IN PERSON & VIRTUAL BOARD MEETING

January 7, 2026, AT 8:30 AM*

INSURANCE, BENEFITS & LEGISLATIVE COMMITTEE MEETING

*The Committee meeting will be held prior to the Board of Retirement meeting scheduled prior.

TO VIEW VIA WEB

https://lacera.com/leadership/board-meetings

TO PROVIDE PUBLIC COMMENT

Members of the public may address the Board orally and in writing. To provide Public Comment, please visit the above link and complete the request form.

Attention: If you have any questions, you may email PublicComment@lacera.com.

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION
300 N. LAKE AVENUE, SUITE 650, PASADENA, CA

AGENDA

A REGULAR MEETING OF THE INSURANCE, BENEFITS & LEGISLATIVE

COMMITTEE AND BOARD OF RETIREMENT*

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

300 N. LAKE AVENUE, SUITE 810, PASADENA, CA 91101

8:30 A.M., WEDNESDAY, JANUARY 7, 2026

This meeting will be conducted by the Insurance, Benefits and Legislative Committee and Board of Retirement both in person and by teleconference under California Government Code Sections 54953.8.3

Any person may view the meeting in person at LACERA's offices or online at https://LACERA.com/leadership/board-meetings.

The Committee may take action on any item on the agenda, and agenda items may be taken out of order.

COMMITTEE TRUSTEES:

Les Robbins, Chair
Aleen Langton, Trustee
Wayne Moore, Trustee
Shawn R. Kehoe, Alternate Trustee

I. CALL TO ORDER

II. PROCEDURE FOR TELECONFERENCE MEETING ATTENDANCE UNDER AB SB707

A. Just Cause (Section 54953.8.3)
B. Statement of Persons Present at SB707 Teleconference Locations

III. APPROVAL OF MINUTES

A. Approval of the Minutes of the Regular Meeting of December 3, 2025

IV. PUBLIC COMMENT

(Members of the public may address the Committee orally and in writing. To provide Public Comment, you should visit https://LACERA.com/leadership/board-meetings and complete the request form.

If you select oral comment, we will contact you via email with information and instructions as to how to access the meeting as a speaker. You will have up to 3 minutes to address the Committee. Oral comment requests will be accepted up to the close of the Public Comment item on the agenda.

If you select written comment, please input your written public comment within the form as soon as possible and up to the close of the meeting. Written comment will be made part of the official record of the meeting. If you would like to remain anonymous at the meeting without stating your name, please leave the name field blank in the request form. If you have any questions, you may email PublicComment@lacera.com.)

V. REPORTS

A. **Engagement Report for December 2025**
Barry W. Lew, Legislative Affairs Officer
(For Information Only)

B. **Staff Activities Report for December 2025**
Cassandra Smith, Director, Retiree Healthcare
(For Information Only)

C. **LACERA Claims Experience**
Michael Szeto, Segal Consulting
(Presentation)

D. **Federal Legislation**
Stephen Murphy, Segal Consulting
(For Discussion Purposes)

VI. ITEMS FOR STAFF REVIEW
(This item summarizes requests and suggestions by individual trustees during the meeting for consideration by staff. These requests and suggestions do not constitute approval or formal action by the Board, which can only be made separately by motion on an agendized item at a future meeting.)

VII. ITEMS FOR FUTURE AGENDAS
(This item provides an opportunity for trustees to identify items to be included on a future agenda as permitted under the Board's Regulations.)

VIII. GOOD OF THE ORDER
(For Information Purposes Only)

IX. ADJOURNMENT

The Board of Retirement has adopted a policy permitting any member of the Board to attend a standing committee meeting open to the public. In the event five or more members of the Board of Retirement (including members appointed to the Committee) are in attendance, the meeting shall constitute a joint meeting of the Committee and the Board of Retirement. Members of the Board of Retirement who are not members of the Committee may attend and participate in a meeting of a Board Committee but may not vote on any matter discussed at the meeting. The only action the Committee may take at the meeting is approval of a recommendation to take further action at a subsequent meeting of the Board.

Any documents subject to public disclosure that relate to an agenda item for an open session of the Committee, that are distributed to members of the Committee less than 72 hours prior to the meeting, will be available for public inspection at the time they are distributed to a majority of the Committee, at LACERA's offices at 300 North Lake Avenue, Suite 820, Pasadena, California during normal business hours from 9:00 a.m. to 5:00 p.m. Monday through Friday *and will also be posted on lacera.com at the same time,* Board Meetings | LACERA*.*

Requests for reasonable modification or accommodation of the telephone public access and Public Comments procedures stated in this agenda from individuals with disabilities, consistent with the Americans with Disabilities Act of 1990, may call the Board Offices at (626) 564-6000, Ext. 4401/4402 from 8:30 a.m. to 5:00 p.m. Monday through Friday or email PublicComment@lacera.com, but no later than 48 hours prior to the time the meeting is to commence.

MINUTES OF THE REGULAR MEETING OF THE INSURANCE, BENEFITS & LEGISLATIVE COMMITTEE AND BOARD OF RETIREMENT*

LOS ANGELES COUNTY EMPLOYEES RETIREMENT ASSOCIATION

300 N. LAKE AVENUE, SUITE 810, PASADENA, CA 91101

8:30 A.M. – 8:55 A.M., WEDNESDAY, DECEMBER 3, 2025

This meeting was conducted by the Insurance, Benefits & Legislative Committee both in person and by teleconference under California Government Code Section 54953(f)

COMMITTEE TRUSTEES

PRESENT: Les Robbins, Chair

Ronald Okum, Vice Chair

Aleen Langton, Trustee

Wayne Moore, Trustee
(Teleconference Due to Just Cause under Section 54953(f))

ABSENT: Shawn R. Kehoe, Alternate Trustee

OTHER BOARD OF RETIREMENT TRUSTEES

Elizabeth Ginsberg, Trustee

JP Harris, Trustee

STAFF, ADVISORS AND PARTICIPANTS

Cassandra Smith, Director, Retiree Healthcare

Luis A. Lugo, Acting Chief Executive Officer

JJ Popowich, Assistant Executive Officer

Laura Guglielmo, Assistant Executive Officer

Steven P. Rice, Chief Counsel

Barry W. Lew, Legislative Affairs Officer

Segal Consulting
Stephen Murphy, Sr. Vice President

I. CALL TO ORDER

This meeting was called to order by Chair Robbins at 8:30 a.m.

II. PROCEDURE FOR TELECONFERENCE MEETING ATTENDANCE UNDER AB 2449, California Government Code Section 54953(f)

A. Just Cause
B. Action on Emergency Circumstance Requests
C. Statement of Persons Present at AB 2449 Teleconference Locations

A physical quorum was present at the noticed meeting location. There was one request received from Trustee Moore related to Just Cause (A) due to illness. Trustee Moore confirmed there were no individuals 18 years or older present at the teleconference location. No requests were received for Emergency Circumstances (B).

III. APPROVAL OF MINUTES

A. Approval of the Minutes of the Regular Meeting of November 5, 2025

Trustee Okum made a motion, Trustee Langton seconded, to approve the minutes of the regular meeting of November 5, 2025. The motion passed by the following roll call vote:

Yes: Okum, Langton, Moore, Robbins

No: None

IV. PUBLIC COMMENT

There were no requests from the public to speak.

V. REPORTS

A. **Engagement Report for November 2025**
Barry W. Lew, Legislative Affairs Officer
(For Information Only)

The engagement report was discussed. This item was received and filed.

B. **Staff Activities Report for November 2025**
Cassandra Smith, Director, Retiree Healthcare
(For Information Only)

The staff activities report was discussed. This item was received and filed.

C. **LACERA Claims Experience**
Stephen Murphy, Segal Consulting
(Presentation)

The LACERA Claims Experience reports through October 2025 were discussed. This item was received and filed.

V. REPORTS (Continued)

D. **Federal Legislation**
Stephen Murphy, Segal Consulting
(For Information Only)

Segal Consulting gave an update on federal legislation. This item was received and filed.

VI. ITEMS FOR STAFF REVIEW
(This item summarizes requests and suggestions by individual trustees during the meeting for consideration by staff. These requests and suggestions do not constitute approval or formal action by the Board, which can only be made separately by motion on an agendized item at a future meeting.)

There was nothing to report.

VII. ITEMS FOR FUTURE AGENDAS
(This item provides an opportunity for trustees to identify items to be included on a future agenda as permitted under the Board's Regulations.)

There was nothing to report.

VIII. GOOD OF THE ORDER
(For Information Purposes Only)

There was nothing to report.

IX. ADJOURNMENT

There being no further business to come before the Committee, the meeting was adjourned at 8:55 a.m.

***The Board of Retirement has adopted a policy permitting any member of the Board to attend a standing committee meeting open to the public. In the event five or more members of the Board of Retirement (including members appointed to the Committee) are in attendance, the meeting shall constitute a joint meeting of the Committee and the Board of Retirement. Members of the Board of Retirement who are not members of the Committee may attend and participate in a meeting of a Board Committee but may not vote on any matter discussed at the meeting. The only action the Committee may take at the meeting is approval of a recommendation to take further action at a subsequent meeting of the Board.**

INSURANCE, BENEFITS & LEGISLATIVE COMMITTEE
ENGAGEMENT REPORT
DECEMBER 2025
FOR INFORMATION ONLY

Senate HELP Committee Hearing on Retirement Savings

The Senate Health, Education, Labor and Pensions Committee held a hearing in early December on retirement savings, addressing Social Security solvency, workplace plan access, and long-term care. Chaired by Sen. Bill Cassidy (R-LA) with Sen. Bernie Sanders (I-VT) as ranking member, the session featured testimony from policy experts and advocates.

The Social Security Administration projects trust fund depletion by 2034, risking benefit cuts without congressional action. Senator Sanders pushed to lift the payroll tax cap to fund Social Security and increase benefits. There was bipartisan agreement that many retirees depend on Social Security as their financial cornerstone.

Workplace plan proposals include allowing workers as young as 18 to join workplace plans since employers are not required to extend eligibility to employees under age 21. Also proposed was automatic re-enrollment since there are participants who either are not aware that they are enrolled in a plan or forget to restart enrollment after pausing their contributions.

Caregiver-focused bills were discussed to allow contributions during unpaid caregiving periods when caregivers leave the workforce and allow catch-up contributions once they return to work. Rising costs and long-term care challenges were highlighted, with calls for structural solutions like Washington State's payroll-funded program, which provides a modest long-term care benefit. (Source) (Source)

Social Security Changes Plan to Limit Disability Benefits

The Social Security Administration (SSA) has scrapped plans to change disability eligibility rules that would have removed age as a factor, following strong opposition and concerns it could deny benefits to hundreds of thousands of older Americans. The proposal, championed by Trump administration officials, aimed to tighten the safety net by requiring claimants to adapt to other work regardless of age. According to the Urban Institute, the concern is that a majority of older Americans who apply for disability benefits do not get another job. Consequently, without disability benefits they would end up taking early retirement benefits, which would reduce their monthly benefits. SSA Commissioner Frank Bisignano confirmed the rule will not move forward, reassuring advocates and groups like AARP that disability benefits remain protected.

The agency also halted efforts to replace its outdated jobs database—still listing obsolete roles like "nut sorter" and "telephone quotation clerk"—with modern labor market data, despite spending over $350 million on the project. Advocates feared the new system,

combined with eliminating age considerations, would drastically reduce approvals. SSA currently factors age, education, and work experience when evaluating claims, giving applicants over 50 a better chance of qualifying.

The reversal comes amid turmoil at SSA, including staffing cuts and service complaints. Disability advocates welcomed the decision, calling the programs a "critical lifeline" for millions. While modernization of job data remains a goal, advocates prefer delays over changes that could harm older Americans. (Source)

Iowa Public Employees Retirement Systems: Study to be Conducted on Employee Benefits

Iowa lawmakers signaled little interest in major changes to the Iowa Public Employees' Retirement System (IPERS) during the 2026 legislative session, despite recommendations from the Iowa DOGE task force to study public employee benefits and consider offering future workers a choice between pension and defined contribution plans. Earlier proposals to shift IPERS entirely to a defined contribution model drew strong backlash from labor groups, who warned such changes could undermine the system's solvency.

Sen. Tim Kraayenbrink, co-chair of the Iowa Legislature's Public Retirement Systems Committee, emphasized that DOGE's ideas are not legislation and said there is "no appetite" for sweeping reforms, though he supports studies to evaluate potential impacts. IPERS officials and advocates urged maintaining the current structure, citing strong fund performance and stability. Critics, including Indivisible Iowa, expressed skepticism about lawmakers' assurances, fearing future shifts under Governor Kim Reynolds.

The IPERS Benefits Advisory Committee unanimously passed a resolution to keep the system as-is. Rep. Adam Zabner called DOGE's proposals "dangerous and unnecessary," pledging to protect retirement security. Officials reported IPERS exceeded 2025 projections and remains one of the nation's strongest systems. (Source)

Increased California State Worker Retirements Anticipated

CalPERS data shows more California public employees are retiring in 2025 compared to recent years, reversing a five-year downward trend. From January to August, over 5,700 state workers retired—an 8% increase from the same period in 2024. Retirement peaked in 2020 during the COVID-19 pandemic, with 12,499 retirements, but dropped to 9,904 in 2024, the lowest in seven years. Factors behind the prior decline include Baby Boomer retirements reducing the pool of older workers and the California Public Employees' Pension Reform Act, which raised retirement ages for full benefits and consequently have to remain in their jobs longer to get the same benefits employees received before pension reform.

Despite speculation that Gov. Gavin Newsom's return-to-office policies might accelerate retirements, data shows no significant impact. July 2024 and July 2025, key dates for telework policy changes, did not coincide with spikes in retirements. A state audit found 45% of departments reported recruitment and retention challenges due to reduced telework, but CalHR cannot attribute a link between these policies and retirement trends. Most retirements occur in December, as timing can maximize cost-of-living adjustments for retirees, who receive COLAs in January. (Source)

Minnesota Joins Colorado in Six-State Consortium of State-Run IRAs

Minnesota has joined the Partnership for a Dignified Retirement (PDR), an interstate consortium of state-facilitated auto-IRA programs led by Colorado SecureSavings. The partnership now includes six states—Colorado, Minnesota, Delaware, Maine, Nevada, and Vermont—collectively managing over $212 million in assets for nearly 140,000 savers. This collaboration aims to reduce fees, expand access to portable retirement savings, and provide employers with an easy enrollment process.

Minnesota's Secure Choice Retirement Program, launching in January 2026, will offer Roth IRA accounts to private-sector workers without workplace retirement plans. Employers will enroll in phases based on workforce size, and employees will be automatically enrolled with an opt-out option. The program is designed to help close the gap for the 30% of Minnesota workers lacking retirement access.

Colorado SecureSavings, the model for PDR programs, has signed up 17,500 businesses and 94,000 savers, accumulating $173 million since its 2023 launch. Vestwell, in partnership with BNY Mellon, provides recordkeeping and administrative services for all partner states. Officials say the partnership demonstrates the power of interstate collaboration to deliver low-cost, high-quality retirement solutions and build financial security for workers nationwide. (Source)

INSURANCE, BENEFITS & LEGISLATIVE COMMITTEE
RETIREE HEALTHCARE BENEFITS PROGRAM
STAFF ACTIVITIES REPORT
DECEMBER 2025
FOR INFORMATION ONLY

2026 - Medicare Part B Premium Reimbursement Program

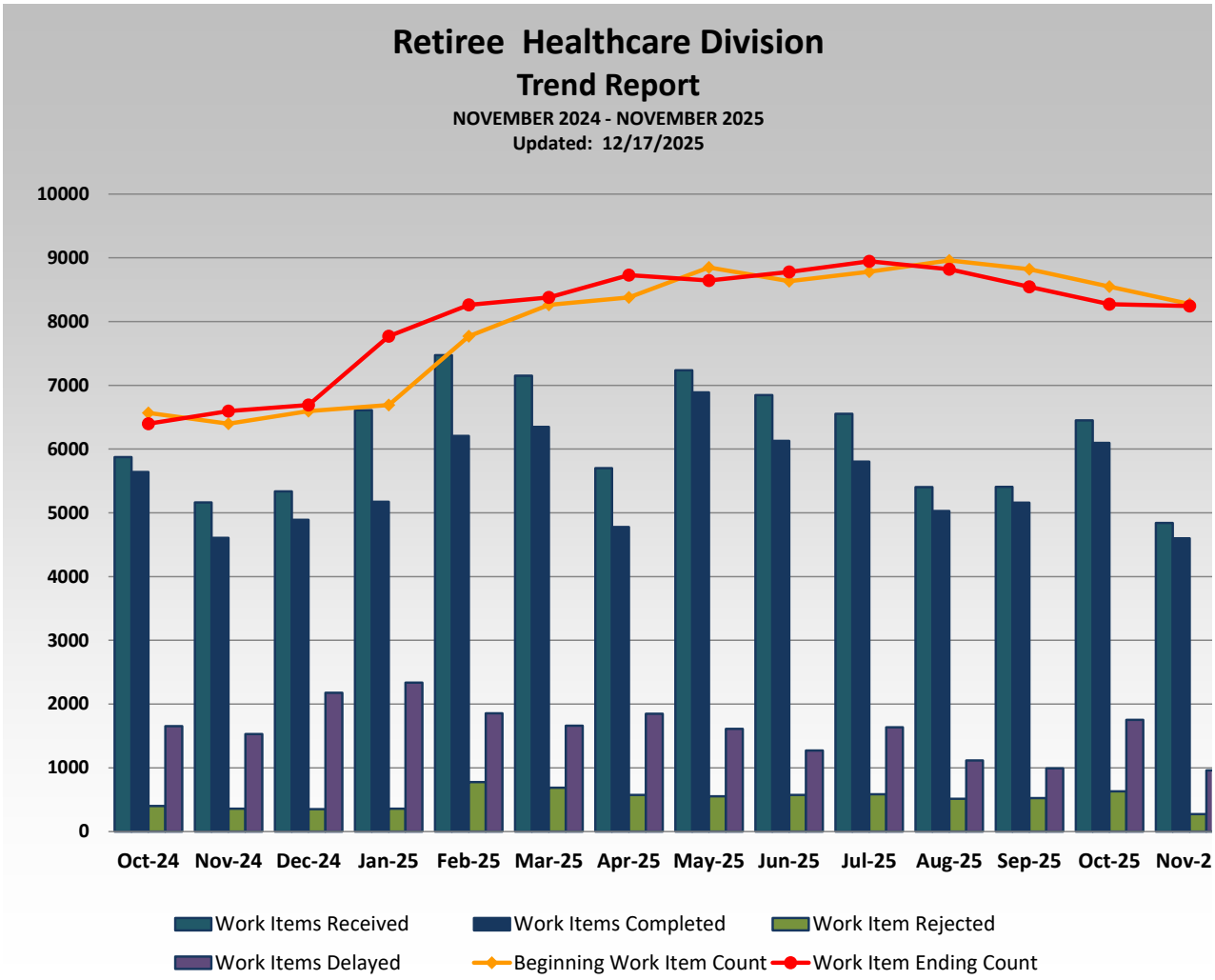
The Board of Supervisors approved the renewal of the Medicare Part B Premium Reimbursement Program for 2026 during its meeting on December 9, 2025.

Staff sent a mass mailing on December 17, 2025, to let members know about this and to submit their 2026 Medicare Part B premium verification for review and processing.

Staff collaborated with the Systems team to update the Medicare Part B rate tables, reflecting the new standard premium amounts for 2026:

- $202.90 (Single-Party)
- $405.80 (Two-Party).

Kudos to RHC, Communications, and Systems staff for their support.

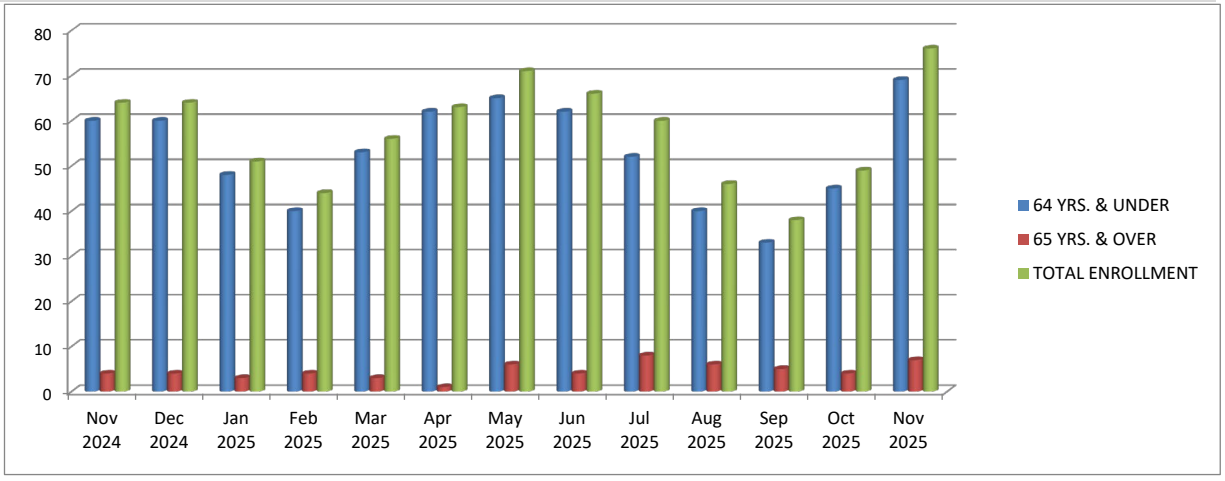


	Beginning Work Item Count	Work Items Received	Work Items Completed	Work Item Rejected	Work Items Delayed	Work Item Ending Count
Oct-24	6568	5873	5640	403	1654	6398
Nov-24	6398	5163	4606	358	1530	6597
Dec-24	6597	5335	4889	353	2177	6690
Jan-25	6690	6611	5173	358	2337	7770
Feb-25	7770	7474	6208	775	1854	8261
Mar-25	8261	7153	6349	687	1660	8378
Apr-25	8378	5702	4776	574	1849	8730
May-25	8849	7237	6888	553	1612	8645
Jun-25	8633	6847	6128	574	1272	8778
Jul-25	8783	6552	5803	586	1635	8946
Aug-25	8960	5405	5030	515	1116	8820
Sep-25	8821	5408	5161	524	992	8544
Oct-25	8550	6452	6098	630	1751	8274
Nov-25	8278	4840	4600	274	959	8244

Retirees Monthly Age Breakdown
NOVEMBER 2024 - NOVEMBER 2025

Disability Retirement

MONTH	64 YRS. & UNDER	65 YRS. & OVER	TOTAL ENROLLMENT
Nov 2024	60	4	64
Dec 2024	60	4	64
Jan 2025	48	3	51
Feb 2025	40	4	44
Mar 2025	53	3	56
Apr 2025	62	1	63
May 2025	65	6	71
Jun 2025	62	4	66
Jul 2025	52	8	60
Aug 2025	40	6	46
Sep 2025	33	5	38
Oct 2025	45	4	49
Nov 2025	69	7	76

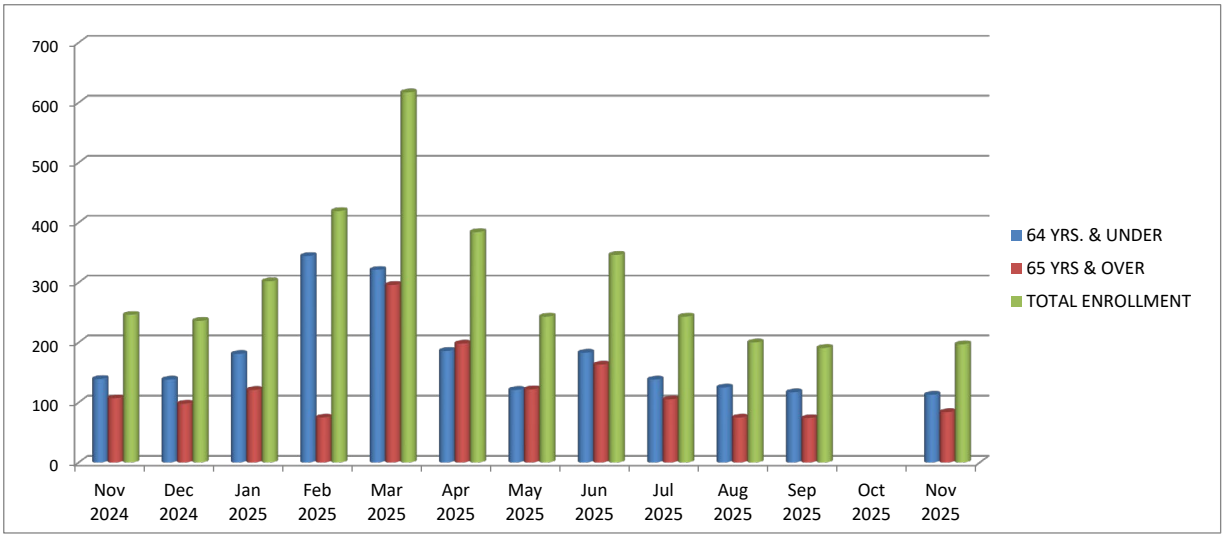


PLEASE NOTE: Next Report will include the following dates: December 1, 2024, through December 31, 2025.

