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2024 COMPLIANCE DEADLINES

DUE DATE	TOPIC	REQUIREMENT
1/1/2024	IRS benefit limits for 2024 take effect	▪ Ensure benefit and payroll systems are properly updated to reflect adjusted limits ▪ Confirm plan's out of pocket limit for essential health benefits doesn't exceed ACA limits for plan year beginning in 2024 ($9,450/$18,900) ▪ FSA maximum contribution limit for 2024 plan years is $3,200 ($640 carryover limit) ▪ Excepted Benefit HRA maximum for 2024 plan years is $2,100
1/1/2024	First-dollar preventive care coverage (applies to non-grandfathered plans)	▪ Confirm health plan covers the latest recommended preventive care services without cost sharing (see https://www.healthcare.gov/coverage/preventive-care-benefits) for latest recommended services
1/1/2024	San Francisco Health Care Security Ordinance (SFHCSO) changes for 2024: ▪ Health care expenditure rates increase to $3.51/hour (businesses with > 100 employees) and $2.34/hour (businesses with 20-99 employees) ▪ Updated notice for posting at workplace ▪ Revocable health care expenditures no longer permitted	▪ Employers subject to the SFHCSO must comply by making required health care expenditure payments on behalf of covered employees (generally those employed >90 days and working at least 8 hours per week in the City)

DUE DATE	TOPIC	REQUIREMENT

1/1/2024	Employer Mandate ("play or pay")	▪ Confirm applicable large employer (ALE) status for 2024
		  ▪ ALEs have at least 50 full-time employee equivalents in prior year (2023)
		  ▪ Determine full-time employee status for 2024 using look-back measurement method or monthly measurement period, as applicable
		▪ Confirm compliance with guidance on cash-out arrangements and wellness incentives
		▪ Determine affordability (8.39% of household income) using W-2, rate of pay, or federal poverty line safe harbor) and minimum value thresholds (60%) for 2024
		▪ 4980H(a) monthly penalty amount = $2,970/12 x Full-time employees (less first 30)
		▪ 4980H (b) monthly penalty amount =$4,460/12 x FT employees receiving a subsidy
		▪ Confirm plan documents/ SPDs and employee handbooks have been updated to reflect any changes made to eligibility criteria

1/1/2024	Grandfathered Health Plans (GF)	▪ Confirm plan's status for 2024:
		  ▪ If plan lost status, confirm that plan has adopted all additional patient rights and benefits required by non-GF plans
		  ▪ If plan maintained its GF status, continue to provide Notice of Grandfathered Status in plan materials provided to participants

DUE DATE	TOPIC	REQUIREMENT
1/1/2024	Compliance effective date for Phase III of Final Transparency in Coverage Rules requiring the hosting of an internet-based price comparison tool to be made available to participants, beneficiaries and enrollees for all covered items and services	▪ **Fully insured plans**—Employers should confirm that their issuer will comply with the price comparison tool requirements beginning with 2024 plan years and ensure this compliance responsibility is reflected in a written agreement ▪ **Self-insured plans**—Employers should reach out to their third-party administrators(TPA)s (or other service providers) to confirm they will be in compliance by the deadline and update agreements to reflect this responsibility. In addition, employers should monitor their TPAs' compliance with this requirement. Unlike fully insured plans, the legal responsibility for this tool stays with a self-insured plan even if its TPA agrees to provide the price comparison tool on its behalf
1/1/2024	Employers with 10 or more filings in the aggregate are required to file certain information returns with the IRS electronically, including those required to comply with the employer shared responsibility provisions under the Affordable Care Act	▪ Employers who are not currently set up for electronic filing should take steps to do so soon, whether on their own or through a third-party. ▪ Reporting entities in a position to perform their own electronic reporting can review the IRS' ACA Information Returns (AIR) Program webpage ▪ Read **here** for more information on the electronic filing process and the AIR System, as well as IRS Publications 5164 and 5165

