2012 ERISA Welfare Plan
Automatic Participant Disclosures Checklist

October 17, 2012

We recognize that many of our clients sponsor ERISA welfare benefit plans and are currently in the throes of planning and preparing their open enrollment process and related participant communications. To assist our clients with that process, we have prepared an **Automatic Participant Disclosures Checklist** for use during open enrollment and throughout the plan year. A copy of this checklist is located on the following pages.

Please note that many of the disclosure requirements, links, and/or other information provided in the checklist may change from time to time; therefore, please check our **Employee Benefits Practice Group newsletters page** periodically for the most current version of this checklist.

If you have questions regarding the information in this checklist, please contact any of the attorneys in our Employee Benefits Practice Group listed below.

Bass, Berry & Sims Employee Benefits Attorneys

Richard Barry
(615) 742-6230
rbarry@bassberry.com

Curtis Fisher
(615) 742-7892
cfisher@bassberry.com

John Kirk
(615) 742-7808
jkirk@bassberry.com

Fritz Richter
(615) 742-6256
frichter@bassberry.com

David Thornton, *Chair*
(901) 543-5922
dthornton@bassberry.com

The materials contained herein have been abridged from the statutory sources and should not be construed or relied upon for legal advice. Readers are urged to consult legal counsel concerning particular situations and specific legal questions.

To ensure compliance with requirements imposed by the IRS, we inform you that this message is not intended to be used, and cannot be used, by the addressee or any other person for the purpose of avoiding penalties that may be imposed under the Internal Revenue Code.

2012 ERISA[1] Welfare Plan
Automatic Participant Disclosures Checklist[2]

Item/Description	Initial Disclosure Requirement(s)	Annual (or Other Periodic) Disclosure Requirement(s)
NEW Summary of Benefits and Coverage Under the Affordable Care Act,[3] the insurer (of an insured plan) or the plan administrator (of a self-funded plan) must provide a standardized summary of benefits and coverage (SBC) available under each applicable group health plan benefit package (typically, each of the medical coverage options available under the plan). The template for the SBC is available at: http://www.dol.gov/ebsa/pdf/SBCtemplate.pdf. Group health plan guidance for drafting the SBC is available at: http://www.dol.gov/ebsa/pdf/SBCInstructionsGroup.pdf. The uniform glossary for use with the SBC is available at: http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf.	Provide to current and eligible participants and beneficiaries* during the first open enrollment period beginning on or after September 23, 2012. For plan years beginning on or after September 23, 2012, the SBC is required to be distributed to participants and beneficiaries: • 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); • as part of annual open enrollment materials, or if no annual open enrollment is held, the SBC must be provided at least 30 days prior to the new plan year (with some flexibility for an insured plan for late insurance policy issuance or renewal); • to special enrollees, within 90 days of their special enrollment; • at any time upon request, within seven business days of the request; and • at least 60 days prior to the effective date of any *mid-year* material change to the benefits/coverage described in the SBC. May be distributed electronically if certain requirements are met (see Q&A10 at http://www.dol.gov/ebsa/pdf/faq-aca8.pdf). Under current guidance, the SBC may be incorporated into the SPD as long as the SBC is intact and prominently displayed at the beginning of the SPD; however, we recommend maintaining the SBC as a standalone document because the SBC distribution requirements are broader than SPD distribution requirements. **The requirement to provide the SBC to the participant's covered dependents will be met if the SBC is provided to the participant, unless the plan has knowledge of a dependent's separate address.*	

[1] The Employee Retirement Income Security Act of 1974.
[2] 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. *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" 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.*
[3] The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010.

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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) or during their initial Medicare Part D enrollment period. The current model notices are available at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Model-Notice-Letters.html.	Distribute to each Medicare Part D eligible individual* who joins (or seeks to join) the plan during the plan year, prior to his or her prescription drug coverage effective date under the plan. **This includes disabled or retired 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).*	Distribute to all covered individuals* each year, prior to** **October 15**, the start of the Medicare annual election period. **If this notice is distributed to all covered individuals (rather than just Medicare Part D eligible 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 Medicare coverage during the year.* ***Guidance clarifies that "prior to" means a notice must have been provided within the last 12 months.*
Summary Annual Report The Summary Annual Report (SAR) summarizes, in narrative form, the Form 5500 Annual Return/Report of Employee Benefit Plan most recently filed for the plan (if applicable).	N/A	Distribute to all plan participants within nine months after the end of the plan year (or two months after the due date of the Form 5500, with an approved extension).
Women's Health and Cancer Rights Act (WHCRA) Notices A group health plan providing mastectomy benefits must also provide coverage for breast reconstruction, prostheses, and physical complications in connection with the mastectomy, as required by WHCRA—these notices describe the availability of that coverage. Model initial and annual notices are available at http://www.dol.gov/ebsa/pdf/cagappc.pdf (pages 109 and 110).	Provide notice to each participant upon enrollment in the applicable group health plan.	Provide notice to all participants annually (either the enrollment notice or the simplified model annual notice will fulfill this annual WHCRA notice requirement).

