EVERYTHING YOU NEED TO KNOW ABOUT ERISA BUT WERE AFRAID TO ASK

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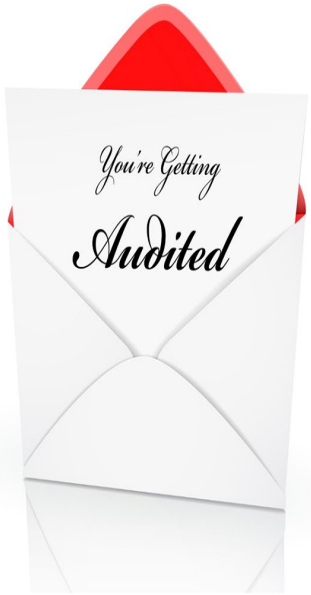
Agenda

Compliance Is Fun!

- Why Does ERISA Compliance Matter?
- ERISA Compliance
  - What Is ERISA and When Does It Apply
  - Focus: **Reporting** and **Disclosure** Requirements for Health and Welfare Benefit Plans
- Foreign Language Requirements
- How to Reach Your Audience: The Distribution Rules
- Open Enrollment: Goals and Strategy
- Operational Compliance
- Resources, Tips and Traps, Checklists, and Questions

Why Does ERISA Compliance Matter?

- Compliance is an employer obligation—not an insurer or broker obligation
- It's the law
- It's a fiduciary responsibility
- Failure to meet compliance obligations could result in:
  - Employee complaints & lawsuits
  - Audits
  - Penalties
  - Stop-loss issues (self-funded plans)
- Mergers and acquisitions: Due diligence inquiries
- Be a hero to the CEO or CFO!
- **Disclosure/Communications**: An important part of ERISA compliance is disclosure, which is all about communicating the terms of your plan to employees



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A Sample of DOL Penalties

Mandate	Penalty
Plan Documents: Failure to Provide to DOL w/in 30 Days	$171/Day
Plan Documents: Failure to Provide to Participants w/in 30 Days	$110/Day
Summary of Benefits & Coverage (SBC): Failure to Provide	$1,264/SBC
Form 5500: Failure to File	$2,400/Day
Form M-1 (MEWAs): Failure to File	$1,746/Day
COBRA: Failure to Provide Notices	$110/Day
Affordable Care Act (ACA): Failure to Provide Patient Protection Notice	$100/Day
Children's Health Insurance Program (CHIP): Failure to Inform Employees	$127/Day
Genetic Information Nondiscrimination Act (GINA): Failure to Comply with Restrictions	$127/Day
Women's Health and Cancer Rights Act (WHCRA): Failure to Provide Notice	$110/Day
Medicare Secondary Payer: Offering an Incentive	$10,360

Benefits Make a Difference

- **MetLife's 17th Annual U.S. Employee Benefit Trends Study (2019):**
  - 80% of employers say benefits play an important role in building & sustaining workplace culture
  - 6 in 10 employees say benefits were an important reason they chose a job
  - Only 4 in 10 employees strongly believe their employers' **benefits communication** is simple to understand. As a result, only half of employees are very confident they made the right decisions during open enrollment

- **MetLife's 19th Annual U.S. Employee Benefit Trends Study (2021):**
  - Employees who say their employer offers a benefits package that meets their needs are 41% more likely to feel resilient and **60% more likely to trust their employer's leadership**
  - What do employees want from their benefits? **82% want benefits to be easy to use**, 78% want benefits that work together

Communications

- **MetLife's 19th Annual U.S. Employee Benefit Trends Study (2021):**
  - 7 in 10 employees want to hear from employer about benefits after they've already signed up
  - **80% of employers are increasing benefit communications (or intend to)**

- **Impact of COVID-19 on Open Enrollment Communications:**
  - The pandemic is changing open enrollment strategy, affecting (a) what you highlight during open enrollment (tailoring your presentation to what employees want and need to hear); (b) how you conduct open enrollment; and (c) how you distribute plan documentation
  - **Set Goals**: Satisfy the legal requirements, and know what you want and need to accomplish during open enrollment (and throughout the year)

ERISA Compliance

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ERISA: What Is It?

- **The Employee Retirement Income Security Act of 1974 (ERISA)**
  - Reporting and disclosure requirements enforced by the Department of Labor (DOL), Employee Benefits Security Administration (EBSA)

- A federal law that regulates **employer-sponsored** (a) pension plans and (b) employee **welfare benefit** plans—whether fully insured or self-funded

- **Exempt:** State and local government plans, church plans, workers' compensation, and plans maintained outside of U.S. for non-resident aliens

- **Exempt:** Benefits that satisfy the DOL "voluntary" safe harbor (more later)

- **Preempts** state laws regulating covered plans, except:
  - Does not preempt state insurance laws—CA insurance law continues to apply to fully insured plans and HMOs (but not self-funded plans)
  - **Example:** Mandated benefit laws that apply to health insurance policies

Defined Terms

- **Plan Sponsor:** In a single-employer plan, the employer
- **Plan Administrator:** In a single-employer plan, typically the employer—responsible for ensuring compliance with ERISA—a **fiduciary**
  - **Note:** Not the same as the third-party administrator (TPA)
- **Employee Welfare Benefit Plan:** A plan, sponsored by an employer, that provides benefits such as medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or prepaid legal services (benefit examples—next slide)
- **Participant:** Covered employee. **Beneficiary:** Covered dependent.
- **Plan Name:** Assigned by Plan Administrator
  - **Example:** "Golf Corporation Employee Welfare Benefit Plan"
- **Plan Number:** Health and welfare plans start at number 501
  - **Example:** Plan 501, Plan 502, etc.
- **Plan Year:** Must be 12 months
  - **Example:** January 1 – December 31
- **Note:** All of these details are specified in the **wraps** and the **Form 5500** (more later)

