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Health and Welfare Plan Developments

DOL Finalizes Association Health Plan Rule

On June 21, 2018, the Department of Labor ("DOL") published the final Association Health Plan rule under the Employee Retirement Income Security Act of 1974 ("ERISA") (the "AHP Final Rule"). The AHP Final Rule amends the definition of "employer" under ERISA and expands the criteria for determining when employers may join together in an association to act as a single employer sponsor of an AHP. Specifically, the AHP Final Rule allows a "*bona fide* group or association" to establish a single employer AHP, provided it meets the following criteria:

1. **Purpose.** The group or association must have at least one substantial business purpose unrelated to providing health coverage or other benefits to its employer members and their employees.

2. **Commonality of Interest.** The employer members must have a commonality of interest; that is, the employer members are either (a) in the same trade, industry or profession; or (b) in the same principal place of business within the same state, or a common metropolitan area (even if the area straddles state lines).

3. **Organization.** The group or association must have a formal organizational structure, including a governing body and by laws (or other similar formalities).

4. **Employer Control.** The employer members must have control, in form and substance, over the functions and activities of the group or association, including its establishment and maintenance of the group health plan (to be determined on a facts and circumstances basis).

5. **Participation.** The group or association may only offer coverage to employees of the employer members, the employees' eligible dependents, and certain eligible former employees of an employer member.

6. **Nondiscrimination.** The AHP must comply with the health nondiscrimination rules of the Health Insurance Portability and

Accountability Act of 1996 ("HIPAA") and the Affordable Care Act ("ACA"), including not conditioning membership upon health factors.

7. **Health Insurance Issuer.** Health insurance issuers may not constitute or control the group or association.

8. **Direct Employer.** Each employer member must be a person acting directly as the employer of at least one person who is a participant in the group health plan.

In a departure from the previous rule, the AHP Final Rule permits working-owners without other employees to participate in an AHP and receive coverage for themselves and their eligible dependents. The new rule also permits existing AHPs to elect to operate as before under the former regulations or elect to follow the AHP Final Rule. Similarly, a group or association may form new group health plans and follow either the previous rule or the AHP Final Rule.

Final Regulations Extend Short-Term, Limited-Duration Insurance

The departments of Health and Human Services, Labor and the Treasury have issued a final rule that allows for the sale and renewal of short-term, limited-duration policies that cover longer periods than the previous maximum period of less than three months. Such policies can now cover an initial period of less than 12 months, and, taking into account any extensions, a maximum duration of no longer than 36 months in total. Short-term, limited-duration insurance provides coverage for people transitioning between different coverage options, such as an individual who is between jobs, a student taking time off from school, or a middle-class family without access to a subsidized plan under the ACA. States will have the primary responsibility to regulate short-term, limited-duration insurance. A number of states have already taken steps to regulate the policy provisions and limit the duration of short-term, limited-duration insurance.

Short-term, limited-duration insurance is not considered individual health insurance coverage for the purposes of the market requirements of the ACA. Accordingly, it is not subject to the requirement to provide essential health benefits, the prohibitions on preexisting condition exclusions or lifetime and annual dollar limits, and is not subject to requirements regarding guaranteed availability and guaranteed renewability. The final rule requires that issuers of short-term, limited-duration insurance policies include a prominent notice explaining that it is not subject to federal requirements for individual health

insurance coverage, that it is not minimum essential coverage, and other information relevant to potential consumers. The final rule will become effective and applicable for insurance policies sold on and after October 2, 2018.

URAC Revokes Accreditation of IRO, Revocation Not Eligible for Review

The U.S. District Court for the District of Columbia recently ruled that BHM Healthcare Solutions, Inc., a formerly-accredited independent review organization ("IRO"), could not seek judicial review of the accrediting entity's decision to revoke its IRO accreditation. Under the ACA, non-grandfathered group health plans and insurers must offer participants and dependents the opportunity for an accredited IRO to review their claim after receiving a final internal adverse benefit determination. URAC was the accreditor in this case, and is the major accreditor of IROs for purposes of the ACA. Although the Court came to its decision under contract law principles, the case illustrates the risk that an IRO may have its accreditation revoked. Accordingly, plan sponsors may wish to address what happens if an accredited IRO has its accreditation revoked in their contracts with IROs. The case is *BHM Healthcare Sols., Inc. v. URAC, Inc.*, 2018 WL 3520435 (D.D.C. July 20, 2018).