Retirees Monthly Age Breakdown
NOVEMBER 2024 - NOVEMBER 2025

Service Retirement

MONTH	64 YRS. & UNDER	65 YRS & OVER	TOTAL ENROLLMENT
Nov 2024	139	107	246
Dec 2024	138	98	236
Jan 2025	181	121	302
Feb 2025	344	75	419
Mar 2025	321	296	617
Apr 2025	186	198	384
May 2025	121	122	243
Jun 2025	183	163	346
Jul 2025	138	105	243
Aug 2025	125	75	200
Sep 2025	117	74	191
Nov 2025	113	84	197



PLEASE NOTE: Next Report will include the following dates: December 1, 2024, through December 31, 2025.

Medicare Part B Reimbursement and Penalty Report

PAY PERIOD 12/31/2025

Deduction Code	No. of Members	Reimbursement Amount	No. of Penalties	Penalty Amount
ANTHEM BC III				
240	7911	$1,454,346.40	0	$0.00
241	128	$23,046.00	0	$0.00
242	1022	$197,453.10	0	$0.00
243	4816	$1,815,774.76	0	$0.00
244	13	$2,319.90	0	$0.00
245	64	$12,944.70	0	$0.00
246	16	$2,883.90	0	$0.00
247	181	$35,785.30	0	$0.00
248	13	$4,299.00	0	$0.00
249	92	$35,930.50	0	$0.00
250	17	$6,257.40	0	$0.00
Plan Total:	**14,273**	**$3,591,040.96**	**0**	**$0.00**
KAISER SR. ADVANTAGE				
394	22	$4,026.80	0	$0.00
397	1	$144.60	0	$0.00
398	13	$5,275.40	0	$0.00
403	12433	$2,238,121.05	0	$0.00
413	1548	$295,600.60	0	$0.00
418	6525	$2,430,872.27	1	$51.50
419	210	$34,371.60	0	$0.00
426	259	$47,733.70	0	$0.00
445	2	$405.80	0	$0.00
451	37	$7,052.90	0	$0.00
455	6	$1,217.40	0	$0.00
457	18	$7,013.70	0	$0.00
459	2	$811.60	0	$0.00
462	89	$16,237.80	0	$0.00
465	3	$608.70	0	$0.00
466	29	$10,234.50	0	$0.00
472	28	$5,332.80	0	$0.00
476	4	$473.20	0	$0.00
478	15	$6,180.60	0	$0.00
479	1	$144.60	0	$0.00
482	79	$13,017.00	0	$0.00
486	3	$793.70	0	$0.00
488	31	$11,667.60	0	$0.00
491	1	$148.50	0	$0.00
492	1	$202.90	0	$0.00
493	1	$387.90	0	$0.00
Plan Total:	**21,361**	**$5,138,077.22**	**1**	**$51.50**

Medicare Part B Reimbursement and Penalty Report

PAY PERIOD 12/31/2025

Deduction Code	No. of Members	Reimbursement Amount	No. of Penalties	Penalty Amount
SCAN				
611	302	$56,668.60	0	$0.00
613	111	$44,368.80	0	$0.00
620	29	$5,226.10	0	$0.00
621	13	$4,383.00	0	$0.00
622	26	$5,244.90	0	$0.00
623	8	$3,050.40	0	$0.00
Plan Total:	**489**	**$118,941.80**	**0**	**$0.00**
UNITED HEALTHCARE GROUP MEDICARE ADV. HMO				
701	2252	$419,310.44	0	$0.00
702	397	$77,300.60	0	$0.00
703	1442	$551,682.30	0	$0.00
704	107	$21,443.40	0	$0.00
705	56	$21,281.60	0	$0.00
Plan Total:	**4,254**	**$1,091,018.34**	**0**	**$0.00**
Grand Total:	**40,377**	**$9,939,078.32**	**1**	**$51.50**

Medicare Part B Reimbursement and Penalty Report

PAY PERIOD 12/31/2025

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Plan Total:	**21,361**	**$5,138,077.22**	**1**	**$51.50**

Medicare Part B Reimbursement and Penalty Report

PAY PERIOD 12/31/2025

Deduction Code	No. of Members	Reimbursement Amount	No. of Penalties	Penalty Amount
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611	302	$56,668.60	0	$0.00
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UNITED HEALTHCARE GROUP MEDICARE ADV. HMO				
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705	56	$21,281.60	0	$0.00
Plan Total:	**4,254**	**$1,091,018.34**	**0**	**$0.00**
LOCAL 1014				
804	206	$56,425.70	0	$0.00
805	244	$56,365.30	0	$0.00
806	778	$343,672.50	0	$0.00
807	69	$15,136.30	0	$0.00
808	24	$10,469.80	0	$0.00
812	266	$59,228.95	0	$0.00
813	2	$405.80	0	$0.00
Plan Total:	**1,589**	**$541,704.35**	**0**	**$0.00**
Grand Total:	**41,966**	**$10,480,782.67**	**1**	**$51.50**

Medical and Dental Vision Insurance Premiums
January 2026

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Medical Plan							
Anthem Blue Cross Prudent Buyer Plan							
201	395	$483,270.48	$66,217.94	$412,171.02	$478,388.96	($6,101.90)	$472,287.06
202	205	$497,305.08	$46,655.42	$441,039.90	$487,695.32	$0.00	$487,695.32
203	78	$211,494.66	$32,754.54	$178,740.12	$211,494.66	$2,711.47	$214,206.13
204	25	$39,223.00	$9,287.99	$28,366.09	$37,654.08	$1,568.92	$39,223.00
SUBTOTAL	**703**	**$1,231,293.22**	**$154,915.89**	**$1,060,317.13**	**$1,215,233.02**	**($1,821.51)**	**$1,213,411.51**
Anthem Blue Cross I							
211	505	$803,493.60	$47,924.37	$760,323.63	$808,248.00	($1,584.80)	$806,663.20
212	204	$588,727.40	$32,522.92	$550,488.68	$583,011.60	$0.00	$583,011.60
213	75	$252,847.50	$23,329.40	$232,889.40	$256,218.80	$0.00	$256,218.80
214	28	$58,719.36	$4,613.64	$54,105.72	$58,719.36	$0.00	$58,719.36
215	2	$1,069.92	$171.19	$898.73	$1,069.92	$0.00	$1,069.92
SUBTOTAL	**814**	**$1,704,857.78**	**$108,561.52**	**$1,598,706.16**	**$1,707,267.68**	**($1,584.80)**	**$1,705,682.88**
Anthem Blue Cross II							
221	2,507	$3,982,602.40	$192,818.33	$3,830,836.45	$4,023,654.78	$1,584.80	$4,025,239.58
222	2,044	$5,887,274.00	$135,636.01	$5,581,331.77	$5,716,967.78	($27,924.79)	$5,689,042.99
223	967	$3,276,903.60	$124,670.60	$3,111,777.40	$3,236,448.00	$3,371.30	$3,239,819.30
224	263	$551,542.56	$54,739.16	$507,289.00	$562,028.16	$0.00	$562,028.16
SUBTOTAL	**5,781**	**$13,698,322.56**	**$507,864.10**	**$13,031,234.62**	**$13,539,098.72**	**($22,968.69)**	**$13,516,130.03**

Medical and Dental Vision Insurance Premiums
January 2026

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Anthem Blue Cross III							
240	7,961	$5,120,055.60	$641,667.16	$4,517,860.87	$5,159,528.03	($13,500.87)	$5,146,027.16
241	127	$263,333.12	$16,581.71	$244,694.12	$261,275.83	($17,060.34)	$244,215.49
242	1,018	$2,116,951.41	$118,995.98	$1,981,497.11	$2,100,493.09	($2,057.29)	$2,098,435.80
243	4,827	$6,199,745.22	$626,675.99	$5,514,753.01	$6,141,429.00	($7,682.26)	$6,133,746.74
244	13	$14,973.79	$1,336.13	$13,637.66	$14,973.79	$0.00	$14,973.79
245	66	$76,020.78	$6,532.19	$75,247.74	$81,779.93	$0.00	$81,779.93
246	16	$41,056.80	$3,592.47	$37,464.33	$41,056.80	$0.00	$41,056.80
247	188	$484,983.45	$16,063.47	$453,523.68	$469,587.15	$0.00	$469,587.15
248	13	$23,258.04	$1,395.49	$21,862.55	$23,258.04	$0.00	$23,258.04
249	92	$166,384.44	$13,310.79	$149,495.49	$162,806.28	$0.00	$162,806.28
250	17	$34,087.04	$2,606.65	$31,480.39	$34,087.04	$0.00	$34,087.04
SUBTOTAL	**14,338**	**$14,540,849.69**	**$1,448,758.03**	**$13,041,516.95**	**$14,490,274.98**	**($40,300.76)**	**$14,449,974.22**
CIGNA Network Model Plan							
301	207	$419,644.89	$103,604.04	$316,040.85	$419,644.89	$0.00	$419,644.89
302	53	$194,038.30	$45,941.92	$148,096.38	$194,038.30	$0.00	$194,038.30
303	5	$21,615.35	$4,751.05	$12,541.23	$17,292.28	$0.00	$17,292.28
304	12	$32,282.28	$12,149.92	$20,132.36	$32,282.28	$0.00	$32,282.28
SUBTOTAL	**277**	**$667,580.82**	**$166,446.93**	**$496,810.82**	**$663,257.75**	**$0.00**	**$663,257.75**

Medical and Dental Vision Insurance Premiums
January 2026

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Kaiser/Senior Advantage							
401	1,617	$2,308,019.72	$159,867.94	$2,138,276.39	$2,298,144.33	$4,232.31	$2,302,376.64
403	12,435	$3,646,333.32	$310,379.21	$3,303,869.14	$3,614,248.35	($6,124.86)	$3,608,123.49
404	445	$608,328.35	$9,350.45	$598,977.90	$608,328.35	($1,367.03)	$606,961.32
405	1,479	$2,091,794.07	$17,905.44	$2,104,522.29	$2,122,427.73	($4,242.99)	$2,118,184.74
411	1,965	$5,596,131.06	$223,676.14	$5,232,374.12	$5,456,050.26	$14,067.70	$5,470,117.96
413	1,528	$2,639,921.94	$114,184.48	$2,474,904.56	$2,589,089.04	$3,319.98	$2,592,409.02
414	47	$130,180.60	$332.37	$132,618.03	$132,950.40	$0.00	$132,950.40
418	6,492	$3,756,839.60	$259,181.90	$3,465,439.78	$3,724,621.68	($5,753.20)	$3,718,868.48
419	214	$356,549.04	$4,820.05	$335,222.09	$340,042.14	$0.00	$340,042.14
420	93	$253,523.58	$1,308.50	$252,215.08	$253,523.58	$0.00	$253,523.58
421	8	$11,286.16	$451.44	$10,834.72	$11,286.16	$0.00	$11,286.16
422	278	$791,605.10	$1,577.57	$756,461.97	$758,039.54	$0.00	$758,039.54
426	258	$441,477.40	$4,007.28	$414,115.02	$418,122.30	$0.00	$418,122.30
428	40	$110,934.40	$554.67	$110,379.73	$110,934.40	$0.00	$110,934.40
430	141	$397,713.06	$2,087.30	$395,625.76	$397,713.06	$0.00	$397,713.06
SUBTOTAL	**27,040**	**$23,140,637.40**	**$1,109,684.74**	**$21,725,836.58**	**$22,835,521.32**	**$4,131.91**	**$22,839,653.23**
Kaiser - Colorado							
450	4	$7,109.00	$568.72	($1,990.52)	($1,421.80)	$0.00	($1,421.80)
451	37	$11,320.20	$1,364.38	$10,551.62	$11,916.00	$0.00	$11,916.00
453	10	$31,467.90	$3,231.85	$28,236.05	$31,467.90	$0.00	$31,467.90
455	6	$10,270.20	$924.32	$9,345.88	$10,270.20	$0.00	$10,270.20
457	18	$10,580.40	$1,034.53	$9,545.87	$10,580.40	$0.00	$10,580.40
459	2	$4,003.20	$80.06	$3,923.14	$4,003.20	$0.00	$4,003.20
SUBTOTAL	**77**	**$74,750.90**	**$7,203.86**	**$59,612.04**	**$66,815.90**	**$0.00**	**$66,815.90**

Medical and Dental Vision Insurance Premiums
January 2026

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Kaiser - Georgia							
440	1	$1,780.87	$196.07	$1,584.80	$1,780.87	$0.00	$1,780.87
441	3	$5,342.61	$588.21	$4,754.40	$5,342.61	$0.00	$5,342.61
442	6	$10,685.22	$1,176.42	$9,508.80	$10,685.22	$0.00	$10,685.22
445	2	$4,373.48	$0.00	$4,373.48	$4,373.48	$0.00	$4,373.48
461	15	$26,713.05	$4,430.76	$22,282.29	$26,713.05	$0.00	$26,713.05
462	88	$36,834.43	$4,891.89	$31,942.54	$36,834.43	($413.87)	$36,420.56
463	3	$10,661.22	$3,516.47	$7,144.75	$10,661.22	$0.00	$10,661.22
465	3	$6,560.22	$349.88	$6,210.34	$6,560.22	$0.00	$6,560.22
466	28	$23,772.46	$1,327.98	$21,624.74	$22,952.72	$0.00	$22,952.72
SUBTOTAL	**149**	**$126,723.56**	**$16,477.68**	**$109,426.14**	**$125,903.82**	**($413.87)**	**$125,489.95**
Kaiser - Hawaii							
471	5	$4,814.20	$577.71	$4,236.49	$4,814.20	$0.00	$4,814.20
472	28	$12,523.00	$2,039.46	$10,483.54	$12,523.00	$0.00	$12,523.00
473	1	$2,222.50	$637.70	$1,584.80	$2,222.50	$0.00	$2,222.50
474	4	$7,670.72	$0.00	$7,670.72	$7,670.72	$0.00	$7,670.72
475	2	$5,745.04	$0.00	$5,745.04	$5,745.04	$0.00	$5,745.04
476	3	$5,608.36	$0.00	$2,804.18	$2,804.18	$0.00	$2,804.18
478	15	$13,297.50	$1,382.94	$12,801.06	$14,184.00	$0.00	$14,184.00
479	1	$2,661.75	$0.00	$2,661.75	$2,661.75	$0.00	$2,661.75
SUBTOTAL	**59**	**$54,543.07**	**$4,637.81**	**$47,987.58**	**$52,625.39**	**$0.00**	**$52,625.39**

Medical and Dental Vision Insurance Premiums
January 2026

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Kaiser - Oregon							
481	2	$2,829.92	$707.48	$2,122.44	$2,829.92	$0.00	$2,829.92
482	79	$45,216.00	$4,510.32	$37,879.68	$42,390.00	($565.20)	$41,824.80
483	5	$8,661.05	$1,117.40	$7,543.65	$8,661.05	$0.00	$8,661.05
484	2	$8,465.76	$0.00	$37,990.54	$37,990.54	$0.00	$37,990.54
485	0	$4,228.88	($857.58)	($3,371.30)	($4,228.88)	$0.00	($4,228.88)
486	3	$5,916.48	$0.00	$7,888.64	$7,888.64	$0.00	$7,888.64
488	31	$34,794.40	$4,803.86	$29,990.54	$34,794.40	$0.00	$34,794.40
491	1	$1,930.86	$0.00	$1,930.86	$1,930.86	$0.00	$1,930.86
492	1	$2,289.41	$0.00	$2,289.41	$2,289.41	$0.00	$2,289.41
493	1	$3,379.12	$15.64	$6,742.60	$6,758.24	$0.00	$6,758.24
SUBTOTAL	**125**	**$117,711.88**	**$10,297.12**	**$131,007.06**	**$141,304.18**	**($565.20)**	**$140,738.98**
SCAN Health Plan							
611	305	$87,916.86	$17,278.68	$71,212.80	$88,491.48	$0.00	$88,491.48
613	111	$62,894.82	$11,762.97	$54,531.57	$66,294.54	$0.00	$66,294.54
SUBTOTAL	**416**	**$150,811.68**	**$29,041.65**	**$125,744.37**	**$154,786.02**	**$0.00**	**$154,786.02**
SCAN Health Plan, AZ							
620	29	$8,331.99	$1,154.98	$7,177.01	$8,331.99	$0.00	$8,331.99
621	12	$7,366.06	$1,167.24	$5,065.58	$6,232.82	$0.00	$6,232.82
SUBTOTAL	**41**	**$15,698.05**	**$2,322.22**	**$12,242.59**	**$14,564.81**	**$0.00**	**$14,564.81**
SCAN Health Plan, NV							
622	27	$7,757.37	$810.21	$7,234.47	$8,044.68	$0.00	$8,044.68
623	8	$4,532.96	$521.29	$4,011.67	$4,532.96	$0.00	$4,532.96
SUBTOTAL	**35**	**$12,290.33**	**$1,331.50**	**$11,246.14**	**$12,577.64**	**$0.00**	**$12,577.64**

Medical and Dental Vision Insurance Premiums
January 2026

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
UHC Medicare Adv.							
701	2,250	$876,024.45	$95,467.65	$775,845.41	$871,313.06	($387.45)	$870,925.61
702	393	$828,383.85	$36,374.14	$783,705.11	$820,079.25	$2,076.15	$822,155.40
703	1,436	$1,106,636.70	$105,166.64	$1,001,470.06	$1,106,636.70	($766.90)	$1,105,869.80
704	108	$258,008.45	$9,231.48	$248,776.97	$258,008.45	$0.00	$258,008.45
705	55	$59,236.80	$3,427.27	$54,751.73	$58,179.00	$0.00	$58,179.00
706	2	$967.32	$58.04	$909.28	$967.32	$0.00	$967.32
SUBTOTAL	**4,244**	**$3,129,257.57**	**$249,725.22**	**$2,865,458.56**	**$3,115,183.78**	**$921.80**	**$3,116,105.58**
United Healthcare							
707	524	$897,554.30	$116,861.12	$772,209.68	$889,070.80	$8,483.50	$897,554.30
708	443	$1,398,221.77	$148,285.70	$1,197,231.48	$1,345,517.18	$14,705.40	$1,360,222.58
709	344	$1,275,676.10	$154,401.18	$1,088,188.22	$1,242,589.40	$31,405.18	$1,273,994.58
SUBTOTAL	**1,311**	**$3,571,452.17**	**$419,548.00**	**$3,057,629.38**	**$3,477,177.38**	**$54,594.08**	**$3,531,771.46**

Medical and Dental Vision Insurance Premiums
January 2026

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Local 1014 Firefighters							
801	84	$121,947.84	$6,765.17	$112,279.15	$119,044.32	$0.00	$119,044.32
802	338	$884,758.94	$27,380.46	$859,786.70	$887,167.16	$0.00	$887,167.16
803	418	$1,290,675.32	$46,377.98	$1,244,297.34	$1,290,675.32	$3,087.74	$1,293,763.06
804	209	$303,417.84	$9,959.03	$296,362.33	$306,321.36	($56,425.70)	$249,895.66
805	245	$641,319.35	$14,815.80	$623,885.92	$638,701.72	($56,365.30)	$582,336.42
806	780	$2,041,751.40	$43,609.71	$1,987,671.17	$2,031,280.88	($343,672.50)	$1,687,608.38
807	69	$213,054.06	$3,458.28	$209,595.78	$213,054.06	($15,136.30)	$197,917.76
808	24	$74,105.76	$1,729.14	$72,376.62	$74,105.76	($10,469.80)	$63,635.96
809	18	$26,131.68	$1,858.24	$24,273.44	$26,131.68	$0.00	$26,131.68
810	9	$23,558.67	$3,088.80	$20,469.87	$23,558.67	$0.00	$23,558.67
811	6	$18,526.44	$2,840.73	$15,685.71	$18,526.44	$0.00	$18,526.44
812	266	$386,168.16	$23,111.93	$365,673.86	$388,785.79	($59,228.95)	$329,556.84
813	2	$5,235.26	$0.00	$5,235.26	$5,235.26	($405.80)	$4,829.46
SUBTOTAL	**2,468**	**$6,030,650.72**	**$184,995.27**	**$5,837,593.15**	**$6,022,588.42**	**($538,616.61)**	**$5,483,971.81**
Kaiser - Washington							
393	5	$10,062.65	$2,138.65	$7,924.00	$10,062.65	$0.00	$10,062.65
394	22	$9,194.02	$1,078.20	$8,115.82	$9,194.02	$0.00	$9,194.02
395	3	$15,005.04	($502.94)	($2,274.01)	($2,776.95)	$0.00	($2,776.95)
397	1	$2,156.64	$0.00	$2,156.64	$2,156.64	$0.00	$2,156.64
398	13	$10,761.66	$1,192.07	$9,569.59	$10,761.66	$0.00	$10,761.66
SUBTOTAL	**44**	**$47,180.01**	**$3,905.98**	**$25,492.04**	**$29,398.02**	**$0.00**	**$29,398.02**
Medical Plan Total	**57,922**	**$68,314,611.41**	**$4,425,717.52**	**$63,237,861.31**	**$67,663,578.83**	**($546,623.65)**	**$67,116,955.18**

Medical and Dental Vision Insurance Premiums
January 2026

Carrier Codes	Member Count	Premium Amount	Member Amount	County Subsidy Amount	Total	Adjustments	Total Paid
Dental/Vision Plan							
CIGNA Indemnity Dental/Vision							
501	27,431	$1,542,184.20	$152,115.83	$1,403,161.03	$1,555,276.86	($1,910.60)	$1,553,366.26
502	25,149	$2,968,304.10	$218,697.53	$2,745,360.95	$2,964,058.48	($2,834.61)	$2,961,223.87
503	11	$762.30	$27.71	$734.59	$762.30	$0.00	$762.30
SUBTOTAL	**52,591**	**$4,511,250.60**	**$370,841.07**	**$4,149,256.57**	**$4,520,097.64**	**($4,745.21)**	**$4,515,352.43**
CIGNA Dental HMO/Vision							
901	4,441	$207,416.60	$20,899.27	$187,774.97	$208,674.24	($372.80)	$208,301.44
902	3,310	$316,798.55	$22,195.19	$293,840.78	$316,035.97	$954.16	$316,990.13
903	2	$94.42	$17.00	$77.42	$94.42	$0.00	$94.42
SUBTOTAL	**7,753**	**$524,309.57**	**$43,111.46**	**$481,693.17**	**$524,804.63**	**$581.36**	**$525,385.99**
Dental/Vision Plan Total	**60,344**	**$5,035,560.17**	**$413,952.53**	**$4,630,949.74**	**$5,044,902.27**	**($4,163.85)**	**$5,040,738.42**
GRAND TOTALS	**118,266**	**$73,350,171.58**	**$4,839,670.05**	**$67,868,811.05**	**$72,708,481.10**	**($550,787.50)**	**$72,157,693.60**

