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ERISA FAQs for Welfare Benefit Plans

What Is ERISA?

ERISA (the Employee Retirement Income Security Act of 1974) is a federal law which deals with employee benefit plans, both qualified retirement plans (e.g., pension and profit sharing plans) and welfare benefit plans (e.g., group insurance and other fringe benefit plans). The goals of ERISA are to provide uniformity and protections to employees. ERISA imposes certain reporting (to the DOL) and disclosure (to plan participants) requirements on employers. ERISA compliance is enforced primarily by the Department of Labor (DOL). However, employee benefit plans may also be regulated by other government agencies, such as the Internal Revenue Service (IRS) and a state's Department of Insurance. Failure to comply with ERISA can result in enforcement actions, penalties, and/or employee lawsuits.

Which Employers Are Subject to ERISA?

ERISA applies to virtually all private-sector corporations, partnerships, and proprietorships, including non-profit corporations—regardless of their size or number of employees. Churches and governmental employers are exempted from ERISA's welfare benefit plan provisions.

Which Benefits are ERISA Plans?

ERISA generally applies to the following benefit plans and fringe benefits, whether they are fully insured or self-insured:

- Medical, Surgical, Hospital, or HMO Group Insurance Plans
- Health Reimbursement Accounts (HRAs)
- Health FSAs (Flexible Spending Accounts)
- Group Dental Insurance Plans
- Group Vision Insurance Plans
- Prescription Drug Plans
- Group Sickness, Accident, and Disability Insurance Plans
- Group Life and AD&D Insurance Plans
- Group Long Term Care Insurance Plans
- Medical Reimbursement Plans
- Wellness Programs (if medical care is offered)
- Voluntary Insurance Plans*
- Retiree Medical Plans

- Group Employee Assistance Plans (EAPs) (if providing counseling, not just referrals)
- Severance Pay Plans
- Group Business Travel Accident Insurance Plans
- Prepaid Legal Services
- Unemployment Benefit Plans
- Vacation Plans
- Apprenticeship or other Training Plans
- Scholarship Plans
- Holiday Plans
- Housing Assistance Plans
- 419A(f)(6) and 419(e) welfare benefit plans
- Split Dollar Life Insurance Plans
- Nonqualified Deferred Compensation Plans (if ongoing scheme to determine eligibility/benefits)
- One employee plans

However, certain self-insured or uninsured plans, such as sick pay, short term disability, paid time off, overtime, jury duty, and vacation pay, may be exempt if benefits are paid:

- as a "normal payroll practice,"
- to currently employed individuals (i.e., not retirees, COBRA participants, or dependents),
- without prefunding or using insurance,
- entirely from the employer's general assets, AND
- without employee contributions.

*Voluntary individual or group insurance plans, in which the employees pay all of the cost, and the employer's role is limited to withholding premiums through payroll deduction and remitting them to an insurer, may be exempt from ERISA—depending on the extent of employer involvement. However, even minimal "sponsorship or endorsement" (e.g., a company's name on the brochures) by the employer may destroy this exemption. A voluntary individual or group insurance plan qualifies under the Voluntary Plan Safe Harbor if:

- it is funded by group or group-type insurance,
- it is completely voluntary,
- there are no employer contributions, AND
- the employer does not endorse the plan.
 - The following does NOT constitute endorsement:
 - Permitting the insurer to publicize the plan
 - Collecting premiums by payroll deduction
 - Remitting premiums to the insurer
 - The following MAY result in loss of Voluntary Plan Safe Harbor:
 - Selecting the insurer
 - Negotiating plan terms/linking coverage to employee status
 - Using the employer's name/associating the plan with other employee plans
 - Recommending the plan to employees
 - Saying ERISA applies
 - Doing more than permitted payroll deductions

- Allowing use of the employer's cafeteria plan
- Assisting employees with claims or disputes

ERISA generally does not apply to:

- Cafeteria plans, §125 Plans, POPs (Premium Only Plans), Premium Conversion Plans, Pre-tax Premium Plans (However, the benefits funded by them are often subject to ERISA. NOTE: These plans must be referenced in the plan document and SPD if they are funding an ERISA Plan)
- Dependent Care Assistance Plans (DCAPs, or Dependent Care FSAs)
- Health Savings Accounts (HSAs) (if employer involvement is limited)
- Paid Time Off Plans (PTO)
- Adoption Assistance Plans
- State mandated benefits, e.g., STD (if not enhanced beyond mandated benefits)
- Educational Assistance or Tuition Reimbursement Plans
- On-site Medical Clinics (if providing First Aid only—not treatment, e.g., flu shots)

ERISA and Insurance Terminology

Beneficiary—a person designated by a participant or by the terms of a plan who is or may become entitled to a benefit under the plan.

