Employer Frequently Asked Questions

What is a Wrap SPD?
ERISA (the federal Employee Retirement Income Security Act) requires employers who are plan administrators of their group health plans to maintain and distribute summary plan descriptions (SPDs) to plan participants. The SPD describes important information about the plan in language that can be understood by the typical participant. The SPD must accurately reflect the contents of the plan and must include specific information required under federal law, much of which is typically missing from the benefits summaries and insurance certificates distributed by insurance companies.

A Wrap SPD is designed to wrap around existing certificates of insurance and benefit plan booklets to provide the information necessary to comply with ERISA's reporting and disclosure requirements. The Wrap SPD includes required ERISA provisions and recommended information to "wrap" around the benefit summaries or booklets, insurance certificates and other relevant plan descriptions for each fully insured or self-funded plan option or component plan. To be compliant with ERISA's reporting and disclosure requirements, the Wrap SPD and accompanying benefit plan component documents must be distributed to plan participants.

What is a Wrap Plan Document?
All ERISA-covered benefit plans, including group health plans and other welfare plans, must, by law, be administered in accordance with a written plan document. ERISA, HIPAA and other federal laws require the plan document to contain certain specified provisions. Many employers assume that insurance contracts for fully insured products are written plan documents. Insurance companies, however, draft their contracts to comply with state insurance laws and, as a result, the contracts do not contain many of the required or recommended provisions that protect the plan, the employer and plan fiduciaries.

A Wrap Plan Document is designed to meet plan documentation requirements under ERISA and other federal laws and to incorporate all other welfare plans, insurance contracts and other relevant documents into a single plan. These materials can be kept together for administrative ease. The Wrap Plan Document provides additional legal protection for the employer and plan fiduciaries and can simplify plan administration.

What does it mean for an employee benefit plan to be "covered" by ERISA?
ERISA is a federal law that covers most private sector employee benefit plans, and which sets forth uniform minimum standards to ensure that such plans are established and maintained in a fair and financially sound manner. Among other things, ERISA requires plan administrators—the people who run plans—to give plan participants in writing the most important facts they need to know about their health benefit plans including plan rules, financial information, and documents on the operation and management of the plan.

One of the most important documents participants are entitled to receive automatically when becoming a participant of an ERISA-covered health benefit plan or a beneficiary receiving benefits under such a plan, is a summary of the plan, called the summary plan description or SPD. For other basic disclosure requirements under ERISA, please refer to the U.S. Department of Labor's Reporting and Disclosure Guide for Employee Benefit Plans.

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Which employee benefit plans are ERISA-covered?
ERISA covers only those plans that constitute an "employee welfare benefit plan." An "employee welfare benefit plan" is any plan established or maintained by an employer that provides any of the following through the purchase of insurance or otherwise:

- Medical, surgical, or hospital care or benefits;
- Benefits in the event of sickness, accident, disability, death or unemployment;
- Vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services; and
- Any benefit described in section 302(c) of the Labor Management Relations Act (other than pensions on retirement or death, and insurance to provide such pensions).

Where there is an employer providing one or more of the described benefits, the U.S. Department of Labor has generally held that there is a "plan," regardless of whether the program of benefits is written or informal, funded or unfunded, or offered on a routine or ad hoc basis.

The following plans are excluded from ERISA:

1. Governmental plans;
2. Church Plans;
3. Plans maintained solely to comply with workers' compensation, unemployment compensation or disability insurance laws;
4. Plans maintained outside the United States;
5. Certain "payroll practices" listed below; and
6. Certain group or group-type insurance programs under which employer involvement is minimal (see "**Are voluntary benefits ERISA-covered?**" below).

The following "payroll practices" are excluded from ERISA:

1. Payments of compensation for work performed by an employee, including compensation at a rate in excess of the normal rate of compensation, such as:
    - Overtime pay;
    - Shift premiums;
    - Holiday premiums;
    - Weekend premiums.
2. Payments of normal compensation to employees out of the employer's general assets during periods of sickness, vacation, holidays, active military duty, serving as a juror, training, sabbatical leave, or while the employee is pursuing further education.

