2026

Employee Benefits Compliance Guide for Large Employers

Groups of 50+

CRC BENEFITS

Any statements made by CRC Benefits employees or agents concerning tax, accounting, or legal matters are not to be relied upon as accounting, tax or legal advice. We recommend that you seek the advice of your own tax, accounting and legal advisers as to whether your health plans are compliant with all applicable laws and regulations, including any applicable state laws.

This guide is a general summary of employer-required information. For a more comprehensive review, please see our Notices, Filings, Documents and Testings guide at: https://insights.crcbenefits.com/acton/attachment/43209/f-f8e18bc5-2ab9-484b-913a-ed2d99129516/1/-/-/-/-/BENE_Compliance_Guide_Annual%20Notices%20for%20Group%20Health%20Plans_25-3605_12182025.pdf. The links contained in this and other documents are verified at the time they are published. If a link does not work, please email us at crcbenefitscompliance@crcgroup.com.

Table of Contents

Affordable Care Act (ACA)

EMPLOYER MANDATE FOR APPLICABLE LARGE EMPLOYERS (ALES)

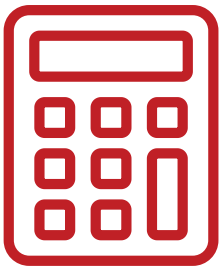
Under the ACA's Employer Shared Responsibility Provisions – or Employer Mandate – applicable large employers (ALEs) must offer health coverage to their full-time employees (and dependent children). This coverage must be affordable and provide minimum value.

An ALE that does not do this is subject to penalties if any full-time employee receives a government subsidy for health coverage through the Health Insurance Marketplace, or "exchange."

How to Determine ALE Status

To qualify as an ALE, an employer must employ, on average, at least 50 full-time employees, including full-time equivalent employees (FTEs), on business days during the preceding calendar year.

To determine ALE status for 2026:



- Calculate the number of full-time employees for all 12 calendar months of 2025. A full-time employee is an employee who is employed on average for at least 30 hours of service per week. See additional qualifications below.
- Calculate the number of FTEs for all 12 calendar months of 2025 by calculating the aggregate number of hours of service (but not more than 120 hours of service for any employee) for all employees who were not full-time employees for that month and dividing the total hours of service by 120.
- Add the number of full-time employees and FTEs (including fractions) calculated above for all 12 calendar months of 2025.
- Add up the monthly numbers from the preceding step and divide the sum by 12. Disregard fractions.
- If the result is more than 50, the company is likely an ALE for 2026.

How to Identify Full-time Employees

Since all eligible full-time employees must be offered affordable minimum value coverage, an employer must determine which employees meet the full-time definition.

A full-time employee is an employee who was employed on average at least 30 hours of service per week.

The final regulations generally treat 130 hours of service in a calendar month as the monthly equivalent of 30 hours of service per week.

The IRS has provided two methods for determining eligible full-time employee status — the monthly measurement method and the look-back measurement method. The employer determines which method to use.

Monthly Measurement Method

- Involves a month-to-month analysis in which eligible full-time employees are identified based on their hours of service for each month
- May cause practical difficulties for employers, particularly if there are employees with varying hours or employment schedules
- Could result in employees moving in and out of employer coverage on a monthly basis

Look-Back Measurement Method

- Allows an employer to determine full-time status based on average hours worked by an employee in a prior period
- Involves a measurement period for counting/averaging hours of service; an administrative period that allows time for enrollment and disenrollment; and a stability period when coverage may need to be provided, depending on an employee's average hours of service during the measurement

OFFER OF COVERAGE AND REPORTING OF COVERAGE FOR ALES

Offer of Coverage

An ALE may be liable for a penalty under the "pay or play" rules if:

- It does not offer coverage to "substantially all" (95%) full-time employees (and dependents), and
- Any one of its eligible full-time employees receives a premium tax credit or cost-sharing reduction for coverage purchased through the Health Insurance Marketplace, or "exchange." Employees who are offered health coverage that is affordable and provides minimum value are generally not eligible for these exchange subsidies.