DUE DATE	TOPIC	REQUIREMENT
1/31/2024 (unless extension applies)	W-2 Reporting of Employer Sponsored Benefits (Transitional relief for employers with less than 250 W-2s until further guidance)	▪ Employers that filed 250 or more IRS Forms W-2 for the prior calendar year must include the aggregate cost of employer-sponsored health plan coverage on employees' Forms W-2. ▪ Include the aggregate cost of medical insurance (generally not dental, vision, disability benefits or FSA unless employer contributions made) ▪ Employers must file Forms W-2 with the Social Security Administration and furnish Forms W-2 to employees ▪ Work with payroll vendor to ensure compliance
1/31/2024	Massachusetts Form 1099-HC due to employees who are state residents to assist them in filing their tax returns; report listing of all Form 1099-HCs issued due to State. *For further information visit https://www.mass.gov/service-details/health-care-reform-for-employers*	▪ Responsibility of health insurer and/or employer (if self-funded) ▪ Confirm that the health plan meets the definition of creditable coverage under Massachusetts state law requirements ▪ Work with health insurer to confirm party responsibility for providing Form and ensure timely distribution
1/31/2024	IRS Forms 1095-C due to employees of self-insured medical plans to comply with CA Individual Mandate	▪ Self-insured plan sponsors comply by providing Form 1095-C statements to all covered employees (and non-employees), regardless of FT status, including completing Part III of the Form 1095-C
2/29/2024 (or 60 days after beginning of plan year being reported to CMS)	For calendar year plans, Medicare Part D disclosure to CMS regarding creditable coverage status of a group health plan's prescription drug coverage	▪ Complete online disclosure form available at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html

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DUE DATE	TOPIC	REQUIREMENT
3/1/2024	Form M-1- Annual Reporting	▪ Applies to administrators of multiple employer welfare associations (MEWA) and entities claiming exemptions from certain federal law requirements ▪ File online at www.askebsa.dol.gov/mewa
3/1/2024	Disclosure Statement to Employees under Code Sections 6055 and 6056	▪ All ALEs must provide a copy of Form 1095-C to their full-time (FT) employees to satisfy Code Section 6056's requirements for the 2023 calendar year ▪ Self-funded employers must also provide Form 1095-C statements to all covered employees (and non-employees), regardless of FT status, to satisfy Code Section 6055's requirements for the 2023 calendar year, including completing Part III of the Form 1095-C ▪ Statements can also be used to satisfy some state individual mandate disclosure requirements
3/1/2024	Disclosure statements to employees to comply with state individual mandate requirements in **New Jersey, Rhode Island,** and the **District of Columbia**	▪ Employers comply by satisfying the IRS deadline and furnishing Forms 1095-B or 1095-C to their employees
4/1/2024 if filing electronically	IRS Reporting Under Code Sections 6055 and 6056	▪ Applicable large employers (ALEs) must file completed Forms 1094-C and 1095-C with IRS to comply with Code Section 6056 ▪ To comply with Code Section 6055, carriers (fully insured plans) and employers that are not ALEs who sponsor self-insured health plans use Forms 1094-B and 1095-B to meet this reporting obligation
4/1/2024	Rhode Island individual mandate reporting due to Division of Taxation is due 4/1/24. For further information, see ADV_2022_29_individual_mandate_deadline.pdf (ri.gov)	▪ Employers (or TPA) of self-funded plans will file Forms 1095-C (Form 1095-B if self-insured sponsor is not an applicable large employer) ▪ Insurance carriers will file Forms 1095-B on behalf of sponsors of fully insured plans

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DUE DATE	TOPIC	REQUIREMENT
4/1/2024	Reporting due to CA Franchise Tax Board to satisfy the California Mandate For further information visit https://www.ftb.ca.gov/file/business/report-mec-info/technical-specifications.html	▪ Employers with self-funded plans must file Form 1095-C with state electronically or by mail (electronic filing required if 250 for more Forms 1095-Cs) ▪ Insurance carriers will file Form 1095-Bs on behalf of fully insured plan sponsors
4/1/2024 (or 5/1/2024 if filing electronically)	District of Columbia Individual Mandate Reporting for further information, visit https://otr.cfo.dc.gov/sites/default/files/dc/sites/otr/publication/attachments/FAQ%20reporting%20SRP%20%288.6.19%29.pdf	▪ Applies to employers with at least one employee residing in Washington D.C. ▪ Same information as filed with the IRS ▪ Must be filed within 30 days of IRS deadline for filing
4/2/2024	Reporting due to State of New Jersey to satisfy state's shared responsibility requirement For more information visit https://nj.gov/treasury/njhealthinsurancemandate/employers.shtml	▪ Employers of self-funded plans will file Forms 1095-C, NJ-1095, or Form 1095-B (if self-insured sponsor is not an applicable large employer) ▪ **Note**: If using Form 1095-C, Parts I, II, and III all must be completed ▪ Insurance carriers will file Forms 1095-B on behalf of sponsors of fully insured plans ▪ Electronic filing only; paper filing will not be accepted
5/1/2024	Annual San Francisco Health Care Security Ordinance (SFHCSO) Reporting	▪ Employers subject to the SFHCSO must file annual report for the 2022calendar year with the Office of Labor Standards Enforcement
5/15/2024 (or 15th day of 5th month following end of plan year)	Form 990 (or 990-EZ)- 3-month extension permitted by filing Form 8868 by this date	▪ Applies to Voluntary Employee Benefit Associations (VEBAs) ▪ No action needed unless benefits are funded through a VEBA trust