PREMIUMS*	CARRIER DEDUCTION CODES	DEDUCTION CODE DEFINITIONS
Anthem Blue Cross Prudent Buyer Plan		
$1,220.38	201	Retiree Only
$2,402.44	202	Retiree and Spouse/Domestic Partner
$2,711.47	203	Retiree, Spouse/Domestic Partner and Children
$1,568.92	204	Retiree and Children
$331.92	205	Survivor Children Only Rates
Anthem Blue Cross Plan I		
$1,584.80	211	Retiree Only
$2,857.90	212	Retiree and Spouse/Domestic Partner
$3,371.30	213	Retiree, Spouse/Domestic Partner and Children
$2,097.12	214	Retiree and Children
$534.96	215	Survivor Children Only Rates
Anthem Blue Cross Plan II		
$1,584.80	221	Retiree Only
$2,857.90	222	Retiree and Spouse/Domestic Partner
$3,371.30	223	Retiree, Spouse/Domestic Partner and Children
$2,097.12	224	Retiree and Children
$534.96	225	Survivor Children Only Rates
Anthem Blue Cross Plan III		
$642.90	240	Retiree Only with Medicare
$2,057.29	241	Retiree and Spouse/Domestic Partner - One with Medicare (Non-Medicare has Anthem Blue Cross I)
$2,057.29	242	Retiree and Spouse/Domestic Partner - One with Medicare (Non-Medicare has Anthem Blue Cross II)
$1,280.41	243	Retiree and Spouse/Domestic Partner - Both with Medicare
$1,151.83	244	Retiree and Children (Retiree has Medicare; Children have Anthem Blue Cross I)
$1,151.83	245	Retiree and Children (Retiree has Medicare; Children have Anthem Blue Cross II)
$2,566.05	246	Retiree, Spouse/Domestic Partner and Children - One with Medicare (Non-Medicare has Anthem Blue Cross I)
$2,566.05	247	Retiree, Spouse/Domestic Partner and Children - One with Medicare (Non-Medicare has Anthem Blue Cross II)
$1,789.08	248	Retiree, Spouse/Domestic Partner and Children - Two with Medicare (Children have Anthem Blue Cross I)
$1,789.08	249	Retiree, Spouse/Domestic Partner and Children - Two with Medicare (Children have Anthem Blue Cross II)
$2,005.12	250	Member, Spouse/Domestic Partner, Child (3 with Medicare)

***Benchmark premiums are bolded.**

PREMIUMS*	CARRIER DEDUCTION CODES	DEDUCTION CODE DEFINITIONS
CIGNA Network Model Plan		
$2,027.27	301	Retiree Only
$3,661.10	302	Retiree and Spouse/Domestic Partner
$4,323.07	303	Retiree, Spouse/Domestic Partner and Children
$2,690.19	304	Retiree and Children
$670.42	305	Survivor Children Only Rates
CIGNA Medicare Select Plus Rx (Available in the Phoenix, AZ area only)		
N/A	321	Retiree Only with Medicare
N/A	322	Retiree and Spouse/Domestic Partner/Domestic Partner - One with Medicare
N/A	324	Retiree and Spouse/Domestic Partner -Both with Medicare
N/A	325	Retiree and Children
N/A	327	Retiree, Spouse/Domestic Partner and Children - One with Medicare
N/A	329	Retiree, Spouse/Domestic Partner and Children - Two with Medicare
Kaiser		
$1,410.77	401	Retiree Only ("Basic")
N/A	402	Retiree Only ("Supplement")
$291.66	403	Retiree Only ("Senior Advantage")
$1,367.03	404	Retiree Only ("Excess I")
$1,414.33	405	Retiree Only - ("Excess II")
N/A	406	Retiree Only ("Excess III")
$2,813.54	411	Retiree and Family (All family members are "Basic")
N/A	412	Retiree and Family (One family member is "Supplement"; others are "Basic")
$1,694.43	413	Retiree and Family (One family member is "Senior Advantage"; others are "Basic")
$2,769.80	414	Retiree and Family (One family member is "Excess I"; others are "Basic")
N/A	415	Retiree and Family (Two or more family members are "Supplement")
N/A	416	Retiree and Family (One family member is "Senior Advantage"; others are "Supplement")
N/A	417	Retiree and Family (One family member is "Excess I"; others are "Supplement")
$575.32	418	Retiree and Family (Two or more family members are "Senior Advantage")
$1,650.69	419	Retiree and Family (One family member is "Excess I"; others are "Senior Advantage"
$2,726.06	420	Retiree and Family (Two or more family members are "Excess I")
N/A	421	Survivor Children Only Rates
$2,817.10	422	Retiree and Family (One family member is "Excess II"; others are "Basic")
N/A	423	Retiree and Family (One family member is "Excess III"; others are "Basic")

***Benchmark premiums are bolded.**

PREMIUMS*	CARRIER DEDUCTION CODES	DEDUCTION CODE DEFINITIONS
Kaiser (continued)		
N/A	424	Retiree and Family (One family member is "Supplement'; others are "Excess II")
N/A	425	Retiree and Family (One family member is "Supplement"; others are "Excess III")
$1,697.99	426	Retiree and Family (One family member is "Senior Advantage"; others are "Excess II")
$N/A	427	Retiree and Family (One family member is "Senior Advantage; others are "Excess III")
$2,773.36	428	Retiree and Family (One family member is "Excess I"; others are "Excess II")
$N/A	429	Retiree and Family One family member is "Excess I"; others are "Excess III")
$2,820.66	430	Retiree and Family (Two or more family members are "Excess II")
$N/A	431	Retiree and Family (One family member is "Excess II"; others are "Excess III")
$N/A	432	Retiree and Family (Two or more family members are "Excess III")
Kaiser Colorado		
$1,421.80	450	Retiree Only ("Basic" under age 65)
$297.90	451	Retiree Only ("Senior Advantage")
$3,146.79	453	Retiree and Family (Two family members are "Basic")
$4,249.55	454	Retiree and Family (Three or more family members are "Basic")
$1,711.70	455	Retiree and Family (One family member is "Senior Advantage"; one family member is "Basic")
$587.80	457	Retiree and Family (Two family members are "Senior Advantage")
$3,043.28	458	Retiree and Family (One family member is "Senior Advantage"; two or more are "Basic")
$2,001.60	459	Retiree and Family (Two family members are "Senior Advantage"; one or more are "Basic")
Kaiser Georgia		
$1,780.87	440	Retiree Only ("Basic" over age 65 with Medicare Part B only
$1,780.87	441	Retiree Only ("Basic over age 65 with Medicare Part A only)
$1,780.87	442	Retiree Only ("Basic over age 65 without Medicare Part A or Medicare Part B)
$413.87	443	Retiree Only ("Basic" over age 65 - Medicare eligible who is classified as having renal failure)
$2,186.74	444	Retiree and Family (One family member is "Senior Advantage"; one family member is "Basic" over age 65 with Medicare Part B only)
$2,186.74	445	Retiree and Family (One family member is "Senior Advantage"; one family member is "Basic" over age 65 with Medicare Part A only)
$2,186.74	446	Retiree and Family (One family member is "Senior Advantage"; one family member is "Basic" over age 65 without Medicare Part A and B)
$1,780.87	461	Retiree Only ("Basic" under age 65)
$413.87	462	Retiree Only ("Senior Advantage")

***Benchmark premiums are bolded.**

PREMIUMS*	CARRIER DEDUCTION CODES	DEDUCTION CODE DEFINITIONS
Kaiser Georgia (continued)		
$3,553.74	463	Retiree and Family (Two family members are "Basic")
$5,326.61	464	Retiree and Family (Three or more family members are "Basic)
$2,186.74	465	Retiree and Family (One family member is "Senior Advantage"; one is "Basic")
$819.74	466	Retiree and Family (Two family members are "Senior Advantage")
$3,959.61	467	Retiree and Family (One family member is "Senior Advantage"; two or more are "Basic")
$2,592.61	468	Retiree and Family (Two family members are "Senior Advantage"; one is "Basic")
$1,225.61	469	Retiree and Family (Three or more family members are "Senior Advantage"; one is "Basic")
$3,959.61	470	Retiree and Family (Three or more family members are "Basic"; one is "Senior Advantage"
Kaiser Hawaii		
$962.84	471	Retiree Only ("Basic" under age 65)
$447.25	472	Retiree Only ("Senior Advantage")
$2,222.50	473	Retiree Only (Over age 65 without Medicare Part A or Medicare Part B)
$1,917.68	474	Retiree and Family (Two family members are "Basic")
$2,872.52	475	Retiree and Family (Three or more family members are "Basic")
$1,402.09	476	Retiree and Family (One family member is "Senior Advantage"; one is "Basic")
$3,177.34	477	Retiree and Family (One family member is "Basic" under age 65; one is over age 65 without Medicare Part A or Medicare Part B)
$886.50	478	Retiree and Family (Two family members are "Senior Advantage"
$2,661.75	479	Retiree and Family (One family member is "Senior Advantage"; one is over age 65 without Medicare Part A or Medicare Part B)
Kaiser Oregon		
$1,414.96	481	Retiree Only ("Basic" under age 65)
$565.20	482	Retiree Only ("Senior Advantage")
$1,732.21	483	Retiree Only (Over age 65 without Medicare Part A or Medicare Part B)
$2,821.92	484	Retiree and Family (Two family members are "Basic")
$4,228.88	485	Retiree and Family (Three or more family members are "Basic")
$1,972.16	486	Retiree and Family (One family member is "Senior Advantage"; one is "Basic")
N/A	487	Retiree Only (Medicare Cost "Supplement" program)
$1,122.40	488	Retiree and Family (Two family members are "Senior Advantage")
$1,373.66	489	Retiree Only (Over age 65 with Medicare Part A only)
$1,732.21	490	Retiree Only (Over age 65 with Medicare Part B only)

***Benchmark premiums are bolded.**

PREMIUMS*	CARRIER DEDUCTION CODES	DEDUCTION CODE DEFINITIONS
Kaiser Oregon (continued)		
$1,930.86	491	Retiree and Family (One family member is "Senior Advantage"; one is over age 65 with Medicare Par A only)
$2,289.41	492	Retiree and Family (One family member is "Senior Advantage"; one is over age 65 without Medicare Part A or Medicare Part B)
$3,379.12	493	Retiree and Family (One family member is "Senior Advantage"; two or more are "Basic")
$2,529.36	494	Retiree and Family (Two family members are "Senior Advantage"; one is "Basic")
$3,456.42	495	Retiree and Family (Two family members are over age 65 without Medicare Part A or Medicare Part B)
$2,739.32	496	Retiree and Family (Two family members are over age 65 with Medicare Part A only)
$2,780.62	497	Retiree and Family (One family member is "Basic"; one is over age 65 with Medicare Part A only)
$3,139.17	498	Retiree and Family (One family member is "Basic"; one is over age 65 without Medicare Part A or Medicare Part B)
Kaiser Washington		
$2,012.53	393	Retiree and Family ("Basic" under age 65)
$417.92	394	Retiree Only ("Senior Advantage")
$3,751.26	395	Retiree and Family (Two family members are "Basic")
$6,275.96	396	Retiree and Family (Three or more family members are "Basic")
$2,156.64	397	Retiree and Family (One family member is "Senior Advantage"; one family member is "Basic")
$827.82	398	Retiree and Family (Two family members are "Senior Advantage")
$4,681.34	399	Retiree and Family (One family member is "Senior Advantage"; two or more are "Basic")
$3,352.52	400	Retiree and Family (Two family members are "Senior Advantage"; one or more are "Basic")

***Benchmark premiums are bolded.**

PREMIUMS*	CARRIER DEDUCTION CODES	DEDUCTION CODE DEFINITIONS

Kaiser Rate Category Definitions

"Basic" - includes those who are under age 65

Medicare Cost ("Supplement")

-Includes people who have both Part A and Part B of Medicare, who were enrolled in Kaiser's Medicare supplement ("M" coverage) before July 1, 1987, and who chose to stay in that Kaiser arrangement.

-It is not open to new enrollments.

-People who have left it cannot return to it.

"Senior Advantage"

-Includes participants who are age 65 or older and who have assigned both Medicare Part A and Part B to Kaiser.

"Excess I"

-Is for participants who have Medicare Part A only.

"Excess II"

-Is for participants in the Excess Plan who either have Medicare Part B only or are not eligible for Medicare.

"Excess III"

-Is for participants in the Excess Plan who either have Medicare Parts A and B and have not assigned their Medicare benefits to Kaiser or have not provided their Medicare status to LACERA. Premium is above the Anthem Blue Cross I and II Benchmark rate.
and II Benchmark.

***Benchmark premiums are bolded.**

PREMIUMS*	CARRIER DEDUCTION CODES	DEDUCTION CODE DEFINITIONS

SCAN Health Plan

$287.31	611	Retiree Only with SCAN
$566.62	613	Retiree and 1 Dependent - Both with SCAN (Retiree and 1 Dependent = Retiree and Spouse/Domestic Partner OR Retiree and 1 Child. Both Retiree and Dependent must have Medicare.)

United Healthcare Medicare Advantage (UHCMA)

(For both members and dependents who are enrolled in UHCMA, or a family combination of UHCMA/UHC)

$387.45	701	Retiree Only with Secure Horizons
$2,076.15	702	Retiree and 1 Dependent - One with Secure Horizons (Retiree and 1 Dependent = Retiree and Spouse/Domestic Partner OR Retiree and 1 Child)
$766.90	703	Retiree and 1 Dependent - Both with Secure Horizons (Retiree and 1 Dependent = Retiree and Spouse/Domestic Partner OR Retiree and 1 Child)
$2,367.05	704	Retiree and 2 or More Dependents - One with Secure Horizons (Retiree and 2 or More Dependents = Retiree, Spouse/Domestic Partner and 1 or More Children OR Retiree and 2 or More Children)
$1,057.80	705	Retiree and 2 or More Dependents - Two with Secure Horizons (Retiree and 2 or More Dependents = Retiree, Spouse/Domestic Partner and 1 or More Children OR Retiree and 2 or More Children)
$483.66	706	Survivor Children Only Rates

United Healthcare (UHC)

(For members and dependents under age 65 [no Medicare])

$1,696.70	707	Retiree Only
$3,100.27	708	Retiree and 1 Dependent
$3,676.30	709	Retiree and 2 Or More Dependents

Local 1014 Firefighters

$1,451.76	801	Member Under 65
$2,617.63	802	Member + 1 Under 65
$3,087.74	803	Member + 2 Under 65
$1,451.76	804	Member with Medicare
$2,617.63	805	Member + 1; 1 Medicare
$2,617.63	806	Member + 1; 2 Medicare
$3,087.74	807	Member + 2; 1 Medicare
$3,087.74	808	Member + 2; 2 Medicare

***Benchmark premiums are bolded.**

PREMIUMS*	CARRIER DEDUCTION CODES	DEDUCTION CODE DEFINITIONS
Local 1014 Firefighters (continued)		
$1,451.76	809	Surviving Spouse Under 65
$2,617.63	810	Surviving Spouse + 1; Under 65
$3,087.74	811	Surviving Spouse + 2 Under 65
$1,451.76	812	Surviving Spouse with Medicare
$2,617.63	813	Surviving Spouse + 1; 1 Medicare
$3,087.74	814	Spouse + 1; 1 Medicare
$2,617.63	815	Surviving Spouse + 1; 2 Medicare
CIGNA Indemnity - Dental/Vision		
$56.20	501	Retiree Only
$117.86	502	Retiree and Dependent(s)
$69.30	503	Survivor Children Only Rates
CIGNA HMO - Dental/Vision		
$46.60	901	Retiree Only
$95.45	902	Retiree and Dependent(s)
$47.21	903	Survivor Children Only Rates

***Benchmark premiums are bolded.**

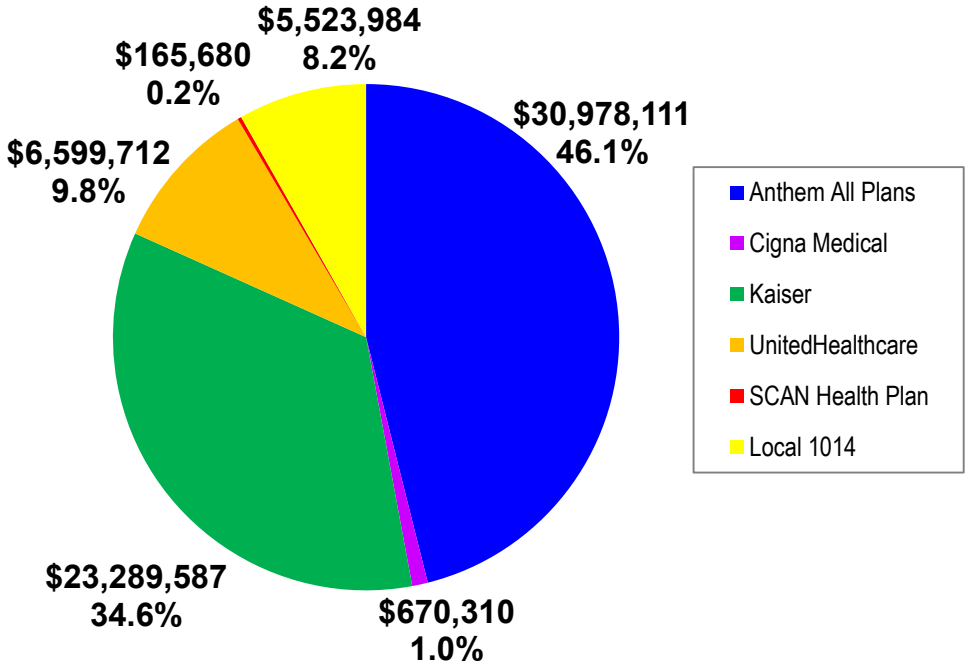
Los Angeles County Employees Retirement Association

Premium & Enrollment

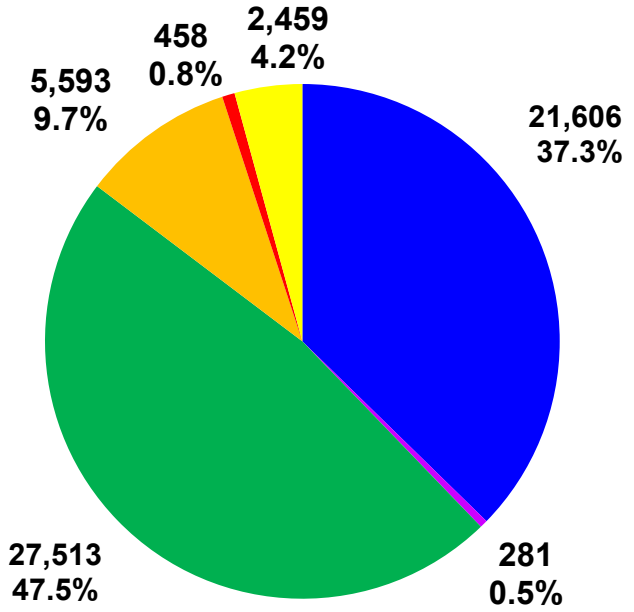
Coverage Month Ending November 2025

Carrier / Plan	Monthly Premium	Percent of Total	Retirees	Percent of Total
Anthem All Plans	$30,978,111	46.1%	21,606	37.3%
Cigna Medical	$670,310	1.0%	281	0.5%
Kaiser	$23,289,587	34.6%	27,513	47.5%
UnitedHealthcare	$6,599,712	9.8%	5,593	9.7%
SCAN Health Plan	$165,680	0.3%	458	0.8%
Local 1014	$5,523,984	8.2%	2,459	4.2%
Combined Medical	**$67,227,383**	**100.0%**	**57,910**	**100.0%**
Cigna Dental & Vision (PPO and HMO)	**$5,042,248**		**60,259**	

Monthly Premium



Retirees

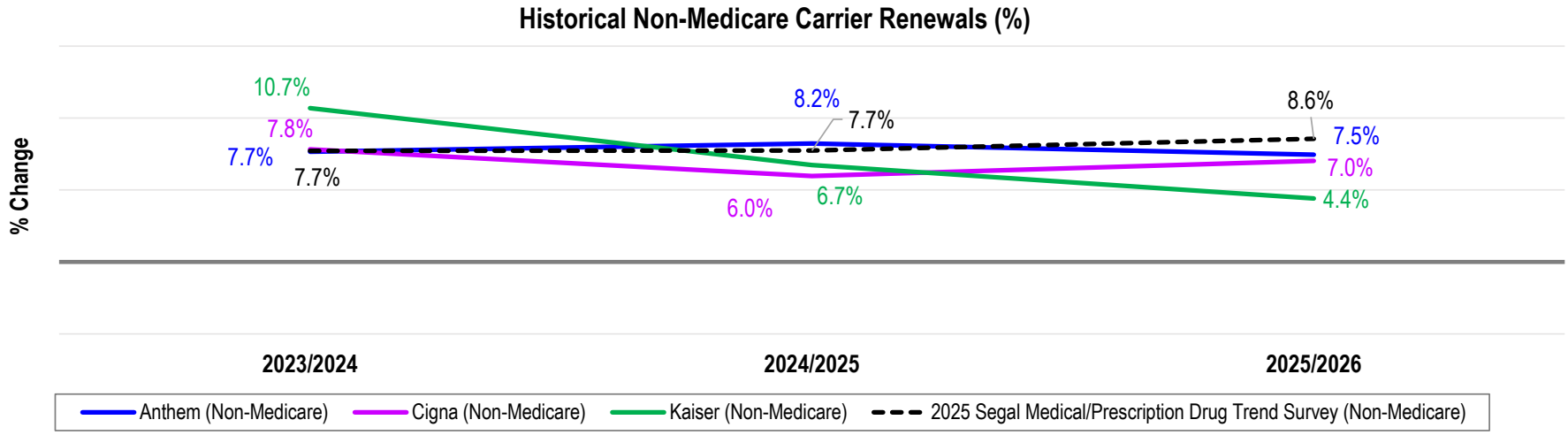


Note: Premiums **include** LACERA's Administrative Fee of $8.00 per member, per plan, per month.

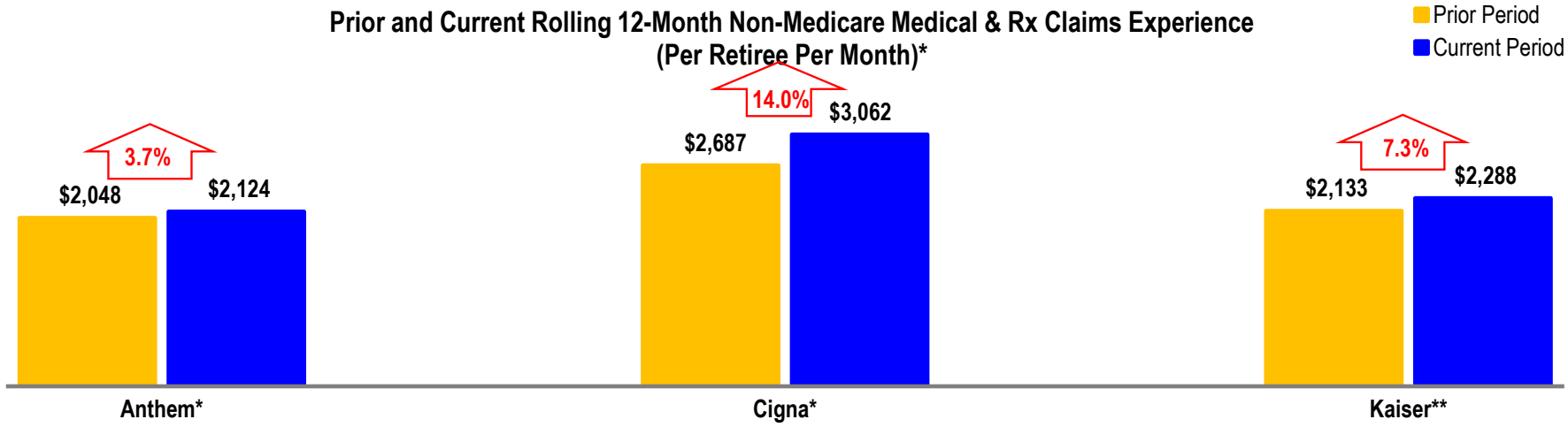
Los Angeles County Employees Retirement Association

Claims Experience by Carrier

Coverage Month Ending November 2025



Note: Segal's Annual Medical/Prescription Drug Trend Survey blends multiple calendar year trends to reflect LACERA's fiscal plan year.



