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Compliance Checklist

For Group Health Plans

This Compliance Checklist outlines general federal group health plan requirements, including certain federal mandates, plan reporting requirements, plan document requirements and required policies and procedures.

This resource is divided into three sections:

- Compliance Checklist Quick Reference Guide: charts each requirement and the timeline for compliance
- Compliance Checklist for Group Health Issues: details each requirement, the penalty for failure to comply, citation of the regulation and applicability based on plan size
- Compliance Model Notices: provides text for model notices and language, which have been provided by federal regulations and guidance

Please note that the Compliance Checklist:

- Contains limited information and is not a comprehensive list of group health plan requirements; therefore, it should not be relied upon as an employer's sole resource for compliance information.
- Includes information related to Health Care Reform provisions which are effective beginning in 2010 - 2015. Future versions will include upcoming Health Care Reform provisions scheduled for implementation in later years.
- Is a federal resource only, and therefore does not cover state mandates. Please check with your state's insurance board for local requirements.
- Is a proprietary NFP Benefits resource and is solely for the use of NFP and Benefits Partners member firms.

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Available Model Notices:

COBRA: Initial COBRA Notice

COBRA: Election Notice

ERISA: ERISA Rights Statement

ERISA: Summary Annual Report (SAR)

FMLA: General Notice

FMLA: Eligibility & Rights and Responsibilities Notice

FMLA: Designation Notice

PPACA: Exchange Notice

PPACA: Grandfathered Health Plans

PPACA: Notice of Adverse Benefit Determination

PPACA: Notice of Final Internal Adverse Benefit Determination

PPACA: Notice of Final External Review Decision

PPACA: Patient Protections

PPACA: Summary of Benefits and Coverage (SBC)

HIPAA: Certificate of Creditable Coverage

HIPAA: Notice of Availability of Reasonable Alternative Standard

HIPAA: Notice of Privacy Practices

HIPAA: Notice of Special Enrollment Rights

HIPAA: General Notice of Pre-existing Condition Exclusion

HIPAA: Employer CHIP Notice

MEDICARE: Part D Creditable Coverage Notice to Eligible Individuals

MEDICARE: Part D Non-creditable Coverage Notice to Eligible Individuals

GINA: EEOC Poster

HSA: Notice to Employees Regarding Employer Contributions to HSA

Newborns' and Mothers' Health Protection Act Model Language

USERRA: Notice of Your Rights Under USERRA

WHCRA: Women's Health and Cancer Rights Act Notice

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Quick Reference Guide

Timeline for compliance of notice or other requirement	Quarterly	Annually	Every 3 Years	Every 5-10 Years	As Required	COBRA Coverage Termed	Coverage Termed	New Enrollee	Newly Eligible	Ongoing	Upon Plan Changes	Upon Request
Cafeteria Plans *Pages 8-10*												
Cafeteria Plan Documents					ü						ü	
Cafeteria Plan Nondiscrimination Testing		ü										
Health FSA Nondiscrimination Testing		ü										
DCAP Nondiscrimination Testing		ü										
Simple Cafeteria Plan Safe Harbor		ü								ü		
Health FSA Limit		ü								ü		
COBRA *Pages 11-12*												
COBRA Initial Notice								ü				
COBRA Election Notice							ü					
Notice of Unavailability of Continuation Coverage							ü					
Notice of Early Termination of COBRA Coverage						ü						
ERISA *Pages 12-16*												
Plan Documents												ü
Summary Plan Description (SPD)				ü				ü				ü
Summary of Material Modification (SMM)								ü			ü	ü
Summary of Material Reduction in Covered Services or Benefits								ü			ü	
Form 5500		ü										
Form 5500-SF		ü										
Accountant's Report		ü										
Summary Annual Report (SAR)		ü										ü
Summary of Benefits and Coverage (SBC)		ü			ü				ü		ü	ü
Fidelity Bond										ü		
FMLA *Pages 16-19*												
General Notice										ü		
Eligibility Notice					ü							
Rights and Responsibilities Notice					ü							

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Quick Reference Guide *continued*

Timeline for compliance of notice or other requirement	Quarterly	Annually	Every 3 Years	Every 5-10 Years	As Required	COBRA Coverage Termed	Coverage Termed	New Enrollee	Newly Eligible	Ongoing	Upon Plan Changes	Upon Request
FMLA *Pages 16-19*												
Designation Notice					ü							
Notice of Opportunity to Change Health Plans					ü							
Notice of Nonpayment of Premiums					ü							
Health Care Reform *Pages 19-29*												
Grandfathered Health Plans					ü			ü				
Prohibition on Stand-alone HRA's		ü						ü				
Dependent Coverage					ü			ü				
Internal Claims and Appeals and External Review Procedures				ü	ü			ü		ü		ü
Annual and Lifetime Dollar Limits		ü			ü			ü				
OTC Medicines or Drugs										ü		
Patient Protections					ü			ü		ü		
Preventive Care Mandate								ü			ü	
Pre-existing Condition Exclusion Prohibition								ü			ü	
Rescission of Coverage					ü	ü	ü					
Patient-centered Outcomes Research (PCOR) Institute Fee		ü								ü		
Notice of Exchange					ü					ü		
Form W-2 Reporting Requirement		ü								ü		
Reinsurance Fee		ü										
Health Insurance Tax (HIT)		ü										
90-day Waiting Periods					ü					ü		
Women's Preventive Care Services											ü	
Maximum Out-of-pocket (MOOP) Limit		ü								ü		
Coverage for Clinical Trials		ü								ü		
Health Care Reform- 2015 *Pages 30-32*												
Employer Mandate		ü			ü					ü		
Information Reporting under Section 6055		ü			ü					ü		

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Quick Reference Guide *continued*

Timeline for compliance of notice or other requirement	Quarterly	Annually	Every 3 Years	Every 5-10 Years	As Required	COBRA Coverage Termed	Coverage Termed	New Enrollee	Newly Eligible	Ongoing	Upon Plan Changes	Upon Request
Health Care Reform- 2015 *Pages 30-32*												
Informational Reporting under Section 6056		ü			ü					ü		
HIPAA Privacy *Pages 32-34*												
Privacy Policies and Procedures										ü		
Security Policies and Procedures										ü		
Notice of Privacy Practices			ü					ü			ü	
Breach Notifications		ü			ü							
Business Associate Agreement										ü		
HIPAA Portability *Pages 35-39*												
Certificate of Creditable Coverage						ü	ü					ü
Special Enrollment Rights									ü			
General Notice of Pre-existing Condition Exclusion									ü			
Individual Notice of Pre-existing Condition Exclusion					ü							
CHIPRA		ü		ü					ü			
Wellness Program Requirements										ü		
HIPAA Nondiscrimination Rules for Eligibility and Benefits										ü		
Medicare/TRICARE *Pages 39-41*												
Medicare Part D Disclosure Notice to CMS		ü									ü	
Medicare Part D Disclosure Notice to Eligible Individuals		ü			ü		ü		ü	ü	ü	ü
Medicare Section 111 Reporting	ü											
Medicare Prohibitions										ü		
TRICARE Prohibitions										ü		
Nondiscrimination *Pages 42-43*												
Section 105(h) Nondiscrimination Testing		ü								ü		
Cafeteria Plan, Health FSA and DCAP Nondiscrimination Testing		ü										
Genetic Information Nondiscrimination Act (GINA)					ü							

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Quick Reference Guide *continued*

Timeline for compliance of notice or other requirement	Quarterly	Annually	Every 3 Years	Every 5-10 Years	As Required	COBRA Coverage Termed	Coverage Termed	New Enrollee	Newly Eligible	Ongoing	Upon Plan Changes	Upon Request
Nondiscrimination *Pages 42-43*												
HIPAA Nondiscrimination												
Taxation *Pages 43-44*												
Taxation of Group Term Life Insurance					ü							
Taxation of Same-sex Benefits					ü							
Other Federal Mandates *Pages 44-46*												
HSA Notice to Employees Regarding Employer Contributions		ü										
Mental Health Parity and Addiction Equity Act (MHPAEA)					ü					ü		
Newborns' and Mothers' Health Protection Act (NMHPA)				ü				ü				
Qualified Medical Child Support Order (QMCSO)					ü							
Uniformed Services Employment and Reemployment Rights Act (USERRA)							ü			ü		
Women's Health and Cancer Rights Act (WHCRA)		ü						ü				

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Cafeteria Plans

Item	Description	Due Date	Penalty	Employer Size
Cafeteria Plan Documents	Applies to every employer that permits employees to pay for benefits with pre-tax dollars. Must have a written document containing the operating rules of the plan, descriptions of each qualified benefit available (i.e., health premiums, health FSA, DCAP, group term life insurance, HSA, etc.), grace period availability, eligibility rules, manner of contributions, maximum employer and employee contributions, ordering rules, plan year, election procedures, timing of and irrevocability of participant elections, allowable qualified changes, claims and reimbursement procedures, substantiation rules, health FSA uniform coverage and use-it-or-lose-it rule (if applicable), run-out period description, and amendment procedure.	Must be formally adopted by the employer prior to the first day of the plan year.	Failure to adopt plan document prior to the plan's effective date or failure to operate in compliance with the document or the regulations can result in disqualification of the plan's favorable tax status.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		
Cafeteria Plan Nondiscrimination Testing	Cafeteria plans provide tax advantages to employees. Accordingly, a cafeteria plan must not discriminate in favor of - (1) Highly compensated individuals as to eligibility to participate (the Eligibility Test); (2) Highly compensated participants as to contributions and benefits (the Contributions and Benefits (C&B) Test); or (3) Key employees as to concentration of benefits (the Key Employee Concentration Test). Note that the cafeteria plan will not cease to be a valid Code Section 125 plan just because it is discriminatory. The term "highly compensated participant" means a participant who is - (1) An officer; (2) A shareholder owning more than 5 percent; (3) Highly compensated as determined by looking at the preceding plan year ($115,000 for 2014 and 2013, $120,000 for 2015); or (4) A spouse, parent, child or grandchild of an individual described above. The term "key employee" means a participant who, during the plan year, is - (1) An officer with annual compensation of $170,000 for 2014 and 2015; (2) More-than-5 percent owner; and (3) More-than-1 percent owner with compensation over $150,000. Simple cafeteria plan safe harbor is available for small employers.	Compliance requirements are ongoing, but nondiscrimination testing must be performed as of the last day of the plan year.	A highly compensated participant or key employee participating in a discriminatory cafeteria plan must include in gross income the value of the taxable benefit with the greatest value that the employee could have elected to receive, even if the employee elects to receive only the nontaxable benefits offered.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

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Cafeteria Plans *continued*

Item	Description	Due Date	Penalty	Employer Size
Health FSA Nondiscrimination Testing	Health FSAs are subject to nondiscrimination testing under both Section 125 Cafeteria Plan Nondiscrimination Testing and Section 105(h) Nondiscrimination Testing. Please check with your advisor to determine strategies to assist with passing this test.	Compliance requirements are ongoing, but nondiscrimination testing must be performed as of the last day of the plan year.	If the health FSA discriminates in favor of highly compensated individuals, then amounts considered to be "excess reimbursements" paid to them will be taxable.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		
DCAP Nondiscrimination Testing	A dependent care assistance program (DCAP) may not favor highly compensated employees (HCEs) and must satisfy four specific nondiscrimination tests: (1) Eligibility Test: A DCAP must not discriminate in favor of HCEs or their dependents as to eligibility to participate. (2) Contributions and Benefits Test: A DCAP must not discriminate in favor of HCEs or their dependents as to contributions and benefits received under the plan. (3) More-than-5 percent Owners Concentration Test: Not more-than-25 percent of the amounts paid or incurred by the employer for dependent care for a plan year may be provided to shareholders or owners (or their spouses or dependents) who own more-than-5 percent in the stock, capital or profits interest in the employer. (4) 55 percent Average Benefits Test: The average DCAP benefits provided to the non-HCEs under all plans of the employer must be at least 55 percent of the average benefits provided to HCEs under all plans of the employer. In general, HCEs for purposes of DCAP testing are employees whose compensation during the preceding plan year exceeded the HCE dollar threshold for that year or who were more-than-5 percent owners in the current or preceding plan year. For 2013 and 2014, the HCE dollar threshold is $115,000. For 2015 (used for 2016 testing), the HCE dollar threshold is $120,000.	Compliance requirements are ongoing. IRC Section 129 does not address when DCAP nondiscrimination testing must be performed. As a general rule, though, testing should be performed at each of the following times: • Before the beginning of the plan year (based on projected data). Such early testing is valuable because anticipated problems may be resolved with election or plan design changes. (It may be useful to perform the testing after open enrollment, to determine whether actual participation reflects projected participation.) • Several months before the end of the plan year (using year-to-date data, plus projections). At this point, the employer can take into account actual data for the year, including new hires, midyear election changes for change in status, terminations of employment, etc. If any testing problems appear at this point, the employer will still have time to make corrections before the end of the plan year. • After the close of the plan year. Final plan testing with year-end numbers should be documented and retained so that the employer can show, upon audit, that the plan passes the appropriate tests. • Before completing any business acquisition or reorganization.	The consequence of failing to meet the requirements of the discrimination tests outlined in this section is that the HCEs as defined in Code Section 414 (q) lose their exclusion for DCAP reimbursements.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