The information above should be used for **general reference purposes only**. The determination of whether a particular program may be excluded from ERISA is very complex, and therefore it is necessary to consult with qualified legal counsel for an analysis of the relevant regulations and case law.

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Are voluntary benefits ERISA-covered?
According to the U.S. Department of Labor, a voluntary welfare benefit program, where the employee pays the entire premium, would not be an ERISA-covered plan if the employer has minimal involvement in plan operations and does not "endorse" the plan. Basically, this means the employer cannot urge or encourage employee participation in the program, or engage in activities that would lead an employee reasonably to conclude that the program is part of a benefit arrangement established or maintained by the employer. Such activities include, but are not limited to:

- Stating that the plan is part of the employer's benefit package (e.g., "the ABC Company Life Insurance Plan");
- Generally being involved with selecting the insurer or coverage amounts; or
- Stating in communications that the employer is "enthusiastic" about the program.

However, the following employer activities are not considered an "endorsement" of the plan:

- Permitting the insurer to publicize the program to employees;
- Collecting premiums through payroll deductions and remitting them to the insurer.

The information above should be used for **general reference purposes only**. The determination of whether a particular program may be excluded from ERISA is very complex, and requires an analysis of whether the employer's specific activities exceed the limitations set forth in the relevant regulations, case law, and U.S. Department of Labor Advisory Opinions.

Isn't distributing the plan booklets or insurance certificates enough to be compliant with government requirements?
No. While carriers do provide plan information, they typically will not provide the required provisions that must be included in an SPD and plan document. So an employer/plan administrator will not be in compliance and faces the risk of penalties and other complications if participants only receive a benefits booklet/summary or certificate of insurance.

Who must provide the Wrap SPD?
The plan administrator (which is typically the employer) is the person specifically designated by the terms of the plan who is responsible for its management. If the plan does not make a designation, the plan sponsor (typically the employer that establishes or maintains the plan) is generally the plan administrator.

Who must receive the Wrap SPD?
The SPD should be distributed automatically to all plan participants. The employer/plan administrator also must furnish copies of the most current SPD and plan document to participants and beneficiaries upon written request and must have copies available for examination. Copies should be furnished no later than 30 days after a written request.

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Are there penalties if an employer does not have an SPD or plan document?
Employers/plan administrators may be liable for serious penalties if they don't provide an SPD or have a current plan document:

- Failure to provide an SPD or plan document within 30 days of receiving a request from a plan participant or beneficiary can result in a penalty of up to $110/day per participant or beneficiary for each violation.
- Lack of an SPD could trigger a plan audit by the U.S. Department of Labor (DOL).
- Having documentation in order protects against disgruntled employees if issues regarding coverage arise.

Can the SPD be distributed electronically?
Yes, as a general rule, materials required to be furnished under ERISA may be provided electronically if the plan administrator takes necessary measures reasonably calculated to ensure that the system for furnishing documents results in receipt of the material. Ways to ensure receipt of an SPD include using return-receipt or notice of undelivered email features, or conducting periodic reviews or surveys to confirm receipt. In addition, in order to provide materials electronically:

- The administrator must take steps reasonably calculated to ensure that the system protects the confidentiality of personal information relating to the individual's accounts and benefits;
- The electronically delivered documents must be prepared and furnished in a manner consistent with the style, format and content requirements applicable to the particular document;
- Notice must be provided to each participant, beneficiary or other individual, at the time the document is furnished electronically, that informs the individual of the significance of the document when it is not otherwise reasonably evident as transmitted (e.g., the attached document describes changes in the benefits provided by your plan) and of the right to request and obtain a paper version of such document; and
- Upon request, the participant, beneficiary or other individual must be furnished a paper version of the electronically furnished documents.