Certificate/Evidence of Coverage (Certificate/Evidence of Insurance, "Cert," or Certificate Booklet)—booklets describing the terms of the insurance coverage that is provided to participants are Certificates of Insurance; they are not Summary Plan Descriptions (SPDs) because they usually do not contain all of the requisite ERISA provisions and leave out key information. This is a very important, yet highly misunderstood, distinction. Note: Certificates of Insurance and Certificates of Coverage are often incorrectly referred to as SPDs - even by experienced benefits professionals.

Claim Fiduciary—a named fiduciary having the authority and responsibility to adjudicate claims in accordance with the provisions of the plan. In the event of a member appeal for review of a denied claim, the claim fiduciary makes the final determination as to whether the claim is covered. The plan sponsor cannot overrule this determination. The claim fiduciary defends its decision and bears the legal costs of the defense. For insured plans, the carrier is typically the claim fiduciary. However, for self-insured plans, the plan sponsor/administrator can name itself or an independent third party as the claim fiduciary.

Employer Sponsored—1) the employer contributes to the cost, 2) participation in the coverage is not voluntary, OR 3) the employer endorses or recommends the plan.

Exclusive Benefit Rule—Plan Assets must be used for the exclusive purpose of paying plan benefits and reasonable administrative expenses of the plan.

Fidelity Bond—a form of insurance protection that covers anyone who handles plan assets. It also insures against a fiduciary's fraud or dishonesty. A fidelity bond must be purchased and in place at

the beginning of the plan year for any funded plan. The bond must be for at least 10% of the plan's assets, with a \$1,000 minimum and a \$500,000 maximum. As a practical matter, this requirement can be met by adding a sponsor's welfare benefit plan to the same fidelity bond covering its pension plan. A bond may not be needed for unfunded plans, which accept employee contributions that are not actually segregated from the employer's general assets.

Fiduciary Liability Insurance—an insurance policy that indemnifies fiduciaries for errors in plan administration, whether or not they are a named fiduciary.

Funded/Unfunded Plan—a plan may have assets (e.g., participant contributions which can be segregated from an employer's general assets), but it is considered unfunded until the assets are actually segregated. At that point, the plan becomes a funded plan. Plan assets may only be used to pay for plan benefits and reasonable administrative expenses.

Group Health Plan—an employment based welfare benefit plan that provides medical care to employees and their dependents directly or through insurance or reimbursement. It can be fully insured or self-insured.

Master Application—an application for group insurance, usually completed by the producer and signed by the producer and employer. It generally contains employer information, benefits requested, eligibility and effective date provisions, employer contribution, participation requirements, etc. The Master Application is often attached to and made part of the Master Contract because it contains the representations upon which the contract of group insurance was issued to the employer.

Master Contract—an insurance policy issued to an employer which provides group insurance benefits to its employees. It usually contains the same information as the Certificate of Coverage, but also has information specifically relating to the employer, such as a grace period for payment of premiums, the policy year, and premium rates.

Medical Care—includes (as used in the ERISA definition of a welfare benefit plan) means amounts paid for:

- the diagnosis, cure, mitigation, treatment, or prevention of disease,
- the purpose of affecting any structure or function of the body,
- insurance covering such medical care, and
- transportation related to such care.

Multiple Employer Trust (MET)—a legal trust generally established by an insurance company for pooling a number of small, unrelated employers. It may provide group insurance coverage on an insured or self-funded basis.

Multiple Employer Welfare Arrangement (MEWA)—An employee welfare benefit plan, or any other arrangement which provides welfare plan benefits to the employees (and their beneficiaries), of two or more employers that are not members of the same controlled group. Exceptions are

collective bargaining agreements, rural electric cooperatives, and rural telephone cooperative associations.

Named Fiduciary—a person or entity who has the authority to control and manage the operation of the plan, and generally decides benefit appeals. The fiduciary has the duty to operate the plan prudently and in the best interests of its participants. An individual acting as a named fiduciary who breaches his duty can be **personally liable** under ERISA. Although ERISA does not require a plan sponsor to carry Fiduciary Liability Insurance, it is prudent for the sponsor to carry this coverage. Note—this is not the same coverage as Employee Benefit Liability insurance or a Fidelity Bond (which is required by ERISA). This is because a relatively benign mistake could turn into an expensive fiduciary liability problem. For example, this could be the case where a Benefits Manager forgets to enroll an employee for coverage, and that employee later dies, becomes disabled, or incurs expensive medical treatment, which is not covered because the insurance company never received his or her enrollment form.