DUE DATE	TOPIC	REQUIREMENT
6/3/2024	Prescription Drug and Health Care Spending Reporting (RxDC Reporting)	▪ Annual report due to the federal government by employer-sponsored health plans and health insurance issuers to report information about prescription drugs and health care spending to the federal government for the 2023 reference year. This reporting process is referred to as the "prescription drug data collection" or "RxDC report" ▪ Most employers will rely on third parties, such as issuers, TPAs , pharmacy benefit managers (PBMs) to prepare and submit the RxDC report for their health plans
7/29/2024 (or 210 days after end of plan year)	Summary of material modifications (SMMs)	▪ Distribute SMMs regarding plan amendments adopted during previous year (2023 that reflect changes to the Summary Plan Description (SPD) (unless revised SPD is distributed that contains the modifications)
7/31/2024 (or last day of the 7th month after end of plan year)	Calendar year Form 5500 reporting deadline	▪ All health and welfare plans with 100+ participants that are subject to ERISA are required to report unless an exemption applies ▪ Small health plans (fewer than 100 participants) that are fully insured, unfunded or a combination of insured/unfunded are generally exempt from the Form 5500 filing requirement. ▪ Employers may request a one-time extension of 2 ½ months by filing a Form 5558

DUE DATE	TOPIC	REQUIREMENT
7/31/2024	Patient Centered Outcomes Research Institute (PCORI) Fee due for plan years ending in 2023	▪ Self-funded group health plans (including retiree plans and HRAs) must pay fee, based on enrollee count, using IRS Form 720 ▪ For plan years ending after 1/1/23 and before 10/1/23 fee is $3.00 per enrollee ▪ For plan years ending on or after 10/1/23 and on or before 12/31/23 (includes most calendar year plans), fee amount per enrollee is $3.22 ▪ If medical plan is not self-funded or level funded, the medical carrier will be responsible for paying this fee directly to the IRS
8/1-10/31/2024 (approximately)	Medical Loss Ratio (MLR) Rebates	▪ Sponsors of insured health plans may receive rebates if their issuers did not meet their MLR for the respective reporting year. Rebates must be provided to plan sponsors by September 30 following the end of the MLR reporting year. ▪ Employers that receive rebates should consider their legal options for using the rebate. Any rebate amount that qualifies as a plan asset under ERISA must be used for the exclusive benefit of the plan's participants and beneficiaries. If received, the rebate amount attributable to plan assets generally must be distributed pro-rata to the members in either premium credits or other benefit within 90 days of receipt ▪ Plan sponsors should document how rebate was used

DUE DATE	TOPIC	REQUIREMENT
8/15/2024 (or 15th day of 8th month following end of plan year if 1st extension was filed)	Form 990 (or 990-EZ), 2nd 3-month extension permitted by filing Form 8868 by this date	▪ Applies to VEBAs
9/30/2024 (or 9 months after end of plan year; additional 2 months permitted if Form 5558 extension filed)	Summary Annual Report	▪ Plan Sponsors that file Form 5500 must provide to covered participants a summary of the information in the Form 5500
10/14/2024	Notice of Medicare Part D Creditable/ Non-Creditable Coverage (Medicare Part D Notice)	▪ Provide to Medicare Part D-eligible participants (employee or dependent who is over age 65 or permanently disabled) annually ▪ Providing Notice during open enrollment to all participants is generally adequate ▪ Model disclosure notices are available on CMS' website.
10/15/2024 (or 9 ½ months after end of the plan year+ extension period)	Form 5500, if extension Form 5558 was filed (calendar year plans)	▪ All health and welfare plans with 100+ participants that are subject to ERISA must report
11/15/2024 (or 15th day of the 11th month after end of the plan year)	Form 990 (or 990-EZ), if second 3- month extension was obtained	▪ Applies to VEBAs only
12/16/2024	Health Insurance Responsibility Disclosure (HIRD) form due to Massachusetts Department of Revenue For more information visit https://www.mass.gov/info-details/health-insurance-responsibility-disclosure-hird-faqs	▪ Applies to employers (regardless of location) with six or more employees within Massachusetts during the previous 12 months ▪ Filing is to be completed electronically from 11/15/2024-12/15/2024

