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October 20, 2011

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N-5653
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210
RIN1210-AB52

Sent via email to E-OHPSCA2715.EBSA@dol.gov

Ladies and Gentlemen,

United Parcel Service, Inc. (“UPS”) is appreciative of the opportunity to submit comments on the proposed regulations and corresponding templates (collectively the “Proposed Regulations”) issued by the agencies in connection with new Public Health Service Act Section 2715 (Section 2715).¹ Section 2715 requires group health plans and health insurers to furnish a summary of benefits and coverage (“SBC”) to enrollees that meet certain standards to ultimately be developed by the agencies. While we applaud the efforts of the agencies and the NAIC, we nevertheless believe the Proposed Regulations fall short of establishing an administratively feasible rule that effectively balances the needs of group health plans (especially self-insured plans sponsored and maintained by large employers) and enrollees in a manner that is consistent with the intent of Congress. We have submitted below our comments and suggestions regarding the Proposed Regulations that we believe, if adopted, will balance the needs of both group health plans and enrollees in a manner that is consistent with the intent of Congress, as set forth in Section 2715.

UPS is a multi-faceted, publicly traded, 104 year old, U.S.-based corporation focused on the effective and efficient worldwide delivery of packages and information. UPS sponsors and maintains 26 health plans, most of which offer several different benefit package options (e.g. PPO, indemnity, high deductible health plan, etc.). UPS health plans cover over 500,000 individuals (employees, retirees and dependents). Although UPS enlists the services of various third party administrators to assist with plan administration, virtually all of UPS’ health plans are “self-insured”, and UPS is ultimately responsible for

¹ See 76 Fed. Reg. 52442 (August 22, 2011); see also 76 Fed. Reg. 52475 (August 22, 2011)[providing the draft template and corresponding instructions.]

ensuring that its group health plans comply with applicable laws, including but not limited to Section 2715.

Overview of UPS' concerns

It has long been UPS' philosophy to maintain an enrollment process that effectively enables employees to make informed choices with respect to the benefits offered by UPS and, as a result, we generally embrace the concepts reflected in Section 2715. Nevertheless, we believe the Proposed Regulations create an administratively infeasible rule that goes beyond that which is necessary for group health plans, such as those maintained by UPS, to satisfy the fundamental requirements set forth in Section 2715. For the reasons expressed in more detail below, we respectfully submit the following comments and suggestions regarding the Proposed Regulations that, if adopted, will balance the needs of both group health plans and enrollees in a manner that is consistent with the intent of Congress, as set forth in Section 2715:

- Delay the effective date of the SBC until the annual enrollment period for the plan year that begins on or after the date that is 12 months after the final regulations are issued;
- Require group health plans to furnish the SBCs only to "participants";
- Require group health plans to automatically furnish SBCs only during the initial enrollment period and following a material change in the information;
- Exempt the SBCs from the consent requirements otherwise applicable to electronic disclosures;
- Following the rule applicable to certain current notice requirements, increase the time period for furnishing an SBC upon request from 7 days (as set forth in the Proposed Regulations) to the "earliest date following a request that the plan or issuer, acting in a reasonable and prompt fashion, can provide the notice."
- Allow plans the flexibility to modify the SBCs as reasonably necessary to account for their unique facts and circumstances.

Each of these comments and suggestions are discussed in more detail below. Our discussion herein is limited to the impact the new SBC rules have on self-insured group health plans such as those sponsored by UPS, even though many of the comments and suggestions will apply equally to health insurers and fully insured plans. Thank you in advance for your consideration of these comments and suggestions.

Comments and Suggestions

- **Delay the effective date of the SBC until the first day of the plan year that begins on or after the date that is 12 months after the final regulations are issued**

The Proposed Regulations indicate that the effective date for group health plans to implement the SBC requirements is March 23, 2012-- only seven months from the date the Proposed Regulations were issued. Even if the requirements set forth in the Proposed Regulations were final, the scope of changes required by the Proposed Regulations to an existing employer's enrollment system and process

(especially a large employer such as UPS who has many different benefit package options) is significant and would require significant time to *properly* implement the changes. Unfortunately, the final regulations have yet to be issued so the period during which plans must make the necessary revisions to comply with the new rules will be even shorter if the effective date is not delayed. Fortunately, the statute supports a delayed effective date in this instance.

