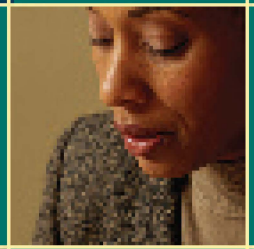
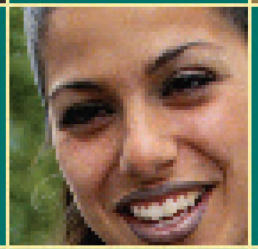
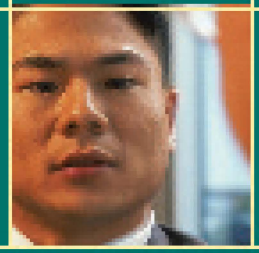
Reporting and Disclosure Guide for Employee Benefit Plans



This publication has been developed by the U.S. Department of Labor, Employee Benefits Security Administration (EBSA).

To view this and other publications, visit the agency's website at **dol.gov/agencies/ebsa**.

To order publications, or to speak with a benefits advisor, contact EBSA at **askebsa.dol.gov.** Or call toll free: **1-866-444-3272**

This material will be made available in alternative format to persons with disabilities upon request: Voice phone: **(202) 693-8644**

If you are deaf, hard of hearing, or have a speech disability, please dial **7-1-1** to access telecommunications relay services.

This booklet constitutes a small entity compliance guide for purposes of the Small Business Regulatory Enforcement Fairness Act of 1996.

Reporting and Disclosure Guide for Employee Benefit Plans

U.S. Department of Labor
Employee Benefits Security Administration

December 2022

Introduction

This **Reporting and Disclosure Guide for Employee Benefit Plans** is a quick reference tool for certain basic reporting and disclosure requirements under the Employee Retirement Income Security Act (ERISA). It has been prepared by the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) with assistance from the Pension Benefit Guaranty Corporation (PBGC).

The first chapter, beginning on page 2, provides an overview of the common disclosures that administrators of employee benefit plans are required to give participants, beneficiaries, and certain other individuals under Title I of ERISA. The chapter has three sections.

- Basic Disclosure Requirements for Pension and Welfare Benefit Plans
- Additional Disclosure Requirements for Welfare Benefit Plans That Are Group Health Plans
- Additional Disclosure Requirements for Retirement Plans

The second chapter, beginning on page 17, provides an overview of reporting and disclosure requirements for defined benefit pension plans under Title IV of ERISA. PBGC administers these provisions. The chapter focuses primarily on single-employer plans and has four sections.

- Pension Insurance Premiums
- Standard Terminations
- Distress Terminations
- Reportable Events and Other Reports

The third chapter, beginning on page 21, provides an overview of the Form 5500 and Form M-1 Annual Reporting requirements. The chapter consists of two quick reference charts.

- Pension and Welfare Benefit Plan Form 5500 Quick Reference Chart
- Form M-1 Quick Reference Chart.

On page 27, there is a list of EBSA and PBGC resources, including agency websites where laws, regulations, instructions, and other official guidance on ERISA's reporting and disclosure requirements are available. Readers should refer to these resources for the most complete information on ERISA's reporting and disclosure requirements.

Not all ERISA reporting and disclosure requirements are reflected in this guide. For example, the guide does not focus on disclosures required by the Internal Revenue Code or the provisions of ERISA for which the Department of the Treasury and Internal Revenue Service (IRS) have regulatory and interpretive authority. For information on IRS notice and disclosure requirements, please visit the IRS website at **irs.gov/Retirement-Plans/Retirement-Plan-Reporting-and-Disclosure**. This guide also does not focus on new disclosure requirements added by the Consolidated Appropriations Act, 2021. For more information on the Consolidated Appropriations Act, 2021, including the No Surprises Act, see **dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act**.

This Department of Labor publication has been updated as of December 2022. Please be sure to check EBSA's website at **dol.gov/ebsa** for the current laws and regulations on the reporting and disclosure provisions included in this publication.

Overview of ERISA Title I Basic Disclosure Requirements[1]

Note: Plan administrators of retirement plans can provide the relevant disclosures below on paper or furnished electronically. To provide disclosures electronically, the plan administrator can either post them on a plan website or send them directly to participants, for example, by text message or by email, and must comply with notification requirements, among other requirements, of the Department's electronic disclosure regulation. There are a number of protections for participants receiving electronic disclosures, including the right to request paper copies or to opt out of electronic delivery. The plan administrator also needs to take reasonable steps to protect the confidentiality of participants' personal information online.

Section 1: Basic Disclosure Requirements for Retirement and Welfare Benefit Plans

Document	Type of Information	To Whom	When
Summary Plan Description (SPD)	The SPD is the primary way to inform participants and beneficiaries about their plan and how it operates. It must be written for an average participant and be comprehensive enough to inform people of their benefits, rights, and obligations under the plan. Must accurately reflect the plan's contents and may not contain outdated information from more than 120 days before its initial disclosure. See 29 CFR §§ 2520.102-2 and 2520.102-3 for style, format, and content requirements.	• Participants • Beneficiaries receiving benefits Also see "Plan Documents" below for persons who have the right to obtain the SPD upon request. See 29 CFR § 2520.102-2(c) for provisions on foreign language assistance when a portion of plan participants are only literate in the same non-English language.	To participants: within 90 days of becoming covered by the plan. To beneficiaries: within 90 days after first receiving benefits. A plan has 120 days after becoming subject to ERISA to distribute the SPD. Otherwise, once every 5 years for amended plans. Once every 10 years for all other plans. See 29 CFR § 2520.104b-2.
Summary of Material Modification (SMM)	The SMM describes modifications to a plan and changes to the information that is required to be in the SPD. The distribution of an updated SPD satisfies this requirement. See 29 CFR § 2520.104b-3.	• Participants • Beneficiaries receiving benefits Also see "Plan Documents" below for persons with the right to obtain SMM upon request.	Within 210 days after the end of the plan year in which the change is adopted.
Summary Annual Report (SAR)	The SAR is a narrative summary of the Form 5500. See 29 CFR § 2520.104b-10(d) for the format.	• Participants • Beneficiaries receiving benefits The SAR is not required for defined benefit pension plans to which Title IV applies and that instead provide the annual funding notice (see below).	Within 9 months after the end of the plan year, or 2 months after the due date for filing Form 5500 (with an approved extension).
Notification of Benefit Determination (Claims Notices or "Explanation of Benefits")	This notification provides information regarding benefit claim determinations. Adverse benefit determinations must include the required disclosures (for example, the specific reason(s) for the denial of a claim, a reference to the specific plan provisions on which the benefit determination is based, and a description of the plan's appeal procedures).	Claimants, including: • Participants • Beneficiaries • Authorized claims representatives.	Requirements vary depending on the type of plan and the type of benefit claim involved. See 29 CFR § 2560.503-1 for the claims procedures requirements.

[1] Please refer to the Department's regulations and other guidance for information on the extent to which charges may be assessed to cover the cost of providing particular information, statements, or documents to participants and beneficiaries required under Title I of ERISA. See, e.g., 29 CFR § 2520.104b-30.

