

## **Reporting Form for Plan Sponsors Offering Limited Wraparound Coverage**

### Purpose of this Form

The Reporting Form for Plan Sponsors Offering Limited Wraparound Coverage (the “Form”) is used by Plan Sponsors of Limited Wraparound Coverage to satisfy the reporting requirement that must be met for the Limited Wraparound Coverage to qualify as an excepted benefit under the Employee Retirement Income Security Act of 1974 (ERISA), the Internal Revenue Code, and the Public Health Service Act under 29 C.F.R. § 2590.732(c)(3)(vii)(E)(2), 26 C.F.R. § 54.9831-1(c)(3)(vii)(E)(2), and 45 C.F.R. § 146.145(b)(3)(vii)(E)(2), respectively. For more information on the requirements that apply to the Limited Wraparound Coverage excepted benefit, see 29 C.F.R. § 2590.732(c)(3)(vii), 26 C.F.R. § 54.9831-1(c)(3)(vii), and 45 C.F.R. § 146.145(b)(3)(vii). See the glossary for definitions of key terms, including Limited Wraparound Coverage and Plan Sponsor.

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### *SECTION 1: WHO MUST FILE*

A Plan Sponsor of Limited Wraparound Coverage must file the Form. Complete and file one form per Limited Wraparound Coverage.

### *SECTION 2: WHEN TO FILE*

A Plan Sponsor of Limited Wraparound Coverage must file the Form on a one-time basis. The Plan Sponsor must file the Form within the later of 60 days after final publication of this Form or 60 days after the first day of the first plan year that Limited Wraparound Coverage is first offered.

### *SECTION 3: WHERE TO FILE*

The completed Form must be emailed to [marketreform@hhs.gov](mailto:marketreform@hhs.gov).

**Part I – Identification Information**

**Line 1(a).** Enter the formal name of the Limited Wraparound Coverage or enough information to identify the Limited Wraparound Coverage. Abbreviate if necessary. Do not use the same name or abbreviation for any other Limited Wraparound Coverage.

**Line 1(b).** Enter the three-digit plan identification number that the Plan Sponsor assigned to the Limited Wraparound Coverage. Plan Sponsors of plans that are not subject to ERISA and that do not have plan identification numbers should create a three-digit sequential number for each Limited Wraparound Coverage for which the Form is submitted.

**Line 2(a).** Enter the name of the Plan Sponsor of the Limited Wraparound Coverage. If this plan covers only the employees of one employer, enter the employer’s name. If this plan covers the employees of multiple employers, enter the name of the Plan Sponsor. Enter the D/B/A (the doing business as) or trade name of the Plan Sponsor if different from the Plan Sponsor’s name. See the glossary for a definition of the term Plan Sponsor. Enter the Plan Sponsor’s current street address. A post office box number may be entered if the Post Office does not deliver mail to the Plan Sponsor’s street address. Enter the name of the city. Enter the two-character abbreviation of the U.S. state or possession and zip code. Enter the foreign routing code, if applicable. Leave U.S. state and zip code blank if entering a foreign routing code and country name. Enter the foreign country, if applicable.

**Line 2(b).** Enter the nine-digit employer identification number (EIN) assigned to the Plan Sponsor, for example, 00-1234567, if applicable.

**Line 2(c).** Enter a valid phone number for the Plan Sponsor.

**Part II - Background Information**

**Line 3.** Check this box if the Limited Wraparound Coverage is maintained pursuant to a collective bargaining agreement.

**Line 4.** Check any applicable box(es). Check the box next to “Eligible individual health insurance” if the Limited Wraparound Coverage is designed to supplement Eligible individual health insurance coverage. Check the box next to “Multi-State Plan” if the Limited Wraparound Coverage is designed to supplement a Multi-State Plan (MSP). Check the box next to “Basic Health Program” if the Limited Wraparound Coverage is designed to supplement Basic Health Program (BHP) coverage. See the glossary for the definition of Eligible individual health insurance, Multi-State Plan, and Basic Health Program.

**Line 5.** Enter the first day of the first plan year for which the Plan Sponsor first offered the Limited Wraparound Coverage and the plan year start and end date of the Limited Wraparound Coverage. If the plan year of the Limited Wraparound Coverage has changed over time, enter the most recent plan year.

**Line 6.** Check the applicable box(es) for the categories of individuals who are eligible to enroll in the Limited Wraparound Coverage. See the glossary for the definition of Full-time employee, Part-time employee and Dependent.

**Line 7.** Indicate the total number of participants enrolled in the Limited Wraparound Coverage at the beginning of the most recent plan year as follows:

**Line 7(a).** Provide the total number of Full-time employee participants enrolled in the Limited Wraparound Coverage at the beginning of the most recent plan year. If none, enter 0.

**Line 7(b).** Provide the total number of Part-time employee participants enrolled in the Limited Wraparound Coverage at the beginning of the most recent plan year. If none, enter 0.

**Line 7(c).** Provide the total number of retired or separated participants entitled to benefits enrolled in the Limited Wraparound Coverage at the beginning of the most recent plan year. If none, enter 0.

