the manifestation of a disease or disorder in a family member	HIPAA privacy policies and procedures and notices should conform with the treatment of genetic information as protected health information and prohibit use and disclosure for underwriting purposes

MICHELLE'S LAW

☐ MICHELLE'S LAW

What:	Who:	When:	How:	Notes:
✓ Plan language regarding Michelle's Law may be removed UNLESS: • the plan or a component plan is subject to a state law mandate requiring it to cover a child over the age of 26 who is a full-time student; or • the plan otherwise covers children over age 26 who are full-time students	✓ Requires plans to extend health coverage to students who would lose eligibility because of a medically necessary leave	✓ N/A	✓ Include language in SPD if a plan requires certification of student status ✓ Any notice about that requirement must describe right to extended coverage during medical leave	Requirement made obsolete in large part, as plans remove concept of "student status" in light of age 26 coverage requirement under PPACA

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PPACA

☐ ***Insurance Mandates and Market Reforms (2010-2013)***

What:	Who:	When:	How:	Notes:
Amend SPDs to reflect coverage mandates for employer plans ✓ Cover dependent children to age 26 ✓ Eliminate lifetime caps for "essential health benefits" ✓ Modify and restrict annual limits on "essential health benefits" ✓ Cover emergency services without prior authorization and at in-network level regardless of provider* ✓ Allow enrollees to designate any in-network doctor their PCP (including OB/GYN and pediatrician)* ✓ Eliminate the rescission right absent fraud or intentional misconduct ✓ Cover certain preventive services without cost sharing* ○ For women, additional preventive care and screenings, as well as all FDA approved contraceptive methods and	✓ Employer-sponsored group health plans ✓ Exceptions apply for retiree-only plans	✓ Effective for plan years beginning on or after September 23, 2010	✓ Existing SPD distribution rules apply	Mandates with an asterisk (*) do not apply to grandfathered plans

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sterilization procedures ✓ Prohibit discrimination under fully-insured plans: must comply with IRC § 105(h) rules that prohibit discrimination in favor of highly compensated employees (**Note**: the application of this rule has been indefinitely delayed)* ✓ Eliminate pre-existing condition exclusions for dependent children under age 19 ✓ Revise claims and appeals process and external review process* ✓ Eliminate reimbursements under health FSAs and HRAs for OTC medications not prescribed by a doctor (effective January 1, 2011)

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☐	***W-2 Informational Reporting***				
	What:	***Who:***	***When:***	***How:***	***Notes:***
	✓ Report the aggregate cost of employer-sponsored group health benefits on IRS Form W-2	✓ Employer-sponsored group health plans ✓ Small employers (those that are required to file fewer than 250 Forms W-2 for the calendar year prior to the reporting year) are not subject to the reporting requirement	✓ By January 31 of each year	✓ Include medical, Rx, employer FSA contributions, and bundled dental and vision	✓ Exclude HRAs, HSA contributions, employee contributions to health care FSAs, and HIPAA-excepted dental and vision benefits ✓ Exclude EAP, wellness, and on-site medical clinic coverage IF employer does not charge a COBRA premium with respect to the coverage

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PPACA

☐ ***Uniform Summary of Benefits and Coverage (SBC)***

What:	Who:	When:	How:	Notes:
✓ SBC rules are designed to create a standardized written description of the health insurance policy so that participants can better understand their coverage ✓ SBC must be provided free of charge, in a consistent four-double-sided-page format with 12-point font ✓ SBC must also be written in a "culturally and linguistically" appropriate manner and use language that is understandable to the average plan participant and beneficiary ✓ **Insured plans**: carrier is responsible for developing SBC ✓ **Self-insured plans**: plan sponsor is responsible for developing SBC ✓ Sponsor that uses two or more service providers with respect to a single plan must synthesize the information into a single SBC ✓ New SBC templates for first open enrollment period that begins on or after April 1, 2017	✓ SBC rules apply to all health plans regardless of grandfathered status ✓ SBC rules do not apply to HSAs, retiree-only plans, stand-alone dental or vision plans, and most FSAs ✓ SBC rules do not apply to HRAs if integrated with major medical coverage ✓ A plan or insurer that willfully fails to provide an SBC is subject to a fine of up to **$1,000** per enrollee per failure	✓ At initial enrollment ✓ At open enrollment/renewal – ✓ At special enrollment – no later than 90 days after enrollment. ✓ Upon changes SBC information - 60 days *before* the effective date of coverage changes or material modification, or if changes occur between application and the first day of coverage, no later than the first day of coverage ✓ Upon request - within 7 business days of consumer's request	✓ SBC may be provided to the participant on behalf of the beneficiary, unless the plan or insurer has knowledge of a separate address for a beneficiary ✓ U.S. Mail (to last known address) ✓ Electronic delivery to *covered* participants and beneficiaries (if the plan sponsor meets the requirements for electronic delivery) ✓ Electronic delivery to participants and beneficiaries who are *eligible but not enrolled*	Model SBC available **Advance Notice Requirement** Plans must notify participants no later than 60 days prior to the effective date of any material modification that would affect the content of the most recently provided SBC, unless the change is made in connection with a renewal or reissuance of coverage Note: Electronic delivery safe harbor – SBCs may be provided electronically to participants and beneficiaries in connection with online enrollment or renewal of coverage or to participants and beneficiaries who request an SBC online (with the option to receive a paper copy upon request)