* Based on Most Recent Claims Experience through Coverage Month.

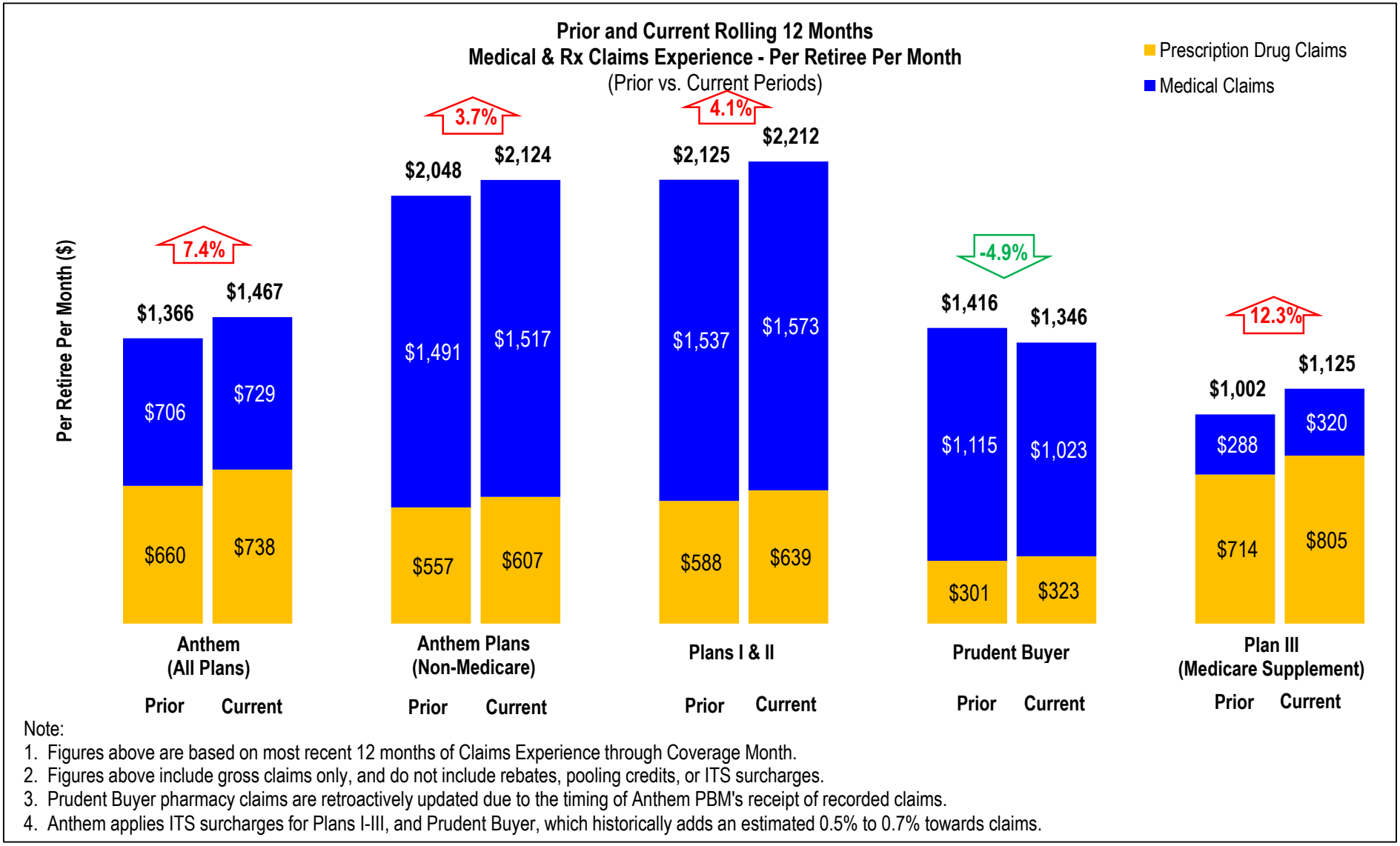
** Kaiser Claims Experience through August 2025.

Note: Figures above include gross claims only, and do not include rebates or pooling credits.

Los Angeles County Employees Retirement Association

Anthem Claims Experience By Plan

Coverage Month Ending November 2025



Note:

1. Figures above are based on most recent 12 months of Claims Experience through Coverage Month.
2. Figures above include gross claims only, and do not include rebates, pooling credits, or ITS surcharges.
3. Prudent Buyer pharmacy claims are retroactively updated due to the timing of Anthem PBM's receipt of recorded claims.
4. Anthem applies ITS surcharges for Plans I-III, and Prudent Buyer, which historically adds an estimated 0.5% to 0.7% towards claims.

Blended (Medical & Rx) Trend	2023/2024	2024/2025	2025/2026
Non-Medicare (80% Medical / 20% Rx)	7.7%	7.7%	8.6%
Medicare (20% Medical / 80% Rx)	6.9%	6.2%	8.1%

Los Angeles County Employees Retirement Association

Kaiser Utilization

Coverage Month Ending November 2025

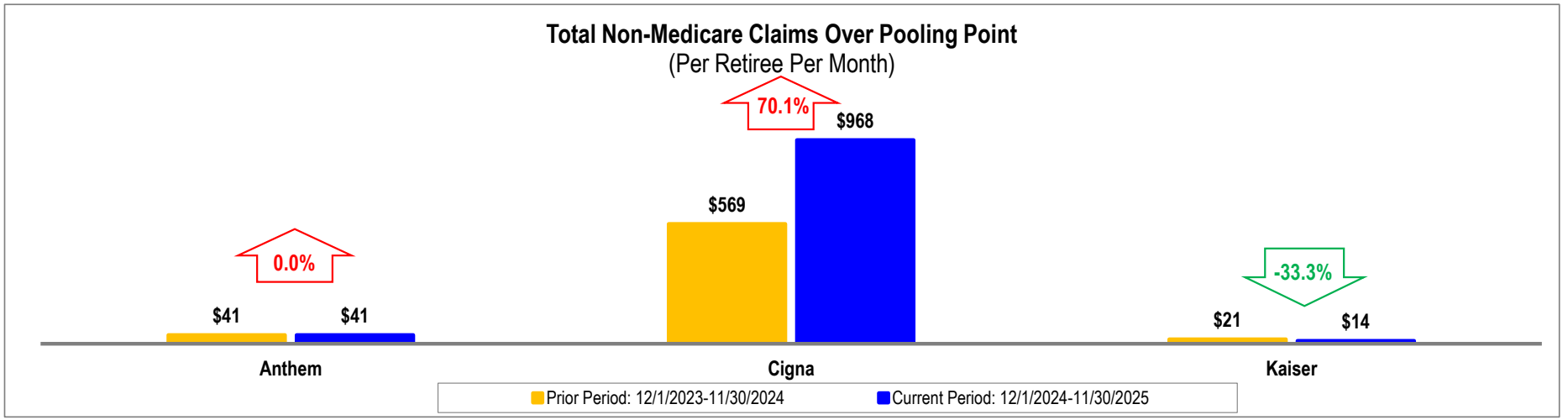
- Kaiser insures approximately 26,500 LACERA retirees with the majority enrolled in Medicare Advantage plans.
- Kaiser's Periodic Utilization Report (PUR) monitors utilization patterns of LACERA's non-Medicare population in California.

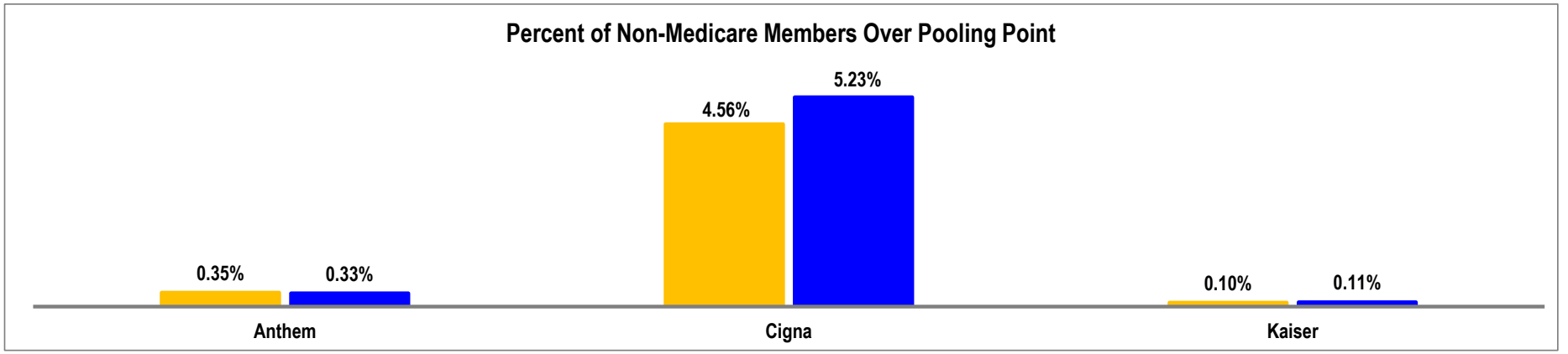
Category	Current Period 9/1/2024 - 8/31/2025	Prior Period 9/1/2023 - 8/31/2024	Change
Average Contract Size	**1.82**	**1.82**	**0.00%**
Average Members	**12,656**	**12,557**	**0.79%**
Inpatient Claims Per Member Per Month	$313.41	$317.22	-1.20%
Outpatient Claims Per Member Per Month	$556.21	$504.29	10.30%
Pharmacy Per Member Per Month	$173.63	$159.24	9.04%
Other Per Member Per Month	$215.68	$194.17	11.08%
Total Claims Per Member Per Month	**$1,258.93**	**$1,174.92**	**7.15%**
Total Paid Claims	**$191,200,169**	**$177,037,581**	**8.00%**
Large Claims over $600,000 Pooling Point			
Number of Claims over Pooling Point	8	7	
Amount over Pooling Point	$1,196,810	$1,749,239	-31.58%
% of Total Paid Claims	**0.63%**	**0.99%**	
Inpatient Days / 1000	700.0	736.8	-4.99%
Inpatient Admits / 1000	95.8	93.9	2.02%
Outpatient Visits / 1000	16,820.8	16,089.8	4.54%
Pharmacy Scripts Per Member Per Year	14.3	13.6	5.15%

Los Angeles County Employees Retirement Association

High Cost Claimants (Anthem, Cigna, & Kaiser)

Coverage Month Ending November 2025





Stop-Loss & Pooling Points Overview:

Plan sponsors mitigate the financial risk associated with individual large claimants through reinsurance. Claims exceeding the specified individual pooling threshold are deducted from the carrier's renewal calculation. The pooling credit is offset by the carrier's pooling expense, which is applied to all policyholders.

Anthem and Cigna figures are based on the most recent Claims Experience through Coverage Month. Kaiser's figures are based on Claims Experience period between September through August.

Pooling Points by Carrier:

1. Anthem's pooling points are $400,000 for Plans I & II, and $300,000 for Prudent Buyer.
2. Cigna's pooling point is $100,000.
3. Kaiser's pooling point is $600,000.

LACERA

Los Angeles County Employees Retirement Association

Anthem Lifetime Max Accumulation Status By Plan

Coverage Month Ending November 2025

	Prior Calendar Year: December 2023 [1,2]			Current Calendar Year: December 2024 [1,3]		
Lifetime Claim Amount [4]	**Plans I & II**	**Prudent Buyer**	**Combined**	**Plans I & II**	**Prudent Buyer**	**Combined**
$1.4M-$1.5M	0	0	**0**	0	0	**0**
$1.3M-$1.4M	0	0	**0**	0	0	**0**
$1.2M-$1.3M	0	0	**0**	0	0	**0**
$1.1M-$1.2M	0	0	**0**	0	0	**0**
$1.0M-$1.1M	3	0	**3**	7	0	**7**
$900K-$999K	19	1	**20**	15	1	**16**
$800K-$899K	27	2	**29**	18	1	**19**
Total	**49**	**3**	**52**	**40**	**2**	**42**

	Prior Month: October 2025 [5,7]			Most Recent Month: November 2025 [6,7]		
Lifetime Claim Amount [4]	**Plans I & II**	**Prudent Buyer**	**Combined**	**Plans I & II**	**Prudent Buyer**	**Combined**
$1.4M-$1.5M	0	0	**0**	0	0	**0**
$1.3M-$1.4M	0	0	**0**	0	0	**0**
$1.2M-$1.3M	0	0	**0**	0	0	**0**
$1.1M-$1.2M	1	0	**1**	1	0	**1**
$1.0M-$1.1M	4	1	**5**	7	1	**8**
$900K-$999K	6	0	**6**	6	0	**6**
$800K-$899K	20	2	**22**	21	2	**23**
Total	**31**	**3**	**34**	**35**	**3**	**38**

The number of members reported will fluctuate period to period due to multiple factors including migration from an Anthem plan to another LACERA-administered plan or members passing away.

[1] Includes two years of historical data.

[2] Based on data provided by Anthem on September 17, 2024.

[3] Based on data provided by Anthem on January 22, 2025.

[4] Members identified by Anthem as terminated were excluded from the counts above.

[5] Based on data provided by Anthem on November 17, 2025.

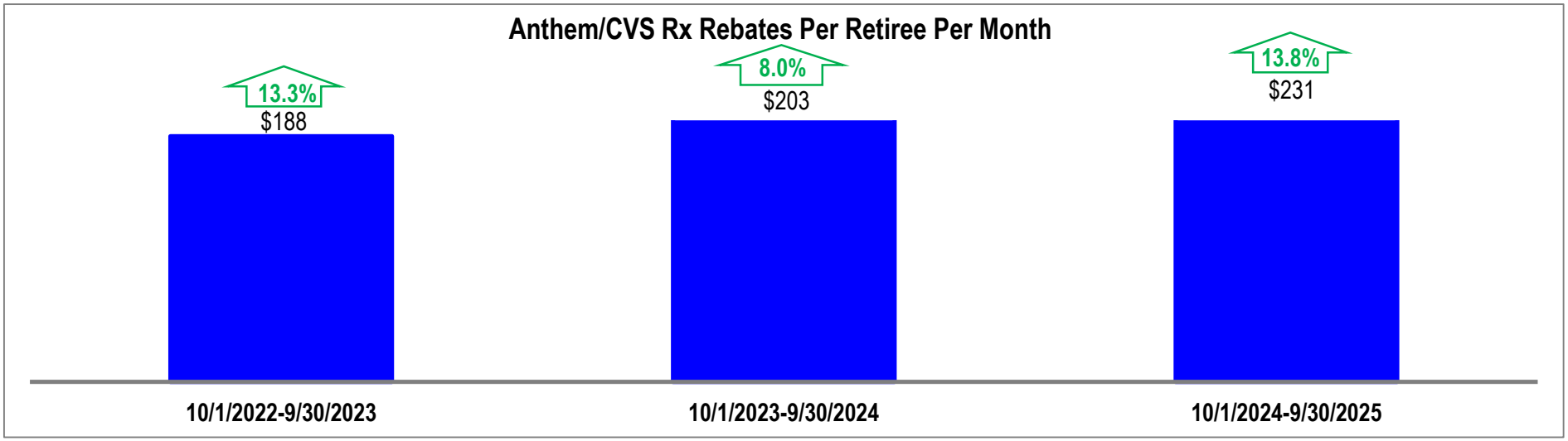
[6] Based on data provided by Anthem on December 17, 2025.

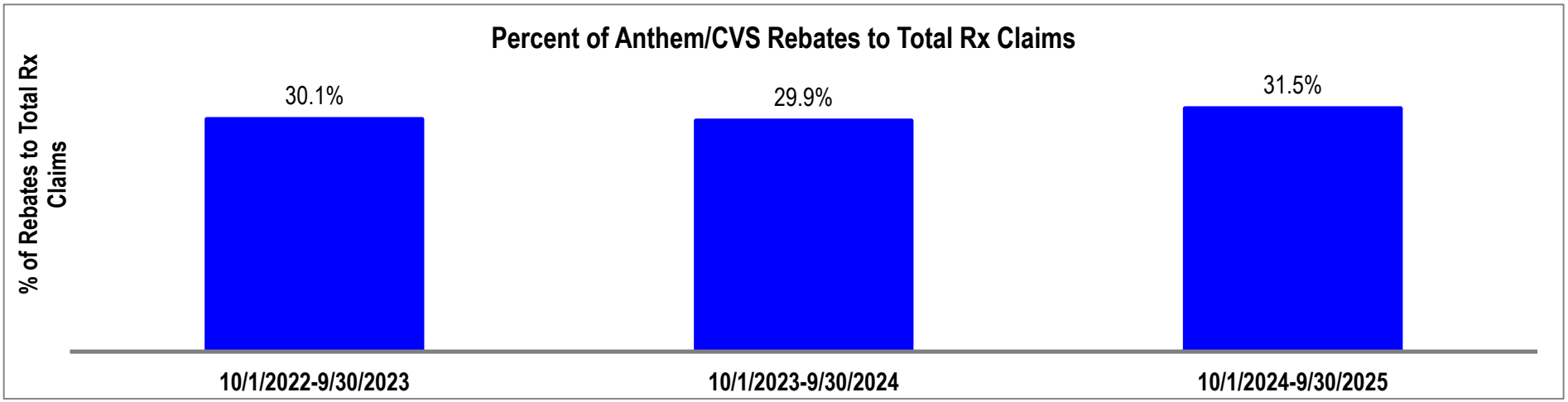
[7] Includes two months of historical data.

Los Angeles County Employees Retirement Association

Prescription Drug Rebates (Anthem)

Coverage Month Ending November 2025





Rebates Overview:

Pharmacy Benefit Managers negotiate volume-based rebates with drug manufacturers of brand medications. Manufacturer rebates are passed on to plan sponsors and are used to offset pharmaceutical claims expenses.

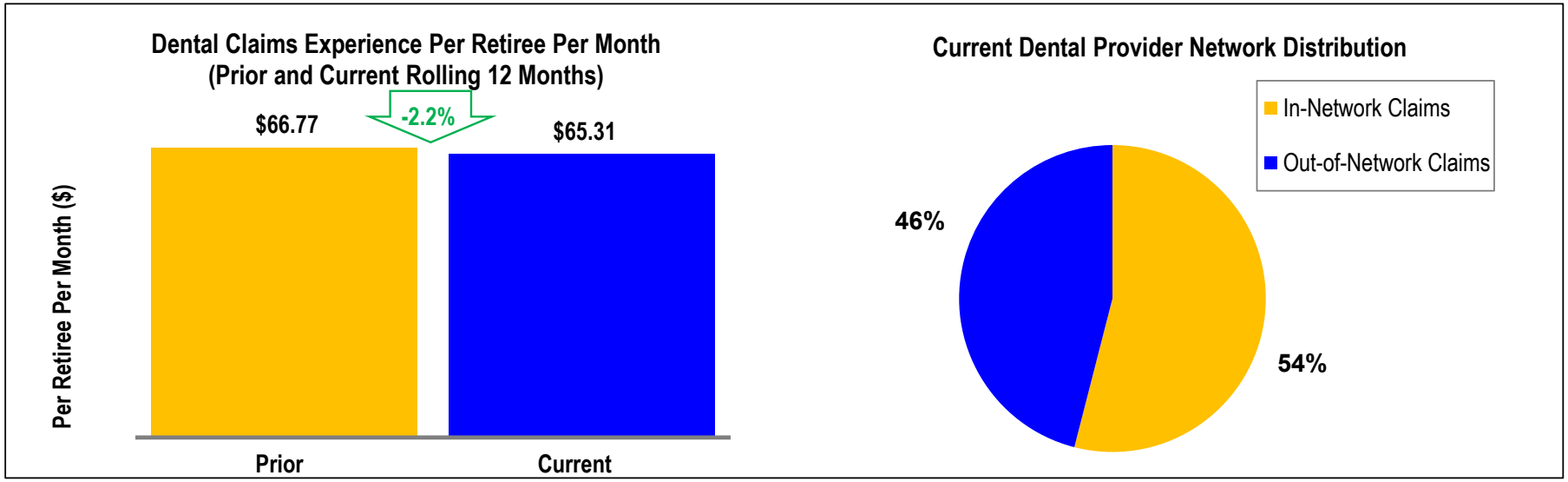
Note:

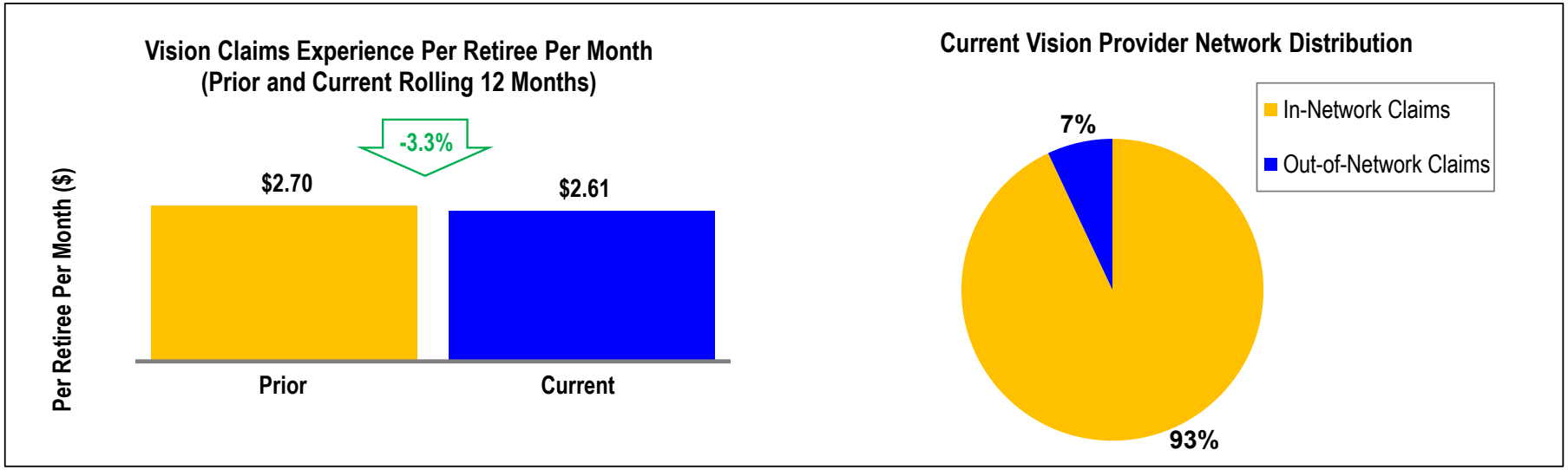
1. Prescription Claims and Rebates Data were provided by CVS.
2. Anthem Prudent Buyer prescription drugs are provided by CarelonRx and are not included in the charts above.