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DUE DATE	TOPIC	REQUIREMENT
12/16/2024 (or 2 months after close of extension period for filing Form 5500)	Summary Annual Report, if extension was filed (calendar year plans)	▪ Plan Sponsors that file Forms 5500 must provide to covered participants
12/31/2024	Update/amend documents for 2024 plan year	▪ Provide updated SBCs in connection with plan's 2025 open enrollment period ▪ Amend cafeteria plan to reflect any changes made in 2024 ▪ Amend/restate wrap document and SPD as necessary
12/31/2024	Nondiscrimination Testing	▪ Ensure applicable nondiscrimination testing is performed at least annually: ❑ Code Section 105(h) for self-funded health plans, including Health Care FSAs and HRAs ❑ Code Section 79 for Group Term Life Insurance ❑ Code Section 125 for Cafeteria Plans ❑ Code Section 505 for VEBAs ❑ Code Section 129 for Dependent Care FSAs ❑ Code Section 127 for Educational Assistance ❑ Code Section 137 for Adoption Assistance
12/31/2024	Attestation of compliance with prohibition on gag clauses	▪ Ensure any contracts with TPAs or other health plan service providers offering access to a network of providers do not violate the CAA's prohibition of gag clauses. ▪ **Fully insured plan sponsors:-** confirm insurer will provide attestation ▪ **Self-insured plans-** consider entering into written agreements with their TPAs to provide the attestation, but the legal responsibility ultimately remains with the health plan

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DUE DATE	TOPIC	REQUIREMENT
12/31/2024	Compliance with nonqualitative treatment parity requirements under the Mental Health Parity and Equity Addiction Act (MHPAEA)	▪ Confirm with carrier (fully insured plans) or the TPA (self-funded plans) that mental health parity analyses will be updated, if necessary for 2025, and be available upon request/audit
NEW HIRES		
New Hires	New Health Insurance Marketplace Coverage Options Notice (Exchange Notice)	▪ Provide to all new hires within 14 days of hire date
FOR NEWLY ELIGIBLE EMPLOYEES OR ENROLLEES		
Newly Eligible	Summary of Benefits and Coverage (SBC)	▪ Provide no later than the 1st day individual is eligible to enroll
Newly Eligible	Medicare Part D Notice	▪ Provide prior to effective date of coverage in plan
Newly Eligible	HIPAA Notice of Special Enrollment Rights	▪ Provide at or prior to the time employee is initially offered opportunity to enroll in plan (could be included in SPD)
Newly Eligible	Notice regarding premium assistance under Medicaid or CHIP (CHIPRA Notice) https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra	▪ Could be included in SPD or with other open enrollment materials
New Enrollees	COBRA General Notice	▪ Provide within 90 days of initial plan enrollment (could be included in SPD if sent within 90-day period)
New Enrollees	Summary Plan Description (SPD)	▪ Plan Sponsors whose health and welfare benefit plans are subject to ERISA must provide within 90 days of plan enrollment
New Enrollees	HIPAA Privacy Rights Notice	▪ If health plans is self-funded, provide at the time of plan enrollment ▪ If health plan is fully-insured, confirm carrier will distribute ▪ Notice
New Enrollees	Women's Health & Cancer Rights Act Notice	▪ Provide upon initial plan enrollment (could be included in SPD)
New Enrollees	Newborns' and Mothers' Health Protection Act notice relating to hospital stays in connection with childbirth	▪ Provide upon initial plan enrollment - include in SPD

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DUE DATE	TOPIC	REQUIREMENT
ANNUAL DISTRIBUTION REQUIREMENTS		
Annual	Women's Health & Cancer Rights Act Notice	▪ Provide at open enrollment (could be included in SPD if distributed annually or with other enrollment materials)
Annual	Notice regarding premium assistance under Medicaid or CHIP (CHIPRA Notice) https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra	▪ Provide to all eligible employees (could be included with other enrollment materials) ▪ Could be included in SPD if distributed annually or with other open enrollment materials
Annual	Michelle's Law notice	▪ Provide at open enrollment if applicable (only would apply if plan covers full-time students over age 26) ▪ Provide at open enrollment (could be included in SPD if distributed annually or with other enrollment materials)
Annual	SBCs	▪ If employee must make affirmative benefit elections: provide SBC at open enrollment to those currently enrolled in plan with other open enrollment materials ▪ If re-enrollment in the plan is automatic: provide SBC no later than 30 days prior to beginning of plan year ▪ If multiple benefit plan options are available at open enrollment, only need to provide a new SBC with respect to the plan option employee is enrolled in. Any request for SBCs of other plan options must be provided within 7 business days
Annual	Medicare Part D Notice	▪ Provide to all Part D eligible individuals covered under, or who apply for coverage under, an employer plan option that provides for prescription drug coverage, before October 15 (October 14, 2024)