Seventh Circuit: Life Insurance Policy Failed to Qualify for ERISA Safe Harbor

The U.S. Court of Appeals for the Seventh Circuit recently held that a supplemental life insurance policy that the plaintiff argued should be exempt from ERISA under the Department of Labor's regulatory safe harbor for certain voluntary benefits was, in fact, governed by ERISA. The Seventh Circuit determined that the policy was subject to ERISA because it satisfied the requirements to be an "employee welfare benefit plan" and did not meet all of the requirements for the regulatory safe harbor. Specifically, the Seventh Circuit found that the policy did not satisfy the safe harbor's requirement that the employer's sole functions be, without endorsing the policy, to: (1) permit the insurer to publicize the policy to employees; (2) collect premiums through payroll deductions or dues checkoffs; and (3) remit premiums to the insurer. Instead, the Seventh Circuit found that the employer had performed all administrative functions associated with maintaining the policy.

The Seventh Circuit cited the SPD as support for its finding. In particular, the Seventh Circuit found it persuasive that the SPD stated that the employer was the policyholder for all components of its plan, of which the supplemental life insurance policy was but one listed item. The Seventh Circuit also found it

persuasive that the SPD stated that the supplemental life insurance policy would remain part of the employer's group insurance policy, though it could be converted to an individual life insurance policy in certain situations. Accordingly, the Seventh Circuit determined that the employer did not strictly adhere to the limited role permitted under the regulatory safe harbor. The Seventh Circuit also declined to consider the supplemental life insurance policy separately from the other benefits in the plan. The case is *Cehovic–Dixneuf v. Wong*, 2018 WL 3373062 (7th Cir. July 11, 2018).

Ninth Circuit Holds Plan Must Cover Room and Board at Residential Treatment Facility

The Ninth Circuit Court of Appeals held that a group health plan which covered room and board costs at a skilled nursing facility violated the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") by denying the same coverage at a residential treatment facility for mental health. *Danny P. v. Catholic Health Initiatives*. The court held that, because the plan covered room and board (and other ancillary services) at skilled nursing facilities for medical treatment, the MHPAEA required it to equally cover residential treatment facilities for mental health; that is, one policy of coverage cannot be more restrictive than another.

HIPAA Covered Entity Required to Pay $4.3 Million in Penalties for Data Breaches

A U.S. Department of Health and Human Services Administrative Law Judge ("ALJ") held that the University of Texas MD Anderson Cancer Center ("MD Anderson") must pay $4.3 million in penalties for data breaches. The Office for Civil Rights ("OCR") investigated MD Anderson following reports of three data breaches. The breaches involved the theft of an unencrypted laptop from an employee's home and the loss of 2 unencrypted USB thumb drives containing the electronic protected health information ("ePHI") of over 33,000 individuals. The OCR's investigation revealed that MD Anderson had encryption policies dating back to 2006 and MD Anderson's internal risk analysis found that a lack of device-level encryption posed a high risk to the ePHI. Notwithstanding these encryption policies and high risk findings, MD Anderson failed to encrypt all of its devices. Based on these discoveries, the OCR imposed a fine for each day of HIPAA noncompliance and each record exposed, which tallied $4,348,000 in penalties.

In the OCR's history of HIPAA enforcement, this is only the second summary judgment granted in its favor, and the $4.3 million is the fourth largest HIPAA

violation penalty ever awarded by an ALJ or settlement for HIPAA violations.

Aetna Faces Class Action Over Wilderness Therapy Exclusion

Aetna Life Insurance Co. ("Aetna") has become the latest major health insurance carrier to be sued over its wilderness therapy exclusion. *H.H. et al. v. Aetna Life Insurance Co*. According to the lawsuit filed in the U.S. District Court for the Southern District of Florida on June 14, 2018, Aetna is alleged to have violated ERISA and the MHPAEA by denying coverage for medically necessary mental health and substance abuse treatment rendered at licensed wilderness therapy programs and residential treatment centers. This is the latest legal challenge regarding coverage for these types of programs.