Section 1: Basic Disclosure Requirements for Retirement and Welfare Benefit Plans, continued

Document	Type of Information	To Whom	When
Plan Documents	The plan administrator must provide copies of certain documents upon written request and must have copies available for examination. The documents include the latest updated SPD, the latest Form 5500, the trust agreement, and other documents that dictate how the plan is established or operated.	• Participant • Beneficiaries Also see 29 CFR § 2520.104a-8 regarding the Department's authority to request documents.	Within 30 days after a written request. Plan administrators must make copies available at principal office of the plan administrator and certain other locations as specified in 29 CFR § 2520.104b-1(b).

Section 2: Additional Disclosure Requirements for Welfare Benefit Plans That Are Group Health Plans [2]

Document	Type of Information	To Whom	When
Summary of Material Reduction in Covered Services or Benefits	This summary explains any group health plan amendments or changes in information required to be in SPD that constitute a "material reduction in covered services or benefits," such as an increase in premiums See 29 CFR § 2520.104b-3(d)(3) for definitions.	Participants.	Generally, within 60 days after adopting a material reduction in group health plan services or benefits. See 29 CFR § 2520.104b-3(d)(2) for when a plan may alternatively have 90 days to provide the required information.
COBRA General Notice[3]	This notice informs employees and spouses of their right to purchase temporary extension of group health coverage when coverage is lost due to a qualifying event. See 29 CFR § 2590.606-1. For more information, visit **dol.gov/agencies/ebsa/laws-and-regulations/laws/COBRA**. A model notice is available at **dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/cobra/model-general-notice.docx**.	• Covered employees • Covered spouses	When group health plan coverage begins.
COBRA Election Notice[3]	This notice informs qualified beneficiaries of their right to elect COBRA coverage when they experience a qualifying event. It also includes information about other coverage options available, such as through a Marketplace.	• Covered employees • Covered spouses • Dependent children who are qualified beneficiaries	Generally, within 14 days after the employer or qualified beneficiary notifies the plan administrator of the qualifying event.

[2] The term "group health plan" means an employee welfare plan to the extent that the plan provides medical care to employees or their dependents directly or through insurance, reimbursement, or otherwise.
[3] COBRA generally applies to group health plans of employers who employed 20 or more employees during the prior calendar year. Provisions of COBRA covering state and local government plans are administered by the Department of Health and Human Services. COBRA does not apply to plans sponsored by certain church-related organizations.

Document	Type of Information	To Whom	When
	See 29 CFR § 2590.606-4. For more information, visit **dol.gov/agencies/ebsa/laws-and-regulations/laws/COBRA**. A model notice is available at **dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/cobra/model-election-notice.docx**.		However, if the employer is also the plan administrator, the administrator has 44 days after the qualifying event to provide the notice. If the plan provides that COBRA continuation coverage starts on the date of loss of coverage, the administrator must provide the notice within 44 days of the date of loss of coverage due to a qualifying event.
Notice of Unavailability of COBRA	This notice informs an individual that they are not entitled to COBRA coverage. See 29 CFR § 2590.606-4(c).	Individuals who notify the administrator of a qualifying event but whom the administrator determines are not eligible for COBRA coverage.	Generally, within 14 days after being notified by the individual of the qualifying event.
Notice of Early Termination of COBRA Coverage	This notice informs a qualified beneficiary that their COBRA coverage will terminate earlier than the maximum period of coverage. See 29 CFR § 2590.606-4(d).	Qualified beneficiaries whose COBRA coverage will terminate earlier than the maximum period of coverage.	As soon as possible after the administrator determines that coverage will terminate.
Medical Child Support Order (MCSO) Notice	A MCSO notice is a notification from a plan administrator that states it has received an order directing the plan to provide health coverage to a participant's noncustodial children and includes the procedures the plan is required to adopt for determining whether the MCSO is qualified. See ERISA § 609(a)(5)(A) for requirements.	• Participants • Any child named in a MCSO • The child's representative	The plan administrator must issue the initial notice, which must include procedures for determining qualification promptly after receiving the MCSO. Then, the administrator must issue a separate notice of whether the MCSO is qualified within a reasonable time after receiving the MCSO.
National Medical Support (NMS) Notice	An NMS notice is used by the state agency responsible for enforcing health care coverage provisions in a MCSO. See ERISA § 609(a)(5) and 29 CFR § 2590.609-2 for requirements. Depending upon certain conditions, the employer must complete and return Part A of the NMS notice to the state agency, or it must transfer Part B of the notice to the plan administrator for a determination on whether the notice is a qualified MCSO.	• State agencies • Employers • Plan administrators • Participants • Custodial parents • Any child named in a MCSO • The child's representative	Within 20 days after the date of the NMS notice or sooner if reasonable, the employer must either send Part A to the state agency, or Part B to the plan administrator. The administrator must then promptly notify affected persons of receipt of the notice and explain the procedures for determining if it is qualified. Within 40 business days after the date of the NMS notice or sooner, if reasonable, the administrator must complete and return Part B to the state agency and provide the required information to affected persons.

Document	Type of Information	To Whom	When
			Under certain circumstances, the employer may be required to send Part A to the state agency after the plan administrator has processed Part B.
Notice of Special Enrollment Rights	This notice describes the group health plan's special enrollment rules, including the eligible employee's right to special enroll within 30 days after the loss of other coverage, marriage, birth of a child, adoption, or placement for adoption. See 29 CFR § 2590.701-6(c) for requirements and a model notice.	Employees eligible to enroll in a group health plan	At or before the date the employee is first offered the opportunity to enroll in the group health plan.
Employer CHIPRA Notice	The employer must inform employees of possible premium assistance opportunities available in the state they reside. A model CHIPRA notice is available at **dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/chipra/model-notice.doc**. See 75 FR 5808-11 for more requirements.	All employees, regardless of enrollment or eligibility status.	Annually.
Wellness Program Disclosure	This disclosure must be given by any group health plan that offers a health-contingent wellness program to obtain a reward. The notice must disclose the availability of a reasonable alternative standard or the possibility that the applicable standard can be waived. It must also include contact information to obtain the alternative and a statement that recommendations of an individual's personal physician will be accommodated. See 29 CFR § 2590.702(f)(2)(v) for requirements and model language.	Participants and beneficiaries eligible to participate in a health-contingent wellness program to obtain a reward	In all plan materials that describe the terms of a health-contingent wellness program (both activity-only and outcome-based wellness programs). For outcome-based wellness programs, this notice must also be included in any disclosure that an individual did not satisfy an initial outcome-based standard. If the plan materials merely mention that a program is available, without describing its terms, this disclosure is not required.
Newborns' Act Description of Rights	This statement must be included in a group health plan's SPD. The statement must describe the federal or state law requirements that apply to the plan or health insurance coverage that relate to a hospital length of stay in connection with childbirth. If the federal law applies in some areas in which the plan operates and state law applies in other areas, the statement should describe the federal or state requirements applicable to each area. See 29 CFR § 2520.102-3(u) for requirements and model language.	Participants	In the Summary Plan Description.

