2026 COMPLIANCE CALENDAR - CALENDAR YEAR PLANS

Significant Due Dates

Deadline	Item/Form	Filling/Disclosure/Plan Action Requirements	Plans Affected
January 2026			
First day of the plan year beginningon or after **January 1, 2026**.	Health FSA Contribution	Health FSA contribution maximum is $3,400 in 2026. This maximum only applies to the employee contribution and does not apply to any employer contribution or carryover amount. The maximum carryover amount from 2026 to 2027 is $680.	Fully Insured and Self-Insured Plans
First day of the plan year beginningon or after **January 1, 2026**.	Dependent Care FSA Contribution	Dependent Care FSA contribution maximum is $7,500 in 2026 ($3,750 for married filing separately).	Fully Insured and Self-Insured Plans
First day of the plan year beginning on or after **January 1, 2026**.	ACA and HSA Out-of-Pocket Maximums	The ACA's out-of-pocket maximums required for non-grandfathered plans increased to: • $10,600 for self-only and $21,200 for all other tiers. The IRS out-of-pocket maximums required for HSA-compatible high deductible health plans (HDHPs) increased to: • HSA - $8,500 for self-only and $17,000 for all other tiers.	Fully Insured and Self-Insured Plans
File 2025 Forms W-2 no later than **January 31, 2026**. Distribute to employees by the same date.	Forms W-2—Health Plan Coverage Reporting	The W-2 must report the total value of "applicable employer sponsored coverage" provided to the employee during 2025.	Sponsors of Fully Insured and Self-Insured plans who send 250 or more Forms W-2.
February 2026			
Add relevant "HIPAA 'Part 2' substance use disorder (SUD) treatment records" language to your plan's HIPAA Notice of Privacy Practices (NPP) by **February 16, 2026**.	HIPAA Notice of Privacy Practices (NPP)	Plan sponsors should ensure that they update language in their HIPAA NPPs to reflect requirements under the HIPAA "Part 2" regulation pertaining to the confidentiality of SUD treatment records.	All group health plans
March 2026			
File 2025 Forms 1094-C and 1095-C (or 1095-B) by **March 2, 2026** (if by paper). Beginning in 2023, and annually thereafter, only employers that send out less than 10 Forms are permitted to file via paper.	Forms 1095-C (or 1095-B) and Forms 1094-C	Refer to the requirements below (in March) pertaining to "ACA Information Reporting Requirements for the 2025 Calendar Year."	Fully Insured Plans sponsored by ALEs report only on Part I and Part II of the Form 1095-C. Self-Insured Plans sponsored by ALEs report on Parts I, II and III of the Form 1095-C. Self-Insured Plans sponsored by employers with fewer than 50 full-time employees and full-time equivalents in the prior calendar year (non-ALEs) report on the Form 1095-B.

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Deadline	Item/Form	Filling/Disclosure/Plan Action Requirements	Plans Affected
No later than 60 days from the beginning of the plan year - **March 2, 2026**.	Part D Creditable Coverage Online Form Notice to CMS	Complete creditable coverage online form. Notifies CMS whether prescription drug coverage offered is creditable or not (as determined under applicable CMS guidelines).	Fully Insured and Self-Insured calendar year plans
Distribute 2025 Forms 1095-C (or 1095-B) to employees by **March 2, 2026.**	Distributing Forms 1095-C (or 1095-B) and Forms 1094-C	**ACA Information Reporting Requirements for the 2025 Calendar Year (Filed and Furnished in 2026):** ACA information reporting rules require applicable large employer (ALE) members, that is, employers with 50 or more full-time and full-time equivalent employees in the prior calendar year, to report on their compliance with the ACA's requirement to offer minimum essential coverage (MEC), minimum value (MV) and affordable coverage to applicable full-time employees. Specifically, filing of the Forms with the IRS, and furnishing them to employees, is typically done early in the year following the calendar year for which reporting is required. The Paperwork Burden Reduction Act (PBRA) now allows employers to provide copies of the Forms 1095-B/1095-C only to employees who request it, so long as a clear and accessible notice informing employees of this right has been distributed.	Fully Insured Plans sponsored by ALEs report only on Part I and Part II of the Form 1095-C. Self-Insured Plans sponsored by ALEs report on Parts I, II and III of the Form 1095-C. Self-Insured Plans sponsored by employers with fewer than 50 full-time employees and full-time equivalents in the prior calendar year (non-ALEs) report on the Form 1095-B.
File Forms 1094-C and 1095-C (or 1095- B) by March 31, 2026 (if electronic). Beginning for filings in 2023 and annually thereafter) - Employers that send 10 or more forms must file electronically.	Forms 1095-C (or 1095-B) and Forms 1094-C	Refer to the requirements in the row above pertaining to "ACA Information Reporting Requirements for the 2025 Calendar Year (Filed and Furnished in 2026)."	Fully Insured Plans sponsored by ALEs report only on Part I and Part II of the Form 1095-C. Self-Insured Plans sponsored by ALEs report on Parts I, II and III of the Form 1095-C. Self-Insured Plans sponsored by employers with fewer than 50 full-time employees and full-time equivalents in the prior calendar year (non-ALEs) report on the Form 1095-B.