**Line 7(d).** Provide the total number of Dependents enrolled in the Limited Wraparound Coverage at the beginning of the most recent plan year. If none, enter 0.

**Line 8.** Provide a list of Additional Benefits provided through the Limited Wraparound Coverage. See the glossary for the definition of the term Additional Benefits.

### **Part III – Attestation and Signature**

This Form must be signed by an authorized representative of the Plan Sponsor. Signing this Form indicates that the information provided in the Form is true, correct, and complete. The authorized representative and preparer may be different.

**Part I – Identification Information**

1. Limited Wraparound Coverage
  - a. Name of Limited Wraparound Coverage \_\_\_\_\_  
\_\_\_\_\_
  - b. Plan identification number of the Limited Wraparound Coverage \_\_\_\_\_  
\_\_\_\_\_
  
2. Plan Sponsor
  - a. Plan Sponsor's name and address; include room or suite number  
\_\_\_\_\_  
\_\_\_\_\_
  - b. Plan Sponsor's Employer Identification Number (EIN) \_\_\_\_\_  
\_\_\_\_\_
  - c. Plan Sponsor's telephone number \_\_\_\_\_

**Part II – Background Information**

3. If the Limited Wraparound Coverage is maintained pursuant to a collective bargaining agreement, check here.
  
4. What type of coverage is the Limited Wraparound Coverage designed to supplement? (check all that apply)
  - Eligible individual health insurance
  - A Multi-State Plan (MSP)
  - Basic Health Program (BHP) coverage
  
5. When did the Plan Sponsor first offer the Limited Wraparound Coverage?
  - a. Date \_\_\_\_\_
  - b. Plan year \_\_\_\_\_
  
6. Who is eligible to enroll in the Limited Wraparound Coverage? (check all that apply)
  - Full-time employees
  - Part-time employees
  - Retired or separated participants entitled to benefits
  - Dependents
  
7. Total number of individuals enrolled in the Limited Wraparound Coverage at the beginning of the most recent plan year (if none, enter zero):

- a. Full-time employees \_\_\_\_\_
- b. Part-time employees \_\_\_\_\_
- c. Retired or separated participants entitled to benefits \_\_\_\_\_
- d. Dependents \_\_\_\_\_

8. Describe the Additional Benefits that the Limited Wraparound Coverage is designed to provide to enrollees.

**Part III – Attestation and Signature**

*Under penalty of perjury, I declare that I have reviewed the information reported on this Form, and to the best of my knowledge and belief, it is true, correct, and complete.*

\_\_\_\_\_  
**Name of Authorized Representative**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Title**

\_\_\_\_\_  
**Date**

**PAPERWORK REDUCTION ACT NOTICE**

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-NEW. The time required to complete this information collection is estimated to average 3 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.

## GLOSSARY

**Additional Benefits** are meaningful benefits beyond the coverage of cost-sharing under the Eligible individual health insurance, BHP, or MSP that is supplemented by the Limited Wraparound Coverage. Examples include, but are not limited to: expanded in-network medical clinics or providers, access to onsite clinics or specific health facilities at no cost, benefits targeted to a specific population (such as coverage for certain orthopedic injuries), home health coverage, and prescriptions that are not on the formulary under the Eligible individual health insurance, BHP or MSP. The Limited Wraparound Coverage must not provide benefits only under a coordination-of-benefits provision and must not consist of an account-based reimbursement arrangement. See Amendments to Excepted Benefits; Final Rules, 80 Fed. Reg. 13995, 13997 (March 18, 2015).

**Basic Health Program (BHP)** means health coverage for certain low income individuals authorized under section 1331 of the Patient Protection and Affordable Care Act.

**Dependent** means any individual who is or may become eligible for coverage under the terms of a group health plan because of a relationship to a participant, including a dependent child and spouse, to the extent they are eligible for coverage under the terms of the plan.

**Eligible individual health insurance** means individual health insurance coverage that is not a grandfathered health plan, is not a transitional individual health insurance plan, and does not consist solely of excepted benefits.

**Full-time employee** means an [employee](#) who is reasonably expected to work an average of at least 30 [hours](#) per [week](#).

**Limited Wraparound Coverage** means the limited benefits provided through a group health plan that wrap around either: (1) Eligible individual health insurance, (2) BHP coverage, or (3) a MSP. The Limited Wraparound Coverage must be a risk-sharing product that covers a defined package of services and must comply with applicable requirements under 29 C.F.R. § 2590.732(c)(3)(vii), 26 C.F.R. § 54.9831-1(c)(3)(vii) and 45 C.F.R. § 146.145(b)(3)(vii).

**Multi-State Plan (MSP)** means health coverage described in section 1334 of the Patient Protection and Affordable Care Act.

**Part-time employee** refers to an employee who is reasonably expected to work less than an average of 30 hours per week. See 26 C.F.R. § 54.4980H-3.

**Plan Sponsor** means an employer, employee organization, or association, committee, joint board of trustees or other similar group of representatives of the parties who establish or maintain the Limited Wraparound Coverage.