Document	Type of Information	To Whom	When
Michelle's Law Enrollment Notice	This notice must include a description of the Michelle's Law provision for continued coverage during medically necessary leaves of absence. See ERISA section 714 (c).	• Participants • Beneficiaries	With any notice regarding a requirement for certification of student status for coverage under the plan. Note that under the Affordable Care Act, plans cannot deny or restrict coverage for a child under the age of 26 based on student status.
Women's Health and Cancer Rights Act (WHCRA) Notices	This notice describes required benefits for mastectomy-related reconstructive surgery, prostheses, and treatment of physical complications of mastectomy.	Participants	Upon enrollment and annually.
Mental Health Parity and Addiction Equity Act (MHPAEA) Criteria for Medically Necessary Determination Notice	This notice must explain the criteria for medically necessary determinations related to mental health/substance use disorder benefits. See 29 CFR § 2590.712(d)(1).	• Any current or potential participant • Beneficiary • Contracting provider	Upon request.
MHPAEA Claims Denial Notice	This notice must provide the reason for any denial of reimbursement or payment for services related to mental health/substance use disorder benefits. See 29 § CFR 2590.712(d)(2).	• Participants • Beneficiaries	Upon request or as otherwise required by other laws.
MHPAEA Increased Cost Exemption	A group health plan claiming MHPAEA's increased cost exemption must provide a notice of the plan's exemption from the parity requirements. See 29 CFR § 2590.712(g)(6)	• Participants • Beneficiaries • EBSA • State regulators	If using the cost exemption.
Grandfathered Plan Disclosure/Notice	This notice must disclose that the plan is grandfathered and must include contact information. See 29 CFR § 2590.715-1251(a)(2).	• Participants • Beneficiaries	In any plan materials describing the benefits or health coverage.
Summary of Benefits and Coverage (SBC) and Uniform Glossary	The SBC is a template that describes the benefits and coverage under the plan. A uniform glossary defines important health coverage and medical terms. See 29 CFR § 2590.715-2715(a) and (c). The required SBC template is available at **dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-template-new.pdf**.	• Plans (provided by group health insurance issuers) • Participants • Beneficiaries	With enrollment materials and upon renewal or reissuance of coverage. To special enrollees by the date the SPD is required to be provided (90 days from enrollment). Also, within 7 days upon request.

Document	Type of Information	To Whom	When
	The Uniform Glossary is available at **dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-new.pdf**. The SBC must include both a website link where an individual can review the Uniform Glossary as well as contact information for obtaining a paper copy.		
Summary of Benefits and Coverage: Notice of Modification	If a plan makes a material modification in any of the plan terms that would affect the content of the SBC, the plan must provide notice of the change. This does not apply to changes that occur in connection with a renewal or reissuance. See 29 CFR § 2590.715-2715(b).	• Participants • Beneficiaries	Within 60 days before the date on which the change will become effective.
Notice Regarding Designation of a Primary Care Provider	If a non-grandfathered plan requires a participant or beneficiary to designate a primary care provider, the plan must provide notice of the terms of the plan or coverage regarding designation of a primary care provider. The notice must include the following: • Participants have the right to designate any participating primary care provider who is available to accept the participant. • Participants can designate any participating pediatrician for a child. • The plan does not require authorization or referral for OB/GYN care by a participating OB/GYN professional. See 29 CFR § 2590.715-2719A(a)(4). For plan years beginning on or after January 1, 2022, grandfathered plans must also provide this information. See 29 CFR § 2590.722. Model language is available at **dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/patient-protection-model-notice.doc**.	Participants	With the Summary Plan Description or any other similar description of benefits

Document	Type of Information	To Whom	When
Internal Claims and Appeals and External Review Notices	**Internal Claims and Appeals** Non-grandfathered plans must provide a notice of adverse benefit determination and a notice of final internal adverse benefit determination. See 29 CFR § 2590.715-2719(b)(2)(ii)(E) for specific content requirements. Model notices are available at: • **dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/revised-model-notice-of-adverse-benefit-determination.doc** • **dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/revised-model-notice-of-final-internal-adverse-benefit-determination.doc** **External Review** After an external review, the independent review organization (IRO) will issue a notice of the final external review decision. See 29 CFR § 2590.715-2719 (c) and (d) for requirements. For plan years beginning on or after January 1, 2022, the external review requirements, including the disclosure requirements, apply to grandfathered plans for claims subject to the No Surprises Act. A model notice is available at **dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/revised-model-notice-of-final-external-review-decision.doc**.	For internal claims and appeals: • Claimants For external review, by the IRO to: • Claimants • The plan	For internal claims and appeals, the timing varies based on the type of claim. For external review, the timing varies based on the type of claims and whether the state or the federal process applies. See 29 CFR § 2590.715-2719 for more information.
External Review Process Disclosure	Non-grandfathered plans following a state external review process must provide a description of the external review process. For plan years beginning on or after January 1, 2022, the external review requirements, including the disclosure requirements, apply to grandfathered plans for claims subject to the No Surprises Act. See 29 CFR § 2590.715-2719(c) for more information.	• Participants • Beneficiaries	In the SPD, policy, certificate, or other evidence of coverage.

Document	Type of Information	To Whom	When
EBSA Form 700	EBSA Form 700 is used to claim an accommodation from the requirement to cover certain contraceptive services without cost-sharing. Other methods to invoke an accommodation, such as providing a notice to the Secretary of Health and Human Services (HHS), are also available. EBSA Form 700 is available at **dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/ebsa-form-700.pdf**. Information about providing notice to HHS is available at **dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/model-notice-to-secretary-of-hhs.pdf**.	For EBSA Form 700: • The plan's health insurance issuer • Third-party administrator The notice to the Secretary of HHS should be sent to HHS by email or mail.	When an organization wishes to claim an accommodation from the requirement to cover certain contraceptive services without cost-sharing.
Employer Notice to Employees of Coverage Options	Employers subject to the Fair Labor Standards Act must provide a notice informing the employee of the existence of the Marketplace, the potential availability of a tax credit, and that an employee may lose the employer contribution if the employee purchases a qualified health plan. See Technical Release 2013-02 & FLSA 18B for requirements. A model notice is available at **dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/model-notice-for-employers-who-offer-a-health-plan-to-some-or-all-employees.doc**.	All employees, regardless of plan eligibility or part-time or full-time status.	To all new employees.
Individual Coverage Health Reimbursement Arrangement (ICHRA) Notice	This notice informs employees of the availability of an ICHRA from their employer and its terms, including the right to opt out. The notice must describe the potential availability of the premium tax credit and explain that if the individual accepts the ICHRA, the individual will not be able to claim a premium tax credit for individual health insurance coverage. Additionally, the notice must explain if the ICHRA is considered affordable, the individual won't be able to claim a premium tax credit even if they opt out. A model notice is available at **dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/rules-and-regulations/completed-rulemaking/1210-AB87/individual-coverage-model-notice.pdf**.	Participants	At least 90 calendar days before the beginning of each plan year. For any participant not eligible at the beginning of the plan year (or not eligible when the notice is provided to participants before the beginning of the plan year): the notice should be provided by the date when the participant is first eligible. For any participant employed by an employer that was established less than 120 days before the first plan year of the ICHRA: by the date when the participant is first eligible.

