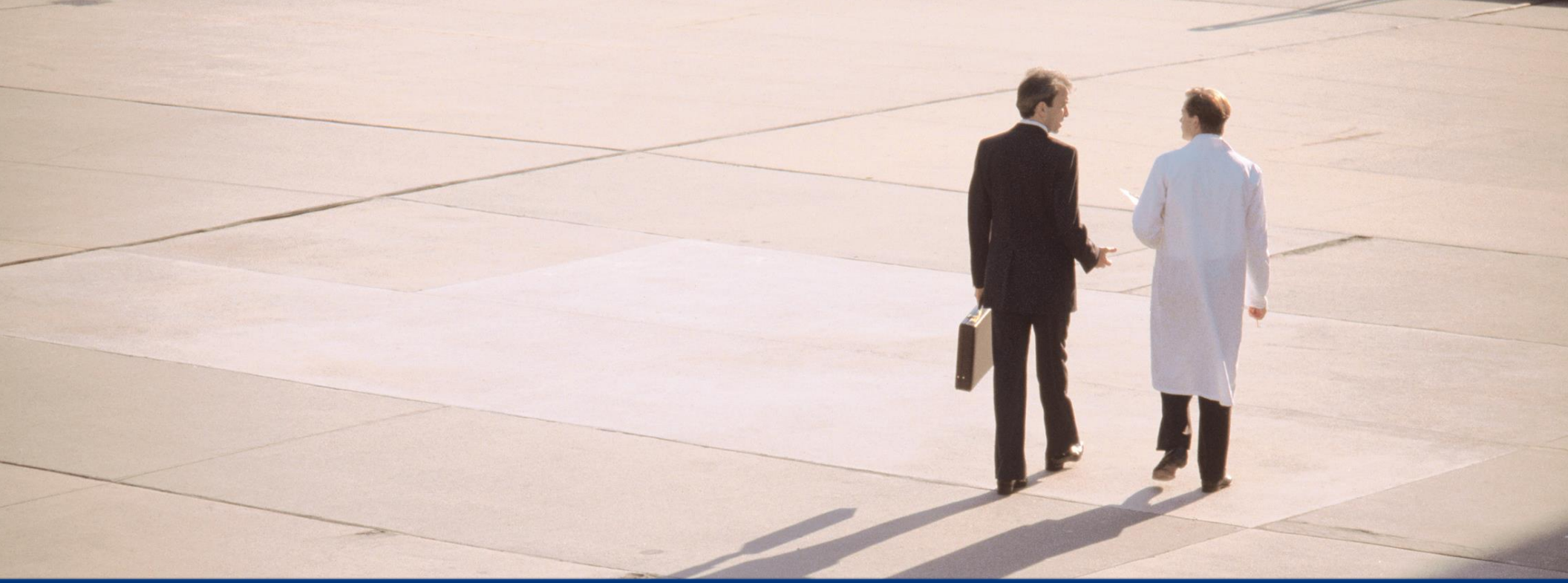

Health Plan Notice Matrix:

The What, When, Who and How of the Dazzling Array of Health Plan Reporting and Disclosure Obligations

Lockton Benefit Group—Lockton Companies, LLC

Revised January 2018

This Matrix summarizes key federal reporting and disclosure obligations imposed upon health plans, primarily plans subject to ERISA. With limited exceptions it does not endeavor to catalogue disclosure obligations that may exist, or purport to exist, under state and local insurance or other laws. Generally, when a notice obligation falls on a Saturday, Sunday, or federal holiday, the notice may be distributed on the next business day.

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Notice	Who Gets It?	When?	How?	Comments
NOTE: For plans subject to ERISA, Department of Labor regulations allow most notices required by ERISA to be furnished as part of other employee communications, such as a newsletter, as long as there is a "prominent" notice on the front of the document advising the reader that the document contains important information about the reader's rights under the Plan and ERISA, and should be read and retained for future reference. ***There are specific exceptions to this general rule.*** Where the notice must be furnished separately, either pursuant to express requirements or as a practical matter (e.g., because the notice is individualized), the manner of distribution is noted in this Matrix.				
Medicare Part D: **Creditable or Non-Creditable Coverage Notice to Individuals** Notice of "creditable" or "non-creditable" coverage. Basically, a comparison of cost of expected claims under the employer's Rx benefit, compared to the standard Medicare Part D benefit.	Each person enrolled in the plan or who is seeking enrollment in the plan, who is also "Medicare eligible," which in this context means covered by Parts A or B.	Prior to the Part D annual enrollment period (10/15–12/7). "Prior to" means within the past 12 months, unless there is a material change in the creditable/non-creditable nature of the coverage. Prior to the individual's personal 7-month Part D enrollment window (begins 3 months prior to month in which becomes eligible for Part *B*). Prior to effective date of coverage in the plan. Upon a material change in the employer's Rx benefit (so it becomes, or ceases to be, "creditable"), and Upon request.	May be mailed or hand-delivered. Notice may be provided electronically to plan participants who can access electronic documents at their regular worksite if they have access to the sponsor's electronic information system on a daily basis as part of their work duties. If this method is chosen, the sponsor must inform the plan participant that the participant is responsible for providing a copy of the electronic disclosure to his or her Medicare-eligible dependents covered under the group health plan. Notice may be provided electronically to retirees if they consent, and other requirements are met. Notice may be combined with other plan materials, including initial or open enrollment materials, but must be "conspicuous." There must be a text box atop the materials, noting in 14-point font that the packet includes a Medicare Part D notice. Single mailing to participant's home is adequate notice to Medicare-enrolled spouse and dependents unless the plan knows such an individual does not reside there.	Applies to ERISA and non-ERISA plans. Actuarial support may or may not be required to attest to creditable coverage. CMS has supplied model notices in English and Spanish. Lockton also maintains model notices. Contact your Lockton Account Service Team. ***Personalized*** notice of creditable or non-creditable coverage should be supplied upon request.

Notice	Who Gets It?	When?	How?	Comments
Medicare Part D: **Creditable Coverage Notice to CMS**	The Centers for Medicare and Medicaid Services (CMS).	Within 60 days after the **beginning** of the plan year. Within 30 days after termination of a plan providing drug benefits. Within 30 days after any change in the creditable or non-creditable nature of the prescription drug coverage under a health plan.	Notice is made electronically, through completion of an online disclosure form.	Applies to ERISA and non-ERISA plans. Early guidance said "plan year" meant the contract year or ERISA plan year; recent HHS comments suggest it might now be the ERISA plan year. Either approach likely remains OK.