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Cafeteria Plans *continued*

Item	Description	Due Date	Penalty	Employer Size
Simple Cafeteria Plan Safe Harbor	Health care reform allows eligible small employers to establish a simple cafeteria plan in order to exempt the plan from certain nondiscrimination tests that are otherwise applicable. An employer eligible to establish a simple cafeteria plan is any employer that, during either of the two preceding years, employed an average of 100 or fewer employees. All employees with at least 1,000 hours of service must be eligible to participate, and employers must make certain employer contributions if they wish to elect this plan design.	Available for plan years beginning on or after Jan. 1, 2011. Employers must adopt the plan no later than the day before the first day the SIMPLE cafeteria plan will be offered. If an existing plan is being amended to provide for the simple plan design, they must amend the plan on a timely basis prior to the beginning of the plan year in which the SIMPLE plan will be offered.	No penalty; plan design will exempt plan from nondiscrimination rules for cafeteria plans, health flexible spending accounts (FSAs), dependent care assistance programs, and group term life insurance as long as contribution, eligibility and participation requirements are met.	100 or Less
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		
Health FSA Limit	Health care reform imposes a $2,500 limit on annual employee salary reduction contributions to health FSAs offered under cafeteria plans. Nonelective employer contributions to health FSAs are not included in this limit. Grandfathered exemptions do not apply to this requirement, so all health FSAs offered under cafeteria plans must comply. This limit is adjusted annually for inflation. For 2015, the limit increased to $2,550.	Effective for the first plan year following Jan. 1, 2013. Plan documents must be amended no later than Dec. 31, 2014, which means amendments may be effective retroactively.	Failure to operate in compliance with the plan document or the regulations can result in disqualification of the plan's favorable tax status. A cafeteria plan that erroneously allowed an employee to elect salary reductions in excess of the limit for a plan year will not fail to qualify as a cafeteria plan for that plan year if the following requirements are met: (1) The terms of the plan apply uniformly to all participants; (2) The error results from a reasonable mistake by the employer or its agent; and (3) Salary reductions in excess of the limit are paid to the employee and reported as wages for federal income tax withholding and employment tax purposes for the employee's taxable year in which, or with which, ends the cafeteria plan year that the correction is made.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

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COBRA

Item	Description	Due Date	Penalty	Employer Size
COBRA Initial Notice	COBRA applies to group health plans sponsored by employers with 20 or more employees in the previous calendar year. The Initial Notice provides general information on COBRA rights. The notice should include plan name, address and telephone number, a general description of continuation coverage under the plan, a description of qualifying event notice requirements and plan procedures. Also include a statement regarding contact information to obtain more complete information. On May 2, 2014, the DOL released a new version of the COBRA Initial Notice, which has been updated to reflect the Marketplace enrollment opportunity. Employers and administrators should ensure they are utilizing the most current version of the notice. The law is unclear on whether Indian Tribal plans are subject to COBRA. Such plans should seek legal counsel.	Must be distributed to new plan participants (and covered spouses, but not dependents) within 90 days of coverage start date.	Legal action may be brought by participants and an ERISA $110 per day fine may be assessed. If violation is not corrected within 30 days of discovery, then employer must self-report violation on IRS Form 8928 and a civil penalty of $100 per day would be assessed.	20+
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		
COBRA Election Notice	Notifies qualified beneficiaries of their right to continue coverage following a qualifying event. Should be written in plain language that the average participant can understand. Must include the plan name, administrator's contact information, qualifying event, coverage termination date, names of qualified beneficiaries (QBs), statement that each QB has an independent right to elect COBRA, election procedures, election deadline, consequences of not electing coverage, coverage description, and payment information. Also include a statement that the notice does not fully describe all QB's rights; more information can be obtained from the SPD. On May 2, 2014, the DOL released a new version of the COBRA Election Notice, which has been updated to reflect the Marketplace enrollment opportunity. Employers and administrators should ensure they are utilizing the most current version of the notice. The law is unclear on whether Indian Tribal plans are subject to COBRA. Such plans should seek legal counsel.	Employer has 30 days to notify plan administrator of qualifying event; plan administrator must distribute notice to covered employees, spouse and dependents within 14 days of employer notification. If employer and plan administrator are the same, there is a combined 44 days from the qualifying event in which the employer is required to provide notice. Longer periods may apply to the notice timeframe for multiple employer plans.	Legal action may be brought by participant and an ERISA $110 per day fine may be assessed. Additionally, employer may be held liable for any medical costs incurred by participant. If violation is not corrected within 30 days of discovery, then employer must self-report violation on IRS Form 8928, and a civil penalty of $100 per day will be assessed.	20+
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		
Notice of Unavailability of Continuation Coverage	Provides explanation as to why individual is not entitled to continuation coverage. Should be written in plain language that the average participant can understand. The law is unclear on whether Indian Tribal plans are subject to COBRA. Such plans should seek legal counsel.	The plan administrator must provide the notice of unavailability within the time period that would apply for providing the election notice. This deadline is generally 14 days after the plan administrator has received notice of a qualifying event. See COBRA Election Notice for more information.	Legal action may be brought by participant and an ERISA $110 per day fine may be assessed. If violation is not corrected within 30 days of discovery, then employer must self-report violation on IRS Form 8928 and a civil penalty of $100 per day will be assessed.	20+
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

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COBRA *continued*

Item	Description	Due Date	Penalty	Employer Size
Notice of Early Termination of COBRA Coverage	Notifies a qualified beneficiary that continuation coverage will terminate earlier than the maximum period. Should be written in plain language that the average participant can understand. Must include the early termination date, reason for early termination and explanation of any conversion rights. The law is unclear on whether Indian Tribal plans are subject to COBRA. Such plans should seek legal counsel.	Must be distributed to a qualified beneficiary as soon as practicable following the administrator's determination that continuation coverage will terminate.	Legal action may be brought by participants and an ERISA $110 per day fine may be assessed. If violation is not corrected within 30 days of discovery, then the employer must self-report a violation on IRS Form 8928 and pay a civil penalty of $100 per day.	20+
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

ERISA

Item	Description	Due Date	Penalty	Employer Size
Plan Documents	The written instruments under which a benefit plan is established or operated. The plan documents must: (1) Designate a named fiduciary and plan administrator; (2) Identify the plan year, plan name, and plan number; (3) Include a description of benefits and eligibility; (4) Describe how benefits will be funded; (5) Include plan amendment and termination procedures; (6) Add required provisions for group health plans (including COBRA, USERRA, HIPAA, QMCSOs); and (7) Include subrogation and reimbursement clauses.	Must be provided to participants and beneficiaries within 30 days of written request. When implementing a new plan, or amending an existing plan, most plan sponsors adopt or amend the plan prior to the first day of the plan year. The expected due dates have been pre-filled taking this into account. However, mid-year plan amendments are permitted when adopted prospectively, so due dates may be manually overridden.	Plan administrator could be subject to a penalty of up to $110 per day. Willful ERISA violations can carry up to 10 years in prison and $100,000 fine.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		
Summary Plan Description (SPD)	Advises participants and beneficiaries of their rights and obligations under the plan. Should be written in plain language so that the average participant can understand. Must include plan name, employer name, type of plan, type of administration, plan administrator name/address/telephone number, legal agent name/address, plan eligibility requirements, summary of benefits, claims procedures, and ERISA rights. If the plan has been amended, an updated SPD incorporating the subsequent SMMs must be prepared and distributed to plan participants every five years. If the plan has not been amended, an updated SPD must be prepared and distributed to plan participants every ten years. Model language for ERISA rights statement is provided.	Must be updated and provided to participants and beneficiaries within 90 days of participation, within 120 days of plan effective date, every five years (when the plan has been amended) and every 10 years (even when the plan has not been amended).	Plan sponsor could be subject to a penalty of up to $110 per day if it does not provide within 30 days after an individual's written request. Willful ERISA violations can carry up to 10 years in prison and a $100,000 fine for individuals and fines up to $500,000 for companies.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

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Compliance Checklist for Group Health Plans

ERISA *continued*

Item	Description	Due Date	Penalty	Employer Size
Summary of Material Modification (SMM)	Summarizes "any material modification to the plan and any change in the information required to be in the SPD." Should be written in plain language that the average participant can understand. Although there is not clear guidance on what constitutes a material modification, more information may be reviewed under Additional Resources below. Further, employers should err on the side of disclosure or consult with legal counsel.	Must be provided to participants and beneficiaries within 210 days of the end of the plan year in which the modification is adopted. Any SMMs that are not yet included in an SPD must be distributed along with the SPD until a revised SPD is distributed. Therefore, any outstanding SMMs must also meet the due date requirements of the SPD, which are listed above. If changes incorporated by the SMM also affect the content of the most recently distributed SBC, the plan may have an accelerated notification requirement under the SBC rules.	Plan sponsor could be subject to a penalty of up to $110 per day if it does not provide within 30 days after an individual's written request. Willful ERISA violations can carry up to 10 years in prison and a $100,000 fine for individuals and fines up to $500,000 for companies.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		
Summary of Material Reduction in Covered Services or Benefits	Summarizes any modification or change to covered services or benefits that would be considered by the average participant to be an important reduction, such as "eliminates or reduces benefits payable, increases amount to be paid by participant, reduces HMO service area, or creates new conditions or requirements for obtaining services or benefits."	Must be provided to participants and beneficiaries within 60 days of when change was adopted.	Plan sponsor could be subject to a penalty of up to $110 per day if it does not provide within 30 days after an individual's written request. Willful ERISA violations can carry up to 10 years in prison and a $100,000 fine for individuals and fines up to $500,000 for companies.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		
Form 5500	Applies to all health and welfare plans subject to ERISA. Serves as the annual reporting requirement under ERISA Title I. There is an exclusion for certain fringe benefit plans (group legal services, education assistance plans, adoption assistance programs) and health plans with less than 100 participants at the beginning of the plan year which are unfunded, fully insured, or a combination of unfunded and fully insured.	Must be submitted electronically (along with the necessary schedules) to the EBSA by the last day of the seventh month following the end of the plan year, or by the extension due date, if Form 5558 is filed.	Both administrative and criminal penalties apply. Administrative penalties range from $25 per day to $1,100 per day. Willful violations can carry penalties up to 10 years in prison and a $100,000 fine.	100 or more
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

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Compliance Checklist for Group Health Plans

ERISA *continued*

Item	Description	Due Date	Penalty	Employer Size
Form 5500-SF	Certain small welfare benefit plans may file a simplified annual reporting form in lieu of a Form 5500. In order to be eligible for the simplified filing, plans must be considered small (i.e., generally have fewer than 100 participants at the beginning of the plan year), meet the conditions for being exempt from providing an accountant's report, have 100 percent of assets invested in certain secure investments, hold no employer securities, and not be a multi-employer plan.	Electronically submitted along with the Form 5500 to the EBSA by the last day of the seventh month following the end of the plan year or by the extension due date, if Form 5558 is filed.	Both administrative and criminal penalties apply. Administrative penalties range from $25 per day to $1,100 per day. Willful violations can carry penalties up to 10 years in prison and a $100,000 fine.	Less than 100
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		
Accountant's Report	Applies to health plans with 100 or more participants. There is an exclusion for plans which are unfunded, insured or a combination of the two that meet the requirements of DOL Reg. Section 2520.104-44.	Submitted electronically along with the Form 5500 to the EBSA by the last day of the seventh month following the end of the plan year, or by the extension due date if Form 5558 is filed.	Both administrative and criminal penalties apply. Administrative penalties range from $25 per day to $1,100 per day. Willful violations can carry penalties up to 10 years in prison and a $100,000 fine.	100 or more
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		
Summary Annual Report (SAR)	Summarizes the Form 5500 financial information in a narrative form. The model language from DOL Reg. Section 2520.104b-10(d) has been provided as a model notice. Unfunded welfare plans, regardless of size are exempt from the SAR requirement.	Must be distributed to participants and beneficiaries within nine months after the end of the plan year. If extension is filed, must be distributed within two months after the end of the period for which the extension was granted.	No specific civil penalties, but willful ERISA violations can carry criminal penalties up to 10 years in prison and $100,000 fine.	100 or more
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