Document	Type of Information	To Whom	When
Transparency in Coverage – Disclosure to the Public	Non-grandfathered plans and issuers must post on a public website machine-readable files on network rates and out-of-network allowed amounts and billed charges for plan years beginning on or after January 1, 2022. FAQs Part 49 deferred enforcement of this requirement until July 1, 2022 (and deferred enforcement for a machine-readable file on prescription drugs while the responsible agencies consider, through notice-and-comment rulemaking, whether the requirement remains appropriate).	The public	July 1, 2022
Transparency in Coverage – Disclosure to Participants and Beneficiaries	Non-grandfathered plans and issuers must provide an online price comparison tool (and in paper form, upon request) containing price and provider information concerning health benefits that allows an individual to compare the cost sharing that the individual would be responsible for paying.	• Participants • Beneficiaries	For plan years beginning on or after January 1, 2023, the 500 items and services identified by the Department of Labor, available at **http://www.cms.gov/healthplan-price-transparency/resources/500-items-services**. For plan years beginning on or after January 1, 2024, all covered items or services

Section 3: Additional Disclosure Requirements for Retirement Plans

Document	Type of Information	To Whom	When
Periodic Pension Benefit Statement (Individual Benefit Statement)	The content of this statement varies depending on the type of plan. In general, all statements must indicate total benefits and total nonforfeitable pension benefits, if any, that have accrued, or the earliest date on which benefits become nonforfeitable. Benefit statements for an individual account plan must also provide: • the value of each investment to which assets in the individual account have been allocated and • two illustrations of the account balance as a stream of estimated monthly lifetime payments (one as a single life annuity and one as a qualified joint and survivor annuity). Model language is available at **dol.gov/sites/dolgov/files/EBSA/employers-and-advisers/plan-administration-and-compliance/retirement/model-benefit-statement-supplement.pdf**. Benefit statements for individual account plans that permit participant investment direction must also include: • an explanation of any limitation or restriction on the participant's or beneficiary's rights under the plan to direct an investment; • an explanation of the importance of a well-balanced and diversified portfolio, including a statement of the risk that holding more than 20 percent of a portfolio in the security of an entity (such as employer securities) may not be adequately diversified; and • a notice directing the participant or beneficiary to the Department of Labor's website for information on individual investing and diversification. See ERISA § 105.	• Participants • Beneficiaries	**For individual account plans that permit participants to direct their investments** At least once each quarter. In addition, upon request from a beneficiary who does not receive statements automatically, limited to one request during any 12-month period. **For individual account plans that do not permit participants to direct their investments** At least once each year. In addition, upon request from a beneficiary who does not receive statements automatically, limited to one request during any 12-month period. **For defined benefit plans** At least once every 3 years. Alternatively, defined benefit plans can satisfy this requirement if at least once each year the administrator provides notice of the availability of the pension benefit statement and the ways to obtain such statement. In addition, upon written request, limited to one request during any 12-month period.
Statement of Accrued and Nonforfeitable Benefits	This statement lists total accrued benefits and total nonforfeitable pension benefits, if any, that have accrued, or the earliest date on which benefits become nonforfeitable. See ERISA § 209.	Participants	Upon request, upon termination of service with the employer, or after the participant has a 1-year break in service. Statements provided upon request are limited to one request during any 12-month period.

Document	Type of Information	To Whom	When
			Only one statement is required if there are consecutive 1-year breaks in service.
Suspension of Benefits Notice	This notice informs employees that their benefit payments are being suspended during certain periods of employment or reemployment. See 29 CFR § 2530.203-3 for requirements.	Employees whose benefits are suspended.	During the first month or the payroll period in which the withholding of benefit payments occurs.
Notice of Transfer of Excess Pension Assets to Retiree Health Benefit Account	This notifies stakeholders that defined benefit plan excess assets are being transferred to a retiree health benefit account. See ERISA § 101(e) for requirements.	The employer sponsoring the pension plan from which transfer is made must give notice to: • The Secretaries of Labor and the Treasury • Each employee organization representing plan participants • The plan administrator The plan administrator must notify: • Participants • Beneficiaries	Within 60 days before the date of the transfer. The employer notice also must be available for inspection in the principal office of the administrator.

Domestic Relations Order (DRO) and Qualified Domestic Relations Order (QDRO) Notices	These notices state that a plan administrator has received a DRO. They must include the procedures for determining whether a DRO is qualified and explain whether the administrator has determined that the DRO is qualified.
	
	For more information, see ERISA § 206(d)(3)(G)(i) and the EBSA booklet **QDROs: The Division of Retirement Benefits Through Qualified Domestic Relations Orders**.
		• Participants
		• Alternate payees. For example:
		  • Spouse
		  • Former spouse
		  • Child
		  • Other dependent of a participant named in a DRO as having a right to receive all or a portion of the participant's plan benefits
			The initial notice, which must include both an acknowledgement that the plan administrator received a DRO and the procedures for determining a DRO qualification, must be issued promptly after receiving the DRO.
			
			A separate notice of whether the DRO is qualified must be issued within a reasonable time after receiving the DRO.

Notice of Significant Reduction in Future Benefit Accruals	This notice explains any plan amendments to defined benefit plans and certain defined contribution plans that provide for either a significant reduction in the rate of future benefit accruals or the elimination or significant reduction in an early retirement benefit or retirement-type subsidy. See 26 CFR § 54.4980F-1 for further information	• Participants • Alternate payees under a QDRO • Contributing employers • Certain employee organizations	Within a reasonable time, generally 45 days, before the effective date of a plan amendment subject to ERISA, except as provided in regulations from the Secretary of the Treasury. See § 204(h) of ERISA and IRC § 4980F.
Notice of Failure to Meet Minimum Funding Standards	This notice declares a failure to make a required installment or other plan contribution to satisfy the minimum funding standard within 60 days of contribution due date. (Not applicable to multiemployer plans). See ERISA § 101(d) for more information.	• Participants • Beneficiaries • Alternative payees under QDROs	Within a reasonable period of time after the failure. Notice is not required if a funding waiver is requested in a timely manner. However, if the waiver is denied, the notice must be provided within 60 days after the denial.

Document	Type of Information	To Whom	When
Section 404(c) Plan Disclosures	This notice contains investment-related and certain other disclosures for participant-directed individual account plans described in 29 CFR § 2550.404c-1. This includes a blackout notice for participant-directed individual account plans described in ERISA section 404(c)(1)(A)(ii), as described below. Special rules apply for qualified investment options under ERISA section 404(c)(4)(C).	• Participants • Beneficiaries	For certain information, before the time when investment instructions are to be made. For other information, upon request.
Notice of Blackout Period for Individual Account Plans	This notice provides advance notice of any period of more than 3 consecutive business days when there is a temporary suspension, limitation, or restriction under an individual account plan on directing or diversifying plan assets, obtaining loans, or obtaining distributions. See ERISA § 101(i) and 29 CFR § 2520.101-3 for further information on the notice requirement.	• Participants and beneficiaries of individual account plans affected by such blackout periods • Issuers of affected employer securities held by the plan	Generally, at least 30 days but not more than 60 days advance notice.
Qualified Default Investment Alternative (QDIA) Notice*	This notice informs participants and beneficiaries of: • the circumstances under which contributions or other assets will be invested on their behalf in a QDIA, • the investment objectives of the QDIA, and • the right of participants and beneficiaries to direct investments out of the QDIA. See 29 CFR § 2550.404c-5. See also ERISA § 514(e)(3).	Participants and beneficiaries on whose behalf an investment in a QDIA may be made	• At least 30 days before the date of plan eligibility, or • At least 30 days before the date of any first investment in a QDIA on behalf of a participant or beneficiary, or • On or before the date of plan eligibility if the participant has the opportunity to make a permissible withdrawal within the first 90 days. Also, annually at least 30 days in advance of each plan year. See 29 CFR § 2550.404c-5
Automatic Contribution Arrangement Notice*	This notice informs participants of their rights and obligations under an automatic contribution arrangement. See ERISA § 514(e)(3).	Each participant to whom the arrangement applies.	Within a reasonable period before the plan year.
Annual Funding Notice	This notice provides basic information about the status and financial condition of a defined benefit pension plan, including: • the plan's funding percentage; • assets and liabilities; • demographic information regarding active, retired, and separated from service participants; • the funding policy; • endangered, critical, or critical and declining status;	• Participants • Beneficiaries receiving benefits • Alternate payees receiving benefits • Labor organizations representing participants under the plan • Each employer of a multiemployer plan that is a party to a collective bargaining agreement pursuant to which a plan is maintained or who would be subject to withdrawal liability	For large plans: Within 120 days after the plan year. For small plans: Before the date on which the annual report is filed or before the latest date the annual report must be filed (including extensions), whichever is earlier. A small plan is defined as having 100 or fewer participants on each day during the plan year preceding the notice year.