Notice	Who Gets It?	When?	How?	Comments
HIPAA: **Privacy Notice** Notice of the plan's privacy practices with respect to "protected health information." Covered entities – such as health plans – are required to supply a "privacy notice" to enrollees.	All enrolled individuals. However, delivery to the enrolled participant (employee or retiree) is deemed to be delivery to all of his or her dependents. However, if a dependent asks for a copy of the notice, the plan must supply it.	At enrollment, and upon request. The notice must be re-issued within 60 days after a material change to its contents. In any event, the responsible party must notify covered individuals every three years that the notice exists, and how they may obtain a copy. Best practice is probably to include the notice in the initial and annual enrollment packets.	If the plan is fully insured, the carrier has the obligation to send the notice, unless the plan sponsor is "hands on" the plan's PHI, in which case both the insurer and the sponsor have an obligation. If the plan is self-funded, the sponsor has the obligation, as a practical matter. The employer may contract with a vendor to provide the notice, but the employer retains the responsibility. The notice must be delivered to the participant (posting is not adequate), but not necessarily in a separate notice. However, the notice is sufficiently large that it's probably best furnished as a separate document. The notice may also be distributed via email if the participant has agreed to accept it that way. Some employers also post the notice on their website, where employee benefits are discussed.	Applies to ERISA and non-ERISA plans. Lockton maintains a model notice. Contact your Lockton Account Service Team.
HIPAA: **Privacy Notice Reminder** This is a reminder of the Plan's privacy notice, reminding participants that the Plan has a privacy notice, and that it is available for review.	All enrolled individuals. However, delivery to the enrolled participant (employee or retiree) is deemed to be delivery to all of his or her dependents.	Every three years. However, if the privacy notice is provided regularly, such as in each initial and annual enrollment packet, or reproduced in the SPD, arguably this notice obligation is moot.	Likely in accordance with the same manner in which the actual Privacy Notice is provided.	Applies to ERISA and non-ERISA plans. Lockton maintains a model notice. Contact your Lockton Account Service Team.

Notice	Who Gets It?	When?	How?	Comments
HIPAA: **Notice of Protected Health Information Security Breach** A notice by plans subject to HIPAA privacy and security standards, to HHS and affected individuals, regarding a breach of "unsecured" protected health information (PHI).	Department of Health and Human Services, affected individuals and in some instances, local media outlets.	Within 60 days of the discovery of a breach, notice must be supplied to each affected individual. The plan must maintain a log or other documentation of the breach or breaches and submit it to HHS once a year. For breaches affecting 500+ individuals, notice must be supplied to HHS immediately and also provide notice to prominent media outlets serving the area.	The notice to individuals must be made by first class mail (or email if preferred by the individual. Electronically, for the notice to HHS. HHS has posted on its website an online form and instructions for reporting breaches of unsecured PHI.	Applies to all plans subject to HIPAA privacy and security. A breach is defined as any impermissible acquisition, access, use, or disclosure of PHI unless the plan demonstrates that there is a low probability that the PHI has been compromised. Plans are required to perform a formal risk assessment for each potential breach. The notice to affected individuals should describe the circumstances of the breach (including the date of the breach and the date of discovery), the information disclosed, steps the affected individuals should take to minimize the potential harm, contact information for additional details, and action taken by the health plan to mitigate any harm. PHI security breaches require consultation with legal counsel.
HIPAA: **Special Enrollment Notice** Notice apprising participants and beneficiaries of their right to enroll immediately if they lose other coverage due to a special enrollment event.	The participant (employee or retiree, as applicable).	At or before the time the participant is first offered an opportunity to enroll.	The notice language should be included in enrollment forms or as a special notice. It should be provided in writing. Electronic notice is permitted, subject to compliance with the DOL's comprehensive regulations for the provision of electronic notices.	Applies to ERISA and non-ERISA plans. An explanation of a plan's special enrollment rights should also be in the SPD. Note that CHIPRA added two new HIPAA special enrollment events. Lockton maintains a model notice.

Notice	Who Gets It?	When?	How?	Comments
HIPAA: **Opt-out of Certain HIPAA-Related Requirements** State and local non-federal self-insured governmental plan's notice of "opt out" from the Mental Health & Substance Abuse Parity rules, the Newborns and Mothers Health Protection Act rules, the Women's Cancer Rights Act rules, and Michelle's Law (but see the "Comments" column).	CMS receives the actual opt-out election. Participants (covered employees/retirees), COBRA beneficiaries, and alternate recipients under QMCSOs receive notice of the election.	(To CMS) Prior to the beginning of each plan year. (To participants) At the time of enrollment and on an annual basis, prior to the beginning of each plan year.	(To CMS) In writing or online. (To participants) In writing.	Applies to state and local non-federal self-insured governmental plans. Notice to participants should include the fact and consequences of the election. CMS has prepared a model notice to enrollees. Notice to participants must accompany annual opt-out election filing with CMS. Additional information is available online. For plan years beginning on or after September 23, 2010, self-funded governmental plans generally may no longer opt-out of the HIPAA portability (i.e., pre-existing condition and special enrollment) and nondiscrimination rules.
HIPAA: **Alternative Standard Available Under Activity- or Outcomes-Based Wellness Program** *See entries under "Health Reform: Wellness Programs" and "Misc. Notices/Reports – EEOC"*				

Notice	Who Gets It?	When?	How?	Comments
COBRA: **General Notice** General explanation of COBRA rights. SPD should reflect COBRA contact points and procedures for notices to the plan.	Participants and, if married, the covered spouse. *Remember to provide to health FSA and HRA participants and beneficiaries.*	Within 90 days after coverage under plan begins. If employee moves to a different plan at open enrollment, must issue new general notice (but not if the move is simply from option to option within a single plan). If employee is enrolled and then adds a spouse, spouse must receive the general notice within 90 days after enrollment.	First class (or better) mail addressed to employee and, if spouse is covered, to spouse or "family." Hand delivery to the employee is adequate for employee, but is not deemed to be delivery to the spouse. Preferred approach is first class (or better) mailing to the employee's address. If plan knows covered dependents live elsewhere, it should send separate notices to the appropriate addresses. Electronic notice is permitted, subject to the DOL's comprehensive regulations for the provision of electronic notices.	Applies to ERISA and non-ERISA plans, except church plans. DOL has supplied model notices in English and Spanish. Lockton also maintains a model notice. Contact your Lockton Account Service Team. The plan is required to send the notice by means "reasonably calculated" to be received, but is not required to guarantee receipt. Qualified small employer HRAs are exempt from COBRA.
COBRA: **Election Notice** Explanation of rights to COBRA coverage, duration of coverage, payment, notice obligations, etc.	Any employee, retiree, or covered dependent that loses coverage on account of a qualifying event. *Remember to supply to health FSA and HRA participants and beneficiaries, upon a qualifying event.*	After a qualifying event. If the event is the employee's death, termination of employment, reduction in hours or Medicare entitlement, or the employer's bankruptcy), the employer must supply notice to the plan administrator within 30 days after the qualifying event (44 days if employer is also the plan administrator). For other qualifying events, within 30 days after receiving the notice of the qualifying event.	Must be in writing. First class (or better) mail addressed to qualified beneficiaries is preferred. Hand delivery to the employee is adequate for employee, but is not deemed to be delivery to the spouse. If employee and spouse are both beneficiaries, address notice to both, or to "family." If employee and children are beneficiaries, address to employee "and family." Plan may send one notice to all beneficiaries if they reside at same address. If not, must send separate notices to separate addresses.	Applies to ERISA and non-ERISA plans, except church plans. DOL has supplied a model notice in English and Spanish. Lockton also maintains a model notice. Contact your Lockton Account Service Team. DOL recently updated the model to reflect information above coverage availability in public health insurance exchanges. The plan is required to send the notice by means "reasonably calculated" to be received, but is not required to guarantee receipt. Qualified small employer HRAs are exempt from COBRA.