Michigan Proposes to Appeal HICA Tax

Michigan acted to repeal and replace the Michigan Health Insurance Claims Assessment ("HICA") tax, pending approval of the tax's replacement by the Centers for Medicare & Medicaid Services ("CMS"). HICA imposes a 1% tax on all paid health care claims in Michigan to fund the state's Medicaid program. The tax is imposed on carriers of fully insured group health plans and third party administrators ("TPA") of self funded group health plans. The replacement tax, the Insurance Provider Assessment ("IPA"), would not apply to self funded group health plans and their TPAs, and further excludes individuals enrolled in a variety of types of coverage (*e.g*., accidental death and dismemberment, long term care, Medicare supplement, stand alone dental, dental, Medicare, Medicare Advantage, Medicare Part D, vision and prescription). Upon approval by CMS, the HICA tax will be repealed and the IPA will be effective on the later of the first day of the calendar quarter wherein CMS grants the approval, or October 1, 2018.

Retirement Plan Developments

Ninth Circuit Holds That Constructive Notice Is Sufficient to Impose Withdrawal Liability on Successor Employer

On June 1, 2018, in *Heavenly Hana LLC v. Hotel Industry of Hawaii Pension Plan,* the Ninth Circuit Court of Appeals held that a successor employer assumes liability for the predecessor employer's unpaid withdrawal liability under the Multiemployer Pension Plan Amendment Act ("MPPAA") because the successor employer had constructive notice thereof. In this case, Heavenly Hana LLC and Green Tree Management, and their parent company, Amstar39 (collectively, "Amstar"), purchased the Ohana Hotel ("Ohana"). Ohana contributed to the Hotel Union &

Hotel Industry of Hawaii Pension Plan (the "Plan") until 10 days prior to the closing date, and formally withdrew from the Plan on the closing date.

Ohana's withdrawal triggered withdrawal liability of over $750,000. The Plan assessed this liability against Amstar, as Ohana's successor, and Amstar challenged the assessment on the grounds that Amstar did not have actual notice of the withdrawal liability. Reversing the lower court, the Ninth Circuit ruled that withdrawal liability can attach if the buyer has constructive notice thereof, which it deemed as "consistent with the MPPAA's intended purpose and liberal construction." The court noted the Ninth and other Circuits have adopted the constructive notice standard in other contexts (such as labor and employment cases).

Applying this constructive notice standard, the court determined Amstar indeed had constructive notice because a reasonable buyer would have discovered Ohana's withdrawal liability. The court based its determination on the fact that (a) Amstar had previously operated a hotel that participated in a multiemployer pension plan, (b) Amstar knew that Ohana's employees were unionized and that Ohana contributed to a multiemployer plan, and (c) the Plan's annual funding notices, which revealed the Plan's underfunded status, were publicly available on the internet.

Court Approves $5.45 Million Settlement Between DOL and ESOP Trustee.

The DOL has reached a $5.45 million settlement with the fiduciaries of the Cactus Feeders Inc. Employee Stock Ownership Plan (the "ESOP") and the ESOP's trustee, Lubbock National Bank ("Lubbock"), thereby resolving *Acosta v. Cactus Feeders.* On June 15, 2018, the court approved the settlement. In this case, the DOL alleged the ESOP's fiduciaries and Lubbock improperly relied on a deficient valuation analysis, despite having the requisite knowledge and experience to have discovered the analysis's defects and that they caused the ESOP to overpay for the shares it purchased.

The settlement includes a process agreement requiring Lubbock to follow certain policies and procedures when serving as a trustee or ERISA fiduciary in future stock purchase or sale transactions (the "Lubbock Agreement"). This marks the fifth settlement agreement between the DOL and an ESOP trustee. Collectively, these settlement agreements are viewed as representing trustee best practices in ESOP transactions.

The first such agreement, in 2014, between the DOL and GreatBanc Trust

Company (the "GBTC Agreement") provided a template for subsequent settlement agreements. Although the DOL modified subsequent agreements as necessary to address additional deficiencies, the Lubbock Agreement is noteworthy in that it is identical to the GBTC Agreement and does not impose any new requirements on Lubbock beyond those imposed on GreatBanc.