Los Angeles County Employees Retirement Association

Cigna Dental & Vision Claims Experience

Coverage Month Ending November 2025





Notes:

1. Figures above are based on most recent 12 months of Claims Experience through Coverage Month.
2. Dental Claims Experience reflects passive use of Cigna's PPO Dental Network.

Segal

Compliance News | November 21, 2025

Retiree Health Plan Sponsors: 2026 Medicare Part B Premiums Increase

The Centers for Medicare & Medicaid Services (CMS) has released the Medicare Part B premiums and deductible and the Part A deductible and coinsurance that will take effect on January 1, 2026. The standard Part B premium will increase by nearly 10 percent and the Part B deductible for all Medicare beneficiaries will increase by just over 10 percent. The Medicare Part A inpatient deductible and coinsurance for hospital stays and care in a skilled nursing facility will increase by more than 3 percent.

Sponsors of group health plans that cover retirees need to know this information when reviewing their coverage for Medicare-eligible retirees, including those enrolled in Medicare Advantage Plans.

Standard Part B premium and deductible

Part B covers physician services, outpatient hospital services, certain home health services, durable medical equipment and other items. According to the November 14, 2025 announcement, the standard monthly Part B premium will be $202.90, an increase of $17.90. In 2026, the annual deductible for Medicare Part B beneficiaries will be $283.00, an increase of $26.00.

CMS stated that the increase in the 2026 Part B standard premium and deductible is mainly due to projected price changes and assumed utilization increases that are consistent with historical experience.

Part B Premium and Deductible

	2025	2026
Standard monthly Part B premium	$185.00	$202.90
Medicare Part B deductible	$257.00	$283.00

Part B and Part D premium adjustments for high-income individuals

High-income Medicare-eligible individuals who enroll in the Part B and D programs are required to pay income-related monthly adjustment amount (IRMAA) premiums. The IRMAA is calculated based upon an enrollee's modified adjusted gross income and income tax filing status. The income-adjusted premiums for 2026 are shown in the table below.

The Part D IRMAA is in addition to the individual's Part D premium. CMS projects the average base monthly premium for standard Part D coverage will be $38.99 for 2026, up from $36.78 in 2025.

Income-Related Adjustments to Part B Premiums and Part D Premium Monthly Adjustment Amounts

Income Ranges for Individual Return Tax Filing Status*	Income Ranges for Joint Return Tax Filing Status	Monthly Adjustment Amounts for Part B Premium	Total Monthly Part B Premium	Part D Premium Monthly Adjustment Amounts
$109,001 to $137,000	$218,001 to $274,000	$81.20	$284.10	$14.50
$137,001 to $171,000	$274,001 to $342,000	$202.90	$405.80	$37.50
$171,001 to $205,000	$342,001 to $410,000	$324.60	$527.50	$60.40
$205,001 to $499,999	$410,001 to $749,999	$446.30	$649.20	$83.30
$500,000+*	$750,000+*	$487.00	$689.90	$91.00

* Married beneficiaries with incomes of more than $109,000 and less than $391,000 who file a separate return from their spouse and lived with their spouse at some time during the taxable year must pay the following Part B monthly premium adjustment in 2026: $446.30 (resulting in a total monthly premium of $649.20). (The Part D monthly adjustment for these couples will be $83.30.) Married beneficiaries with income of more $391,000 who file a separate return from their spouse and lived with their spouse at some time during the taxable year must pay the following premium adjustment in 2026: $487.00 (resulting in a total monthly premium of $689.90). (The Part D monthly adjustment for these couples will be $91.00.)

Part B coverage option for Medicare enrollees who have had a kidney transplant

Medicare enrollees who receive a kidney transplant lose eligibility for full Medicare coverage after 36 months. They can elect to pay a premium to continue Part B coverage of only immunosuppressive drugs. In 2026, the immunosuppressive drug premium will be at least $121.60 per month. High-income beneficiaries will pay a higher premium for this coverage, as shown in the following table.

Income-Related Adjustments for Part B Immunosuppressive Drug Coverage

Income Ranges for Individual Return Tax Filing Status*	Income Ranges for Joint Return Tax Filing Status	Monthly Adjustment Amounts	Total Monthly Premium
$109,001 to $137,000	$218,001 to $274,000	$81.10	$202.70
$137,001 to $171,000	$274,001 to $342,000	$202.70	$324.30
$171,001 to $205,000	$342,001 to $410,000	$324.30	$445.90
$205,001 to $499,999	$410,001 to $749,999	$445.90	$567.50
$500,000+*	$750,000+*	$486.50	$608.10

* Married beneficiaries with incomes of more than $109,000 and less than $391,000 who file a separate return from their spouse and lived with their spouse at some time during the taxable year must pay the following premium adjustment in 2026 for Part B immunosuppressive drug coverage: $445.90 (resulting in a total monthly premium for that coverage of $567.50). Married beneficiaries with income of more $391,000 who file a separate return from their spouse and lived with their spouse at some time during the taxable year must pay the following premium adjustment in 2026 for Part B immunosuppressive drug coverage: $486.50 (resulting in a total monthly premium for that coverage of $608.10).

Part A deductible and coinsurance

Part A pays for inpatient hospital, skilled nursing facility, hospice and certain home healthcare services.

Part A Deductible and Coinsurance

	2025	2026
First-day Part A hospital deductible	$1,676.00	$1,736.00
Daily Part A coinsurance for the 61st through 90th day of a hospital stay*	$419.00	$434.00
Daily Part A coinsurance for hospital stays longer than 90 days	$838.00	$868.00
Daily Part A coinsurance for the 21st through 100th day in a skilled nursing facility	$209.50	$217.00

* There is no cost-sharing requirement for the second through 60th day of a hospital stay.

Many public plans and employers have current and future retirees that do not have, or will not qualify for, zero-premium Part A coverage. Alternative market opportunities and strategies exist to provide benefits to these retirees in a more effective manner.

Action items

The premium increase is potentially significant, particularly for low-wage beneficiaries and for plan sponsors that reimburse all or part of an individual's Part B premium. Plan sponsors that reimburse a portion of these premiums for Medicare-eligible retirees should ensure that plan documents clearly state the terms for premium reimbursement. Terms that are vague or unclear should be clarified. Plan sponsors should also determine whether they will pay any part of the IRMAA premiums.

Segal

Compliance News | December 18, 2025

Government Entities Must Meet Website Accessibility Rules

All state and local governments must meet web content accessibility standards established by the Department of Justice (DOJ) to ensure that online content is usable by those with a disability. The standards apply to websites and tools used by government employees.

For public entities that have a population of at least 50,000, the compliance deadline is April 24, 2026.

Smaller public entities (i.e., population <50,000) and special district governments (e.g., utility district, transit authority or water and sewer board) have just over an additional year to comply: April 26, 2027.

Noncompliance exposes governmental entities to significant legal risks, including investigations initiated by the DOJ and potential private litigation.

Background on website accessibility requirements and guidance

Under Title II of the Americans with Disabilities Act (ADA), state and local governments and their agencies are prohibited from discriminating against individuals based on a disability. This includes access to digital information or services from state, county and municipalities, public schools and universities, public transportation agencies and courts. Title II nondiscrimination requirements apply to websites, online forms, internal portals, mobile applications and other digital services.

Although the DOJ has long recognized that Title II of the ADA applies to websites and digital services provided by public entities, it did not finalize the criteria for accessibility standards until June 24, 2024, when it issued a final rule on Accessibility of Web Information and Services of State and Local Government Entities, which amended the regulations implementing Title II of the ADA.

The final rule includes defined standards to give greater clarity in exactly how state and local governments can meet their ADA obligations and ensure equal access to government services for individuals with disabilities. It mandates that both public-facing and internal digital assets of state and local governments meet accessibility standards.

This mandate extends to internal tools used by government employees as well as to online services provided to the public, including via text, images, audio, video, interactive elements, animations and electronic documents, on websites or mobile apps.

The DOJ's final rule on public entity web content accessibility

The DOJ's final rule adopts the 2018 Web Content Accessibility Guidelines (WCAG) 2.1, developed by the World Wide Web Consortium Web Accessibility Initiative, as its technical standard, although WCAG 2.1 was superseded by WCAG 2.2 in 2023. WCAG 2.1 includes detailed technical specifications and is intended for use by web content developers, web authoring tool developers and web accessibility evaluation tool developers.

There are three WCAG conformance levels: A (lowest), AA (middle) and AAA (greatest). The DOL's final rule requires that all web-based information aims to meet AA level as the official technical standard under Title II. Conformance with Level AA requires satisfying Level A success criteria as well.

Similar to security standards under the Health Insurance Portability and Accountability Act (HIPAA), the WCAG framework establishes principles that must be met for digital content but it does not prescribe specific technical standards. The general principles include guidelines, each of which includes specific success criteria.

The final rule also offers flexibility in situations in which compliance is not practicable or in which noncompliance has minimal impact on accessibility.

Exceptions to the rule

The final rule exempts these five categories of web and electronic content from the technical accessibility standards:

1. Archived web content
2. Preexisting conventional electronic documents that are not actively used for application, access or participation in the public entity's services
3. Third-party posted content, except where the posting occurs via contractual or licensing arrangements with the public entity
4. Password-protected or otherwise secured conventional electronic documents relating to a specific individual, their property or account
5. Preexisting social media posts

However, upon an individual's request, a public entity must provide otherwise exempted content in an accessible format, consistent with applicable effective communication requirements under the ADA regulations. The method of accommodation depends on the specific circumstances and the individual's access needs.

Implications of the DOJ's web content accessibility requirements for public entities

State and local governments are leaders in promoting accessibility. Many have already adopted the WCAG 2.1 standards.

Public entities should review the standards and the DOJ's final rule with their legal counsel and address any compliance issues identified before the relevant deadline.

To mitigate risk and fulfill statutory obligations, state and local governments should adopt a comprehensive and compliance framework that encompasses developing internal policies, training staff, creating an inventory of all digital assets, embedding accessibility requirements in procurement processes and performing accessibility audits.

To anticipate future accessibility needs, public entities may want to consider adopting WCAG 2.2 instead of WCAG 2.1.

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Compliance News | December 18, 2025

Reporting and Disclosure Guide for Benefit Plans 2026

Sponsors of benefit plans subject to ERISA face a maze of federal reporting and disclosure deadlines. Missing one can mean costly penalties or unwanted audits.

That's why our 2026 *Reporting and Disclosure Guide for Benefit Plans* is an essential resource for plan sponsors. It's a comprehensive, time-saving guide designed to help you stay ahead and avoid compliance headaches.

Why download?

Our *Reporting and Disclosure Guide for Benefit Plans* is:

- **An all-in-one compliance roadmap.** Instantly see what's required, when and for which plan types — health and welfare plans, retirement plans, DB and DC retirement plans and more.
- **Easy to use.** It's organized by plan type, not agency, so you find what matters fast.
- **Popular and indispensable.** Each year, plan sponsors rely on this guide to keep their plans on track and their teams prepared.
- **Protection for your organization.** Avoid litigation and be ready for government audits with clear, actionable guidance.

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What's in the guide?

- Key dates and requirements for 2026
- Practical tips for staying compliant
- Direct answers to your toughest reporting questions
- Coverage of all major federal agencies:
  - Department of Labor
  - Centers for Medicare & Medicaid Services
  - Internal Revenue Service
  - Pension Benefit Guaranty Corporation

Ready to simplify compliance?

Download your copy now and join the thousands of plan sponsors who make this guide their go-to resource every year.

2026 Reporting and Disclosure Guide for Benefit Plans

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Important Notes

This annual *Reporting and Disclosure Guide for Benefit Plans* is for sponsors of plans subject to ERISA, both single-employer and multiemployer plans.

All due dates in this guide reflect that if a 2026 statutory or regulatory due date falls on a Saturday, Sunday or legal holiday, the due date is the next business day.

Contact us

If you have questions about the 2026 *Reporting and Disclosure Guide for Benefit Plans*, contact your Segal compliance consultant or one of Segal's Compliance Practice leaders:

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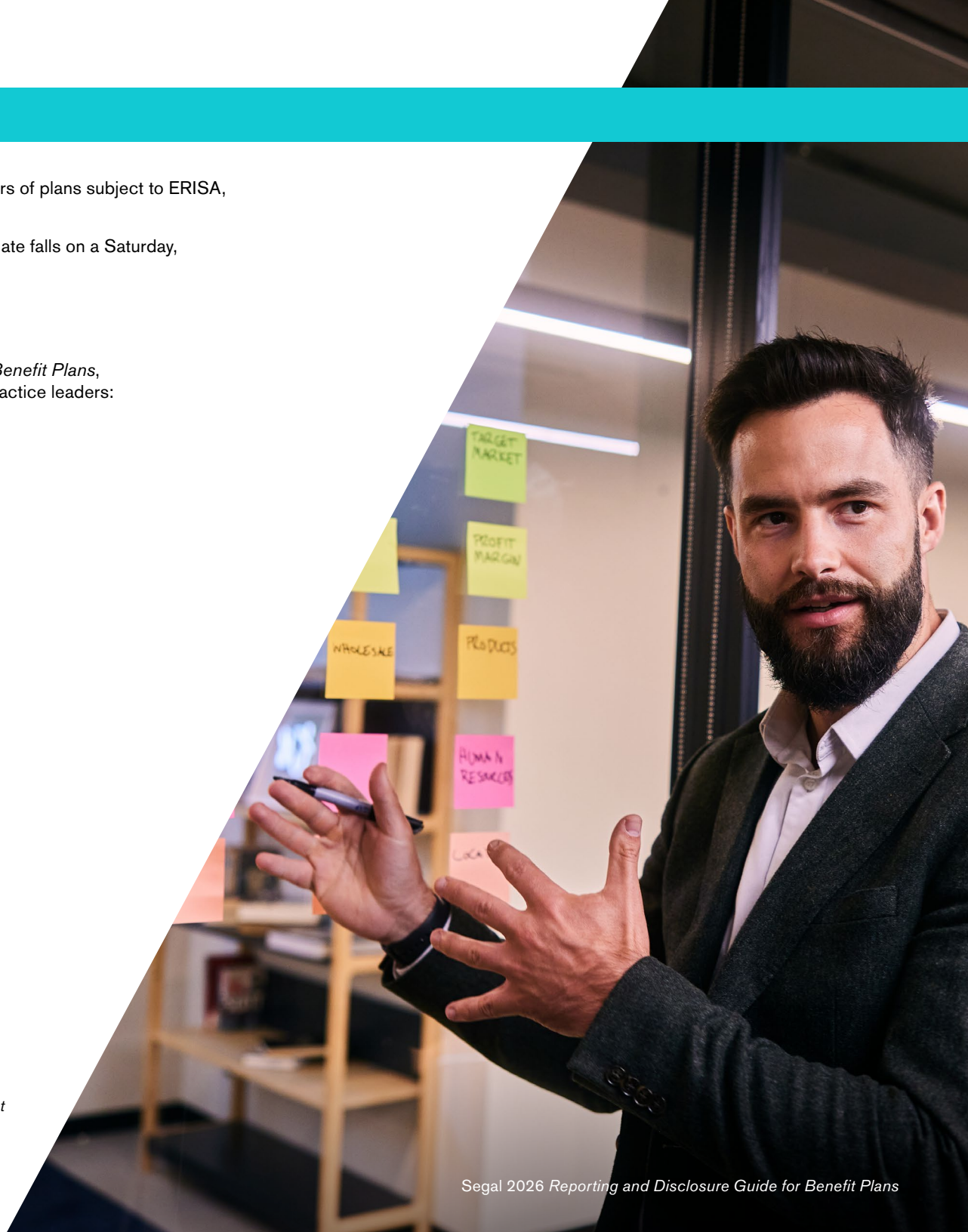

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Requirements for All Plans Subject to ERISA

Item	Plans Affected	Recipients	Sender	Due Date
Form 1099-MISC (Report of Miscellaneous Information) — Internal Revenue Code (IRC) §6041 Use if plan makes direct payments of $600 or more for services, rent and specified other purposes. Generally, not needed if payment is to a corporation other than payments to an attorney in connection with legal services. Use form 1099-NEC to report nonemployee compensation. See Instructions for Form 1099-MISC.	Retirement plans and health and welfare benefit plans	Sent to service provider or other recipient of payment. Filed with IRS (e-filing is required for 10 or more forms)	Payer	Send to recipients by 2/2/26. File with the IRS by 3/31/26 if filing electronically, or by 3/2/26 if filing on paper. File with Form 1096 if filing on paper.
Form 1099-NEC (Nonemployee Compensation) — IRC §6041 Use if plan makes payments of $600 or more for services (including parts and materials) performed by someone who is not an employee and payments for attorneys' fees. Also file for each person from whom you have withheld any federal income tax under the backup withholding rules regardless of the amount of the payment. See Instructions for Form 1099-NEC.	Retirement plans and health and welfare benefit plans	Sent to service provider or other recipient of payment. Filed with IRS (e-filing required for 10 or more forms)	Payer	Send to recipients by 2/2/26. File with the IRS by 2/2/26 if using either paper or electronic filing. File with Form 1096 if filing on paper.
Form W-2 (Wage and Tax Statement) (if plan has employees) — IRC §3401, ACA §9002 & IRC §6051(a)(14) For reporting wages, nonqualified deferred compensation, sick pay, group legal services contributions or benefits, supplemental unemployment benefits, premiums paid by employer for group-term life insurance above $50,000, employer contributions to medical savings accounts, payments under adoption assistance plans and other taxable/reportable benefits. ACA requires employers to report cost of coverage under an employer-sponsored group health plan on each employee's Form W-2. Cost of coverage includes medical and prescription drug coverage and health FSA value for plan year in excess of employee's cafeteria plan salary reduction, but dental, vision and HRA contributions are not required to be reported. Amounts contributed to a multiemployer plan would not be reported. See Form W-2 and instructions.	All plans with employees	Sent to employees/ participants. Filed with Social Security Administration (SSA) (magnetic media required for 250 or more forms). Taxpayers filing 10 or more information returns must file electronically.	Employer	Send to participants by 2/2/26. File Form W-3 to transmit Copy A of Forms W-2 with SSA by 2/2/26 (whether filing on paper or electronically).

Item	Plans Affected	Recipients	Sender	Due Date
Summary Plan Description (SPD) — Employee Retirement Income Security Act (ERISA) §§102 & 104(b) & DOL Reg. §§2520.102-2 & 3 & 2520.104b-2 Summary of plan provisions and certain standard language as required by ERISA	All employee benefit plans subject to Title I of ERISA; alternative reporting requirements for top-hat, apprenticeship and certain other plans	Sent to participants and to beneficiaries receiving benefits. No filing requirement. See "Plan Documents."	Plan administrator	For new plans, 120 days after plan's effective date; for amended plans, once every five years; for all other plans, once every 10 years. To new participants, within 90 days of becoming a participant; to beneficiaries receiving benefits under pension plan, within 90 days after first receiving benefits
Summary of Material Modifications (SMM) — ERISA §§102 & 104(b)(1) & DOL Reg. §2520.104b-3 Summary of changes in any information required in SPD	All employee benefit plans subject to Title I of ERISA; alternative reporting requirements for top-hat, apprenticeship and certain other plans	Sent to participants and to beneficiaries receiving benefits, with exceptions for certain updates. No filing requirement. See "Plan Documents."	Plan administrator	Within 210 days after end of plan year in which substantial modification is adopted unless a revised SPD is distributed containing modification. To new participants, within 90 days of becoming a participant; to beneficiaries, within 90 days after first receiving benefits
Plan Documents — ERISA §§104(b)(2) & (4) & DOL Reg. §2520.104b-1(b)(3) Maintain and provide copies upon request of plan and trust instruments, most recent annual report, SPD, any SMMs, any collective bargaining agreements and all contracts or other instruments under which plan is established or operated	All employee benefit plans subject to Title I of ERISA	Copies sent to participants and beneficiaries upon written request. No filing requirement, but must be maintained and made available for inspection at principal office of plan administrator	Plan administrator	Copies must be provided within 30 days after a written request.

Item	Plans Affected	Recipients	Sender	Due Date
Form 5500 Series (Annual Return/Report of Employee Benefit Plan) and Schedules[1] — ERISA §§103-104 & 4065, DOL Reg. §2520.103 & IRC §6058 Annual report filed by employee benefit plans subject to ERISA and IRC for purposes of providing plan information to DOL, IRS and PBGC. A short form (5500-SF) is available for plans with fewer than 100 participants as of first day of plan year that are exempt from financial audit requirements, are fully invested in certain secure investments and hold no employer stock. (Plans with one participant must use Form 5500-EZ.) Only certain schedules are required to be filed with Form 5500-SF. Plans generally have to file using DOL's EFAST2 system using credentials through Login.gov. More information available.	All employee benefit plans (exceptions for top-hat plans, certain welfare arrangements, apprenticeship plans and dependent-care assistance plans).	Sent to participants and beneficiaries on written request. Filing requirements vary with type and size of plan. Filed with DOL. Electronic filing is required.	Plan administrator	Within seven months after end of plan year, unless extension is received by filing Form 5558 before due date. See "Form 5558 (Application for Extension of Time)" below. For corporations and controlled groups, where plan year and taxable year are same, deadline is extended automatically to corporate return due date. If filing for a Direct Filing Entity (DFE), 9½ months after close of DFE's year, no extension is permitted.
Form 5558 (Application for Extension of Time) To request extension of time in which to file Form 5500 or Form 8955-SSA or both (maximum 2½ months)	All employee benefit plans subject to Form 5500 or Form 8955-SSA reporting	Filed with IRS Note: Beginning January 1, 2025, Form 5558 may be filed electronically under the EFAST2 system. Plan sponsors intending to file Form 5558 for an extension should check to make sure they use the latest version of the form and instructions.	Plan administrator	On or before statutory due date for filing Form 5500 or Form 8955-SSA. Filing required, but approval is automatic.

[1] Schedules can include: Schedule A – Insurance Information; Schedule C – Service Provider Information; Schedule D – Direct Filing Entity (DFE)/Participating Plan Information (filed by plans that participate or invest in a DFE); Schedule G – Financial Transaction Schedules (filed by plans that answer "yes" to lines 4b, 4c and/or 4d of Schedule H); Schedule H – Financial Information (filed by large plans); Schedule I – Financial Information – Small Plan (filed by small plans – fewer than 100 participants); Schedule MB – Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information (filed by multiemployer DB plans and single-employer money purchase plans amortizing funding waivers); Schedule R – Retirement Plan Information (filed by DB plans and, with certain exceptions, DC plans); and Schedule SB – Single-Employer Defined Benefit Plan Actuarial Information (filed by single-employer DB plans and money purchase plans that are not amortizing funding waivers).

Requirements for All Health and Welfare Plans

ACA requirements

No Surprises Act requirements for group health plans

Wellness program requirements

HIPAA privacy and security requirements

Medicare and Medicaid requirements

COBRA requirements

IRS requirements for group health plans

Additional requirements for group health plans

Health and welfare plans must also satisfy the requirements for all plans.

