



Open Enrollment Checklist

Open enrollment is one of the most important times of the year for both employers and employees. In addition to communicating benefit changes and helping employees make informed enrollment decisions, employers should take time to review key compliance, reporting, and documentation requirements that may apply to their benefit programs.

This checklist is designed to help guide your planning process and identify common items that are often reviewed during open enrollment preparation. Not every item will apply to every employer or benefit plan, but working through these considerations can help support a smoother enrollment experience and reduce the risk of compliance issues later.

I. ERISA REQUIREMENTS

Distributing Open Enrollment Materials

DOL regulations provide a safe harbor that describes specific circumstances in which ERISA plans may use electronic delivery methods to furnish documents and other information required under ERISA. The DOL's electronic disclosure rules apply to all types of ERISA required communications from the plan, including open enrollment materials, Summary Plan Descriptions (SPDs), Summaries of Material Modifications (SMMs), Summary Annual Reports (SARs), and QMCSO notices.



For employees who have access to a work computer and to whom a computer is integral to their daily work, documents may be provided electronically. Employees who do not use a computer need advance notice that describes what documents will be provided electronically and how they will be provided electronically. Employees must consent to receive documents electronically, and their consent must include: the right to withdraw consent at any time; procedures to withdraw consent; and the right to receive the paper document free of charge.

Note: in July 2026, the DOL issued proposed rules to change the requirements for electronic distribution. These rules, if finalized, would streamline the process for electronic distribution of documents and reduce the administrative burden. Until the rules are final, employers should continue to use the existing rules and safe harbor for electronic distribution.

☐ **Distribute open enrollment materials in a compliant manner.**

Update Plan Documents

A Summary Plan Description is a summary of an ERISA plan document. It is a summary of the plan's terms and should be written so an average participant can understand what it says. If an employer sponsors employee benefits and it is subject to ERISA, it must create and distribute an SPD to plan participants. It should be distributed when employees become eligible, within 30 days of request, and every 5 years if no changes have been made.

Even if an employer is not covered under ERISA, they should also have non-ERISA plan documents and distribute to the participants in the benefit plans.

☐ **Review the Plan Document and SPD and ensure it is up to date with the current plan offerings prior to open enrollment.**

Voluntary Benefits

Voluntary benefits are benefits employees can opt in to in addition to the benefits offered by their employers. Examples of voluntary benefits include hospital indemnity plans, critical illness plans, etc. The DOL regulations do offer a safe harbor exception from the definition of “employee welfare benefit plan” under ERISA for voluntary benefit programs in which an employer’s involvement in operating the program is minimal. The courts have not interpreted consistently what constitutes minimal involvement to satisfy the safe harbor. Therefore, whether a plan is or is not subject to ERISA can be ambiguous and may require a review by qualified counsel to determine.



Review voluntary benefits and plan documents to know whether they are subject to ERISA.

II. OTHER DOCUMENT DISTRIBUTION

Summary of Benefits and Coverage (SBC)

An SBC is a summary of the plan’s terms in a specific format, usually provided by the carrier or TPA. Group health plans and Plan Administrators must provide the SBC to plan participants and beneficiaries at no charge. The ACA establishes a penalty of up to \$1,105 for each willful failure to provide the SBC. Failing to provide the SBC may also trigger an excise tax of \$100 per day per individual for each day of noncompliance.



Confirm that current Summary of Benefits and Coverage (SBC) documents have been obtained and distributed to participants.

Annual Compliance Notices

The DOL, EEOC/HIPAA and HHS required notices include the following:

- Exchange Notice (also known as Notice of Coverage Options) – this is the only notice that needs to be provided to all new hires within 14 days. The rest of the notices need to be provided to plan participants.
- COBRA Election Notice
- Medicaid and the Children’s Health Insurance Program Reauthorization Act (CHIPRA)
- Mental Health Parity
- Newborns’ Act Disclosure

- Special Enrollment Notice
- Women's Health and Cancer Rights Act
- Wellness Program Disclosure
- Notice of Privacy Practices
- Medicare Part D Notice of Creditable Coverage
- ACA Reporting Notice (if not distributing Form 1095-Cs automatically)



Review your annual notice packet and confirm it is up to date and reflects your benefit plan design (such as wellness programs).