Employer Penalties

Employers may be liable for penalties:

- If an employer does not offer coverage to at least 95% of its full-time employees, the 4980H(a) penalty can be assessed on all FT employees, less the first 30, at $3,340 per employee.
- If an employer offers MEC, or does not meet an affordable offer of coverage, or the plan does not meet Minimum Value (MV), the 4980H(b) penalty will be assessed on each employee receiving a tax credit on the Marketplace. The 2026 penalty is $5,010 per full-time employee who receives a premium tax credit.

ALEs must:

- Offer minimum essential coverage to all eligible full-time employees
- Ensure that at least one of the plans offered provides minimum value (60% actuarial value)
- Ensure that the minimum value plan offered is affordable to all eligible full-time employees. This means the employee contribution for the lowest cost single minimum value plan does not exceed 9.96% of an employee's earnings based on the employee's W-2 Box 1 wages, the employee's rate of pay, or the federal poverty level for a single individual.

Reporting of Coverage

The ACA requires ALEs to report information to the IRS and to employees regarding the employer-sponsored health coverage.

The IRS uses this information to verify employer-sponsored coverage and to administer the employer-shared responsibility provisions according to IRS Code Section 6055 and 6056.

The ACA also requires all entities that are Applicable Large Employers (ALEs) to file an annual return with the IRS – and individuals – reporting information for each individual who is offered this coverage.

Reporting for ALEs, Step by Step

- Determine which reporting requirements apply to the company and its health plans
- Determine the information needed for reporting
- Coordinate internal and external resources to help compile the required data for Forms 1094-C and 1095-C
- Complete the appropriate forms for the 2025 reporting year
- Furnish statements to individuals on or before March 2, 2026, and file returns with the IRS on or before March 31, 2026 electronically
- IRS filing requirements are revised for 2024 and subsequent years and will require electronic filing.

OUT-OF-POCKET LIMITS FOR NON-GRANDFATHERED PLANS

Under the ACA, non-grandfathered health plans are subject to limits on cost sharing for essential health benefits (EHB).

The annual limit on total enrollee cost sharing for EHB for plan years beginning on or after January 1, 2026 is $10,600 for self-only coverage and $20,300 for family coverage.

What Employers Should Do

- Review the plan's out-of-pocket maximum to make sure it complies with the ACA's limits for the 2026 plan year ($10,600 for self-only coverage and $20,300 for family coverage)
- If the company has a high deductible health plan (HDHP) that is compatible with a health savings account (HSA), the plan's out-of-pocket maximum must be lower than the ACA's limit.
- For 2026 plan years, the out-of-pocket maximum limit for HDHPs is $8,500 for self-only coverage and $17,000 for family coverage.
- If the plan uses multiple service providers to administer benefits, confirm that the plan coordinates all claims for EHB across the plan's service providers or divides the out-of-pocket maximum across the categories of benefits, with a combined limit that does not exceed the maximum for 2026.
- Group health plans with a family out-of-pocket maximum that is higher than the ACA's self-only out-of-pocket maximum limit must embed an individual out-of-pocket maximum in family coverage so that no individual's out-of-pocket expenses exceed $10,600 for the 2026 plan year.

REQUIRED PREVENTIVE CARE BENEFITS

The ACA requires non-grandfathered health plans to cover certain preventive health services without imposing cost-sharing requirements (such as deductibles, copayments, or coinsurance) for the services.

Health plans are required to adjust first-dollar coverage of preventive care services based on the latest preventive care recommendations.

Companies with non-grandfathered plans should confirm that the plan covers the latest recommended preventive care services without imposing any cost sharing.

Employers should monitor guidelines for preventive services, which are regularly updated to reflect new scientific and medical advances. As new services are approved, non-grandfathered group health plans will be required to cover them with no cost sharing for plan years beginning one year later.

More information is available at U.S. Preventive Services Task Force and www.HealthCare.gov.