Notice	Who Gets It?	When?	How?	Comments
COBRA: **Notice of Unavailability of COBRA Coverage** Notice intended to apprise employees and dependents that COBRA coverage is not available.	All persons who would have been entitled to COBRA as a result of the event, if COBRA were available.	Within 14 days after an individual requests COBRA coverage (or provides notice of an event (such as divorce, legal separation or child's emancipation) that would have been a qualifying event but for some other reason), but no COBRA coverage is available.	In writing. Plan may send one notice to all beneficiaries if they reside at same address. If not, must send separate notices to separate addresses. If sent to employee and spouse, should be addressed to both.	Applies to ERISA and non-ERISA plans, except church plans. No DOL model notice. Lockton maintains a model notice. Contact your Lockton Account Service Team. The plan is required to send the notice by means "reasonably calculated" to be received, but is not required to guarantee receipt. Qualified small employer HRAs are exempt from COBRA.
COBRA: **Notice of Early Termination of COBRA Coverage** Notice that COBRA coverage is terminating *early* (not required if COBRA coverage is exhausted).	COBRA qualified beneficiaries whose COBRA coverage will terminate early.	As soon as practicable after the plan administrator determines that COBRA coverage will be terminated prematurely.	In writing. Plan may send one notice to all beneficiaries if they reside at same address. If not, must send separate notices to separate addresses. If sent to employee and spouse, should be addressed to both. May be included with HIPAA certificate of creditable coverage.	Applies to ERISA and non-ERISA plans, except church plans. No DOL model notice. Lockton maintains a model notice. Contact your Lockton Account Service Team. The plan is required to send the notice by means "reasonably calculated" to be received, but is not required to guarantee receipt. Qualified small employer HRAs are exempt from COBRA.

Notice	Who Gets It?	When?	How?	Comments
COBRA: **Notice of Insignificant Premium Shortfall** Notice that individual underpaid a COBRA premium by an insignificant amount.	COBRA qualified beneficiaries who underpaid a COBRA premium by an insignificant amount.	Provide a reasonable grace period (e.g., 30 days) to cure the underpayment.	In writing.	Applies to ERISA and non-ERISA plans, except church plans. If an individual underpays a COBRA premium by an "insignificant" amount (by not more than 10 percent of premium due), the plan must send a notice of underpayment – and supply an opportunity to cure the deficiency – before terminating COBRA coverage. There is no DOL model notice. Qualified small employer HRAs are exempt from COBRA.

Notice	Who Gets It?	When?	How?	Comments
Health Reform: **Notice of Grandfathered Status** This is a notice apprising participants and beneficiaries of the plan's intent to retain grandfathered status, with respect to one or more coverage options. This notice applies only to plans that intend to retain grandfathered status into the ensuing plan year.	The participant (e.g., the employee) who receives other plan materials.	Presumably, not later than the first day of the plan year beginning on or after September, 23, 2010.	**Notice should be included in plan materials supplied to participants. Most sponsors will include this in open enrollment materials.** Electronic notice should be acceptable, subject to compliance with comprehensive federal regulations for the provision of electronic notices.	Applies to ERISA and non-ERISA plans (grandfathered plans only). There does not appear to be any special notice required if a plan *loses* grandfather status. In that event, of course, the plan should be amended to reflect the new mandates that apply to it. The health reform benefit mandates do not apply to HIPAA "excepted benefits"[1] maintained by non-governmental employers (federal authorities will not enforce the mandates against excepted benefits maintained by governmental employers). Thus, grandfather status is irrelevant with respect to these benefits. The DOL has supplied model notices in English and Spanish. Contact your Lockton Account Service Team. **This notice is, of course, moot after the plan loses grandfathered status.**

[1] HIPAA "excepted benefits" include retiree-only plans, most dental and vision coverage, and most health flexible spending accounts. With respect to dental and vision coverage, the coverage must be limited in scope, and either offered under a separate plan or insurance contract or, if part of a larger health plan, the coverage must be insured or participants must be able to elect in or out of the coverage and, if electing in, pay additional premium for it.

Notice	Who Gets It?	When?	How?	Comments
Health Reform: **Notice of Right to Designate Primary Care Provider, and No Obligation for Pre-Authorization for Ob/Gyn Care** This is a notice apprising participants in network plans of their right to designate a PCP, including their right to designate a Pediatrician as their child's PCP, and of their right to obtain Ob/Gyn care without pre-authorization or referral.	Any participant in a plan that requires designation of a primary care provider or that provides coverage for Ob/Gyn care and requires designation of a primary care provider.	The rule applies the first day of the plan year beginning on or after September 23, 2010. Notice is provided when the plan issues summary plan descriptions or similar summaries. The notice may be included in the summaries.	In writing, as part of (or with) any summary plan description or similar plan summary. Electronic distribution is likely permitted in accordance with comprehensive federal regulations for the provision of electronic notices.	Applies to ERISA and non-ERISA plans (non-grandfathered plans only). Neither this notice obligation nor the underlying mandate apply to HIPAA "excepted benefits"[1] maintained by non-governmental employers. Federal authorities will not enforce the requirement against excepted benefits maintained by governmental employers. The DOL has supplied model notices in English and Spanish. Contact your Lockton Account Service Team.
Health Reform: **Wellness Programs - Alternative Standard Available Under Activity- or Outcomes-Based Wellness Program** Activity- and outcomes-based wellness programs must disclose the availability of a reasonable alternative standard if the program provides a reward for satisfying a standard related to a health factor. See also the entries under, *"Misc. Notices/Reports – EEOC"*	Participants (covered employees/retirees), COBRA and other beneficiaries receiving benefits, and alternate recipients, to the extent they're eligible for wellness program participation.	A specific time period is not addressed in the final regulations or their codification in the health reform statute; however, such disclosure must be included in all plan materials describing the terms of the program. Communications that refer to the wellness program but do not provide details about it (such as the Summary of Benefits and Coverage) are not required to provide this disclosure.	A specific method for distribution is not addressed in the final regulations; however, such disclosure must be included in all plan materials describing the terms of the program (written or online).	Applies to ERISA and non-ERISA plans. The final regulations include model language that can be used to satisfy the disclosure requirement. Plan materials are not required to describe a specific reasonable alternative standard, only the availability of one. The plan may, and in some cases must, accept the recommendations of the individual's physician as the appropriate alternative standard. See Lockton HRAP Alert, 6/7/13 for details.

Notice	Who Gets It?	When?	How?	Comments
Health Reform: **Report on Wellness Programs and Quality/Safety Measures** Plans must report information on programs to enhance wellness.	The federal government.	Timing TBD. Will be addressed in pending regulations.	Presumably, electronically via a web portal. Federal authorities will issue a model report form.	Applies to ERISA and non-ERISA plans (non-grandfathered plans only).
Health Reform: **Disclosure Regarding Insurance Exchanges** Health reform requires employers subject to the FLSA to notify employees and others of the impending availability of coverage through an Insurance Exchange.	Employees, including part-time employees, and employees not eligible for or enrolled in the employer's health plan, must receive the notice.	By October 1, 2013, for current employees, and within 14 days of hire for employees hired after September, 2013. Note: This is *not* an annual notice requirement.	Hand delivered, supplied by first class mail, or sent electronically in compliance with DOL standards for electronic delivery of other required notices.	An employer, not plan, obligation, arising under the Fair Labor Standards Act. DOL guidance does not outright prohibit the inclusion of the notice in other materials, but including it in a "benefits guide" or employee newsletter might not always be adequate because of the requirements that all employees receive the notice, and receive it automatically and within 14 days after hire. There is no express penalty for failure to provide the notice.

