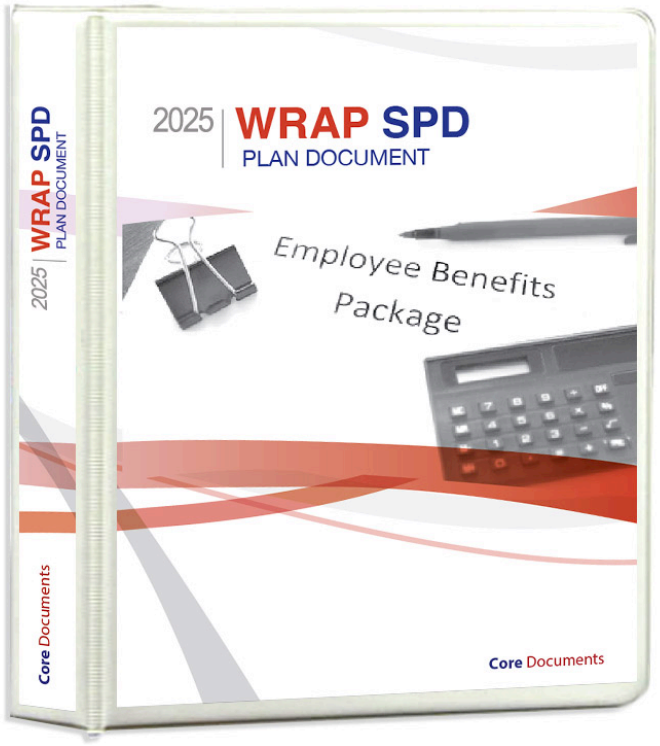
# Core SPD | Wrap SPD Plan Document




AVOID THE ACA

**$110** per day fine

with a Core Wrap SPD

## When does an employer need an ERISA Wrap SPD?

The Core SPD package enables employers to meet the ERISA/ ACA requirement for only $149 for a fully insured plan, or $179 for a self-funded health plan.

If you offer group health insurance, you are now required by ERISA law to distribute a Wrap SPD to all participants in your group plan. Failure to meet this requirement can result in large ACA fines and penalties of up to $110 per day.

Here is a brief summary of what employers need to know about the Wrap SPD:

- The requirement applies to all employer sponsored group health insurance offerings, including a one-person plan.
- The Wrap SPD must be distributed within 120 days of the Plan's effective date.
- The Wrap SPD requirement is enforced by the Department of Labor and the Affordable Care Act (ACA).
- To be compliant with ERISA and the ACA, a Wrap SPD Plan Document must contain statutorily defined information about employer benefit offering.
- Failure to provide the ERISA Wrap SPD within 30 days of request triggers a fine of $110 per day.
- Not having a Wrap SPD can also trigger an audit by the Department of Labor.
- The insurance company's Master Contract, Certificate of Coverage, or Summary of Benefits is not a Wrap SPD.

## Setup your Core SPD in 3 easy steps:

### Design your plan document:

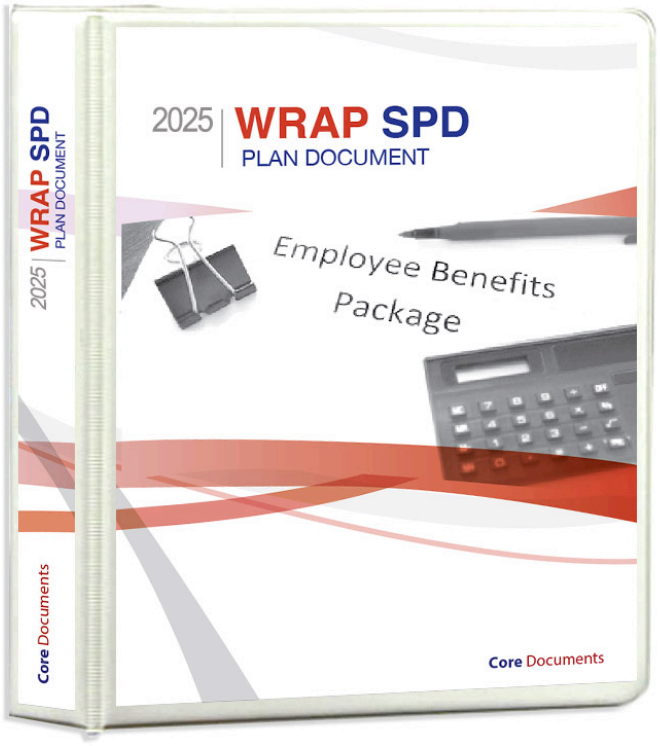
- Gather information on your plan to create the Wrap SPD (the attached information worksheet is a helpful guide);

### Order your plan document:

- Place your online order for the Core SPD document package.
- Your personalized plan document package arrives at your inbox within a business day or two.

### Start your plan:

- Print, review, and sign the plan document where indicated;
- Give a copy of the Wrap SPD to each eligible employee; and then,
- Keep the Core SPD plan document package on file with other personnel paperwork -- there is no requirement to file the plan document with any agency.

