



ERISA Plans Docs. 101

April 10, 2024

*This presentation does not constitute legal advice.
Please consult legal & tax counsel re: specific
guidance for benefit Plan actions based upon the facts
& circumstances of the inquiry.*

Agenda – ERISA Plan Documents 101

- ERISA Review
- Basic Plan Documents
- Additional Plan Documents
- Q2 Remaining Webinars



Olivia Ash, JD, MS
Benefits Compliance Counsel
Indiana-licensed Attorney & Teacher

Benefits Compliance Pillars at Patriot



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Employee Retirement Income Security Act (ERISA) of 1974 – 50 Year Anniversary

Regulates pension, retirement, and welfare plans

- Title I - regulates employee health & welfare plans
 - Most plans subject to ERISA
 - Church & government plans excepted
 - Amended to include additional regulations



How ERISA Governs Plans



Streamlines regulations via federal preemption



Requires plans to provide plan information to participants



Outlines requirements for protection of plan assets and fiduciary responsibilities



Requires plans to establish a grievance and appeals process for participants and beneficiaries



Gives participants the right to sue for benefits and breaches of fiduciary duty

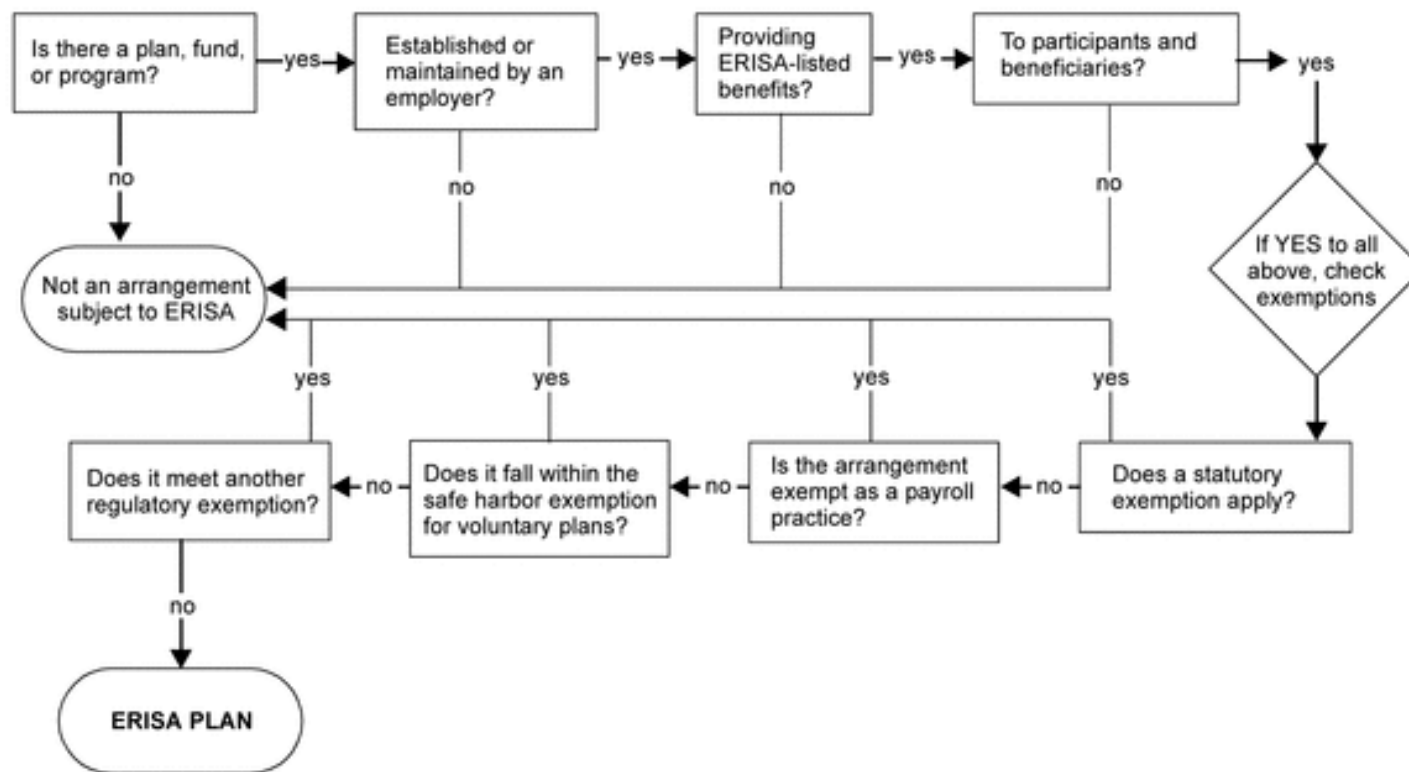
★ What is an ERISA Plan?