Unless an individual has the ability to effectively access documents furnished in electronic form at any location where the individual is reasonably expected to perform his or her duties as an employee, and access to the employer or plan sponsor's electronic information system is an integral part of an individual's job duties, he or she must affirmatively consent to receive documents through electronic media. In the case of documents to be furnished through the Internet or other electronic communication network, consent must be given in a manner that reasonably demonstrates the individual's ability to access information in the electronic form that will be used to provide the information. Prior to consenting, the individual must be provided a clear and conspicuous statement indicating:

- The types of documents to which the consent would apply;
- That consent can be withdrawn at any time without charge;
- The procedures for withdrawing consent and for updating the individual's address for receipt of electronically furnished documents or other information;
- 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
- Any hardware and software requirements for accessing and retaining the documents.

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If plan participants have already received their component benefit plan documents, like the benefits booklets and certificate of insurance, can just the Wrap SPD be distributed or do all the documents have to be distributed at the same time?
Wrap SPD and benefit plan component documents do not have to be distributed at the same time, as long as the plan participants receive all the required documents with the most current information that applies to plan benefits.

Do employers of all sizes need to provide Wrap SPDs?
ERISA requires plan administrators—the people who run plans—to give plan participants in writing the most important facts they need to know about their health benefit plans including plan rules and documents on the operation and management of the plan. Participants are entitled to receive a summary plan description (SPD) automatically when becoming a participant of an "ERISA-covered health benefit plan." (See WrapDoc FAQs titled, **What does it mean for an employee benefit plan to be "covered" by ERISA?** and **Which employee benefit plans are ERISA-covered?**) The plan administrator is legally obligated to provide the SPD to participants free of charge.

Which notices and Affordable Care Act (ACA) provisions are included in the Wrap SPD and/or Wrap Plan Document?
ACA Provisions:

- ***Disclosure of Grandfathered Health Plan Status*** – This disclosure will appear automatically in Appendix A of the Wrap SPD, depending on the information entered when creating the Wrap. The definition of a "grandfathered plan" can also be found in Article II, section 2.9 of the Wrap Plan Document.
- ***Dependent Coverage to Age 26*** – Article II, section 2.3 of the Wrap Plan Document addresses the definition of "dependent" to include a participant's eligible children who have not attained age 26, and, for grandfathered plans, prior to plan years beginning before January 1, 2014, who are not eligible to enroll in another employer's medical plan, other than the medical plan of a parent.
- ***Pay or Play*** – The Wrap Plan Document and Wrap SPD were recently revised to include provisions relating to the requirement under Health Care Reform that companies with 50 or more full-time employees (including full-time equivalent employees or FTEs) comply with the ACA's provisions regarding the definition of "full-time employees." This revision can be located in the "Eligibility and Benefits" section of the Wrap SPD and in Article III, section 3.1(b) of the Wrap Plan Document.
- ***Medical Loss Ratio*** – The Wrap Plan Document and Wrap SPD were also revised to state that the employer or plan administrator of the group health plan may have fiduciary responsibilities regarding the distribution of dividends, demutualizations, and the use of Medical Loss Ratio rebates. This revision is located in the "Eligibility and Benefits" section of the Wrap SPD and in Article V, section 5.2(d) of the Wrap Plan Document.

Other Health Care Notices:

- ***Newborns' and Mothers' Health Protection Act*** – This notice can be located in the "Special Rules for Maternity and Infant Coverage" section of the Wrap SPD, and in Article VII, section 7.6 of the Wrap Plan Document.
- The initial notice regarding the ***Women's Health and Cancer Rights Act*** can be located in the "Special Rule for Women's Health Coverage" section of the Wrap SPD, and in Article VII, section 7.7 of the Wrap Plan Document. Please note that there is also an annual requirement for this notice—a model annual notice can be found here (on the last page).