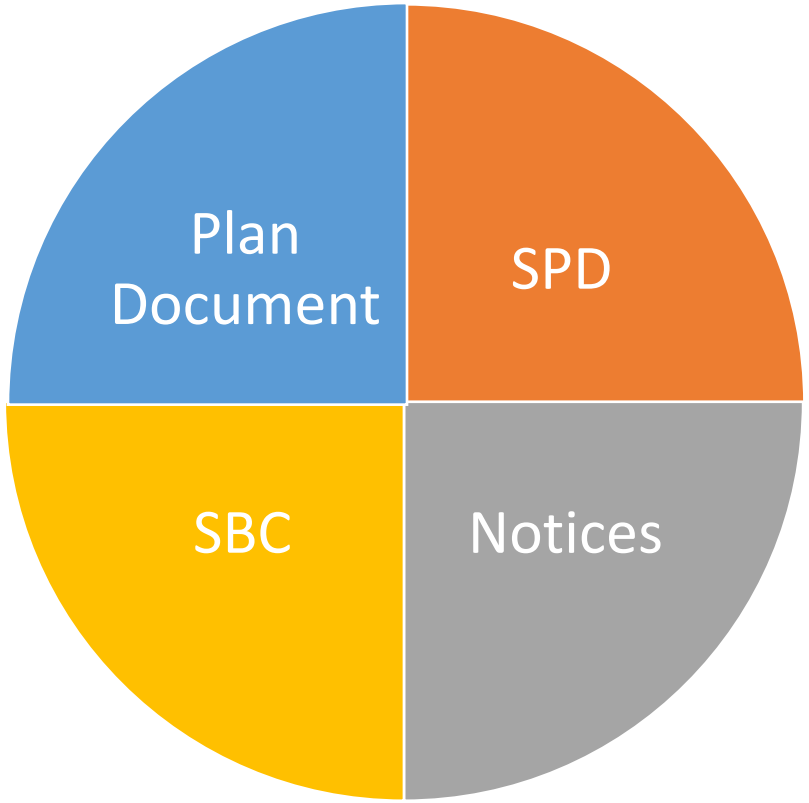
Employee Welfare Benefit Plans Include . . .

Health	Dental	Vision	Health FSA
HRA	STD	LTD	Life
AD&D	Prepaid Legal	Some EAPs	Some Wellness

Voluntary Plans

- Plans that satisfy the DOL's voluntary plan "safe harbor" are not considered "employee welfare benefit plans" and are exempt from ERISA
- The safe harbor requirements are:
  - No employer contributions
  - Participation is voluntary
  - The employer does not "endorse" the program (but the employer may publicize and collect premiums through payroll deductions)
  - The employer cannot receive consideration in the form of cash or otherwise
- If voluntary, do not add to the wrap, because not an ERISA plan

ERISA Disclosure (Documentation) Requirements



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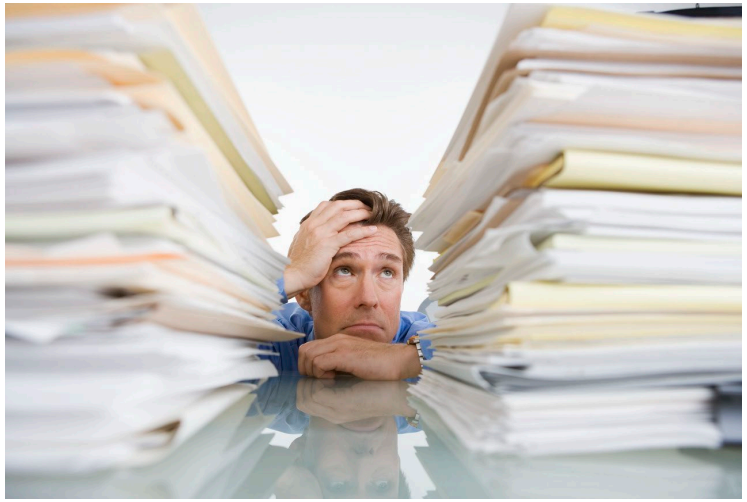
Disclosure (Documentation) Requirements

The HMO gave us an evidence of coverage (EOC).

That's all we need, right?



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Plan Document

- "Every employee benefit plan shall be **established and maintained** pursuant to a written instrument" (ERISA § 402)
- The **plan document** is the legal document that governs the plan, and it is not the same as the **SPD** (next topic)—these are **two** separate documentation requirements
  - The plan document must contain certain terms required by ERISA—and are almost never included in the insurers' documents—Plan Administrators supply these terms using a **wrap** (more later)
  - Written in "the language of lawyers"?
- **Important:** Do not distribute, but must provide **upon request** (30 days) or pay a penalty ($110/day)
- **Important**: No small plan exemption
- **Audit Tip:** The DOL will ask for this if there is an audit—item no. 1 or 2 on the list

Summary Plan Description (SPD)

If I don’t distribute the plan document to participants,

what do I distribute?

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Summary Plan Description (SPD)

- The primary method for **communicating** plan terms
- The SPD shall be written in a manner calculated to be **understood** by the average plan participant; objective: “clear, simple communication”
- The SPD shall be sufficiently **accurate and comprehensive** to reasonably apprise participants/beneficiaries of their rights and obligations under the plan
- The SPD must comply with:
  - **Style and format** regulations
  - **Content** regulations (over)
  - **Foreign language** regulations (more later)
- The SPD must be **distributed** in a manner (in-person, mail, electronically) that is “reasonably calculated to ensure **actual receipt**”—follow the rules (more later)

Summary Plan Description (SPD)