As noted in the preamble to the Proposed Regulations, the March 23, 2012 effective date is based on the following language from Section 2715:

Not later than 24 months after the date of enactment of the Patient Protection and Affordable Care Act, each entity described in paragraph (3) shall provide, prior to any enrollment restriction, a summary of benefits and coverage explanation pursuant to the standards developed by the Secretary under subsection (a) . . .²

Although March 23, 2012 is indeed 24 months from the enactment date of the ACA, compliance with the new rule is contingent on the specific standards required to be established by the agencies *no later than 12 months after the effective date of the ACA* (i.e. March 23, 2011) — standards that have yet to be finalized as of the date of this letter.³ Consequently, the statute necessarily contemplates *no less than 12 months* between the date the agencies establish the specific standards and the date group health plans must implement the new rule. An effective date that provides *at least 12 months* after the final regulations are issued to comply would be consistent with the intent of Congress, and would give group health plans a reasonable period of time after the final regulations are issued to properly evaluate its current procedures, make the necessary changes to its existing enrollment process and then accurately implement the new SBC rules.

Moreover, the agencies should provide that the requirement to provide the SBC is effective for the first annual enrollment period for the plan year beginning on or after the date that is 12 months after the final regulations are issued. The annual enrollment period represents the most natural transition point from the prior enrollment process to the enrollment process required by the SBC rules and will facilitate the most effective and efficient implementation of the new rules. For example, plan changes are typically effective on the first day of the plan year and are communicated during the annual enrollment period. If the SBC rules are effective no sooner than the annual enrollment period for the plan year beginning on or after the date that is one year after the final regulations are issued, then group health plan sponsors will be able to incorporate the plan changes into the first SBC required to be furnished by the plan—an efficient approach. Otherwise, plan sponsors will be forced to create SBCs for mid-year enrollments that reflect “stale” plan provisions only to revise the SBCs shortly thereafter to incorporate plan changes, thereby duplicating the plan sponsor’s efforts—a much less efficient approach. Such an effective date is consistent with the statutory language, which clearly contemplates that the effective date for furnishing SBCs could be more than 12 months after the standards are developed by the agencies. For example, even if the agencies had issued the standards by September 23, 2010, the implementation date for plans was still a date that was *no later than* March 23, 2012--1 year and 6 months after the standards were developed in our example.

NOTE: We respectfully request guidance from the agencies regarding the effective date as soon as possible. Plan sponsors (including but not limited to UPS) and insurers are already beginning to expend

² Section 2715(d)(1)

³ Section 2715(a)

time and expense to quickly change their enrollment systems to comply by March 23, 2012 with rules that have yet to be finalized. This is time and expense that is better spent on implementation of final rules that on a date that gives plans adequate time to comply.

- **Require plans to automatically furnish the SBC only to “participants”**

Section 2715(d) requires group health plans and issuers to furnish SBCs to “enrollees”. The term “enrollees” is not defined in the statute nor is it defined in the HIPAA subparts (including the regulations to the HIPAA subparts) to which Section 2715 was added; however, the Proposed Regulations define “enrollee” to mean a “participant” or “beneficiary” as defined by ERISA Section 3(7). Thus, under the Proposed Regulations, a plan must furnish SBCs both to the participant (i.e., the employee, retiree, survivor, or qualified beneficiary) *and*, if the beneficiary is enrolled separately or resides at a different address, the plan must furnish an SBC to a beneficiary (e.g., a spouse or child) -- *even though the beneficiary has no enrollment rights under the plan (i.e. only the participant can enroll the beneficiary)*. Although we acknowledge that the ultimate goal of these rules is to give each person an apples to apples comparison to other coverage that may be available, including but not limited to coverage under a spouse’s or adult child’s employer’s plan, requiring plans to furnish the SBC to beneficiaries is inconsistent with rules previously issued by the agencies with respect to other similar documents and notices that describe terms and conditions that impact the beneficiary—especially where the beneficiary does not have participant-like rights under the plan (e.g. the right of a qualified beneficiary spouse to independently elect COBRA continuation coverage). For example, plans are only required to furnish the notice of special enrollment rights and the general preexisting condition exclusion/limitation notice to the participant even though such rules directly impact the participant’s decision regarding enrollment of a beneficiary. Also, the Department of Labor only requires plans to automatically furnish a summary plan description—the plan’s governing document effectively summarized by the SBC—to participants in a welfare plan even though the summary plan description describes the extent to which the beneficiary is covered by the plan. It is arguably assumed in each instance that the participant shares the information with the beneficiary. Moreover, a beneficiary is entitled under the rules mentioned above to request a copy of the applicable document or notice, which effectively balances the needs of the plan with those of the beneficiary—a standard we wish to achieve with the SBC rules.

