2024 COMPLIANCE CHECKLIST

EMPLOYEE BENEFITS: GROUP SIZE 2-49

The following checklist is a summary self-audit compliance guide for various employee benefit plans under ERISA, the Internal Revenue Code, HIPAA and other applicable statutes. The checklist is intended to help ensure the Company's "welfare benefit plans" comply with ERISA and certain other statutes.

This checklist applies to "welfare benefit plans" as defined under ERISA. This means that certain items in this summary checklist are not applicable to government entities and "church plans" since they are exempt from ERISA. Also, this checklist is not applicable to retirement plans. That is, this checklist is directed at only "welfare benefit plans" such as group health plans, group term life insurance, disability plans, etc.

LAW	GOVERNS	NOTICE REQUIREMENT	METHOD OF DELIVERY	DATE VERIFIED	OPEN ITEM
Affordable Care Act	Group health plans and health insurance issuers	Statement of grandfathered status—Listed in Certificate of Coverage if applicable.	With enrollment materials or any other reasonable method, including DOL approved electronic delivery.		
		Notice of rescission—30 day advance written notice to affected participants if coverage is being terminated due to fraud or intentional misrepresentation of material fact.	Any reasonable method, including DOL approved electronic delivery.		
		Notice of patient protections and selections of providers—Only required if plan requires designation of primary care provider. Listed in Certificate of Coverage.	With enrollment materials or any other reasonable method, including DOL approved electronic delivery.		
		Uniform summary of benefits and coverage—Plan administrator and issuer must provide to participants and beneficiaries at the following times: • With any written enrollment materials distributed for enrollment; • If written materials for enrollment are not provided, no later than when the participant is first eligible to enroll in coverage; • By the first day of coverage, if there was any change to the information that was provided upon application and before the first day of coverage; • To special enrollees, no later than the deadline for providing the SPD; • Upon renewal, if participants and beneficiaries must renew to maintain coverage; and • Upon request.	Mail or hand delivered, or electronically if provided in connection with online enrollment.		

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		60-Day Advance Notice of Plan Changes (mid-plan year only)—Plans and issuers must provide at least 60 days' advance notice of mid-year material modifications in plan terms or coverage that would affect the content of the SBC and are not reflected in the most recent SBC. This notice requirement became effective when the SBC requirement went into effect.	Mail or hand delivered, or electronically if provided in connection with online enrollment.		
Affordable Care Act	Employers sponsoring group health plans	IRS Form W-2—Aggregate cost of applicable employer sponsored coverage must be included on employees' Forms W-2. Small employers (those filing fewer than 250 W-2 Forms) and employers contributing only to certain plans, such as multi-employer plans or HSAs, are exempt at least until further guidance is issued.	On Form W-2		
Affordable Care Act	Employers sponsoring group health plans	Non-grandfathered health plans are subject to limits on cost sharing for essential health benefits (EHB). Under the ACA, a health plan's out-of-pocket maximum for EHB may not exceed **$9,450** for self-only coverage and **$18,900** for family coverage, effective for plan years beginning on or after January 1, 2024. If you have an HSA-compatible HDHP, keep in mind that your plan's out-of-pocket maximum must be lower than the ACA's limit. For 2024, the out-of-pocket maximum limit for HDHPs is **$8,050** for self-only coverage and **$16,100** for family coverage. In addition, if you have an HSA-compatible HDHP, for 2024 the minimum deductible for individual and family is as follows: • Embedded deductible: self-only and family have an embedded deductible, the minimum deductibles are $3,200 individual and $3,200 family • Non-embedded deductible: self-only and family have a non-embedded deductible, the minimum deductible is $1,600 individual and $3,200 family	Compliance reminder, language included in SBC's and SPD's		
Affordable Care Act	All employers subject to the FLSA	Exchange Notice—The ACA requires employers to provide all new hires with a written notice about the health insurance Exchanges within 14 days of date of hire.	By mail or DOL approved electronic delivery.		
Affordable Care Act	Employers who have self-insured medical plans including HRAs.	Patient-Centered Outcomes Research Institute (PCORI) Fee—Under the ACA, PCORI fees are established each year by the IRS. PCORI fees have been extended to apply for the 2020–2029 fiscal years	Fees are filed with IRS via Form 720 by July 31 each year.		
Affordable Care Act	Employers who sponsor ICHRAs	Employers that sponsor ICHRAs must provide an annual notice to eligible employees at least 90 days before the beginning of each plan year. Notice includes specific information about the ICHRA and its impact on the ACA's premium tax credit. Model notice available for customization.	By mail or DOL approved electronic delivery.		