ACA requirements

Item	Plans Affected	Recipients	Sender	Due Date
Summary of Benefits and Coverage (SBC) — ACA §1001(5), 26 CFR §54.9815-2715, 29 CFR §2590.715-2715 & 45 CFR §147.200 Plans must provide a summary, not to exceed four double-sided pages, of plan benefits, coverage and cost-sharing arrangements, including exceptions, reductions, limitations and continuation of coverage information. This notice must be provided in addition to all other notices — SPD, Summary of Material Modifications (SMM) and Summary of Material Reduction in Covered Services/Benefits (SMR). Instructions and Template available	Group health plans and health insurers	Sent to participants and beneficiaries. No filing requirement	Plan administrator or health insurer	Annually with open enrollment materials or, if plan does not conduct open enrollment, 30 days prior to start of plan year. Must also provide to special enrollees within 90 days of enrollment and within seven business days of a request from a participant or beneficiary
Notice of Change to SBC — ACA §1001(5), 26 CFR §54.9815-2715(b), 29 CFR §2590.715-2715(b) & 45 CFR §147.200(b) Plans must provide advance notice of any mid-year material modification in an SBC. A material modification is a change that would be important to a participant to an item listed in an SBC.	Group health plans and health insurers	Sent to participants and beneficiaries. No filing requirement	Plan administrator or health insurer	If a health plan makes any material modification in any terms of plan that affects content of SBC and takes effect in middle of a plan year, plan or insurer must provide notice of modification no later than 60 days prior to date on which modification will become effective.
Notice of Rescission — 26 CFR §54.9815-2712T, 29 CFR §2590.715-2712 & 45 CFR §147.128 Plans must provide advance written notice of retroactive termination of coverage due to fraud or intentional misrepresentation of material facts by participant.	Group health plans and health insurers	Sent to participants and beneficiaries. No filing requirement	Plan administrator or health insurer	Written notice must be provided at least 30 days before coverage may be retroactively terminated.
Notice to Employees of Coverage Options — Fair Labor Standards Act (FLSA) §18B (added by ACA §1512) Employer must provide new employees with notices about health insurance marketplaces and their options for health coverage.	Employers subject to FLSA	Sent to new employees whether enrolled in employer's group health plan or not. No filing requirement	Employer	Written notice must be provided to new hires within 14 days of employee's start date.

ACA requirements *(continued)*

Item	Plans Affected	Recipients	Sender	Due Date
Disclosure of Patient Protections: Choice of Providers — 26 CFR §54.9815-2719AT(a)(4), 29 CFR §2590.715-2719A(a)(4) & 45 CFR §147.138(a)(4) Group health plans, including grandfathered plans, that require designation of a primary care provider (PCP) must provide notice of the right to choose a PCP, pediatrician or network provider specializing in obstetrical or gynecological care. Notice must be included with SPD or other description of benefits.	Group health plans including grandfathered plans	Sent to participants. No filing requirement	Plan administrator or health insurer	Notice must be provided with SPD or other similar description of benefits.
Disclosure of "Grandfathered" Status[2] (grandfathered plans only) — 26 Code of Federal Regulations (CFR) §54.9815-1251T(a)(2), 29 CFR §2590.715-1251(a)(2) & 45 CFR §147.140(a)(2) A grandfathered plan must include a statement to that effect in any and all materials describing benefits provided under plan to alert participants and beneficiaries that certain consumer protections may not apply. Sample notice available.	Grandfathered group health plans	Sent to participants and beneficiaries receiving benefits. No filing requirement	Plan administrator or health insurer	Notice must be provided in any and all materials describing benefits.
Patient-Centered Outcomes Research Institute (PCORI) Fee — 26 CFR §46.4376-1 Plans and insurers pay fees to fund PCORI, which funds research projects in area of evidence-based medicine with goal to advance quality of care. Initially set to sunset in 2019, Congress extended the fees for an additional 10 years. Fees now apply through plan years ending on or before 9/30/29.[3]	Self-insured group health plans (insurer reports and pays for insured group coverage)	File with Internal Revenue Service (IRS) (Form 720)	Plan sponsor or plan administrator	7/31 of calendar year that immediately follows last day of plan year to which fees apply. For example, for a non-calendar-year plan ending on 9/30, fees are due next 7/31.

[2] "Grandfathered plans" are those in existence when the ACA was enacted on 3/23/10, which have not made certain benefit or employee or employer contribution changes that would result in the loss of grandfather status, and which have complied with certain notice requirements.

[3] These fees were extended by Section 104 of Division N of the Further Consolidated Appropriations Act, Public Law 116-94.

ACA requirements *(continued)*

Item	Plans Affected	Recipients	Sender	Due Date
Form 1095-C (Employer-Provided Health Insurance Offer and Coverage) & Form 1094-C (Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns) — IRC §6056 Large employers (50 or more full-time employees, including equivalents), including multiemployer plans that are large employers, must provide full-time employees with Form 1095-C, documenting offer of coverage, and file all such forms with IRS (along with Form 1094-C transmittal).	Large employers. Enrollment information for self-insured group health plans is also captured on Form 1095-C.	Sent to full-time employees. Beginning for 2024 reports due in 2025, an alternative distribution method is available if the plan (1) posts a notice prominently on its website stating that individuals may receive a copy of their 1095-B upon request. This notice must be posted by the due date for furnishing the statement (3/2/26) and remain on the website until 10/15/26. This notice must provide an email address and physical address to which a request may be sent, as well as a telephone number to use for asking questions and (2) provides Form 1095-C to any responsible individual by the later of 1/31 of the year following the year to which the form relates or within 30 days after the date the request is received. Forms must also be filed with IRS.	Large employers	For 2025 reports due in 2026, must be filed with IRS by 3/2/26 (3/31/26 if filed electronically) and sent to employees by 3/2/26. Final regulations published 12/15/22[4] provide a permanent automatic 30-day extension of the deadline for group health plans and employers to furnish Forms 1095-B and 1095-C to employees and plan participants and eliminate transitional good-faith relief for calendar years after 2020.

[4] 87 Fed. Reg. 76570 (December 15, 2022)

[5] 87 Fed. Reg. 76570 (December 15, 2022)

ACA requirements *(continued)*

Item	Plans Affected	Recipients	Sender	Due Date
Form 1095-B (Health Coverage) & Form 1094-B (Transmittal of Health Coverage Information Returns) — IRC §6055 Group health plans (including multiemployer plans), as well as employers that are not large employers, which offer self-insured minimum essential coverage must provide participants with Form 1095-B, documenting enrollment in plan coverage, and file all such forms with IRS (along with Form 1094-B transmittal).	Self-insured group health plans, including those offered by small employers. If plan (or plan option) is insured, health insurance carrier is responsible for Form 1095-B.	Sent to participants (or other "responsible individual"). An alternative distribution method is available if the plan (1) posts a notice prominently on its website stating that individuals may receive a copy of their 1095-B upon request. This notice must provide an email address and physical address to which a request may be sent, as well as a telephone number to use for asking questions, and (2) provides Form 1095-B to any responsible individual within 30 days of the date the request is received. (Relief applies as long as the individual mandate penalty is $0.) Forms must also be filed with IRS.	Plan administrator if plan is self-insured. Insurance carrier if plan (or plan option) is insured	Must be filed with IRS by 3/2/26 (3/31/26, if filed electronically) and sent to employees by 3/2/26. Generally, must file Forms 1094-B and 1095-B by 2/28 if filing on paper (or 3/31 if filing electronically) of the year following the calendar year to which the return relates. For calendar year 2025, Forms 1094-C and 1095-C are required to be filed by 3/2/26 if filing on paper or 3/31/26 if filing electronically. Final regulations published 12/15/22[5] provide a permanent automatic 30-day extension of the deadline for group health plans and employers to furnish Forms 1095-B and 1095-C to employees and plan participants and eliminate transitional good-faith relief for calendar years after 2020.
Transparency Rule — Disclosure to Public — Section 2715 of the PHSA, 26 CFR §54.9815–2715A3; 29 CFR §2590.715–2715A3; 45 CFR §147.212 Plans are required to post on a public website machine-readable files containing in-network rates, out-of-network allowable charges and prescription drug negotiated rates.	Group health plans and health insurers, but does not apply to excepted benefits, account-based plans or grandfathered plans	Posted on the plan's public website (plan may also link to a service provider website)	Plan administrator	Plan years beginning on or after 1/1/22. In ACA FAQ 49, the requirement to post prescription drug files was delayed pending future rulemaking. That FAQ was rescinded in FAQ 61.

[5] 87 Fed. Reg. 76570 (December 15, 2022)

ACA requirements *(continued)*

Item	Plans Affected	Recipients	Sender	Due Date
Transparency Rule — Disclosure to Participants — Section 2715 of the PHSA, 26 CFR §54.9815–2715A2; 29 CFR §2590.715–2715A2; 45 CFR §147.211 Plans are required to provide an online tool to allow participants to look up price and provider information concerning benefits, including accumulated amounts.	Group health plans and health insurers, but does not apply to excepted benefits, account-based plans or grandfathered plans	Information must be made available online or via paper, phone or email method	Plan administrator of group health plan or health insurance issuer	Beginning with plan years beginning on or after 1/1/23 for top 500 services and 1/1/24 for remaining items and services. Must be made available in plain language, without subscription or other fee, through a self-service tool on a public internet website that provides real-time responses based on cost-sharing information that is accurate at the time of the request or via paper or phone no later than two business days after request is received.
Notice of Availability of Language Assistance Services and Auxiliary Aids and Services — Section 1557 of the ACA, 45 CFR §92.11 Covered entities must provide language assistance services and appropriate auxiliary aids and services free of charge when necessary for compliance with Section 1557. The Notice of Availability must be in English and at least the 15 most commonly spoken languages of the relevant state or states.	Group health plans that receive federal financial assistance from HHS, including those that receive the Retiree Drug Subsidy	Sent to participants annually, upon request, at a conspicuous location on the plan's website and in certain other communications	Plan administrator	2024 Final Rule effective 7/5/24. However, pursuant to decisions by various district courts regarding the 2024 Final Rule, certain provisions regarding gender identity are stayed nationwide.

No Surprises Act requirements for group health plans

Item	Plans Affected	Recipients	Sender	Due Date
Notice of Protection Against Surprise Billing — ERISA §716; IRC §9816; PHSA §2799A-1 Group health plans and health insurance issuers must post on a public website of the plan or issuer, and include on each explanation of benefits form for a No Surprises Act item or service a notice of participants' rights to protections from balance billing by out-of-network providers and facilities.	Group health plans and health insurers, not including excepted benefits, account-based plans, retiree-only plans	Posted on public website and included with explanations of benefits forms	Plan administrator	Plan years beginning on or after 1/1/22
Notice of Right to Continue Care — ERISA §718; IRC §9818; PHSA §2799A-3 Plans must notify each individual enrolled under the plan who is a "continuing care patient" with respect to a provider/facility at the time of a termination of the provider's contract (or change in terms of participation), on a timely basis, of the termination and the individual's right to elect continued transitional care from the provider/facility.	Group health plans and health insurers, not including excepted benefits, account-based plans, retiree-only plans	Continuing care patients	Plan administrator or issuer	Notice due at time contractual relationship or provider participation is terminated
Price Comparison Tool — ERISA §719; IRC §9819; PHSA §2799A-4 Internet-based tool allowing participants to look up cost information	Group health plans and health insurers, not including excepted benefits, account-based plans, retiree-only plans	Online tool	Plan administrator	Initially plan years beginning on or after 1/1/22, except delayed to coincide with the Transparency online tool, therefore plan years beginning on or after 1/1/23
No Surprises Act Claims Processing — ERISA §716; IRC §9816; PHSA §2799A-1 Plans must pay providers and facilities within 30 days of receiving a clean claim, include the Qualifying Payment Amount (QPA) on No Surprises Act claims payments, notify providers and facilities of a 30-day open negotiation period and participate in Independent Dispute Resolution process. If a claim is downcoded during claims processing, plans must inform the provider and facility of the code submitted and the downcoding.	Group health plans and health insurers, not including excepted benefits, account-based plans, retiree-only plans	Sent by plans and insurers to healthcare providers and facilities	Plan administrator	Plan years beginning on or after 1/1/22

No Surprises Act requirements for group health plans *(continued)*

Item	Plans Affected	Recipients	Sender	Due Date
Identification Cards — ERISA §716(e); IRC §9816(e); PHSA §2799A-1(e) Plans must include in clear writing, on any physical or electronic plan or insurance identification card issued to participants or dependents, deductibles; out-of-pocket maximums; and a telephone number and internet website address to seek consumer assistance information.	Group health plans and health insurers, not including excepted benefits, account-based plans, retiree-only plans	Sent by plans and insurers to participants	Plan administrator	Plan years beginning on or after 1/1/22
Prescription Drug Reporting (RxDC) — ERISA §725; IRC §9825; PHSA §2799A-10 Plans must report information concerning plan participants, prescription drug costs, and medical costs to the DOL/HHS. Costs must be reported for years beginning in 2020. Additional information is available.	Group health plans and health insurers, not including excepted benefits, account-based plans, retiree-only plans	Filed on CMS portal via the Health Insurance Oversight System (HIOS)	For insured plans and arrangements, the insurer (although the employer should confirm that the insurer is filing on its behalf). For self-funded plans, the plan sponsor or by a third-party administrator or pharmacy benefit manager (PBM) through written agreement	June 1 for the calendar year immediately preceding the calendar year in which the RxDC report is due
Air Ambulance Claims Reporting — ERISA §723; IRC §9823; PHSA §2799A-8 Plans must report claims information concerning air ambulance services and payments for calendar years 2022 and 2023 to the DOL/HHS.	Group health plans and health insurers, not including excepted benefits, account-based plans, retiree-only plans	Filing method not yet announced	Plan administrator	Filing dates not yet announced. Reporting postponed until after final rules are published.

No Surprises Act requirements for group health plans *(continued)*

Item	Plans Affected	Recipients	Sender	Due Date
Gag-Clause Attestation — ERISA §724; IRC §9824; PHSA §2799A-9 Group health plans and health insurance issuers may not enter into an agreement with a provider, network, TPA or other service provider that would directly or indirectly restrict the plan or issuer from providing provider-specific cost or quality information to referring providers, the plan sponsor, participants/beneficiaries (or people eligible for coverage under the plan). Plans must provide annual attestation to the government that they are in compliance with this section. Additional information is available.	Group health plans and health insurers, not including excepted benefits, account-based plans, retiree-only plans	Filed on federal portal	Plan administrator	Attestations covering the period since the last preceding attestation are due by 12/31 of each year.

Wellness program requirements

Item	Plans Affected	Recipients	Sender	Due Date
Wellness Program Notice of Availability of Reasonable Alternative Disclosures — 26 CFR §54.9802-1(f), 29 CFR §2590.702(f) & 45 CFR §146.21(f) Plans must disclose in all plan materials that describe a health-contingent wellness program availability of a reasonable-alternative standard to qualify for wellness program's reward.	Group health plans and health insurers	Include in all plan materials describing terms of wellness program	Plan administrator or health insurer	Include in SPD, enrollment materials and other materials describing terms of wellness program
Wellness Program Notice Required by Equal Employment Opportunity Commission (EEOC) — 29 CFR §1630.14(d)(2)(iv) If wellness program includes disability-related inquiries or medical examinations, plan sponsor must provide a notice describing what medical information will be obtained, how it will be used and how it will be protected from improper disclosure. Sample language available.	Health programs, whether offered as part of a group health plan or separately from plan	Sent to participants. No filing requirement	Plan sponsor or administrator	Provide to participants before they are asked to answer disability-related inquiries or undergo medical examinations

HIPAA privacy and security requirements

Item	Plans Affected	Recipients	Sender	Due Date
HIPAA Notice of Privacy Practices for PHI — HHS Reg. §164.520 Notice to participants describing their rights, plan's legal duties with respect to PHI and plan's uses and disclosures of PHI. (Note: the Notice of Privacy Practices is required to be updated by 2/16/2026, to include required provisions relating to substance use disorder records.)	Group health plans	Sent to participants. No filing requirement	Plan administrator	At enrollment and when there is a material revision to notice. Notice of material revision must generally be provided within 60 days of revision. However, plans that post information about revision (or a revised notice) prominently on their website by effective date of revision do not have to provide individual notice of revision (or revised notice) until plan's next annual mailing. No less frequently than once every three years, plan must notify covered individuals that a Notice of Privacy Practices is available and how to obtain it.
Breach Notification for Unsecured PHI Under HITECH Act[6] — HHS Reg. §164.400 et seq. Notice to participants with respect to unauthorized acquisition, access, use or disclosure of unsecured PHI. Notice must include description of what happened, description of information involved, steps individuals should take to protect themselves from potential harm resulting from breach, brief description of investigation and mitigation steps, and contact information.	Group health plans as well as other covered entities under HIPAA and their business associates	Sent to each affected individual by first-class mail at individual's last known address. Email permitted only if individual specifically authorizes. Filed with HHS and prominent media outlets for breaches involving more than 500 individuals (contemporaneous with participant notice). Filed with HHS annually for breaches involving fewer than 500 individuals	Plan administrator	Within 60 days of discovery of breach of unsecured PHI

[6] The HITECH Act, enacted as part of the American Recovery and Reinvestment Act of 2009, imposes notification requirements on covered entities, business associates, vendors of personal health records and related entities in the event of certain security breaches relating to PHI.

Medicare and Medicaid requirements

Item	Plans Affected	Recipients	Sender	Due Date
Notice of Creditable Coverage — 42 United States Code (USC) §1395w-113(b)(6) & Public Health Service Act (PHSA) Reg. §§423.56 & 423.884 Written notice stating whether a group health plan's prescription drug coverage is, on average, at least as good as standard prescription drug coverage under Medicare Part D. Model Notice available.	Group health plans that provide prescription drug coverage to Part D-eligible individuals, except with respect to individuals covered under a Part D plan	Sent to participants and beneficiaries eligible for Part D. No filing requirement	Plan sponsor	Notice must be provided (1) prior to annual Part D open enrollment period (10/15/26–12/7/26); (2) prior to individual's initial enrollment period for Part D; (3) prior to effective date of coverage for any Part D-eligible individual who joins plan; (4) when plan no longer offers drug coverage or when coverage changes so it is no longer creditable; and (5) upon request by individual. If plan provides notice to all participants annually, Centers for Medicare & Medicaid Services (CMS) will consider #1 and #2 to be met. "Prior to" means within past 12 months.
Creditable Coverage Disclosure Notice to Centers for Medicare & Medicaid Services (CMS) — 42 USC §1395w-113(b)(6) & PHSA Reg. §423.56(e) Written disclosure to CMS stating whether a group health plan's prescription drug coverage is, on average, at least as good as standard prescription drug coverage under Medicare Part D	Group health plans that provide prescription drug coverage to Part D-eligible individuals, except entities that contract with or become a Part D plan. Plans approved for RDS are exempt from providing notice with respect to retirees for whom plan is claiming subsidy.	No participant reporting requirement. Filed with CMS through online form	Plan sponsor	Annually, 60 days after beginning of plan year. Also within 30 days of termination of plan's prescription drug coverage or after a change in creditable status of plan
Application for RDS and Attestation of Actuarial Equivalence (plans that have retiree drug coverage actuarially equivalent to Medicare Part D only) — 42 USC §1395w-132 & PHSA Reg. §423.884 RDS is available to group health plans that have retiree drug coverage that is actuarially equivalent to Medicare Part D coverage. Subsidy is available for each retiree (or spouse or dependent) who is eligible for, but not enrolled in, Part D. Application and attestation must be complete by deadline in last column. List of retirees for whom plan may receive a subsidy must also be submitted in a timely manner to complete application. Additional cost submissions are required to receive subsidy payment along with a final reconciliation due 15 months after end of RDS plan year.	Group health plans that provide retiree drug coverage and are applying for RDS under Medicare Modernization Act of 2003[7]	No participant reporting requirement. Filed with CMS through online RDS system.	Plan sponsor	Subsidy application, initial retiree list and attestation must be submitted annually, at least 90 days prior to start of plan year (e.g., for plan years beginning 4/1, new application and new attestation must be completed by 1/1). Attestation must also be provided no later than 90 days before a material change to drug coverage that potentially causes plan to no longer be actuarially equivalent. Reconciliation must be completed within 15 months after end of plan year.

[7] Medicare Modernization Act of 2003 is an abbreviation used by CMS for Medicare Prescription Drug, Improvement and Modernization Act of 2003.

Medicare and Medicaid requirements *(continued)*

Item	Plans Affected	Recipients	Sender	Due Date
Medicare Secondary Payer (MSP) Data Reporting Requirements Under Medicare, Medicaid and State Children's Health Insurance Program (CHIP) Extension Act of 2007 — 42 USC §1395y(b)(7) Report information about certain participants and beneficiaries who are also Medicare enrollees for purpose of enforcing MSP rules. Maximum penalty is $1,000, as adjusted annually under 45 CFR part 102 for each day of noncompliance.	Group health plans. HRA coverage that reflects an annual benefit level of $5,000 or more.	No participant reporting requirement. Filed with CMS	Insurers, third-party administrators and, starting in 2020, pharmacy benefit managers. For self-insured, self-administered group health plans, plan administrator or plan fiduciary	All plans should already be registered and reporting on medical benefits. Reporting was extended to prescription drug benefits starting in 2020.[8]
Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Disclosure of Plan Benefits — ERISA §701(f)(3)(B)(ii) Required disclosure, upon request, of information about plan benefits to state Medicaid or CHIP to allow states to evaluate an employment-based plan to determine whether premium reimbursement is a cost-effective way to provide medical or child health assistance to an individual	Group health plans and health insurers	No participant reporting requirement. Filed with requesting state	Plan administrator	If requested by state Medicaid or CHIP, provide within 30 days of date that request was sent to plan.
CHIPRA Notice to Employees — ERISA §701(f)(3)(B)(i) Employers that maintain a group health plan in a state that provides premium assistance under Medicaid or CHIP must notify all employees of potential opportunities for premium assistance in state in which employee resides. Sample notice is available and is frequently updated by EBSA.	Group health plans and health insurers	Sent to participants and beneficiaries. No filing requirement	Employer	Annually, by first day of plan year

[8] These requirements were extended to prescription drug benefits by Section 4002 of the SUPPORT for Patients and Communities Act, Public Law 115-271

COBRA requirements

Item	Plans Affected	Recipients	Sender	Due Date
General Notice of Continuation of Health Coverage Under COBRA — ERISA §606(a)(1), IRC §4980B(f)(6)(A) & DOL Reg. §2590.606-1,4 Notice to participants and spouses upon initial enrollment of their right to continue self-paid health coverage. Model notice available.	Group health plans	Mail to participant and spouse at home address. If plan knows that spouse resides at a separate address, a separate distribution should be made to the spouse. No filing requirement	Plan administrator	General Notice (or Initial Notice) — generally within 90 days of when coverage begins (participants and spouses only). Model notice available.
COBRA Election Notice — ERISA §606(a)(2), IRC §4980B(f)(6(B),(D) & DOL Reg. CFR §2590.606-2, 3, 4(b) The election notice must inform the qualified beneficiary of his or her right to elect COBRA. Model notice available.	Group health plans	Participants and beneficiaries who lose coverage under the group health plan on account of a qualifying event. No filing requirement	Plan administrator	Employer required to notify its group health plan administrator within 30 days after an employee's employment is terminated, or employment hours are reduced. Within 14 days of that notification, the plan administrator is required to send the COBRA Election Notice to notify the individual of his or her COBRA rights. If the employer also is the plan administrator and issues COBRA notices directly, the employer has the entire 44-day period in which to issue the COBRA Election Notice.
Notice of Unavailability of Continuation Coverage Under COBRA — DOL Reg. §2590.606-4(c) Notice to qualified beneficiaries that have sent a qualifying event notice to plan administrator of reasons why they are not entitled to COBRA coverage	Group health plans	Sent to affected qualified beneficiaries. No filing requirement	Plan administrator	Within same time frame that plan administrator would have had to provide an election notice had person been eligible for COBRA (generally 14 days after receipt of notice of a qualifying event or, where employer is also administrator, 44 days after notice of qualifying event)
Notice of Termination of Continuation Coverage — DOL Reg. §2590.606-4(d) Notice to qualified beneficiaries that their COBRA coverage is terminating early (i.e., before end of maximum coverage period)	Group health plans	Sent to affected qualified beneficiaries. No filing requirement	Plan administrator	As soon as practicable following administrator's determination that continuation coverage shall terminate early

COBRA requirements *(continued)*

Item	Plans Affected	Recipients	Sender	Due Date
Notice of Insufficient Payment of COBRA Premium — Treas. Reg. §54.4980B-8, Q&A5(d) Notice to qualified beneficiary that payment for COBRA continuation coverage was less (but not "significantly less") than correct amount	Group health plans	Sent to affected qualified beneficiaries. No filing requirement	Plan administrator	Plan must provide reasonable period to cure deficiency before terminating COBRA. A 30-day grace period will be considered reasonable.
Notice of COBRA Premium Increase Plans may increase COBRA premiums for qualified beneficiaries if the cost to the plan increases, but generally plans must fix premiums before each 12-month premium cycle. See EBSA: An Employer's Guide to Group Health Continuation Coverage Under COBRA	Group health plans	Enrolled COBRA beneficiaries	Plan administrator or COBRA administrator	Prior to the beginning of the plan year for which the increase applies

IRS requirements for group health plans

Item	Plans Affected	Recipients	Sender	Due Date
Form W-2 (Wage and Tax Statement) — IRC §3401, ACA §9002 & IRC §6051(a)(14) For reporting wages, nonqualified deferred compensation, sick pay, group legal services contributions or benefits, supplemental unemployment benefits, premiums for group-term life insurance above $50,000, employer contributions to medical savings accounts, payments under adoption assistance plans and other taxable/reportable benefits. ACA requires employers to report cost of coverage under an employer-sponsored group health plan on each employee's Form W-2. Cost of coverage includes medical and prescription drug coverage and health FSA value for plan year in excess of employee's cafeteria plan salary reduction, but dental, vision and HRA contributions are not required to be reported. Amounts contributed to a multiemployer plan would not be reported.	Health and welfare benefit plans, employers	Sent to employees. Filed with Social Security Administration (SSA) (magnetic media required for 250 or more forms)	Employer	Send to participants by 2/2/26. File Form W-3 with SSA by 2/2/26 (whether filing on paper or electronically). Deadline for filing with SSA has been accelerated to same deadline as for providing to participants.
Form 990 & Form 990EZ (Annual Return of Organization Exempt from Income Tax) — IRC §501(c) Use Form 990EZ if annual gross receipts were less than $200,000 and total year-end assets were less than $500,000 at the end of the tax year; otherwise use Form 990	Health and welfare benefit plans organized under IRC Section 501(c).	Sent to participants on written request. Filed with IRS	Plan administrator	Must be filed by 15th day of fifth month after end of plan year. Use Form 8868 to request 90-day extensions.
Form 8928 (Return of Certain Excise Taxes Under Chapter 43 of IRC) — IRC §§4980B & 4980D Group health plans may be subject to excise taxes for failure to comply with certain requirements related to administration of health benefits, including Consolidated Omnibus Budget Reconciliation Act (COBRA) and HIPAA portability and nondiscrimination. ACA mandates also are subject to applicable excise taxes. Group health plans must self-report compliance failures on Form 8928 and pay related excise taxes.	Group health plans	No participant reporting requirement. Filed with IRS	Plan administrator	Must be filed on or before due date for filing responsible party's federal income tax return. An automatic six-month extension is available by filing Form 7004 (which must be filed on or before regular filing date for Form 8928).