*Use of the IRS sample Automatic Enrollment Notice posted on the IRS website may be used to satisfy these two notice requirements. See Field Assistance Bulletin 2008-03, Question 8.

Document	Type of Information	To Whom	When
	• explanation of events having a material effect on liabilities or assets; • rules on termination or insolvency; • a description of the benefits guaranteed by PBGC; • annual report information; • information disclosed to PBGC, if applicable; and • any additional information the plan administrator elects to include. See ERISA § 101(f) and 29 CFR § 2520.101-5.	• PBGC	
Multiemployer Plan Summary Report	This report contains certain financial information, such as: • contribution schedules, • benefit formulas, • number of employers obligated to contribute, • number of participants on whose behalf no contributions were made for a specified period of time, • number of withdrawing employers, and • withdrawal liability. See ERISA § 104(d).	• Each employee organization • Each employer that has an obligation to contribute to the plan	Within 30 days after the due date of the annual report.
Multiemployer Pension Plan Information Made Available on Request	This information includes copies of periodic actuarial reports; quarterly, semi-annual, or annual financial reports; and amortization extension applications. See ERISA § 101(k) and 29 CFR § 2520.101-6.	• Participants • Beneficiaries receiving benefits • Each labor organization representing participants under the plan • Each employer that has an obligation to contribute to the plan	Within 30 days of written request. A requester is not entitled to receive more than one copy of any report or application during any 12-month period.
Multiemployer Plan Notice of Potential Withdrawal Liability	This notice provides an estimated amount of the employer's withdrawal liability and how such estimated liability was determined. See ERISA § 101(l).	Any employer who has an obligation to contribute to the plan.	Generally, within 180 days of a written request.
Notice of Funding-based Limitation	The plan administrator of a single-employer or multiple-employer defined benefit plan must provide a notice of specified funding-based limits on benefit accruals and benefit distributions. See ERISA § 101(j).	• Participants • Beneficiaries	Generally, within 30 days after a plan becomes subject to a specified funding-based limitation. Also, any other time determined by the Secretary of the Treasury. See IRS Notice 2012-46.

Document	Type of Information	To Whom	When
Notice of Right to Divest	This notice advises participants of their right to sell company stock and reinvest the proceeds into other investments available under the plan. The notice must also describe the importance of diversifying the investment or retirement account assets. See ERISA § 101(m). IRS Notice 2006-107 provides a model notice.	• Participants • Alternate payees with accounts under the plan • Beneficiaries of deceased participants See ERISA § 204(j).	Within 30 days before the first date on which the individuals are eligible to exercise their rights.
Disclosures required for the Fiduciary Safe Harbor for Automatic Rollovers to Individual Retirement Plans for Certain Mandatory Distributions Exceeding $1,000.	To qualify for the safe harbor, a plan fiduciary must provide participants with a SPD or SMM that describes the plan's automatic rollover provisions. This must include a disclosure that if a participant is subject to mandatory distribution and fails to make an election regarding a form of benefit distribution, the participant's account balance will be rolled over into an individual retirement plan. See 29 CFR § 2550.404a-2.	Separating participants subject to mandatory distributions under the Internal Revenue Code.	Before mandatory distributions are made. The disclosure will be sufficient if provided in conjunction with the notice required under Code section 402(f), which must be provided to a plan participant no less than 30 days and no more than 180 days before the date of a distribution. See IRS Notice 2009-68.
Notice of Plan Termination pursuant to the Safe Harbor for Distributions from Terminated Individual Account Plans	A plan fiduciary (including a qualified termination administrator) must provide a notice to participants and beneficiaries of the plan's termination, distribution options, and procedures to make an election. In addition, the notice must: • provide information about the account balance; • explain, if known, what fees, if any, will be paid from the participant or beneficiary's retirement plan; and • provide the name, address, and telephone number of the individual retirement plan provider, if known, and of the plan administrator or other fiduciary from whom information about the termination may be obtained. See 29 CFR § 2550.404a-3.	Participants or beneficiaries in terminated individual account plans	During the winding up process of the plan termination. Participants and beneficiaries have 30 days from the receipt of the notice to elect a form of distribution.

Document	Type of Information	To Whom	When
Notice of Critical or Endangered Status	The sponsor of a multiemployer defined benefit pension plan must provide notice if the plan is in critical or endangered status because of funding or liquidity problems. The notice must include an explanation of the possibility that certain adjustable benefits may be reduced. See IRC § 432.	• Participants • Beneficiaries • The bargaining parties • PBGC • The Department of Labor	Within 30 days after the plan actuary's annual certification, if the actuary certifies that the plan is in critical or endangered status. For a model critical status notice, see **dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/public-disclosure/status-notices/critical/model-notice.doc**.
Participant Plan and Investment Fee Disclosures	These disclosures include information about the administrative and investment costs of participation in 401(k)-type plans. The disclosures should include general information about the mechanics and structure of the plan, such as how to give investment directions. It also includes information about the plan's administrative costs (e.g., recordkeeping, legal) and individual charges that may be assessed to participants (for loans, QDROs, etc.). They should also include: • a comparative chart with information about the plan's investment options, including investment fees and expenses, • performance and benchmark data, • a website link that leads to supplemental investment information, and • a glossary of terms to assist participants in understanding the plan's investment options. See 29 CFR § 2550.404a-5.	Participants and beneficiaries with the authority to direct their own investments in individual account plans.	General information about the plan and potential administrative and individual costs, as well as a comparative chart of key information about plan investment options: Annually (at least once in any 14-month period). Statements of the dollar amount of administrative and individual fees that were charged to participants' accounts: Quarterly. This information may, in certain circumstances, be included in the plan's SPD and participants' Periodic Pension Benefit Statements.
Plan Service Provider Disclosures	Certain plan service providers must provide detailed information about the compensation, both direct and indirect, that they will receive for providing services to pension plans. Service providers may also have to provide information to assist plans in complying with other ERISA reporting and disclosure requirements, such as the Form 5500 Annual Report and Participant Plan and Investment Fee Disclosures. See 29 CFR § 2550.408(b)-2(c) for definitions of which service providers must comply and the specific disclosures that must be provided.	Plan fiduciaries responsible for hiring pension plan service providers.	Generally, reasonably in advance of entering into a contract or arrangement with the service provider. See 29 CFR § 2550.408b-2(c) for provisions on when changes or updates to previously disclosed information must be provided.