DUE DATE	TOPIC	REQUIREMENT
ANNUAL DISTRIBUTION REQUIREMENTS		
Annual	Nondiscrimination Testing	▪ Ensure applicable nondiscrimination testing is performed at least annually: ❑ Code Section 105(h) for self-funded health plans, including Health Care FSAs and HRAs ❑ Code Section 79 for Group Term Life Insurance ❑ Code Section 125 for Cafeteria Plans ❑ Code Section 505 for VEBAs ❑ Code Section 129 for Dependent Care FSAs ❑ Code Section 127 for Educational Assistance ❑ Code Section 137 for Adoption Assistance
Annual	Attestation of compliance with prohibition on gag clauses	▪ Ensure any contracts with TPAs or other health plan service providers offering access to a network of providers do not violate the CAA's prohibition of gag clauses. ▪ **Fully insured plan sponsors** should confirm insurer will provide attestation ▪ **Self-insured plan sponsors** should consider entering into written agreements with their TPAs to provide the attestation, but the legal responsibility ultimately remains with the health plan
Annual	Compliance with nonqualitative treatment parity requirements under the Mental Health Parity and Equity Addiction Act (MHPAEA)	▪ Confirm with carrier (fully insured plans) or the TPA (self-funded plans) that mental health parity analyses will be updated, if necessary for 2025, and be available upon request/audit

DUE DATE	TOPIC	REQUIREMENT
ANNUAL DISTRIBUTION REQUIREMENTS		
Annual	Wellness Program Disclosure	▪ Employers with health-contingent wellness programs must provide a notice that informs employees there is an alternative way to qualify for the program's reward. This notice must be included in all plan materials that describe the terms of the wellness program. If wellness program materials are being distributed at open enrollment (or renewal time), the notice should be included with those materials. Sample language is available in the DOL's compliance assistance guide ▪ To comply with the Americans with Disabilities Act (ADA), wellness plans that collect health information or involve medical exams must provide a notice to employees that explains how the information will be used, collected and kept confidential. Employees must receive this notice before providing any health information and with enough time to decide whether to participate in the program. Employers implementing a wellness program for the upcoming plan year should include this notice in their open enrollment materials. The Equal Employment Opportunity Commission (EEOC) has provided a sample notice for employers to use.

DUE DATE	TOPIC	REQUIREMENT
MISCELLANEOUS/ONGOING REQUIREMENTS		
Upon material change or reduction to plan terms or coverage to SBC	Advance Notice of Material Modifications	▪ Notice must be provided to plan participants no later than 60 days prior to effective date of change if not reflected in the most recent SBC provided and change occurs mid-plan year (updated SBC could be provided in lieu of Notice)
Upon material change or reduction to plan terms or coverage impacting information required to be included in SPD	▪ Summary of Material Modifications (SMM) ▪ Summary of Material Reductions(SMR)	▪ SMM (that are not SMRs) amending SPD must be provided to plan participants no later than 210 days after the end of the plan year in which the change was adopted ▪ SMR amending SPD must be provided to plan participants no later than 60 days after adoption date
Grandfathered Plans	Statement of Grandfathered status	▪ Include DOL model language on all plan related materials provided to participants/ beneficiaries that are grandfathered under ACA
Ongoing	Notice of Patient Protections (applies to health plans that require designation of primary care provider)	▪ If applicable and plan is not grandfathered, include in SPD or other benefit summaries
Ongoing	Notice of participation in Early Retiree Reinsurance Program (ERRP)	▪ Provide to plan participants within a reasonable time after receipt of its ERRP reimbursement (or sooner) ▪ NOTE: ERRP ended 1/1/14
Ongoing	ERISA plan document; cafeteria plan document	▪ Provide within 30 days of receipt of written request
Ongoing	SBCs	▪ Provide to plan participants at special enrollment within 90 days of plan enrollment ▪ Provide no later than 7 days following receipt of request