- The SPD must satisfy the **content** rules in ERISA § 102 and the SPD content regulations—required information includes:
  - Plan name, plan number, plan year
  - Employer name, address, and tax ID
  - The name and address of the Plan Administrator
  - Source of contributions (for example, employer or employee)
  - **Eligibility terms** (including ACA measurement methodologies) and waiting period
  - The Statement of ERISA Rights
  - And more . . . .
- **Note:** Many (almost all) of these mandatory terms will not be included in insurers' documents—Plan Administrators supply these terms using a **wrap** (more over)

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Wrap Documents: Strategy and Use

- May use the “wrap” method for both plan document and SPD
- **Satisfy Content Rules and Regulations:** Use a wrap to supply the terms not included in the insurers’ documentation, and then:
  - Incorporate into the wrap the insurers’ documentation, and all other essential written material, and the entire package (wrap plus EOCs, etc.) constitutes the plan document or SPD
- **Be Proactive:** Employer can also use a wrap to provide terms that will assist in the administration of the plan
  - **Examples:** Specify ability to amend or terminate the plan; clarify distribution of medical loss ratio rebates; obtain more favorable standard of review in event of lawsuit
- **Establishing Plan(s):** Wrap documents assist with Form 5500 planning and filing (more later)

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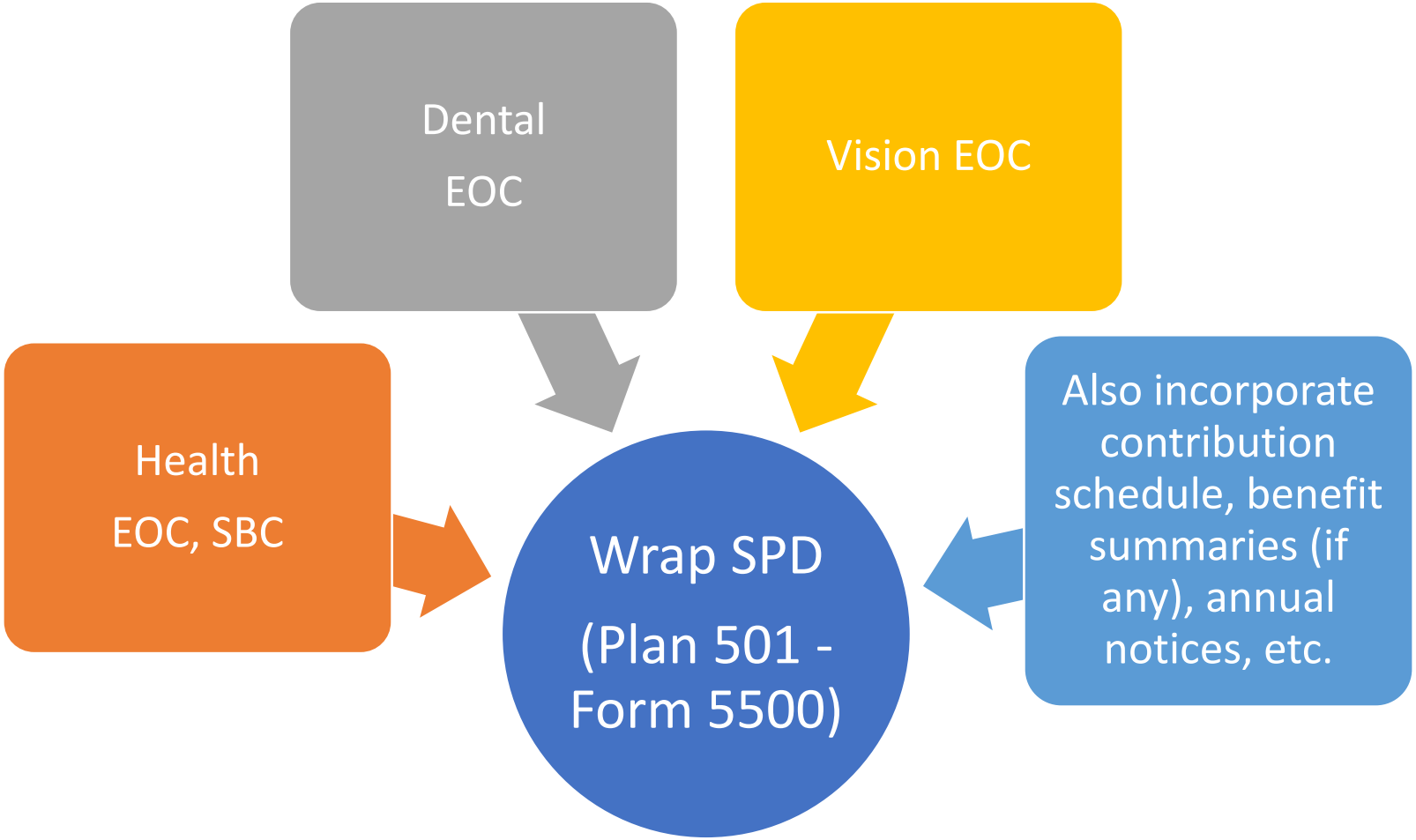
Wrap SPD Example: "Golf Corporation Employee Welfare Benefit Plan"—Plan 501

- **Golf's Goals:** (a) Satisfy ERISA content requirements, & (b) combine all welfare benefits into one plan
- Golf offers its employees:
  - A fully insured **health** plan (insurer provides EOC & SBC),
  - A fully insured **dental** plan (insurer provides EOC), &
  - A fully insured **vision** plan (insurer provides EOC)

- Eligibility:
  - The waiting period is first of the month following date of hire; employees who average 30 or more hours per week are eligible for coverage; Golf has adopted a 12-month look-back measurement period for ACA purposes
- Golf distributes a premium contribution schedule at open enrollment
- On behalf of Golf, broker distributes at open enrollment a benefit summary with annual notices

Wrap SPD Example: "Golf Corporation Employee Welfare Benefit Plan"—Plan 501



Summary of Benefits & Coverage (SBC)