- A plan, fund, or program;
- Established or maintained by the employer;
- To provide a benefit* to participants or beneficiaries:



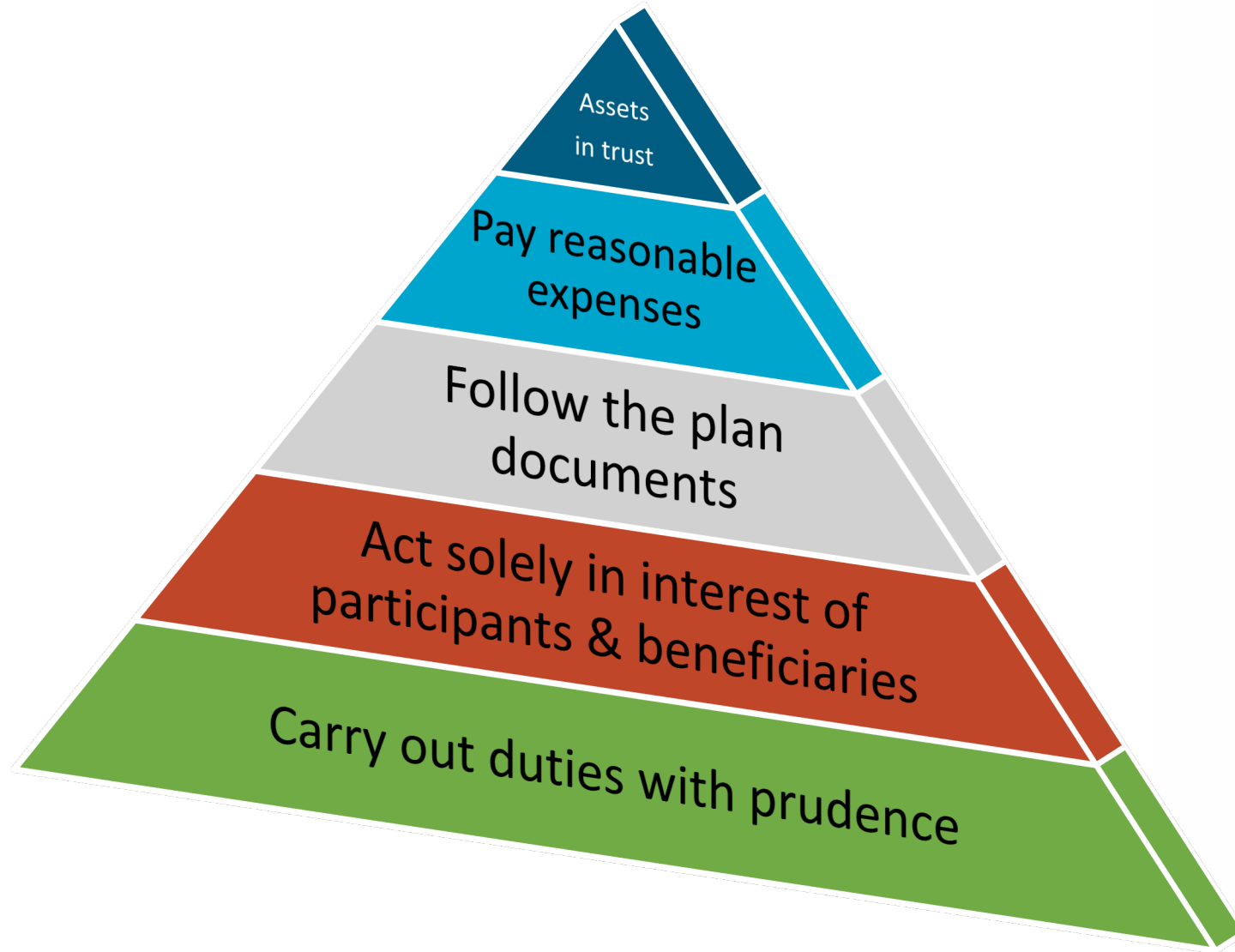
What types of benefits?

