



ERISA Reporting and Disclosure Requirements for Welfare Plans

The Employment Retirement and Income Security Act of 1974 (ERISA) was enacted to protect the benefit rights of participants and beneficiaries of employee benefit plans. ERISA regulations are issued by three separate federal agencies – the Internal Revenue Service (IRS), the Department of Labor (DOL) and Pension Benefit Guaranty Corporation (PBGC).

Title I of ERISA requires plan sponsors of welfare benefits plans, typically employers, provide certain reporting to the DOL and disclosure to plan participants about their benefit plans that are subject to ERISA. Most retirement plans may also subject to ERISA regulations or our firm may be subject to DOL penalties.

What Welfare Plans are Subject to ERISA?

In brief, plans that provide benefits in the event of illness, accident or death are considered ERISA plans. The following are considered welfare benefit plans subject to ERISA reporting and disclosure requirements:

- Group Medical Plans, including health care flexible spending accounts and medical reimbursement plans
- Group Dental and Vision plans
- Group Life Insurance plans
- Group Insured Short-Term Disability plans
- Group Long Term-Disability plans
- Employee Assistance Plans (EAPs) that provide medical benefits, such as office visits to a medical professional
- Pre-Paid Legal Services
- Travel Accident Plans
- Funded Scholarship Plans
- Formal Severance Plans

Plans in which participation is voluntary, no contribution is made by the employer, and the employer does not actively sponsor, are not subject to ERISA reporting and disclosure. If the employer has involvement in administering the program and endorses it, the plan may be subject to ERISA.

Government plans, church plans, state mandated plans, foreign plans and unfunded excess benefit plans are excluded from ERISA.

Certain plans are exempt from ERISA requirements because they are considered payroll and employment practices when uninsured and paid out of the employer's general assets, such as vacation pay, holiday pay and short term disability pay or sick leave.



What ERISA Reporting is required?

Annual reports, called for 5500s, must be filed with the Employee Benefit Security Administration (EBSA), the DOL agency that oversees and enforces ERISA.

A plan with less than 100 covered participants at the beginning of a plan year is exempt from filing a Form 5500 if it is fully-insured, unfunded, or a combination of insured and unfunded (unfunded plans do not have plan assets held in a trust).

Form 5500 returns ask for information about the plan, including the plan name, plan year, plan sponsor, plan number, participants, insurance cost and financial data. The Form 5500 return for a welfare plan may require additional schedules, as follows:

- Schedule A – Insurance carrier information, insured premiums and claims data, broker information and commissions
- Schedule C – Service contract provider information and fees paid by the plan
- Schedule H – Financial data for large plans (100+ participants) with plan assets
- Schedule I – Financial data for small plan with plan assets

The return must be completed and filed with the EBSA within seven (7) months after the end of the plan year. You can automatically extend the filing deadline, by up to two and half months, by filing the Form 5558 (Application for Extension of Time) prior to the normal 5500 filing due date.

What are the ERISA Disclosure Requirements?

Summary Annual Report

Once a Form 5500 is completed and filed, you must prepare a Summary Annual Report (SAR) for each of your welfare benefit plans subject to ERISA reporting. The SAR summarized the Form 5500 information and notifies participants that the Form 5500 has been filed and that a copy is available to participants who request a copy.

SARs must be distributed to covered participants within nine (9) months after the end of the plan year. A sample SAR is available from the DOL.

A SAR is not required for plans that are not required to file a Form 5500. Additionally, a SAR is not required for welfare plans that are totally funded and uninsured, even if the plan is required to file a Form 5500 because it had at least 100 participants at the beginning of the plan year.



Summary Plan Description

ERISA requires that a Summary Plan Description is distributed to covered participants within 90 days after becoming newly covered by the plan, or within 120 days of a new plan being established. The purpose of the SPD is to describe the plan to the participants, in an easy to understand terms.

ERISA has detailed requirements of what information must be in the SPD, including the name of the plan, plan sponsor, plan administrator, plan year, employer tax identification number, type of welfare plan, type of administration, eligibility information, summary of the benefits, detailed description of the plan benefits for group health plans, provider network availability for group health plans, procedures for QCMOSs, COBRA rights, plan contributions, claims procedures, limitations, exclusions etc. A "Statement of ERISA Rights" is also required.

The benefits booklet that our insurer or third-party administrator provides for your welfare benefit plans may not include all the SPD requirements. Therefore, it may be necessary for an employer to prepare a separate SPD that includes all the pertinent information, and refers to the "group certificate" or other benefits booklet that you receive from your insurer for certain information. A "wrap" SPD may encompass all of your welfare benefits plans, such as medical, dental, life, and disability, under one ERISA plan number and on Form 5500 filing.

Summary of Material Modifications

Any change in your plan that materially affects the design or pricing must be communicated to participants in a Summary of Material Modifications (SMM). The SMM must be distributed to covered participants within 210 days after the end of the plan year in which a material modification has been made.

If the material modification is a reduction in group health plan benefits, the SMM must be distributed to participants with 60 days of the adoption date. DOL guidelines examples of reductions that would constitute material modification to a group medical plan, such as: the elimination of benefits payable, reduction of benefits payable, increase in premiums, deductibles, co-payments or coinsurance, or a new requirement (Pre-certification) to obtain service under the plan.

Other ERISA Requirements

ERISA regulations also include the following requirements, in brief:

- Plans must be in writing and therefore a plan document is required;
- Plans must follow fiduciary standards;



- Plans with plans assets/funded plans must purchase fidelity bonds to cover those that handle the funds;
- Copies of certain documents, such as the latest SPD, SMM, plan documents or Form 5500, must be furnish to participants upon request; and
- Group Health plans are subject to COBRA and HIPAA

If you have any questions about how ERISA applies to your employer benefit program, please contact Craig Broome, craig@employersupport.com Employer Support Services.