FLEXIBLE SPENDING ACCOUNT (FSA) CONTRIBUTION LIMITS

The ACA imposes a dollar limit on employees' salary reduction contributions to a health FSA offered under a cafeteria plan. It is important for employers to communicate the health FSA limit to employees during open enrollment.

- The ACA first set the health FSA contribution limit at $2,500 and has increased the dollar limit since then to account for the cost of living.
- For the 2026 plan year, the health FSA limit is $3,400. Companies should confirm that their health FSA will not allow employees to make pre-tax contributions in excess of that limit.

An employer may impose its own dollar limit on employees' salary reduction contributions to a health FSA, as long as it does not exceed the ACA's maximum limit in effect for the plan year.

PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE (PCORI) FEES

The Consolidated Appropriations Act of 2019 extended the PCORI fees until 2029. Employers that sponsor certain self-insured health plans (including HRAs not treated as excepted benefits) are responsible for fees to fund the Patient-Centered Outcomes Research Institute (PCORI).

Fees increased to $3.84 per covered life in 2025 and are due July 21, 2026 with IRS Form 720.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) AND HEALTH SAVINGS ACCOUNT (HSA) LIMITS

If a company offers an HSA-compatible HDHP to employees, it's important to confirm that the HDHP's minimum deductible and out-of-pocket maximum comply with the 2026 limits. The IRS limits for HSA contributions will increase effective January 1, 2026, and HDHP cost-sharing limits will increase effective for plan years beginning on or after January 1, 2025.

What Employers Should Do Now

- Check whether their HDHP's cost-sharing limits need to be adjusted for the 2026 limits.
- Update enrollment materials to reflect the increased limits that apply for 2026 (if the employer communicates limits to employees during enrollment).

The chart below shows the HDHP and HSA limits for 2026 compared to 2025. It also includes the catch-up contribution limit that applies to HSA-eligible individuals who are age 55 or older, which is not adjusted for inflation and generally stays the same from year to year.

TYPE OF LIMIT		2025	2026	CHANGE
HSA Contribution Limit	Self-only	$4,300	$4,400	Up $100
	Family	$8,550	$8,750	Up $200
HSA Catch-Up Contributions (not subject to adjustment for inflation)	Age 55 or older	$1,000	$1,000	No Change
HDHP Minimum Deductible	Self-only	$1,650	$1,700	Up $50
	Family	$3,300	$3,400	Up $100
HDHP Maximum Out-of-Pocket Expense Limit (deductibles, copayments & other amounts, but not premiums)	Self-only	$8,300	$8,500	Up $200
	Family	$16,600	$17,000	Up $400

ACA Disclosure and Notice Requirements

The ACA and ERISA both mandate that employers issue a number of disclosures and notices to employees. In this section, you will find details on:

- Summary of Benefits and Coverage (SBC) and Glossary
- Summary Plan Description (SPD)
- Summary of Material Modifications (SMM)
- Summary Annual Report (SAR)
- Medical Loss Ratio (MLR) Rebates
- Form W-2 Reporting of Employer-Provided Health Coverage
- Grandfathered Plan Notice
- Notice of Rescission
- Notice of Patient Protections
- Health Insurance Marketplace Notice
- Section 1557 Nondiscrimination Requirements

SUMMARY OF BENEFITS AND COVERAGE (SBC) AND GLOSSARY

Health plans and health insurance issuers must provide an SBC and Glossary to applicants and enrollees to help them understand their coverage and make coverage decisions.