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Affordable Care Act	Employers with self- insured health plans (including level-funded and graded-funded) that provide minimum essential coverage (MEC)	Code §6055 Reporting—Effective in2015, sponsors of self-insured health plans that provide MEC must file an annual return with the IRS regarding the health coverage. These employers must also provide a related annual statement to covered individuals. The deadlines for these returns and statements are as follows: • Section 6055 returns must be filed with the IRS annually, no later than April 1 (February 28 for paper returns, available to employers with fewer than 10 returns) of the year after the calendar year in which MEC is provided. • The statements for covered individuals must be provided by March 1 of the year after the calendar year in which MEC is provided.	Filed with the IRS		
Consolidated Appropriations Act of 2021 (CAA)	Group Health Plans and Health Insurance Issuers	Transparency in Coverage Requirements (TiC) – Group health plans and health insurance issuers are subject to requirements designed to increase health care transparency and protect consumers against surprise medical bills. In general, most employers will rely on their issuers, TPAs and other service providers to satisfy the requirements. Excepted benefits and account-based group health plans such as HRAs and FSAs are not subject to these requirements. • Ban on Balance Billing: Plans and issuers must provide protections against balance billing and out of network cost sharing with respect to ER services, air ambulance and nonemergency services furnished by nonparticipating providers at participating facilities. • Plans and issuers must publicly post a notice of these protections and include the notice with any EOB for an item or service to which the protections may apply. • Public Posting of MRFs: Non-grandfathered plans and issuers must make an internet based self-service tool available to participants, beneficiaries and enrollees to disclose the personalized price and cost-sharing liability for covered items and services, including prescription drugs. An initial list of 500 shoppable services must be available on or after January 1, 2023. A listing of remaining items and services will be required for plan years that begin on or after January 1, 2024. • Most employers will rely on their health insurance issuers and TPAs to provide the MRFs and cost comparison tool. Employers should confirm their issuer or TPA will comply with these transparency requirements by applicable deadlines. • Reporting Prescription Drug Costs – RxDC reporting was initially required to be submitted by December 27, 2022, however, the Departments provided a submission grace period, through January 31, 2023. Annual prescription drug data collection report (RxDC) due to CMS by June 1st of each year.			
Consolidated Appropriations Act of 2021 (CAA)	Group Health Plans and Health Insurance Issuers	Special enforcement policies apply to the following provisions pending further guidance by the Departments. • Prohibition on Gag Clauses: Plans and issuers cannot enter into contracts with providers, TPAs or other service providers that would restrict the plan or issuer from providing, accessing or sharing certain information about provider price and quality. Plans and issuers must annually submit an attestation of compliance with these requirements. Health plans and issuers must submit first attestation of compliance with the prohibition on gag clauses by December 31, 2023, covering the period beginning December 27, 2020, through the date of attestation. Subsequent annual attestations, covering			

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		- the period since the last attestation, are due by December 31st of each following year. - Broker and Service Provider Compensation Disclosures: Brokers and Consultants must disclose any direct or indirect compensation they may receive for their services to ERISA covered group health plan sponsors. - Continuity of Care: Plans and issuers must provide continuity of care to qualifying covered individuals when terminations of certain contractual relationships result in changes in provider or facility network status. - Insurance Identification Cards: Plans and issuers must include on any physical or electronic ID card, any applicable deductibles and out of pocket maximums, telephone number and website address for individuals to seek consumer assistance. - Accuracy of Provider Network Directories: Plans and issuers must maintain participating provider directories on a public website; regularly verify and update and have a process in place for responding to request for information. - Advanced Explanation of Benefits (EOB): Plans and issuers must provide an advanced EOB to covered individuals after receiving a good faith estimate of charges. Enforcement of this requirement is delayed until further notice.			
Cafeteria Plans	Employers with any pre-tax plans, including premium only plans.	IRS regulations require a written plan document when offering a cafeteria plan which includes Section 125 Health FSA, Section 132 Dependent Care, and/or Premium Only Plans. Premium Only Plans allow employers to set up pre-tax deductions for an employee portion of any benefit premiums. Additionally, individuals that are not considered employees, ie. Self-employed, partners in a partnership, or individuals that are more than 2% shareholder in a Subchapter S corporation cannot participate in a Section 125 Plan. They can sponsor a Cafeteria Plan; they just cannot participate.	With enrollment materials or any other reasonable method, including DOL approved electronic delivery.		
Cafeteria Plans	Employers with any pre- tax plans.	Annually, obtain election forms for Cafeteria Plans.			
Health Reimbursement Arrangements	Employers offering Health Reimbursement Arrangements(HRA)	Health Reimbursement Arrangements(HRAs) are employer-funded health care accounts that reimburse employees for their eligible out-of-pocket medical expenses on a tax-favored basis. HRA's are subject to employee benefit laws, including ERISA, COBRA, HIPAA, and the Internal Revenue Code's (Code) nondiscrimination rules as self-funded plans.			
COBRA	Employers that had 20+ employees on more than 50% of the typical business days during the previous calendar year Government and church plans are exempt	Initial/General COBRA notice—Plan administrator must provide generally within 90 days of when group health plan coverage begins.	If not married, any approved method. If married, by mailing a single notice that is jointly addressed to the employee and spouse.		