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## What is an ERISA Wrap Summary Plan Description (SPD)?

The Wrap SPD is the main vehicle for communicating plan rights and obligations to participants and beneficiaries. Employers offering a group benefit plan must one and distribute it to all plan participants no later than 120 days after the plan effective date.

The Wrap SPD has been around for years. It is mandated by ERISA, DOL and now the Affordable Care Act (ACA). It wasn't until the ACA added several new employee notification requirements and its stiff $110 per day penalties for non-compliance that most employers became motivated to comply with the requirement.

Wrap SPDs are typically not long or overly complicated documents, but they are valuable in the sense that they supplement the carrier booklet and fill in any necessary gaps. Plus, an employer providing a group benefit plan must have one to protect against the significant ACA fines and penalties.

## What is the "wrap" part of the SPD?

The term "wraparound" as it relates to SPDs originally came from DOL guidance suggesting the supplemental document be formally bound to the benefit plan booklet. The combination of the two documents would, upon distribution to participants, represent a joint, compliant Wrap SPD for a particular benefit plan.

Obviously times have changed, and most of these documents are now provided electronically. While the "wraparound" no longer applies in the literal sense, the concept remains.

## There is an SPD in my Plan Document package -- will that suffice?

Your Section 125 Plan or HRA Plan Document and SPD does not constitute an ERISA Wrap SPD Document for the employer group health insurance plan.

Also, the insurance company's Master Contract, Certificate of Coverage, and Summary of Benefits do not meet the a Wrap SPD requirement.

The above items may constitute some of the plan documents but they do not constitute the ERISA, DOL, and ACA-required Wrap SPD document that must be prepared by the employer.

## What kind of information does the Wrap SPD contain?

Here is a partial list of what the document communicates:

- The plan name.
- The plan sponsor/employer's name, EIN, and address.
- The plan administrator's name, address, and phone number.
- Each plan trustee's name, title, and address of principal place of business (if the plan has a trust).
- The name and address of the plan's agent for service of legal process, along with a statement that service may be made on a plan trustee or administrator.
- The type of plan administration, e.g., administered by contract, insurer, or sponsor.
- Eligibility terms, e.g., classes of eligible employees, employment waiting period, and hours per week, and the effective date of participation, e.g., next day or first of the month following satisfaction of an eligibility waiting period.
- ·A summary of any plan provisions governing the benefits, rights, and obligations of participants under the plan on termination or amendment of the plan or elimination of benefits.
- Plan provisions.
- Claims procedures.

## Visit us online today

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To see all of our products and services, visit us at www.coredocuments.com.

# Core SPD | Wrap SPD Plan Document

If you have questions while completing this worksheet, please call us at 1-888-755-3373.

When this form is complete, please go to www.corespd.com to order.

## Ordering Information Worksheet

This form is provided for your convenience while gathering information for the Core HSA document package. It is a fillable PDF form. Click on the line next to "First Name" to begin and then tab from field to field.

**Purchaser Information** (Person buying document for Employer listed below, i.e. Agent, CPA, payroll co., etc.; "N/A" in "First Name" if not applicable.)

First Name _____ Last Name _____

Company _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Mobile _____ Fax _____

Email _____ Web site _____

Ship Plan Document package to: ☐ Purchaser ☐ Employer

**Employer Information for SPD**

(Owner/controller, document signer; exactly as it should appear in the SPD. Company and contact will also be the Plan Sponsor, Agent for Legal Process, Plan Administrator, and Plan Fiduciary.)

First Name _____ Last Name _____

**Company Name** _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Mobile _____ Fax _____

Email _____ Web site _____

**Form of Business:** ☐ S Corporation ☐ C Corporation ☐ LLC ☐ Partnership ☐ Sole Proprietorship ☐ Government ☐ Non-Profit 501(c)(3)

**Employer Fed. ID #** _____ State of Incorporation _____ No. of Employees _____

Legal Name(s) of **Affiliated Company(ies)** that will be covered by the Plan (if any):

1) _____ FEIN#_____

2) _____ FEIN#_____

3) _____ FEIN#_____

**Plan Administrator**

☐ Employer (use 'employer' information, above) ☐ Other (provide information below)

First Name _____ Last Name _____

Company _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Email _____

**Name of Fully Insured Plan Insurance Carrier(s):** (i.e. Blue Cross Blue Shield or Aetna Health Insurance)

☐ Health Insurance Carrier 1: _____

☐ Health Insurance Carrier 2:_____

☐ Health Insurance Carrier 3: _____

**Effective Date**

☐ A new plan with an effective date of _____.

☐ Amend and restate an existing Section 125 POP as of _____.

If this is an amended and restated plan, state the (old) original effective date: _____.

**Plan Year** The first plan year will be:

☐ A 12-month consecutive period beginning date _____ and ending date _____.

☐ A short plan year beginning date _____ and ending date _____.

**Waiting Period** Employees are eligible to participate in the plan on: ☐ the 1st day of employment, or ☐ the 1st day following, or ☐ the 1st day of the month following _____ days of employment.