Overview of Basic PBGC Reporting and Disclosure Requirements

Section 1: Pension Insurance Premiums (for covered single-employer and multiemployer defined benefit plans) (ERISA §§ 4006 and 4007; 29 CFR Parts 4006 and 4007)*

Document	Type of Information	To Whom	When
Comprehensive Premium Filing	This filing provides information about the premium owed for the plan year, including supporting data.	• PBGC	Generally, by the 15th day of the 10th full calendar month in the plan year.

Section 2: Standard Terminations (for covered single-employer defined benefit plans) (ERISA §§ 4041 and 4050; 29 CFR Parts 4041 and 4050)

Document	Type of Information	To Whom	When
Notice of Intent to Terminate	This provides notice about a plan's proposed termination and the termination process.	• Participants • Beneficiaries • Alternate payees • Union	At least 60 and no more than 90 days before the proposed termination date. If potential insurers are not known at this time, a supplemental notice must be provided no later than 45 days before distribution date.
Form 500 - Standard Termination Notice	This form is used to provide notice of a plan's proposed termination and provides plan data.	PBGC	No later than 180 days after the proposed termination date.
Notice of Plan Benefits	This notice provides information on each person's benefits.	• Participants • Beneficiaries • Alternate payees	No later than the time Form 500 (Standard Termination Notice) is filed with PBGC.
Form 501 - Post-Distribution Certification	This form is used to certify that the distribution of plan assets has been properly completed.	PBGC	Within 30 days after the last distribution date for plan benefits, or within 60 days after the last distribution if email certification is sent to PBGC within 30 days after the last distribution date. PBGC may assess a penalty for late filing of a Form 501 only if it is filed more than 90 days after the distribution deadline (including extensions).

*Premium filings must be submitted via PBGC's online application, My Plan Administration Account (My PAA). Premium payments may be made online or via paper check. My PAA and more information can be found at PBGC's website (**pbgc.gov**) by clicking on Employers & Practitioners and then Premium Filings.

Document	Type of Information	To Whom	When
Form MP-100 (Missing Participants)	This form is used to report information about participants and beneficiaries covered by a terminating plan that the plan cannot locate.	PBGC	Generally, the same as the Form 501 due date. (See above for the timing.)

Section 3: Distress Terminations (for covered single-employer defined benefit plans) (ERISA §§ 4041 and 4050; 29 CFR Parts 4041 and 4050)

Document	Type of Information	To Whom	When
Form 600 - Distress Termination Notice of Intent to Terminate (NOIT)	This form is used to provide notice of a plan's proposed distress termination, demonstrate satisfaction of distress criteria, and provide plan and sponsor/controlled group data.	PBGC	At least 60 days and no more than 90 days before the proposed termination date, except with PBGC approval.
Notice of Intent to Terminate to Affected Parties Other than PBGC	This notice provides notice about a plan's proposed distress termination and the termination process.	• Participants • Beneficiaries • Alternate payees • Union	By the time Form 600 (Notice of Intent to Terminate) is filed with PBGC.
Disclosure of Termination Information	A plan administrator must disclose information it has submitted to PBGC in connection with a distress termination. See ERISA § 4041(c)(2). Note that a plan administrator or a plan sponsor must also disclose information it has submitted to PBGC in connection with a PBGC-initiated termination. See ERISA § 4042(c)(3).	• Participants • Beneficiaries • Alternate payees • Union	Within 15 days after the plan administrator: • receives an affected party's request for the information, or • provides new information to PBGC that relates to a previous request.
Notice of Request to Bankruptcy Court to Approve Termination	This provides notice of a sponsor's/ controlled group member's request to Bankruptcy Court to approve the plan termination based upon a reorganization test.	PBGC	Concurrent with request to Bankruptcy Court.
Form 601 (and Schedule EA-D) - Distress Termination Notice, Single-Employer Plan Termination	This form is used to provide information on the plan and sufficiency of plan assets to provide benefits.	PBGC	By the 120th day after the proposed termination date.

Document	Type of Information	To Whom	When
Form 602 - Post-Distribution Certification for Distress Termination	This form certifies that the distribution of plan assets has been properly completed and the plan is sufficient for guaranteed benefits.	PBGC	Within 30 days after the distribution of plan assets is completed. PBGC may assess a penalty for late filing of a Form 602 only if it is filed more than 90 days after the distribution deadline (including extensions).
Form MP-100	This form is used to report information about participants and beneficiaries covered by a terminating plan that the plan cannot locate (required only if the plan is sufficient for guaranteed benefits).	PBGC	Generally, the same as the Form 602 due date. (See above for the timing.)

Section 4: Reportable Events and Other Reports (for covered single-employer defined benefit plans)

Document	Type of Information	To Whom	When
Form 10 - Post-Event Notice of Reportable Events	This form is used to report information relating to an event, the plan, and the controlled group when there is a(n): • failure to make a required contribution, • active participant reduction, • change in controlled group, • application for funding waiver, • liquidation, • loan default, and • various other events. See ERISA § 4043 and 29 CFR Part 4043.	PBGC	Within 30 days after the plan administrator or contributing sponsor knows (or has reason to know) the event has occurred.
Form 10-Advance - Advance Notice of Reportable Events	This form is used to report information relating to an event, the plan, and the controlled group when there is a: • change in controlled group, • liquidation, • loan default, • transfer of benefit liabilities, and • various other events. This requirement applies to privately held controlled groups with plans that have aggregate unfunded vested benefits over $50 million and an aggregate funded vested percentage under 90 percent. See ERISA § 4043 and 29 CFR Part 4043.	PBGC	At least 30 days before the effective date of the event. Extensions may apply.

Document	Type of Information	To Whom	When
Form 200 - Notice of Failure to Make Required Contributions	This form is used to report information relating to the plan and controlled group if the plan has aggregate missed contributions of more than $1 million. See ERISA § 302(f)(4) and 29 CFR Part 4043, subparts A and D.	PBGC	Within 10 days after the contribution due date.
Reporting following a Substantial Cessation of Operations (filer may use Form 4062(e) Series – Notices Following a Substantial Cessation of Operations)	These notices advise of a substantial cessation of operations and provide information about an employer's election to make additional contributions to an affected plan. See ERISA §§ 4062(e) and 4063(a).	PBGC	Varies depending on the event required to be reported to PBGC.
Reporting of Withdrawal of Substantial Employer	This notice advises of certain withdrawals of substantial employers and asks PBGC to determine the resulting liability. See ERISA § 4063(a).	PBGC	Within 60 days after the event.
Annual Financial and Actuarial Information Reporting	This filing provides actuarial and financial information for certain controlled groups with substantial underfunding. See ERISA § 4010 and 29 CFR Part 4010.	PBGC	Within 105 days after the close of the filer's information year, with a possible extension for certain required actuarial information until 15 days after the filing deadline for annual report (Form 5500).

Overview of Form 5500 and Form M-1 Annual Reporting Requirements

Form 5500 Annual Reporting Requirements

The Form 5500 Annual Return/Report series is used by plan administrators and certain direct filing entities (DFEs) to satisfy annual reporting obligations under ERISA and the Internal Revenue Code. The Department of Labor, the IRS, and PBGC publish

- Form 5500, Annual Return/Report of Employee Benefit Plan
- Form 5500-SF, Short Form Annual Return/Report of Small Employee Benefit Plan

The IRS publishes Form 5500-EZ, Annual Return of a One-Participant Retirement Plan or a Foreign Plan.

