2023 Welfare Plan Automatic Participant Disclosures Checklist[1]

Item/Description	Initial Disclosure Requirement(s)	Annual (or Other Periodic) Disclosure Requirement(s)
Summary Plan Description (SPD) ERISA[2] requires plan sponsors to distribute SPDs to inform participants of their benefits, rights, and obligations under the plan and describe how the plan operates. Department of Labor (DOL) regulations (available here) prescribe an extensive list of contents that must be included in an SPD. Changes to the SPD are communicated to participants either through a **summary of material modifications (SMM)** or the issuance of an updated SPD. Among other contents required to appear in the SPD, the following must be included: • Group health plans providing coverage for maternity or newborn infant care must include a description of the requirements for a hospital length of stay in connection with childbirth under federal or state law, as applicable (model language is provided here, see page 140, and language may need to be supplemented with additional state law requirements, if applicable). • See the **Patient Protections Notice** requirement below. • See the **Notice of Grandfathered Health Plan Status** requirement below. *Note that the inclusion of many of the other participant disclosures described in this checklist in the SPD will satisfy the applicable disclosure requirements so long as the SPD is distributed to all required recipients by the applicable deadline.*	Provide current SPD (including all SMMs) to each participant **within 90 days** of enrollment in the plan.	Provide SMM (or updated SPD) to all participants **within 210 days** of the end of the plan year in which the change was adopted. *However, any "material reduction" in covered group health plan services or benefits must be communicated to participants **within 60 days** of the adoption of the change (unless group health plan updates are instead provided at least quarterly) (but see also **Summary of Benefits and Coverage (SBC)** requirement below regarding mid-year material changes).* An SPD must be updated (incorporating all SMMs) and distributed to all participants at least every five years (10 years if no changes were made to the plan during that period).

[1] Other disclosures are required upon the happening of certain events (for example, a COBRA election notice must be provided upon notice of a "qualifying event" causing a loss of coverage under the group health plan), but those are outside the scope of this checklist. The disclosures described in this checklist are limited to the disclosures required to be provided automatically at the time of eligibility/enrollment or periodically thereafter for existing welfare plans. *Note that not all of the items in this checklist will apply to all welfare plans; for example, stand-alone retiree-only plans and certain "excepted benefits" (e.g., limited-scope dental and vision plans and certain employee assistance programs (EAPs)) are exempt from many of these requirements; certain small employers may be exempt from COBRA and other requirements; non-federal governmental plans may have opted out of one or more of certain compliance obligations; etc.* Additional requirements may apply outside the scope of this document, like information reporting required on IRS Forms 1094-B and 1095-B (with instructions), Forms 1094-C and 1095-C (with instructions), and Form W-2 reporting of healthcare costs in Box 12, using code DD (with instructions).

[2] The Employee Retirement Income Security Act of 1974, as amended.

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Summary Annual Report (SAR) ERISA requires a summary, in narrative form, of the Form 5500 Annual Return/Report of Employee Benefit Plan most recently filed for the plan (if applicable). DOL-prescribed SAR contents.	N/A	Provide to all plan participants within **nine months after the plan year's end** (or two months after the due date of Form 5500 with an approved extension).
General COBRA[3] Notice This notice describes to participants and their covered family members their right to purchase a temporary extension of group health plan coverage when coverage is lost because of certain "qualifying events" under COBRA. Model notice in English; Model notice in Spanish.	Provide to each covered employee and covered spouse* no more than 90 days after group health plan coverage begins. **A single notice may be mailed to the employee's home, addressed to both the employee and spouse if the spouse is known to reside there.*	N/A
HIPAA[4] Notice of Privacy Practices A group health plan (or an insurer) subject to the HIPAA privacy rules must provide this notice describing the uses and disclosures of protected health information (PHI) and the individual's rights and the plan's (or insurer's) duties with respect to that PHI. Model notice, scroll down to "NPP Health Plan Files"	Provide to new enrollees in the plan at the time of enrollment. (Notice to the covered participant is deemed to provide notice to his or her covered dependents.)	At least **once every three years**, notify all participants of the *availability* of the Notice of Privacy Practices and how to obtain it. If there is a material change to the notice: • A group health plan that posts the notice on a website that is maintained for the plan must post the revised notice by the effective date of the material change and provide the revised notice in the next annual mailing to plan participants (e.g., open enrollment mailing). • A group health plan that does not post the notice on a website must provide the revised notice (or information about the material change and how to obtain the revised notice) to plan participants within 60 days of the effective date of the material change.