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Compliance Checklist for Group Health Plans

ERISA *continued*

Item	Description	Due Date	Penalty	Employer Size
Summary of Benefits and Coverage (SBC)	Group health plans are required to provide a Summary of Benefits and Coverage (SBC) that accurately describes the benefits and coverage under the applicable plan or coverage to all applicants and enrollees. The summary may be provided in paper or electronic form and must include certain required content. A template has been provided by HHS, along with instructions, language for the section in the template labeled "Why That Matters," coverage examples and a tool for calculating cost for the coverage examples. The Uniform Glossary is also required to be provided upon request. Guidance released on Feb. 14, 2012 relating to the SBC, clarified that the same rules relating to the "culturally and linguistically appropriate manner," that apply to the claims and appeals notices also apply to the SBC requirement, so the two rules remain consistent. The regulations regarding this requirement look to whether 10 percent or more of the population residing in a county is literate only in the same non-English language (based on U.S. Census data) and imposes certain requirements when a plan or insurer sends a notice to an address in a county that meets the 10 percent threshold. The Culturally and Linguistically County Data may be reviewed by following the link below. Significantly, the SBC requirement applies to all plans, regardless of grandfathered status or plan size.	The SBC should be distributed to existing employees with the open enrollment materials, prior to the beginning of the plan year. New hires should receive the SBC with application materials, prior to the first day of coverage. For participants and beneficiaries who enroll in group health plan coverage outside of open enrollment (i.e., special enrollees), the SBC must be provided within 90 days of enrollment. A revised SBC must be distributed to participants 60 days prior to the effective date of any change to the information found in the SBC. The SBC must also be provided to a participant or beneficiary upon request, as soon as practicable, but in no event later than seven business days following the request. A revised SBC, provided in a timely manner and notifying eligible participants of any changes, will also satisfy the requirement to provide an SMM or notice of material reduction.	A penalty of up to $1,000 per failure. The fine cannot be paid from plan or trust assets. Church plans are subject to different penalties and procedures for noncompliance.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

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Compliance Checklist for Group Health Plans

ERISA *continued*

Item	Description	Due Date	Penalty	Employer Size
Fidelity Bond	Plan officials who handle plan funds or other plan property generally must be covered by a fidelity bond. A fidelity bond is a type of insurance that protects the plan against loss by reason of acts of fraud or dishonesty on the part of persons covered by the bond. A plan official must be bonded for at least 10 percent of the amount of funds he or she handles, subject to a minimum bond amount of $1,000 per plan with respect to which the plan official has handling functions. In most instances, the maximum bond amount that can be required under ERISA with respect to any one plan official is $500,000 per plan. Employers with insured plans usually are not subject to the bonding requirements for those plans. No bonding is required when premiums or other payments made to purchase benefits are paid directly from the employer's general assets to the insurance carrier. Unfunded plans are exempt from ERISA bonding requirements, and a self-insured plan is considered unfunded if the company pays the health claims directly out of the employer's general assets. If there is any segregation of the employer and employee contributions to a trust or another account in the name of the plan, then the plan is funded and subject to the ERISA bonding requirement.	There are no notices for this requirement, although the existence of a Fidelity Bond is reported on Form 5500. The bond should be maintained on an ongoing basis.	A plan's fiduciaries can be held personally liable under ERISA's general fiduciary duty rules for any loss to the plan that should have been but was not covered by a bond. Willful ERISA violations can also carry up to 10 years in prison and a $100,000 fine.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

FMLA

Item	Description	Due Date	Penalty	Employer Size
General Notice	The FMLA applies to private-sector employers with 50 or more employees for each working day in 20 or more workweeks in the current or preceding calendar year. However, FMLA applies to governmental employers of all sizes. Every employer covered by the FMLA is required to provide a notice explaining the FMLA and providing information about the procedures for filing complaints of violations of the FMLA with the Wage and Hour Division of the DOL. Electronic posting is sufficient to meet this posting requirement as long as it otherwise meets the requirements. If an employer's workforce is comprised of a significant portion of workers who are not literate in English, the employer must provide the general notice in a language in which the employees are literate. Final FMLA regulations effective March 8, 2013 require a review of an employer's policies and procedures to incorporate the changes to the law. In conjunction with the final rule, the DOL provided a revised General Notice. Employers must ensure they have posted the newest General Notice by March 8, 2013.	Employers must keep the notice posted on its premises at all times. The most recent model notice is effective March 8, 2013. Employers with FMLA-eligible employees must include the notice in employee handbooks or other written guidance on employee benefits or leave rights or must distribute a copy of the general notice to each new employee upon hiring.	An employer may be liable for compensation and benefits lost by reason of the violation, for other actual monetary losses sustained as a direct result of the violation, and for appropriate equitable relief, including employment, reinstatement, promotion or any other relief.	50 or more
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

continues >

FMLA *continued*

Item	Description	Due Date	Penalty	Employer Size
Eligibility Notice	The employer must notify the employee of the employee's eligibility to take FMLA leave. If the employee is not eligible for FMLA leave, the notice must state at least one reason why the employee is not eligible (e.g., the number of months the employee has been employed by the employer, the number of hours of service worked for the employer during the 12-month period, and whether the employee is employed at a worksite where 50 or more employees are employed by the employer within 75 miles of that worksite). Notification of eligibility may be oral or in writing. Final FMLA regulations effective March 8, 2013 require a review of an employer's policies and procedures to incorporate the changes to the law. When an employer acquires knowledge that an employee's leave may be for FMLA, an employer must ensure the most recent changes (and reasons for leave) under the law are taken into consideration. On June 20, 2014, the DOL announced a proposed rule extending the protections of FMLA to all eligible employees in legal same-sex marriages, regardless of where they reside. This rule, if adopted, would require employers in all states to provide leave to legally married same-sex spouses even if the state of the employee's residence or the state of the employer's business does not recognize same-sex marriage, ensuring consistent FMLA rights across the nation no matter where an employee may reside. Since the rule is only in proposed format and cannot yet be relied upon, employers should be prepared to revise and deploy internal policies and procedures upon finalization of the definition; however, employers are not yet required to use the amended definition of "spouse."	The notice must be provided within five business days (absent extenuating circumstances) of when an employee requests FMLA leave, or when the employer acquires knowledge that an employee's leave may be for an FMLA-qualifying reason.	An employer may be liable for compensation and benefits lost by reason of the violation, for other actual monetary losses sustained as a direct result of the violation, and for appropriate equitable relief, including employment, reinstatement, promotion or any other relief.	50 or more
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

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FMLA *continued*

Item	Description	Due Date	Penalty	Employer Size
Rights and Responsibilities Notice	Employers must provide written notice detailing the specific expectations and obligations of the employee related to FMLA leave and consequences of failure to meet these obligations, including: (1) The leave may be counted against the employee's annual FMLA leave entitlement; (2) Any requirement to furnish certification of a serious health condition, etc., and the consequences of failing to do so; (3) Employee's right to substitute paid leave, whether employer will require such, and the conditions related to substitution; (4) Requirement to make premium payments to maintain benefits, how to make such payments and the consequences of failure to make timely payments; (5) Employee's status as a "key employee" and that restoration may be denied following FMLA leave and conditions for such denial; (6) Employee's rights to maintain benefits during FMLA leave and restoration to the same or an equivalent job upon return; and (7) Employee's potential liability for payment of premiums paid by the employer during FMLA leave if the employee fails to return to work. Final FMLA regulations effective March 8, 2013 require a review of an employer's policies and procedures to incorporate the changes to the law and may expand the rights of an employee entitled to leave.	This notice shall be provided to the employee each time the Eligibility Notice is provided. If leave has already begun, the notice should be mailed to the employee's address of record. Additional requirements if the information provided by this notice changes.	An employer may be liable for compensation and benefits lost by reason of the violation, for other actual monetary losses sustained as a direct result of the violation, and for appropriate equitable relief, including employment, reinstatement, promotion or any other relief.	50 or more
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		
Designation Notice	The employer must notify the employee whether the employee's leave will be designated and will be counted as FMLA leave. If the employer will require the employee to present a fitness-for-duty certification to be restored to employment, the employer must provide notice of such requirement with the designation notice. Final FMLA regulations effective March 8, 2013 require a review of an employer's policies and procedures to incorporate the changes to the law. When designating leave as FMLA, an employer must ensure the most recent changes are taken into consideration. On June 20, 2014, the DOL announced a proposed rule extending the protections of FMLA to all eligible employees in legal same-sex marriages, regardless of where they reside. This rule, if adopted, would require employers in all states to provide leave to legally married same-sex spouses even if the state of the employee's residence or the state of the employer's business does not recognize same-sex marriage, ensuring consistent FMLA rights across the nation no matter where an employee may reside. Since the rule is only in proposed format and cannot yet be relied upon, employers should be prepared to revise and deploy internal policies and procedures upon finalization of the definition; however, employers are not yet required to use the amended definition of "spouse."	Within 5 days of when the employer has enough information to determine whether the leave is being taken for an FMLA-qualifying reason (e.g., after receiving a certification).	An employer may be liable for compensation and benefits lost by reason of the violation, for other actual monetary losses sustained as a direct result of the violation and for appropriate equitable relief, including employment, reinstatement, promotion or any other relief.	50 or more
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

continues >

Compliance Checklist for Group Health Plans

FMLA *continued*

Item	Description	Due Date	Penalty	Employer Size
Notice of Opportunity to Change Health Plans	If an employer provides a new health plan, has open enrollment or changes health benefits or plans while an employee is on FMLA leave, then the employee is entitled to the new or changed plans/benefits to the same extent as if the employee were not on leave.	Notice of an opportunity to change health plans or benefits must be given to an employee on FMLA leave when given to active employees. Therefore, the due date is ongoing and typically occurs around an employer's open enrollment season.	An employer may be liable for compensation and benefits lost by reason of the violation, for other actual monetary losses sustained as a direct result of the violation and for appropriate equitable relief, including employment, reinstatement, promotion or any other relief.	50 or more
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		
Notice of Nonpayment of Premiums	In the absence of an established employer policy providing a longer grace period, an employer's obligation to maintain the health insurance coverage of an employee on FMLA leave also ceases if the employee's payment of his or her share of the premium is more than 30 days late.	The notice must be mailed to the employee at least 15 days before coverage is to cease and must advise the employee that coverage will be dropped on a specified date at least 15 days after the date of the letter, unless the payment has been received by that specified date.	An employer may be liable for compensation and benefits lost by reason of the violation, for other actual monetary losses sustained as a direct result of the violation and for appropriate equitable relief, including employment, reinstatement, promotion or any other relief.	50 or more
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

Health Care Reform

Item	Description	Due Date	Penalty	Employer Size
Grandfathered Health Plans	To maintain grandfathered status, a plan must provide notice to participants that the plan or coverage is believed to be a grandfathered plan, and provide contact information for questions or complaints. This disclosure requirement applies to any SPD, SMM or benefit enrollment materials provided to participants or beneficiaries. To maintain status as a grandfathered health plan, the plan or coverage must also document the terms in existence on March 23, 2010 (e.g., plan documents, policies, certificate or contracts of insurance, SPDs, etc.), and retain documentation as long as the plan maintains grandfathered status.	If grandfathered, provide notice in any plan materials describing benefits beginning with the first plan year on or after Sept. 23, 2010. Make records available for examination upon request.	Loss of grandfathered status will result in additional responsibilities under health care reform.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

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Health Care Reform *continued*