DFEs are investment or insurance arrangements that plans can participate in. They include:

- master trust investment accounts (MTIAs),
- bank common/collective trusts (CCTs),
- insurance pooled separate accounts (PSAs),
- 103-12 investment entities (103-12 IEs), and
- group insurance arrangements (GIAs).

All DFEs are allowed to file the Form 5500 directly with EBSA, but it is mandatory for MTIAs. If an employee benefit plan participates in a CCT, PSA, 103-12 IE, or GIA that files a Form 5500 as a DFE, then it is eligible for certain annual reporting relief in connection with the plan's own Form 5500 filing requirement.

All Forms 5500 and Forms 5500-SF must be filed online using the ERISA Filing Acceptance System (EFAST2). Filers may use EFAST2's web-based IFILE filing system or an EFAST2-approved vendor. All delinquent and amended filings of Title I plans must also be submitted through EFAST2. More information about filing with EFAST2 is available at **efast.dol.gov.**

The Form 5500 filing requirements vary depending on whether the filer is a small plan with fewer than 100 participants as of the beginning of the plan year, a large plan with 100 or more participants as of the beginning of the plan year, or a DFE.

After this section, there is a quick reference chart that describes the basic Form 5500 filing requirements. Certain small plans may be eligible to file the simplified Form 5500-SF instead of the Form 5500. Check the chart to determine a plan's eligibility.

A "one-participant" plan which is required to file the Form 5500-EZ may elect to file online with EFAST2's IFILE or through an EFAST2-approved vendor rather than filing a Form 5500-EZ on paper with the IRS. For instructions on how to file the Form 5500-EZ on paper, see the instructions for the Form 5500-EZ which can be found at **www.irs.gov/pub/irs-pdf/i5500ez.pdf**, or call the IRS at 1-877-829-5500.

The Form 5500 and the Form 5500-SF filed by plan administrators and the Form 5500 filed by GIAs are due by the last day of the 7th calendar month after the end of the plan or GIA year (not to exceed 12 months in length). See the Form 5500 and the Form 5500-SF instructions for information on extensions up to an additional 2 ½ months. The Form 5500 filed by DFEs other than GIAs are due no later than 9 ½ months after the end of the DFE year.

Certain employee benefit plans are exempt from the annual reporting requirements or are eligible for limited reporting options. The major classes of plans that are exempt or eligible for limited reporting are described in the Form 5500 and the Form 5500-SF instructions. All welfare plans required to file Form M-1, Report for Multiple Employer Welfare Arrangements (MEWAs) and Certain Entities Claiming Exception (ECEs), must file an annual report in the Form 5500 Annual Return/Report series regardless of plan size or type of funding.[1]

[1] See 78 Fed. Reg. 13781, 13796, 13899 (Mar. 1, 2013).

Check the EFAST website at **efast.dol.gov** and the latest Form 5500 and Form 5500-SF instructions for information on who is required to file, how to complete the forms, when to file, EFAST2-approved software, and electronic filing options. You can also visit **dol.gov/agencies/ebsa/key-topics/reporting-and-filing/form-5500** to view the Form 5500 and the Form 5500-SF. Schedules and instructions are also posted on that website.

Form M-1 Annual Reporting Requirements

Administrators of multiple employer welfare arrangements (MEWAs) and certain other entities that offer or provide medical care coverage to employees of two or more employers are generally required to file the Form M-1, Report for Multiple Employer Welfare Arrangements (MEWAs) and Certain Entities Claiming Exception (ECEs). After this section, there is a quick reference chart on reporting requirements for MEWAs and ECEs.

The Form M-1 must be filed online using the M-1 Online Filing System. You can file the Form M-1 and find more information, including frequently asked questions, at **askebsa.dol.gov/mewa**.

Quick Reference Chart of Form 5500, Schedules, and Attachments (Not Applicable for Form 5500-SF Filers)*[1]

	Large Pension Plan	Small Pension Plan[2]	Large Welfare Plan	Small Welfare Plan[2]	DFE
Form 5500	Must complete.	Must complete.	Must complete.[3]	Must complete.[3]	Must complete.
Schedule A (Insurance Information)	Must complete if plan has insurance contracts.	Must complete if plan has insurance contracts.[4]	Must complete if plan has insurance contracts.	Must complete if plan has insurance contracts.[4]	Must complete if MTIA, 103-12 IE, or GIA has insurance contracts.
Schedule C (Service Provider Information)	Must complete Part I if service provider was paid $5,000 or more, Part II if a service provider failed to provide information necessary for the completion of Part I, and Part III if an accountant or actuary was terminated.	Not required.	Must complete Part I if service provider was paid $5,000 or more, Part II if a service provider failed to provide information necessary for the completion of Part I, and Part III if an accountant or actuary was terminated.	Not required.	MTIAs, GIAs, and 103-12 IEs must complete Part I if service provider paid $5,000 or more, and Part II if a service provider failed to provide information necessary for the completion of Part I. GIAs and 103-12 IEs must complete Part III if accountant was terminated.
Schedule D (DFE/ Participating Plan Information)	Must complete Part I if plan participated in a CCT, PSA, MTIA, or 103-12 IE.	Must complete Part I if plan participated in a CCT, PSA, MTIA, or 103-12 IE.[4]	Must complete Part I if plan participated in a CCT, PSA, MTIA, or 103-12 IE.	Must complete Part I if plan participated in a CCT, PSA, MTIA, or 103-12 IE.[4]	All DFEs must complete Part II, and DFEs that invest in a CCT, PSA, or 103-12 IE must also complete Part I.
Schedule G (Financial Schedules)	Must complete if Schedule H, lines 4b, 4c, or 4d are "Yes."	Not required.	Must complete if Schedule H, lines 4b, 4c, or 4d are "Yes."[3]	Not required.[3]	Must complete if Schedule H, lines 4b, 4c, or 4d for a GIA, MTIA, or 103-12 IE are "Yes."
Schedule H (Financial Information)	Must complete.[5]	Not required.	Must complete.[3, 5]	Not required.	All DFEs must complete Parts I, II, and III. MTIAs, 103-12 IEs, and GIAs must also complete Part IV.[5]
Schedule I (Financial Information)	Not required.	Must complete.[4]	Not required.	Must complete.[4]	Not required.

*See footnotes for certain exemptions and other technical requirements. All footnotes for this chart are on page 24.

	Large Pension Plan	Small Pension Plan[2]	Large Welfare Plan	Small Welfare Plan[2]	DFE
Schedule MB (Actuarial Information)	Must complete if multiemployer defined benefit plan or money purchase plan subject to minimum funding standards.[6]	Must complete if multiemployer defined benefit plan or money purchase plan subject to minimum funding standards.[6]	Not required.	Not required.	Not required.
Schedule R (Pension Plan Information)	Must complete.[7]	Must complete.[4, 7]	Not required.	Not required.	Not required.
Schedule SB (Actuarial Information)	Must complete if single-employer or multiple-employer defined benefit plan, including an eligible combined plan and subject to minimum funding standards.	Must complete if single-employer or multiple-employer defined benefit plan, including an eligible combined plan and subject to minimum funding standards.	Not required.	Not required.	Not required.
Accountant's Report	Must attach.	Not required unless Schedule I, line 4k, is checked "No."	Must attach.[3]	Not required.	Must attach for a GIA or 103-12 IE.