Additional requirements for group health plans

Item	Plans Affected	Recipients	Sender	Due Date
Summary Annual Report — ERISA §104(b)(3) & DOL Reg. §2520.104b-10 Narrative summary of financial information reported on Form 5500 (see "Form 5500 Series") and statement of right to receive annual report. See sample report under "General Reporting and Filing Compliance Assistance" tab.	Employee benefit plans subject to Title I of ERISA, however not required for (1) a totally unfunded welfare plan where benefits are paid solely from the general assets of the employer, (2) welfare plans with fewer than 100 participants at the beginning of the plan year, or (3) plans established for a select group of management/ highly compensated employees. Also not required for defined benefit (DB) plans subject to Title IV of ERISA and as exempted in DOL Reg. §2520.104b-10(g)	Sent to participants and beneficiaries receiving benefits. No filing requirement	Plan administrator	Generally, later of nine months after plan year ends or, where an extension of time for filing Form 5500 has been granted by IRS, two months after Form 5500 is due
Summary of Material Reduction in Covered Services or Benefits — ERISA §104(b) & DOL Reg. §2520.104b-3(d) Summary description of modification or change that would be considered by average plan participant to be an important reduction in covered services or benefits	Group health plans subject to Title I of ERISA	Sent to participants. No filing requirement	Plan administrator	No later than 60 days after adoption of modification or change, or at regular intervals of no more than 90 days
Women's Health and Cancer Rights Act (WHCRA) Notices (plans that cover mastectomy-related service only) — ERISA §713 Description of benefits under WHCRA and any deductibles and coinsurance limits applicable to such benefits. Sample notice available	Group health plans that provide for mastectomy benefits	Sent to participants and beneficiaries. No filing requirement	Plan administrator or health insurer	Upon enrollment in plan and annually thereafter

Additional requirements for group health plans *(continued)*

Item	Plans Affected	Recipients	Sender	Due Date
Notice of Special Enrollment Rights — ERISA §701 & IRC §9801 Notice to participants of HIPAA special enrollment rights upon acquiring a new dependent or loss of other coverage. In addition, notice must include special enrollment rights when an individual loses coverage under a CHIP) or Medicaid, or becomes eligible to receive premium assistance under those programs for group health plan coverage. Sample notice available. (Caution should be exercised with sample notice as it does not include CHIP or Medicaid language.)	Group health plans	Sent to participants. No filing requirement	Plan administrator or health insurer	On or before date participant is offered opportunity to enroll in group health plan
Notice of Coverage Relating to Hospital Length of Stay in Connection with Childbirth — ERISA §711(d) & DOL Reg. §2520.102-3(u) Notice to participants in SPD that describes any requirements under both federal and state law regarding minimum length of a hospital stay in connection with childbirth. Sample notice available.	Group health plans that provide maternity or newborn coverage	Sent to participants. No filing requirement	Plan administrator or health insurer	Within SPD time frame
Michelle's Law (plans that cover dependents 26 years of age or older on basis of student status) — ERISA §714 & IRC §9813 Requires extended coverage for post-secondary education students on medical leave	Group health plans that determine eligibility for coverage based on student status. After ACA, generally applicable only to plans that cover dependents 26 years of age or older on basis of student status.	Sent to participants. Any notice regarding student status certification must describe rights to continued coverage during a medically necessary leave of absence. No filing requirement	Plan administrator or health insurer	Whenever notice of student status certification is provided. Only applicable to plans that use student status to determine eligibility for those age 26 or older

Requirements for All Retirement Plans

Retirement plans must also satisfy the requirements for all plans.

Item	Plans Affected	Recipients	Sender	Due Date
Form 1099-R Report of distributions from retirement plans, including distributions of excess deferrals or excess contributions from certain DC plans (e.g., §401(k) plans), as well as cost of life insurance, if any, purchased in plan that is taxable to participant, and other types of fully or partially taxable distribution amounts. Form 1099-R and instructions both available.	DB and DC plans	Sent to participants, retirees and beneficiaries receiving benefits other than those who are nonresident aliens (who receive Form 1042-S instead). Filed with IRS (e-filing is required for 10 or more forms).	Payer	Send to participants by 2/2/26. File with IRS by 3/31/26 if filing electronically or by 3/2/26 if filing on paper. File with Form 1096 if filing on paper.
Periodic Pension Benefit Statements — ERISA §105(a) & DOL Field Assistance Bulletins (FABs) 2006-3 & 2007-3; Interim Final DOL Reg. §2520.105-3 DOL Temporary Implementing FAQs July 26, 2021: Statement informing participants of their accrued benefit at normal retirement age and if not vested when vesting will occur. Must describe any permitted disparity or floor-offset provision. For DC plans, must also note value of each investment. DOL to provide a model. DC plans must provide lifetime income illustrations annually. The DOL has provided model language and specific assumptions that must be used if the plan and its fiduciaries want protection from fiduciary liability. DOL issued an Interim Final Rule (IFR) outlining the requirements for the lifetime income illustrations on 8/18/20, effective 9/18/21. Final rules have not been issued.	DB and DC plans (for statements), DC plans (for lifetime income illustrations)	**DC plans with participant-directed investments:** Sent to participants and beneficiaries with accounts who may direct investments. **DC plans without participant-directed investments:** Sent to participants and beneficiaries with accounts. **DB plans:** Sent to active participants with vested benefits. No filing requirement	Plan administrator	**DC plans with participant-directed investments:** Benefit statements must be sent within 45 days after close of each quarter. One quarterly statements each year must include lifetime benefit illustrations. **DC plans without participant-directed investments:** Benefit statements must be sent on or before the date the Form 5500 is filed by plan (but in no event later than date, including extensions, on which Form 5500 is required to be filed by plan) for the plan year to which statement relates. **DB plans:** Every three years or provide annual notice of availability of benefit statement. A statement can be requested only once every 12 months. Under current guidance, statements are generally due within 45 days after close of applicable plan year.

Item	Plans Affected	Recipients	Sender	Due Date
Report at Termination or One-Year Break in Service — ERISA §209(a) A report of benefits that are due or that may become due to a participant. Report must be in same form and contain same information as periodic benefit statement under ERISA §105(a). This reporting requirement appears to target nonvested participants at termination of employment or after a one-year break in service; other required disclosures provide this information for actives and terminated vested participants. See "Periodic Pension Benefit Statements" and "Notice to Separated Participants with Deferred Vested Benefits."	DB and DC plans	Sent to participants at termination of service with employer, after a one-year break in service (as defined in ERISA §203(b)(3)(A)) or upon request. No filing requirement	Plan administrator	Report can be requested only once every 12 months and only one report is required with respect to consecutive one-year breaks in service. Report provided at such time as may be required by regulations, but no regulations have yet been issued. Informal guidance from DOL indicates good-faith compliance is required. Plan administrators should consult with counsel about whether they need to report additional information to nonvested participants at termination, based on plan type (DB or DC) and current disclosure practices, for good-faith compliance.
Notice and Reminder of Election Regarding Withholding from Annuity and Pension Plan Payments — IRC §3405(e)(10) & Temp. Treas. Reg. §35.3405-1T, Part D Notice regarding a recipient's right to elect out of income tax withholding from periodic payments. Absent an election out of withholding, withholding is required. See sample notice and election forms. (Different withholding requirements apply for non-periodic payments and eligible rollover amounts, and to individuals living abroad.)	DB and DC plans	Sent to participants and beneficiaries applying for periodic distributions. No filing requirement; amount withheld is remitted to IRS.	Plan administrator	Notice is optional within six months before first payment and is required with first payment (even if provided earlier). Reminder of election (including right to make elections or revoke such elections) is required, thereafter, once each calendar year.
Explanation of Rollover and Certain Tax Options — IRC §402(f), Treas. Regs. §§1.402(f)-1 & Notice 2020-62 Notice to recipient of a distribution eligible for rollover to an eligible retirement plan (i.e., an individual retirement account (IRA), §403(b), governmental §457(b) or §401(a) qualified plan) explaining rules for rollovers and mandatory withholding on amounts not rolled over. Model notice available. IRS has stated that the safe harbor model must be updated to reflect changes in rollover rules for law changes that occurred since the last model issued.	DB and DC plans	Sent to participants and beneficiaries who will receive or can elect to receive eligible rollover distributions. No filing requirement	Plan administrator	Generally, at least 30 but no more than 90 days prior to distribution date (or if plan administrator chooses, the annuity starting date).

Item	Plans Affected	Recipients	Sender	Due Date
Form 8955-SSA (Annual Registration Statement Identifying Separated Participants with Deferred Vested Benefits) — IRC §6057 Provides information on recently terminated vested participants	DB and DC plans	Filed with IRS. See "Notice to Separated Participants with Deferred Vested Benefits" below for related notice to participants and information about answering Question 8 of this form.	Plan administrator	Due date for Form 8955-SSA is last day of seventh month following close of plan year. Extensions may be requested. See "Form 5558 (Application for Extension of Time)." Form 8955-SSA must be filed electronically if plan administrator is required to file 10 returns of any type during calendar year that includes first day of plan year. Returns include information returns (e.g., Form(s) W-2 and 1099), income tax returns, employment tax returns (including quarterly Forms 941) and excise tax returns. A paper filing will be treated as a failure to file if a filer is required to file electronically and does not. Form 8955-SSA available. See information about exceptions to electronic filing requirement.
Notice to Separated Participants with Deferred Vested Benefits — IRC §6057(e), ERISA §105(c) & Treas. Reg. §301.6057-1(e) Notice to each separated participant providing information about participant's deferred vested benefit as filed on Form 8955-SSA. IRS guidance in form of answers to frequently asked questions (FAQs) permits notice requirement to be satisfied by information timely provided in other documents. See FAQs.	DB and DC plans	Sent to separated participants with deferred vested benefits listed on Form 8955-SSA with respect to a plan year. No filing requirement	Plan administrator	No later than date on which related Form 8955-SSA is required to be filed (including extensions). See "Form 8955-SSA" above.
Notice of Right to Defer Distribution and Consequences of Failure to Defer Distribution — ERISA §205(g), IRC §411(a)(11), Notice 2007-7 & Treas. Prop. Reg. §1.411(a)-11 Notice explaining right to defer distribution and consequences of failing to defer distribution, including, for DB plans, a description of how much larger benefits could be if commencement of distributions is deferred or, for DC plans, a description of available investment options (including fees) and portion of SPD that contains special rules that might materially affect a participant's decision.	DB and DC plans	Sent to participants. No filing requirement.	Plan administrator	At least 30 but no more than 180 days before annuity starting date unless right to 30-day notice is waived, in which case due date cannot be less than seven days before distribution date unless certain requirements are met. Reasonable compliance standard until final regulations are issued

Requirements for DB Plans

Additional requirements for all DB plans

Additional requirements for single-employer DB plans

Additional requirements for multiemployer DB plans

DB plans must also satisfy the requirements for all plans and the requirements for all retirement plans.

Additional requirements for all DB plans

Item	Plans Affected	Recipients	Sender	Due Date
Annual Funding Notice — ERISA §101(f) & DOL Reg. §2520.101-5; FAB 2013-1, FAB 2015-01, FAB 2023-01 and FAB 2025-02 Required notice that must contain certain identifying and funding information. For single-employer plans, required information includes Funding Target Attainment Percentage (FTAP) for current and two preceding plan years; total assets (with credit balances) and liabilities for those three years; number of plan participants who are receiving benefits, are terminated vested participants or are active participants; a statement of funding policy and asset allocation and other information. For multiemployer plans, the notice must provide basic information about funded status and financial condition of DB plan, including plan's funded percentage, assets and liabilities, participants and beneficiaries, funding and investment policies and a description of benefits guaranteed by Pension Benefit Guaranty Corporation (PBGC). Additional information must be included if plan is in endangered, critical or critical and declining status. See appendices to FAB 2025-02 for revised model single-employer and multiemployer notices to reflect changes made by SECURE 2.0. See also FAB 2023-01 for additional model language for multiemployer plans that received special financial assistance.	DB plans subject to Title IV of ERISA	Sent to participants, beneficiaries receiving benefits, participating unions and contributing employers. Filed with PBGC	Plan administrator	Within 120 days after close of plan year; if 100 or fewer participants, due at earlier of date annual report is filed or is due (with extensions)
Intranet Posting of DB Plan Actuarial Information — ERISA §104(b)(5) If a DB plan sponsor (or plan administrator on behalf of sponsor) maintains an intranet site (not public) for communicating with employees or participants, sponsor (or plan administrator) must post on that site "identification and basic plan information and actuarial information" as filed in plan's Form 5500.	Apparently only DB plans, but no guidance has been issued	Notice of posting not currently required. No filing requirement	Sponsor or plan administrator on behalf of sponsor	Unknown (guidance not yet issued). DOL must post full Form 5500 on DOL website within 90 days of Form 5500 filing date.

Additional requirements for all DB plans *(continued)*

Item	Plans Affected	Recipients	Sender	Due Date
Suspension of Benefits Notice — IRC §411(a)(3)(B), ERISA §203(a)(3) & DOL Reg. §2530.203-3 Notice of suspension of benefits during covered employment that continues after plan's normal retirement age (NRA) or on reemployment after NRA	DB plans that contain suspension-of-benefits provisions	Sent to participants working past or rehired after NRA. No filing requirement	Plan administrator	During first month in which benefit is suspended at or after NRA (at NRA if participant continues to work after NRA). Information also required in SPD. Plans that include employment verification requirements and related presumptions must also provide an annual notice.
PBGC Comprehensive Premium Filing — ERISA §4007 & PBGC Reg. §4007.11 Form used to file flat-rate premium payment and, for single-employer plans, variable-rate premium payment. See instructions and information about premium filing.	DB plans	No participant reporting requirement. Filed with PBGC. Electronic filing is mandatory, absent a PBGC-granted exemption for good cause.	Plan administrator	Generally, the 15th day of 10th calendar month after first day of plan year. For plan years beginning in 2025, the requirement was moved to the 15th day of the 9th calendar month. See PBGC Technical Update Number 25-1 for a special rule for 2025 plan year filings only.
Notice of Reduction in Future Accruals — ERISA §204(h), IRC §4980F & Treas. Reg. §54.4980F-1 Notice of amendment significantly reducing rate of future accruals, including reductions in early retirement benefits or retirement-type subsidies	DB plans and DC plans subject to funding rules	Sent to participants and alternate payees expected to be affected, unions representing affected participants, and contributing employers. No filing requirement.	Plan administrator	For single-employer plans, generally, 45 days before effective date of amendment. For multiemployer plans, generally 15 days before effective date of amendment. There are special rules for small plans (generally fewer than 100 participants with accrued benefits) and certain corporate transactions.
Explanation of Qualified Joint and Survivor Annuity (QJSA) & Qualified Optional Survivor Annuity (QOSA) — ERISA §205(c), IRC §417(a)(3) & Treas. Reg. §§1.401(a)-11, 1.401(a)-20, 1.417(a)(3)-1 & 1.417(e)-1 Notice explaining terms and conditions of QJSA and QOSA, right to waive, right to revoke waiver, spousal consent requirement, consequences of failing to defer commencement of benefits and explanation and relative value of other optional benefit forms	DB plans, DC plans subject to funding rules and certain other DC plans	Sent to participants. No filing requirement	Plan administrator	At least 30 but no more than 180 days before annuity starting date unless right to 30-day notice is waived, in which case due date cannot be less than seven days before distribution date unless certain requirements are met
Explanation of Qualified Preretirement Survivor Annuity (QPSA) — ERISA §205(c), IRC §417(a)(3) & Treas. Reg. §§1.401(a)-11, 1.401(a)-20,1.417(a)(3)-1 & 1.417(e)-1 Notice explaining terms and conditions of QPSA, right to waive, right to revoke waiver and spousal consent requirement	DB plans, DC plans subject to funding rules and certain other DC plans	Sent to vested participants and nonvested participants who are active employees. No filing requirement	Plan administrator	Generally, during period from beginning of plan year in which employee turns age 32 to end of plan year in which employee turns age 34. Special rules apply for participants who commence participation after age 34 or separate from service before age 35. A plan that fully subsidizes QPSAs and does not allow a participant to waive the QPSA or to select a nonspouse beneficiary need not provide this notice.

Additional requirements for single-employer DB plans

Item	Plans Affected	Recipients	Sender	Due Date
Notice of Failure to Meet Minimum Funding Standard — ERISA §101(d) Required notice of employer's failure to make required minimum funding payments	DB plans and DC plans subject to funding requirements	Sent to participants, beneficiaries and alternate payees. No filing requirement	Plan administrator	DOL regulations to prescribe time and manner for furnishing notice. Until then DOL's position is "within a reasonable period of time after failure." Failure occurs if required contributions are not made within 60 days of due date.
Notice of Benefit Limitations and Restrictions — ERISA §§101(j) & 502(c)(4) & 206(g); IRC §436 & IRS Notice 2012-46 Notice that plan has become subject to benefit restrictions on unpredictable contingent benefits, prohibited payments or limitation on benefit accruals, as applicable, when plan's adjusted FTAP is less than specified percentages	Single-employer DB plans	Sent to participants and beneficiaries. No filing requirement	Plan administrator	Generally, within 30 days after plan is subject to benefit limitations relating to unpredictable contingent event benefits and prohibited payments, benefit accruals are required to cease, or a new annuity election is available because a prohibited benefit payment period has ended
PBGC Form 10-Advance (Advance Notice of Reportable Events) — ERISA §4043 & PBGC Reg. §4043 Subparts A & C Report of change or liquidation of plan sponsor or controlled group member, insolvency, transfer of benefit liabilities, extraordinary dividend or stock redemption, application for minimum funding waiver or loan default	PBGC-covered single-employer DB plans sponsored by a member of a controlled group with no non-public companies if members have single-employer plans that have aggregate unfunded vested benefits totaling more than $50 million and an aggregate vested benefit funding percentage of less than 90 percent	Filed with PBGC; electronic filing required using PBGC's e-Filing Portal. See this link for more information about Reportable Events & Large Unpaid Contributions. No participant disclosure requirement.	Each contributing sponsor; however, filing by any one sponsor satisfies requirement	In general, plan sponsor must notify PBGC 30 days before effective date of event. PBGC has extended 30-day deadline for some events in specified circumstances. PBGC has waived advance reporting for certain reportable events in specified circumstances.
PBGC Form 10 (Post-Event Notice of Reportable Events) — ERISA §4043 & PBGC Reg. §4043 Subparts A & B Report of reduction in number of active participants, failure to make minimum funding payments, inability to pay benefits when due, distribution to a substantial owner, transfer of benefit liabilities, change or liquidation of sponsor or controlled group member, insolvency, extraordinary dividend or stock redemption, application for minimum funding waiver and loan default unless an exception is satisfied	PBGC-covered DB plans	Filed with PBGC; electronic filing required using PBGC's e-Filing Portal. See this link for more information about Reportable Events & Large Unpaid Contributions. No participant disclosure requirement.	Each contributing sponsor and plan administrator; however, filing by any one sponsor satisfies requirement	Generally, within 30 days after plan administrator or contributing sponsor knows or has reason to know a reportable event has occurred. This deadline is extended for some events and for certain types of information in certain specified circumstances. PBGC has waived post-event reporting in certain circumstances, including, for some events, good financial health of sponsor or plan not owing variable-rate premiums.

Additional requirements for single-employer DB plans *(continued)*

Item	Plans Affected	Recipients	Sender	Due Date
PBGC Financial and Actuarial Information Reporting (if prior year's FTAP of any plan in controlled group is less than 80 percent) — ERISA §4010 & PBGC Reg. §4010 Annual financial and actuarial information notice of plan's funding status and limits on PBGC's guarantee	PBGC-covered DB plans if prior year's FTAP of any plan in controlled group is less than 80 percent (using non-stabilized interest rates). There is an exception where all PBGC-covered single-employer plans of controlled group members have in aggregate less than $15 million in unfunded vested benefits (using non-stabilized interest rates). There is also an exception for controlled groups with plans with fewer than 500 participants. ERISA also requires reporting if there are missed contributions of $1 million or more or a lien for $1 million or more, but regulation provides a waiver if event was already reported to PBGC as a reportable event.	Filed with PBGC; electronic filing required using PBGC's e-Filing Portal. See this link for more information about 4010 reporting. No participant disclosure requirement.	Contributing sponsor and each member of contributing sponsor's controlled group. One report on behalf of entire controlled group satisfies requirement	On or before 105th day after end of filer's fiscal year (or calendar year, if controlled group members have different fiscal years).