Item	Description	Due Date	Penalty	Employer Size
Prohibition on Stand-alone HRA's	Group health plans are prohibited from placing certain annual dollar limits on the value of essential health benefits. Annual dollar limits on essential health benefits are completely prohibited for plan years beginning on or after Jan. 1, 2014. Due to this requirement, stand-alone HRAs are essentially prohibited going forward. HRAs must either be integrated or designed to be an excepted benefit, including a retiree-only HRA or limited purpose dental/vision plan.	Stand-alone HRAs are prohibited for plan years beginning on or after Jan. 1, 2014.	If violation is not corrected within 30 days of discovery, then employer must self-report violation on IRS Form 8928, and pay a civil penalty of $100 per day. Church plans are subject to different penalties and procedures for noncompliance. Governmental plans are exempt from $100 per day penalty under Section 4980D.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		
Dependent Coverage	If a group health plan or insurer provides dependent coverage of children, the plan must make such coverage available until a child turns 26, regardless of student status, marital status, residency, etc. Effective in 2014, the special transition rule for grandfathered plans that eliminates required coverage if child has other employer-sponsored coverage is no longer in effect. Thus, all plans (including grandfathered plans) can no longer take into account other employer-sponsored coverage. A plan amendment or plan restatement revising the definition of dependent to comply with this requirement is required. Grandfathered plans must amend the plan to remove the transition rule if applicable. State insurance laws may be more generous and require coverage of adult children past the age of 26. Michelle's Law - Michelle's Law requires that a group health plan or issuer not terminate coverage of a dependent child due to a medically necessary leave of absence that causes the child to lose student status. Although this law has become less necessary due to the dependent coverage up to 26 mandate under PPACA, Michelle's law will still apply if a plan covers dependents that are not "children" under the IRS definition or if a state law requires coverage for dependents older than 26.	Effective for plan years beginning on or after Sept. 23, 2010. In 2014, grandfathered plans must remove the transition rule from the plan excluding coverage for those with other coverage available.	If violation is not corrected within 30 days of discovery, then employer must self-report violation on IRS Form 8928, and a civil penalty of $100 per day will be assessed. Church plans are subject to different penalties and procedures for noncompliance. Governmental plans are exempt from the $100 per day penalty under Section 4980D.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

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Health Care Reform *continued*

Item	Description	Due Date	Penalty	Employer Size
Internal Claims and Appeals and External Review Procedures	Internal Appeals - In addition to the claims procedure rules under 29 CFR 2560.503-1, group health plans and insurance issuers must now meet these additional internal appeals requirements: (1) The scope of adverse benefit determinations must include rescissions of coverage. (2) Plans or issuers must provide claimants with any new or additional evidence considered, relied upon, or generated by the plan or issuer in connection with a claim. (3) Plans or issuers must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. (4) Plans or issuers must defer to the attending provider as to whether a claim involves urgent care and must provide notices concerning urgent care as soon as possible (no later than 72 hours). (5) Any notice of adverse benefits must include information sufficient to identify the claim involved; an adequate description of the reasons for the determination; a description of available internal appeals and external review processes; and contact information for any health insurance consumer assistance ombudsmen established under PSA Section 2793 (List of Consumer Assistance Programs below). (6) Any notice of adverse benefits must be provided in a culturally and linguistically appropriate manner. This is required if at least 10 percent of people living in the county speak the same non-English language. (List of counties below) If a plan fails to comply with these requirements, the claimant is deemed to have exhausted the internal claims and appeals process. External Review - Plans and issuers must comply with either a State external review process or the Federal external review process. Under the DOL Private Accredited Independent Review Organization (IRO) process, self-funded plans must comply with all of the standards articulated in TR 2011-02. Additionally, to be eligible for a safe harbor from enforcement on external review, self-funded plans will be required to contract with at least two IROs by Jan. 1, 2012 and at least three IROs by July 1, 2012. Grandfathered plans are exempt from the internal claims and appeals and external review requirements.	Due date is ongoing for all non-grandfathered plans.	If violation is not corrected within 30 days of discovery, then employer must self-report violation on IRS Form 8928, and a civil penalty of $100 per day will be assessed. Church plans are subject to different penalties and procedures for noncompliance. Governmental plans are exempt from the $100 per day penalty under Section 4980D.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

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Health Care Reform *continued*

Item	Description	Due Date	Penalty	Employer Size
Annual and Lifetime Dollar Limits	Lifetime dollar limits on essential benefits were prohibited under PPACA effective for plan years beginning with Sept. 23, 2010, and thereafter. Individuals who have exhausted a lifetime limit under a group health plan and who are otherwise eligible must be given a written notice that the lifetime limit no longer applies. If individuals who exhausted a lifetime dollar limit are no longer enrolled, they must be provided a written notice informing them of an opportunity to enroll. Similarly, group health plans are prohibited from placing certain annual dollar limits on the value of essential health benefits. Annual dollar limits on essential health benefits were completely prohibited for plan years beginning on or after Jan. 1, 2014.	Eligible individuals must be given a written notice that the lifetime limit no longer applies. Individuals no longer enrolled due to exhaustion of the lifetime limit should have been provided a 30-day special enrollment opportunity in the first plan year beginning on or after Sept. 23, 2010. This was a one-time enrollment opportunity. Specific information regarding annual limits on essential health benefits should be included in plan documents. A plan amendment is required prior to the first day of each new plan year during increases of limits each year. Subsequent SMM or revised SPD should be provided to plan participants upon amending the plan.	If violation is not corrected within 30 days of discovery, then employer must self-report violation on IRS Form 8928, and a civil penalty of $100 per day will be assessed. Church plans are subject to different penalties and procedures for noncompliance. Governmental plans are exempt from the $100 per day penalty under Section 4980D.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		
OTC Medicines or Drugs	PPACA prohibits distributions from HSAs and Archer MSAs and reimbursements from health FSAs and HRAs to cover expenses for over-the-counter (OTC) medicines or drugs without a prescription (except insulin). The restrictions do not apply to non-medicine items available OTC (e.g., equipment, supplies, and medical devices).	Applies to expenses incurred after Dec. 31, 2010.	Failure to abide by requirements may result in severe tax consequences for plan and individuals receiving reimbursements.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

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Health Care Reform *continued*

Item	Description	Due Date	Penalty	Employer Size
Patient Protections	If a group health plan provides benefits for emergency services, the plan may not require preauthorization; must provide coverage regardless of whether the provider is in- or out-of-network; may not impose any administrative requirement or coverage limitation that is more restrictive than would be imposed on in-network emergency services; and must comply with certain cost-sharing requirements. The plan may apply cost-sharing requirements other than copayments and coinsurance to emergency services provided out-of-network if the cost-sharing generally applies to out-of-network benefits. A group health plan may not require preauthorization or referral by the plan or a primary care physician to obtain services from an OB/GYN or pediatrician. Group health plans that require designation of a primary care provider must provide a notice to each plan participant describing the plan's requirements regarding designation of a primary care provider and certain other rights of the participant or beneficiary. Grandfathered plans are exempt from this requirement.	Effective for plan years beginning on or after Sept. 23, 2010. The notice is required to be provided whenever an SPD or other description of plan benefits is provided to a participant or beneficiary.	If violation is not corrected within 30 days of discovery, then employer must self-report violation on IRS Form 8928, and a civil penalty of $100 per day will be assessed. Church plans are subject to different penalties and procedures for noncompliance. Governmental plans are exempt from the $100 per day penalty under Section 4980D.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		
Preventive Care Mandate	Group health plans must provide certain preventive services without imposing any cost-sharing, including copays, coinsurance or deductibles. Coverage must be provided for: (1) Evidence-based items or services with an A or B rating recommended by the U.S. Preventive Services Task Force (USPSTF); (2) Immunizations for routine use in children, adolescents or adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; (3) Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children and adolescents; and (4) Other evidence-informed preventive care and screenings for women provided for in comprehensive guidelines supported by HRSA. The current list of required preventive services is available at www.healthcare.gov/center/regulations/prevention.html. It will be updated on an ongoing basis as the various agencies submit recommendations and those recommendations are approved. There are approximately nine (9) new recommendations for plan years beginning Jan. 1, 2015. Grandfathered plans are exempt from this requirement.	Preventive services at no cost sharing were effective for plan years beginning on or after Sept. 23, 2010. However, recommendations from the various agencies may have staggered effective dates. The recommendations from the USPSTF are considered issued on the last day of the month on which the task force publishes it.	If violation is not corrected within 30 days of discovery, then employer must self-report violation on IRS Form 8928, and a civil penalty of $100 per day will be assessed. Governmental plans are exempt from the $100 per day penalty under Section 4980D.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

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Health Care Reform *continued*

Item	Description	Due Date	Penalty	Employer Size
Pre-existing Condition Exclusion Prohibition	Group health plans may not include any pre-existing condition exclusions for any person, for plan years beginning on or after Jan. 1, 2014. ERISA plan documents must be amended to reflect a plan design change. ERISA requires either the SPD be revised to reflect plan changes or plans must append an SMM to the existing SPD. Additionally, the General Notice of Pre-existing Condition Exclusion is no longer necessary for plans to include.	Effective for plan years beginning on or after Jan. 1, 2014.	If violation is not corrected within 30 days of discovery, then employer must self-report violation on IRS Form 8928, and a civil penalty of $100 per day will be assessed. Church plans are subject to different penalties and procedures for noncompliance. Governmental plans are exempt from the $100 per day penalty under Section 4980D.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		
Rescission of Coverage	Group health plans and insurers are prohibited from rescinding coverage for individuals who are covered under the plan, except in cases of fraud or intentional misrepresentation. "Rescission" is defined as a cancellation or discontinuance of coverage that has retroactive effect. A rescission of coverage triggers the requirement to provide a notice of adverse benefit determination (see the section on Internal and External Appeals for more details on this requirement).	Effective for plan years beginning on or after Sept. 23, 2010. Thirty days' advance written notice is required before coverage may be rescinded.	If violation is not corrected within 30 days of discovery, then employer must self-report violation on IRS Form 8928, and a civil penalty of $100 per day will be assessed. Church plans are subject to different penalties and procedures for noncompliance. Governmental plans are exempt from the $100 per day penalty under Section 4980D.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		
Patient-centered Outcomes Research (PCOR) Institute Fee	Health care reform requires PCOR fees to be paid to the IRS by health insurers and sponsors of self-insured health plans (including health FSA and HRAs) to fund research into the clinical effectiveness of medical treatments, procedures, drugs and other strategies. The fees will fund a new nonprofit corporation called the Patient-centered Outcomes Research (PCOR) Institute. The fee is reported and paid by filing IRS Form 720.	The PCOR fee applies to plan years ending after Oct. 1, 2012, and before Oct. 1, 2019. The fee is $1 per covered life for plan years ending before Oct. 1, 2013, and $2 per covered life for plan years ending after Oct. 1, 2013 and before Oct. 1, 2014. Notice 2014-56, released on Sept. 18, 2014, sets the PCOR contribution at $2.08 for plan years that end on or after Oct. 1, 2014 and before Oct. 1, 2015. For plan years ending on or after Oct. 1, 2015, the adjusted applicable dollar amount will be published in future Internal Revenue Bulletins.	The fees are expected to be assessed, collected and enforced in the same manner as taxes under other IRC provisions.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

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Health Care Reform *continued*

Item	Description	Due Date	Penalty	Employer Size
Notice of Exchange	All employers subject to the Fair Labor Standards Act (FLSA)- and regardless of whether they offer a group health plan- must provide information relating to health insurance exchanges, which will include information about the consequences of purchasing a qualified health plan through the exchange in lieu of employer-sponsored coverage. The DOL provided two model exchange notices, each is available in English and Spanish, as well as in PDF format or in modifiable Word format. One notice is used for employers that do not offer a health plan and the other is used for employers that offer a health plan to some or all of their employees. Employers may use one of these model notices, as applicable, or a modified version, provided the notice meets the content requirements. The notice may be mailed via first class or distributed electronically in accordance with the DOL's electronic disclosure requirements. Hand delivery, provided the employer can ensure all employees receive the notice, has been informally approved through discussions with the DOL.	Employers are required to provide the notice to each new employee at the time of hiring beginning Oct. 1, 2013. For 2014, the DOL will consider a notice to be provided at the time of hiring if the notice is provided within 14 days of an employee's start date. With respect to employees who are current employees before Oct. 1, 2013, employers were required to provide the notice no later than Oct. 1, 2013. The notice is required to be provided automatically, free of charge.	The regulations do not identify a specific penalty for failing to comply with the notice requirement. The DOL clarified in a Sept. 2013 FAQ posted on the DOL website that no penalty applies for failure to distribute the notice. However, the DOL or plan participants may bring a civil action against an employer for failure to comply.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		
Form W-2 Reporting Requirement	Employers must report the "aggregate cost" of "applicable employer-sponsored coverage" on an employee's Form W-2. The aggregate cost includes amounts paid by both employers and employees, including all contributions for the employee's spouse and dependents, and all amounts reported as income as a result of coverage (including the cost of coverage for an adult dependent over age 26 or for a domestic partner). Applicable employer-sponsored coverage includes any group health plan coverage such as major medical, dental, vision, executive medical plans and employee assistance programs, as well as contributions by an employer to a health FSA. Applicable employer-sponsored coverage does not include: (1) Contributions by an employee to a health FSA through salary reductions; (2) Contributions to an HSA or Archer MSA; (3) Coverage under an HRA; (4) Non-coordinated coverage for a specific illness or disease; (5) Coverage under a HIPAA-excepted benefit, including stand-alone dental or vision plans (but not on-site medical clinics); (6) Coverage for long-term care; (7) Multiemployer plans; (8) Self-insured group health plans not subject to COBRA (e.g., plans sponsored by church organizations); and (9) Coverage provided under a government plan that provides coverage primarily for members of the military and their families. Self-insured church plans are exempt.	Large employers, defined as those that file 250 Forms W-2 or more, must begin reporting on Forms W-2 issued in Jan. 2013 for the 2012 tax year. It is optional for small employers, defined as those that file fewer than 250 Forms W-2, to begin reporting at this same time. There is currently a transition rule in place for these small employers that will not require them to report the cost of health coverage until further guidance is issued.	Failure to properly report the cost of employer-sponsored health coverage on Form W-2 may result in penalties of $200 per Form W-2, up to a maximum of $3 million. Church plans are subject to different penalties and procedures for noncompliance. Governmental plans are exempt from the $100 per day penalty under Section 4980D.	250+
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

