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DUE DATE	TOPIC	REQUIREMENT
6/1/2023	Prescription Drug and Health Care Spending Reporting	▪ Annual report due to the federal government by employer-sponsored health plans and health insurance issuers to report information about prescription drugs and health care spending to the federal government for the 2022 reference year. This reporting process is referred to as the "prescription drug data collection" ("RxDC report"). ▪ Most employers will rely on third parties, such as issuers, third-party administrators (TPAs) or pharmacy benefit managers (PBMs) to prepare and submit the RxDC report for their health plans
6/30/2023 (60 days after beginning of plan year)	Medicare Part D disclosure to CMS (for plans with plan years beginning 5/1)	▪ (Plan sponsors of plans with plan years beginning 5/1 must complete online disclosure form regarding creditable coverage status of their group health plans' Rx coverage. The disclosure form is available at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html
6/30/2023 (last day of 7th month following end of the plan year)	Form 5500 filing due for ERISA plans with 12/1 plan years	▪ All ERISA health and welfare plans with plan years beginning 12/1 with 100+ participants are required to report (unless extension filed).
7/1/2023	Washington Cares Fund Payroll Tax Withholding Begins	▪ Applicable to employers with employees in Washington State unless exemption applies
7/10/2023	End of COVID-19 Outbreak Period	▪ Health plans can go back to their nonextended deadlines for purposes of HIPAA special enrollment, COBRA continuation coverage, and claims and appeals procedures. ▪ Plan sponsors should discuss with their carriers, third-party administrators, and COBRA administrators on required changes to plan documents and processes that may be required; assign related responsibilities

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DUE DATE	TOPIC	REQUIREMENT
7/28/2023 (or 210 days after end of plan year)	Summary of material modifications (SMMs) for calendar year plans	▪ Distribute SMMs regarding plan amendments adopted during previous year (2022) that reflect changes to the Summary Plan Description (SPD) (unless revised SPD is distributed that contains the modifications)
7/31/2023 (or 60 days after beginning of plan year)	Medicare Part D disclosure to CMS (for plans with plan years beginning 6/1)	▪ Plan sponsors of plans with plan years beginning 6/1 must complete online disclosure form regarding creditable coverage status of their group health plans' Rx coverage. The disclosure form is available at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html
7/31/2023 (or last day of the 7th month after end of plan year)	Form 5500 reporting deadline for plans with calendar year (1/1) plan years	▪ All health and welfare plans with 1/1 plan years and greater than 100+ participants that are subject to ERISA are required to report unless an exemption applies ▪ Small health plans (fewer than 100 participants) that are fully insured, unfunded or a combination of insured/unfunded are generally exempt from the Form 5500 filing requirement. ▪ Employers may request a one-time extension of 2.5 months by filing a Form 5558
7/31/2023	Patient Centered Outcomes Research Institute (PCORI) Fee due for plan years ending in 2022	▪ Self-funded group health plans (including retiree plans and HRAs) must pay fee, based on enrollee count, using IRS Form 720 ▪ For plan years ending after 1/1/22 and before 10/1/22 fee is $2.79 per enrollee ▪ For plan years ending on or after 10/1/22 and on or before 12/31/22 (includes most calendar year plans), fee amount per enrollee is $3.00 ▪ If medical plan is not self-funded the medical carrier will be responsible for paying this fee directly to the IRS