- Medical, surgical, or hospital
- Sickness, accidental, disability, death
- Daycare centers
- Scholarship funds
- Prepaid legal services
- Benefits:
 - Unemployment
 - Vacation
 - Apprenticeship or training
 - Holiday/severance
 - Housing assistance



ERISA Fiduciary

A person using discretion in administering & managing a plan or controlling the plan's assets is a fiduciary to the extent of that discretion or control.




★ **Functional Fiduciary: any person who**

1. Exercises **discretionary authority** or control over management of the plan or disposition of plan assets;
2. Gives **investment advice for a fee**; or
3. Has **any discretionary authority or responsibility in the administration of** such plan.



Functional Fiduciary

“Any individual who ‘de facto’ performs specified, discretionary duties respecting management, assets, or administration of the plan.”





Funded v. Insured – Plan Types

FUNDED → if uses plan assets to provide benefits

UNFUNDED → if provides benefits **solely** from ER's general assets

If ER accepts EE dollars → FUNDED, even if ER keeps \$ in a general account



ERISA Roles & Responsibilities

Plan → legal entity

Plan Sponsor → the employer

- Fund, establish, maintain, amend, and end plans

Plan Administrator → Plan Sponsor*

- Primary role to administer plan
- Assumes liability for failures
- Named in plan document
- Administrative duties:
 - **Plan disclosures & recordkeeping**
 - COBRA, HIPAA, QMCSO, Form 5500 filing

What about the TPA?

- NOT fiduciary unless specifically named
- Unless they make **final decisions on claims** or **access** to accounts with **plan assets**



Plan Administrator

§ 2510.3-16 Definition of “plan administrator.”

(a) *In general.* The term “plan administrator” or “administrator” means the person specifically so designated by the terms of the instrument under which the plan is operated.

If an administrator is **not so designated**, the **plan administrator is the plan sponsor**, as defined in section 3(16)(B) of ERISA.

ERISA Governance

- Provides fiduciary **responsibilities** for those **managing** plan assets.
- Requires plan administrators **provide** participants **information** about plan features and funding.
- Requires a **grievance & appeals** process for participants.
- Gives participants the right to sue the plan administrator for benefits & **breaches** of fiduciary **duty**.

★ ERISA Essential Elements

- A **written** plan → describes the benefit structure & guides day-to-day operations;
- A **trust** → hold the plan's **assets***;
- A **recordkeeping system** → track contribution & benefit payments, maintain participant & beneficiary information, & accurately prepare **reporting** documents; and
- **Documents** → **provide plan information to participating employees & government.**

Basic ERISA Plan Disclosures

- ✓ Summary Plan Description (SPD)
- ✓ Summary of Material Modifications (SMM)
- ✓ Summary Annual Report (SAR)
- ✓ Explanation of Benefits (EOB)
- ✓ Plan Document*
- ✓ Summary of Benefits and Coverage (SBC) and Uniform Glossary
- ✓ Summary of Benefits and Coverage: Notice of Modification
- ✓ Summary of Material Reductions in Covered Services/Benefits
- ✓ COBRA Notices: General; Election; Unavailability, Early Termination

Plan Document

Every ERISA plan **must be established & maintained** pursuant to a **written instrument or plan document** that gives participants the **most important facts about their health benefit plan**: plan rules, financial information, and documentation on **how it operates & is managed**.

