Form 5500 Filing Requirements With Wrap Documents

Prepared by:
Brady C. Bizarro, Esq. and Jennifer McCormick, Esq.
The Phia Group, LLC

LORMAN®

Published on www.lorman.com - August 2019

INTRODUCING

Lorman's New Approach to Continuing Education

ALL-ACCESS PASS

The All-Access Pass grants you UNLIMITED access to Lorman's ever-growing library of training resources:

- ☑ **Unlimited Live Webinars** - 120 live webinars added every month
- ☑ **Unlimited OnDemand and MP3 Downloads** - Over 1,500 courses available
- ☑ **Videos -** More than 1300 available
- ☑ **Slide Decks -** More than 2300 available
- ☑ White Papers
- ☑ Reports
- ☑ Articles
- ☑ ... and much more!

Join the thousands of other pass-holders that have already trusted us for their professional development by choosing the All-Access Pass.

Get Your All-Access Pass Today!

SAVE 20%

Learn more: www.lorman.com/pass/?s=special20

Use Discount Code Q7014393 and Priority Code 18536 to receive the 20% AAP discount.

*Discount cannot be combined with any other discounts.

Form 5500 Filing Requirements with Wrap Documents

I. Overview

- A. Wrap Documents: Purpose, Types, Requirements
- B. Form 5500: In-Depth Review
- C. Case Studies and Best Practices

II. Wrap Documents

- A. Background in re employee welfare benefit plans
  - i. When employers provide benefits to employees, they have established an employee welfare benefit plan, under the Employee Retirement Income Security Act of 1974 ("ERISA").
  - ii. Types of employee benefit plans: medical, dental, vision, prescription, disability, HRA
  - iii. With a few exceptions, employers providing these plans must comply with ERISA.
  - iv. ERISA is a broad body of law encompassing many areas of compliance, including the requirement for health plans to create and distribute a summary plan description and plan document.
  - v. ERISA – maintain and distribute SPD to plan participants which accurately reflects plan content information and info as required under federal law… and administer plan in accordance with SPD, which must be made available to participants timely
  - vi. SPD/PD requirements
    1. PD
       - a. The plan document tells participants about plan benefits and provides guidelines to be used by the plan administrator in decision-making.
       - b. ERISA § 402 requires benefits plans be established and maintained according to a written instrument.
       - c. This written instrument describes plan operation and administration procedures generally includes:
         - i. The named fiduciary (i.e. individual who has authority and responsibility to administer the plan)
         - ii. Plan amendment and termination procedures
         - iii. Source of plan contributions
         - iv. Responsibility delegation between the employer and TPA

v. It is not required to be distributed to the participants unless requested.

2. SPD

a. The summary plan description is a summary of the plan's terms.

b. ERISA § 102 prescribes information that must be included in the summary plan description, including, but not limited to:

i. Name of the Plan

ii. Name and address of the Employer(s)

iii. Name, address, and phone number of Plan Administrator

iv. Name and address for Agent for Service of Process

v. Employer Identification Number (EIN)

vi. Type of Plan (i.e. group health plan)

vii. Type of Administration (i.e. TPA)

c. Provision of the SPD is a plan administrator responsibility, and is required to be distributed to participants.

3. Combined PD/SPD is ok

a. *Rhea v. Alan Ritchey, Inc. (858 F.3d 340 (5th Cir. 2017))*: A combined plan document and summary plan description is an acceptable document structure for ERISA compliance. In this case, a federal appellate court affirmed a trial court's holding that *a single document can serve as both the formal Plan Document ("a written instrument") and the SPD for an ERISA plan*. The court held that the employee benefit plan's SPD sufficiently complied with section 1102(b) of ERISA by giving sufficient information regarding how the plan is funded or how it can be amended.

vii. PD/SPD timing requirements matter

1. Timing

a. ***90 days*** - An SPD should be delivered to participants within 90 days after coverage takes effect (whether requested or not).

b. ***120 days -*** A new plan's SPD must be furnished within 120 days after the plan was established.

c. ***210 days -*** An amendment must be furnished within 210 days after the close of the plan year.

d. ***5 years -*** An updated SPD must be furnished to participants (10 years if no changes).