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DUE DATE	TOPIC	REQUIREMENT
8/1-10/31/2023 (approximately)	Medical Loss Ratio (MLR) Rebates	▪ Sponsors of insured health plans may receive rebates if their issuers did not meet their MLR for the respective reporting year. Rebates must be provided to plan sponsors by September 30 following the end of the MLR reporting year. ▪ Employers that receive rebates should consider their legal options for using the rebate. Any rebate amount that qualifies as a plan asset under ERISA must be used for the exclusive benefit of the plan's participants and beneficiaries. If received, the rebate amount attributable to plan assets generally must be distributed pro-rata to the members in either premium credits or other benefit within 90 days of receipt ▪ Plan sponsors should document how rebate was used
8/15/2023 (or 15th day of 8th month following end of plan year if 1st extension was filed)	Form 990 (or 990-EZ), 2nd 3-month extension permitted by filing Form 8868 by this date	▪ Applies to VEBAs
8/31/2023 (or 60 days after the beginning of the plan year)	Medicare Part D disclosure to CMS (for plans with plan years beginning 7/1)	▪ Plan sponsors of plans with plan years beginning 7/1 must complete online disclosure form regarding creditable coverage status of their group health plans' Rx coverage. The disclosure form is available at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html
8/31/2023 (or last day of the 7th month after the end of plan year)	Form 5500 filing due for ERISA plans with 2/1 plan years	▪ All ERISA health and welfare plans with plan years beginning 2/1 with 100+ participants are required to report (unless extension filed).

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DUE DATE	TOPIC	REQUIREMENT
9/30/2023(or 60 days after the beginning of the plan year)	Medicare Part D disclosure to CMS (for plans with plan years beginning 8/1)	▪ Plan sponsors of plans with plan years beginning 8/1 must complete online disclosure form regarding creditable coverage status of their group health plans' Rx coverage. The disclosure form is available at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html
9/30/2023 (or last day of the 7th month after the end of plan year)	Form 5500 filing due for ERISA plans with 3/1 plan years	▪ All ERISA health and welfare plans with plan years beginning 3/1 with 100+ participants are required to report (unless extension filed).
10/2/2023 (or 9 months after end of plan year; additional 2 months permitted if Form 5558 extension filed)	Summary Annual Report (calendar year plan years)	▪ Plan Sponsors that file Form 5500 must provide to covered participants a summary of the information in the Form 5500
10/13/2023	Notice of Medicare Part D Creditable/ Non-Creditable Coverage (Medicare Part D Notice)	▪ Provide to Medicare Part D-eligible participants (employee or dependent who is over age 65 or permanently disabled) annually ▪ Providing Notice during open enrollment to all participants is generally adequate ▪ Model disclosure notices are available on CMS' website.
10/16/2023 (or 9 ½ months after end of the plan year+ extension period)	Form 5500 (calendar year plan years) if extension Form 5558 was filed	▪ All health and welfare plans with 100+ participants that are subject to ERISA must report

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DUE DATE	TOPIC	REQUIREMENT
10/31/2023 (60 days after the beginning of the plan year)	Medicare Part D disclosure to CMS (for plans with plan years beginning 9/1)	▪ Plan sponsors of plans with plan years beginning 9/1 must complete online disclosure form regarding creditable coverage status of their group health plans' Rx coverage. The disclosure form is available at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html
10/31/2023(last day of the 7th month after the end of the plan year	Form 5500 filing due for ERISA plans with 4/1 plan years	▪ All ERISA health and welfare plans with plan years beginning 4/1 with 100+ participants are required to report (unless extension filed).
11/15/2023 (or 15th day of the 11th month after end of the plan year)	Form 990 (or 990-EZ), if second 3- month extension was obtained)	▪ Applies to VEBAs only
11/30/2023 (60 days after the beginning of the plan year)	Medicare Part D disclosure to CMS (for plans with plan years beginning 10/1)	▪ Plan sponsors of plans with plan years beginning 10/1 must complete online disclosure form regarding creditable coverage status of their group health plans' Rx coverage. The disclosure form is available at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html
11/30/2023 (last day of the 7th month after the end of the plan year	Form 5500 filing due for ERISA plans with 5/1 plan years	▪ All ERISA health and welfare plans with plan years beginning 5/1 with 100+ participants are required to report (unless extension filed).