IRS Final Regulations Revise QMAC and QNEC Rules, Allow Funding by Forfeitures

On July 19, 2018, the Internal Revenue Service ("IRS") and Treasury Department issued final regulations revising the definitions of qualified matching contributions ("QMACs") and qualified non-elective contributions ("QNECs") to help ensure that defined contribution plans can fund QMACs and QNECs with the amounts in plan forfeiture accounts. Under the revised definitions, employer contributions to a plan can qualify as QNECs and QMACs if they are nonforfeitable and their distribution is limited at the time they are allocated to participants' accounts. Under the prior definitions, the contributions were required to meet these requirements when they were first contributed to a plan. The final regulations apply to plan years beginning on or after July 20, 2018, but can be relied upon for prior periods. We previously reported on the proposed version of the regulations in the February 2017 Benefits Counselor.

PBGC Staff Provides Guidance on Premiums for Plan Termination and Spin-Off

On July 25, 2018, the Pension Benefit Guaranty Corporation ("PBGC") staff updated the "Premiums" section of its "Staff Responses to Practitioner Questions" webpage to opine on the premiums applicable to a plan following a plan termination late in the plan year and the subsequent establishment of a new, but substantially identical, spin-off plan.

The PBGC's premium regulations (29 CFR Part 4006) provide that:

- a single-employer plan exiting the defined benefit system (via a standard termination) is exempt from the variable-rate premium ("VRP") in its final year, and
- premiums are pro-rated for new plans created as the result of a spinoff from another plan if the new plan's initial plan year is a short plan year (i.e., less than 12 months).

In each of these situations, the plan owes a significantly lower PBGC premium that it would have had the applicable special rule not applied.

According to the PBGC staff, the PBGC has learned that some plans avoid paying a significant portion of the statutory VRP by (1) spinning off most plan participants late in the year into a new, identical plan that has a new name, EIN, and plan number, leaving only a small group of retirees in the original plan and (2) terminating the remainder of the original plan (i.e., purchasing annuities for the remaining retirees).

The PBGC staff determined that case law under ERISA suggests that this two-step transaction, and similar transactions, should be disregarded. The PBGC staff advised that PBGC premiums would be assessed as if such transactions had not occurred. The PBGC staff stated that they were "especially skeptical" of such two-step transactions because plans could engage in them repeatedly. The interpretations presented on the "Staff Responses to Practitioner Questions" webpage reflect the views of the staff of PBGC, and are not rules, regulations, or statements of the PBGC.

PBGC Proposes Changes to Terminated and Insolvent Multiemployer Plans' Valuation, Reporting and Disclosure Requirements

On July 16, 2018, the PBGC published proposed regulations that would affect multiemployer plans terminated by a mass withdrawal or plans in critical status and insolvent or expected to become insolvent. Areas that the proposed regulations would amend include the annual valuation requirement, withdrawal liability payments, terminated and insolvent plan notices, and applications to the PBGC for financial assistance.

The proposed regulations would make the following changes to the annual valuation requirement for multiemployer plans terminated by mass withdrawal:

- Replace the rule only requiring a valuation every three years for plans with nonforfeitable benefits of $25 million or less with a rule requiring a new valuation every five years for plans with nonforfeitable benefits of $50 million or less;
- Require the filing of actuarial valuations or alternative valuation information with the PBGC if a plan is (1) insolvent (active or terminated) and receiving financial assistance from the PBGC or (2) terminated by plan amendment and expected to become insolvent.

- Require the filing of actuarial valuations or alternative valuation information with the PBGC within 180 days after the end of the plan year for which the actuarial valuation is performed.

These changes would apply to actuarial valuations prepared for plan years ending after the effective date of the final regulations.

Withdrawal Liability

The proposed regulations would require that plans subject to the actuarial valuation requirement send the PBGC information about withdrawal liability payments and whether any employers have withdrawn without being assessed withdrawal liability. Plan sponsors would file the information with the PBGC within 180 days after the end of the plan year in which the plan terminates, and annually thereafter. These changes would apply for plan years ending after the effective date of any final regulations.

Insolvency Notices and Updates

The proposed regulations would make the following changes to the notices of insolvency and insolvency benefit level:

- Require a critical status plan or a plan terminated by mass withdrawal to provide notices of insolvency if the plan is insolvent in the current plan year or is expected to be insolvent in the next plan year;
- Make both notices due by the later of 90 days before the beginning of the insolvency year or 30 days after the date the insolvency determination is made;
- Allow a plan to provide a single combined notice for the same insolvency year;
- Eliminate most of the annual updates to the notices of insolvency benefit level; and
- Eliminate outdated content requirements from the notices and move the content requirements to instructions on the PBGC website.