Document	Details	To Whom?	Timing
<p>Summary Plan Description (SPD)</p>	<p>The SPD is the primary way to inform participants and beneficiaries about their plan and how it operates.</p> <p>It must be written for an <i>average participant</i> and be comprehensive enough to inform people of their benefits, rights, and obligations under the plan.</p> <p>Must accurately reflect the plan’s contents, & may not contain outdated information from more than 120 days before its initial disclosure.</p>	<p>Participants & Beneficiaries receiving benefits</p>	<p>Upon request</p> <p>To participants: within 90 days of becoming covered by the plan.</p> <p>To beneficiaries: within 90 days after first receiving benefits.</p> <p>A plan has 120 days after becoming subject to ERISA to distribute the SPD.</p> <p>Otherwise, once every 5 years for amended plans. Once every 10 years for all other plans.</p>

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SPD Must Contain

- ✓ Plan Identifying Information:
 - ✓ Name of Plan
 - ✓ Name & Address of Employer
 - ✓ Plan Sponsor's EIN
 - ✓ Plan Number
 - ✓ Type of Plan (medical, FSA, disability, etc.)
 - ✓ Type of plan administration (insurer, contract, etc.)
 - ✓ Plan administrator's name address & telephone number
 - ✓ Name and address of agent for service of legal process
 - ✓ Statement that the plan administrator may be served with process
 - ✓ Plan year Information about plan trustees (if applicable)
 - ✓ Certain information about collective bargaining agreements (if applicable)

SPD Must Contain

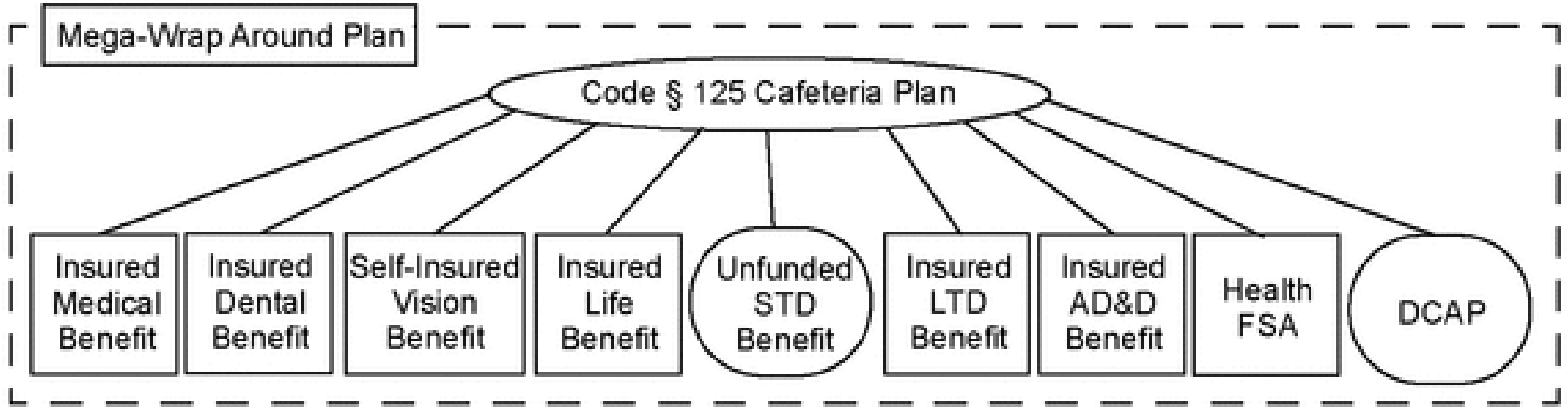
- ✓ Description of plan eligibility provisions
- ✓ Description of plan benefits
- ✓ Description of circumstances that would cause a denial of benefits
- ✓ Amendment and termination provisions
- ✓ Subrogation provisions
- ✓ Plan contributions and funding
- ✓ Coordination of benefits, and offset provisions
- ✓ Claim procedures and limits for lawsuits (if plan imposed)
- ✓ Statement of ERISA rights
- ✓ Offer of assistance in non-English language (if plan covers minimum number of non-English speaking participants)
- ✓ Description of employer's refund allocation policy (for insured plans relying on Form 5500 exemptions)
- ✓ Grant of discretion for plan administrator to interpret plan and make factual determinations