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DUE DATE	TOPIC	REQUIREMENT
12/15/2023	Health Insurance Responsibility Disclosure (HIRD) form due to Massachusetts Department of Revenue For more information visit https://www.mass.gov/info-details/health-insurance-responsibility-disclosure-hird-faqs	▪ Applies to employers (regardless of location) with six or more employees within Massachusetts during the previous 12 months ▪ Filing is to be completed electronically from 11/15/2023-12/15/2023
12/15/2023 (or 2 months after close of extension period for filing Form 5500)	Summary Annual Report (calendar year plan years) if extension was filed	▪ Plan Sponsors that file Forms 5500 must provide to covered participants
12/29/2023 (60 days after the beginning of the plan year)	Medicare Part D disclosure to CMS (for plans with plan years beginning 11/1)	▪ Plan sponsors of plans with plan years beginning 11/1 must complete online disclosure form regarding creditable coverage status of their group health plans' Rx coverage. The disclosure form is available at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html
12/29/2023 (last day of the 7th month after the end of plan year)	Form 5500 filing due for ERISA plans with 6/1 plan years	▪ All ERISA health and welfare plans with plan years beginning 6/1 with 100+ participants are required to report (unless extension filed).
12/29/2023	Update/amend documents for 2023 plan year	▪ Provide updated SBCs in connection with plan's 2023 open enrollment period ▪ Amend cafeteria plan to reflect any changes made in 2023 ▪ Amend/restate wrap document and SPD as necessary

DUE DATE	TOPIC	REQUIREMENT
12/31/2023	Attestation of compliance with prohibition on gag clauses	▪ Ensure any contracts with TPAs or other health plan service providers offering access to a network of providers do not violate the CAA's prohibition of gag clauses ▪ **Fully insured plans**- if the issuer for a fully insured health plan provides the attestation, the plan does not also need to provide an attestation. ▪ **Self-insured plans-** consider entering into written agreements with their third-party administrators to provide the attestation, but the legal responsibility ultimately remains with the health plan
1/1/2024	Compliance effective date for Phase III of Final Transparency in Coverage Rules requiring the hosting of an internet-based price comparison tool available to participants, beneficiaries and enrollees for all covered items and services	▪ **Fully insured plans**—Employers should confirm that their issuer will comply with the price comparison tool requirements beginning with 2024 plan years and ensure this compliance responsibility is reflected in a written agreement ▪ **Self-insured plans**—Employers should reach out to their TPAs (or other service providers) to confirm they will be in compliance by the deadline and update agreements to reflect this responsibility. In addition, employers should monitor their TPAs' compliance with this requirement. Unlike fully insured plans, the legal responsibility for this tool stays with a self-insured plan even if its TPA agrees to provide the price comparison tool on its behalf

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DUE DATE	TOPIC	REQUIREMENT
NEW HIRES		
New Hires	New Health Insurance Marketplace Coverage Options Notice (Exchange Notice)	▪ Provide to all new hires within 14 days of hire date
FOR NEWLY ELIGIBLE EMPLOYEES OR ENROLLEES		
Newly Eligible	Summary of Benefits and Coverage (SBC)	▪ Provide no later than the 1st day individual is eligible to enroll
Newly Eligible	Medicare Part D Notice	▪ Provide prior to effective date of coverage in plan
Newly Eligible	HIPAA Notice of Special Enrollment Rights	▪ Provide at or prior to the time employee is initially offered opportunity to enroll in plan (could be included in SPD)
Newly Eligible	Notice regarding premium assistance under Medicaid or CHIP (CHIPRA Notice) https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra	▪ Could be included in SPD or with other open enrollment materials
New Enrollees	COBRA General Notice	▪ Provide within 90 days of initial plan enrollment (could be included in SPD if sent within 90-day period)
New Enrollees	Summary Plan Description (SPD)	▪ Plan Sponsors whose health and welfare benefit plans are subject to ERISA must provide within 90 days of plan enrollment
New Enrollees	HIPAA Privacy Rights Notice	▪ If health plans is self-funded, provide at the time of plan enrollment ▪ If health plan is fully-insured, confirm carrier will distribute ▪ Notice
New Enrollees	Women's Health & Cancer Rights Act Notice	▪ Provide upon initial plan enrollment (could be included in SPD)
New Enrollees	Newborns' and Mothers' Health Protection Act notice relating to hospital stays in connection with childbirth	▪ Provide upon initial plan enrollment - include in SPD

