Compliance Overview

Best Practices for Documenting Employee Benefit Plans

Documenting employee benefit plans is a critical compliance step for employers that can be easily overlooked. Most private sector employers are subject to the Employee Retirement Income Security Act (ERISA), which sets minimum standards for employee benefit plans. Under ERISA, welfare benefit plans must be described in a written plan document. In addition, employers must explain the plans' terms to participants by providing them with a summary plan description (SPD).

In addition, employers that allow employees to pay for their benefits on a pre-tax basis through payroll deductions must comply with the requirements of Internal Revenue Code (Code) Section 125. One of these requirements is that an employer must adopt a written Section 125 plan document on or before the first day of the plan year. Employers should also confirm that other benefit offerings are documented, including medical opt-out payments and dependent care flexible spending accounts (FSAs).

These documentation requirements are ongoing. Employers should review their plan documents and employee communications at least annually to determine whether updates are needed. Any significant changes should be communicated to participants as soon as possible.

This Compliance Overview summarizes best practices for documenting employee benefit plans.

Highlights

Why Plan Documentation Is Important

Not having a plan document or SPD can have serious consequences for employers, such as:

- Not being able to respond to participant requests for documents, which can trigger penalties under ERISA and be detrimental to employee relations;
- Making it difficult to prove that the plan's terms support eligibility or benefit decisions if a dispute over benefits arises;
- Triggering more scrutiny and possible penalties in the event of a DOL audit; and
- Causing negative tax consequences for employees if the IRS audits the employer's Section 125 compliance.

Links and Resources

- The DOL's Reporting and Disclosure Guide for Employee Benefit Plans
- Code Section 125
- Final rule on ICHRAs
- IRS Publication 503, Child and Dependent Care Expenses

Provided by **MST Insurance Solutions, Inc.**

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Use a "Wrap Document" to Comply with ERISA's Requirements for Plan Documents/SPDs

ERISA Requirements

ERISA sets minimum standards for employee benefit plans maintained by private-sector employers. Among other requirements, ERISA requires employers to maintain an official plan document for their employee benefit plans and provide plan participants with an SPD. Employers often overlook these requirements or mistakenly think documents provided by an insurance carrier or third-party administrator (TPA) will satisfy ERISA's requirements on their own. There are no specific penalties under ERISA for failing to adopt an official plan document or provide participants with an SPD. However, not having these documents can have serious consequences for an employer, including the following:

- An employer may be charged up to **$110 per day** if it does not provide the SPD or other plan documents within 30 days after an **individual's request**. These penalties may apply even where a plan document or SPD does not exist;
- Failure to have a plan document (or failing to distribute an SPD) may **put an employer at a disadvantage if a participant brings a lawsuit for benefits under the plan**. Without these documents, it may be difficult for an employer to prove that the plan's terms support benefit decisions; and
- The U.S. Department of Labor (DOL) will almost always ask to see a copy of the plan document and SPD, in addition to other plan-related documents, if it selects an employer's health plan for audit. If an employer cannot respond to the DOL's document requests, then additional document requests, interviews, on-site visits or even DOL enforcement actions may be triggered. Also, the DOL may charge a plan administrator up to **$195 per day (up to a maximum of $1,956 per request) if it does not provide plan documentation to the DOL upon request**.

Wrap Documents

Often, the detailed benefit descriptions provided by an insurance carrier or TPA for a welfare benefit do not contain all the information required by ERISA for a plan document or SPD. A wrap document is a relatively simple document that supplements existing documentation for a welfare benefit plan and fills in the missing ERISA-required provisions. Because the wrap document incorporates the carrier's or TPA's benefit description by reference, the plan's benefit provisions continue to be governed by the terms of those documents. When wrap documents are used, the ERISA plan document and SPD are comprised of two pieces:

1. The carrier's or TPA's benefit description, providing detailed information on the plan's benefits and procedures; and
2. The wrap document, which fills in the ERISA-required information that is missing from the benefit description or booklet.

To comply with ERISA, both the wrap SPD and the carrier's or TPA's benefit description must be distributed to plan participants by the appropriate deadline.

Adopt a Section 125 Plan Document Before Allowing Pre-tax Contributions

Code Section 125 allows employers to establish a type of tax savings arrangement, called a Section 125 plan or cafeteria plan, for their employees. A Section 125 plan provides employees with an opportunity to pay for certain benefits on a pre-tax basis, such as medical, dental and vision coverage, allowing them to increase their take-home pay. This type of plan is commonly referred to as a premium-only plan (or POP) or premium conversion plan (or PCP). To avoid taxation, the Section 125 plan must meet the specific requirements of Code Section 125 and underlying IRS regulations. One of these requirements is that a Section 125 plan must be maintained pursuant to a **written plan document that is adopted by the employer on or before the first day of the plan year.**

According to the IRS' 2007 proposed regulations, if there is no written plan document in place (or if the written plan document does not comply with the IRS' content or timing requirements), employees' elections between taxable and nontaxable benefits will result in **taxable income to the employees**.