[3] The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.
[4] The Health Insurance Portability and Accountability Act of 1996, as amended.

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Notice of Special Enrollment Rights Under HIPAA and CHIPRA[5] This notice describes the rights of certain individuals to enroll in a group health plan upon the happening of certain events (and under certain circumstances), such as the loss of other coverage; gaining a new dependent through marriage, birth, adoption, or placement for adoption (with notice within at least 30 days); or becoming eligible for premium assistance under Medicaid or a Children's Health Insurance Program (CHIP) (with notice within 60 days). Model language (page 138). *The notice must be revised to also include a description of the Medicaid- and CHIP-related special enrollment events.*	Provide notice to each eligible employee at or before the time the employee is initially offered the opportunity to enroll in the group health plan.	N/A (although this notice is not required to be provided annually, for plans using the Affordable Care Act[6] look-back measurement method to determine medical plan eligibility, it is a good practice to include this notice in annual open enrollment materials since that may correspond with specific individuals' initial opportunity to enroll).
Employer Notice Regarding Premium Assistance Under Medicaid or CHIPRA This notice informs employees of potential opportunities for premium assistance under a Medicaid or CHIPRA program of the state where the employee resides (if applicable). Model notice (available in English and Spanish and Word and PDF versions). *This notice is updated periodically (at least annually) — take care to use the most recently updated notice at the time of distribution*.	N/A	**Annually** distribute to each employee (regardless of the employee's medical plan enrollment status) who resides in a state where medical premium assistance is available under that state's Medicaid or CHIPRA program.* Refer to the most recent model notice for a current list of applicable states. **An employer may distribute the notice to all employees for administrative simplicity.*
Women's Health and Cancer Rights Act (WHCRA) Notices This notice describes the requirement under WHCRA for a group health plan providing mastectomy benefits and coverage for breast reconstruction, prostheses, and physical complications in connection with the mastectomy. Model initial and annual notices (pages 141 and 142).	Provide notice to each participant upon enrollment in the applicable group health plan.	Provide notice to all participants **annually** (either the initial notice or the simplified model annual notice will fulfill this annual WHCRA notice requirement).

[5] The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, as amended.
[6] The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, and subsequently amended.