- Plans and issuers must provide the SBC and Glossary to participants and beneficiaries who enroll or re-enroll during an open enrollment period.
- The SBC and Glossary also must be provided to participants and beneficiaries who enroll other than through an open enrollment period, including those who are newly eligible for coverage and special enrollees.
- In connection with a plan's 2026 open enrollment period, the SBC should be included with the plan's application materials.
- The SBC and Glossary must generally be provided no later than 30 days before the beginning of the new plan year, generally coinciding with the open enrollment period.
- For self-funded plans, the plan administrator is responsible for providing the SBC.
- For insured plans, both the plan and the issuer are obligated to provide the SBC and Glossary, although this obligation is satisfied for both parties if either one provides the SBC. Most issuers pass the responsibility to employers to distribute the SBC and Glossary. However, employers should confirm that their health insurance issuer will assume responsibility for providing the SBCs.
- Employers that enter into a binding contract with another party to provide the SBC and Glossary must satisfy additional obligations, including monitoring compliance.
- Employers must ensure that enrollees are provided with notice of any material modification that would affect the content of the SBC (and that occurs other than in connection with coverage renewal or reissuance) no later than 60 days prior to the effective date of the change.
- The SBC template and related materials are available from the U.S. Department of Labor.

SUMMARY PLAN DESCRIPTION (SPD)

Under ERISA, plan administrators must provide an SPD to new participants within 90 days after plan coverage begins.

Any changes made to the plan should be reflected in an updated SPD booklet or described to participants through a summary of material modifications (SMM).

Also, an updated SPD must be furnished every five years if changes are made to SPD information or the plan is amended. Otherwise, a new SPD must be provided every 10 years.

SUMMARY OF MATERIAL MODIFICATIONS (SMM)

The plan administrator must provide an SMM automatically to participants within 210 days after the end of the plan year in which the change was adopted. If benefits or services are materially reduced, participants generally must be provided with the SMM within 60 days from adoption. Also, plan administrators and issuers must provide 60 days' advance notice of any material modification to plan terms or coverage that takes effect mid-plan year and affects the content of the Summary of Benefits and Coverage (SBC). The 60-day notice can be provided to participants through an updated SBC or by issuing an SMM.

SUMMARY ANNUAL REPORT (SAR)

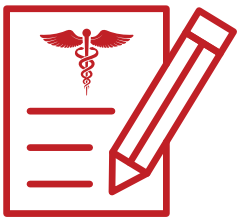
Plan administrators with 100 or more plan participants are required to file a Form 5500 and must provide participants with a narrative summary of the information in the Form 5500, called a Summary Annual Report (SAR).

The plan administrator generally must provide the SAR within nine months of the close of the plan year.

If an extension of time to file the Form 5500 is obtained, the plan administrator must furnish the SAR within two months after the close of the extension period.

Get more details on Form 5500 from the U.S. Department of Labor website.

MEDICAL LOSS RATIO (MLR) REBATES



The ACA requires health insurance issuers to submit data on the proportion of premium revenues spent on clinical services and quality improvement, also known as the Medical Loss Ratio (MLR).

It also requires them to issue rebates to enrollees if this percentage does not meet minimum standards.

Under the ACA, insurance companies must spend at least 80% or 85% of premium dollars on medical care, with the rate review provisions imposing tighter limits on health insurance rate increases.

If an issuer fails to meet the applicable MLR standard in any given year, as of 2012, the issuer is required to provide a rebate to its customers.

These rules do not apply to employers who operate self-insured plans. For employers in level-funded arrangements, the excess refund after the plan year ends should be treated similarly to an MLR rebate.

More **information on MLR rebates** is available from the Centers for Medicare and Medicaid Services at **cms.gov.**

GRANDFATHERED PLAN NOTICE

Employers with a grandfathered plan must review it to confirm that it still qualifies for grandfathered status.

If so, materials describing the plan's benefits must include a notice regarding the plan's status as a grandfathered plan.

The notice must include contact information for questions or complaints.

Model language is available from the U.S. Department of Labor.

Plans that lose grandfathered status immediately become subject to the same health reform requirements as non-grandfathered plans.

NOTICE OF RESCISSIONS

Plan Administrators or issuers must provide a notice of rescission to affected participants at least 30 days before the rescission occurs.

NOTICE OF PATIENT PROTECTIONS

Under the ACA, non-grandfathered group health plans and issuers that require designation of a participating primary care provider must permit each participant, beneficiary and enrollee to designate any available participating primary care provider (including a pediatrician for children).