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Health Care Reform *continued*

Item	Description	Due Date	Penalty	Employer Size
Reinsurance Fee	Beginning in 2014, each state that operates an exchange is required to establish a temporary reinsurance program for the individual market, to which health insurers and group health plans are required to contribute. The program is temporary in nature, phasing out after 2016. The reinsurance program shifts the risk of covering high expenses from the primary insurer to a reinsurer. For the first year of the program, the fee will be $63 per covered life, per year, payable annually. The fee decreases to $44 per covered life in 2015, and $27 in 2016. Self-funded, self-administered plans are exempt from this fee in 2015 and 2016. Also, expatriate plans (both self- and fully insured) are exempt from the reinsurance fee for benefit years 2015 and 2016.	The fee is payable in two installments. The reinsurance component of the fee will be due at the beginning of the calendar year following the year for which the fee is due. The remainder of the fee will be due at the end of the calendar year following the year for which the fee is due. In practical terms, this means that for the 2015 benefit year, the payment may be split into two payments with $33 due by Jan. 15, 2016 and $11 due Nov. 15, 2016. For the 2016 benefit year, the payment may be split into two payments with $21.60 due by Jan. 15, 2017 and $5.40 due Nov. 15, 2017.	Failure to comply will potentially trigger an excise tax of $100 per day for each individual for whom the failure applies, if the failure is not corrected within 30 days of knowledge. The tax would be self-reported on Form 8928.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		
Health Insurance Tax (HIT)	Health care reform implemented the Health Insurance Tax (HIT) to help fund the cost of PPACA implementation and exchanges. This fee applies to any "covered entity" engaged in the business of providing health insurance with respect to U.S. citizens, residents and certain other persons present in the US. Put simply, this fee only applies to insurers, and the regulations specifically exclude self-insured plans. The HIT is meant to collect a specified amount of money per year - in 2014, the HIT must collect $8 billion. For 2015 and 2016 the amount is $11.3 billion, for 2017 the amount is $13.9 billion and for 2018 the amount is $14.3 billion. In 2019 and beyond, the amount will be adjusted for the rate of premium growth. The aggregate annual fee for insurers is apportioned among the various insurers based on a ratio designed to reflect market share of U.S. health insurance business, looking at the ratio of the insurer's net premiums to the aggregate net premiums of all insurers for the preceding calendar year.	The annual fee is payable by the insurer by the annual due date outlined by the Secretary of the Treasury, but in no event later than September 30th of each calendar year in which a fee must be paid. The first fee, for the 2014 calendar year is due by Sept. 30, 2015.	While this requirement applies to insurers and not employers, the penalty on a covered entity (insurer) for a failure to report by the due date is $10,000 plus the lesser of (i) an amount equal to $1,000 times the number of days during which the failure continues, or (ii) the amount of the fee for which the report was required. The fee must be paid on notice and demand in the same manner as a tax under the IRS Code. There is also an accuracy-related penalty that may be assessed for underreporting.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

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Health Care Reform *continued*

Item	Description	Due Date	Penalty	Employer Size
90-day Waiting Periods	Group health plans and insurers are prohibited from applying excessive waiting periods- defined as a waiting period that exceeds 90 days. There is no size restriction on this requirement and therefore, the prohibition applies to all group health plans and insurers, regardless of the size of the employer or plan sponsor. Employers may require that an individual complete a bona-fide orientation period before becoming eligible for coverage. The orientation period may be a maximum period of one month, after which the 90-day waiting period would begin. The purpose of the waiting period is for the employer and employee to evaluate whether the employment situation is satisfactory for each party and for orientation and training processes to take place. Note, however, that a large employer would be at risk for a penalty under the employer mandate if it imposed a 30-day orientation and a 90-day waiting period on an employee who works more than 30 hours. State law may impose a more limited waiting period requirement.	This requirement is effective for plan years beginning on or after Jan. 1, 2014. Importantly, with respect to individuals who are in a waiting period for coverage when the requirement goes into effect, the waiting period can no longer apply to the individual if it would exceed 90 days. For example, if a plan year is effective June 1, 2014, and an individual is on the 85th day of a waiting period at that point, the employer must permit the employee to become eligible for the plan on the 91st day. All calendar days must be counted, including weekends and holidays.	Failure to comply will potentially trigger an excise tax of $100 per day for each individual for whom the failure applies, if the failure is not corrected within 30 days of knowledge. The tax would be self-reported on Form 8928.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

continues >

Health Care Reform *continued*

Item	Description	Due Date	Penalty	Employer Size
Women's Preventive Care Services	Non-grandfathered group health plans must provide coverage for certain women's preventive care services including contraceptive methods, well-women visits, screening for gestational diabetes and human papillomavirus testing. The requirement is part of the preventive services mandate, which requires coverage with no cost sharing to the participant. Religiously affiliated nonprofit employers, such as schools or hospitals, which do not meet the definition of a church, may qualify for a delay related to providing coverage for contraceptive services. As a result of the U.S. Supreme Court decision in Burwell v. Hobby Lobby Stores, on Aug. 22, 2014, HHS, the DOL and EBSA jointly released guidance incorporating the Supreme Court's decision into existing regulations. The guidance includes an interim final rule, a new proposed rule applicable to closely held for-profit entities and a new model notice. The current regulations already provided for an accommodation process (using a self-certification form, EBSA Form 700) with respect to the requirement to offer contraceptive coverage for non-grandfathered employer-sponsored group health plans at zero cost sharing for those plans established and maintained by certain nonprofit religious employers, as well as those who are religious-based institutions of higher education. The interim final rule essentially allows for an alternative pathway so that participants may still access coverage for the full range of FDA-approved contraceptives, as prescribed by a health care provider, without cost sharing. The nonprofit religious employer will provide notice to HHS of their religious objection, and then HHS and the DOL will notify insurers and TPAs so that enrollees may receive separate coverage for contraceptive services with no additional cost to the enrollee or employer. HHS also provided a model notice to be used by "eligible organizations" to notify HHS of a religious objection to cover: 1) all contraceptive services, or 2) a subset of contraceptive services. The notice may also, but is not required to, be used by an eligible organization to provide updated information to HHS. Finally, the agencies also issued a proposed rule soliciting comments on how they might extend the same accommodations outlined above to closely held, for-profit entities (like Hobby Lobby). Under the proposed rule, the definition of "eligible organization" would be expanded to include closely held for-profit entities that have a religious objection to providing coverage for some or all of the contraceptive services otherwise required to be covered. In the meantime, such employers can use either EBSA Form 700 or the model notice described above to notify their insurers and TPAs of their intent to decline offering all, or some, contraceptive coverage. Employers who do not wish to cover 1) contraceptive services, or 2) a subset of contraceptive services should work with legal counsel to ensure compliance with these intense requirements. A list of required covered services is available at www.hrsa.gov/womensguidelines	Effective for plan years beginning on or after Aug. 1, 2012. For certain religiously affiliated nonprofit employers, effective for plan years beginning on or after Jan. 1, 2014.	If violation is not corrected within 30 days of discovery, then employer must self-report violation on IRS Form 8928, and a civil penalty of $100 per day will be assessed. Governmental plans are exempt from the $100 per day penalty under Section 4980D.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

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Health Care Reform *continued*

Item	Description	Due Date	Penalty	Employer Size
Maximum Out-of-pocket (MOOP) Limit	For plan years beginning on or after Jan. 1, 2014, non-grandfathered plans could not have a maximum out-of-pocket (MOOP) that exceeds $6,350 for self-only coverage and $12,700 for family coverage (which is anything other than self-only coverage). These were the same limits that applied to qualifying HDHP plans. For plan years beginning on or after Jan. 1, 2015, the limits no longer match qualifying HDHP plans because the MOOP limit is now tied to the "premium adjustment percentage"- the average annual change in health insurance premiums. This means that the PPACA MOOP are $6,600 for self-only coverage and $13,200 for family coverage. The HDHP limits for 2015 plan years are $6,450 and $12,900 for self-only and family coverage, respectively. Importantly, non-grandfathered plans that set the MOOP limit in accordance with PPACA may end up disqualifying participants from establishing and contributing to an HSA. For this reason, there have been informal comments stating that setting the MOOP at the lower amount will allow participants to retain HSA eligibility. Complicating this further, the MOOP maximum limits only apply to essential health benefits provided in-network, while the HDHP limits generally include all covered benefits payable under the terms of the plan.	Due for plan years beginning on or after Jan. 1, 2014 and on an ongoing basis. Does not apply to grandfathered plans.	There is no specific penalty for noncompliance. However, the general PPACA penalty would likely apply: $100 per day per individual.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		
Coverage for Clinical Trials	Group health plans and insurers may not deny qualified individuals coverage for participating in a clinical trial, deny coverage for any related service or items, or discriminate against the individual for such participation. A "qualified individual" is one who has been approved to participate in a clinical trial for the treatment of cancer or other life-threatening condition and who provides either physician or scientific recommendation for such participation.	The clinical trial coverage requirements apply for plan years beginning on or after Jan. 1, 2014.	There does not appear to be a specific penalty for non-compliance. However, the general PPACA penalty would likely apply: $100 per day per individual.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

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Health Care Reform- 2015

Item	Description	Due Date	Penalty	Employer Size
Employer Mandate	PPACA requires that by Jan. 1, 2015, most employers must decide whether to “pay or play” in the realm of employer-sponsored group health plans. On Feb. 10, 2014, the final regulations announced an additional one-year delay for employers with 50–99 FTEs so long as four conditions are satisfied. Therefore, employers with between 50-99 FTEs who satisfy the four conditions, should plan to comply for the first plan year beginning on or after Jan. 1, 2016. Employers with 100+ employees must plan to comply for the first plan year beginning on or after Jan. 1, 2015. An employer may be required to “pay” a penalty for failing to offer a group health plan, providing unaffordable coverage or providing coverage that provides less than the minimum value requirement. The penalty would be triggered if one of the employer’s full-time employees obtained coverage through a health insurance exchange and qualified for a premium tax subsidy. Alternatively, an employer will not pay a penalty if it decides to “play” by offering affordable, minimum value group health coverage for its employees (and their dependents). PPACA also refers to the “pay or play” requirement as “shared responsibility,” or "employer mandate," and employers need to understand the possible impact on plan designs, contribution strategies and workforce planning. Dependent Coverage and the Employer Mandate - IRC Section 4980H requires applicable large employers to offer “to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan.” In defining the term dependents, the final regulations largely adopted the proposed definition of an employee’s child (as defined in IRC Section 152(f)(1)), but excluded both foster children and stepchildren as well as a child who is not a U.S. citizen, unless that child is a resident of a country contiguous to the United States (or is within the exception for adopted children).	PPACA’s employer mandate applies for employers with 100+ FTEs beginning Jan. 1, 2015. Therefore, beginning on Jan. 1, 2015, employers must provide affordable minimum value coverage to all full-time employees working 30 hours or more per week (and their dependents) (or risk a penalty). There are special rules for employers with non-calendar year plans, as well as employers with between 50-99 FTEs. Ask your advisor for details. Although effective in 2015, employers with non-calendar year plans may need to adjust benefit offerings for the plan year beginning in 2014, since that plan year will extend into 2015.	The employer mandate penalty actually consists of two separate taxes. Both taxes hinge on whether an employer offers eligible employer-sponsored health coverage to full-time employees, but the nature of the penalty will depend on the cost to employees and the terms of coverage. The penalties are referred to as the “A” penalty and the “B” penalty, because of the subsections of the Internal Revenue Code (IRC) where they are located, IRC Section 4980H (a) and 4980H(b). The “A” penalty generally applies to applicable large employers not offering coverage beginning Jan. 1, 2015. Under this penalty, employers may be assessed $2,000 per employee, minus the first 30 employees (80 employees in 2015) if: (1) The employer fails to offer “substantially all” its full-time employees the opportunity to enroll in minimum essential coverage AND (2) At least one full-time employee is certified as having received a premium tax credit. The “B” penalty generally applies to applicable large employer offering some level of substandard coverage beginning Jan. 1, 2015. Under this penalty, employers may be assessed the lesser of the "A" penalty or the “B” penalty which is $3,000 for each employee who receives a premium tax credit. The "B" penalty is assessed if the employer offers health coverage to at least 95 percent of its full-time employees (70 percent in 2015), but at least one full-time employee receives a premium tax credit to help pay for coverage on an exchange, which may occur because (1) The employer did not offer coverage to that employee; OR (2) The coverage the employer offered that employee was either unaffordable to the employee or did not provide minimum value.	50 or more
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