SPD: Additional Musts for Group Health Plans

- ✓ Detailed description of group health plan benefit provisions
 - ✓ Cost sharing provisions, premiums and deductibles
 - ✓ Co-insurance and co-payment amounts
 - ✓ Annual lifetime caps
 - ✓ Any benefit limitations
 - ✓ When existing and new drugs are covered
 - ✓ When medical tests, devices and procedures are covered
 - ✓ Preventive services covered and amounts
 - ✓ Pre-authorizations or utilization review requirements
 - ✓ Use of network providers, composition of provider networks, and when out-of-network services are covered
 - ✓ Conditions or limitations on primary care providers or specialists
 - ✓ Condition of limitations for emergency medical care

SPD: Additional Musts for Group Health Plans

- ✓ Role of health insurers (do they provide insurance or administration)
- ✓ Procedures for obtaining pre-authorizations, approvals, or utilization review decisions
- ✓ Effect of provider discounts on co-pays, deductibles or any other plan aspect
- ✓ Information of COBRA
- ✓ HIPAA preexisting condition and special enrollment disclosures
- ✓ Mental Health Parity Act – mental health parity disclosures
- ✓ Women's Health and Cancer Rights Act – coverage for reconstructive surgery after mastectomy
- ✓ Newborns' and Mothers' Health Protection Act – minimum hospital stays after childbirth disclosures
- ✓ Qualified Medical Child Support Order (QMCSO) information
- ✓ Coverage for adopted children
- ✓ Disclaimer stating that if there is a discrepancy between the SPD and the plan document, the plan document controls.



KEY

[- -] = ERISA Wrap Plan [] = ERISA Benefit (component) () = Non-ERISA Benefit (component)

COMPANY Health and Welfare Benefit Plan

BASIC WRAP PLAN DOCUMENT

including as components:

COMPANY Medical Plan

COMPANY Dental Plan

...Vision Plan

....Group Life/AD&D Plan

....Long-Term Disability Plan

...Employee Assistance Program (EAP)

...Health Flexible Spending Account (FSA)

....Limited Purpose FSA

Initial Effective Date: January 1, 2019

Amended and Restated Effective: January 1, 2023

Document	Details	To Whom?	Timing
<p>Summary of Material Modification (SMM)</p>	<p>The SMM describes modifications to a plan and changes to the information that is required to be in the SPD. The distribution of an updated SPD satisfies this requirement.</p>	<p>Participants & Beneficiaries receiving benefits</p>	<p>Within 210 days after the end of the plan year in which the change is adopted.</p>

Document	Details	To Whom?	Timing
Summary Annual Report (SAR)	The SAR is a narrative summary of the Form 5500.	Participants & Beneficiaries receiving benefits. The SAR is not required for defined benefit pension plans to which Title IV applies and that instead provide the annual funding notice.	Within 9 months after the end of the plan year, or 2 months after the due date for filing Form 5500 (with an approved extension).

Document	Details	To Whom?	Timing
<p>Summary of Benefits and Coverage (SBC) and Uniform Glossary</p>	<p>The SBC is a template that describes the benefits and coverage under the plan. A uniform glossary defines important health coverage and medical terms.</p> <p>See 29 CFR § 2590.715-2715(a) and (c).</p> <p>The SBC must include both a website link where an individual can review the Uniform Glossary as well as contact information for obtaining a paper copy.</p>	<p>Plans (provided by group health insurance issuers)</p> <p>Participants & Beneficiaries</p>	<p>With enrollment materials and upon renewal or reissuance of coverage.</p> <p>To special enrollees by the date the SPD is required to be provided (90 days from enrollment).</p> <p>Also, within 7 days upon request.</p>