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☐ ***Notice of Exchange***

What:	Who:	When:	How:	Notes:
✓ Employees must be informed of the existence of an Exchange, given a description of the services provided by the Exchange, and told how to contact the Exchange to request assistance. ✓ Employees must be informed that they may be eligible for a premium tax credit or a cost-sharing reduction through the Exchange if the employer plan's share of the total cost of benefits under the plan is less than 60%. ✓ Employees must be informed that (a) if they purchase a qualified health plan through the Exchange, then they may lose any employer contribution toward the cost of employer-provided coverage; and (b) all or a portion of employer contributions to employer-provided coverage may be excludable for federal income tax purposes	✓ All employers who are subject to the Fair Labor Standards Act	✓ To new employees within 14 days of their start date ✓ One time only at time of hire – not an annual requirement	✓ To each employee, regardless of group plan enrollment status or part-time or full-time status ✓ Not required to provide a separate notice to dependents who are or may become eligible for coverage under the plan but who are not employees ✓ Must be provided in writing in a manner calculated to be understood by average employee ✓ Hand Delivery ✓ U.S. mail ✓ Electronic delivery (if the plan sponsor meets the requirements for electronic delivery)	DOL models available (also available in Spanish): •Notice for Employers Without Health Plans at http://www.dol.gov/ebsa/pdf/FLSAwithoutplans.pdf •Notice for Employers With Health Plans at http://www.dol.gov/ebsa/pdf/FLSAwithplans.pdf Notices may be modified provided they meet the minimum content requirements.

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PPACA

☐ ***PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE (PCORI) FEE (A/K/A COMPARATIVE EFFECTIVENESS FEE)***

What:	Who:	When:	How:	Notes:
✓ Fee funds the Patient-Centered Outcomes Research Institute, which was established by PPACA to evaluate and compare health outcomes and the clinical effectiveness, risks and benefits of medical treatments, services, procedures, drugs, and other strategies or items that treat, manage, diagnose, or prevent illness or injury ✓ For calendar year plans, the regulations and the requirement to pay fees generally apply to the 2012 through 2018 plan years	✓ Insured and self-insured medical plans regardless of grandfathered status, including retiree-only plans but excluding HIPAA-excepted benefits such as stand-alone dental or vision plans and most health FSAs ✓ Includes most HRAs	✓ Fee applies to policy and plan years ending on or after October 1, 2012 and before October 1, 2019 The amount of the fee is $2.08 for plan years ending after September 30, 2014 and before October 1, 2015 ✓ Fee increases to $2.17 plan years ending after September 30, 2015, and before October 1, 2016	✓ Insurers and plan sponsors must report and pay the fee annually on IRS Form 720, which will be due by July 31 of each year ✓ A return will cover policy or plan years that end during the preceding calendar year (e.g., the July 31, 2016 filing will cover all plan years ending in 2015).	**Responsibility for Payment** **Insured plans**: Insurer is responsible for paying the fee **Self-insured plans**: Plan sponsor is responsible for paying the fee Various methods exist for counting members; consult with broker/consultant or benefits counsel for assistance Form 720 may be filed electronically

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☐ INCREASE TO MEDICARE PAYROLL TAX

What:	Who:	When:	How:	Notes:
✓ Increase to the 1.45% Medicare tax by 0.9% for wages in excess of \$200,000 (\$250,000 for joint filers) ○ FICA: 6.2% Social Security tax on wages up to \$118,500 (in 2015 and 2016), plus Medicare tax of 1.45% on all wages ✓ 0.9% tax paid by the employee	✓ Employers with employees earning in excess of \$200,000 in wages	✓ 0.9% increase was effective starting in 2013	✓ Employers must withhold an additional 0.9% Medicare tax on wages in excess of \$200,000	Employers responsible for withholding on amounts over \$200,000, even for married employees filing jointly

PPACA

☐ HEALTH INSURANCE TAX (HIT)