Notice	Who Gets It?	When?	How?	Comments
Health Reform: **Report of Minimum Essential Coverage (Section 6055 Reporting)** Health reform requires employers and insurers to report minimum essential coverage supplied to "primary insureds" and their dependents.	Each "primary insured" (e.g., employee, retiree, COBRA beneficiary, etc.) who had coverage for at least a day during the prior calendar year; copy to the IRS.	**To the primary insured:** January 31 following the year in which the coverage was provided. **To the IRS:** Last day of February following the year in which the coverage was provided or, if filed electronically, March 31 following the year in which coverage was provided.	**Self-insured coverage:** Form 1095-C from the employer; a copy of all Forms 1095-C issued by the employer are transmitted to the IRS with a Form 1094-C. **Insured coverage:** The insurer issues Form 1095-B to the primary insureds, copies to the IRS with Form 1094-B.	These forms also indicate, by month, coverage of specific dependents (identified by SSN or date of birth). Where a self-insured employer provides coverage to individuals who were non-employees throughout the year (such as retirees, partners, outside directors and COBRA beneficiaries) it may report their coverage on either Form 1095-B or Form 1095-C. The purpose of this filing is to allow the government to determine whether an individual has satisfied the individual mandate to have minimum essential coverage.
Health Reform: **Report Demonstrating Compliance with the Employer Mandate (Section 6056 Reporting)** The health reform law requires employers subject to the "play or pay" mandate to report information on the health insurance (if any) offered to their full-time employees (employees working on average at least 30 hours per week), to demonstrate compliance with the employer mandate.	Each individual who, for at least a month in the prior calendar year, was a full-time employee of an employer subject to the employer mandate; copy to the IRS.	**To the full-time employee:** January 31 following the year to which the report relates. **To the IRS:** Last day of February following the year to which the report relates or, if filed electronically, March 31 following the year to which the report relates.	On Form 1095-C from the employer; a copy of all Forms 1095-C issued by the employer are transmitted to the IRS with a Form 1094-C.	A self-insured employer satisfies Section 6055 and 6056 reporting with respect to a full-time employee on the same Form 1095-C; Part I identifies the employer and the employee, Part II accomplishes Section 6056 reporting and, if the employee had self-insured coverage during the prior year, Part III reflects the months of coverage. An employer providing insured coverage to a full-time employee would not complete Part III. The intent of this filing is to allow the government to determine whether an employer to whom the "play or pay" mandate applies has satisfied that mandate.

Notice	Who Gets It?	When?	How?	Comments
Health Reform: **Notice of Retroactive Coverage Cancellation (i.e., "Rescission")** As a general rule, the health reform law permits plans to cancel coverage for an individual or group *retroactively* only in the case of fraud or material misrepresentation, as prohibited by the plan, and only after 30 days notice. *There are exceptions for certain retroactive cancellations due to administrative delays and errors were the participant hasn't paid any required premium for the period for which coverage would be cancelled retroactively.*	The affected participant who is losing coverage *retroactively* for reasons other than, for example, non-payment of premium, or short-term delays in administrative processing of adds and drops. Presumably, if the affected individual is a dependent, notice to the participant is considered notice to the dependent. The regulations require notice to "the participant" (i.e., the covered employee).	The rule applies the first day of the plan year beginning on or after September 23, 2010. Notice of rescission must be provided no fewer than 30 days prior to the date coverage is cancelled.	In writing. Electronic distribution is likely permitted in accordance with comprehensive federal regulations for the provision of electronic notices. Retroactive cancellation of coverage is, with respect to non-grandfathered plans, an "adverse benefit determination" subject to enhanced disclosure obligations under new guidelines for processing claims appeals. It appears notice of retroactive coverage cancellation must meet the same standards that apply to explanations of benefits.	Applies to ERISA and non-ERISA plans (grandfathered and non-grandfathered plans). Coverage rescissions under non-grandfathered plans are subject to expanded appeal rights, a fact which probably explains in part the 30-day advance notice requirement (i.e., the desire to allow the member time to appeal). Neither the prohibition on retroactive coverage rescissions (except in cases of fraud) nor, therefore, this notice obligation applies to HIPAA "excepted benefits"[1] maintained by non-governmental employers. Federal authorities will not enforce the requirement against excepted benefits maintained by governmental employers. The DOL has supplied model notices for use in the claims and appeals context in English and Spanish. Contact your Lockton Account Service Team. Also see the separate discussion below regarding the claims and appeals notice obligations under health reform.

Notice	Who Gets It?	When?	How?	Comments
Health Reform: **Notice that Expatriate Coverage Qualifies as Minimum Essential Coverage (MEC)** Notice informs enrollees their expat coverage issued by a non-U.S. insurer satisfies the individual mandate	The participant (e.g., the employee) who is a U.S. resident or national who is covered under the expatriate coverage issued by a non-U.S. insurer.	Coincident with the distribution of plan materials.	The notice must be included in plan materials.	HHS has not issued specific language required to satisfy the notice requirement. Guidance is not clear whether this is an annual notice.
Health Reform: **W-2 Reporting of Health Plan Values** The health reform law requires plan sponsors who (on EIN-by-EIN basis) submitted at least 250 W-2s to the IRS for the previous year, to report the values of certain coverages. Applies beginning with the 2012 W-2 reporting year.	Employees and the IRS. There is no obligation to issue a W-2 showing health coverage values to an individual who would not otherwise be entitled to a W-2, such as former employees, spouses and dependents on COBRA, retirees, etc.	The W-2 is due by the deadline for submitting W-2 data to IRS and furnishing a copy to individuals (generally, January 30 of the following year).	Electronically to the IRS, in writing to employees.	Applies to employer sponsors of grandfathered and non-grandfathered plans. The W-2 reporting is merely informational. The obligation applies with respect to reportable coverage whether taxable or nontaxable. Dental and vision coverage is exempt if offered under a separate policy, certificate, or contract of insurance, or not "integrated" with reportable health coverage; the meaning of "integrated" coverage is not clear but presumably means there is no separate election and premium for the dental or vision coverage. HRA contributions are exempt. Health FSAs funded solely by pre-tax contributions are exempt; Health FSAs that include employer contributions might be required to report, but only in rare cases. *Continued*

Notice	Who Gets It?	When?	How?	Comments
				Other reporting exclusions apply to multiemployer coverage, voluntary coverages entirely paid for by employees with after-tax dollars, long-term care coverage and HSA contributions. Also, on-site clinics, employee assistance programs, and wellness programs are exempt if the programs don't supply medical care or, even if they do, the employer does not charge a premium for COBRA coverage with respect to the program. Insured plans will report the premium cost; self-insured will typically use the COBRA rate (minus the two percent). An employer (EIN by EIN basis) is excused from reporting if it was required to file fewer than 250 forms for the prior calendar year.