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Health Care Reform- 2015 *continued*

Item	Description	Due Date	Penalty	Employer Size
Information Reporting under Section 6055	Beginning in 2016, PPACA requires employers sponsoring self-insured group health plans, regardless of size, to report certain plan coverage information to the IRS and to provide statements to employees under IRS Code Section 6055. Employers only subject to Section 6055 (small self-insured employers) will need to complete and submit Forms 1094-B and Form 1095-B. Employees must be provided with a copy of Form 1095-B or a substitute. Employers subject to both Sections 6055 and 6056 (i.e., those with 50 or more full-time employees (FTEs), including equivalents, that sponsor self-insured plans) may combine reporting into one by using Forms 1094-C and both sections of Form 1095-C. Grandfathered plans must comply with the reporting requirements.	Generally, the Section 6055 reporting due date mirrors the Form W-2 due dates. Specifically, employers must file their reports on or before Feb. 28 (March 31, if filing electronically) of the year following the calendar year to which the reporting relates. However, for the first year (reporting on 2015 calendar-year compliance), reports are due Feb. 29, 2016 (because of the leap year), or March 31, 2016, if filing electronically. This date applies regardless of the plan year of the employer-sponsored coverage (e.g., reporting is due on those dates for 2015 compliance even if the plan year runs from May 1 through April 30). In addition, like the Form W-2, employers must distribute employee statements by Jan. 31 of the following year (i.e., Feb. 1, 2016, because Jan. 31, 2016, is a Sunday) for 2015 compliance — although employers may apply for a 30-day limited extension.	The penalty is generally $200 per failure per year, with a maximum penalty of $3 million. For 2015 reporting only (due in early 2016), no reporting penalties will apply where the employer is using good faith efforts to comply.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

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Health Care Reform- 2015 *continued*

Item	Description	Due Date	Penalty	Employer Size
Informational Reporting under Section 6056	Beginning in 2016, PPACA requires applicable large employers sponsoring group health plans to report certain plan coverage information to the IRS and to provide statements to employees. Applicable large employers includes those with 50 or more FTEs (including equivalents), regardless of when they become subject to PPACA's employer mandate. Applicable large employers will need to complete and submit Forms 1094-C and 1095-C (6056 section only). Employees must be provided with a copy of Form 1095-C or a substitute. Employers subject to both Sections 6055 and 6056 (i.e., those with 50 or more full-time employees (FTEs), including equivalents, that sponsor self-insured plans) may combine reporting into one by using Forms 1094-C and both sections of Form 1095-C. Grandfathered plans must comply with the reporting requirements.	Generally, the Section 6056 reporting due date mirrors the Form W-2 due dates. Specifically, employers must file their reports on or before Feb. 28 (March 31, if filing electronically) of the year following the calendar year to which the reporting relates. However, for the first year (reporting on 2015 calendar-year compliance), reports are due Feb. 29, 2016 (because of the leap year), or March 31, 2016, if filing electronically. This date applies regardless of the plan year of the employer-sponsored coverage (e.g., reporting is due on those dates for 2015 compliance even if the plan year runs from May 1 through April 30). In addition, like the Form W-2, employers must distribute employee statements by Jan. 31 of the following year (i.e., Feb. 1, 2016, because Jan. 31, 2016, is a Sunday) for 2015 compliance — although employers may apply for a 30-day limited extension.	The penalty is generally $200 per failure per year, with a maximum penalty of $3 million. For 2015 reporting only (due in early 2016), no reporting penalties will apply where the employer is using good faith efforts to comply.	50 or more
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

HIPAA Privacy

Item	Description	Due Date	Penalty	Employer Size
Privacy Policies and Procedures	Requires health plans to establish written privacy policies and procedures, which include a definition of protected health information (PHI), permitted uses and disclosures of PHI, authorization requirement for other uses and disclosures, designation of privacy official and privacy contact, sanctions for violations, privacy safeguards, complaints procedure, prohibition of retaliation and waiver of rights, documentation and record retention, establishment of business associate agreements. Fully insured plans that do not have access to PHI need only to comply with prohibition policies. Effective March 26, 2013, must be updated to reflect provisions of the Final HIPAA Omnibus rule, issued on Jan. 25, 2013. To comply with the final rules, and in order to properly distribute the new model notice (see Notice of Privacy Practices), self-insured plan sponsors would enter the requested information into the model and then distribute the notice. This will also require an update to the employer's Privacy Policies and Procedures.	Employers must revisit and revise their Privacy Policies and Procedures in accordance with the final rules by Sept. 23, 2013.	Civil penalties range from $100 to $50,000 per violation. Criminal penalties may also apply, including a fine up to $250,000 and imprisonment up to 10 years.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

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HIPAA Privacy *continued*

Item	Description	Due Date	Penalty	Employer Size
Security Policies and Procedures	Requires health plans to establish written policies and procedures for creating, receiving, maintaining and transmitting electronic PHI, maintain a record of those activities, and amend business associate agreements as necessary. The security rule does not provide any special exceptions for fully insured plans. Effective March 26, 2013, must be updated to reflect provisions of the Final HIPAA Omnibus rule, issued on Jan. 25, 2013.	Large plans (more than $5 million in receipts) should have complied by April 20, 2005; small plans by April 20, 2006. Requirement is ongoing.	Civil penalties range from $100 to $50,000 per violation. Criminal penalties may also apply including a fine up to $250,000 and imprisonment up to 10 years.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		
Notice of Privacy Practices	Requires group health plans to notify participants of their privacy rights, plan's responsibilities, privacy contact, effective date and the plan's permitted uses and disclosures of PHI and informing people of their individual rights. Fully-insured plans that do not have access to PHI do not need to comply. Notices must be revised by Sept. 23, 2013 to reflect provisions of the final HIPAA omnibus rule. For Indian tribal plans, the law is not entirely clear whether HIPAA applies. Such plans should engage legal counsel to determine applicability.	Must be distributed to new enrollees "at the time of enrollment" and to all participants within 60 days of a material change. Once every three years, a notice must be distributed notifying participants that a notice is available, along with instructions for receiving a copy.	Civil penalties range from $100 to $50,000 per violation. Criminal penalties may also apply including a fine up to $250,000 and imprisonment up to 10 years.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		
Breach Notifications	Applies to covered entities and business associates. Covered entity must notify affected individuals in writing if their unsecured PHI has been breached. See "More Information" to learn about what information must be included in this notification. Final regulations issued on Jan. 25, 2013 changed the definition of a “breach” of unsecured PHI. The new definition presumes there is a breach – and generally requires notification – unless a risk assessment demonstrates a low probability that PHI has been compromised. The risk assessment must consider at least the following factors: the nature of the PHI, the unauthorized person who received the disclosure, whether the PHI was actually acquired or viewed, and the extent to which the risk has been mitigated. If the breach affects more than 500 individuals in the same state or jurisdiction, the HHS secretary and prominent media outlets in the area must also be notified. Information involving breaches affecting fewer than 500 must be maintained in a log and reported to HHS annually. If a business associate experiences a breach, they must contact the covered entity with the information required to be included in the participant notice.	Notice must be sent to affected individual, media outlet, HHS or covered entity without unreasonable delay but no later than 60 days following the breach discovery date. The annual notification to HHS is due within 60 days following the end of the calendar year.	Civil penalties range from $100 to $50,000 per violation. Criminal penalties may also apply including a fine up to $250,000 and imprisonment up to 10 years.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

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HIPAA Privacy *continued*

Item	Description	Due Date	Penalty	Employer Size
Business Associate Agreement	Requires that health plans/covered entities enter into written agreements with business associates to require the associates to appropriately use, disclose and safeguard PHI in its possession. A "business associate" is a person or entity that performs certain functions that involve the use or disclosure of PHI on behalf of a covered entity. Examples of business associates include: a TPA that assists with claims processing; an attorney whose legal services to a health plan involve access to protected health information; a pharmacy benefits manager that manages a health plan's pharmacist network; an insurance broker that assist with claims disputes; subcontractors that create, receive, maintain or transmit PHI on behalf of another business associate. A fully insured plan is not a covered entity and therefore is not required to comply if the only information they receive/handle is summary health information and enrollment information. A business associate agreement must contain certain required provisions specifying the permitted uses and disclosures of PHI and assigning appropriate obligations and liabilities to the parties.	If the covered entity did not have an existing agreement with the business associate in place prior to Jan. 25, 2013, an agreement must be put in place by the Sept. 23, 2013. If the covered entity does have an existing agreement with the business associate in place prior to Jan. 25, 2013, and does not "renew or modify" the agreement between March 26, 2013 and Sept. 23, 2013, the covered entity may take advantage of a transition rule and has until Sept. 22, 2014 to amend the agreement to comply with the final HIPAA rules. The existing agreement, however, must have complied with prior versions of the HIPAA rules. If the covered entity does have an existing agreement with the business associate in place prior to Jan. 25, 2013, but "renews or modifies" the agreement between March 26, 2013 and Sept. 23, 2013, the covered entity cannot take advantage of the transition rule and was required to amend the agreement by Sept. 23, 2013.	Civil penalties range from $100 to $50,000 per violation. Criminal penalties may also apply including a fine up to $250,000 and imprisonment up to 10 years.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

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HIPAA Portability

Item	Description	Due Date	Penalty	Employer Size
Certificate of Creditable Coverage	Certifies prior group health plan creditable coverage. Must include issue date, individual's name/identification, and administrator name/address/telephone number. This requirement is now phased out due to the prohibition on pre-existing conditions. However, proposed guidance indicated employers and insurers must continue to provide this notice until Dec. 31, 2014. The law is unclear on whether self-insured Indian Tribal plans are subject to HIPAA Portability provisions. Such plans should seek legal counsel.	Must be distributed to participant upon loss of coverage (time frame same as Election Notice); upon loss of COBRA coverage ("as soon as practicable"); upon request within two years of loss of coverage ("promptly").	Internal Revenue Service (IRS) may assess a $100 per day penalty. If violation is not corrected within 30 days of discovery, then employer must self-report violation on IRS Form 8928 and a civil penalty of $100 per day would be assessed. HHS may impose a penalty of $100 per failure to comply up to a maximum of $25,000 per year. If violation is not corrected within 30 days of discovery, then employer must self-report violation on IRS Form 8928 and a civil penalty of $100 per day would be assessed.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		
Special Enrollment Rights	HIPAA requires group health plans to provide special enrollment opportunities to certain employees, dependents and COBRA-qualified beneficiaries. These opportunities are commonly known as HIPAA “special enrollment rights” (SER). A HIPAA SER arises upon the occurrence of any of the following: o A loss of eligibility under other coverage; o A loss of eligibility under Medicaid/CHIP; o Birth of a child; o Marriage of an employee; o Adoption (or placement for adoption) of a child with the employee; and o Gain of eligibility for CHIP premium assistance. A special notice, the HIPAA special enrollment rights notice, notifies eligible participants of special enrollment rights, including a description of special enrollment events and enrollment procedures. The model language from DOL Reg. Section 2590.701-6(c)(1) is available. The law is unclear on whether self-insured Indian Tribal plans are subject to HIPAA Portability provisions. Such plans should seek legal counsel.	If a participant experiences one of the listed events, they have a minimum of 30 days (longer if the plan allows) to notify the plan sponsor of the event and request enrollment for themselves and affected dependents in the plan. Two events, the loss of eligibility under Medicaid/CHIP and the gain of eligibility CHIP premium assistance allow 60 days to request enrollment. A separate requirement, the notice must be distributed to eligible participants "at or before the time an employee is initially offered the opportunity to enroll in a group health plan." Should not be provided only to those who enroll in the plan (such as with the SPD) as this would not be a sufficient distribution method.	HHS may impose a penalty of $100 per failure to comply up to a maximum of $25,000 per year. If violation is not corrected within 30 days of discovery, then employer must self-report violation on IRS Form 8928 and a civil penalty of $100 per day would be assessed.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