Consequently, the final regulations should only require group health plans to automatically furnish the applicable SBCs to the “participant” as defined under ERISA, even where the beneficiary is enrolled separately or resides at a different address, provided that the beneficiaries are entitled to request a copy of the SBC free of charge.⁴

- **Require plans to automatically furnish the SBCs only during the initial enrollment period and following a material change in the information.**

Section 2715(d) requires group health plans to automatically furnish an SBC to enrollees at “enrollment or reenrollment (where applicable).”⁵ The Proposed Regulations generally reiterate this requirement but clarify that a plan must automatically furnish an SBC for each benefit package option for

⁴ A participant entitled to an automatic SBC would also include any beneficiary who is granted participant-like rights, such as a qualified beneficiary under COBRA or a survivor.

⁵ Section 2715(d)(1)(B).

which the participant or beneficiary is otherwise eligible both at initial enrollment and following a special enrollment request. In the case of annual enrollment, the Proposed Regulations further clarify that a plan need only send an SBC for the benefit package in which the participant or beneficiary is enrolled (but if not enrolled, then the plan must send an SBC for each option for which the participant or beneficiary is eligible). Although we applaud the relief provided by the agencies in the Proposed Regulations with respect to SBCs provided at annual enrollment, we believe the general rule overreaches that which is necessary to achieve the goal to the extent the participant has already received the applicable SBCs. If they have already received the SBCs, then they should be deemed to have received them at subsequent enrollments unless there has been a material change. Automatically sending multiple copies of the same SBCs will create confusion for participants (and beneficiaries) who will be required to spend additional time comparing subsequent SBCs to previously furnished SBCs. Absent a material change in the information included in a previously furnished SBC, plans should not be required to furnish multiple copies of the SBCs (absent a material change in the information) to the extent that the plan satisfies the following requirements:

- At the time of the initial enrollment (when the SBC is initially provided), the participant is notified in writing (e.g. a postcard) of the right to request a written copy of the SBCs, and
- The SBCs are made available on a company website which the participant is effectively able to access.
- Alternatively, at each subsequent enrollment, the plan furnishes the participant with a reminder of where the SBC is located on the company's website and the participant's right to request a paper copy. This is similar to the manner in which HIPAA privacy notices are furnished.⁶

The right to request a paper copy and/or access the document on a website ensures the participant is effectively able to access the information, if needed, which effectively balances the needs of both the plan and the participant.

- **Exempt the SBC from the otherwise applicable consent requirements**

The Proposed Rules permit plans to furnish SBCs electronically if the plan complies with ERISA's disclosure requirements.⁷ Fundamentally, ERISA requires plans to send materials required to be furnished under ERISA by "measures reasonably calculated to ensure actual receipt of the material by the plan participant."⁸ The Department of Labor has established a safe harbor rule for electronic disclosures of documents required to be furnished by ERISA.⁹ Under the safe harbor, recipients who are *not* "worksite" employees¹⁰ must provide affirmative consent, or confirm consent electronically in a manner

⁶ 45 C.F.R. 164.520

⁷ See 29 C.F.R. 2520.104b-1. Under the Proposed Rules, nonfederal governmental plans may furnish an SBC electronically in accordance with ERISA's disclosure rules or rules established in the Proposed Regulations for issuers in the individual market.

⁸ See 29 C.F.R. 2520.104b-1(b)(1).

⁹ See 29 C.F.R. 2520.104b-1(c).

¹⁰ Worksite employees, as referenced herein, are employees who are described in ERISA's electronic disclosure safe harbor as individuals who are (i) effectively able to access the electronic documents from any location that they are

that reasonably demonstrates the participant's ability to access the information in the form in which the materials will be provided prior to actually providing such materials to the recipient.¹¹ Thus, in order to furnish the SBC electronically to a participant or beneficiary that is not a worksite employee, the plan must, among others, obtain affirmative electronic consent *prior to* furnishing the documents in electronic format.

The consent requirement applied to enrollment materials, such as the SBC, unnecessarily creates a substantial hardship on group health plans that will effectively prevent plans from utilizing electronic media to furnish the SBC. Many of the participants required to receive an SBC (and beneficiaries, if required to receive an SBC) are not "worksite" employees and must provide affirmative consent or confirm consent electronically prior to receiving the SBC. Unfortunately, consent is typically collected and gathered during the enrollment process.