Notice	Who Gets It?	When?	How?	Comments
Health Reform: **Patient-Centered Outcomes Research Institute (PCORI) Tax Submission** Insurers and self-insured plan sponsors owe a tax, based on the number of covered lives under the plan, to fund comparative effectiveness research.	The Internal Revenue Service.	By July 31 following each plan year that ends after Sept., 2012. See IRS table of due dates and amounts. *E.g., a calendar year plan files by July 31, 2013, for the plan year ending December 31, 2012.* Fee stops applying for plan years ending after Sept. 2019.	On IRS Form 720. The IRS has authorized several methods plan sponsors may use for computing the number of covered lives. See Lockton HRAP Alerts for details.	Applies to insurers and sponsors of self-insured plans. Tax was $1 per covered life for the plan year *ending* after September 2012; increased to $2 per covered life for the plan year ending after September 2013, adjusted for inflation for plan yeas ending after September 2014. The fee does not apply to "excepted benefits" such as most dental and vision coverage, most health FSAs, on-site clinics, long-term care, critical illness and most indemnity policies. EAPs, disease management and wellness programs not supplying significant benefits are exempt, as are stop-loss contracts. There is no exception for COBRA coverage, retiree-only plans or for governmental plans. However, most expatriate coverage is exempt, and the plan does not count individuals (and their dependents) whose addresses are outside the US. The fee does not apply to separate health reimbursement arrangements (HRAs) where the HRA and the medical plan are self-insured and have the same plan year. Where the medical plan is insured or the HRA has a different plan year, the HRA sponsor owes the fee for the HRA, but bases the amount due solely on the number of covered employees and retirees.

Notice	Who Gets It?	When?	How?	Comments
Health Reform: **Transitional Reinsurance Program Tax** This tax is imposed on insurers and administrators of self-insured plans for 2014-16, to fund transitional reinsurance programs in the states.	The Department of Health and Human Services	Insurers and self-insured plan sponsors report their covered lives for the calendar year by November 15 of that year (based on 9 months' enrollment data); tax is due no later than January 15, with the option to pay a portion of it by the following November 15.	The reporting and payment processes must be completed online through Pay.gov. Covered lives will be counted in a fashion similar to how they are counted for purposes of the PCORI tax (above).	Applies to insurers and sponsors of self-insured plans. Fee is $63 per covered life for 2014, $44 per covered life for 2015, and $27 per covered life for 2016. Applies to major medical coverage; many plan/program exemptions similar to exemptions for PCORI tax (above). Key differences include exemption available for coverage that pays secondary to Medicare.
Health Reform: **Plan Summaries (referred to as a "summary of benefits and coverage" or SBC)** The health reform law requires insurance carriers and plan sponsors to furnish "plain English" summaries of health plan benefits.	Enrollees. Notice to the eligible employee will be deemed notice to dependents if all members of the family unit reside at the same address.	**Initial Enrollments:** By the time written enrollment materials are provided; if none, not later than the first day the individual may enroll. If renewal is *automatic*, the SBC must be furnished no later than 30 days *prior* to the first day of the new plan year. **Special Enrollment:** Not later than 90 days *after* the special enrollment. **Mid-Year Material Plan Change:** Not later than 60 days *prior* to the effective date of the change. **Upon Request:** As soon as practicable, but not later than seven business days after the request.	In writing or electronically. Electronic distribution is permitted in connection with online enrollment or online renewal of coverage. Otherwise, electronic distribution will have to be accomplished in accordance with comprehensive federal regulations for the provision of electronic notices.	Applies to ERISA and non-ERISA plans. Applies to grandfathered and non-grandfathered plans. Summaries must be "culturally and linguistically appropriate." See discussion above. The requirement does not apply to HIPAA "excepted benefits"[1] maintained by non-governmental employers. Presumably, federal authorities will not enforce the requirement against excepted benefits maintained by governmental employers. The federal agencies have issued final regulations and a model SBC and accompanying glossary of terms and instructions.

Notice	Who Gets It?	When?	How?	Comments
Claims and Appeals: ERISA plans are subject to a variety of rules regarding the time within which health plan claims and appeals must be decided, and information they must supply upon an adverse benefit determination. We have not endeavored to describe those detailed rules here. However, we describe below the new claims and appeals rules that apply under health reform. Generally, health reform's claims and appeals rules start with ERISA's claims and appeals rules, bolster them in several ways, and then apply them to ERISA *and non-ERISA plans*, but only once the plans lose grandfathered status. Keep in mind the federal agencies have revised the new health reform rules for claims and appeals more than once and additional revisions are likely.				
Health Reform: **Claims and Appeals/Notice of External Review Process** The health reform law requires group health plans to issue a notice describing the new external review process under the state or federal procedures, as applicable.	All plan participants.	Not later than the first day of the plan year beginning on or after September 23, 2010.	No model notice has been issued yet. We assume most plans will provide this notice in their SPDs.	Applies to ERISA and non-ERISA plans (non-grandfathered plans only).
Health Reform: **Claims and Appeals/Notice of Adverse Benefit Determination (e.g., full or partial denial of claims, similar coverage or benefit determinations, etc.)** A group health plan must provide a written notice of an adverse benefit determination for initial claim denials.	The claimant or authorized representative.	**Urgent Care Claims:** 72 hours **Pre-Service Claims:** 15 days **Post-Service Claims:** 30 days **Concurrent Care Claims:** 24 hours for Urgent Care Claims; in other cases, the above periods apply.	In writing, using measures reasonably calculated to ensure actual receipt. Notification for urgent care claims may be provided orally, but written notice must follow within 3 days. Electronic notice is permitted, subject to compliance with the DOL's comprehensive regulations for the provision of electronic notices.	Applies to ERISA and non-ERISA plans (non-grandfathered plans only, as of the first day of the plan year beginning on or after September 23, 2010; some deadlines are deferred (see below)). ERISA group plans must comply with the current DOL claims regulations, except to the extent modified by applicable provisions of the health reform law. *Continued*

Notice	Who Gets It?	When?	How?	Comments
				Health reform requires the notice be provided in a "culturally and linguistically appropriate" manner and include several additional disclosures. Specifically, if 10% or more of a county's residents are literate in a non-English language, an EOB supplied to an enrollee residing in that county must include a statement offering language assistance. The statement must be in the relevant non-English language (limited to Spanish, Chinese, Tagalog or Navajo). *Plan sponsors will want to ensure their carriers (for insured plans) or third-party administrators (for self-insured plans) are prepared to comply with these requirements.* The DOL has supplied model notices in English and Spanish. Contact your Lockton Account Service Team.