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General Notice of Preexisting Condition Exclusion When a group health plan imposes any preexisting condition exclusion(s), the exclusion(s) must be fully disclosed along with a description of the right of the individual to demonstrate "creditable coverage" to avoid all or part of the exclusion. A model notice is available at http://www.dol.gov/ebsa/pdf/cagappc.pdf (beginning on page 99).	If applicable, include in "written application materials" for initial plan enrollment (if written application materials are not provided, the notice should be provided as soon as possible following a request for plan enrollment).	If applicable, include in "written application materials" for annual plan enrollment (if written application materials are not provided, the notice should be provided as soon as possible following a request for plan enrollment).
Notice of Special Enrollment Rights Under HIPAA[4] and CHIPRA[5] This notice describes the rights of certain individual(s) 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; or becoming eligible for premium assistance under Medicaid or a Children's Health Insurance Program (CHIP). Model language is available at http://www.dol.gov/ebsa/pdf/cagappc.pdf (on page 102), although it must be revised to 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
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.	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 the current notice.

[4] The Health Insurance Portability and Accountability Act of 1996.
[5] The Children's Health Insurance Program Reauthorization Act of 2009.

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Employer Notice Regarding Premium Assistance Under Medicaid or CHIP This notice informs employees of potential opportunities for premium assistance under a Medicaid or CHIP program of the state in which the employee resides. The DOL provides (and periodically updates) a model notice (available at http://www.dol.gov/ebsa/pdf/chipmodelnotice.pdf)—*care should be taken to ensure most currently available notice is used 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 in which medical premium assistance is available under that state's Medicaid or CHIP program* (for a current list of states, refer to the most recent model notice). **For administrative simplicity, an employer may distribute the notice to all employees.*
General COBRA Notice Formerly (and often still) referred to as the initial COBRA notice, the general 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.[6] The current model general COBRA notice is available at http://www.dol.gov/ebsa/modelgeneralnotice.doc.	Distribute to each covered employee and covered spouse* within 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 at that address).*	N/A

[6] The Consolidated Omnibus Budget Reconciliation Act of 1985.

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Summary Plan Description A summary plan description (SPD) informs participants about their benefits, rights, and obligations under the plan and describes how the plan operates. The Department of Labor prescribes 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 also 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 at http://www.dol.gov/ebsa/pdf/cagappc.pdf (on page 108)). • See the **Wellness Program Disclosure** requirement below. • See the **Patient Protection Notice** requirement below. • See the **Notice of Grandfathered Health Plan Status** requirement below. • See the **Notice of Waiver from Annual Limit 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 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).* An SPD must be updated (incorporating all SMMs) and distributed to all participants at least every five years (ten years, if no changes were made to the plan during that period).

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Wellness Program Disclosure—*Availability of Reasonable Alternative Standard* If a group health plan includes a wellness program that rewards an individual for satisfying a standard *related to a health factor*, a description of the availability of a reasonable alternative standard for obtaining the reward must be described. A model notice is available at http://www.dol.gov/ebsa/pdf/cagappc.pdf (beginning on page 107).	Include (if applicable) in all plan materials describing the terms of the wellness program.	
Patient Protections Notice The Affordable Care Act requires that a non-grandfathered group health plan describe to covered individuals their rights to (1) choose a primary care provider or a pediatrician (when the plan requires designation of a primary care physician), and/or (2) obtain obstetrical or gynecological care without prior authorization. A model notice is available at http://www.dol.gov/ebsa/patientprotectionmodelnotice.doc.	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. A model notice is available at http://www.dol.gov/ebsa/grandfatherregmodelnotice.doc.	Include (if applicable) in any plan materials describing the benefits provided under the plan, including the SPD.	

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Notice of Waiver from Annual Limit Requirement Any limited benefit group health plan (or mini-med plan) that has received a waiver from compliance with the Affordable Care Act restrictions on annual limits on essential health benefits must disclose the plan's receipt of the waiver and describe that the plan does not meet the minimum annual limit. The most current version of the model notice, along with related guidance, is available at http://cciio.cms.gov/resources/files/06162011_annual_limit_guidance_2011-2012_final.pdf.	Provide (if applicable) to current and eligible participants in the applicable plan "as part of any informational or educational materials" about the plan, including the SPD. Notice must be provided in **bold 14-point type**, and must otherwise be prominently displayed.	