Plan Documents FAQ

What is a plan document under ERISA?

An ERISA plan document is the official governing document for the plan. ERISA requires that it include the plan's terms, including eligibility, benefits, exclusions, a named fiduciary and plan administrator, claims and appeals procedures, funding information, and other items.

What is a summary plan description/SPD?

A SPD 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.

What is a combo plan document/SPD?

A combo plan document/SPD is written as a single plan document that articulates it is intended to be a combination document. Unless you have a combination document, every employer subject to ERISA must have two documents under ERISA: a plan document and a SPD.

What is a wrap document or wrap plan?

A wrap plan is a type of plan document. It includes all the required information under ERISA and "wraps around" the insurance policy or certificate of coverage to create a full plan document. A wrap document will incorporate documents from the insurer, care should be taken to ensure there are no contradictions between them, and that the incorporated carrier documents are stored with the plan documents for easy reference.

What is a mega wrap or umbrella wrap?

A mega wrap or umbrella wrap is a wrap document that wraps together multiple plans subject to ERISA into one plan. A mega wrap or umbrella wrap should be carefully drafted if it includes plans that are not subject to ERISA, to prevent them from becoming subject to ERISA. A mega wrap or umbrella wrap should not wrap a health and welfare plan with a pension or retirement plan. A mega wrap or umbrella wrap could have separate policy/contract years for the ERISA benefits within the wrap.

Information entered on Schedule A should pertain to the insurance contract or policy year ending with or within the plan year (for reporting purposes, a year cannot exceed 12 months). Example. If an insurance contract year begins

on July 1 and ends on June 30, and the plan year begins on January 1 and ends on December 31, the information on the Schedule A attached to the Form 5500 should be for the insurance contract year ending on June 30.

What are cafeteria plan documents?

An employer that adopts a cafeteria plan (allowing employees to pay for benefits on a pre-tax basis) must have a cafeteria plan documents in place as well. These documents describe the available benefits, participation rules, election procedures, contribution limits and processes, applicable grace period provisions, document the adoption of the plan, election forms, salary reduction agreements, reimbursement request forms, mid-year election change forms, claims denial forms, COBRA forms, and HIPAA disclosures, and more

What employers need a plan document and a SPD?

All employer subject to ERISA need a plan document and a SPD, or a combination plan document/SPD for all ERISA plans. There are no exceptions for small employers, and it does not matter if the plan is fully insured or self-funded.

What employers need cafeteria plan documents?

All employers who allow for benefit premiums to be paid pre-tax must adopt a cafeteria plan and have the accompanying documents to administer the plan. There are no exceptions for small employers, and it does not matter if the plan is fully insured or self-funded.

Can an employer use the insurance policy or certificate of coverage from the insurance carrier as a plan document?

No. Carrier provided documents will not include the required ERISA provisions. Carrier documents will lack required information such as who the fiduciary is, funding information, the ERISA plan number, and more. An employer may adopt a Premium Only Plan (POP) or have the required verbiage in their Flexible Spending Account SPD.

What is an ERISA plan?

Health insurance (medical, dental, vision, prescription drug, health reimbursement arrangements (HRAs) and health flexible spending accounts (FSA);
Group life insurance;
Disability income or salary continuance unless paid entirely by the employer from its general assets;
Severance pay;
Funded vacation benefits, apprenticeship or other training programs, day care centers, scholarship funds, and prepaid legal services; and
Any benefit described in section 302(c) of the Labor Management Relations Act (other than pensions on retirement or death).
Employee Assistance Programs (EAP) has the potential of being an ERISA plan. If the EAP is a referral only program, determine if the EAP falls within the meaning of Section 3(1). Opinion No. 91-26A. If the EAP provides for counseling or face to face visits, determine if the EAP falls within the meaning of Section 3(1) Opinion No. 88-04A & 83-35A.

What is not an ERISA plan?

Health savings accounts
Voluntary plans that meet safe harbor requirements
Adoption assistance
On-site first aid facilities

An employer that is subject to ERISA and allows for premiums to be paid pretax needs either 2 or 3 sets of plan documents:

1: Combination Plan Document and SPD

2: Cafeteria Plan Documents

1: Plan Document

2: Summary Plan Description (SPD)