Plans and issuers that provide obstetrical/gynecological care and require a designation of a participating primary care provider may not require preauthorization or referral for obstetrical/gynecological care.

If a non-grandfathered plan requires participants to designate a participating primary care provider, the plan or issuer must provide a notice of these patient protections whenever the SPD or similar description of benefits is provided to a participant.

If an employer's plan is subject to this notice requirement, they should confirm that it is included in the plan's open enrollment materials.

Model language is available from the U.S. Department of Labor.

HEALTH INSURANCE MARKETPLACE NOTICE

Employers must supply **a written notice with information** about the Health Insurance Marketplace to each new employee at the time of hiring, within 14 days of the employee's start date.

Employers are not required to provide a separate notice to dependents.

SECTION 1557 NONDISCRIMINATION REQUIREMENTS

Entities that administer any health program or activity that receives federal financial assistance (such as hospitals that accept Medicare or doctors who accept Medicaid) must confirm compliance with the **final rule implementing section 1557 of the ACA**, which prohibits discrimination on the basis of race, color, national origin, sex, age, or disability.

Certain notice and tagline requirements must also be met.

The U.S. Department of Health and Human Services provides **more information** on this notice requirement.

Other Disclosures, Notices and Reporting Requirements

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

The Consolidated Omnibus Budget Reconciliation Act (COBRA) applies to employers with 20 or more employees that sponsor group health plans.

Plan administrators must provide an initial COBRA notice to new participants and certain dependents within 90 days after plan coverage begins.

The initial COBRA notice may be incorporated into the plan's SPD.

A model initial COBRA notice is available from the U.S. Department of Labor.

The COBRA Election Notice must generally be provided to the qualifying beneficiary within 14 days after being notified of the qualifying event (or 44 days after the qualifying event if the employer is the plan administrator).

Other notices may be required, if applicable, such as Notices of Unavailability of COBRA, Early Termination of COBRA, Insufficient Payments, and Premium Change Notices.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) NOTICE REQUIREMENTS

Special Enrollment Rights

At or prior to the time of enrollment, a group health plan must provide each eligible employee with a notice of his or her special enrollment rights under HIPAA. This notice may be included in the plan's SPD.

Model language for this disclosure is available on the U.S. Department of Labor website.

Privacy Rule

The HIPAA Privacy Rule requires covered entities, including group health plans and issuers to provide a Notice of Privacy Practices – or Privacy Notice – to each individual who is the subject of protected health information.

Health plans are required to send the Privacy Notice at certain times, including to new enrollees at the time of enrollment.

In addition, at least once every three years, health plans must either redistribute the Privacy Notice or notify participants that the Privacy Notice is available and explain how to obtain a copy.

Self-insured health plans are required to maintain and provide their own Privacy Notices.

Special rules apply for fully insured plans, under which the health insurance issuer – and not the health plan itself – is primarily responsible for the Privacy Notice.

Model Privacy Notices are available through the U.S. Department of Health and Human Services.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA)

States may offer eligible low-income children and their families a premium assistance subsidy to help pay for employer-sponsored coverage.

If an employer's group health plan covers residents in a state that provides a premium subsidy, the employer must send an annual notice about the available assistance to all employees residing in the state.

A model notice is available from the Department of Labor.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

The WHCRA applies to group health plans that provide coverage for mastectomy benefits.
Plans with fewer than two participants who are current employees (for example, retiree health plans) are exempt.

The WHCRA requires health plans that provide medical and surgical benefits for a mastectomy to cover:

- All stages of reconstruction of the breast on which a mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and physical complications of mastectomy, including lymphedemas

Plans must provide a notice describing rights under WHCRA upon enrollment and on an annual basis after enrollment.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA)

Under the NMHPA, group health plans may not restrict the benefits of mothers and newborns for hospital stays to less than 48 hours following a vaginal delivery and 96 hours following a delivery by cesarean section.