Moreover, the current electronic safe harbor under ERISA fails to take into account technologies that have arisen, both in the workplace and at home, that have effectively increased the access to electronic media--- a possibility specifically acknowledged by the Department of Labor earlier this year.¹² Consequently, the current electronic safe harbor disclosure rule under ERISA is outdated in light of today's technology. In lieu of the current electronic safe harbor rules under ERISA, we propose that the agencies adopt a rule that exempts the SBC from the consent requirements provided that the following requirements are satisfied:

- (i) The plan provides written notice (e.g. a post card) of the right to request a copy, and
- (ii) The written notice identifies the hardware and software requirements to access the electronic media in which the SBC is furnished.

This approach satisfies the fundamental disclosure rule set forth under ERISA because it utilizes measures that ensure actual receipt. For example, if the individual is not effectively able to access the electronic media, the participant is able to request a paper copy. In addition, the suggested approach is similar in nature to the rules set forth in Treas. Reg. 1.401(a)-21(c) ("IRS Disclosure Rule") that are otherwise applicable to notices required to be sent by certain employee benefit plans (e.g. cafeteria plan notices and election material).¹³ Under the IRS Disclosure Rule, prior consent is not required provided that the following two requirements are satisfied: (i) the participant has the effective ability to access the document in the applicable electronic medium and (ii) at the time the notice is provided, the participant is notified of his/her right to receive a paper copy.

The suggested approach is also consistent with the E-Sign legislation on which the ERISA and IRS electronic disclosure rules are generally based. Under E-Sign, a federal agency (such as the agencies) is authorized to exempt a document or notice from the consent requirement to the extent that

expected to perform their duties as an employee and (ii) are expected to access the employer's electronic information system as an integral part of their duties.

¹¹ See 29 C.F.R. 2520.104b-1(c)(2).

¹² See 76 Fed. Reg. 19285 (April 7, 2011)

¹³ The IRS Disclosure Rules identified above generally do not apply to documents required to be furnished under Title I of ERISA; however, they are referenced here to illustrate a rule similar to which we believe should be adopted with respect to the SBC.

- (i) The exemption is necessary to eliminate a substantial burden on electronic commerce and
- (ii) The lack of consent will not increase the material risk of harm.¹⁴

The exemption is necessary in this instance because application of the consent requirement to SBCs provided at the time of enrollment or reenrollment in the plan will effectively prevent the utilization of electronic media to furnish the SBC, which imposes a substantial burden on electronic commerce. Moreover, the risk of harm is not increased (it is arguably decreased) due to the plan's notice of the right to request a paper copy along with identification of the applicable hardware and software requirements needed to access the electronic media.

- **Increase the time period for providing the SBC upon request from 7 days (as set forth in the Proposed Regulations) to the “earliest date following a request that the plan, acting in a reasonable and prompt fashion, can provide the SBC**

Section 2715 does not prescribe a time period for furnishing the SBC upon request; however, the Proposed Regulations require group health plans to furnish the SBC within 7 days of a request by the participant or beneficiary (including a request for special enrollment). For large employers such as UPS, it is simply not feasible to furnish an SBC within 7 days of the request. Companies such as UPS are often de-centralized and/or utilize multiple vendors to handle plan administration, which will prevent compliance with an otherwise unreasonably short turn around. For example, requests from different sources would be made to an enrollment vendor, who would need time to identify the options for which the individual is eligible and then, send an electronic request for the appropriate SBCs to a fulfillment vendor who would need to process the electronic file, print and mail (if able, send electronically) the SBCs to the participant. Even if the participant or beneficiary requested the SBC directly from the enrollment vendor, it would not be feasible to deliver the SBC by mail within 7 days.

Instead, a rule similar to that which is applicable to the general pre-existing condition notice required under the HIPAA portability regulations is more appropriate for SBCs.¹⁵ Similar to that rule, group health plans should be required to furnish the SBC by the earliest possible date following a request that the plan, acting in a reasonable and prompt fashion, could provide the SBC.