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COBRA	Employers that had 20+ employees on more than 50% of the typical business days during the previous calendar year Government and church plans are exempt	Notice to plan administrator—Employer must notify plan administrator within 30 days of (a) qualifying event or (b) the date coverage would be lost as a result of the qualifying event, whichever is later.			
		COBRA election notice—Plan administrator must generally provide within 14 days after being notified by the employer or qualified beneficiary of the qualifying event (or 44 days after qualifying event if employer is also plan administrator). Note: Employers may consider including information regarding portability and/or conversion rights specific to ancillary benefits (ie. Life/AD&D) if applicable.	Any reasonable method, including DOL approved electronic delivery.		
		Notice of unavailability of COBRA—Plan administrator must provide this notice generally within 14 days after being notified by the individual of the qualifying event.	Any reasonable method, including DOL approved electronic delivery.		
		Notice of early termination of COBRA coverage—Plan administrator must provide as soon as practicable following the plan administrator's determination that coverage will terminate.	Any reasonable method, including DOL approved electronic delivery.		
		Notice of insufficient payment—Plan administrator must provide reasonable period of time to cure deficiency before terminating COBRA (for example, 30-day grace period).	Any reasonable method, including DOL approved electronic delivery.		
		Premium change notice—Plan administrator should provide at least one month prior to effective date.	Any reasonable method, including DOL approved electronic delivery.		
CONTINUATION LAW	Employers with less than 20 employees in applicable states.	Notice to terminated employee at time of termination	Any reasonable method, including DOL approved electronic delivery.		
ERISA	ERISA employee welfare benefit plans, unless exempted	Summary Plan Descriptions (SPD)—Plan administrator must provide SPDs automatically to participants: • within 90 days of becoming covered by the plan; • within 120 days after becoming subject to ERISA; or • upon request. • updated SPDs must be furnished every 5 years if changes made to SPD information or plan is amended. Otherwise, must furnish every 10 years.	With enrollment materials or any other reasonable method, including DOL approved electronic delivery.		
		Summary of material modification—Plan administrators must provide automatically to participants within 210 days after the end of the plan year in which the change is adopted. However, note the requirements regarding 60 days advance notice of changes that affect information in the SBC. The 60-day notice can be provided to participants through an updated SBC or by issuing an SMM.	Any reasonable method, including DOL approved electronic delivery.		
		Plan Documents/Wrap Documents—Plan administrator must provide copies no later than 30 days after a written request and made available for inspection at principal office and certain other locations. Where a wrap document also acts as the SPD, it should be distributed on the SPD schedule.	Mail or hand delivered, or electronically if provided in connection with online enrollment.		
		Summary of material reduction in covered services or benefits—Generally within 60 days of adoption of material reduction in group health plan services or benefits. However, note the requirements regarding 60 days advance notice of changes that affect information in the SBC. The 60-day notice can be provided to participants through an updated SBC or by issuing an SMM.	Any reasonable method, including DOL approved electronic delivery.		