- Simple and concise explanation of benefits
  - Only for major medical, not stand-alone dental and vision
- Plans must provide SBC to participants and beneficiaries
  - Fully insured: Carrier will prepare (employer must distribute)
  - Self-funded: Plan Administrator must prepare
- **Foreign language requirements:** Must provide the SBC in a "culturally and linguistically appropriate manner" (more later)
- **Note:** New templates have been issued for use for plan years starting on or after **January 1, 2021**
- **Penalty:** $1,264/failure
- **§4980H Compliance Tip:** SBCs state if plan is MEC, MV

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Insurance Company 1: Plan Option 1

Coverage Period: 01/01/2022-12/31/2022
Coverage for: Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, [insert contact information]. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.[insert].com or call 1-800-[insert] to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500 / individual or $1,000 / family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $300 for prescription drug coverage and $300 for occupational therapy services. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers $2,500 individual / $5,000 family; for out-of-network providers $4,000 individual / $8,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.[insert].com or call 1-800-[insert] for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

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Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Weight loss programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: [insert State, HHS, DOL, and/or other applicable agency contact information]. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: [insert applicable contact information from insert].

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码[insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

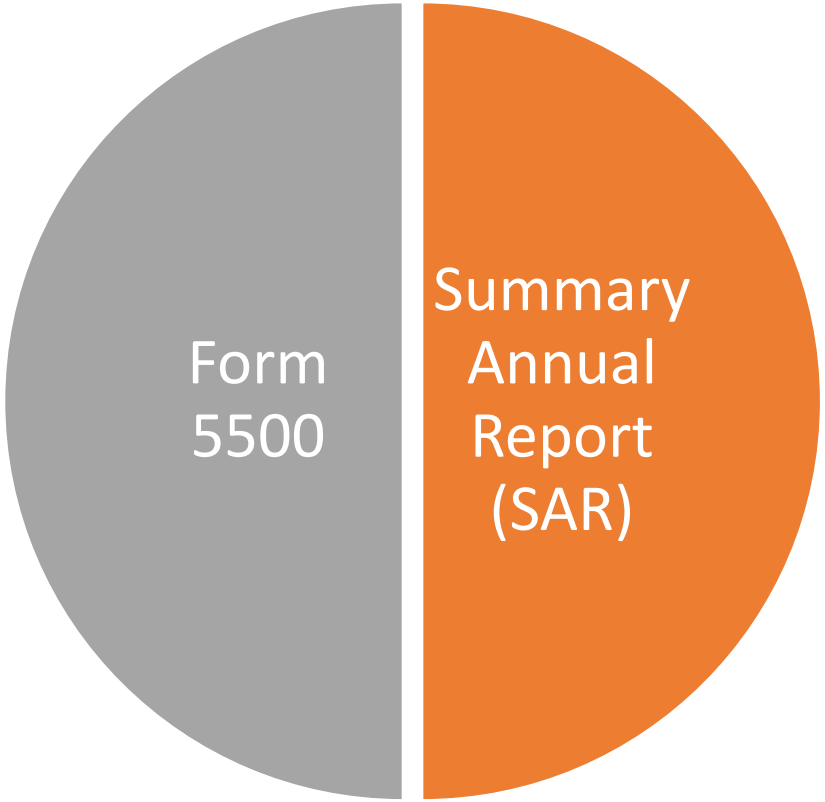
PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

[* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].]

Mandatory Notices & Open Enrollment Checklist

- ❑SPD(s):
  - Includes wrap (eligibility, waiting period, etc.), EOCs, plan amendments (SMMs & SMRs), contribution schedule, and all other materials incorporated by wrap
- ❑Summary of Benefits & Coverage (SBC) (health plan only)
- ❑Women's Health and Cancer Rights Act notice
- ❑Newborns' and Mothers' Health Protection Act notice
- ❑HIPAA notice of special enrollment rights
- ❑Michelle's Law notice
- ❑Medicare Part D creditable coverage notice
- ❑CHIP Notice
- ❑Initial COBRA notice (new hire)
- ❑Exchange Notice (new hire)
- ❑HIPAA Notice of Privacy Practices (if the plan is self-funded, such as a health FSA, every 3 years)
- ❑Cafeteria plan election form (if applicable)
- ❑HIPAA and ADA wellness program notices (if applicable)
- ❑Grandfathered plan notice (if applicable)
- ❑Notice of Patient Protections (if applicable)

ERISA Reporting Requirements



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ERISA Reporting Requirements

- **Form 5500:** The Plan Administrator of an ERISA plan must file an "**annual report**"—the Form 5500
  - **Small plan exemption:** Form 5500 filing exemption for ERISA plans with fewer than **100 participants** at the beginning of the plan year and that are (a) fully insured, (b) unfunded, or (c) a combination of fully insured and unfunded (**note:** this small plan exemption applies to the Form 5500 only—not to other ERISA mandates)
  - Must file by the last day of 7th month after end of the plan year (**July 31** for calendar year plan)
  - One Form 5500 for each plan (more over); start plan numbering at 501; plan year is 12 months
  - **Audit Tip:** 1st item the DOL looks at the start of an audit
  - **Penalty:** $2,400/day for failure to timely file (DFVCP may be available)

- **SAR:** Summary Annual Report (SAR)
  - Distribute to participants within 9 months after end of plan year (**Sept. 30** for calendar year plan)

Form 5500 Examples: Small Plan Exemption

- **Example:**
  - Tennis Corp. offers its employees a fully insured health plan
  - At the beginning of the plan year, the health plan had 70 active participants and 3 COBRA qualified beneficiaries (QBs)
  - **Conclusion:** Tennis Corp. qualifies for the small plan exemption and does not have to file a Form 5500
  - **Note:** Tennis Corp. is still subject to all other ERISA requirements
- **Example:**
  - Beach Club offers its employees a fully insured health plan and a fully insured dental plan
  - At the beginning of the plan year, the health plan had 90 active participants and the dental plan had 70 active participants
  - 50 of the dental plan participants were also enrolled in the health plan, and 20 were only enrolled in the dental plan
  - **Conclusion:** Does the small plan exemption apply? It depends.