The NMHPA applies to group health plans that provide maternity or newborn infant coverage.

The plan's SPD must include a statement describing the NMHPA's protections for mothers and newborns.

Model language for this disclosure is available on the U.S. Department of Labor's website.

MEDICARE PART D CREDITABLE COVERAGE

The Medicare Part D requirements apply to group health plan sponsors that provide prescription drug coverage to individuals who are eligible for Medicare Part D coverage.

Employer-sponsored health plans offering prescription drug coverage to individuals who are eligible for coverage under Medicare Part D must comply with the disclosure requirements outlined below.

Disclosure Notices for Creditable or Non-Creditable Coverage

- A disclosure notice must be provided to Medicare Part D eligible individuals who are covered by, or apply for, prescription drug coverage under the employer's health plan.
- The purpose of the notice is to disclose the status (creditable or non-prescription drug coverage). It must be provided at certain times, including before the Medicare Part D Annual Coordinated Election Period (October 15 through December 7 of each year).

Disclosure to Centers for Medicare and Medicaid Services (CMS)

- On an annual basis (within 60 days after the beginning of the plan year) and upon any change that affects the plan's creditable coverage status, employers must disclose to CMS whether the plan's coverage is creditable.
- Model forms are available from CMS.

ADDITIONAL MEDICARE TAX FOR HIGH EARNERS

Remember to withhold Additional Medicare Tax (0.9%) on wages or compensation paid to an employee in excess of $200,000 in a calendar year.
There is further guidance in the form of a Q&A on the IRS website.

MICHELLE'S LAW

Michelle's Law ensures that dependent students who take a medically necessary leave of absence do not lose health insurance coverage.
This law applies to employer-sponsored group health plans. Plans with fewer than two participants who are current employees (for example, retiree health plans) are exempt.

If a health plan requires a certification of student status for coverage, plan administrators and issuers must include a description of Michelle's Law with any notice regarding a requirement for certification of student status.

Michelle's Law was enacted before the ACA required group health plans to provide coverage for dependent children up to age 26, regardless of student status. Now that the ACA's coverage expansion for dependents is effective, Michelle's Law has limited applicability. In general, it will only apply if a plan offers coverage for dependents who are not covered by the ACA mandate (for example, dependents who are older than age 26) and conditions eligibility on student status.

WELLNESS PROGRAM NOTICES

Group health plans that include wellness programs may be required to provide certain notices regarding the program's design.

As a general rule, these notices should be provided when the wellness program is communicated to employees and before employees provide any health-related information or undergo medical examinations.

HIPAA WELLNESS PROGRAM NOTICE

HIPAA imposes a notice requirement on health-contingent wellness programs offered under group health plans.

Health-contingent wellness plans require individuals to satisfy standards related to health factors (for example, not smoking) in order to obtain rewards.

The notice must disclose the availability of a reasonable alternative standard to qualify for the reward (and, if applicable, the possibility of waiver of the otherwise applicable standard) in all plan materials describing the terms of a health-contingent wellness program.

The U.S. Department of Labor's **Compliance Assistance Guide** includes a model notice that can be used to satisfy this requirement.

ADA WELLNESS PROGRAM NOTICE

Employers with 15 or more employees are subject to the Americans with Disabilities Act (ADA).

Wellness programs that include health-related questions or medical exams must comply with the ADA's requirements, including an employee notice requirement.

Employers must give participating employees a notice that tells them what information will be collected as part of the wellness program, with whom it will be shared and for what purpose, the limits on disclosure and the way information will be kept confidential.

The EEOC has provided a **sample notice** to help employers comply with this ADA requirement.

Compliance

Our leading experts at CRC Benefits have the answers to your Affordable Care Act and other healthcare and employee benefits-related compliance questions. Whether you need insights or guidance on how to handle general ACA rules, regulations, transition relief, marketplace notices, affordability, coding 1094/1095 forms and more – CRC Benefits can help make it happen.

 crcbenefits.com  www.crcbenefits.com  crcbenefits

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