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Deadline	Item/Form	Filling/Disclosure/Plan Action Requirements	Plans Affected
June 2026			
Due **June 1, 2026.**	Prescription Drug Data Collection Reporting	**RxDC Reporting:** Submit the prescription drug data collection report (the "RxDC Report") to report information about prescription drugs and health care spending on the plan to the federal government annually. Most employers will rely on third parties, such as health insurance issuers, third-party administrators (TPAs) or pharmacy benefit managers (PBMs) to prepare and submit the RxDC Report for their health plans. However, if those entities are not submitting, then it is the employer's responsibility.	Employer Sponsored Group Health Plans and Health Insurance Issuers
July 2026			
Due at the end of the 7th month following the end of the plan year. The 2025 Form 5500 is due **July 31, 2026** for calendar-year plans, unless extended.	Form 5500 for Each Active and Retiree Health and Welfare Plan	**Form 5500 Filing:** File Form 5500 electronically with the U.S. Department of Labor. See instructions on electronic filing. A one-time extension of up to two and one-half months is available by filing s Form 5558 Application or Extension of Time to File Certain Employee Plan Returns) on or before the regular due date.	Employee benefit plans covered by Part 1 of Title I of ERISA, including Fully Insured and Self-Insured medical plans. Plans with 100 or more enrolled at the beginning of the plan year.
Due **July 31, 2026**, for 2025 plan year.	Form 720 to Report and Pay PCORI Fee	**PCORI Fee Requirements for the 2025 Plan Year:** File Form 720 with IRS. See IRS instructions. Note: The PCORI fee for plan years ending on or after October 1, 2025, and before October 1, 2026, is $3.84 per covered life.	Self-Insured Medical Plans and Fully Insured Plans with an HRA
September 2026			
Within nine months after the end of the plan year, or, if the Form 5500 annual report is extended, within two months after the close of the extension period for filing theForm 5500. Due by September 30, 2026 for calendar-year plans, unless the Form 5500 is extended.	Summary Annual Report (No Extension of Form 5500)	**Summary Annual Report (SAR):** Deliver by the same method applicable to the plan's SPD.	Fully Insured and Self-Insured Plans with 100 or more enrolled at beginning of plan year and filed the annual Form 5500 by July 31, 2026.