3: Cafeteria Plan Documents

Required Components of Plan Documents

Named fiduciary
Procedure for allocation of responsibilities
Funding Policy
How payments are made
Claims procedures
Amendment procedures
Distribution of assets on plan termination
COBRA and USERRA rules
HIPAA Portability Provisions
HIPAA Privacy and Security Provisions
Minimum hospital stays after childbirth
Qualifying Medical Support Order rules
Disclosures regarding mental health parity, substance use disorder benefits, requirements for reconstructive surgery following mastectomies, coverage for adopted children, coverage of pediatric vaccines, the incorporation of ERISA into health care reform
Permission to use plan assets to pay plan administrative expenses
Eligibility
Benefits provided
Contributions
Exceptions and limitations that lead to a loss/denial of benefits
Provisions required by other laws, such as FMLA,
Administration procedures
Original plan date, restatement dates, if the plan documents supersedes prior plan documents
Definitions of employee and dependents
Proof of dependent eligibility
Waiting periods, coverage effective dates, coverage termination dates, open enrollment, and special enrollment

Rehire rules
Erroneous payment processes
No guarantee of employment or tax consequences
Indemnification
Non-assignment of benefits
Precedence in the event of a conflict among documents
Appointment of a personal representative
Use of Medical Loss Ratio payments
Subrogation terms
Discretionary authority
Governing state law, subject to preemption
Successor employer provisions

Required Items for SPDs

Plan identifying information – the name of the plan, the plan sponsor's EIN, the ERISA plan number, the type of welfare plan, the type of administration of the plan, the name, business address, and business telephone number of the plan administrator, the name, title, address, and principal place of business of each trustee (if there is a trust), the name of the person designated as the agent of service, and their address, a statement referring to the collective bargaining agreement and information on how to obtain a copy of it, if applicable, the date of the end of the plan year, and how records are kept policy, calendar, or fiscal year basis).
Eligibility provisions, including measurement/tracking methods for applicable large employers
Description of plan benefits and provisions, including cost-sharing, premiums, deductibles, co-insurance, copayments, limits or caps, extent to which preventive services are covered, under what circumstances existing and new drugs are covered, under what circumstances coverage is provided for testing, devices, and procedures, provisions regarding networks, and any coverage that is provided out of network, conditions or limits on the selection of primary care providers or specialty providers, conditions or limits on emergency medical care, provisions regarding preauthorization or utilization review.
If a listing of network providers is not included in the SPD, information on obtaining the listing of network providers must be included
Description of circumstances causing a denial or loss of benefits
Plan amendment provisions
Plan termination provisions

Plan subrogation/reimbursement provisions
Information on contributions and funding
Procedures for benefit claims and appeals of denials, which includes a disclosure of the DOL office where information regarding ERISA rights can be obtained
Any time limits for the filing of a lawsuit
Discretionary authority disclosure
Statement of ERISA rights
Information about assistance in non-English languages as applicable
Explanation of the policy regarding overpaid or erroneously paid benefits
Explanation of insurer refunds, including Medical Loss Ratio payments
The role of the health insurer, including the name and address of the issuer, whether the benefits are guaranteed under contract or policy, and the nature of any administration services
Claims procedures including preauthorization, approvals, utilization review decisions
Information on health plan provider discounts
COBRA and other applicable continuation rights
USERRA rights
HIPAA disclosures
Newborns and Mothers Health Protection Act disclosures
Qualified Medical Support Order disclosures
Michelle's Law disclosure (still required despite being obsolete)
Women's Health and Cancer Rights Act
Mental Health Parity and Mental Health Parity and Addiction Equity Act
Genetic Information Nondiscrimination Act requirements
Information on any other applicable federal mandates or laws
Health care reform disclosures should be included in applicable sections listed above: annual and lifetime limits on essential health benefits, appeals processes, clinical trial coverage, cost-sharing limits, age 26 mandate, exchange information, grandfathered plan status, health FSA limits, OTC drug limits, patient protections, pre-existing condition exclusion prohibitions, rescissions prohibition, prohibition on excessive waiting periods
Look-back measurement method
Wellness program reasonable alternative statement
Change in status rules

Required Components of Plan Documents

Cafeteria plan documents should contain the following information:

The plan year
Description of available benefits
Participation rules
Election procedures
Manner of contribution
Maximum amount of contributions
The plan year
Rules for purchasing and selling paid time off
Provisions for flexible spending arrangements (FSAs)
Grace period provisions, if applicable
Provisions relating to distributions from a health FSA to an HSA, if applicable

Cafeteria plans need documents covering the following:

Evidence of the adoption of the plan
Agreements with third parties relating to the plan
Election forms
Salary reduction agreements
Reimbursement request forms (if applicable)
Mid-year election change forms and permissible events for election changes
COBRA forms
HIPAA disclosures and privacy notices
Business Associate Agreements as applicable
Claim denial forms

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