COBRA Participants and OE Materials

COBRA is a federal law that allows workers and their dependents to temporarily keep their health coverage after qualifying events such as death of the covered employee, termination of employment for any reason except gross misconduct, reduction in hours, divorce or legal separation, or a child losing dependent status. COBRA allows participants whose employer has 20 or more employees to keep the same health benefits they had while employed. Participants are responsible for paying 100% of the cost, plus 2% for administrative costs.

COBRA coverage must be identical to the coverage currently available to similarly situated active employees and their dependents. COBRA participants must have access to Open Enrollment.



Ensure COBRA participants receive the same open enrollment opportunities and communications as similarly situated active employees.

Cafeteria Plan Documents

Benefits offered through a cafeteria plan allow employees to make pre-tax elections and select which of the offered benefits they would like to enroll in. Employees can choose to cover other individuals, including spouses and dependents, if the employer's plan allows. These elections are prospective, with an exception for birth, adoption, and placement for adoption as well as new hires. The IRS considers pre-tax elections to generally be irrevocable unless a permitted Qualifying Life Event occurs, or there is an exception. These events include marriage, birth, adoption, loss of coverage, participants who lose CHIP or Medicaid, etc.



Identify and review that Cafeteria Plan documents are up to date.

Employee Benefit Guide

An Employee Benefit Guide provides an overview of the benefits offered by the employer. It should include details on the health and welfare benefits, and paid time off. The guide should include the eligibility requirements for each benefit, how to enroll or opt out of specific benefits, and the costs associated with benefits. The guide should be a resource for employees to make informed decisions about their benefits.

- ☐ **Update and distribute Employee Benefit Guide.**

III. REPORTING

ACA Employer Mandate Tracking

Employers who have 50 or more full-time equivalent employees (ALEs) will pay a penalty if they don't offer affordable, minimum value health care coverage to 95% of their full-time employees and dependent children up to 26. Employers need to track the hours of employees who are part-time or have a variable hour schedule that could become full-time. If they reach full-time status (30+ hours per week), they need to be offered benefits. The Employer should keep a signed written or electronic record that coverage was offered, even if the employee declines.

- ☐ **Identify if using the monthly or look back measurement method.**
- ☐ **Confirm that hours are being tracked, either internally or through a vendor, and document whether coverage was offered.**

ACA Reporting and IRS Filing

In order to ensure the benefits offered are affordable, ALEs need to meet one of the following affordability safe harbors: W-2, Rate of Pay, and Federal Poverty Level.

- ☐ **Verify affordability safe harbor.**
- ☐ **If applicable, confirm who is filing the Form 1094 and 1095s.**

CMS Reporting

Employers are not required to offer creditable coverage to individuals, but employers who do provide prescription drug coverage to Medicare Part D eligible individuals must determine whether their drug coverage is as good or better (creditable) than what Medicare Part D would provide, as certified by an actuary or through a design-based safe harbor.

Many insurance carriers, HMOs and TPAs for self-funded plans will perform the calculations to determine if a plan is creditable or not.

Plans that are unable to determine their creditable coverage status with one of the applicable safe harbor methods must utilize an actuary to provide a determination.

There are two required disclosures regarding prescription drug benefits:

1. Medicare Part D creditable coverage status must be communicated to participants in the group health plan and COBRA by October 15; and
2. Employers must disclose creditable coverage status to CMS using their online disclosure form within 60 days after the start of the plan year.



File disclosure with CMS and notify the participants of your creditable coverage status.