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Deadline	Item/Form	Filling/Disclosure/Plan Action Requirements	Plans Affected
October 2026			
Furnish to Medicare beneficiaries seeking enrollment in the health plans **prior to October 15, 2026**.	**Medicare Part D Creditable Coverage Notice**	**Medicare Part D Disclosure:** Notice provided to all Medicare-eligible individuals regarding status of prescription drug coverage as either creditable or non-creditable(determined in accordance with CMS guidelines). Deliver by same method applicable to the plan's SPD. It is recommended to send to all covered individuals on the Plan as the Plan Sponsor may not be aware of Medicare-eligible dependents on the plan and should not ask/request this information.	Fully Insured and Self-Insured Plans
The 2025 Form 5500 is due by **October 15, 2026, for calendar-year plans** (IF EXTENDED). The Summary Annual Report (SAR) for the extended filing is due by **December 15, 2026**.	**Form 5500 (Extended Deadline)**	File Form 5500 electronically with Department of Labor. See **instructions on electronic filing**. A one-time extension of up to two and one-half months is available by filing Form 5558 (Application for Extension of Time to File Certain Employee Plan Returns) on or before the due date.	Fully Insured and Self-Insured Plans with 100 or more enrolled at beginning of plan year, only if an extension was filed
December 2026			
Gag Clause Attestation form completed and uploaded **prior to December 31, 2026** to CMS here.	**Gag Clause Attestation**	Confirm that third-party administrator (TPA) or applicable insurance carrier is complying with the CAA's "Gag Clause Prohibition and Attestation" rules. Confirm that TPA or applicable insurance carrier is submitting the required annual attestation to CMS by December 31, 2026. If not, then the employer must complete the online attestation.	Fully Insured and Self-Insured Plans
Disclosures to ALL employees provided at time of hire			
Within 14 days of the date of hire.	**Marketplace Notice (or Exchange Notice)**	Goes to all employees without regard to whether or not they are eligible for health coverage. Deliver by the same method applicable to the plan's SPD.	Fully Insured and Self-Insured Plans

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Deadline	Item/Form	Filling/Disclosure/Plan Action Requirements	Plans Affected
Enrollment-Related Disclosures			
At the time a Medicare beneficiary eligible for the medical plan seeks coverage under the plan.	**Part D Creditable Coverage Notice (Applies Only to a Plan Sponsor's Major Medical Plans)**	Notice provided to all Medicare-eligible individuals regarding status of prescription drug coverage as either creditable or non-creditable(determined in accordance with CMS guidelines). Deliver by the same method applicable to the plan's SPD. Recommendation is to send to all covered individuals as Plan Sponsor may not be aware of Medicare-eligible dependents.	Fully Insured and Self-Insured Plans
At or before the time an eligible employee is first offered an enrollment opportunity in the health plan.	**HIPAA Special Enrollment Notice**	Use the HIPAA Special Enrollment Notice provided by CSG within your other annual benefits notices. Deliver by the same method applicable to the plan's SPD.	Fully Insured and Self-Insured Plans
Upon enrollment in the plan.	**Women's Health and Cancer Rights Act Notice**	Use notice provided by CSG within annual benefits notices. Deliver by the same method applicable to the plan's SPD.	Fully Insured and Self-Insured Plans
At the time an eligible person is offered an enrollment opportunity in the health plan.	**Summary of Benefits and Coverage (SBC)**	Delivery rules: • First class mail • Electronically in accordance with specific guidance issued by DOL. Can include copy within Enrollment System. • Single SBC sent to address of employee is considered notice to everyone residing at the same address; however, separate SBCs are required to "beneficiaries" residing at a separate address (e.g., an alternate recipient subject to a QMCSO).	Fully Insured and Self-Insured Plans
Following enrollment in any group health plan.	**HIPAA Privacy Notice**	Provide to individuals who enroll in (or automatically enrolled in) the Medical, Dental, Vision, Health FSA, and Employee Assistance Plans. A single notice to the enrolled employee or retiree is deemed notice to all other covered individuals. NOTE: If provided electronically, advance consent must be obtained.	Fully Insured and Self-Insured Plans
Disclosures that must be furnished automatically WHEN AN EMPLOYEE OR RETIREE FIRST BECOMES ELIGIBLE FOR THE HEALTH PLAN			
To covered individuals within 90 days after coverage under a group health plan begins.	**COBRA General Notice**	Applies to employers with 20 or more employees and applies to all group health plans sponsored by such employer. A single notice addressed to both the covered employee and covered spouse/adult child may be delivered if (i) spouse/ adult child and covered employee reside at same address and (ii) become covered at same time. A separate notice must be delivered to spouse if spouse enrolls separately or lives at separate address. Notice must also be sent to covered children who do not live with employee or spouse who receives notice (e.g., QMCSO child).	Fully Insured and Self-Insured Plans. Employer with 20 or more employees in the preceding calendar year