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ERISA	ERISA employee welfare benefit plans, unless exempted	Electronic Distribution of ERISA Disclosures—The regulations contain guidelines for providing disclosures to: (1) employees with work-related computer access; and (2) other plan participants and beneficiaries who consent to receive disclosures electronically. Employees with Work-related Computer Access: ERISA disclosures may be delivered electronically to employees that: • Have the ability to effectively access documents furnished in electronic form at any location where the employees are reasonably expected to perform their duties; and • Are expected to have access to the employer's electronic information system as an integral part of those duties. Merely providing employees with access to a computer in a common area (for example, a computer kiosk) is not a permissible means to electronically furnish ERISA required documents. Beneficiaries and Other Plan Participants Who Consent to Receive Disclosures Electronically: A plan administrator must obtain written consent prior to electronically delivering ERISA disclosures to beneficiaries and other plan participants who do not have work-related access to a computer. The consent may be received in either electronic or paper form. Prior to consenting, an individual must be given a clear and conspicuous statement that explains: • The types of documents to which the consent will apply; • That consent can be withdrawn at any time without charge; • The procedures for withdrawing consent and for updating the address used for receipt of electronically furnished documents; • The right to request and obtain a paper version of an electronically furnished document, including whether the paper version will be provided free of charge; and • Hardware or software needed to access and retain the documents delivered electronically. Actual Receipt: Employers must take steps to ensure that the electronic delivery results in actual receipt. For example, this may include using electronic mail features, such as a return receipt or notice that the email was not delivered or conducting periodic reviews or surveys to confirm receipt of the transmitted information.			

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Genetic Information Nondiscrimination Act (GINA)	All group health plans and health insurers	GINA prohibits health plans and health insurance issuers from discriminating based on genetic information. GINA generally prohibits group health plans and health insurance issuers from (1) adjusting group premium or contribution amounts on the basis of genetic information; (2) requesting or requiring an individual (or their family members) to undergo a genetic test; and (3) collecting genetic information, either for underwriting purposes or prior to or in connection with enrollment. No separate notice requirement outside of plan documents.	Included in plan documents.		
Internal Revenue Code	Cafeteria Plans and Self-Funded Group Health Plans subject to Discrimination Rules	Cafeteria Plan Non-Discrimination Testing (includes Section 125 Health FSA, Section 132 Dependent Care, and/or Premium Only Plans) – must be performed annually with the recommendation of twice per year, at the beginning of the plan year and 60 days before the end of the plan year to ensure compliance. Non-discrimination rules are required to prevent plans from discriminating in favor of individuals who are either highly compensated or key employees (HCEs). Self-Funded Group Plan Non-Discrimination Testing—Although most employers do not comply with this requirement when eligibility and contributions match. Testing is recommended when eligibility and contributions differ among classes or if there are significant waivers.			
Internal Revenue Code	Fully Insured Group Health Plans subject to Discrimination Rules	Postponed until IRS issues rules			
HIPAA and the ACA—Wellness Programs	Group health plans and issuers that offer health-contingent wellness programs	Notice of Alternative Standard—Plans and issuers must disclose the availability of an alternative standard in all materials describing the wellness program. EEOC Notice—Effective as of the first day of the plan year that begins on or after January 1, 2017, the Americans with Disabilities Act (ADA) requires employers who offer wellness programs that ask disability related questions or require a medical exam to provide a notice to employees informing them what information will be collected, how it will be used, who will receive it, and what will be done to keep it confidential. Wellness programs often gather health information through voluntary health risk assessments (HRAs) or voluntary biometric screenings that include medical examinations (such as tests to detect high blood pressure, high cholesterol, or diabetes).	Presumably acceptable to include with open enrollment materials. Any reasonable method.		
HIPAA – Portability	Group health plans and insures of group health plan insurance coverage, unless exception applies	Notice of Special Enrollment Rights—Plan administrators must provide at or before the time an employee is initially offered the opportunity to enroll in the group health plan.	Any reasonable method, including DOL approved electronic delivery.		

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HIPAA and the ACA—Wellness Programs	Group health plans and issuers that offer health-contingent wellness programs	Notice of Alternative Standard—Plans and issuers must disclose the availability of an alternative standard in all materials describing the wellness program. EEOC Notice—Effective as of the first day of the plan year that begins on or after January 1, 2017, the Americans with Disabilities Act (ADA) requires employers who offer wellness programs that ask disability related questions or require a medical exam to provide a notice to employees informing them what information will be collected, how it will be used, who will receive it, and what will be done to keep it confidential. Wellness programs often gather health information through voluntary health risk assessments (HRAs) or voluntary biometric screenings that include medical examinations (such as tests to detect high blood pressure, high cholesterol, or diabetes).	Presumably acceptable to include with open enrollment materials. Any reasonable method.		
HIPAA—Privacy and Security	Covered Entities: Group health plans, health care clearing-houses, health care providers that transmit any health information electronically, and enrolled sponsors of Medicare prescription drug discount card, unless exception applies. Business Associates: entities that create, receive, maintain, or transmit protected health information (PHI) on behalf of a Covered Entity.	Notice of Privacy Practices— Must be provided when a participant enrolls, upon request and within 60 days of a material revision. At least once every three years, participants must be notified about the availability of the Notice of Privacy Practices.	No electronic delivery without consent. Inclusion with enrollment materials is acceptable.		
		Notice of Breach of Unsecured PHI—Only if HIPAA breach occurs. Covered entities and their business associates must provide notification following a breach of unsecured PHI without unreasonable delay and in no case later than 60 days following the discovery of the breach.	First class mail.		
CHIPRA (Children's Health Insurance Program Reauthoriza-tion Act of 2009)	Employers that maintain group health plans covering employees in states that provide premium assistance subsidies under a Medicaid plan or CHIP	Annual Employer CHIP Notice—If an employer's group health plan covers residents in a state that provides a premium subsidy, the employer must send an annual notice about the available assistance to all employees residing in that state.	Any reasonable method, including DOL approved electronic delivery.		