What:	Who:	When:	How:	Notes:
✓ Health insurance industry tax on the fully-insured market (includes medical, dental and vision)	✓ Insured medical, dental and vision regardless of grandfathered status ✓ Does not apply to self-insured plans	✓ \$11.3 billion in 2015-2016, deferred in 2017, and, if not deferred again, \$14.3 billion in 2018 ✓ After 2018, the tax rises according to an index based on net premium growth	✓ HIT obligation is divided among insurers based on each insurer's net premiums ✓ Not-for-profit insurers are taxed on 50% of net premiums	Employers that drop coverage or switch from fully-insured to self-insured—increase HIT obligation to those remaining fully-insured

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☐ *TRANSITIONAL REINSURANCE PROGRAM FEE*

What:	Who:	When:	How:	Notes:
✓ Transitional Reinsurance Program fee is intended to stabilize premiums in the individual markets	✓ Insured and self-insured medical plans regardless of grandfathered status ✓ No exceptions for non-ERISA health plans (e.g., governmental or church plans) ✓ Does not apply to HIPAA-excepted benefits, post-65 retiree plans, HRAs and other plans that do not provide "minimum value"	✓ Temporary fee applies from 2014-2016 on a calendar year basis ✓ The amount of the fee is $27 per member per year in 2016 ✓ Applies on a per-member basis ✓ For 2015 and 2016, plans that are both self-administered and self-insured are exempt	✓ Fee is assessed on carriers and plan sponsors of self-funded plans ✓ Plan sponsors must report membership to HHS by November 15 of each year (2014—2016) ✓ HHS will notify plan sponsor of fee liability by December 15 ✓ Payment to HHS will be due within 30 days of notification from HHS	**Responsibility for Payment** **Insured plans**: Insurer is responsible for paying the fee **Self-insured plans**: Plan sponsor is responsible for paying the fee Payment of this fee can be treated as ordinary and necessary business expense for deduction purposes TPAs may complete the reinsurance contribution process, including payment, on behalf of a self-funded plan Payments will be remitted on the **pay.gov** website

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PPACA

☐ NOTICE REQUIREMENTS

	What:	Who:	When:	How:	Notes:
	✓ Grandfathered plan statement ✓ If the plan wishes to maintain "grandfathered" status under PPACA, must include notice in all communications to participants describing benefits available under the plan	✓ Employer-sponsored group health plans that are grandfathered	✓ Effective for plan years beginning on or after September 23, 2010	✓ Existing SPD distribution rules apply.	DOL model notice available: http://www.dol.gov/ebsa/grandfatherregmodelnotice.doc
☐	**What:**	**Who:**	**When:**	**How:**	**Notes:**
	✓ Patient Protection disclosure ✓ For benefit options that require the designation of primary care providers by participants or beneficiaries	✓ Employer-sponsored group health plans that require designation of a primary care physician	✓ Effective for plan years beginning on or after September 23, 2010	✓ Existing SPD distribution rules apply	DOL model notice available: http://www.dol.gov/ebsa/patientprotectionmodelnotice.doc

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PPACA

☐ INSURANCE MANDATES AND MARKET REFORMS (2014)

What:	Who:	When:	How:	Notes:
Amend SPDs to reflect coverage mandates for employer-sponsored group health plans ✓ Cover dependent children to age 26 without exception ✓ Eliminate annual dollar limits on "essential health benefits" ✓ Eliminate pre-existing condition exclusions and limitations ✓ Limits on participant cost-sharing for covered, in-network essential health benefits (out-of-pocket limits)* ○ $6,850 / $13,700 in 2016 ○ $7,150 / $14,300 in 2017 ✓ Required coverage for clinical trials for life-threatening diseases* ✓ 90 day limit on waiting periods once eligible for coverage	✓ Employer-sponsored group health plans	✓ Effective for plan years beginning on or after January 1, 2014	✓ Existing SPD distribution rules apply	Mandates with an asterisk (*) do not apply to grandfathered plans Regarding the out-of-pocket limit, family plans must include an embedded individual out-of-pocket limit that is no greater than $6,850 ($7,150 in 2017)

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2016 WELFARE PLAN COMPLIANCE CALENDAR
UPDATED MAY 1, 2016

PPACA

☐ MEDICAL LOSS RATIO (MLR) REBATES

What:	Who:	When:	How:	Notes:
✓ The MLR rule requires health insurance companies in the group or individual market to provide an annual rebate to enrollees if the insurer's "medical loss ratio" falls below a certain minimum level—generally, 85 percent in the large group market and 80 percent in the small group or individual market	✓ Health insurance carriers and employers that sponsor group health plans	✓ Annually; carriers to start distributing rebates by August of each year ✓ Portion of rebate attributable to employee contributions **must be used within three months of receipt** by the policyholder to provide refunds or pay premiums, or ERISA's trust rules will apply	✓ The portion of the rebate that is considered a plan asset must be handled according to ERISA's general standards of fiduciary conduct ✓ Generally, the portion of the rebate attributable to employee contributions may be used to reduce premiums for current plan participants	If the employer finds that the cost of distributing shares of a rebate to former participants approximates the amount of the proceeds, the employer may decide to distribute the portion of a rebate attributable to employee contributions to current participants using a "reasonable, fair, and objective" method of allocation. Similarly, if distributing cash payments to participants is not cost-effective (for example, the payments would be de minimis amounts, or would have tax consequences for participants) the employer may apply the rebate toward future premium payments or benefit enhancements.