These changes would apply as of the effective date of any final regulations.

Application for PBGC Financial Assistance

The proposed regulations would require plans to file an initial application for

financial assistance from the PBGC at least 90 days before the first day of the month for which the resource benefit level will be below the level of guaranteed benefits. Any recurring applications would need to be filed as soon as practicable after the plan determines it will be unable to pay guaranteed benefits when due for a month. The contents of the financial assistance applications would be listed in instructions on the PBGC website.

NYU Defeats ERISA Class Action over Retirement Plans

The U.S. District Court for the Southern District of New York recently ruled in favor of New York University ("NYU") in a class-action suit in which plaintiffs claimed that it violated its fiduciary duties under ERISA by imprudently managing two of its retirement plans. The plaintiffs claimed that NYU imprudently managed the selection and monitoring of two recordkeeping vendors, resulting in excessively high fees, and that it acted imprudently by failing to remove two investment options. The Court held that NYU did not breach its duties by acting imprudently. Rather, the Court found that NYU engaged in a prudent process for selecting and monitoring its recordkeepers and the investment options at issue. The Court's decision ended the first trial in the series of ERISA class actions filed against universities in recent years. The case is *Sacerdote v. New York University*, 2018 WL 3629598 (S.D.N.Y. July 31, 2018).

PBGC Changes Disaster Relief Announcement Procedure

In an effort to simplify how it provides relief from filing deadlines and penalties following a disaster, the PBGC's disaster relief announcements will now be tied to the disaster relief announcements issued by the IRS. Historically, the PBGC issued stand alone announcements *after* the IRS granted relief. Consequently, filers were required to wait for the PBGC to act after any given IRS disaster relief announcement to confirm that the PBGC was also providing relief.

Going forward, the PBGC will issue a one time announcement explaining the applicable PBGC disaster relief each time the IRS grants relief in response to a particular disaster. Unless a filing is on the Exceptions List (see below), the PBGC will grant relief when, where and for the same time duration the IRS grants relief for affected taxpayers. The Exceptions List includes: certain notices of reportable events under ERISA section 4043; notices of large missed contributions under ERISA section 303(k); and obligations related to distress terminations for which the PBGC has issued a distribution notice.

IRS Abused Discretion in Revoking ESOP's Favorable Determination Letter

The Tax Court recently ruled that the IRS abused its discretion in revoking a favorable determination letter previously issued to an employee stock ownership plan ("ESOP") and its related trust.

The ESOP trust had acquired all of the outstanding shares of stock of the plan sponsor and another related management entity, which were S corporations. Because the ESOP trust was the sole owner of both entities, all net income flowed through to the ESOP trust. Accordingly, the ESOP trust's net assets as of the end of the initial plan year consisted of the plan sponsor and related entity's stock, income from the plan sponsor and the related entity, and employer contributions. In addition, a portion of the shares of the plan sponsor's stock and all of the shares of the related entity's stock were allocated to the former owner's participant account during the initial plan year. The remaining shares of the plan sponsor's stock were also allocated to participants' accounts during the initial plan year.

After forming the ESOP and trust, the plan sponsor used its existing external accountant to prepare and file the Form 5500 each year. The accountant also performed and submitted appraisals valuing the stock held in the ESOP trust. When the IRS notified the plan sponsor that it would audit the ESOP, the plan sponsor retained the accountant to represent it through the audit.

During the audit, the IRS identified multiple grounds for revoking the ESOP and trust's qualified status, including: (1) the allocation of annual additions in excess of the dollar limit in Code Sec. 415(c)(1)(A); (2) the failure to use an independent appraiser to perform annual valuations of the employer securities in the trust; and (3) the failure to timely amend the ESOP to include mandatory provisions regarding qualified military service.

After receiving notice of the issues that could possibly disqualify the ESOP and trust, the accountant submitted a protest. In his protest, the accountant listed his qualifications, including his educational background in accounting, his CPA licensure, his membership in professional organizations, his experience teaching courses on ESOPs and appraisals of closely held corporations, his experience performing appraisals, and his firm's advertisements as an appraiser of businesses and estates.

However, the IRS issued a final revocation letter to the plan sponsor retroactively revoking the favorable determination letter and determining that the ESOP was not qualified under the Code for the above-stated reasons.