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Which notices and Affordable Care Act (ACA) provisions are included in the Wrap SPD and/or Wrap Plan Document? (CONT'D)
The following notices and ACA provisions are not included in the Wrap SPD and/or Wrap Plan Document:

- ***Summary of Benefits and Coverage (SBC)*** – Information regarding the requirement to provide an SBC can be located in the "SBC Templates" section of WrapDoc360.
- ***Notice of Patient Protections*** – This notice is located in the "Other Notices" section of WrapDoc360. It is not included in the Wrap SPD and Wrap Plan Document templates because the requirement to provide the notice only applies to non-grandfathered plans that require the designation by a participant or beneficiary of a primary care provider. Carriers will typically provide this notice, as the applicable regulations provide that it must be included whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits under the plan or health insurance coverage.
- ***Notice of Coverage Options (Health Insurance Exchange Notice)*** – This notice is also located in the "Other Notices" section of WrapDoc360 and is not included in the Wrap SPD and Wrap Plan Document because it must be provided to employees at the time of hiring, within 14 days of the employee's start date.
- ***Notice of Rescission of Coverage & PCORI Fees*** – WrapDoc360 does not address the notice with respect to rescinding coverage or filings related to Patient-Centered Outcomes Research Institute (PCORI) fees (which only apply to employers sponsoring certain self-insured health plans).
- ***Mental Health Parity & Addiction Equity Act (MHPAEA)*** – Plans subject to the MHPAEA must disclose the criteria for medical necessity determinations with respect to mental health and substance use disorder benefits available to any current or potential participant, beneficiary, or contracting provider upon request. Pre-ACA, this requirement generally applied to plans sponsored by an employer with 50 or more employees that offered medical/surgical benefits and mental health or substance use disorder benefits. Under ACA, most non-grandfathered plans are required to cover mental health and substance use disorder services as one category of "essential health benefits" that comply with the MHPAEA requirements for plan years starting in 2014. Specific plan rules regarding parity should be included in the benefit component plan documents describing the plan's coverage of mental health and substance use disorder benefits and related financial requirements and treatment limitations.

What is the difference between an 'employment-based orientation period' and a 'waiting period' under Health Care Reform?
The Affordable Care Act (ACA) prohibits group health plans from applying any waiting period that exceeds 90 days for plan years beginning in 2014. A **waiting period** is defined as the period of time that must pass before coverage for an employee or dependent who is "otherwise eligible" to enroll under the terms of a group health plan can become effective. Being "otherwise eligible" for coverage means having met the plan's eligibility conditions (such as, for example, satisfying a reasonable and bona fide **employment-based orientation period**).

Therefore, *before the waiting period begins*, an employer can require employees to complete a reasonable and bona fide employment-based orientation period. In order to be a permissible eligibility condition under the law, the reasonable and bona fide employment-based orientation period must not exceed one month, and the maximum 90-day waiting period must begin on the first day after the orientation period.

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What is the difference between an 'employment-based orientation period' and a 'waiting period' under Health Care Reform? (CONT'D)

Calculating the Length of an Orientation Period

One month would be determined by adding one calendar month and subtracting one calendar day, measured from an employee's start date in a position that is otherwise eligible for coverage or, if there is not a corresponding date in the next calendar month, the last day of the next calendar month. (For example, if an employee's start date is May 3, the last permitted day of the orientation period is June 2; if the employee's start date is August 31, the last permitted day of the orientation period is September 30.)

Calculating the Length of a Waiting Period

After an individual is determined to be otherwise eligible for coverage under the terms of the plan, any waiting period may not extend beyond 90 days. All calendar days are counted beginning on the first day of the waiting period, including weekends and holidays. (A plan that imposes a 90-day waiting period may, for administrative convenience, choose to permit coverage to become effective earlier than the 91st day if the 91st day is a weekend or holiday.)

Effect on Employer Shared Responsibility ("Pay or Play")

Employers with at least 50 full-time employees (including full-time equivalent employees) should review the final regulations regarding employment-based orientation periods and the ACA's 90-day waiting period limit to determine their impact on the "Pay or Play" guidelines.