TAXSAVER PLAN

"Your Satisfaction Is Our Success"

WHAT YOU NEED TO KNOW....

PLAN DOCUMENTS, WRAP AND MEGA-WRAP PLANS:

Plan Documents are an essential piece to Health & Welfare Benefit Plan administration. Plan Documents often protect the Employer in a court of law and define the administrative practices during each plan year. And, though reading Plan Documents can often put you to sleep, there are some key points that you should look for when reading your Plan Documents:

1. Is the name of the Plan consistent with the name on the 5500 for that benefit plan?
2. Is the plan number consistent with the plan number on the 5500?
3. Does the Plan have all the necessary components of an ERISA Plan Document?

    *Is there a named fiduciary?
    *Is there a procedure for allocation of responsibilities?
    *Is the funding policy stated?
    *Is the policy of how payments are made stated?
    *Is the claims procedure clearly outlined?
    *Is the amendment procedure defined?
    *Does the plan describe the distribution process of plan assets at plan termination?
    *Are COBRA and USERRA rules defined for group health plans?
    *Are HIPAA, Special Enrollment Rights and Non-Discrimination provisions defined for group health plans?
    *Are HIPAA Privacy and Security rights defined for group health plans?
    *Is the minimum hospital stay after childbirth explained for group health plans?
    *Are the QMCSO rules defined?

4. Are the eligibility definitions and waiting periods consistent with how you administer the plan?
5. Is the SPD or SMM consistent with the language of the Plan Document?

It is also important to note that if the Plan files only one 5500 filing each year, there must be a Wrap Document or Mega-Wrap Document in place. A Wrap Document is a concise document that incorporates the general administration of multiple insurance Plans. A Mega-Wrap Plan Document bundles different benefits into one legal document. A Wrap-around SPD is also created in conjunction with the Wrap Document to distribute to participants. The language provided in a Wrap Document

and SPD often fills in language that is missing for the insurers' standard plan documents and SPDs.

5500 FILINGS:

An employer is required to file a 5500 when they have 100 or more covered employees in an ERISA group benefit plan on the first day of the plan year. A SAR (Summary Annual Report) should also accompany a 5500 filing. The SAR summarizes the information provided on the 5500 and should be furnished to participants within nine months of the end of the plan year, or two months after the form has been filed when an extension is requested. A totally unfunded plan (such as a Health FSA Plan) does not require a SAR if the Health FSA 5500 is filed as a stand alone plan. Non-ERISA plans and fringe benefit plans, such as a Cafeteria Plan, are not required to file 5500s. However, if you have 100 or more covered employees in the Health FSA Plan as of the first day of the plan year, you must file on this fringe benefit.

Components of the 5500 filing include:

*Schedule As: plans that are partially or totally insured must file a separate Schedule A for each insurance policy.
*Schedule Cs: pertains to service provider information, providing information on the 40 top-paid service providers receiving $5,000 or more in compensation paid by the plan. Please note that if the fee paid to the provider is not paid out of plan assets, no Schedule C is required.
*Schedule F: this schedule is no longer required for fringe plans, such as a Cafeteria Plan. However, any ERISA welfare plans associated with a cafeteria plan must still file a Form 5500 unless an exemption applies.

If you have concerns about the 5500s you have filed, or possibly not filed, please contact us to discuss.

NON-DISCRIMINATION TESTING:

Code Section 125 of the IRC requires that Plans test for non-discrimination. This has been a part of the regulation since inception. Because the regulations have always been proposed versus final, many employers felt it was not necessary to test. However, it is the responsibility of the Plan Sponsor to operate the plan with the proposed regulation in mind.

There are various tests to be performed. First there are test for the Section 125 Plan itself. Secondly, there are underlying test for the various plans under the umbrella of the Section 125 Plan. These would normally include the Health Spending Account, the Dependent Care Assistance Program and the Health Plan if it's self funded.

The purpose of all testing is to determine if the Plan discriminates. A Plan can not discriminate in favor of the highly compensated employee (HCE) both in terms of eligibility and benefits. Who are these HCEs? Well, that is somewhat of a problem because they vary as to definition in each Plan. Once they are separated into their respective groups, then you test each plan as to eligibility, benefits and utilization. One can compare these tests to inviting guest to a party. The first test is to determine who you invite, then of those invited what did you offer each to eat, and lastly what they actually ate while there.

Testing a normal Section 125 Plan with both a health spending account and a dependent care account plan comprises eleven tests.

The overall Section 125 Plan is tested as to:
- Eligibility
- Contribution and Benefits
- Key Concentration

The Health FSA is tested as to:
- Eligibility
- Benefits

The Dependent Care Plan is tested as to:
- Eligibility
- Contribution and Benefits
- More than 5% Owner Concentration Test
- 55% Average Benefit Test

Self Funded Medical Plan is tested as to:
- Eligibility
- Benefits

There is a new Safe Harbor test for Premium Only Plans (POP).

The proposed regulations never addressed when the test need to be preformed. The proposed final regulations state that the Plan must be tested on the final day of the plan.

Regardless, TSP recommends that test be preformed by mid plan year so that corrections can be made to bring the plan into compliance.

Next month, we will detail IIAS practices and debit cards.

As always, we are here to answer your questions.

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