**Eligibility Requirements:** All employees who work _____ or more hours per week.

**Funding Mechanism:** ☐Employer General Assets ☐Employee Contributions ☐ Trust Account ☐Union or Collective Bargained Agreement ☐Other Employee Organization

**Assigned Plan Number:** ☐501 ☐502 ☐503 ☐ _____ Plan identification for reporting purposes.

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**Documenting Method for Identifying Full-Time Employees:** (Search - IRS Notice 2012-58 for information)

☐**Monthly Measurement Period** ☐**Look Back Period Alternative Method** Effective in 2014, the health care reform law imposes penalties on employers with **at least 50 full-time equivalent employees** if they do not offer health coverage to their employees or if they offer health coverage to their employees that is not "affordable" or does not provide "minimum value" and certain other requirements are met. The Core Wrap SPD defaults to the standard *Monthly Measurement Period* where every employee working 31 or more hours last month are full-time. The *Look Back Period* alternative method is for groups with employees who work a flexible schedule (or as needed) and there is no way to actually determine if they will be full-time (for purposes of the ACA fines) or part time (30 hours or less). The *Look Back Method* allows for a Safe Harbor period of time, determined by the employer, of not less than 3 months, and not more than 12 months for identifying full- time or part-time status.

**Notice of Patient Protections and Selection of Providers:**

If a group health plan or health insurance issuer requires the designation by a participant or beneficiary of a primary care provider, the plan or issuer must provide a notice informing each participant of the terms of the plan or health insurance coverage regarding designation of a primary care provider.

**Does your health insurance require the designation of a Primary Care Provider:** ☐Yes ☐No

***Notes: Please include any additional information you believe is relevant to your Plan(s) here.***

_____

_____

_____

_____

## *Choose either the 'Deluxe Binder Option' or the 'Basic PDF Option':*

☐ **Deluxe Binder – New Core Group Insurance SPD Wrap Plan Document** **$199.00** ☐

*In email PDF version processed ASAP, AND Printed in 3-ring binder, with tabbed index, shipped via Priority Mail.*

***OR***


☐ **Basic PDF Option - New Core Group Insurance SPD Wrap** **$149.00** ☐

*PDF Document Processed Quickly and Sent Via E-Mail*

## *Options that can be added to the SPD Wrap Deluxe Binder or the Basic PDF Option:*

☐ **Supplemental/Ancillary Insurance SPD Module** **$30.00** ☐

*Include supplemental/ancillary benefit insurance plans such as dental, vision, critical Illness plans, hospital indemnity, STD, LTD, life etc.*

**List the Supplemental Insurance Carriers and Benefit Plan Name:**

- ❑ Dental Insurance: _____
- ❑ Vision Insurance: _____
- ❑ Group Term Life Insurance: _____
- ❑ Accidental Death Dismemberment Insurance: _____
- ❑ Short Term Disability Illness Insurance: _____
- ❑ Long Term Disability Illness Insurance: _____
- ❑ Accident Insurance: _____
- ❑ Critical Illness Insurance: _____
- ❑ Cancer Insurance: _____
- ❑ Intensive Care Insurance: _____
- ❑ Life Insurance: _____

☐ **Self-Funded Health Plan Module** **$30.00** ☐

Name of TPA: _____

Name of Reinsurance Carrier: _____

☐ **Rush Order - Your order automatically queued for immediate processing** **$25.00** ☐

**TOTAL** _____ $ TOTAL

# Core SPD | Wrap SPD Plan Document

If you have questions while completing this worksheet, please call us at 1-888-755-3373.

## Invoice me via email, please complete the following:

**Company Name:** _____ **Contact:** _____

**Email Address for Invoice:** _____

## If paying by check, please complete the following:

Your order can be processed with the following checking account information and authorization.

Name as it appears on the check:

_____

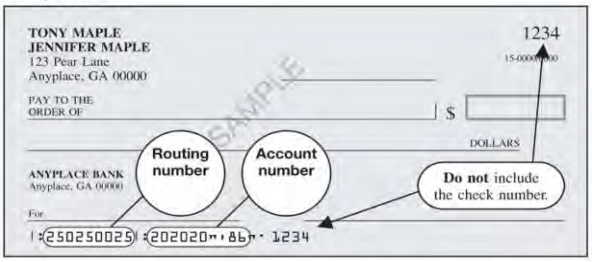
Bank Name: _____

Bank Routing Number: _____

Bank Account Number: _____

Total amount to be charged: $_____

Sample Check




CAUTION *The routing and account numbers may be in different places on your check.*

X_____ Date: _____
Signature

## If paying by credit card, please complete the following:

Card Number: _____

Expiration Date: ____ /____

Total amount to be charged: $_____

Name as it appears on card: _____

X_____ Date: _____
Signature

**Refund Policy:** Purchaser understands that goods and services provided by Core Documents, Inc. are non-refundable. Orders cancelled prior to sending/shipping are subject to cancellation fees applied to the cost of goods and services provided during the review, draft, and preparation of your order.

Please sign and fax completed form to (941)795-4802. Attach additional pages of plan design information if needed.

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Toll Free Voice: 888-755-3373 Fax: 941-795-4802