- **Allow a reasonable period of time to furnish the SBC where annual enrollment materials are not otherwise provided**

The Proposed Rules require plans that do not provide written materials with the initial enrollment to furnish the SBC no later than the first day that the enrollee is permitted to enroll in the plan. This creates an unworkable rule for plans with enrollment periods that begin on the date of hire or eligibility date (e.g. plans that provide coverage effective as of the date of hire). A rule similar to that applied to the general pre-existing notice required under the HIPAA portability regulations is more appropriate here.¹⁶

¹⁴ 17 U.S.C. 7004(d)(1);

¹⁵ See 29 C.F.R. 2590.701-2(c)(1)

¹⁶ See 29 C.F.R. 2590.701-2(c)(1)

Under that approach, plans would be required to furnish the SBC by the earliest date on which the plan, acting in a reasonable and prompt fashion, could provide the SBC.

In addition, we respectfully request the agencies issue a clarification that SBCs are not required where participants have no voluntary enrollment rights. For example, many plans (e.g., plans subject to collective bargaining) provide only package of benefits for which the participant and dependents are automatically covered at no cost to the participant. An SBC should not be required in this instance.

- **Allow plans flexibility necessary to design SBCs that account for their unique facts and circumstances and satisfy the general content and format requirements set forth in the statute**

Section 2715 and the Proposed Regulations identify general format and content requirements applicable to the SBC. The NAIC has also drafted a template with instructions that would, if adopted by the agencies, result in a rigid, inflexible template that must be completed by all group health plans in strict accordance with the instructions, regardless of the circumstances applicable to that plan. While we applaud the efforts of both the agencies and the NAIC to carry out Congress' intent to provide enrollees with an "apples to apples" comparison--no matter what the circumstance, absolute uniformity implemented through a rigid template isn't feasible, especially with respect to self-insured health plans, and falls short of facilitating such an apples to apples comparison.

One of the most attractive elements of maintaining a self-insured health plan is the ability to design a unique plan that best fits the unique needs of both the employer/plan sponsor and its employees. This ability to create unique plan designs necessarily results in a panoply of designs that cannot be adequately accounted for in a draft template. If plans are unable to modify the format and content to accurately summarize the unique terms of its plan, the SBC will provide an incomplete and inaccurate overview of the coverage, which will adversely impact the participant's "apples to apples" comparison desired by Congress. Therefore, plans should be allowed flexibility to revise the template as reasonably necessary to accommodate its unique design so long as the general form and content requirements are satisfied. Moreover, plans should be permitted to satisfy certain content requirements set forth in Section 2715 by reference to other governing documents, such as the Summary Plan Description, so long as the SBC generally addresses the item. For example, a plan may often adopt a number of limitations and exclusions with respect to a coverage type required to be addressed in the SBC. In those situations, acknowledging that limitations and exclusions apply with a reference to the Summary Plan Description should satisfy the statutory requirements and the intent of Congress. Otherwise, the SBC lends itself to misleading the participant.

By way of illustration, we have identified below a few of the changes to the Proposed Regulations and the template that we believe are required in order to ensure flexibility, within the confines of Section 2715, and to better facilitate the effective communication of group health plan benefits.

<i>Item</i>	<i>Suggestion</i>
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<p>The current terminology reflects terms typically used only in the fully insured market. Thus, terms such as “premiums”, “policy” and “insurer” are not relevant to self-insured plans.</p>	<p>Allow plans to substitute terms that are more commonly associated with self-insured plans such as “contributions” (in lieu of premiums) and “plan (in lieu of policy).</p>
<p>The instructions to the template require certain information to be on certain pages of the SBC. In order to accommodate plan designs not accounted for in the template, revisions will have to be made that will impact where information is provided within the SBC.</p>	<p>The instructions should be revised to eliminate any such requirements. As long as the SBC satisfies the general format and content requirements, the location of information should be irrelevant.</p>
<p>The Proposed Regulations and the template require plans to identify the total “premium” (i.e. the total cost of coverage to the employer). This is not a requirement set forth in Section 2715. Moreover, as currently contemplated, this does not provide meaningful information to employees as to their required contribution. If the goal of this requirement is to inform employees of the total cost of coverage (including both the employer and employee contribution), that objective is already fulfilled by the new W-2 reporting requirement.</p>	<p>The agencies should eliminate the requirement to identify the total cost of coverage on the SBC. Moreover, plans should be permitted to identify the participant’s share in a separate document that is made available separately in the same manner as the uniform glossary. These employee contribution amounts often change each year; therefore, if required to be included with the SBC, plans would be required to furnish an SBC for each option for which the participant is eligible during each annual enrollment period, even if the Participant is enrolled.</p>
<p>The template fails to account for other possible plan features within a benefit package option, such as out of area benefits (benefits provided to those who do not live within a network offered by the plan) and “integrated” health reimbursement arrangement (“HRA”) coverage (coverage that reimburses only allowable expenses subject to a deductible or copayment up to a specified annual limit)—each of which creates additional communication related complexities—especially in light of the format limitations.</p>	<p>Allow plans to revise as necessary to reflect alternative health care features, such as out of area coverage, or HRA so long as the general format and content requirements are satisfied.</p>
<p>Section 2715 and the Proposed Regulations (including the template) require plans to identify exceptions and limitations with respect to certain common medical events (e.g. hospital stay). It is simply not feasible to adequately describe the nuances of exclusions and limitations that often apply with respect to the specific services required to be addressed.</p>	<p>Such exclusions and limitations are already required by ERISA to be included in the Summary Plan Description. Consequently, the intent of Congress as set forth in Section 2715 would be satisfied if plans simply acknowledged that there are limitations and/or exclusions and then referred the participant to the Summary Plan Description (which is required by ERISA to be available upon request, even if the participant has yet to enroll).</p>