Document	Details	To Whom?	Timing
<p>COBRA General Notice³</p>	<p><u>This notice informs employees and spouses of their right to purchase temporary extension of group health coverage when coverage is lost due to a qualifying event.</u></p> <p><u>See 29 CFR § 2590.606-1.</u></p> <p><u>A model notice is available</u></p>	<p>Covered employees</p> <p>Covered spouses</p>	<p>When group health plan coverage begins.</p>
<p>COBRA Election Notice³</p>	<p>This notice informs qualified beneficiaries of their right to elect COBRA coverage when they experience a qualifying event. It also includes information about other coverage options available, such as through a Marketplace.</p> <p>See 29 CFR § 2590.606-4.</p> <p>A model notice is available</p>	<p>Covered employees</p> <p>Covered spouses</p> <p>Dependent children who are qualified beneficiaries</p>	<p>Generally, within 14 days after the employer or qualified beneficiary notifies the plan administrator of the qualifying event.</p> <p>If the employer is also the plan administrator, the administrator has 44 days after the qualifying event to provide the notice.</p> <p>If the plan provides that COBRA continuation coverage starts on the date of loss of coverage, the administrator must provide the notice within 44 days of the date of loss of coverage due to a qualifying event.</p>

Document	Details	To Whom?	Timing
<p>Notification of Benefit Determination</p> <p>(Claims Notices or “Explanation of Benefits” EOB)</p>	<p>This notification provides information regarding benefit claim determinations. Adverse benefit determinations must include the required disclosures (for example, the specific reason(s) for the denial of a claim, a reference to the specific plan provisions on which the benefit determination is based, and a description of the plan’s appeal procedures).</p>	<p>Claimants, including:</p> <ul style="list-style-type: none"> • Participants • Beneficiaries • Authorized claims representatives. 	<p>Requirements vary depending on the type of plan and the type of benefit claim involved.</p>

Document	Details	To Whom?	Timing
<p>Plan Document(s) Certificate of Coverage or Plan Booklet with elements added</p>	<p>The plan administrator must provide copies of certain documents upon written request & must have copies available for examination.</p> <p>These include the latest updated SPD, the latest Form 5500, the trust agreement, and other documents that dictate how the plan is established or operated.</p>	<ul style="list-style-type: none"> • Participant • Beneficiaries <p>Also see 29 CFR § 2520.104a-8 regarding the Department’s authority to request documents.</p>	<p>Within 30 days after a written request.</p> <p>Plan administrators must make copies available at principal office of the plan administrator and certain other locations as specified in 29 CFR § 2520.104b-1(b).</p>

Plan Document

- ✓ Written
- ✓ Fully insured plan → Certificate of Coverage
- ✓ Self-funded → Drafted Word Doc/SPD with WRAP
- ✓ SPD often shared opposed to “Plan Document”
- ✓ Guiding instrument & must be followed
- ✓ Must be current*
- ✓ May amend



Additional ERISA Plan Documents

- ✓ Medical Child Support Order (MCSO) Notice
- ✓ National Medical Support (NMS) Notice
- ✓ Notice of Special Enrollment Rights
- ✓ Grandfathered Plan Disclosure/Notice
- ✓ Employer CHIPRA Notice
- ✓ Wellness Program Disclosure
- ✓ Newborns' Act Description of Rights
- ✓ Michelle's Law Enrollment Notice
- ✓ Mental Health Parity and Addiction Equity Act (MHPAEA) Criteria for Medically Necessary Determination Notice
 - ✓ Claims Denial Notice
 - ✓ Increased Cost Exemption

Additional ERISA Plan Documents

- ✓ Women's Health and Cancer Rights Act (WHCRA) Notices
- ✓ Transparency in Coverage – Disclosure to the Public (MRFs)
 - ✓ Disclosure to Participants and Beneficiaries (Price Comparison Tool)
- ✓ Notice Regarding Designation of a Primary Care Provider
- ✓ Employer Notice to Employees of Coverage Options (FLSA)
- ✓ Individual Coverage Health Reimbursement Arrangement (ICHRA) Notice
- ✓ EBSA Form 700 (Contraceptive coverage accommodation)
- ✓ External Review Process Disclosure
- ✓ Internal Claims and Appeals and External Review Notices

May – The CAA Revisited

June – ERISA's Fiduciary Duties

July – Transparency in Coverage (TiC) Act

August – Federal Family & Medical Leave Basics

September – Cafeteria Plans & Nondiscrimination Testing

October – HIPAA Privacy for Plans

November – HIPAA Security for Plans

December – A Look Ahead at 2025

Thank you!



Olivia Ash, JD, MS
Benefits Compliance Counsel
oash@patriotgis.com