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HIPAA Portability *continued*

Item	Description	Due Date	Penalty	Employer Size
General Notice of Pre-existing Condition Exclusion	Applies to a group health plan (or issuer) that imposes a pre-existing condition exclusion. Must include the existence of any plan exclusion relating to pre-existing conditions, the terms of the exclusion, right to provide proof of creditable coverage, right to request certificate of creditable coverage from prior plan or issuer, contact name/address/telephone number, and statement that current plan or issuer will assist in obtaining prior certificate, if necessary. This requirement is now phased out due to the prohibition on pre-existing conditions. The law is unclear on whether self-insured Indian Tribal plans are subject to HIPAA Portability provisions. Such plans should seek legal counsel.	Must be distributed to eligible participants "as part of any written application materials distributed by the plan or issuer for enrollment." If enrollment materials are not distributed, at the earliest date possible following enrollment request. Note that due to the prohibition on pre-existing condition exclusions, this requirement is obsolete for plan years beginning on or after Jan. 1, 2014.	HHS may impose a penalty of $100 per failure to comply up to a maximum of $25,000 per year. If violation is not corrected within 30 days of discovery, then employer must self-report violation on IRS Form 8928 and a civil penalty of $100 per day would be assessed.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		
Individual Notice of Pre-existing Condition Exclusion	Notifies participant of the length of time remaining after reducing the maximum exclusion period by the amount of time documented in a certificate of creditable coverage. Must include exclusion period remaining for participant, last day of period, source or basis of determination, right to submit additional creditable coverage, and description of any appeal procedures. Does not apply to individuals under 19 years of age beginning in the plan years on or after Sept. 23, 2010, or individuals of all ages for plan years beginning Jan. 1, 2014. Due to the prohibition on pre-existing condition exclusions, this requirement is obsolete for plan years beginning on or after Jan. 1, 2014. The law is unclear on whether self-insured Indian Tribal plans are subject to HIPAA Portability provisions. Such plans should seek legal counsel.	Must be distributed to participants who have submitted a certificate of creditable coverage documenting less than the maximum exclusion period "by the earliest date following a determination." Due to the prohibition on pre-existing condition exclusions, this requirement is obsolete for plan years beginning on or after Jan. 1, 2014.	HHS may impose a penalty of $100 per failure to comply up to a maximum of $25,000 per year. If violation is not corrected within 30 days of discovery, then employer must self-report violation on IRS Form 8928 and a civil penalty of $100 per day would be assessed.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

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HIPAA Portability *continued*

Item	Description	Due Date	Penalty	Employer Size
CHIPRA	The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) requires that a group health plan allow an employee or dependent to enroll in the plan within 60 days of the employee's Medicaid or CHIP coverage being terminated or upon eligibility for employment assistance under Medicaid or CHIP. In addition, employers that maintain a group health plan in a state that provides medical assistance or child health assistance under a state Medicaid or state child health plan are required to provide the Employer CHIP Notice. The following states meet this standard: AL, AK, AZ, CO, FL, GA, ID, IN, IA, KS, KY, LA, ME, MA, MN, MO, MT, NE, NV, NH, NJ, NY, NC, ND, OK, OR, PA, RI, SC, SD, TX, UT, VT, VA, WA, WV, WI and WY. The law is unclear on whether self-insured Indian Tribal plans are subject to HIPAA Portability provisions. Such plans should seek legal counsel.	Notices must be distributed annually on the first day of the plan year each year. A model notice is available.	Civil penalties of up to $100 a day for failure to comply with the new notice and disclosure requirements may be assessed.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

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HIPAA Portability *continued*

Item	Description	Due Date	Penalty	Employer Size
Wellness Program Requirements	There are two types of wellness programs, those that base a reward on participation only, and those that base a reward on satisfying a health standard (health-contingent). If the program is only participation-based but provides a reward such as a premium discount or reduction in copays or deductibles, then the program must be available to all similarly situated individuals in order to comply with the HIPAA nondiscrimination requirements. If the program bases the reward on satisfying a health standard- whether activity-only, or outcomes-based (such as not smoking or maintaining a certain cholesterol level), then the following five requirements must be met: (1) The total reward must not exceed 30 percent of the cost of coverage under the plan (up to 50 percent for rewards based on tobacco use) under PPACA. (2) The program must be reasonably designed to promote health and prevent disease. (3) The program must give eligible individuals the opportunity to qualify for the reward at least once per year. (4) The reward must be available to all similarly situated individuals. The program must allow a reasonable alternative standard for obtaining the reward to any individual for whom it is unreasonably difficult due to a medical condition (or if medically inadvisable) to satisfy the initial standard. Note that pursuant to the final regulations released on June 3, 2013, a participant must be given the entire plan year to complete the alternative standard. Further, at the point the employee completes the alternative standard, the employee is entitled to the full reward, which means that they receive the reward retroactively back to the first day of the plan year. (5) The plan must provide a disclosure in all materials describing the terms of the program and the availability of a reasonable alternative standard in order to obtain a reward. A model notice is provided. Self-insured church plans are exempt. The law is unclear on whether Indian Tribal plans are subject to HIPAA Portability provisions. Such plans should seek legal counsel.	Final regulations issued June 3, 2013, are applicable for group health plans and health insurance issuers providing group health plans, including grandfathered plans, for plan or policy years starting on or after Jan. 1, 2014. Wellness program materials and employee communications should be reviewed annually. In addition, if the wellness program is connected with the health plan (e.g., the reward relates to health plan premiums or other benefits, such as a reduction in premiums or an HRA/HSA contribution), the plan documents of the health plan must describe the wellness program's effect on the plan. Plan documents should be in compliance by the first day of the plan year.	HHS may impose a penalty of $100 per failure to comply up to a maximum of $25,000 per year. If violation is not corrected within 30 days of discovery, then employer must self-report violation on IRS Form 8928, and a civil penalty of $100 per day would be assessed. Finally, the DOL may bring a civil action to enforce HIPAA portability requirements.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

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HIPAA Portability *continued*

Item	Description	Due Date	Penalty	Employer Size
HIPAA Nondiscrimination Rules for Eligibility and Benefits	Group health plans are prohibited from discriminating in terms of eligibility, benefits, and contributions based on health status, which would include claims experience, medical condition, and disability. Specific practices that are prohibited by HIPAA are nonconfinement clauses, impermissible source-of-injury restrictions and impermissible actively-at-work clauses. HIPAA also permits an employer to provide different benefits to different groups of similarly situated employees or dependents, so long as the benefits are uniformly available to all similarly situated individuals. The following groups may be treated as distinct groups of similarly situated individuals: (1) Groups of participants (employees or former employees) based on a bona fide employment-based classification; (2) Participants as a separate group from beneficiaries (spouses and dependent children; or (3) Groups of beneficiaries based on employment classification of or type of relationship to the participant Examples of bona fide employment-based classifications include: Full-time/part-time; occupation; date of hire; geographic location; membership in a collective bargaining agreement; length of service; and current/former employee. Note that self-insured church plans that have been in existence since July 1997 may qualify for a limited exemption. Note also that for self-insured Indian tribal plans, the law is unclear as to whether the HIPAA portability rules apply. Such plans should seek outside counsel regarding applicability.	Compliance requirements are ongoing. Testing should be performed throughout the plan year so that by the end of the plan year (when a penalty would be assessed) the plan is in compliance.	HHS may impose a penalty of $100 per failure to comply up to a maximum of $25,000 per year. If violation is not corrected within 30 days of discovery, then employer must self-report violation on IRS Form 8928 and a civil penalty of $100 per day would be assessed.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

Medicare/TRICARE

Item	Description	Due Date	Penalty	Employer Size
Medicare Part D Disclosure Notice to CMS	Applies to group health plans and individual health insurance policies that offer prescription drug coverage to Medicare eligible individuals. Entities that are contracted directly with Medicare as a Part D plan are exempt. Plan must disclose to CMS whether the plan's prescription drug coverage is creditable or non-creditable.	The online notification must be completed annually within 60 days of beginning of plan year; within 30 days of prescription drug plan termination; and within 30 days of a change in the creditable coverage status.	No specific penalties have yet been announced. However, an employer who is claiming the retiree drug subsidy would no longer be eligible for the subsidy.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

continues >

Medicare/TRICARE *continued*

Item	Description	Due Date	Penalty	Employer Size
Medicare Part D Disclosure Notice to Eligible Individuals	Applies to group health plans and individual health insurance policies that offer prescription drug coverage to Medicare eligible individuals. Entities that are contracted directly with Medicare as a Part D plan are exempt. Notice must be sent to Medicare Part D eligible individuals. Notice must include the determination of whether the plan's prescription drug coverage is creditable or non-creditable, the definition of creditable coverage, an explanation of why creditable coverage is important, an explanation of the individual's right to notice, and an explanation of benefit plan provisions that affect Medicare Part D eligible individuals. If the coverage is non-creditable, must also include a statement that an individual can generally only enroll in Medicare Part D during open enrollment of each year. Both a Creditable Coverage Model Notice and Non-creditable Coverage Model Notice are available.	There are six due dates associated with this requirement: (1) On an annual basis prior to Oct. 15th; (2) Prior to an individual's Initial Enrollment Period for Medicare Part D; (3) Prior to a Medicare eligible individual's effective date with the plan; (4) Upon a change to the plan's creditable coverage status; (5) Upon the prescription drug plan's termination; and 6) Upon request.	No specific penalties have yet been announced. However, an employer who is claiming the retiree drug subsidy would no longer be eligible for the subsidy.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		
Medicare Section 111 Reporting	Applies to group health plans, including HRAs. However, health FSAs, HSAs and stand-alone vision, dental and prescription plans are exempt. There are two exceptions: o Small plans sponsored by employers with fewer than 20 employees need only report those receiving a kidney transplant or kidney dialysis. o Plans with less than $5,000 annual benefit maximum are exempt, which was a change from the lower threshold of $1,000, effective Oct. 3, 2011. The reporting assists CMS in determining coordination of benefit responsibilities between the group health plan and Medicare. The Responsible Reporting Entity (RRE) is the insurer for fully insured plan, the TPA for self-insured plan and the plan administrator for self-insured plan that self-administers. Information to be reported includes the Social Security number (or Medicare Health Insurance Claim Number), gender, name and date of birth of certain active covered individuals.	Information must be reported to CMS on a quarterly basis according to the schedule CMS provides upon registration in the system.	RRE shall be subject to civil money penalty of $1,000 per day per individual not reported.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

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Medicare/TRICARE *continued*

Item	Description	Due Date	Penalty	Employer Size
Medicare Prohibitions	Employers with 20 or more employees are prohibited from: (1) Providing financial or other incentives for a Medicare-eligible employee not to enroll (or to terminate enrollment) under a group health plan which would be a primary plan due to age-based Medicare entitlement; and (2) "Taking into account" age-based Medicare entitlement in a manner that results in depriving a Medicare-eligible employee of the opportunity to elect to participate in the group health plan to the same extent as similarly situated employees who are not Medicare eligible. There are no express notice requirements. However, SPDs must disclose information regarding when a group health plan pays primary or secondary to Medicare. Note that this prohibition applies to disability-based Medicare entitlement when the employer size is 100 or more.	The final regulations, as amended in 73 Fed. Reg. 9679, were effective March 24, 2008.	Potential civil penalty of up to $5,000 for each violation. Medicare also authorizes the federal government to collect the amount that Medicare paid as primary payer or the amount that should have been paid under the group health plan. If legal action is brought to collect, double damages may be assessed. The IRS may also impose an excise tax of 25 percent on employers with nonconforming plans.	20+
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		
TRICARE Prohibitions	Employers are prohibited from engaging in certain activities with respect to employees who are eligible for coverage under TRICARE. In particular, employers are prohibited from: (1) Providing financial or other incentives for a TRICARE-eligible employee not to enroll (or to terminate enrollment) under a group health plan; and (2) Depriving a TRICARE-eligible employee of the opportunity to elect to participate in the group health plan in the same manner and to the same extent as similarly situated employees who are not TRICARE eligible. There are no express notice requirements. However, SPDs must disclose information regarding when a group health plan pays primary or secondary to TRICARE.	The final regulations were effective on June 18, 2010, and compliance is ongoing.	Potential civil penalty of up to $5,000 for each violation. Remedies for violation also include remedies under the Federal Claims Collection Act. TRICARE also authorizes the federal government to collect reasonable charges from a third-party payer.	20+
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