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Form 5500 Example: How Many Plans/Forms 5500s?

- **Example:**
  - Golf Corp. has a calendar year plan year
    - January 1 – December 31
  - Golf Corp. offers its employees 3 fully insured benefit options:
    - Health (as of January 1: 150 participants)
    - Dental (as of January 1: 120 participants)
    - Vision (as of January 1: 105 participants)
- **Conclusions:**
  - Must Golf Corp. file a Form 5500? Yes.
  - If so, when? No later than July 31st (SAR due September 30th).
  - How many Form 5500s must Golf Corp. file? Golf Corp. has control over this decision (see next slide).

Form 5500 Examples

No Wrap

(3 Form 5500s)

Plan 501	Plan 502	Plan 503
• Health	• Dental	• Vision

With Wrap

(1 Form 5500)

Plan 501
• Health • Dental • Vision

Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

OMB Nos. 1210-0110
1210-0089

2021

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2021 or fiscal plan year beginning 01/01/2021 and ending 12/31/2021

A This return/report is for:
- ☐ a multiemployer plan
- ☐ a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)
- ☑ a single-employer plan
- ☐ a DFE (specify) ____

B This return/report is:
- ☐ the first return/report
- ☐ the final return/report
- ☐ an amended return/report
- ☐ a short plan year return/report (less than 12 months)

C If the plan is a collectively-bargained plan, check here. . . . . ▶ ☐

D Check box if filing under:
- ☐ Form 5558
- ☐ automatic extension
- ☐ the DFVC program
- ☐ special extension (enter description)

E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. . . . . ▶ ☐

Part II Basic Plan Information—enter all requested information

1a Name of plan
Golf Corporation Employee Welfare Benefit Plan

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 01/01/2010

2a Plan sponsor's name (employer, if for a single-employer plan)
Mailing address (include room, apt., suite no. and street, or P.O. Box)
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)

Golf Corporation, Inc.
111 South Main Street
Anytown, CA 90000

2b Employer Identification Number (EIN)
55-555555555

2c Plan Sponsor's telephone number
555-555-5555

2d Business code (see instructions)
713900

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

3a Plan administrator's name and address ☑ Same as Plan Sponsor	**3b** Administrator's EIN 55-555555	
	3c Administrator's telephone number 555-555-5555	
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:	**4b** EIN	
a Sponsor's name	**4d** PN	
c Plan Name		
5 Total number of participants at the beginning of the plan year	**5**	110
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1)**, **6a(2)**, **6b**, **6c**, and **6d**).		
a(1) Total number of active participants at the beginning of the plan year	**6a(1)**	
a(2) Total number of active participants at the end of the plan year	**6a(2)**	
b Retired or separated participants receiving benefits	**6b**	
c Other retired or separated participants entitled to future benefits	**6c**	
d Subtotal. Add lines **6a(2)**, **6b**, and **6c**	**6d**	
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	**6e**	
f Total. Add lines **6d** and **6e**	**6f**	
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

4a, 4d, 4e

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Foreign Language Requirements

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SPD: Foreign Language Requirements

- Plan may have to provide a translated **notice** explaining that **assistance** is available in the common non-English language, and provide the assistance
- Determination made based on the employer's workforce; provide if:
  - Plan covers **fewer than 100 participants** at beginning of plan year, and 25% or more are literate only in same non-English language, **or**
  - Plan covers **≥100 participants** at beginning of plan year, and the lesser of (i) ≥500 **or** (ii) 10% or more are literate only in same non-English language
- The SPD does not have to be translated—only the notice
- **Assistance** must be calculated to provide participants a **reasonable opportunity to become informed** of their rights and obligations under the plan
- **Compliance Tip:** Sample language provided

SPD: Foreign Language Requirements: Examples

- **Example:** Tennis Club has one facility in Manhattan. 90 employees are covered by the health plan on the first day of the plan year. 30 of these participants speak only Spanish.
- **Conclusion:** Tennis Club must provide a notice in Spanish with its SPD (over 25%). (Note: Location not relevant under SPD rules.)

- **Example:** Yacht & Country Club has one facility in Clearwater, FL. 200 employees are covered by the health plan on the first day of the plan year. 30 of these participants speak only Spanish.
- **Conclusion:** Yacht must provide a notice in Spanish with its SPD (over 10%).

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SPD: Foreign Language Requirements: Examples

- **Example:** Park Corp. maintains a health plan which covers 1,000 participants. At the beginning of the plan year 500 covered employees are literate only in Spanish, 101 are literate only in Vietnamese, and the remaining 399 are literate in English.
- **Conclusion:** Each of the 1,000 employees must receive an SPD in English, containing an assistance notice in both Spanish and Vietnamese. (Example from the regulations.)

- **Example:** 6,000 Park employees are covered by the health plan on the first day of the plan year. 300 of these participants speak only Spanish (5%).
- **Conclusion:** Park does not have to provide a notice in Spanish with its SPD (under 10% and under 500). But, should Park do so? What if 500 employees speak Spanish (8.3%)? Then Park must provide notice (≥500).

SBC: Foreign Language Requirements

- Must provide the SBC in a "**culturally and linguistically appropriate manner**"
  - Must include a notice, in SBC, that a translated version is available; must provide translated version upon request
  - Sample taglines provided (see SBC template)
  - Unlike the SPD, the SBC may have to be translated

- Unlike SPD, determination based on county population, not employee census
  - The SBC must be provided in a non-English language if 10% or more of the population residing in the county is literate only in the same non-English language (**Chinese, Spanish, Tagalog, and Navajo**)
  - CMS provides a list (CLAS County Data)
  - https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/CLAS-County-Data_Jan-2016-update-FINAL.pdf

SBC Foreign Language Requirements: Examples

- **Example:** Club California, with 2 facilities, has a total of 90 employees participating in its health plan as of the first day of the plan year. Of these,
  - 30 plan participants live in Los Angeles County
  - 30 plan participants live in Orange County, CA
  - 30 plan participants live in San Francisco County
- **Conclusion:** Upon request, Club California must provide an SBC translated into Spanish for LA and OC residents, and an SBC translated into Chinese for SF County residents. (What about SPD? Not enough facts.)

