[New Schedule] Schedule J (Form 5500)—Group Health Plan Information

For calendar plan year 20XX or fiscal plan year beginning DD/MM/20XX and ending DD/MM/20XX+1

A Name of plan

B Three-digit plan number (PN)

C Plan sponsor's name as shown on Line 2a of Form 5500

D Employer Identification Number (EIN)

Plans that have fewer than 100 participants at the beginning of the plan year and are fully insured (see instructions) complete only basic identifying information and Part I, Lines 1-8. GIAs must complete a separate Schedule J for each participating plan.

Part I— Group Health Plan Characteristics

1 Approximate number of persons (including participants, beneficiaries and dependents of participants) covered under the plan at the end of the plan year?

2 The plan offers health coverage to the following (check all that apply):

[] employees

[] spouses

[] children

[] retirees

[] retirees only

3 Indicate which of the following types of benefit(s) and design characteristics are included under the plan. (Check all that apply):

[] medical/surgical benefits

[] mental health/substance use disorder benefits

[] pharmacy or prescription drug benefits

[] wellness program

[] preventive care services

[] emergency services

[] pregnancy benefits

[] vision

[] dental

4 Health funding and benefit arrangement (check all that apply):

4a(1)(a) [] health insurance issuer. If you check this box, enter name(s), EIN, and National Insurance Product Registry Number of insurance carriers providing benefits under the plan.

4a(1)(b) If the health funding or benefit arrangement is through a prototype/off-the-shelf insurance product, enter the identification number of the prototype/off-the-shelf insurance product.

4a(1)(c) Please check whether one or both of the following are used to pay premiums:

[] employer contributions

[] participant contributions

4a(2) [] benefits paid from general assets of the employer

[] employer contributions

[] participant contributions

4a(3) [] trust

[] employer contributions

[] participant contributions

5 Check all that apply to the plan:

[] one or more benefit package options claiming grandfathered status under the Affordable Care Act

[] high deductible health plan

[] health reimbursement arrangement (HRA) or plan includes an HRA

[] health flexible spending account (FSA) or plan includes an FSA

6a How many persons were offered COBRA benefits during the plan year?

6b Of the persons counted in line 6a, how many persons elected COBRA benefits?

6c How many persons were receiving coverage under the plan through COBRA during the plan year?

7a Did the plan or plan sponsor receive any rebates, reimbursement, or refunds other than those reported on Schedule A from service providers during the plan year? [] Yes [] No If "Yes," you must complete Line 7b. If "No," skip to Line 8.

7b(1) If you answered "Yes" to Line 7a, enter separately the amount and date received of each rebate, reimbursement, or refund. For each rebate, reimbursement, or refund listed, complete elements 7b(2) and 7b(3).

(2) Type of service provider that provided each rebate, reimbursement, or refund

[] health insurance issuer

[] third-party administrator

[] pharmacy benefit manager

[] other (specify)

(3) How each rebate, reimbursement, or refund was used (Check all that apply):

[] amount returned to participants

[] premium holiday

[] payment of benefits

[] other

8a If any benefits were provided pursuant to an insurance policy that was not reported on Schedule A, were there any premium payment delinquencies for premiums due but unpaid during the year ? [] Yes [] No If "Yes," enter number of times delinquent and for each delinquency enter the number of days delinquent

8b. If you answered "Yes" to line 8a, indicate whether any premium delinquency resulted in a lapse in coverage. If you answered "No" to line 8a, enter "N/A". [] Yes [] No [] N/A

Part II- Service Provider and Stop Loss Insurance Information (Repeat as many line entries as necessary to report all service providers under each category that have not already been reported on Schedule A or Schedule C.)

9 Third Party Administrator/Claims Processor, including a health insurance issuer subject to an "administrative services only (ASO)" or other agreement: [] N/A

a Name, address and telephone number

b EIN

c NAIC NPN

d If third party administrator/claims processing or similar services are being provided to the plan through a prototype/off-the-shelf ASO arrangement, enter the identification number of such insurance product

10 Mental Health Benefits Manager: [] N/A

a Name, address and telephone number

b EIN

c NAIC NPN

11 Substance Use Disorder Benefits Manager: [] N/A

a Name, address and telephone number

b EIN

c NAIC NPN

12 Pharmacy Benefit Manager/Drug Provider: [] N/A

a Name, address and telephone number

b EIN

c NAIC NPN

13 Independent Review Organization: [] N/A

a Name, address and telephone number

b EIN

c NAIC NPN

14 Wellness Program Manager: [] N/A (may be the same contact information for wellness program required under 29 CFR 2590.702(f)(2)(v)).

a Name, address and telephone number

b EIN

c NAIC NPN

15 Was there a stop loss policy associated with the plan's obligation to pay health benefits? If so, complete the following (Include information on all stop loss policies issued in connection with plan benefits, including policies with the employer/plan sponsor as the insured).

a Name of insurance carrier

b EIN

c NAIC NPN

d Total premium

e Attachment point of coverage

Individual attachment point of coverage (if applicable)

Aggregate attachment point of coverage (if applicable)

f Claim Limit

Individual claim limit (if applicable)

Aggregate claim limit (if applicable)

g Policy or contract year from _____ to _____.

h. Check this box if the employer/plan sponsor is the insured []

Part III—Financial Information. Plans that complete Schedule H skip to Part IV.