Nonquantitative Treatment Limitations Testing (NQTL)

All group health plan sponsors of both fully insured and self-funded plans must consider the requirements of the Mental Health Parity and Addiction Equity Act and the Patient Protection and Affordable Care Act (ACA). MHPAEA is a federal law that generally requires large group health plans and health insurance issuers to provide mental health or substance use disorder (MH/SUD) benefits equal to medical/surgical benefits.

The CAA of 2021 requires group health plans and health insurance carriers to perform comparative analyses to demonstrate compliance with mental health parity requirements.

Fully insured plan sponsors should reach out to their carriers to determine how the carrier will be handling the requirements. Self-funded plan sponsors should put an action plan in place to complete the testing. A small number of third-party administrators are offering this service to their self-funded clients.

Alera Group strongly recommends that employers sponsoring self-funded health plans complete this analysis for plan years starting in 2022 and

annually thereafter in the event they are audited by the Department of Labor or a plan participant requests a copy of the analysis. This analysis takes a long time to complete and it is recommended to start as soon as a plan renews.

- ☐ **If fully insured, confirm NQTL testing with carrier**
- ☐ **If self-funded, perform NQTL testing.**

State Reporting Requirements

Ensure that you are familiar with your state's various requirements. For example, Illinois requires any employer that provides health insurance coverage to employees working in Illinois to provide a disclosure comparing the plan's covered benefits against the essential health benefits (EHBs) that state-regulated individual health insurance policies must provide.

The following states have mandated disability programs: California, New Jersey, New York, Rhode Island and Hawaii, as well as Puerto Rico.

Employers in some states, cities and boroughs are required to provide transportation benefits, including Illinois, New Jersey; New York City employers in Manhattan, Brooklyn, Queens, Staten Island, and the Bronx; Seattle, Washington; and California's San Francisco Bay Area, including Richmond and Berkeley; and Washington, D.C.

Employers that have any employees that work in San Francisco are subject to the Health Care Security Ordinance (HCSO).

Employers of all sizes that have any employees residing in Hawaii must offer a Hawaii-sitused plan to those employees and meet affordability requirements much more stringent than the ACA.

AleraHR is a great resource for state requirements, make sure you are receiving their updates.

- ☐ **Complete state reporting requirements where your company and your employees are located.**

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- ☐ **Update Plan Documents**
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- ☐ **Annual Compliance Notices**
Review your annual notice packet and confirm it is up to date and reflects your benefit plan design (such as wellness programs).
- ☐ **Voluntary Benefits**
Review voluntary benefits and plan documents to know whether they are subject to ERISA.
- ☐ **COBRA Participants and OE Materials**
Ensure COBRA participants receive the same open enrollment opportunities and communications as similarly situated active employees.

II: OTHER DOCUMENT DISTRIBUTION

- ☐ **Summary of Benefits and Coverage (SBC)**
Confirm that current Summary of Benefits and Coverage (SBC) documents have been obtained and distributed to participants.
- ☐ **Cafeteria Plan Documents**
Identify and review that Cafeteria Plan documents are up to date.

- ☐ **Employee Benefit Guide**
Update and distribute Employee Benefit Guide

III. REPORTING

- ☐ **ACA Employer Mandate Tracking**
Identify if using the monthly or look back measurement method.
- ☐ Confirm that hours are being tracked, either internally or through a vendor, and document whether coverage was offered.
- ☐ **ACA Reporting and IRS Filing**
Verify affordability safe harbor.
- ☐ If applicable, confirm who is filing the Form 1094 and 1095s
- ☐ **CMS Reporting**
File disclosure with CMS and notify the participants of your creditable coverage status
- ☐ **Nonquantitative Treatment Limitations Testing (NQTL)**
If fully insured, confirm NQTL testing with carrier
- ☐ If self-funded, perform NQTL testing.
- ☐ **State Reporting Requirements**
Complete state reporting requirements where your company and your employees are located.



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*STATISTICS ACCURATE AS OF MARCH 31, 2026.

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