- **Example:** Club Marin has a total of 90 employees participating in its health plan as of the first day of the plan year. All plan participants live in Marin County, CA. 30 participants speak only Spanish.
- **Conclusion:** Club Marin does not have to provide a translated SBC to these participants; Marin County, CA is not on the CMS list. (However: Remember that under the SPD rules, a notice in Spanish must be provided with the SPD.)

SBC: Foreign Language Requirements: Examples

- **Example (SBC v. SPD):** Country Club has a total of 90 employees participating in its health plan as of the first day of the plan year. All plan participants live in Los Angeles County. 30 participants speak only Spanish and 30 speak only Japanese.
- **Conclusion:**
  - Club must provide a translated SBC to the Spanish-speaking participants.
  - Club does not have to provide a translated SBC to the Japanese-speaking participants but may voluntarily do so; Japanese is not one of the 4 languages specified.
  - Under the SPD rules, notices in Spanish and Japanese must be provided with the SPD.

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How You Reach Your Audience

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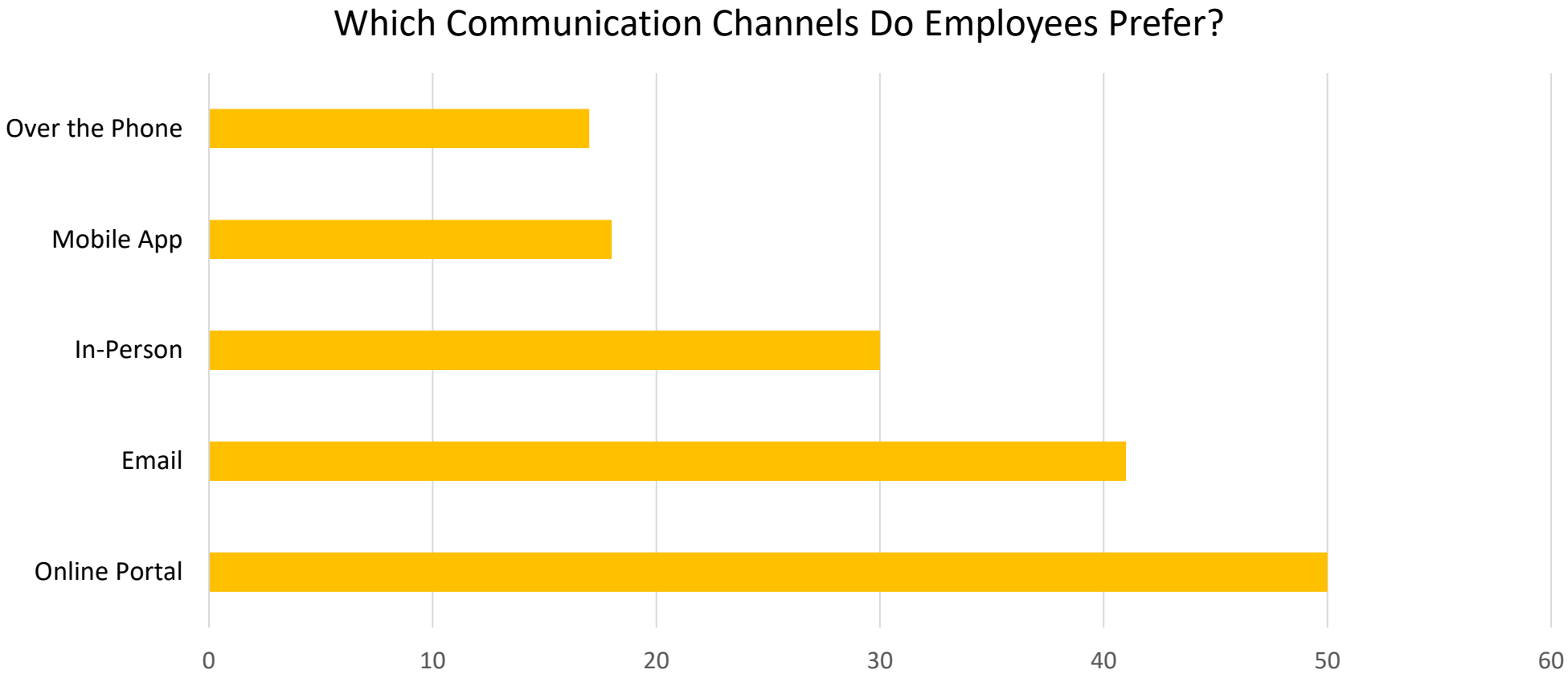
MetLife's 19th Annual U.S. Employee Benefit Trends Study (2021)



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How to Reach Your Audience

- **Scenario:** Carol is the head of HR for Golf Manufacturing Co., Inc. It's open enrollment time, and Carol has a stack of SPDs, SBCs, and benefit summaries to distribute. It's a lot of paper. Golf has:
  - 40 office staff—they are all on their company computers throughout the day
  - 10 sales staff—they are on the road, with company email, mobile phone, and laptop
  - 60 production employees—they do not have email or computer access
  - 5 COBRA qualified beneficiaries
  - 2 employees out on FMLA/CFRA
- Carol considers the following options:
  1) Leave a stack of the documents in the break room for everyone
  2) Set up a computer kiosk in the break room
  3) Distribute materials electronically to office and sales staff; conduct in-person meetings for production staff; mail to COBRA QBs and those on leave

How You Reach Your Audience

- **The ERISA Requirement:**
  - Must use a method reasonably calculated to ensure **actual** receipt (cannot simply leave a stack of SPDs and SBCs in the break room)
  - Target your audience; design optimal approach for each segment of your workforce
  - Do not forget those teleworking, on leave, vacation, too busy to show up, COBRA QBs, etc.
- **Your choices include:**
  - By hand, in-person meetings, or regular mail (first class the best option)
  - Internet/e-mail or DVDs/CDs/flash drives (more details next)
- **Compliance Tip:** Track and maintain records!
- **Compliance Tip:** These are the legal requirements. Don't stop there. Identify your communication goals and design an optimal strategy (see Resources, later).