Notice	Who Gets It?	When?	How?	Comments
Health Reform: **Claims and Appeals/Notice of Final Internal Adverse Benefit Determination (e.g., notice of plan's *internal* decision on a claim appeal)** A group health plan must provide written notice for an adverse benefit determination that has been upheld by the plan at completion of the plan's internal appeals procedures, or with respect to which the internal appeals procedures have been exhausted.	The claimant or authorized representative.	**Urgent Care Claims:** 72 hours **Pre-Service Claims:** 30 days **Post-Service Claims:** 60 days **Concurrent Care Claims:** 72 hours for Urgent Care Claims; in other cases, before treatment ends or is reduced, where adverse benefit determination is plan decision to reduce or terminate concurrent care early.	In writing, using measures reasonably calculated to ensure actual receipt. Electronic notice is permitted, subject to compliance with the DOL's comprehensive regulations for the provision of electronic notices.	Applies to ERISA and non-ERISA plans (non-grandfathered plans only, as of the first day of the plan year beginning on or after September 23, 2010; some deadlines are deferred (see below)). ERISA group plans must comply with the current DOL claims regulations, except to the extent modified by applicable provisions of health reform. Health reform requires the notice be provided in a "culturally and linguistically appropriate" manner and include additional disclosures. See discussion above. *Plan sponsors will want to ensure their carriers (for insured plans) or third-party administrators (for self-insured plans) are prepared to comply with these requirements.* The DOL has supplied model notices in English and Spanish. Contact your Lockton Account Service Team.

Notice	Who Gets It?	When?	How?	Comments
Health Reform: **Claims and Appeals/Preliminary Notice Regarding Request for External Review** Plans must provide notice to individuals filing for an external review of a claim, regarding whether the individual is eligible for external review.	The claimant or authorized representative.	Within 1 business day following completion of the preliminary review. The Plan has 5 business days following the date of receipt of the external review request to complete the preliminary review.	In writing.	Applies to ERISA and non-ERISA plans (non-grandfathered self-insured plans subject to the federal external review process as of the first day of the plan year beginning on or after September 23, 2010). If the claimant's request for external review is complete, but not eligible for external review, the notification must include the reasons for its ineligibility, and contact information for the EBSA. If the request is not complete, the notification must describe the information or materials needed to make the request complete and the plan must allow a claimant to perfect the request for external review within the 4-month filing period or within the 48-hour period following the receipt of the notification, whichever is later. *Plan sponsors will want to ensure their carriers (for insured plans) or third-party administrators (for self-insured plans) are prepared to comply with these requirements.*

Notice	Who Gets It?	When?	How?	Comments
Health Reform: **Claims and Appeals/Notice of Final External Review Decision** The health reform law provides for an external review process following exhaustion of the internal appeals process. Similar to the internal claims and appeals process, an Independent Review Organization (IRO) must provide a notice of its final decision.	**Federal Process:** An IRO must provide notice to the claimant or authorized representative and the Plan. **State Process:** An external review examiner must provide notice to the claimant or authorized representative and the insurance company.	**External Review:** Within 45 days of receipt of the request for the external review. **Expedited External Review:** As expeditiously as the claimant's medical condition may require, but in no event more than 72 hours after receipt of the request for an expedited external review.	**External Review:** In writing. Unclear how may be distributed "in writing." **Expedited External Review:** May be provided in an electronic form, but a follow-up written notice must be provided within 48 hours from the initial notice.	Applies to ERISA & non-ERISA plans (non-grandfathered plans only, as of the first day of the plan year beginning on or after September 23, 2010). The primary focus here is on self-funded plans subject to the external review process. The external review obligation for fully-insured plans lies with the carriers and is subject to applicable state review guidelines, as they may be supplemented by federal standards. In the case of self-insured plans, the plan sponsor will want to ensure that the IRO is properly and timely handling this notice. The DOL has supplied model notices in English and Spanish. Contact your Lockton Account Service Team.

Notice	Who Gets It?	When?	How?	Comments
Misc. Notices/Reports: **Women's Cancer Rights Act Notice** General explanation of the plan's coverage of breast reconstruction and prostheses following mastectomy.	Participants (covered employees/retirees), COBRA, and other beneficiaries receiving benefits, and alternate recipients.	At enrollment and annually (prior to the beginning of the plan year) thereafter.	In writing. Notice may be a separate document or included in the SPD (as long as furnished timely). A separate notice included in the annual enrollment packet is appropriate and typical, but must be "prominent." Electronic notice is permitted, subject to the DOL's comprehensive regulations for the provision of electronic notices.	Applies to ERISA and non-ERISA plans. State and local self-insured governmental plans may opt out. Lockton maintains a model notice. Contact your Lockton Account Service Team.
Misc. Notices/Reports: **Michelle's Law Notice** A notice summarizing the availability of continued pre-COBRA coverage for ill college students.	Participants, COBRA beneficiaries and alternate recipients under a QMCSO (presumably; guidance not yet issued).	Apparently only required if the plan provides notice reflecting that certification of student status is required in order to cover a college-age dependent child. Such notice must include a description of the continued coverage available to ill college students, under Michelle's Law.	Apparently, with any notice (supplied by the plan) concerning a requirement to certify student status as a pre-requisite to coverage of a college-age dependent child.	Applies to ERISA and non-ERISA plans. State and local self-insured governmental plans may opt-out. Does not apply to "excepted benefits" such as most dental and vision coverage, most health FSAs, on-site clinics, long-term care, critical illness and most indemnity policies. Due to health reform, this notice appears to have continuing relevance only for plans that impose a "full-time student" requirement below age 26, on children who are not natural, step, adopted, or foster children, and/or continue coverage to students beyond age 26.
Misc. Notices/Reports: **USERRA Notice** Notice of employees' rights and obligations under the Uniformed Services Employment and Reemployment Rights Act.	Employees.	If notice is not already posted, it should be posted immediately.	Notice may be posted where labor relations notices are posted.	Applies to all employers. The DOL has provided a model notice. There is a model notice for federal executive agencies, and a separate model notice for private employers and state and local governments.

Notice	Who Gets It?	When?	How?	Comments
Misc. Notices/Reports: **Notice of Premium Assistance Under Medicaid or the Children's Health Insurance Program** Notice to inform employees of potential opportunities currently available in the state in which the employee resides for group health plan premiums assistance under Medicaid and the Children's Health Insurance Program (CHIP).	Every employee, regardless of enrollment status, residing in a state which offers premium assistance under Medicaid or CHIP, if the employer provides health plan coverage to individuals in that state. Currently, about 40 states offer such assistance.	Annually.	In writing. May be furnished with enrollment packets, other plan materials, or SPDs. ***Regulations require the notice to be a separate document***, even if offered with enrollment materials. May be hand-delivered, or delivered via first-class mail. Electronic distribution is permitted in accordance with the DOL's comprehensive regulations for the provision of electronic notices.	Applies to ERISA and non-ERISA plans. The DOL has provided a model notice on its website. Contact your Lockton Account Service Team. This notice will be updated annually to reflect any changes in the number of States offering premium assistance programs. Currently, about 40 states offer such assistance.
Misc. Notices/Reports: **Notice of Cancellation of Coverage During FMLA Leave (for nonpayment)** Notice that the employer is canceling an employee's coverage during FMLA leave, for nonpayment of premium when payment is more than 30 days late.	The covered employee who is on FMLA leave.	The notice is provided once the employee's premium payment is more than 30 days late and at least 15 days prior to the date coverage will cease.	In writing, by mail (preferably first-class) to the covered employee.	Applies to all employers subject to the FMLA. The notice must provide that coverage will terminate upon a specified date that is at least 15 days after the date of the notice if payment is not received. Once proper notice is supplied, coverage may be cancelled retroactively to the date when the unpaid premium was due ***only*** if the employer has an established policy to that effect. Else, coverage continues through the 30-day grace period. There is no model notice.