Include Any Medical Opt-out Payments Under the Section 125 Plan Document

Some employers offer their eligible employees a cash incentive to waive coverage under the employer's group health plan. These arrangements, known as "opt-out payments" or "cash in lieu of benefits," are a cost-saving tool for employers that provide employees with a taxable cash benefit. While medical opt-out payments are generally permissible, there are various legal issues that impact the design of these arrangements. Also, because opt-out payments give employees a choice between health coverage and taxable compensation, they must be offered through a Section 125 plan to avoid taxation of participants who elect health care benefits. Employers offering opt-out incentives should ensure that they update their Section 125 plan document to include the medical opt-out payment as a covered benefit.

Adopt an ICHRA to Reimburse Individual Insurance Premiums

In general, employers cannot reimburse employees' individual health insurance premiums without violating the Affordable Care Act (ACA) and risking excise tax penalties. An exception to this prohibition allows employers to adopt an increasingly popular type of health reimbursement arrangement (HRA), an individual coverage HRA (ICHRA), to reimburse employees' premiums for individual health insurance policies and Medicare coverage on a tax-free basis.

Employers can decide which classes of employees are eligible for the ICHRA and how much is contributed for each employee class. Employers may also continue to offer a traditional group health plan if the ICHRA and the traditional group health plan are offered to different classes of employees. However, employers cannot offer any employee a choice between an ICHRA and a traditional group health plan.

ICHRAs are group health plans subject to ERISA, which means they must have an official plan document and be described to participants through an SPD. Employers with ICHRAs also must:

- Substantiate that eligible employees and dependents are enrolled in individual health insurance (or Medicare) coverage. This substantiation must be provided in advance of each plan year and prior to each expense reimbursement;
- Allow eligible employees to opt out of ICHRA coverage in advance of each plan year; and
- Provide an annual notice to eligible participants regarding the ICHRA and its interaction with the ACA's premium tax credit.

If the ICHRA does not cover employees' full premiums for individual insurance coverage, the employer may permit employees to pay the balance of the premiums on a pre-tax basis through its Section 125 plan. However, federal tax law prohibits employers from allowing employees to pay for Exchange coverage on a pre-tax basis, which means this pre-tax payment option is only available for coverage that is purchased outside of an ACA Exchange.

Remember: Dependent Care FSAs Require a Plan Document and Employee Notification

Code Section 129 allows employers to provide dependent care assistance benefits for their employees on a tax-free basis. These benefit plans are referred to as dependent care FSAs or dependent care reimbursement accounts (DCRAs). Most dependent care FSAs are structured so that employees make contributions on a pre-tax basis through a Section 125 cafeteria plan. Effective Jan. 1, 2026, married employees who file a joint tax return and unmarried employees may contribute up to $7,500 each year to their DCRAs. The annual limit for married employees who file separate tax returns is $3,750. These limits do not receive annual adjustments for inflation.

In general, benefits that an employee receives from their dependent care FSA are nontaxable if the expenses are for the care of one or more qualifying individuals (for example, a child under the age of 13) and the employee incurs the expense in order to enable the employee (and the employee's spouse, if applicable) to be gainfully employed.

Although dependent care FSAs are not subject to ERISA, employers that sponsor these plans are required to have a written plan document in place that describes the dependent care assistance benefits and complies with the requirements of Code Sections 129 and 125. Employers are also required to notify employees of the DCRA's availability and terms, similar to the SPD requirement for ERISA-covered benefits.

Reviewing and Updating Plan Documents Each Year for Changes

Employers should review their welfare plan documents each year to see if they should be updated for any changes to plan design or administration. An ideal time for this review is before the start of each plan year, so any changes made for the current plan year can be incorporated into the plan document before the plan year ends, and any necessary adjustments can be made for the upcoming plan year. An outdated plan document can be detrimental to an employer in the event of a benefits dispute or DOL audit.

Also, any material changes to plan design or operation should be communicated to participants through an updated SPD or a summary of material modifications (SMM). In general, the deadline for providing an updated SPD or SMM is 210 days after the close of the plan year in which the change was adopted. However, if benefits or services are materially reduced, participants must be provided notice within 60 days from the change's adoption. However, as a best practice, these changes should be communicated to plan participants as soon as possible, even if the deadline is later.

In addition, employers must provide 60 days' advance notice of any material modification to plan terms or coverage that takes effect mid-plan year and impacts the content of the summary of benefits and coverage (SBC). The 60-day notice can be provided to participants through an updated SBC or by issuing an SMM. A "material modification" is any change to a plan's coverage that (independently or in connection with other changes taking place at the same time) would be considered by the average plan participant to be an important change in covered benefits or other terms of coverage.