Electronic Distribution

- **Note:** The rules are old (2002) and do not reflect current usage, but they are the rules we have to work with
- Do you need **consent** to distribute electronically?
  - You **do not** need consent for employees whose access to the employer's electronic info system is an integral part of their duties
  - You **do** need consent for employees/participants who do not
- Consent form: Follow the rules
- Take steps to ensure actual receipt: Follow the rules, such as using return-receipt and conducting periodic surveys/reviews to confirm receipt; computer kiosk not sufficient
- Must provide a notice that apprises the individual of the significance of the document
- Furnish a paper copy upon request (no charge)

- **What about Carol?**

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Open Enrollment

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Some Open Enrollment Best Practices

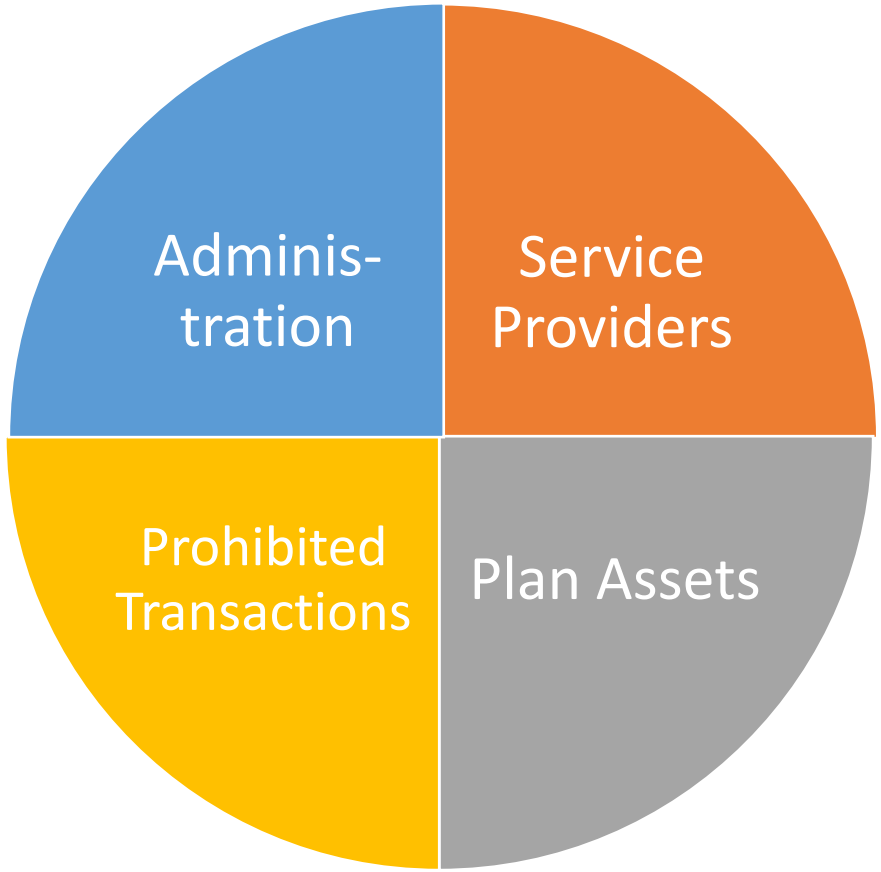
- **What You Must Do:**
  - Distribute open enrollment packets, including SPD, SBC, & mandatory notices
  - Satisfy foreign language requirements
  - Follow distribution rules to ensure you reach everyone, and do not forget about those on leave, working from home, out of the office, COBRA qualified beneficiaries, etc.
  - Keep records of who you distributed to, what you distributed, how you did it, and when
  - Keep records of elections and waivers

Some Open Enrollment Best Practices

- **Key Elements of Your Communication Strategy:**
  - Communicating benefit options available to employees—and how they might impact the employee—as well as significant plan changes
  - Communicating eligibility and contribution requirements
  - Communicating the value of the benefit package—including choosing the best options
  - Highlighting important or over-looked benefits, such as free preventive care, using in-network providers and generics and other available cost savings, under-utilized benefits, etc.
  - Explaining that benefit elections cannot be changed mid-year, unless the employee experiences a “special enrollment” event—and other issues/problems/questions that frequently arise as part of benefits administration

Operational Compliance

Operational Compliance



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Operational Compliance

- The **Plan Administrator**—typically the employer—is a **fiduciary**; others may also be named as or deemed to be fiduciaries
- Under ERISA, fiduciary responsibilities include:
  - Acting solely in the interest of plan participants and their beneficiaries and with the exclusive purpose of providing benefits to them;
  - Carrying out their duties prudently;
  - Following the plan documents (unless inconsistent with ERISA);
  - Handling plan assets consistent with ERISA; and
  - Paying only reasonable plan expenses