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Medicare Part D	Group health plan sponsors that provide prescription drug coverage, except entities that contract with or become a Part D plan	Disclosure Notices for Creditable or Non-creditable Coverage—At a minimum, must be provided by the plan sponsor at the following times: • Distribute once a year at the same time each year (e.g., in the annual open enrollment materials) • Before an individual is first eligible for Medicare Part D. The employer complies with this requirement if the Notice is distributed to all plan participants annually. • Before the effective date of coverage for any Medicare eligible individual that joins the plan. • Whenever prescription drug coverage ends or changes so that is no longer creditable or becomes creditable. • Upon request.	By mail or DOL approved electronic delivery.		
		Disclosure to CMS—Plan sponsor must make on an annual basis (60 days after the beginning of the plan year) and upon any change that affects creditable coverage status (within 30 days of the change).	Online disclosure.		
Medicare Secondary Payer (MSP) – Reporting Requirements (Medicare, Medicaid and SCHIP Extension Act of 2007)	Responsible Reporting Entities (RREs)—For group health plans, RREs are insurers and administrators of group health plans	MSP Reporting Requirements—Plan administrators and issuers must file quarterly reports with CMS containing information on certain participants and beneficiaries for MSP purposes. All group health plans should be registered and reporting, except some Health Reimbursement Accounts (HRAs) that have until the end of the first quarter of 2011 to comply. The Medicare, Medicaid and SCHIP Extension Act of 2007 amended the MSP rules to require plan administrators and health insurance issuers to report certain participant information to CMS for purposes of coordinating benefits with Medicare. More information about this reporting requirement, including a health plan user guide, is available at: www.cms.gov?MandatoryInsRep/.			
Mental Health Parity and Addiction Equity Act (MHPAEA)	Employer-sponsored group health plans	The MHPEA imposes parity requirements on group health plans that provide benefits for mental health or substance abuse disorder benefits. Plans must offer the same access to care and patient costs for mental health and substance use disorder benefits as those that apply to general medical or surgical benefits. Under the MHPAEA, the plan administrator or health insurance issuer must disclose the criteria for medical necessity determinations with respect to mental health or substance use disorder benefits to any current or potential participant, beneficiary or contracting provider upon request and the reason of any denial of reimbursement or payment for services with respect to mental health or substance use disorder benefits to the participant or beneficiary.	Posting of notice in each establishment or by including the notice in an employee handbook or other document.		