DUE DATE	TOPIC	REQUIREMENT
Ongoing	SPD	▪ Provide updated version to all participants at least every 5 years (10 years if no changes) ▪ Provide within 30 days of request by plan participant ▪ Provide within 30 days of request by DOL
Ongoing	Newborns' and Mothers' Health Protection Act Notice	▪ Include in SPD
Ongoing	Medicare Part D Notice	▪ Provide to Medicare eligible participants upon any change that affects whether or not coverage is "creditable" ▪ Provide upon request
Ongoing	Medicare Fee	▪ Withhold an additional Medicare Tax of 0.9% on wages in excess of $200,000 in a calendar year
Ongoing	HIPAA Privacy Notice	▪ Provide any updated Notice to participants within 60 days ▪ Provide notice of availability to receive Notice every three years
Ongoing	COBRA Notice of Qualifying Event	▪ Provide Notice to COBRA administrator generally within 30 days of qualifying event
Ongoing	COBRA Election Notice	▪ COBRA administrator must provide Notice to plan participants and beneficiaries within 14 days after being notified by employer of qualifying event ▪ If employer is also the COBRA administrator, employer has 44 days from date of qualifying event (or loss of coverage) to send Notice to participants/beneficiaries
Ongoing	Notice of Unavailability of COBRA Coverage	▪ Provide to individuals who are not qualified for COBRA coverage within 14 days after receiving COBRA Notice of Qualifying Event (requesting COBRA)

DUE DATE	TOPIC	REQUIREMENT
Ongoing	Notice of Early Termination of COBRA Coverage	▪ Provide to COBRA beneficiaries as soon as practicable following a determination that their COBRA coverage will terminate before the maximum coverage period
Ongoing	Medical Child Support Order (MCSO) Notice	▪ Provide immediately upon receipt of support order to participants, any child named in the order, and the child's representative
Ongoing	Notice of determination of MCSO status	▪ Provide to affected employee/participant within reasonable period after MCSO is received
Ongoing	National Medical Support (NMSO) Notice	▪ Notify affected persons of receipt of NMSO as soon as practicable ▪ Provide Part A to state agency or Part B to the plan administrator within 20 days after date of Notice ▪ COBRA administrators must complete and return Part B to the state agency and affected persons within 40 business days
Ongoing	QMCSO Procedures	▪ Include in SPD ▪ If not in the SPD, provide procedures to participants along with Medical Child Support Order Notice or National Medical Support Notice
Ongoing	Notice of Rescission of Coverage	▪ Provide to affected participants at least 30 days prior to rescinding coverage
Ongoing	No Surprises Act Billing Notice	▪ Provide upon request ▪ Confirm with carrier /TPA notice has been posted to their website
Ongoing	Provider Network Directories	▪ Confirm with carriers/ TPAs that provider network directories are current and regularly updated

DUE DATE	TOPIC	REQUIREMENT
Ongoing	HIPAA Notice of Breach of Unsecured Protected Health Information	▪ Provide to affected individuals within 60 days after breach discovery ▪ For breaches affecting fewer than 500 individuals file annual report with HHS within 60 days after end of the year of the breach ▪ For breaches affecting more than 500 individuals report to HHS/media outlets within 60 days of discovery
Ongoing	Mental Health Parity & Addiction Equity Act (MHPAEA) Disclosure	▪ Upon request, provide disclosure of criteria used by plan for determining medical necessity for mental health or substance use disorder benefits
Ongoing	MHPAEA Nonquantitative Treatment Limitation Analysis	▪ Provide upon request
Ongoing	Genetic Information Nondiscrimination Act Disclosure	▪ Provide upon request
Ongoing	Gag Clause Attestation Certification	▪ Provide upon request
Ongoing	Compliance with Transparency in Coverage Rules	▪ Confirm with carriers/ TPAs that machine readable files and price transparency tools are current and being updated on a regular basis
Ongoing	San Francisco Health Care Security Ordinance (SFHCSO)	▪ This applies to for-profit employers with 20+ employees, and non-profit employers with 50+ working within City and County of San Francisco ▪ Covered employers must make a minimum health care expenditure on behalf of covered employees who work in San Francisco at least 8 hours per week or make a contribution to a City health care program or medical expense reimbursement account established on behalf of the covered employee ▪ Notice must be posted in workplaces with covered employees ▪ Covered employers must file an annual report with the Office of Labor Standards Enforcement by April 30th of each year