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Deadline	Item/Form	Filling/Disclosure/Plan Action Requirements	Plans Affected
ERISA requires SPD to be providedto the participant within 90 days of becoming covered in the plan.	**Summary Plan Description (includes any certificate of coverage provided by insurance carrier)**	Must deliver SPD to participants by means "reasonably calculated to ensure actual receipt." **Permissible delivery methods:** • Hand delivery • First class mail • Electronic (compliance with the "electronic disclosure" safe harbor in U.S. Department of Labor regulations will satisfy the general disclosure standard)	Fully Insured and Self-Insured plans with 2 or more participants
Provide to all employees annually. The rules do not establish a due date or time period.	**CHIPRA Subsidy Notice**	Employers that maintain group health plans in states that provide Medicaid or CHIP assistance in the form of premium assistance subsidies are required to give written notice to their employees, informing them of the potential opportunities for premium assistance currently available in the state in which they reside to help them pay for group health coverage. Deliver by the same methods applicable to the plan's SPD. Do not have to send to dependents.	Fully Insured and Self-Insured Plans
Disclosures that must be furnished ANNUALLY to the individuals eligible for or enrolled in a plan			
Upon enrollment in the plan.	**Women's Health and Cancer Rights Act Notice**	Use notice provided by CSG within the annual benefits notices. Delivery by same methods applicable to SPD.	Fully Insured and Self-Insured Plans
Provide to all employees annually. Rules do not establish a due date or time period.	**CHIPRA Special Enrollment Notice**	Employers that maintain group health plans in states that provide Medicaid or CHIP assistance in the form of premium assistance subsidies are required to give written notice to their employees, informing them of the potential opportunities for premium assistance currently available in the state in which they reside to help them pay for group health coverage. Use notice provided by CSG within the annual benefits notices. Deliver by the same methods applicable to the plan's SPD.	Fully Insured and Self-Insured Plans
Disclosures provided annually to ALL employees without regard to health and welfare plan eligibility			
At the time the eligible employeeis offered an annual enrollment opportunity in the health plan.	**Summary of Benefits and Coverage (SBC)**	**Rules for SBC disclosure: deliver by:** • First class mail • Electronically in accordance with specific guidance issued by the U.S. Dept. of Labor to the extent that enrollment is conducted electronically. • Single SBC sent to address of employee is considered notice to everyone residing at the same address; however, separate SBCs are required to "beneficiaries" residing at a separate address (e.g., an alternate recipient subject to a QMCSO)	Fully Insured and Self-Insured Plans

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Deadline	Item/Form	Filling/Disclosure/Plan Action Requirements	Plans Affected
Notice of Child Support Order—Applies to Any Health Plan			
As soon as possible upon receipt of Support Order.	**Notice of Medical Child Support Order (MCSO)**	Plan Administrator, upon receipt of MCSO, must promptly issue a notice to participant and each alternate recipient of the receipt of the MCSO (including plan's procedures for determining its qualified status). Plan Administrator must also issue a separate notice to the participant and each alternate recipient as to whether the MCSO is qualified within a reasonable time after its receipt. "Reasonable" depends on the facts and circumstances but should not be longer than 40 days.	Fully Insured and Self-Insured Plans
As soon as possible upon receipt of Support Order.	**National Medical Child Support Order Notice (NMSN)**	The employer/Plan Sponsor must either send Part A to the applicable State agency (if coverage cannot be provided due to one of the permitted reasons), or Part B to the Plan Administrator, within 20 business days of the date of the NMSN (or sooner if possible). Plan Administrator must promptly notify affected persons of receipt of the NMSN and review the procedures for determining its qualified status. Plan Administrator must within 40 business days after the date of NMSN (or sooner if reasonable) complete and return Part B to the issuing agency and provide required information to affected persons.	Fully Insured and Self-Insured Plans
PHI Privacy Breach—Applies to Any Health Plan			
Concurrently with the notice to individuals.	**Notice of Breach Involving More than 500 Covered Individuals**	File the Notice electronically here.	Fully Insured and Self-Insured Plans if Breach Occurred
Without unreasonable delay, but not later than 60 days after discovery of the breach.	**Notice of Breach to Affected Individuals**	See HIPAA Privacy Policies and Procedures for more information regarding the method of delivery (including procedures for handling returned mail).	Fully Insured and Self-Insured Plans if Breach Occurred
Without unreasonable delay, but not later than 60 days after discovery of the breach.	**Notice of Breach to the Media**	See HIPAA Privacy Policies and Procedures for more information.	Fully Insured and Self-Insured Plans if Breach Occurred
Request for Documents and Notices			
Within 30 days of the request.	**Requests for documents or instruments governing the terms of the plan (e.g., SPD, plan document, Form 5500)**	This includes the plan document, the SPD, the Form 5500, trust agreements, contracts or other instruments under which the plan is established or operated. Deliver by the same methods applicable to the plan's SPD.	Fully Insured and Self-Insured Plans