Item/Description	Initial Disclosure Requirement(s)	Annual (or Other Periodic) Disclosure Requirement(s)
Notice of Creditable or Non-Creditable Prescription Drug Coverage This notice describes to Medicare Part D eligible individuals whether their prescription drug coverage under the plan constitutes "creditable coverage" under Medicare Part D rules to help them determine whether to enroll in Part D coverage during the annual Medicare Part D election period (October 15 to December 7, for coverage generally effective January 1) or their initial Medicare Part D enrollment period. Model notices.	Provide to each Medicare Part D eligible individual* who joins (or seeks to join) the plan during the plan year prior to the prescription drug coverage effective date under the plan. **This includes participants, COBRA continuees, covered spouses and dependents. A single notice may be provided to the individual, the individual's spouse and/or dependent(s) covered under the same plan (unless the spouse or dependent is known to reside at a different address).*	Provide to Medicare Part D eligible individuals* **each year, prior to** October 15**, the start of the Medicare annual election period. **If this notice is annually distributed to all covered individuals by this due date, the plan is relieved of the requirement to also distribute the notice to covered individuals who first become eligible for Part D coverage during the year.* *** "Prior to" means a notice must have been provided within the last 12 months.*
Summary of Benefits and Coverage (SBC) The Affordable Care Act requires group health plans to provide a standardized summary of benefits and coverage available under each applicable group health plan benefit package (typically, each of the medical coverage options available under the plan). The new SBC template, group health plan guidance for drafting the SBC, uniform glossary for use with the SBC, and other guidance are all available here.	Provide to individuals* as part of initial application materials** for enrollment (and again by the first day of coverage if there are changes to the information in the SBC between application and enrollment). ** This includes participants and COBRA continuees, as well as covered spouses and dependents. A single notice may be provided to the individual and his or her spouse and/or dependent(s) covered under the same plan (unless the spouse or dependent is known to reside at a different address).* *** The SBC is not required at application if provided earlier upon request, and there have been no changes to SBC.*	Provide to individuals:* • As part of annual open enrollment materials, if no annual open enrollment is held, at least 30 days prior to the new plan year (with some flexibility for an insured plan for late insurance policy issuance or renewal). • Within 90 days of their special enrollment. • At any time upon request, within seven business days of the request. • At least 60 days prior to the effective date of any *mid-year* material change to the benefits/coverage described in the SBC. ** This includes participants and COBRA continuees, as well as covered spouses and dependents. A single notice may be provided to the individual and the individual's spouse and/or dependent(s) covered under the same plan (unless the spouse or dependent is known to reside at a different address).*

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Patient Protections Notice The Affordable Care Act requires non-grandfathered group health plans to describe to covered individuals their rights to (1) choose a primary care provider or a pediatrician (when the plan requires designation of the same) and/or (2) obtain obstetrical or gynecological care without prior authorization. Model notice (page 150).	Include (if applicable) whenever an SPD or other description of benefits is provided.	
Notice of Grandfathered Health Plan Status The Affordable Care Act requires that any group health plan believed to be a "grandfathered health plan" must disclose its status as a grandfathered health plan. Model notice (page 149).	Include (if applicable) in any plan materials describing the benefits provided under the plan, including the SPD.	
Employer Notice to Employees of Coverage Options The Fair Labor Standards Act (FLSA), as amended by the Affordable Care Act, requires FLSA-subject employers to provide notice to employees of health coverage alternatives available through the Health Insurance Marketplace and some of the consequences of participating. Model notices — one for employers that offer health plan coverage to some or all employees and the other for employers that do not (both in English and Spanish versions) — and related guidance is available here.	Provide to all employees (regardless of plan eligibility or enrollment status) at the time of hiring (or within 14 days of the employee's start date).	N/A

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Wellness Program Disclosures: **HIPAA** If a group health plan offers a wellness program that rewards an individual for satisfying a standard *related to a health factor (which includes performing or completing an activity related to a health factor),* then the plan must disclose the availability of a reasonable alternative standard for obtaining the reward. The disclosure must include contact information for obtaining the alternative and a statement that the recommendations of an individual's physician will be accommodated. Model language (page 139). The applicable regulations also provide other examples of permissible language (in the various examples starting on page 773). **GINA**[7] When a wellness program (e.g., a health risk assessment) requests family or medical history or other genetic information of an employee or an employee's spouse, the individual must provide knowing, voluntary, and written authorization on a form that describes the genetic information obtained, how it will be used, and any restrictions on its disclosure. **ADA**[8] If a wellness program makes disability-related inquiries or requests employees to complete a medical examination, the program must be voluntary. The ADA requires a notice that explains what information will be collected, how it will be used, restrictions on disclosure of the information, who will receive it, and the methods used to keep it confidential.[9] Sample notice.	*If applicable:* Include in all plan materials describing the terms of the wellness program. GINA disclosures must be provided to employees and spouses who participate in the wellness program prior to the completion of the program. ADA notice must be provided to employees before they provide any health information and with enough time for the employee to decide whether to participate.	

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[7] Genetic Information Nondiscrimination Act of 2008, as amended.
[8] Americans with Disabilities Act of 1990, as amended.