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Nondiscrimination

Item	Description	Due Date	Penalty	Employer Size
Section 105(h) Nondiscrimination Testing	Self-insured and non-grandfathered fully insured group health plans may not discriminate on eligibility or benefits in favor of highly compensated individuals (HCIs). An HCI is an individual who is: (1) One of the five highest-paid officers; (2) A shareholder who owns more than 10 percent of the value of stock of the employer's stock; or (3) Among the highest-paid 25 percent of all employees (other than excludable employees who aren't participants). Section 105(h) establishes two nondiscrimination tests-the Eligibility Test and the Benefits Test. To pass the Eligibility Test, a plan must benefit one of the following: (1) 70 percent or more of all nonexcludable employees; (2) 80 percent or more of all nonexcludable employees who are eligible to benefit, if 70 percent or more of all nonexcludable employees are eligible to participate under the plan; or (3) A nondiscriminatory classification of employees (a bona fide business class and a sufficient ratio of benefiting non-HCIs to benefiting HCIs). Under the Benefits Test, all benefits provided to the HCIs who are participating in the plan must be provided to all other participants. Note that for fully insured Indian Tribal plans, the law is unclear whether the section 105(h) nondiscrimination rules apply. Such plans should seek legal counsel regarding applicability.	Self-insured Plans: Compliance requirements are ongoing. Testing should be performed throughout the year, and completed by the last day of the plan year to ensure plan compliance. Non-grandfathered fully insured: IRS Notice 2011-1 that compliance with the rules will not be required for fully insured plans until the agencies have issued regulations or other guidance regarding the rules.	Non-grandfathered fully insured: excise taxes or civil money penalties of $100 per day per individual discriminated against. Self-insured: If a self-insured medical plan fails to pass either test, the favorable tax treatment for the HCIs will be lost. HCIs will lose their tax exclusions and will be taxed on their "excess reimbursements" from the plan.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		
Cafeteria Plan, Health FSA and DCAP Nondiscrimination Testing	See Cafeteria Plans for a more detailed explanation regarding these required tests.	See Cafeteria Plans for a more detailed explanation regarding due dates.	See Cafeteria Plans for a more detailed explanation regarding penalty information.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

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Nondiscrimination *continued*

Item	Description	Due Date	Penalty	Employer Size
Genetic Information Nondiscrimination Act (GINA)	The Genetic Information Nondiscrimination Act of 2008 (GINA) consists of two principal Titles: Title I (the health insurance provisions) and Title II (the employment nondiscrimination requirements). Generally, GINA restricts the use of genetic information in connection with health coverage and employment. The employment nondiscrimination requirements prohibit employers from discriminating against any employee with respect to the compensation, terms, conditions or privileges of employment on the basis of "genetic information." The health insurance provisions prohibit group health plans from using genetic information to do any of the following: adjusting group premium or contribution amounts on the basis of genetic information; requesting or requiring an individual or an individual's family members to undergo genetic testing; or requesting, requiring or purchasing genetic information for underwriting or enrollment purposes. Employers are required to post a notice explaining the provisions of GINA: "Equal Employment Opportunity is the Law." In addition, Final HIPAA regulations published on Jan. 25, 2013 prohibit health plans from using or disclosing genetic information for underwriting or enrollment purposes.	Compliance requirements are ongoing. Final regulations became effective Jan. 10, 2011.	Violations of the health insurance provisions of Title I are subject to enforcement under ERISA, the PHSA and the IRC. Remedies available for violations of GINA's Title II provisions include certain compensatory and punitive damages, reasonable attorney's fees and injunctive relief.	15 or more
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		
HIPAA Nondiscrimination	See HIPAA for a more detailed explanation regarding these requirements.	See HIPAA for a more detailed explanation regarding due dates.	See HIPAA for a more detailed explanation regarding penalty information.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

Taxation

Item	Description	Due Date	Penalty	Employer Size
Taxation of Group Term Life Insurance	Applies to employers who directly or indirectly provide group term life insurance. An individual is subject to Social Security and Medicare taxes on the cost of the coverage that exceeds $50,000. An employer is considered to indirectly provide coverage if they arrange for the payment of premiums and one employee pays less than the rate indicated on the IRS Premium Table and one employee pays more than the rate indicated on the Premium Table.	The cost of the excess coverage should be included in the gross income of the employee for the taxable year in which the coverage was provided. Thus, compliance should be reviewed by the end of the plan year.	Failure to properly report income and taxation may result in IRS action.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

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Taxation *continued*

Item	Description	Due Date	Penalty	Employer Size
Taxation of Same-sex Benefits	On June 26, 2013, the Supreme Court ruled in United States v. Windsor that Section 3 of the 1996 Defense of Marriage Act ("DOMA") is unconstitutional. Section 3 of DOMA prohibited the U.S. government from conferring any federal benefits to same-sex couples who were married in any jurisdiction. DOMA's limitations on the definitions of "marriage" and "spouse" affected a myriad of federal laws, including the IRC, ERISA, COBRA, and HIPAA, and thus deprived same-sex couples legally married under the laws of certain states of certain legal protections and preferred tax treatment under spousal retirement and health care benefits. The Court's ruling means this differential treatment of opposite-sex and same-sex married couples is not permissible in any state that allows or recognizes same-sex marriages. Windsor did not address Section 2 of DOMA which declares states and territories of the United States have the right to deny recognition of same-sex marriages that originated in other states or territories. Importantly, Windsor did not discuss treatment of same-sex domestic partnerships or civil union partners. Therefore, in the absence of additional guidance, benefits provided to same-sex domestic partners and civil union partners remain taxable.	On Aug. 29, 2013, the IRS issued Revenue Ruling 2013-72, addressing same-sex marriages for federal tax purposes. For employers, the ruling means that the tax advantages of coverage for employer-sponsored health insurance and other benefits is now available to a same-sex spouse on the same basis as an opposite-sex spouse. Employers that were previously providing coverage to same-sex spouses may immediately stop imputing federal tax relating to that coverage (although state taxes may still apply). As to same-sex domestic partners or civil unions, employers should continue to impute income on the value of employer-sponsored insurance coverage when the partner does not qualify as the employee's federal tax dependent. More about qualifications for tax dependency may be reviewed at the links below. Compliance should be reviewed by the end of the plan year.	Failure to impute income for same-sex domestic partners or civil unions may result in the plan's loss of tax-qualified status and tax penalties for the individuals (since they would be getting tax advantages that they were not qualified for). In addition, an employer's failure to properly report income and taxation may result in IRS action, and additional action may be taken at the State level.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

Other Federal Mandates

Item	Description	Due Date	Penalty	Employer Size
HSA Notice to Employees Regarding Employer Contributions	Applies to employers who make a contribution to employee HSAs and who have participants who have not established an HSA by Dec. 31. Employer HSA contributions made under a Section 125 Cafeteria Plan are exempt. Must include a statement that each HSA-eligible employee will receive a comparable employer contribution if by the last day of the following February, the employee's HSA is established and the employee notifies the employer of the account. A model notice is available.	Employer must provide to all HSA eligible participants (or only those who have not timely established an HSA) no earlier than 90 days before the employer's first HSA contribution for the calendar year and no later than Jan. 15 of the following calendar year.	May result in failure of the HSA comparability rules, which carry a penalty of 35 percent excise tax for the employer on all calendar year employer contributions.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

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Other Federal Mandates *continued*

Item	Description	Due Date	Penalty	Employer Size
Mental Health Parity and Addiction Equity Act (MHPAEA)	Applies to group health plans that provide coverage for mental health and substance use disorders (MH/SUD). Requires that coverage for MH/SUD benefits be in parity with the coverage provided for medical/surgical benefits. In order for MH/SUD benefits to be considered in parity with medical/surgical benefits, they cannot be given financial requirements or quantitative treatment limitations that are more restrictive than those given to substantially all medical/surgical benefits in the same classification. Financial requirements include deductibles, copayments, coinsurance, and out of pocket maximums. Types of quantitative treatments are annual, episode, and lifetime day and visit limits. MH/SUD benefits must also be in parity with medical/surgical benefits when it comes to nonquantitative treatment limitations, such as medical management standards, formulary design, and standards for provider admission to participate in-network. Plans sponsored by employers with 50 or fewer employees were originally exempt from MHPAEA. However, under health care reform, if an employer is providing coverage through a group policy purchased in the small group market for policy years beginning on or after Jan. 1, 2014, that group policy must include an essential health benefits package. To meet this requirement, a group policy must provide coverage for ten different categories of benefits, including coverage for "mental health and substance abuse disorder services, including behavioral health treatment." The inclusion of these mental health benefits in a group policy will trigger the MHPAEA requirements, since the MH/SUD benefits would be offered in addition to medical/surgical benefits. However, small grandfathered plans (which don't require essential health benefits) and self-funded group health plans (which are subject to ERISA because of preemption) may still qualify for a small employer exemption. Note that non-federal self-insured governmental plans may opt out of the MHPAEA requirements. Note also that the law is unclear whether Indian tribal plans are subject to the MHPAEA requirements. Such plans should engage legal counsel regarding applicability.	MHPAEA is effective for plan years beginning on or after Oct. 3, 2009.	If violation is not corrected within 30 days of discovery, then employer must self-report violation on IRS Form 8928 and a civil penalty of $100 per day would be assessed.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		
Newborns' and Mothers' Health Protection Act (NMHPA)	Self-insured group health plans must provide coverage for a minimum stay of 48 hours for hospital stays related to childbirth. Coverage for the hospital stay of a vaginal delivery must be no less than 48 hours and 96 hours for a cesarean section. Fully insured plans would be subject to any applicable state laws. Model language is available. Note that non-federal, self-insured governmental plans may opt out of the NMHPA requirements. Also note that for Indian tribal plans, the law is unclear as to whether such plans are subject to the NMHPA requirements. Such plans should seek legal counsel regarding applicability.	Must be disclosed in SPD. Employers should review SPDs by the first day of the plan year to ensure that SPDs include proper NMHPA disclosure language.	Legal action may be brought by participant and an ERISA $110 per day fine may be assessed. If violation is not corrected within 30 days of discovery, then employer must self-report violation on IRS Form 8928 and a civil penalty of $100 per day would be assessed.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

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Other Federal Mandates *continued*

Item	Description	Due Date	Penalty	Employer Size
Qualified Medical Child Support Order (QMCSO)	Requires that a group health plan establish written procedures for determining the qualification of a Medical Child Support Order (MCSO). When an order is received, it identifies a child of a plan eligible participant and the child's (alternate recipient's) right to receive benefits under a group health plan. The plan administrator must respond to the issuing state authority with the determination of whether the order is qualified and if coverage is available. If so, the administrator must take appropriate action to enroll the child in benefits and must respond to the state authority with the coverage effective date, description of coverage and any action necessary from alternate recipient. Also note that DOL guidance provides that where a plan does not offer dependent-only coverage, the plan must enroll both the dependent child and the eligible employee if the employee was not previously enrolled in the plan. However, the expiration of the period of coverage required by the order does not give the employee a right to disenroll from the plan.	Plan administrator must respond to state authority within 40 days of receiving order; employer must forward to administrator or respond directly to state authority within 20 days. A copy of the determination should also be provided to the employee/participant. Plan documents and SPDs should be reviewed by the first day of the plan year to ensure that its written procedures for determining the qualification of an MCSO are properly described.	Legal action may be brought by alternate recipient or state authority.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		
Uniformed Services Employment and Reemployment Rights Act (USERRA)	Applies to all employers regardless of size. Employees absent from work due to uniformed service must be offered the option to continue, at their own expense, group health coverage for a period up to 24 months. For periods of leave of 30 days or less, employer must continue to pay normal share of premiums.	Employer must post or distribute to employees a notice of the Act's provisions. Notices should be posted by first day of plan year, and plan documents, policies and procedures and employee handbooks should be reviewed for compliance by first day of plan year.	Legal action may be brought by employee or DOL.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		
Women's Health and Cancer Rights Act (WHCRA)	Requires group health plans that provide medical and surgical mastectomy benefits to notify participants that the plan provides certain benefits for reconstructive surgery, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses and physical complications. Model language for both enrollment and annual notice is available. For self-insured church plans and for Indian tribal plans, the law is unclear as to whether WHCRA applies. Such plans should seek legal counsel regarding applicability. Non-federal, self-insured governmental plans may opt out of the WHCRA requirements.	Must be distributed to participants upon enrollment and annually. Compliance should be reviewed prior to the beginning of the plan year.	Legal action may be brought by participant and an ERISA $110 per day fine may be assessed.	All sizes
	In compliance? ☐ Yes ☐ No ☐ N/A	**Comments/Plan of action:**		

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Presented by:

Name	Signature	Date

Presented to:

Name	Signature	Date