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A health plan must provide a HIPAA Notice of Privacy Practices and Privacy Notice to individuals— • no later than the date by which the plan is required to comply with the HIPAA PrivacyRule; • on an ongoing basis after the compliance date, at the time of an individual's enrollment in the plan; and upon request by any individual.	**HIPAA Notice of Privacy Practices and HIPAA Privacy Notice**	Employers can deliver by the same methods applicable to the plan's SPD. May be provided electronically if requested electronically, but it is not acceptable to simply "post" these materials on a website or make them available to employees on the plan sponsor's intranet.	Fully Insured and Self-Insured Plans
Within 7 business days of the request.	**Summary of Benefits and Coverage (SBC) required by ACA**	The SBC may be provided electronically if requested electronically.	Fully Insured and Self-Insured Plans
Changes to the Plan			
Within 210 days of the last day of the plan year in which the changeis adopted.	**Summary of Material Modification (SMM) to a Health and Welfare Plan(Other than a material reduction in health plan benefits)**	This is a notice of changes to the plan that are not material reductions in the health plan's benefits, such as lower deductibles, changes in eligibility (other than to eliminate classes of individuals previously eligible or other material reductions). We generally recommend that plan sponsors provide notice as soon as possible prior to the effective date of the change. Deliver by the same methods applicable to plan's SPD.	Fully insured and self-insured plans with 2 or more enrolled and a material change has occurred.

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ERISA requires a notice of material reduction in covered health benefits to be delivered within 60 days of the date the change is adopted by the plan.	**Notice of Material Reduction in Benefits of a Health and Welfare Plan**	**This is a notice of any material reduction in covered services, such as:** • an elimination of benefits payable under the plan; • a reduction of benefits payable under the plan (including a reduction that occurs as a result of a change in formulas, methodologies, or schedules that serve as the basis for making benefit determinations); • an increase in premiums, deductibles, co-insurance, copayments, or other amounts to be paid by a participant or beneficiary; • a reduction in the service area covered by an HMO; and • an imposition of new conditions or requirements (i.e., preauthorization requirements) to obtaining services or benefits under the plan.	Fully insured and Self-Insured plans with 2 or more enrolled and a material change has occurred.
Notice must be provided 60 days prior to the effective date of the change.	**Material changes in SBC information that is effective other than first day of plan year (applies only to medical plans)**	Deliver by same methods applicable to SBC.	Fully Insured and Self-Insured plans with 2 or more enrolled and a material change has occurred.

Notices and Disclosures Triggered by Events

Deadline	Item/Form	Filling/Disclosure/Plan Action Requirements	Plans Affected
Termination of Health Coverage or Reduction in Hours of Service that Causes a Loss of Coverage Notice of a Qualifying Event (divorce, dependent child aging out)			
The COBRA administrator must provide notice of the qualifying event within 44 days of a termination of employment or reduction in hours of employment that causes a loss of coverage under the terms of the applicable group health plan.	**COBRA Election Notice (applies to all group health plans, including Medical, Dental, Vision, EAP, Wellness, Health FSA and HRA)**	Deliver by Certificate of Mailing or Certified Mail. A single notice addressed to both the covered employee and covered spouse/ adult child may be delivered if spouse/adult child and covered employee reside at same address. Notice must be provided to the COBRA administrator as soon as possible following the termination of employment/ reduction of hours of employment to ensure that the COBRA administrator timely delivers the notice.	Fully Insured and Self-Insured Plans Employer with 20 or more employees in preceding calendar year

