Sample ERISA Plan Document **Revised: 2013/12/31**

Instructions: This sample group health plan is intended for adoption by self-employed individuals and organizations with only one person (or family) both owning the organization and serving as the sole employee(s).

Sponsoring a group health plan will allow the employees to comply with the ACA individual mandate without purchasing commercial insurance and avoid associated penalties.

Fill in the information in this sample plan and revise it as necessary for adoption by your organization.

ERISA Section 402 requires an employee benefit plan be established and maintained according to a written instrument. This plan is meant to be used with the sample summary plan description. Along with other materials, it must be sufficient, to allow for the creation of the summary plan description as well as meet the requirements of section 402.

The plan must specify the process for selecting a fiduciary, funding policy, assignment of operational responsibilities, amendment process, and basis for payments to and from the plan. It is expected the individual owning the business will serve as fiduciary.

It is recommended funding be entirely from the general funds of the business. Otherwise, fiduciaries must be bonded and the funds must be held in trust according to strict rules.

It is not necessary that a plan cover spouses or children, however the mandate penalty may apply to an individual that does not have coverage for a spouse filing a joint return or a child that can be claimed as a dependent. Spouses filing separate returns may face higher taxes.

A plan has flexibility in which benefits are covered, however it may be simpler to avoid using unwanted benefits than to try and enumerate which benefits should be excluded.

ERISA requires that plans process enrollments required by qualified child support orders and that individuals that lose coverage be issued a certificate of creditable coverage. It is simpler to allow all employees to enroll right away than to manage enrollment periods.

With respect to claims procedures, it is advisable to provide that beneficiaries are reimbursed for claims rather than pay providers, as providers can require any transaction be made electronically according to HIPAA standards. There are stiff fines for incorrectly processing a HIPAA transaction. In practice, in may be simpler not to file claims at all. Large average claims may be subject to tax.

ERISA rules require that a plan have a procedure for review of denied claims by the fiduciary, but do not detail those procedures.

This document is a sample for reference only and does not constitute legal advice. The relevant laws, regulations and guidance should be reviewed prior to adopting a plan.

[Plan Name]
Plan Description
Effective [Effective Date]

This Plan Description provides the process for establishment and maintenance of *[Plan Name].*

Contents

Administrative Information

Plan Sponsor

This plan is sponsored by, administered by, and covers employees of:
[Sponsor Name]
[Sponsor Address]
[Sponsor Phone]

Administration

The sponsor shall appoint an individual to serve as plan fiduciary. The fiduciary shall be responsible for administering and operating the plan.

Funding

The plan will be funded from the general assets of the business. It is anticipated that there will be few claims and these funds will be adequate. Claims shall be paid as they are processed.

Plan Amendments

The sponsor may amend the plan at any time. The summary plan description shall be updated to incorporate any changes. If the amendments are material, a summary of material modification shall be distributed.

Plan Eligibility

The plan shall be open to all employees. Enrolled employees may additionally elect to have coverage apply to their spouses and/or children.

Plan Benefits

The plan shall pay for all medical expenses of covered individuals.

Enrollment Procedures

Upon adoption of the plan, upon hiring, and upon request, employees shall be informed of their eligibility under the plan and provided with a Summary Plan Description.

Eligible individuals seeking to modify their enrollment status shall submit a request to the administrator indicating their name and date of birth, as well as the name and date of birth of any spouse or children covered or to be covered, and the type of enrollment or coverage action sought.

The administrator shall process the request and record the enrollment status and identities of covered individuals in an enrollment ledger.

Employees may enroll, end enrollment, or change dependent coverage at any time, subject to the limitations of qualified child support orders. Enrollees should inform the administrator of a change in status regarding eligibility for coverage, such as a death or divorce.

If the administrator receives a child support order, the administrator shall notify the plan beneficiary and alternate recipients. The administrator shall determine if the order includes the name and mailing address of the participant and each alternate recipient or their agent, the coverage to be provided, and the period to which the order replies. If so, the administrator shall determine if the named participant is eligible to participate in the plan, if the plan provides the coverage required, and if the present period is covered under the terms of the order. If the order qualifies in all respects, the alternate recipients' custodians may submit a request to be enrolled. The administrator shall notify the beneficiary and alternate recipients or their representatives of their qualification status.

The administrator shall terminate the enrollment or coverage of any person known to be no longer eligible to participate in the plan and record the termination. An individual who has coverage terminated shall be issued a certificate of creditable coverage.

Claims Procedures

Beneficiaries may submit a claim to the administrator for reimbursement of expenses paid to medical providers. The plan will not pay any claims for expenses not actually paid by a beneficiary. The plan will not pay providers directly.

The claim should include 1) the identity of the covered individuals receiving care, 2) the amount of reimbursement sought, and 3) receipts clearly showing the amounts paid for covered expenses. Claims must be submitted not later than 30 days after the day the expense is incurred.

The administrator shall process the claim and if the evidence shows a covered individual paid covered medical expenses and the claim was filed in a timely manner, the administrator shall record the expense and reimburse the covered individual. If the claim is rejected, the administrator shall notify the person making the claim and record the claim and the reason for the rejection.

A rejection may be appealed to the fiduciary, who shall examine the claim. As appropriate the appeal may be conducted in writing, in person, or through other communications. The fiduciary may accept or reject the claim, or may attempt to obtain additional information regarding the claim.

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