16 Contributions received during the plan year or receivable as of end of plan year:

a Employer contributions received

b Employer contributions receivable

c Participant contributions received

d Participant contributions receivable

e Other contributions received or receivable (including non-cash)

f Total contributions. Add Lines 16 a-e.

17 Was there a failure to transmit to the plan any participant contributions or repayments as of the earliest date on which such contributions can reasonably be segregated from the employer's general assets as described in 29 CFR 2510.3-102? [] Yes [] No

Part IV—Health Benefit Claims Processing and Payment.

18a Enter the number of post-service benefit claims submitted during the plan year.

(1) How many of those claims were approved during the plan year?

(2) How many of those claims were denied during the plan year?

(3) How many of those claims were pending at the end of the plan year?

18b Enter the number of post-service benefit claim denials appealed during the plan year.

(1) How many of those appeals were upheld during the plan year as denials?

(2) How many of those appeals were overturned and approved during the plan year after appeal?

18c Enter the number of pre-service benefit claims appealed during the plan year.

(1) How many of those appeals were upheld during the plan year as denials?

(2) How many of those appeals were approved during the plan year after appeal?

19 Were there any claims for benefits or appeals of adverse benefit determinations that were not adjudicated within the required timeframes? [] Yes [] No. If "Yes," enter

(1) Number of claims

(2) Number of appeals

20 Did the plan fail to pay any claims during the plan year within one (1) month of being approved for payment? [] Yes [] No If "Yes," enter the

(1) Number of claims not paid within one (1) month

(2) Total amount not paid within one (1) month

(3) Number of claims not paid within three (3) months or longer

21 Total dollar amount of benefits paid pursuant to claims during the plan year.

Part V—Compliance Information. [Current Form 5500 Part III; the move limits plans required to complete this part to those providing health benefits] Plans that file the Form M-1, skip questions 24-30.

22a Were all plan assets held in trust, held by an insurance company qualified to do business in a State, or as insurance contracts or policies issued by such an insurance company? (See section 403 of ERISA and 29 CFR 2550.403a-1 and 2550.403b-1)?

[] Yes [] No If you check "No," you must complete Line 22b.

22b Check all that apply and enter an explanation if checking "Other":

[] Plan assets not held in trust based on reliance on Technical Release 92-01

[] Other (explain)

23 Are the plan's summary plan description (SPD), including any summary descriptions of modifications, and summary of benefits and coverage (SBC) in compliance with the applicable content requirements? (See instructions.)

23a Summary Plan Description (SPD): [] Yes [] No

23b Summary of Benefits and Coverage (SBC) [] Yes [] No

24 Is the coverage provided by the plan in compliance with the provisions of the Health Insurance Portability and Accountability Act of 1996, as incorporated in ERISA, and the Department's regulations thereunder?

[] Yes [] No [] N/A

25 Is the coverage provided by the plan in compliance with the provisions of Title I of the Genetic Information Nondiscrimination Act of 2008 as incorporated in ERISA, and the Department's regulations issued thereunder?

[] Yes [] No [] N/A

26 Is the coverage provided by the plan in compliance with the Mental Health Parity Act of 1996 and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and the Department's regulations issued thereunder?

[] Yes [] No [] N/A

27 Is the coverage provided by the plan in compliance with the Newborns' and Mothers' Health Protection Act of 1996 and the Department's regulations issued thereunder?

[] Yes [] No [] N/A

28 Is the coverage provided by the plan in compliance with the Women's Health and Cancer Rights Act of 1998?

[] Yes [] No [] N/A

29 Is the coverage provided by the plan in compliance with Michelle's Law?

[] Yes [] No [] N/A

30 Is the coverage provided by the plan in compliance with the Affordable Care Act and the Department's regulations issued thereunder?

[] Yes [] No [] N/A

31a Was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) [] Yes [] No If "Yes" is checked, complete Lines 31b and 31c.

31b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) [] Yes [] No

31c Enter the Receipt Confirmation Code for the 20XX Form M-1 annual report. If the plan was not required to file the 20XX Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 Annual Return/Report filing to rejection as incomplete.)

Receipt Confirmation Code