Additional requirements for single-employer DB plans *(continued)*

Item	Plans Affected	Recipients	Sender	Due Date
PBGC Form 200 (Notice of Failure to Make Required Contributions) — IRC §430(k)(4), ERISA §303(k)(4) & PBGC Reg. §4043.81 Notification of plan sponsor's failure to pay quarterly contributions to a DB plan where total unpaid balance is at least $1 million	PBGC-covered DB plans	Filed with PBGC; electronic filing required using PBGC's e-Filing Portal. See this link for more information about Reportable Events & Large Unpaid Contributions. No participant disclosure requirement.	Contributing sponsor; and if contributing sponsor is a member of a "parent-subsidiary" controlled group, ultimate parent; however, filing by either one satisfies requirement	No later than 10 days after due date for any required payment that was not paid when due
Substantial Cessation of Operations Notice — ERISA §§4062(e) Notice to advise PBGC of permanent cessations of operations at a facility in any location if, as a result of such cessation, there is a "workforce reduction" of more than 15 percent of all employees eligible to participate in any plan of any employer in controlled group. Requirement does not apply to a plan if — for year before year of cessation — it did not have at least 100 participants as of its valuation date or if ratio of market value of assets to funding target was 90 percent or greater.	DB plans	Sent to PBGC using applicable form from the PBGC 4062(e) Form Series. More information available.	Plan sponsor	60 days after cessation or trigger is otherwise satisfied

Additional requirements for multiemployer DB plans

Item	Plans Affected	Recipients	Sender	Due Date
Disclosure of Multiemployer Information (Including Actuarial and Financial Reports) — ERISA §101(k) & DOL Reg. §2520.101-6 (not yet revised for Multiemployer Pension Reform Act (MPRA) of 2014) Copies of periodic actuarial reports (including sensitivity testing), certain financial reports, applications for amortization extension, current SPD, plan and trust documents, Forms 5500, annual funding notices, audited financials, Funding Improvement Plan and/or Rehabilitation Plan and an employer's own participation agreements	DB plans	Sent to participants, beneficiaries, participating unions or contributing employers upon request. No filing requirement	Plan administrator	Within 30 days of written request. Requesting party is entitled to receive only one copy of any report or application during any 12-month period. Requests for certain documents limited to latest or current version, or to those in plan's possession for five years or less, or, for an employer's participation agreements, current and five immediately preceding years
Notice of Potential Withdrawal Liability — ERISA §101(l) Notice providing estimated amount of employer's withdrawal liability and how such estimated liability was determined	DB plans	Sent to contributing employers with an obligation to contribute, upon request. No filing requirement.	Trustees	Generally, within 180 days of a written request. Employers are entitled to receive only one notice during any 12-month period.
Multiemployer Plan Summary Report — ERISA §104(d) Report provides certain financial information, such as contribution schedules, benefit formulas, number of employers obligated to contribute under a collective bargaining agreement, number of participants on whose behalf no contributions were made for a specified period, number of withdrawing employers and withdrawal liability. Most information required to be provided is similar to (but not the same as) information required under ERISA §103(f)(2) on Form 5500 Schedule R, Retirement Plan Information.	DB plans	Sent to participating unions and contributing employers. No filing requirement	Plan administrator	Within 30 days after Form 5500 filing due date (including extensions)

Additional requirements for multiemployer DB plans *(continued)*

Item	Plans Affected	Recipients	Sender	Due Date
Form 15315 (Annual Certification for Multiemployer Defined Benefit Plans) — ERISA §305(b)(3)(A) & IRC §432(b)(3)(A) Certification by actuary of whether DB plan is in endangered or seriously endangered status for plan year, is or will be in critical status for plan year or any of the succeeding five plan years or is or will be in critical and declining status for plan year. Additional certifications include whether an endangered plan will be neither endangered nor critical (i.e., green) by end of 10th plan year after certification year under special rule in ERISA §305(b)(5), and whether a plan that is not in critical status for a plan year but is projected to be in critical status in any of succeeding five plan years and elects to be in critical status in the current plan year under ERISA §305(b)(4). If plan has a Funding Improvement Plan or Rehabilitation Plan, actuary must certify whether or not plan is making scheduled progress.	DB plans	Filed with IRS and sent to trustees. See "Notice of Endangered or Critical Status" below for related notice to participants, beneficiaries, participating unions and contributing employers. A separate notice to bargaining parties and PBGC is required for a plan that would be in endangered status but for special rule in ERISA §305(b)(5) and different notices are required for a plan that is projected to be in critical status in succeeding five years under ERISA §305(b)(4) depending on whether plan elects, or does not elect, to be in critical status for current year.	Actuary	Not later than the 90th day of each plan year
Notice of Endangered or Critical Status — ERISA §305(b)(3)(D) & IRC §432(b)(3)(D) Notice of plan's funded status as endangered, critical or critical and declining. If a plan is in critical status, notice must explain that adjustable benefits, as defined in ERISA §305(e)(8)(A)(iv), may be reduced. Plans certified to be in critical and declining status should include that information in notice, subject to trustees' determination with advice of counsel.	DB plans in endangered or critical status	Sent to participants, beneficiaries, participating unions and contributing employers. Filed with PBGC and DOL. See "Form 15315 (Annual Certification for Multiemployer Defined Benefit Plans", above, for related notice to IRS and trustees.	Trustees	Within 30 days after certification of endangered, critical or critical and declining status

Additional requirements for multiemployer DB plans *(continued)*

Item	Plans Affected	Recipients	Sender	Due Date
Notice to Bargaining Parties for Endangered or Critical Plans — ERISA §305(c)(1)(B) & IRC §432(c)(1)(B) for endangered plans; ERISA §305(e)(1)(B) & IRC §432(e)(1)(B) for critical plans Notice provides bargaining parties with schedules showing revisions to benefit structures and/or contribution increases needed to reach funding benchmarks.	DB plans in endangered, critical or critical and declining status	Sent to participating unions and contributing employers. No filing requirement	Trustees	Within 30 days after adoption of Funding Improvement Plan by endangered plans or adoption of Rehabilitation Plan by critical or critical and declining plans
Notice to Participants and Beneficiaries of Reductions Under Rehabilitation Plan — ERISA §305(e)(8)(C) & IRC §432(e)(8)(C) Notice of any reduction to adjustable benefits	DB plans in critical or critical and declining status that adopt reductions in adjustable benefits	Sent to participants, beneficiaries, participating unions and contributing employers. No filing requirement	Trustees	At least 30 days before effective date of reductions
Annual Statement of Compliance for Plans That Receive Special Financial Assistance (SFA) — ERISA §4262(m) & PBGC Reg. §4262.16(i) Required annual statement that SFA-recipient plan is in compliance with SFA terms and conditions as provided under PBGC regulations and ERISA §4262. Statement includes certification of compliance by authorized trustee or authorized representative	DB plans that receive SFA	Filed with PBGC; electronic filing required using e-Filing Portal. See model language and more information for SFA plan filings.	Authorized current trustee or authorized representative	No later than 90 days after the end of each plan year through the last plan year ending in 2051. If six or fewer months remain in plan year after the month that includes the date plan first received SFA payment, first statement must cover period from date plan received SFA payment through last day of the plan year following the plan year in which plan received SFA and and must be filed no later than the 90 days after the end of that plan year.

Requirements for DC Plans

Additional requirements for all DC plans

Additional requirements for single-employer money purchase/annuity DC plans

Additional requirements for multiemployer money purchase/annuity DC plans

Additional requirements for profit-sharing DC plans

Additional requirements for 401(k) plans

DC plans must also satisfy the requirements for all plans and the requirements for all retirement plans.

Additional requirements for all DC plans

Item	Plans Affected	Recipients	Sender	Due Date
Notice of Availability of Investment Advice (if provided) — ERISA §§408(b)(14) & 408(g)(1) & DOL Reg. §2550.408g-1 Required notice to participants and beneficiaries in DC plans with participant-directed investments regarding availability of investment advice services. Must be an "eligible investment advice arrangement" within the meaning of DOL Reg. §2550.408g-1(b)(2). Absent notice and compliance with ERISA requirements, a transaction involving provision of investment advice may be a prohibited transaction. A model notice is in the appendix to the regulations.	DC plans with participant-directed investments if plan sponsor wants to make investment advice services available with respect to such investments	Sent to participants and beneficiaries. No filing requirement	Investment adviser	Before initial provision of investment advice and annually thereafter with updates more often (if necessary).
Blackout Period Notification (if participant-directed) — ERISA §101(i) & DOL Reg. §2520.101-3 Advance notice of a period of more than three consecutive business days during which normal rights to direct investment of assets in accounts or obtain plan loans or distributions are restricted	DC plans with participant-directed investments	Sent to participants and beneficiaries affected by blackout period; also sent to issuers of affected employer securities held by plan. No filing requirement	Plan administrator	At least 30, but no more than 60 days, before beginning of a blackout period. Notice period can be shorter if a plan fiduciary determines that, due to events beyond plan administrator's control (e.g., a system outage), 30-day notice is not possible.
Disclosure of Plan Fees and Expenses (if participant-directed) — ERISA §404(a) & DOL Reg. §2550.404a-5 Required annual disclosure of specified plan information and specified investment-related information, quarterly statements of fees deducted from individual accounts and, upon request, disclosure of certain specified investment-related information. Required annual investment information must be in form of a chart as specified in regulations. A model comparative chart is in the appendix to the regulations.	DC plans with participant-directed investments	Sent to participants, including employees who are eligible to participate, but who have not actually enrolled, and plan beneficiaries. No filing requirement	Plan administrator	Generally, required annual information must be provided on or before date participant or beneficiary can first direct investments and at least annually thereafter. Quarterly statements must be provided within 45 days after end of quarter.

Additional requirements for all DC plans *(continued)*

Item	Plans Affected	Recipients	Sender	Due Date
Section 404(c) Disclosures (if participant-directed)— ERISA §404(c) & DOL Reg. §2550.404c-1 Disclosures required for a participant-directed DC plan that wants to limit its fiduciary liability for participant and beneficiary investment decisions. Disclosures include a statement that plan is intended to be an ERISA §404(c) plan and that fiduciaries may be released from liability for any losses that are direct and necessary result of investment instructions from participant or beneficiary; required disclosures under ERISA §404(a) (see "Disclosure of Plan Fees and Expenses" above); and a description of confidentiality procedures applicable to investment direction of employer securities in an employer security investment option if available.	DC plans with participant-directed investments that want protection under ERISA §404(c)	Provided to participants and beneficiaries. No filing requirement	Plan administrator	ERISA §404(c) disclosures must be provided before a participant makes an investment decision in order for a plan's fiduciary liability with respect to decision to be limited. The disclosure can be included in the SPD.
Notice of Qualified Default Investment Alternative (QDIA) (if participant-directed) — IRC §414(w), ERISA §404(c)(5) & DOL Reg. §2550.404c-5(d) Notice describes right to direct investments in a broad range of investment alternatives and how accounts will be invested in absence of participant direction. Notice may be combined with other ERISA §404(c) notices. (See "§404(c) Disclosures" above.) See sample notice.	DC plans with participant-directed investments	Sent to participants and beneficiaries. No filing requirement	Plan administrator	Initial notice at least 30 days before date of plan eligibility or first investment in QDIA. May be as late as date of plan eligibility if plan is an EACA (participant may make a permissible withdrawal within 90 days without penalty). Thereafter, annual notice at least 30 days before start of next plan year

Additional requirements for all DC plans *(continued)*

Item	Plans Affected	Recipients	Sender	Due Date
Notice of Right to Divest Employer Securities — ERISA §§101(m) & 204(j), IRC §401(a)(35), Treas. Reg. §1.401(a)(35)-1 & Notice 2006-107 Notification to participants in DC plans whose account balances are invested in publicly traded securities of their employer of right to diversify into alternative investments and importance of diversification. See model notice. IRS regulations provide exceptions for plans that hold employer securities indirectly as part of certain broader investment funds (including for multiemployer DC plans, funds managed by an ERISA 3(38) investment manager) that meet specified requirements.	DC plans with publicly-traded employer securities, including DC plans without participant-directed investments	Sent to participants and beneficiaries. No filing requirement	Plan administrator	No later than 30 days before date participant is first eligible to exercise right of diversification. Informal IRS guidance indicates that multiemployer plans are not required to be amended for IRC §401(a)(35) until year following year in which plan **fails to qualify** for exception described above.
Summary Annual Report — ERISA §104(b)(3) & DOL Reg. §2520.104b-10 Narrative summary of financial information reported on Form 5500 (see "Form 5500 Series") and statement of right to receive annual report. See sample report; "General Reporting and Filing Compliance Assistance" tab	Employee benefit plans subject to Title I of ERISA, except for DB plans subject to Title IV of ERISA and as exempted in DOL Reg. §2520.104b-10(g)	Sent to participants and beneficiaries receiving benefits. No filing requirement	Plan administrator	Generally, later of nine months after plan year ends or, where an extension of time for filing Form 5500 has been granted by IRS, two months after Form 5500 is due

Additional requirements for single-employer money purchase/annuity DC plans

Item	Plans Affected	Recipients	Sender	Due Date
Notice of Failure to Meet Minimum Funding Standard — ERISA §101(d) Required notice of employer's failure to make required minimum funding payments	DB plans and DC plans subject to funding requirements	Sent to participants, beneficiaries and alternate payees. No filing requirement	Plan administrator	DOL to prescribe time and manner for furnishing notice. Until then DOL's position is "within a reasonable period of time after failure." Failure occurs if required contributions are not made within 60 days of due date.
Notice of Reduction in Future Accruals — ERISA §204(h), IRC §4980F & Treas. Reg. §54.4980F-1 Notice of amendment significantly reducing rate of future accruals, including reductions in early retirement benefits or retirement-type subsidies	DB plans and DC plans subject to funding rules	Sent to participants and alternate payees expected to be affected, unions representing affected participants and contributing employers. No filing requirement	Plan administrator	For single-employer plans, generally, 45 days before effective date of amendment. For multiemployer plans, generally 15 days before effective date of amendment. There are special rules for small plans (generally fewer than 100 participants with accrued benefits) and certain corporate transactions.
Explanation of Qualified Joint and Survivor Annuity (QJSA) & Qualified Optional Survivor Annuity (QOSA) — ERISA §205(c), IRC §417(a)(3) & Treas. Reg. §§1.401(a)-11, 1.401(a)-20, 1.417(a)(3)-1 & 1.417(e)-1 Notice explaining terms and conditions of QJSA and QOSA, right to waive, right to revoke waiver, spousal consent requirement, consequences of failing to defer commencement of benefits and explanation and relative value of other optional benefit forms	DB plans, DC plans subject to funding rules and certain other DC plans	Sent to participants. No filing requirement	Plan administrator	At least 30 but no more than 180 days before annuity starting date unless right to 30-day notice is waived, in which case due date cannot be less than seven days before distribution date unless certain requirements are met.
Explanation of Qualified Preretirement Survivor Annuity (QPSA) — ERISA §205(c), IRC §417(a)(3) & Treas. Reg. §§1.401(a)-11, 1.401(a)-20,1.417(a)(3)-1 & 1.417(e)-1 Notice explaining terms and conditions of QPSA, right to waive, right to revoke waiver and spousal consent requirement	DB plans, DC plans subject to funding rules and certain other DC plans	Sent to vested participants and nonvested participants who are active employees. No filing requirement	Plan administrator	Generally, during period from beginning of plan year in which employee turns age 32 to end of plan year in which employee turns age 34. Special rules apply for participants who commence participation after 34 or separate from service before 35. A plan that fully subsidizes QPSAs and does not allow a participant to waive it or to select a nonspouse beneficiary need not provide this notice.

Additional requirements for multiemployer money purchase/annuity DC plans

Item	Plans Affected	Recipients	Sender	Due Date
Notice of Reduction in Future Accruals — ERISA §204(h), IRC §4980F & Treas. Reg. §54.4980F-1 Notice of amendment significantly reducing rate of future accruals, including reductions in early retirement benefits or retirement-type subsidies	DB plans and DC plans subject to funding rules	Sent to participants and alternate payees expected to be affected, unions representing affected participants and contributing employers. No filing requirement	Plan administrator	For single employer plans, generally, 45 days before effective date of amendment. For multiemployer plans, generally 15 days before effective date of amendment. There are special rules for small plans (generally fewer than 100 participants with accrued benefits) and certain corporate transactions.
Explanation of Qualified Joint and Survivor Annuity (QJSA) & Qualified Optional Survivor Annuity (QOSA) — ERISA §205(c), IRC §417(a)(3) & Treas. Reg. §§1.401(a)-11, 1.401(a)-20, 1.417(a)(3)-1 & 1.417(e)-1 Notice explaining terms and conditions of QJSA and QOSA, right to waive, right to revoke waiver, spousal consent requirement, consequences of failing to defer commencement of benefits and explanation and relative value of other optional benefit forms	DB plans, DC plans subject to funding rules and certain other DC plans	Sent to participants. No filing requirement	Plan administrator	At least 30 but no more than 180 days before annuity starting date unless right to 30-day notice is waived, in which case due date cannot be less than seven days before distribution date unless certain requirements are met.
Explanation of Qualified Preretirement Survivor Annuity (QPSA) — ERISA §205(c), IRC §417(a)(3) & Treas. Reg. §§1.401(a)-11, 1.401(a)-20,1.417(a)(3)-1 & 1.417(e)-1 Notice explaining terms and conditions of QPSA, right to waive, right to revoke waiver and spousal consent requirement	DB plans, DC plans subject to funding rules and certain other DC plans	Sent to vested participants and nonvested participants who are active employees. No filing requirement.	Plan administrator	Generally, during period from beginning of plan year in which employee turns age 32 to end of plan year in which employee turns age 34. Special rules apply for participants who commence participation after 34 or separate from service before 35. A plan that fully subsidizes QPSAs and does not allow a participant to waive it or to select a nonspouse beneficiary need not provide this notice.

Additional requirements for all profit-sharing DC plans

Item	Plans Affected	Recipients	Sender	Due Date
Explanation of Qualified Joint and Survivor Annuity (QJSA) & Qualified Optional Survivor Annuity (QOSA) (if plan offers an annuity form of payment) — ERISA §205(c), IRC §417(a)(3) & Treas. Reg. §§1.401(a)-11, 1.401(a)-20, 1.417(a)(3)-1 & 1.417(e)-1 Notice explaining terms and conditions of QJSA and QOSA, right to waive, right to revoke waiver, spousal consent requirement, consequences of failing to defer commencement of benefits and explanation and relative value of other optional benefit forms	DB plans, DC plans subject to funding rules and certain other DC plans	Sent to participants. No filing requirement	Plan administrator	At least 30 but no more than 180 days before annuity starting date unless right to 30-day notice is waived, in which case due date cannot be less than seven days before distribution date unless certain requirements are met.
Explanation of Qualified Preretirement Survivor Annuity (QPSA) (if plan offers an annuity form of payment) — ERISA §205(c), IRC §417(a)(3) & Treas. Reg. §§1.401(a)-11, 1.401(a)-20,1.417(a)(3)-1 & 1.417(e)-1 Notice explaining terms and conditions of QPSA, right to waive, right to revoke waiver and spousal consent requirement	DB plans, DC plans subject to funding rules and certain other DC plans	Sent to vested participants and nonvested participants who are active employees. No filing requirement	Plan administrator	Generally, during period from beginning of plan year in which employee turns age 32 to end of plan year in which employee turns age 34. Special rules apply for participants who commence participation after 34 or separate from service before 35. A plan that fully subsidizes QPSAs and does not allow a participant to waive the QPSA or to select a nonspouse beneficiary need not provide this notice.

Additional requirements for all §401(k) plans

Item	Plans Affected	Recipients	Sender	Due Date
Notice of Intent to Use §401(k) and §401(m) Safe-Harbor Formula (if plan is a "safe-harbor" 401(k) plan) — IRC §401(k)(12), Treas. Reg. §1.401(k)-3(d) & Notices 2016-16 and 2020-86 Notice to participants describing their rights and obligations under a §401(k) or §401(m) plan, including a description of safe-harbor matching employer contribution formula, how and when to make deferral elections and other required information. Requirements, including notice requirements, related to mid-year changes in safe-harbor matching contributions are found in Notice 2016-16. Effective for plan years beginning after 12/31/19, the notice requirement was eliminated for plans using a safe-harbor formula with non-elective contributions. The requirement remains for safe-harbor plans using matching contributions. Elimination of the notice does not eliminate the right of employees to make or change an election at least once per year. See Notice 2020-86.	§401(k) plans	Sent to participants and all employees eligible to participate under safe-harbor formula. No filing requirement	Plan administrator	**Initial notice for new plan or newly eligible employees:** No more than 90 days before and no later than eligibility date. **Annual notice:** At least 30 but no more than 90 days before beginning of plan year.
Notice of 401(k) Qualified Automatic Contribution Arrangement (QACA) & Eligible Automatic Contribution Arrangement (EACA) — IRC §§401(k)(13)(E) & 414(w)(4), ERISA §§404(c)(5) & 514(e)(3), Treas. Reg. §1.401(k)-3(k)(4) & DOL Reg. §2550.404c-5(d) Notice describes rights and obligations under 401(k) plan with automatic enrollment arrangement, including right to elect not to have salary deferrals made on employee's behalf, right to elect a different deferral percentage and how contributions will be invested in absence of an investment election. See sample notice.	401(k) plans using automatic enrollment	Sent to participants and each employee eligible to participate for year. No filing requirement	Plan administrator	Within a reasonable period before each plan year (or eligibility for enrollment for new hires). A period of at least 30 but no more than 90 days before beginning of plan year is deemed to be reasonable. Employees hired after beginning of year must be given notice a reasonable time prior to first payroll deduction.

Additional requirements for 401(k) plans *(continued)*

Item	Plans Affected	Recipients	Sender	Due Date
Explanation of Qualified Joint and Survivor Annuity (QJSA) & Qualified Optional Survivor Annuity (QOSA) — ERISA §205(c), IRC §417(a)(3) & Treas. Reg. §§1.401(a)-11, 1.401(a)-20, 1.417(a)(3)-1 & 1.417(e)-1 (if plan offers annuity form of payment) Notice explaining terms and conditions of QJSA and QOSA, right to waive, right to revoke waiver, spousal consent requirement, consequences of failing to defer commencement of benefits and explanation and relative value of other optional benefit forms	DB plans, DC plans subject to funding rules and certain other DC plans	Sent to participants. No filing requirement.	Plan administrator	At least 30 but no more than 180 days before annuity starting date unless right to 30-day notice is waived, in which case due date cannot be less than seven days before distribution date unless certain requirements are met.
Explanation of Qualified Preretirement Survivor Annuity (QPSA) — ERISA §205(c), IRC §417(a)(3) & Treas. Reg. §§1.401(a)-11, 1.401(a)-20,1.417(a)(3)-1 & 1.417(e)-1 (if plan offers annuity form of payment) Notice explaining terms and conditions of QPSA, right to waive, right to revoke waiver and spousal consent requirement	DB plans, DC plans subject to funding rules and certain other DC plans	Sent to vested participants and nonvested participants who are active employees. No filing requirement	Plan administrator	Generally, during period from beginning of plan year in which employee turns age 32 to end of plan year in which employee turns age 34. Special rules apply for participants who commence participation after age 34 or separate from service before age 35. A plan that fully subsidizes QPSAs and does not allow a participant to waive the QPSA or to select a nonspouse beneficiary need not provide this notice.

This Reporting and Disclosure Guide for Benefit Plans, *which was posted in December 2025, is for informational purposes only and does not constitute legal or tax advice. It is intended to indicate general reporting and disclosure requirements applicable to ERISA-covered retirement plans and health and welfare benefits on an annual basis. It is not exhaustive and does not cover all fact patterns, such as special requirements that may apply in a particular year due to an extraordinary event (e.g., plan termination) or that may apply only to a particular class of participants (e.g., highly compensated employees or nonresident aliens). You are encouraged to discuss the issues raised here with your legal, tax and other advisors before determining how the issues apply to your specific situations.*

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