2. Consequences

a. 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.

b. Lack of an SPD could trigger a plan audit by the U.S. Department of Labor (DOL); DOL has increased its audit staff and national enforcement initiatives to investigate employers' compliance with Health Care Reform, resulting in companies of all sizes being audited and being required to provide an SPD and Plan Document.

c. … so if you have a crappy certificate of coverage … you need a wrap to avoid this penalty

d. Many crappy COCs do not include the ERISA info … and the requirement to do so is on the Plan Administrator; not the insurance company

e. So if you have a doc or are not sure whether it complies with ERISA … how do you solve that problem? A wrap!

B. What is a Wrap Document

i. Drafting tool used to supplement existent material that otherwise may lack the requirements as outlined under ERISA (see PD and SPD requirements above)

ii. It incorporates by reference the existing materials, but also "wraps" in ERISA required information

iii. As a result, the Wrap Document + PD = complete plan materials

iv. This is necessary when the insurance policy, certificate of coverage, etc. does not meet the ERISA requirements (i.e. insurance policy focuses on X state law, not ERISA compliance)

C. Wrap Documents vs. SPDs

i. Unlike a standard SPD, the content of a wrap document is highly dependent upon what an employer wants to accomplish and which component benefit plans the employer wants to contain within the wrap document.

1. EX: Employers will need to determine which benefits they want to wrap – typically the decision is based on whether or not they

are required to report for each plan. For example, if an employer has separate Medical, Vision, and Dental Plans. The Dental Plan qualifies for an exemption and does not have to file a 5500 and the Medical Plan is required to file a 5500. If the employer wraps all three Plans into the Wrap Document, they will then be required to report for the Dental Plan as well. The decision to create a wrap document is a facts and circumstances determination for an employer, including the decision about which benefits to include within the wrap.

ii. Purposes of a Wrap Document

1. Single 5500 – wrap all benefits into one mega plan, 5500 filing becomes easier.

a. Wrap documents are often used for administrative simplification purposes so that the employer can file one form 5500.

b. A wrap document containing both health benefits and other welfare benefits only needs to file one Form 5500, as such wrap documents are often used for administrative simplification purposes so that the employer can file one form 5500

c. The creation of a wrap document to file one form 5500 is the most common use of wrap documents for employers with self-funded plans.

d. Form 5500 instructions provide that one Form 5500 is required for each "plan."

e. If the plan sponsor chooses to bundle the benefits, benefits are bundled with a wrap document.

2. Meet ERISA SPD/PD requirements

a. Wrap documents are also used to meet ERISA's SPD and PD requirements if the component benefit plans do not comply with the SPD and PD requirements.

b. Using a wrap document to meet SPD/PD requirements is typically why fully-insured plans use wrap documents as fully-insured certificates generally do not contain all of the necessary information.

c. If the employer wants to use the wrap document to meet ERISA SPD and PD requirements, the wrap document or the component benefit plan must then include all SPD and PD items required by ERISA.

D. Types of Wrap Documents

i. When an employer begins to use a wrap documents, the employer is creating a new plan.

ii. Typically the following "types" of wrap documents are commonly referred to:

1. Basic Wrap (i.e., Single Benefit Plan Wrap Document) – The use of a wrap document for one benefit, also referred to as a basic a wrap, is utilized to allow the plan to meet the SPD/PD documentation requirements of ERISA.

2. Mega Wrap Document (i.e., comprehensive) – A "mega wrap," as the name implies, is the common term used when an employer bundles multiple benefits within a wrap document to form one plan to ease the administrative burden and allow the employer to file one form 5500.