Notice	Who Gets It?	When?	How?	Comments
Misc. Notices/Reports: **Notice of Comparable Contributions to Health Savings Accounts** A notice, by employers whose HSA contributions are subject to the "comparability" rules, to employees who failed to establish an HSA by year's end, or who did so but failed to tell the employer. The notice advises such employees of the availability of comparable employer contributions to their HSAs.	Employees who are eligible to make HSA contributions, where the employer makes its own contributions to employees' HSAs and is required to make "comparable" contributions to the HSAs of comparable employees. To benefit from the comparable contributions, the employee must establish an HSA and notify the employer by the end of February following the year for which the employer must make comparable contributions.	Annually, no earlier than 90 days before the first HSA employer contribution for that calendar year (if the contribution is subject to the comparability rules) and no later than January 15 of the following calendar year. If subject to these rules, the employer must make the comparable contributions for the prior year, with interest, by April 15.	In writing, or electronically in accordance with IRS guidelines. The IRS has supplied a model notice.	Applies to all employers making HSA contributions subject to the comparability rules. Employers who make contributions to employees' HSA are subject to the comparability rules ***unless*** they allow employees to make their own pre-tax contributions to their respective HSAs, through the employer's Section 125 cafeteria plan. ***Most employers satisfy this exception.***
Misc. Notices/Reports: **EEOC Notice Under ADA for Employees Participating in Wellness Programs** A notice required under the Americans with Disabilities Act for employees participating in wellness programs involving medical examinations or disability-related inquiries.	Employees participating in wellness programs involving medical examinations (e.g., biometrics) or disability-related inquiries (e.g., health risk questionnaires).	Prior to the employees' participation.	May be provided via hand delivery, mail or electronically. Most programs will supply the notice as part of registration for biometrics, or as part of a log-in process for an online health risk questionnaire.	The EEOC has offered a model notice.
Misc. Notices/Reports: **EEOC Authorization Under GINA for Spouse's Participation in Wellness Programs** An authorization required under the Genetic Information Nondiscrimination Act when an employer's wellness program offers an incentive in exchange for a spouse's participation in a health risk assessment, including biometrics.	Wellness programs offering an incentive to spouses for participation in a wellness program, where the spouse is asked to supply information about his/her health history or health condition, must obtain this authorization.	Prior to the spouse's participation.	May be provided via hand delivery, mail or electronically. Most programs will supply the notice as part of registration for biometrics, or as part of a log-in process for an online health risk questionnaire.	There is no model authorization provided by the EEOC. Lockton has prepared a model authorization. Most wellness vendors will have their own model form.

Notice	Who Gets It?	When?	How?	Comments
Misc. Notices/Reports: **Notice of Qualifying Small Employer Health Reimbursement Arrangement (QSEHRA)**	All employees eligible to participate in the QSEHRA, regardless of enrollment status.	Annual Notice: At least 90 days before beginning of the "year" Initial Enrollment: first date the employee is eligible to participate in QSEHRA *Transitional Relief: IRS Notice 2017-20 acknowledged that additional guidance concerning the content of these notices will be issued in the near future. In the meantime, an employer who established a QSEHRA to begin any time during 2017 is not required to give the initial written notice to eligible employees until after additional IRS guidance has been issued.* ***Until that time, no penalty will be assessed for failure to provide the initial written notice.*** *For employers who choose to provide a notice before further guidance is issued, content of the notice can be based on a reasonable good faith interpretation of the statute.*	In writing.	Applies to small employers ***not subject to the ACA employer mandate***, meaning the employer employs fewer than 50 full-time employees (including full-time equivalent employees), and who sponsor a QSEHRA that reimburses employees for medical insurance premiums on a tax-free basis. The notice must: • Describe the employee's benefit under the QSEHRA. • Include a statement that the employee should give the information about his or her QSEHRA benefit to any health insurance marketplace through which the employee qualifies for ACA subsidies to defray the cost of the insurance. • Include statement that if the employee is not covered by Minimum Essential Coverage, he or she may be subject to ACA individual mandate penalties and may have to include the QSEHRA benefit in his or her taxable income. *We expect a model notice to be provided by the IRS in the near future to provide additional guidance as to required content.*

Notice	Who Gets It?	When?	How?	Comments
Misc. Notices/Reports: **W-2 Reporting of Imputed Taxable Income**	Employees and the IRS.	By January 31.	Reported on W-2s mailed to employees, and submitted to the IRS.	An employer obligation. Imputed income can arise under health plans where coverage is provided to non-dependent domestic partners and/or their children, or to an employee's non-dependent adult children beyond the year in which the children attain age 26. Note that imputed income can also arise under group-term life plans and some LTD programs. State income taxation may vary from federal taxation, depending on the circumstance.

Notice	Who Gets It?	When?	How?	Comments
Standard ERISA Notices/Reports: **Annual Report (Form 5500)**	The Department of Labor	Within 7 months after the close of the Plan Year (an automatic 2-1/2-month extension is available for the asking).	On a Form 5500, with appropriate schedules attached.	Applies to ERISA plans only. Exemptions apply to unfunded or insured welfare plans that have fewer than 100 participants at the beginning of the plan year.
Standard ERISA Notices/Reports: **Summary Annual Report** Summary of pertinent information from the plan's Form 5500 filing.	Participants (employees and retirees) in the health plan, COBRA and other beneficiaries receiving benefits, and alternate recipients under QMCSOs.	Within 9 months after end of the plan year or, if later, two months after the extended deadline for filing the plan's Form 5500.	In writing. Electronic notice is permitted, subject to compliance with the DOL's comprehensive regulations for the provision of electronic notices.	Applies to ERISA plans only, even if the plan filed a Form 5500. The SAR requirement does not apply to plans that pay benefits exclusively from the employer's general assets (i.e. no trust, no insurance contract, participant contributions are made through a Section 125 plan, etc.).
Standard ERISA Notices/Reports: **Plan Documents** Plan and related documents such as insurance contracts, trust agreements, etc.	Participants (employees and retirees), beneficiaries, COBRA beneficiaries, and alternate recipients, upon written request.	Within 30 days after receipt of the written request.	In writing. The plan may make a reasonable charge for copying, not to exceed 25 cents per page.	Applies to ERISA plans only. There is a $110 per day penalty for each day the administrator fails to supply the requested documents without good cause, after 30 days.
Standard ERISA Notices/Reports: **Summary Plan Description** A plain summary of the plan's key provisions.	Participants (employees and retirees), COBRA beneficiaries, and alternate recipients under a QMCSO.	Within 90 days after coverage begins or, for a new plan, within 120 days after the plan begins.	In writing. May be hand delivered or mailed. Electronic SPD is permitted, subject to the DOL's comprehen-sive regulations for the provision of electronic notices.	Applies to ERISA plans only. DOL regulations describe the required contents of an SPD. Must restate the SPD every five years (10 years if no changes). Note the differences between the SPD obligation, and the obligation (under health reform) to furnish a Summary of Benefits and Coverage (SBC).