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Mental Health Parity and Addiction Equity Act (MHPAEA)	Employer sponsored group health plans (of employers with over 50 employees) offering mental health and substance use disorder benefits.	The cost exemption will apply to a group health plan if its cost increase exceeds 2 percent in the first plan year and 1 percent in a subsequent year. If the 2-percent or 1-percent increased cost is incurred, the plan is exempt for the plan year following the year the cost was incurred. Thus, the exemption lasts one year and then the plan is required to comply again. A group health plan or health insurance issuer must promptly notify the Secretaries of the DOL, HHS and the Treasury, the appropriate state agencies, and participants and beneficiaries in the plan of such election. A notification to the Secretaries must include:	Group health plans claiming the increased cost exemption must promptly notify the appropriate federal and state agencies, plan participants and beneficiaries. Notice must also be provided upon request.		
		• A description of the number of covered lives under the plan (or coverage) involved at the time of the notification, and as applicable, at the time of any prior election of the cost-exemption by such plan (or coverage); • For both the plan ear upon which a cost exemption is sought and the year prior, a description of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan; and For both the plan year upon which a cost exemption is sought and the year prior, the actual total costs of coverage with respect to mental health and substance use disorder benefits under the plan.			
		The plan administrator or the health insurance issuer must disclose the criteria for medical necessity determinations with respect to MH/SUD benefits to any current or potential participant, beneficiary or contracting provider upon request and the reason for any denial of reimbursement or payment for services with respect to MH/SUD benefits to the participant or beneficiary.	Notice of criteria for medically necessary determination – Plan administrators and health insurance issuers must disclose the criteria for medically necessary determinations with respect to mental health/substance use disorder (MH/SUD) benefits.		
		Comparative analyses of NQTLs used- Plan administrators and health insurance issuer must conduct comparative analyses of the nonquantitative treatment limitations (NQTLs) used for medical and surgical benefits as compared to mental health and substance use disorder (MH/SUD) benefits. The comparative analyses, and certain other information, must be made available upon request to applicable agencies beginning Feb. 10, 2021.			
Michelle's Law	Employer-sponsored group health plans	Michelle's Law Notice—Plan administrators and group health plan insurers must include with any notice regarding a requirement for certification of student status. The ACA's coverage mandate for adult children limits the impact of Michelle's Law. However, group health plans that extend coverage past the age of 26 for adult children who are students will still be subject to the requirements of Michelle's Law.	Included in certification of student status.		
Newborns' and Mothers' Health Protection Act (NMHPA)	Group health plans that provide maternity or newborn infant coverage	NMHPA Notice—Include in SPD/SMM; SPD/SMM timeframes applicable.	SPD/SMM timeframes: With enrollment materials or any other reasonable method, including DOL approved electronic delivery.		

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Qualified Medical Child Support Orders	Plan administrators of group health plans and state child support enforcement agencies	Medical Child Support Order (MCSO) notice— • Upon receipt of MCSO, administrator must issue notice including procedures for determining qualified status. • Notice regarding qualified status.			
		National Medical Support (NMS) notice— • Employer must send Part A to the State agency or Part B to the plan administrator within 40 days after the date of the notice or sooner if reasonable. • Administrator must notify affected persons of receipt of the notice and procedures for determining qualified status.			
Qualified Small Employer Health Reimbursement Arrangements (QSEHRAs) ***Effective for plan years beginning on or after Jan. 1, 2017**	Non-ALEs that do not maintain a group health plan for their employees	**QSEHRA Notice**—An employer funding a QSEHRA for any year must provide a written notice to each eligible employee. This notice must be provided within **90 days** of the beginning of the year. For employees who become eligible to participate in the QSEHRA during the year, the notice must be provided by the date on which the employee becomes eligible to participate.	Presumably any reasonable method.		
No Surprises Act	Group health plans and health insurance issuers	Surprise billing notice – For plan years beginning on or after January 1, 2022, group health plans and health insurance issuers are required to make publicly available, post on a public website of the plan or issuer and include on each applicable explanation of benefits a description of the restrictions against balance billing.	TPAs or PBMs to assist in fulfilling these requirements, but the plan must monitor the other party to ensure compliance.		
State and Local Sick Leave Laws	All public and private employers	Applicable employers must provide notice of the right to take paid sick and safe leave to employees either by posting a notice in a conspicuous place in each establishment, or by including the notice in an employee handbook or other document.	Posting of notice in each establishment or by including the notice in an employee handbook or other document.		
State and Local Leave Laws	All ERISA And Non-ERISA employers	Review Group Health and disability plan documents to ensure the existence of provisions that speak to the continuation of coverage during approved Leave of Absence (LOA). If it is a practice to provide for continuations of coverage during company-approved leave even following the exhaust of federal/state leave plans, this should be clearly indicated in the plan document's LOA provisions.			
State and Local Laws as they relate to health benefits	All ERISA and Non-ERISA employers	Review state and local laws and regulations specific to health benefits as they apply to employee's state and/ or city of residence to ensure that the administration of your plan is in compliance. If you have an employee that resides outside the state where the policy is headquartered, there may be state and local laws that may impact your health plan.			
Uniformed Services Employment and Re-employment Rights Act (USERRA)	All public and private employers, regardless of size	USERRA Notice—Employers can fulfill USERRA's notice requirement by posting the DOL sample notice where the employer customarily places notices for employees.	Employers can fulfill USERRA's notice requirement by posting the DOL sample notice where the employer customarily places notices for employees.		
Women's Health and Cancer Rights Act (WHCRA)	Group health plans that provide coverage for mastectomy benefits	WHCRA Notice—Plan administrators and issuers must provide notice upon enrollment in the plan and annually thereafter.	Any reasonable method, including DOL approved electronic delivery.		

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