E. Wrap Document Requirements

i. Introduction and Establishment of the Wrap Document

1. Notification that such document (together with the component plans) constitutes a legal instruction impt for tax and legal implications and that such doc IBR one or more documents that in more detail, describes certain provisions of the employee benefit plan and SPD

2. The Employer establishes the document as one ee benefit plan doc and SPD

3. Any information relevant to the plan being maintained pursuant to a CBA

4. Notification if any of the component plans retain GF status under ACA

5. Effective (or restated) date

6. ERISA SPD information (i.e. plan sponsor, named fiduciary, plan sponsor ID, plan year, effective date, plan number…. (see below), type of plan (medical, RX, dental, vision, group-term basic life, basic AD&D, voluntary Life Ad&d, short term disability, long term disability, cafeteria, employee assistance plan, wellness), and the agent for service of process

a. Note: The Wrap Document and the component benefit plan(s) should not have the same ERISA plan number. A Wrap Document is a new plan document and is assigned its own ERISA welfare plan number. The Wrap Document number would be used for Form 5500 filing purposes to report all of the benefits that have been wrapped. The component benefit plan's ERISA plan number will essentially be "retired" once the Wrap Document is

assigned an ERISA plan number—however, the group may choose to use the plan number for internal reference purposes. Plan numbers are not to be reused even if they are no longer in use ("retired"). The Plan will need to ensure that the Wrap Document's ERISA plan number is listed correctly.

7. Notice of non English assistance … The Offer of Assistance in a Foreign Language for SPDs: ERISA does not require SPDs to be translated into languages other than English, but if the Plan covers a certain minimum number of participants who are only literate in the same foreign language, the Plan is required to provide language assistance to those participants. An SPD must contain a notice in a foreign language, prominently featured, informing participants of where they can obtain additional assistance in that language, under the following circumstances: (1) For plans that cover fewer than 100 participants at the beginning of the plan year, when 25% or more are literate only in the same non-English language; or (2) For plans that cover 100 or more participants at the beginning of the plan year, when the lesser of (a) 500 or more participants, or (b) 10% or more of all participants are literate only in the same non-English language. SPDs must be distributed to newly eligible participants within 90 days of their joining the plan, but distribution upon employment to someone who is likely to fulfill eligibility requirements is also common.

8. Funding Medium and Type of Plan Administration information

    a. EX: The Medical and Prescription Drug benefits are fully insured OR self-insured. The Medical benefits are administered by Sample insurance company. The Prescription Drug benefits are administered by Sample insurance company. Both the Company and the participating Employees contribute to the premiums OR Medical and Prescription Drug benefits. The participating Employees contribute to the premiums OR Medical and Prescription Drug benefits. The Company contributes to the premiums or Medical and Prescription Drug benefits.

9. A list of insurance companies and/or administrators

ii. Definitions

1. Define the different types of benefits … what does ad&d mean? COBRA? Component benefit program? Plan, plan administrator, plan year

2. Covered person - may vary between options so sample - Covered Person means an individual who has properly enrolled

in, and who participates in a Component Benefit Plan in accordance with the terms and conditions established for that benefit plan, and who has not for any reason become ineligible to participate further in that benefit plan. Participation requirements are described in the individual Component Benefit Plans.