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Deadline	Item/Form	Filling/Disclosure/Plan Action Requirements	Plans Affected
Ongoing Compliance Requirements			
Ongoing requirement (accurate plan information must be available upon request by a federal or state government agency)	Comparative Analysis of NQTLs required under the MHPAEA, as amended by the CAA	**Ensure Compliance with Mental Health Parity Rules:** Ensure that your insurer, third-party administrator (TPA), or other applicable plan service provider has completed the required comparative analysis of your plan's non-quantitative treatment limitations (NQTLs) showing compliance with the current mental health parity requirements of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as amended by the Consolidated Appropriations Act, 2021 (CAA). The CAA requires health plans and insurers that provide both medical/surgical (MED/S) benefits and mental health or substance use disorder (MH/SUD) benefits to perform and document comparative analyses of the design and application of any NQTLs that are imposed on MH/SUD benefits. NQTLs are generally defined as non-numerical limits on the scope or duration of the benefits. These can include prior authorization requirements, requirements to pay for higher-cost therapies until lower-cost therapies have been shown not to work (e.g., "step therapy" or "fail-first" policies) and limits on access to out-of-network providers. Insurance carriers for fully insured plans have created the required NQTL comparative analyses. Sponsors of self-insured plans, however, have additional work to ensure compliance, and must either obtain the NQTL analysis from their TPA or applicable insurance carrier, or if these entities cannot provide it, from a separate service provider. This requirement went into effect on February 10, 2021. Effective 5/15/2025, the Departments of Labor, Health and Human Services and Treasury issued a statement regarding the enforcement of the 2024 Mental Health Parity and Addiction Equity Act (MHPAEA) final regulation (Final Rule), stating that they will not be enforcing several provisions of the Final Rule, including the required fiduciary attestation and other provisions until 18 months after a decision in a federal court case (*ERISA Industry Committee (ERIC) v. HHS*) regarding the Final Rule. However, the requirement to complete and retain an NQTL analysis, as required under the CAA statute (and discussed in the paragraph above), has not been repealed, and could technically still be enforced during this temporary pause of the Final Rule.	Fully Insured and Self-Insured Plans. **Self-Insured Plans:** Although some TPAs and insurers working with such sponsors have completed such NQTL analyses on behalf of these plans, it is the obligation of the plan sponsor to ensure that it has been completed. **Fully Insured Plans:** Sponsors of these plans should request a copy of the NQTL analysis from their insurance carriers and retain it in the event it is requested upon audit.
Contracts entered into (or extended) with broker, consultant or other covered service provider, on or after December 27, 2021.	**Required Compensation Disclosure**	**Ensure Compliance with CAA Fee Disclosure Rules:** Whether your plan is self-insured or fully insured, ensure that your organization has designated a "responsible plan fiduciary" to determine if the service providers for your group health plans (including brokers and consultants) are providing those services for "reasonable compensation." These CAA rules amended ERISA's fee disclosure requirements previously only applicable to retirement plans. These requirements went into effect for service provider contracts entered into or extended on or after December 27, 2021.	Fully Insured and Self-Insured Plans
MRF Disclosures: For plan years beginning January 1, 2022, and thereafter, but with enforcement only starting July 1, 2022. **Price Estimator Tool:** For plan years beginning on or after January 1, 2023, and thereafter.	**Transparency in Coverage Rule - Machine Readable File Disclosure and Price Estimator Tool.**	**Ensure Compliance with CAA Transparency in Coverage Rules:** Whether your plan is self-insured or fully insured, ensure that your third-party administrator (TPA) or applicable insurance carrier is complying with the CAA's Transparency in Coverage Regulation, including (1) creating and publishing machine-readable files (MRFs) detailing their plan's costs and coverage requirements on a public website and updated monthly; and (2) providing members with a real-time online benefit cost estimator tool to help members to understand and compare their personalized out-of-pocket costs for covered network and out-of-network services.	Fully Insured and Self-Insured Plans

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