[1] This chart provides only general guidance. Not all rules and requirements are reflected. Refer to specific Form 5500 instructions for complete information on filing requirements (e.g., *Who Must File* and *What To File*). For example, a pension plan is exempt from filing any schedules if the plan uses Code section 408 individual retirement accounts as the sole funding vehicle for providing benefits. See *Limited Pension Plan Reporting*.

[2] Pension plans and welfare plans with fewer than 100 participants at the beginning of the plan year that are not exempt from filing an annual return/report may be eligible to file the Form 5500-SF, a simplified report. In addition to the limitation on the number of participants, a Form 5500-SF may only be filed for a plan that is exempt from the requirement that the plan's books and records be audited by an independent qualified public accountant (but not by reason of enhanced bonding), has 100 percent of its assets invested in certain secure investments with a readily determinable fair market value, holds no employer securities, and is not a multiemployer plan. See *Who Must File*.

[3] Unfunded, fully insured, or combination unfunded/fully insured welfare plans covering fewer than 100 participants at the beginning of the plan year that meet the requirements of 29 CFR 2520.104-20 are exempt from filing an annual report. See *Who Must File*. Such a plan with 100 or more participants must file an annual report, but is exempt under 29 CFR 2520.104-44 from the accountant's report requirement and completing Schedule H, but MUST complete Schedule G, Part III, to report any nonexempt transactions. See *What to File*. All Plans required to file Form M-1, *Report for Multiple-Employer Welfare Arrangements (MEWAs) and Certain Entities Claiming Exception (ECEs)* must file a Form 5500 regardless of plan size or type of funding.

[4] Do not complete if filing the Form 5500-SF instead of the Form 5500.

[5] Schedules of assets and reportable (5%) transactions also must be filed with the Form 5500 if Schedule H, line 4i or 4j is "Yes."

[6] Money purchase defined contribution plans that are amortizing a funding waiver are required to complete lines 3, 9, and 10 of the Schedule MB in accordance with the instructions. Also see instructions for line 5 of Schedule R and line 12a of Form 5500-SF.

[7] Schedule R should not be completed when the Form 5500 Annual Return/Report is filed for a pension plan that uses, as the sole funding vehicle for providing benefits, individual accounts or annuities (as described in Code section 408). See the Form 5500 instructions for Limited Pension Plan Reporting for more information.

MEWAs and ECEs Quick Reference Chart: Form M-1[1]

Document	Type of Information	To Whom	When
Form M-1 Report for Multiple Employer Welfare Arrangements (MEWAs) and Certain Entities Claiming Exception (ECEs)	This form includes: • MEWA or ECE custodial and financial information, • states in which coverage is provided, • insurance information, • number of participants covered, • information about enforcement actions, and • information about compliance with Part 7 of ERISA, including any litigation alleging non-compliance. Administrators of MEWAs and ECEs that offer or provide coverage for medical care to employees of two or more employers (including one or more self-employed individuals) are generally required to file the Form M-1. An ECE is an entity that claims it is not a MEWA due to the exception in the definition of MEWA for entities that are established and maintained under or pursuant to one or more agreements that the Secretary of Labor finds to be collective bargaining agreements. An ECE must file this report during the first three years after the ECE is originated. For more information on this exception, see 29 CFR § 2510.3-40.	EBSA	**Annual Report** Generally, due by March 1st of the year after the calendar year for which report is required. A 60-day extension is available. For ECEs, an annual report is required to be filed only if the ECE was last originated within the 3 years before the annual filing due date. **MEWA Registration** A MEWA may have to register more than once during the reporting year. MEWA registration generally is required: • 30 days before operating in any state • Within 30 days of knowingly operating in any additional state or states that were not indicated on a previous Form M-1 filing • Within 30 days of operating with regard to the employees of an additional employer (or employers, including one or more self-employed individuals) after a merger with another MEWA • Within 30 days of the date the number of employees receiving coverage for medical care under the MEWA is at least 50 percent greater than the number of such employees on the last day of the previous calendar year • Within 30 days of experiencing a material change as defined in the Form M-1 instructions **ECE Origination** An ECE may be originated more than once during the reporting year. ECE origination filings generally must be made: • 30 days before operating with regard to the employees of two or more employers (including one or more self-employed individuals) • Within 30 days from when ECE begins operating following a merger with another ECE (unless all of the ECEs that participate in the merger previously were last originated at least 3 years prior to the merger) • Within 30 days from when the number of employees receiving coverage for medical care under the ECE is at least 50 percent greater than the number of such employees on the last day of the previous

[1] This chart provides only general guidance, and not all rules and requirements are reflected.

Document	Type of Information	To Whom	When
			calendar year (unless the increase is due to a merger with another ECE under which all ECEs that participate in the merger were last originated 3 years prior to the merger). **ECE Special Filing** Due within 30 days of a special filing event, only if the ECE was last originated within 3 years before a special filing event. Special filing events, which may occur more than once during the reporting year, include: • The ECE begins knowingly operating in any additional state or states that were not indicated on a previous Form M-1 filing. • The ECE experiences a material change as defined in the Form M-1 instructions.

EBSA Resources

For more information about EBSA's reporting and disclosure requirements, contact:

U.S. Department of Labor
Employee Benefits Security Administration
200 Constitution Ave., N.W.
Washington, DC 20210
1-866-444-3272
Website: **dol.gov/ebsa**

For assistance completing the Form 5500, call the EFAST2 Help Desk at 1-866-463-3278.

For more information on the Form 5500, visit **dol.gov/agencies/ebsa/key-topics/reporting-and-filing/form-5500**.

For assistance completing the Form M-1, call (202) 693-8409.

The following publications may be helpful in providing a more detailed explanation on specific subject matter:

An Employer's Guide to Group Health Continuation Coverage Under COBRA

QDROs: The Division of Retirement Benefits Through Qualified Domestic Relations Orders

Troubleshooter's Guide to Filing the ERISA Annual Report (Form 5500)

These and other EBSA publications may be obtained by calling toll-free at 1-866-444-3272 or visiting **dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/publications**.

PBGC Resources

For information about PBGC's reporting and disclosure requirements, call 1-800-736-2444 or (202) 326-4242.

To request information or assistance via email, use the applicable email address shown below:

- Premiums: **pbgc_premiums@custhelp.com**
- Reportable events: **post-event.report@pbgc.gov** or **advancereport@pbgc.gov**
- 4010 filings: **ERISA.4010@pbgc.gov**
- Standard Terminations: **standard@pbgc.gov**
- Distress terminations: **distress@pbgc.gov**

For other topics, see PBGC's practitioner contact email list at: **pbgc.gov/about/pg/contact/contact-prac.**

To request assistance via mail or delivery service, write to:

Pension Benefit Guaranty Corporation
445 12 Street SW
Washington, DC 20024-2101
Attention: *[insert applicable department name]*

For questions on distress terminations, reportable events and 4010 filings, you can also call 202-229-4070 or write to us at the address above and add **Attention: Corporate Finance and Restructuring Department.**

For additional information, visit PBGC's website: **pbgc.gov**

EMPLOYEE BENEFITS SECURITY ADMINISTRATION
UNITED STATES DEPARTMENT OF LABOR

December 2022