3. Basic terms that assist in the understanding of the benefits covered and who is eligible

iii. Eligibility, Participation and Coverage

1. Define when employees are eligible to participate and refer read to the component benefit plan for specifics, conditions and/or limitations
2. Define termination of benefits
3. Miscellaneous federal law / regulatory information
    a. Outline basic info about FMLA
    b. Section 609 of ERISA (i.e. If not otherwise provided for herein, the Plan shall provide coverage to a child solely to the extent required by a qualified medical child support order under Section 609(a) of ERISA or to an adoptive child or child placed for adoption solely to the extent required by Section 609(c) of ERISA. Further, the Plan shall be interpreted and administered as necessary to comply with Section 609 of ERISA and the rulings and regulations issued thereunder)
    c. coverage contingent upon payment of contributions
    d. USERRA
    e. Coordination with State Medicaid Programs
    f. Women's Health and Cancer Rights Act
    g. Newborns' and Mothers' Health Protection Act
    h. Information regarding the Children's Health Insurance Program Reauthorization Act of 2009 (i.e. the plan complies with CHIP)
    i. Michelle's Law
    j. GINA
    k. HIPAA info …
        i. Hybrid HIPAA info - Hybrid Entity Status - With regard to HIPAA's Privacy and Security Rules, this Plan is a "hybrid entity" because the Plan's activities and the Component Benefit Plans

available hereunder include both covered and noncovered functions. "Hybrid entity" means a single legal entity: (1) That is a "covered entity" under HIPAA; (2) Whose business activities include both covered and noncovered functions; and (3) That designates health care components in accordance with 45 C.F.R. §164.105(a)(2)(iii)(D). As set forth in Appendix A, the Plan has designated its health care components in accordance with 45 C.F.R. § 164.105 and will comply with the requirements of a hybrid entity under applicable regulations.

ii. Info in re the component plans provide a separate Notice of Privacy Practices – (ex) This Notice describes how the respective Component Benefit Plan uses and discloses your personal health information. It also describes certain rights you have regarding this information. Please see the applicable Component Benefit Plan for how to obtain additional copies of the Notice of Privacy Practices.

iii. Info regarding the security rule (ex) The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under the Health Insurance Portability and Accountability Act (HIPAA). Please see the applicable Component Benefit Plan for information regarding disclosures of Electronic Protected Health Information ("Electronic PHI") to the insurance company and/or Plan Sponsor for policy and/or plan administration functions and the applicable procedures related to the security of this information.

iv. Benefits

1. A brief paragraph outlining that participants have the right to benefits as outlined w/in the relevant component benefit plan

a. EX: Medical and Prescription Drug Benefits: Covered Persons shall have the right to the medical benefits and

prescription drug benefits described in the applicable Component Benefit Plan. Such benefits shall be subject to the terms, conditions, and limitations set forth in such applicable Component Benefit Plan. A description of such benefits, including the amount payable, required deductibles, co-payments, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Component Benefit Plan. If applicable, the medical benefits include an integrated HRA intended to qualify as a medical reimbursement plan under Section 105 and 106 of the Internal Revenue Code of 1986, as amended (the "Code").

v. Coordination of Benefits

1. The wrap plan document can include coordination of benefit (COB) provisions. However, we caution the inclusion of detailed COB information as it may invite conflict between the wrap and Component Benefit Plans.

a. Sample language - Coordination of benefits provisions are set forth in Component Benefit Plans where applicable. For more information regarding coordination of benefits, see the applicable Component Benefit Plan.

vi. Continuation of Coverage

1. The wrap plan document can include continuation coverage provisions. However, we caution the inclusion of detailed continuation coverage information as it may invite conflict.

2. COBRA information

vii. Contributions, Funding and Plan Assets

1. Information regarding the employer contributions and employee contributions and funding information

a. EX: Employer: The Employer shall pay, as contributions to the Plan, all or a portion, as determined by the Company, of the cost of the benefits provided under the Plan. Employee: From time to time, the Company shall determine, on a fixed dollar or percentage basis, the amount, if any, of contributions required from Covered Persons who are Employees to entitle them and their Dependents, if applicable, to be covered by and receive benefits under the Plan. The amount of such contribution shall be as set forth in any election or enrollment materials, whether paper or electronic as part of a web-based enrollment process, issued or posted in conjunction with the Plan or the Company's Cafeteria Plan (if applicable), as such materials may be changed from time to time. Any such election or enrollment materials are hereby incorporated by reference into the Plan as if set forth in full herein.