	<p>NOTE: The Proposed Regulations should take into consideration that UPS already provides detailed descriptions of benefits (e.g. plans subject to ERISA provide summary plan description) and other materials designed to facilitate an effective enrollment process. The SBC, which merely summarizes terms otherwise required to be addressed in the summary plan description, only touches the surface with respect to such terms. Thus, distributing an SBC and an SPD puts the plan at risk for having a conflict (despite the caveat language that the SPD controls) with the SPD. Moreover, it requires plans to duplicate terms, which also creates potential for a conflict. See proposed safe harbor below.</p>
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The need for such flexibility is further underscored by the fact we already satisfy the general requirements set forth in Section 2715 as a result of applicable law (e.g. ERISA’s reporting and disclosure obligation and the cafeteria plan rules set forth in Code Section 125) or “best practices” implemented to ensure an effective and efficient administration. For example, ERISA requires plans to distribute a summary plan description to each participant that describes benefits offered under the plan, including cost sharing requirements, and any applicable exclusions.¹⁷ The cafeteria plan requirements further require plans to provide participants with information necessary to make an informed election, which would necessarily include the employee contribution amount. Moreover, it is essential to efficient, cost effective administration that plans provide information to participants at the time of enrollment that adequately describes the options available to mitigate claims of mistaken elections and mid-year changes that in many cases are often prohibited under applicable law (e.g. the cafeteria plan rules); therefore, most plans already send enrollment materials that adequately summarize the benefits offered. Thus, the Proposed Rules impose unnecessarily burdensome obligations on plans to duplicate that which they are already required by law to do or as necessary to ensure effective and efficient enrollment.

Thus, we propose that the agencies establish a safe harbor where group health plans are deemed to be in compliance with the requirements set forth in Section 2715 to the extent that the following requirements are satisfied through one or more documents provided to participants:

- The documents and materials are written in English with clear and concise contact information for assistance;
- The documents and materials enable participants to compare their share of the costs to enroll in any plan(s) available in their area (e.g. payroll deduction amounts, premium contributions, co-pays, percent of in-network versus out-of-network cost covered);

¹⁷ 29 U.S.C. 1022; 29 C.F.R. 2520.102-2.

- The documents and materials describe key terms such as co-pay, co-insurance, skilled nursing facility, in-network and out-of-network providers.
- The documents and materials describe generally covered services and excluded services;
- The documents and materials are sent to the participant's last known address, and/or participant provided e-mail account (in conjunction with return / failed receipt verification functionality), and/or is provided through a web site that participants individually register to use and/or is readily accessible in the course of their employment;
- The documents and materials notify participants of their claims and appeal rights; and
- The plan notifies participants of material changes within existing ERISA timing requirements

Documents and materials that plans would use to disseminate this information would include a combination of documents such as summary plan descriptions (including summaries of material modifications), health care plan comparison updates and enrollment materials, all of which would be provided in paper form or electronic form (e.g. email or web sites). If the combination of documents provided to participants both during and after enrollment satisfy the requirements identified above, then the plan (or health insurer, if applicable) would deem to satisfy Section 2715.

We appreciate the opportunity to submit comments and suggestions.

Sincerely Yours,

United Parcel Service, Inc.