The plan sponsor challenged the IRS's decision, which resulted in the Tax Court's finding that the IRS abused its discretion in revoking the determination letter on each count.

- With regard to the IRS's allegation regarding excess annual additions, the Tax Court observed that the plan sponsor and other management entity were S corporations, and the plan sponsor showed that there were no distributions or "dividends" paid from it or from the management entity to the trust. Rather, the Tax Court determined that income and losses correctly flowed through from the plan sponsor and management entity to the ESOP trust. The Tax Court also concluded that the plan sponsor correctly valued the stock at the time it was first contributed and allocated to the participant's account. Rather, the participant's account balance increased due to the plan sponsor and related entity's income during the initial plan year and an increase in the value of stock. Therefore, the Tax Court concluded that IRS acted arbitrarily by recharacterizing allocations to the participant's account as plan contributions.

- The Tax Court also found that the IRS abused its discretion when it held that the plan sponsor did not use an independent appraiser. The IRS concluded that the ESOP's appraiser was not independent because he performed numerous services for the ESOP and trust each year, including preparing the Form 5500 and other recordkeeping functions in addition to receiving a regular income from the plan sponsor. The IRS had also noted that the appraiser did not advertise his services as a securities appraiser. The Tax Court disagreed, noting that the regulations regarding "qualified appraisers" exclude certain listed persons, but concluding that the regulations do not exclude persons beyond those listed and the appraiser did not fall in any of the prohibited categories. The Tax Court also concluded that the regulations do not require an appraiser to advertise to the public to be qualified. Rather, the individual must hold himself out to the public as an appraiser or perform appraisals regularly, which he did.

- Finally, the Tax Court determined the IRS abused its discretion by determining that the ESOP had not been timely amended for required language under Internal Revenue Code section 414(u) regarding qualified military service. The Court relied upon testimony that the restated plan documents were signed shortly after receipt of the IRS's favorable determination letter, as well as the fact that there was water damage to the plan sponsor's building shortly after the IRS approved the restated ESOP document and amendments.

General Employee Benefits

Ninth Circuit Rules ERISA Fiduciary Breach Claim Not Subject to Arbitration

The U.S. Court of Appeals for the Ninth Circuit recently upheld a decision that the University of Southern California ("USC") could not send a proposed class action under ERISA to arbitration. The Ninth Circuit agreed with the district court that employees who signed arbitration agreements as conditions of employment could still bring fiduciary claims on behalf of the benefit plans under ERISA. According to the court, the dispute was not bound by the arbitration agreements between USC and the employees because the agreements only covered claims brought on the employees' own behalf, and the claims in the present case were brought on behalf of the ERISA benefit plans. The case is *Munro v. University of Southern California*, case number 17-55550, in the U.S. Court of Appeals for the Ninth Circuit.

Fifth Circuit Vacates DOL Fiduciary Rule

On June 21, 2018, the Fifth Circuit Court of Appeals formally vacated the DOL Fiduciary Rule, including the Best Interest Contract and Principal Transactions Exemptions, effective immediately. This order finalizes the Fifth Circuit's March 15 decision in *U.S. Chamber of Commerce v. DOL*, where the court held that the DOL exceeded its authority in promulgating the Fiduciary Rule. The DOL was directed to pay the appeal costs of the financial industry groups that challenged the rule.

Consequently, the "five part test" from the 1975 regulations for determining who is a fiduciary is restored. However, as discussed in our June 2018 Benefits Counselor, the DOL issued a temporary nonenforcement policy in its Field Assistance Bulletin 2018 02 ("FAB 2018 02"), under which the DOL will not pursue prohibited transaction claims against fiduciaries working diligently and in good faith to comply with the exemptions' impartial conduct standards until the DOL issues new guidance.

Upcoming Compliance Deadlines and Reminders

Summary Annual Report ("SAR") Deadline for Calendar Year Defined Contribution Plans. Plan administrators must distribute SARs to participants and beneficiaries within nine months of the plan's year end (*e.g.*, for plan years that ended December 31, 2017, the SAR is due September 30, 2018). However, if a plan has received an extension for filing its Form 5500, the nine month SAR

deadline is extended by two months.

Form 5500 Filing Deadline for Calendar Year Plans with Extensions. For plans that obtained an extension for filing their Form 5500, the Form 5500 must be filed by October 15, 2018.