viii. Plan Administration – information regarding the Plan Administrator's duties

ix. Claims Procedures

1. Brief information regarding the variable claims procedures for the different types of benefits

a. EX: Claims and Appeals for Self-Insured Benefits - For purposes of determining the amount of, and entitlement to, benefits under the Component Benefit Plans provided through a self-insured benefit plan, the Plan Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-insured arrangement. To obtain benefits from a self-insured arrangement, the Covered Person

must complete, execute, and submit to the Plan Administrator a written claim on the form available from the Plan Administrator. The Plan Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary to decide a claim. The Plan Administrator will decide a Covered Person's claim in accordance with reasonable claims procedures, as required by ERISA. If the Plan Administrator denies a claim in whole or in part, then the Covered Person will receive a written notification setting forth the reason(s) for the denial. If a claim is denied, the Covered Person may appeal to the Plan Administrator for a review of the denied claim. The Plan Administrator will decide the appeal in accordance with reasonable claims procedures, as required by ERISA. If the Covered Person does not appeal on time, then the Covered Person may lose his or her right to file suit in a state or federal court, because he or she will not have exhausted the internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court). See the documentation with respect to the applicable Component Benefit Plan among the applicable Attachments for more information about how to file a claim and appeal a denied claim, and for details regarding the claims procedures applicable to a claim.

2. Information regarding the claims procedures with a disclaimer

    a. EX: These provisions shall not apply to the extent that claims and appeals procedures are set forth differently in a Component Benefit Plan. In addition, the provisions of this Section shall not

be interpreted so as to override applicable state laws that are more protective of Covered Persons' rights with respect to claims and appeals under ERISA plans, to the extent such state laws are not preempted by ERISA.

3. Information about other party liability (ex) reference to component plan or specific language regarding subrogation and right of recovery options

x. General miscellaneous information (ex) no employment rights granted (i.e. this is not a contract), right to offset future payments, misrepresentation and fraud, governing law, governing instrument, disclaimers (plan makes no warranty about the services or whether they are excludable from the person's gross income), indemnification

xi. Amendment, Termination or Merger – right to amend, term or merge… and the effect… and reserve the right to change modify or cancel funding arrangements

xii. HIPAA section

xiii. Statement of ERISA Rights

xiv. Appendix that outlines all the component benefit plans

1. It's not an ERISA SPD requirement to include mailing addresses, fax numbers, e-mails in this section; however, the Plan could choose to include this information with the phone number. At a minimum, the contact phone number should be listed.

2. EX:

Medical Benefits:

Plan Name: ABC Co Medical Plan

Plan Effective Date: January 1, 2015

Plan Number: 501

Group Number: AB65

Third Party Administrator:

BCBS of Ohio
1234 Main Street
Cleveland, OH 44111
Phone: 330-867-5309
Fax: 330-867-5300
www.bsbsohio.com

xv. Appendix that outlines individuals able to have access to PHI

xvi. Appendix that outlines participating employers

F. Wrap Document Considerations

i. Caution against the inclusion of duplicate provisions (such as coordination of benefit terms and continuation coverage) in the wrap document as it may invite conflict between the wrap document and component benefit plans.

ii. If the wrap document is meant to meet ERISA's SPD and PD requirements, we suggest making general references to certain provisions (including, but not limited to, coordination of benefit provisions and continuation coverage provisions) and note that those provisions are located and addressed in the applicable component benefit plan.

iii. Updates and modifications – new policy information; benefits information – update the Wrap Document accordingly

iv. Terminology associated with wrap documents deviates greatly in the self-funded industry and health insurance industry as a whole.

1. If an employer is creating a wrap document, it's imperative the employer clearly communicate the employer's intent for the wrap document, including whether or not the wrap should serve as an SPD/PD. The need for a wrap document and the determination of which benefits to include within the wrap is a business decision for each employer.

v. Maintaining a Wrap Document is a preference - no group is required to sustain one even if they do offer multiple Plans. However, employers typically choose to have a Wrap Document as an approach to simplify 5500 reporting.