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PPACA

☐ CODE SECTION 6055 AND 6056 REPORTING

What:	Who:	When:	How:	Notes:
✓ The ACA requires reporting by certain entities starting in 2015 (first reporting is due in the first quarter of 2016 reflecting the 2015 calendar year) ✓ Sections 6055: Provider reporting (e.g., insurance carriers, self-insured plans, multiemployer plans) ✓ Section 6056: Applicable Large Employers (50 or more full-time equivalent employees (FTEs) on average in the prior calendar year)	✓ Section 6055 is provider reporting – employers with self-insured plans will report on all covered employees, including covered non-employees ✓ Section 6056 is "applicable large employer" (**ALE**) reporting, which reports on coverage offered, if any, to full-time employees and their families	✓ Section 6055 and 6056 reporting **to individuals**: March 31, 2016, for 2015 calendar year ✓ Section 6055 and 6056 reporting **to the IRS**: May 31, 2016, or June 30, 2016 if filing electronically ✓ For calendar year 2016 filings and future years, due dates will be January 31 for reporting to individuals and, for the IRS forms, the last day of February, or March 31 if filing electronically ✓ Electronic filing required if filing more than 250 forms.	✓ Forms 1094-B and 1094-C: Summary Report to the IRS ✓ Forms 1095-B and 1095-C: Report to IRS and Individuals ✓ Series-B forms: Used by insurance companies and small, self-insured plans (non-ALEs) ✓ Series-C forms: ✓ Used by ALEs to report full-time employees and, if self-insured, to report covered individuals ✓ Self-insured ALEs use Series-C forms for purposes of Section 6055 and 6056 reporting	Calendar year 2015 reporting includes employers with 50-99 FTEs who are exempt from pay-or-play penalties in 2015 These employers must certify on their Section 6056 reporting filed in 2016 that they qualify for the transition relief

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2016 Welfare Plan Compliance Calendar
Updated May 1, 2016

NONDISCRIMINATION					
☐	***Best Practice***				
	What:	**Who:**	**When:**	**How:**	**Notes:**
	✓ To the extent applicable, plan sponsors should test their plans at least annually for nondiscrimination	✓ Self-funded group health plans (Code §105) ✓ Cafeteria plans (Code §125) ✓ Health FSAs (Code §§ 105 and 125) ✓ Dependent care FSAs (Code §129) ✓ Group term life insurance plans (Code §79)	✓ Best practice is to test three times per year ✓ At the beginning of the plan year; ✓ Shortly after the end of the plan year; and ✓ Before the end of the plan year, which will enable the plan sponsor to make any necessary adjustments prior to year-end	✓ Work with benefits counsel or your broker / administrator	In accordance with PPACA, the nondiscrimination rules applicable to self-funded plans under Code §105 will apply to fully insured plans in the future, once further guidance is released

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2016 WELFARE PLAN COMPLIANCE CALENDAR
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HEALTH CARE FSA				
☐ ***BEST PRACTICE***				
What:	***Who:***	***When:***	***How:***	***Notes:***
✓ Inform participants that their FSA elections cannot exceed $2,550 in 2016; amend plan if necessary ✓ Ensure that health FSAs qualify as HIPAA-excepted	✓ Health FSAs	✓ Effective for plan years beginning on or after January 1, 2014	✓ Work with benefits counsel or your broker	Rule applies on a plan year basis A health FSA is HIPAA-excepted as long as employees are offered other, non-excepted group health plan coverage, and the maximum amount available under the FSA does not exceed $500 or two-times the employee's salary reduction election, if greater

Note: **This Compliance Calendar is provided as a service to clients and friends of Marathas Barrow Weatherhead Lent LLP. It is designed only to give general information on the material actually covered. It is not intended to be a comprehensive summary of the law or on recent developments in the law, treat exhaustively the subject matter covered, provide legal advice or tender a legal opinion. Questions concerning legal compliance should be always discussed with a licensed attorney with the requisite experience in the practice area of concern. For more information about the Compliance Calendar, please call Peter Marathas at (617) 830-5456 or Stacy Barrow at (617) 830-5457 or e-mail them at pmarathas@marbarlaw.com and sbarrow@marbarlaw.com.**

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