Notice	Who Gets It?	When?	How?	Comments
Standard ERISA Notices/Reports: **Summary of Material Reduction in Benefits** Notice of amendments that effect a material reduction in benefits.	Participants (employees and retirees), COBRA and other beneficiaries receiving benefits, and alternate recipients under QMCSOs.	Within 60 days after adoption of the change. Note: "adoption" means when the employer formally approves the change.	In writing. Electronic notice is permitted, subject to compliance with the DOL's comprehensive regulations for the provision of electronic notices.	Applies to ERISA plans only. A reduction is "material" if a typical participant would reasonably consider it as such. This can include elimination of benefits and networks, reduction in service area, increase in premiums, deductibles, co-pays and coinsurance, additional pre-authorization requirements, etc. Note that changes to the information required to be contained in an SBC must be provided *earlier* than this deadline. A plan may satisfy this SMR obligation with the same document it uses to satisfy the "summary of the change to SBC information."
Standard ERISA Notices/Reports: **Summary of Material Modification** Description of material plan amendments, other than amendments making material reduction in benefits.	Participants (employees and retirees), COBRA and other beneficiaries receiving benefits, and alternate recipients under QMCSOs.	Within 210 days after the close of the year in which the change is adopted.	In writing. Electronic notice is permitted, subject to compliance with the DOL's comprehensive regulations for the provision of electronic notices.	Applies to ERISA plans only. Compare this disclosure obligation with the accelerated due dates for Summaries of Material Reductions in Benefits, and for updated Summaries of Benefits and Coverage.

Notice	Who Gets It?	When?	How?	Comments
Standard ERISA Notices/Reports: **Form M-1 (MEWAs)** Multiple employer health plans only.	The Department of Labor	Not less than 30 days prior to the MEWA's origination. Thereafter, each March 1 (but see exception, below). In addition, within 30 days after: the MEWA begins operating in an additional state; a participant increase of 50% or more; a merger with another MEWA; or after a material change in the financial or custodial information reported in Part II of the Form M-1. An annual report (March 1) is not required if between Oct. 1 and Dec. 1 of the prior year the MEWA experienced an origination or special filing event and timely filed the M-1. An automatic 60-day extension of time is available by filling out certain initial portions of the Form, as described in the instructions. There is no delinquent filer program for late M-1 filings.	On a Form M-1. Filing must be done online.	Applies to ERISA plans only. If the participating employers do not control the plan design and administration, it's possible that each employer will need to file a separate Form 5500 for its respective slice of the larger MEWA. Filing is only required of health plans that are MEWAs. Some MEWAs are exempt from filing, including those with at least 25% common ownership of participating employers, or where the non-employees whose coverage gives rise to MEWA status amount to 1% of less of the total number of covered employees (this does not mean the arrangement is not a MEWA; it merely means that filing the M-1 is excused).

Notice	Who Gets It?	When?	How?	Comments
Standard ERISA Notices/Reports: **Form M-1 (for "Entities Claiming Exemption" (ECEs) from M-1 obligation due to collectively bargained status)**	The Department of Labor	Not less than 30 days prior to the ECE's origination. Thereafter, each March 1 if the ECE was last originated within the 3 years before the relevant March 1 annual filing due date (an ECE may be "originated" more than once). In addition, within 30 days after: a participant increase of 50% or more, or a merger with another ECE (generally; see instructions). In addition, within 30 days after the ECE begins operating in an additional state, or after a material change in the financial or custodial information reported in Part II of the Form M-1, but only if the event occurs within 3 years after an origination event. An automatic 60-day extension of time is available by filing out certain initial portions of the Form, as described in the instructions. There is no delinquent filer program for late M-1 filings.	On a Form M-1. Filing must be done online.	Applies to ERISA plans only. Some ECEs are exempt. See the instructions.

Notice	Who Gets It?	When?	How?	Comments
State & Local Notices: **Massachusetts Form 1099-HC**	Employees in Massachusetts who had creditable coverage under the employer's plan during the calendar year; and the Massachusetts Department of Revenue.	By January 31.	By mail or hand-delivery to employees; by electronic file to the Department of Revenue. The employer has the obligation; but if the plan is insured and the contract was issued or delivered in MA, the carrier has the obligation.	An employer obligation. The obligation may be preempted by ERISA, but to our knowledge there has not been a challenge lodged against the requirement. Penalties of $50 per Form, up to $50,000 maximum, apply for failures to comply. Forms should also be provided to retirees and COBRA beneficiaries.
State and Local Notices: **San Francisco Health Care Expenditures and Reports** The City's Health Care Security Ordinance may require quarterly payments to the City; **and** it requires an annual filing from covered employers.	Employers who satisfy the Health Care Security Ordinance by making health care contributions to the City, on employees' behalf, submit contributions to the Department of Public Health. The annual report is filed with the Office of Labor Standards Enforcement.	Quarterly contributions, if any, are due 30 days after the close of each calendar quarter. The annual report is filed by April 30 of each year.	Contributions are made online via the Department of Public Health website; the employer also submits online a roster of covered employees and the employer's contribution on their behalf. The annual report is a written report submitted on a form supplied with employer's annual business registration form.	An employer obligation. Making quarterly contributions to the City is only one way to satisfy the Health Care Security Ordinance's health care expenditure obligation. See Lockton's *Employer's Guide to the San Francisco Health Care Security Ordinance.*
State and Local Notices: **San Francisco Employee Health Care Payment Confirmation** The employer also has disclosure obligations to employees, in certain cases.	Where the employer makes health care contributions to the City on behalf of covered employees, it must supply employees with a notice to that effect.	The City's regulations do not specify a timing requirement for the notice.	The City's regulations do not specify a method of delivery. We suspect mere posting of a notice is not adequate.	An employer obligation. The Payment Confirmation may be downloaded from the City's Office of Labor Standards Enforcement (OLSE) website. See Lockton's *Employer's Guide to the San Francisco Health Care Security Ordinance.*

Notice	Who Gets It?	When?	How?	Comments
State and Local Notices: **Notice of San Francisco Health Care Security Ordinance**	Employees.	If notice is not already posted, it should be posted immediately.	Notice may be posted.	Applies to businesses with 20 or more employees (and nonprofit organizations with 50 or more employees) who are subject to the San Francisco Health Care Security Ordinance.
State and Local Notices: **San Francisco Commuter Benefits Compliance Reporting Form**	The San Francisco Commute Smart Program.	April 30th for the current calendar year.	The City provides an online form on its website.	Applies to businesses with a location in San Francisco (including non-profit organizations) with 20 or more employees nationwide. Employers are required to offer at minimum, one of three commuter benefits (i.e., pre-tax deduction for transit or vanpool expenses, monthly subsidy for transit or vanpool expenses, or company-funded shuttle service). Employers must also distribute (electronically or hard copy) and post a separate Commuter Benefits Ordinance Employee Flyer. The flyer is available online.