Operational Compliance

- **Administering the Plan:** Administer according to plan terms
  - Fiduciary obligation
  - Cannot discriminate among participants and beneficiaries
  - Failure to do so could result in loss of stop-loss coverage
  - Failure to do so could result in a complaint (and subsequent audit) or litigation
- **Plan Assets**: Participant contributions are treated as **plan assets**
  - **Exclusive Benefit Rule**: Plan assets shall be used only for the benefit of participants and beneficiaries and to offset certain plan expenses
  - Timely disbursement (medical loss ratio rebates, payment of premiums)
  - Rebates and refunds may be treated as plan assets

Operational Compliance

- **Prohibited Transactions**: Certain transactions are prohibited to prevent dealings with parties who may be able to exercise improper influence over the plan; also, fiduciaries cannot engage in self-dealing
  - Identify "**parties in interest**"—who generally cannot do business with the plan—and any transactions with them
  - Determine whether there is an exemption permitting the transaction
- **Service Providers:** Hiring service providers is a fiduciary function
  - Identify, monitor, and audit service providers
  - Benchmark services and costs (under the rules, **must be reasonable**)
    - **New!** **CAA** broker/consultant disclosure mandate
  - Review contracts to ensure plan's interests are protected; for example,
    - Outline who is (or is not) responsible for specific tasks, handling of funds, fiduciary status, subcontracting, record keeping and control, timeliness, and indemnification

Resources & Checklists

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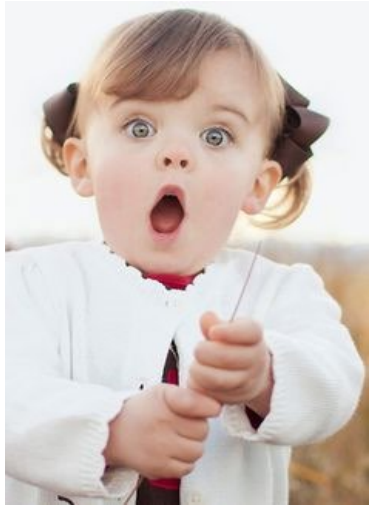
Tips & Traps

Opportunities for Miscommunication

- Plan document, SPD, SBC, and other plan materials do not match
- Information explained in open enrollment meeting doesn't match SPD
- Benefit terms described in other workplace materials (**handbook**, job descriptions/ads, employment contracts, website, etc.) are not consistent with SPD
- Plan materials never reach the participant or beneficiary
- Supervisors provide inaccurate information: HR should be sole point of contact on benefit issues

Some DOL Audit Document Requests You Might Not Be Expecting

- Plan Document
- Participant census
- Enrollment package
- Lists of parties in interest and service providers
- Description of employer/employee contributions
- Insurer invoices and proof of premium payments
- Documents relating to rebates/refunds and disposition (plan assets)
- Process for collecting premium from COBRA QBs
- Wellness program materials
- Mental health parity plan terms
- CAA mental health parity analyses
- Sample notices of claims determinations
- Fiduciary liability insurance policy
- Cybersecurity



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Open Enrollment Goals: A Checklist

- ❑ Meeting legal obligations
  - Distribute mandatory documents according to the rules
- ❑ Reaching everyone
  - Do not forget about those on leave, out of the office, COBRA qualified beneficiaries, etc.
- ❑ Communicating plan terms with clarity and accuracy
  - Highlight key changes (enhancements and reductions)
- ❑ Communicating options
  - Explaining the impact of each election choice
- ❑ Communicating value
  - Explain overall value, as well as often over-looked benefits and opportunities
- ❑ Assisting with benefit administration
  - Address frequent challenges or areas of confusion up-front (mid-year election changes, for ex.); enrollment forms/waivers
- ❑ **Compliance Tip:** Keep records: Who you distributed to, what you distributed, how you did it, and when

When to Distribute SPDs

New participants	Within 90 days
New plans	Within 120 Days
SMMs	210 days after the end of the plan year in which adopted
SMRs (health plans only)	Within 60 days or quarterly newsletter
If plan has been amended	Every 5 years
If plan has not been amended	Every 10 years

When to Distribute SBCs

Triggering Event	Timing
Upon Application (Initial Enrollment): If a plan distributes application materials	Provide SBC with application materials
Upon Application (Initial Enrollment): If a plan does not distribute application materials	Provide no later than the 1st day on which the participant is eligible to enroll in coverage
Changes: If there is a change in content of SBC after application and before first day of coverage	Provide an updated SBC no later than first day of coverage
Upon Renewal (**Open Enrollment**): If during open enrollment a participant must actively elect to maintain or change coverage	Provide SBC with open enrollment materials
Upon Renewal (**Open Enrollment**): If there is no requirement to renew (evergreen) or change options, renewal is automatic	Provide no later than 30 days prior to the first day of the new plan or policy year
Special Enrollees	Provide no later than the date SPD must be provided (90 days from enrollment)
Upon Request	Within 7 business days

Resources

- U.S. Department of Labor, Employee Benefits Security Administration (EBSA):
  - *Reporting and Disclosure Guide for Employee Benefit Plans* (Sept. 2017)
  - *Compliance Assistance Guide: Health Benefits Coverage under Federal Law,* including *Self-Compliance Tool for Part 7 of ERISA: Health Care-Related Provisions* (Nov. 2014)
  - *Understanding Your Fiduciary Responsibilities under a Group Health Plan* (Sept. 2015)
  - *An Employer's Guide to Group Health Continuation Coverage under COBRA* (Sept. 2015)
  - *Qualified Medical Child Support Orders* (QMCSOs) (2020)
- J. Hanley, *Deskless Yet Informed*, Benefits Quarterly (4th Quarter 2019)
- California:
  - California Department of Insurance (www.insurance.ca.gov)
  - California Department of Managed Health Care (www.dmhc.ca.gov)

Questions?

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The information provided during this program does not constitute legal advice. This program only provides a summary of certain complex and always evolving laws and regulations. Attendees should consult their legal counsel for guidance on the application and implementation of the many federal and state laws that impact employee benefit plans and the workplace, including the topics discussed during this program.

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