DUE DATE	TOPIC	REQUIREMENT
ANNUAL DISTRIBUTION REQUIREMENTS		
Annual	Women's Health & Cancer Rights Act Notice	▪ Provide at open enrollment (could be included in SPD if distributed annually or with other enrollment materials)
Annual	Notice regarding premium assistance under Medicaid or CHIP (CHIPRA Notice) https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra	▪ Provide to all eligible employees (could be included with other enrollment materials) ▪ Could be included in SPD if distributed annually or with other open enrollment materials
Annual	Michelle's Law notice	▪ Provide at open enrollment if applicable (only would apply if plan covers full-time students over age 26) ▪ Provide at open enrollment (could be included in SPD if distributed annually or with other enrollment materials)
Annual	SBCs	▪ If employee must make affirmative benefit elections: provide SBC at open enrollment to those currently enrolled in plan with other open enrollment materials ▪ If re-enrollment in the plan is automatic: provide SBC no later than 30 days prior to beginning of plan year ▪ If multiple benefit plan options are available at open enrollment, only need to provide a new SBC with respect to the plan option employee is enrolled in. Any request for SBCs of other plan options must be provided within 7 business days
Annual	Medicare Part D Notice	▪ Provide to all Part D eligible individuals covered under, or who apply for coverage under, an employer plan option that provides for prescription drug coverage, before October 15 (October 13, 2023)

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DUE DATE	TOPIC	REQUIREMENT
ANNUAL DISTRIBUTION REQUIREMENTS		
Annual	Nondiscrimination Testing	▪ Ensure applicable nondiscrimination testing is performed at least annually: · Code Section 105(h) · Code Section 79 · Code Section 125 · Code Section 505 · Code Section 129
MISCELLANEOUS/ONGOING REQUIREMENTS		
Upon material change or reduction to plan terms or coverage to SBC	Advance Notice of Material Modifications	▪ Notice must be provided to plan participants no later than 60 days prior to effective date of change if not reflected in the most recent SBC provided and change occurs mid-plan year (updated SBC could be provided in lieu of Notice)
Upon material change or reduction to plan terms or coverage impacting information required to be included in SPD	▪ Summary of Material Modifications (SMM) ▪ Summary of Material Reductions(SMR)	▪ SMM (that are not SMRs) amending SPD must be provided to plan participants no later than 210 days after the end of the plan year in which the change was adopted ▪ SMR amending SPD must be provided to plan participants no later than 60 days after adoption date
Grandfathered Plans	Statement of Grandfathered status	▪ Include DOL model language on all plan related materials provided to participants/ beneficiaries that are grandfathered under ACA

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DUE DATE	TOPIC	REQUIREMENT
Ongoing	Notice of Patient Protections (applies to health plans that require designation of primary care provider)	▪ If applicable and plan is not grandfathered, include in SPD or other benefit summaries
Ongoing	Notice of participation in Early Retiree Reinsurance Program (ERRP)	▪ Provide to plan participants within a reasonable time after receipt of its ERRP reimbursement (or sooner) ▪ NOTE: ERRP ended 1/1/14
Ongoing	ERISA plan document; cafeteria plan document	▪ Provide within 30 days of receipt of written request
Ongoing	SBCs	▪ Provide to plan participants at special enrollment within 90 days of plan enrollment ▪ Provide no later than 7 days following receipt of request
Ongoing	SPD	▪ Provide updated version to all participants at least every 5 years (10 years if no changes) ▪ Provide within 30 days of request by plan participant ▪ Provide within 30 days of request by DOL
Ongoing	Newborns' and Mothers' Health Protection Act Notice	▪ Include in SPD
Ongoing	Medicare Part D Notice	▪ Provide to Medicare eligible participants upon any change that affects whether or not coverage is "creditable" ▪ Provide upon request
Ongoing	Medicare Fee	▪ Withhold an additional Medicare Tax of 0.9% on wages in excess of $200,000 in a calendar year
Ongoing	HIPAA Privacy Notice	▪ Provide any updated Notice to participants within 60 days ▪ Provide notice of availability to receive Notice every three years
Ongoing	COBRA Notice of Qualifying Event	▪ Provide Notice to COBRA administrator generally within 30 days of qualifying event

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DUE DATE	TOPIC	REQUIREMENT
Ongoing	COBRA Election Notice	▪ COBRA administrator must provide Notice to plan participants and beneficiaries within 14 days after being notified by employer of qualifying event ▪ If employer is also the COBRA administrator, employer has 44 days from date of qualifying event (or loss of coverage) to send Notice to participants/beneficiaries
Ongoing	Notice of Unavailability of COBRA Coverage	▪ Provide to individuals who are not qualified for COBRA coverage within 14 days after receiving COBRA Notice of Qualifying Event (requesting COBRA)
Ongoing	Notice of Early Termination of COBRA Coverage	▪ Provide to COBRA beneficiaries as soon as practicable following a determination that their COBRA coverage will terminate before the maximum coverage period
Ongoing	Medical Child Support Order (MCSO) Notice	▪ Provide immediately upon receipt of support order to participants, any child named in the order, and the child's representative
Ongoing	Notice of determination of MCSO status	▪ Provide to affected employee/participant within reasonable period after MCSO is received
Ongoing	National Medical Support (NMSO) Notice	▪ Notify affected persons of receipt of NMSO as soon as practicable ▪ Provide Part A to state agency or Part B to the plan administrator within 20 days after date of Notice ▪ COBRA administrators must complete and return Part B to the state agency and affected persons within 40 business days
Ongoing	QMCSO Procedures	▪ Include in SPD ▪ If not in the SPD, provide procedures to participants along with Medical Child Support Order Notice or National Medical Support Notice

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DUE DATE	TOPIC	REQUIREMENT
Ongoing	Notice of Rescission of Coverage	▪ Provide to affected participants at least 30 days prior to rescinding coverage
Ongoing	HIPAA Notice of Breach of Unsecured Protected Health Information	▪ Provide to affected individuals within 60 days after breach discovery ▪ For breaches affecting fewer than 500 individuals file annual report with HHS within 60 days after end of the year of the breach ▪ For breaches affecting more than 500 individuals report to HHS/media outlets within 60 days of discovery
Ongoing	Mental Health Parity & Addiction Equity Act Disclosure	▪ Upon request, provide disclosure of criteria used by plan for determining medical necessity for mental health or substance use disorder benefits
Ongoing	Wellness Program Disclosure	▪ Include statement in all plan materials communicated to employees that describe terms of the wellness program
Ongoing	Bay Area Commuter Benefits Program	▪ Employers with 50+ full time employees within the geographic boundaries of the Bay Area Air Quality Management District are required to register with the District ▪ Commuter benefit options include (1) Pre-tax transit/vanpooling costs up to maximum limit permitted under federal law; (2) transit/vanpool subsidy up to $75 per month to offset monthly transit costs; (3) low-cost or free shuttle/vanpool/bus service; or (4) similar alternative option ▪ Update registration annually as requested by District ▪ Keep records to document implementation of program ▪ See http://commuterbenefits.511.org for further information

DUE DATE	TOPIC	REQUIREMENT
Ongoing	San Francisco Commuter Benefits Ordinance	▪ Employers with a location in San Francisco that have at least 20 employees nationwide but less than 50 employees in the SF Bay Area (thus, San Francisco employers not subject to the Bay Area Commuter Benefits Program) must comply ▪ Provide a pre-tax transportation program, a monthly subsidy for transit, vanpool expenses equivalent to the price of a SF Muni Fast Pass, and/or a company-funded bus or van service to and from the work location ▪ Complete one-time registration form- see: www.SFEnvironment.org/CBOcompliance
Ongoing	San Francisco Health Care Security Ordinance (SFHCSO)	▪ This applies to for-profit employers with 20+ employees, and non-profit employers with 50+ working within City and County of San Francisco ▪ Covered employers must make a minimum health care expenditure on behalf of covered employees who work in San Francisco at least 8 hours per week or make a contribution to a City health care program or medical expense reimbursement account established on behalf of the covered employee ▪ Notice must be posted in workplaces with covered employees ▪ Covered employers must file an annual report with the Office of Labor Standards Enforcement by April 30th of each year