Other Fiduciaries—anyone (even employees, whether or not they are a named fiduciary) who performs fiduciary functions, such as exercising discretionary responsibility, authority, or control over plan management decisions, disposition of plan assets, or rendering investment advice. An ERISA fiduciary is held to a very high standard, which requires more careful decision making and disclosure than would otherwise be required in a business relationship. He or she must act solely in the best interests of the plan and its participants and beneficiaries, and use plan assets for the exclusive purpose of paying plan benefits or reasonable expenses of the plan. He or she must act with care, skill, prudence, and diligence to diversify the plan's assets to minimize the risk of large losses, and to act in accordance with the plan documents governing the plan. ERISA fiduciaries, whether or not named, who breach their fiduciary duties, are personally liable for damages to the plan. They may also be liable for additional special DOL penalties and be subject to criminal penalties.

Participant—an employee or former employee who is or may become eligible to receive a benefit from an employee benefit plan or whose beneficiaries may be eligible to receive any such benefit. This term is sometimes used more generally to mean an employee or former employee receiving benefits under a plan.

Plan Sponsor—the sponsoring employer

Plan Administrator—typically the plan sponsor, or employer, unless another party is designated. The plan administrator is directly responsible for plan compliance and is liable for compliance penalties—even if it has delegated the performance of its duties to another party. The plan administrator may amend, modify, or terminate the plan, if this right is properly reserved in writing. The term "plan administrator" is a source of much confusion because it is often thought that when an employer uses a Third Party Administrator (TPA) to administer its plan and adjudicate claims, the TPA should be named as plan administrator. However, the plan administrator is almost always the employer, not a TPA or an insurance company.

Plan Assets—there are at least three ways a plan could be considered to have assets:

1. Participant & beneficiary contributions—Contributions by participants and beneficiaries are plan assets by definition (even though the IRS for tax purposes may treat participant contributions as employer contributions). Salary reductions or withheld amounts become plan assets as soon as they can be reasonably segregated from the employer's general assets, but not later than 90 days. For practical purposes, such contributions become plan assets shortly after they are withheld from pay.
2. Use of a separate account to pay benefits—When the employer pays benefits out of a formal trust fund or an ordinary bank account held in the name of the plan.
3. Amounts attributable to plan assets—Insurance company refunds, reimbursements, subrogation recoveries, and payments from stop-loss policies.

Plan Number—a three-digit number assigned by the plan administrator. If there is one plan, it should be numbered 501. If there is more than one plan, they should be numbered 501, 502, 503, 504, and so on.

Plan Year—any twelve-month period chosen by the administrator for reporting purposes. Note—this is not necessarily the same as the policy year of underlying insurance contracts.

Policy Year/Anniversary—the twelve-month period for which coverage is provided and premiums are established. This is not necessarily the same as the ERISA plan year. The policy anniversary is the date that the insurance policy/contract renews and premium rates are re-determined.

Summary of Benefits (Benefit Summary)—a short (1 to 4 pages) handout summarizing and highlighting the features of coverage contained in the Certificate of Coverage, e.g., deductibles, copays, coinsurance, exclusions, etc.

Third Party Administrator (TPA)—a person or entity that administers the plan and adjudicates claims. A TPA is usually not the plan administrator.

Trust Rule—In general, plan assets must be held in a formal trust for the exclusive purpose of paying plan benefits and reasonable administrative expenses of the plan. Employee contributions are considered plan assets. However, there are some exceptions to this rule.

- If an employer collects employee contributions for a self-funded plan through a cafeteria plan and does not segregate any plan funds from its general assets (whether contributions or benefits), the plan is deemed to have no assets.
- Likewise, if an employer sponsoring a fully insured plan does not segregate funds, promptly forwards employee contributions to the carrier, and promptly delivers insurer refunds to participants, the plan is deemed to have no assets.
- However, even if an employer collects employee contributions through a cafeteria plan, but segregates those funds or other funds (e.g., employer paid benefits or employer paid premiums), the employer must create a trust to hold ALL plan assets.

Voluntary Employee's Beneficiary Association (VEBA)—an organization organized to pay life, sick, accident, and similar benefits to members or their dependents, or designated beneficiaries if no part of the net earnings of the association goes to the benefit of any private shareholder or individual.

Welfare Benefit Plan—a program established by an employer or an employee organization that provides for its participants or their beneficiaries:

- medical, surgical, or hospital care or benefits,
- benefits in the event of sickness, accident, disability, death or unemployment,
- vacation benefits, apprenticeship or other training programs,
- day care centers,
- scholarship funds, or
- prepaid legal services.

Wrap Plan—an umbrella plan document and SPD, through which several component welfare benefit plans are provided. A wrap plan saves the employer from the time and expense of preparing an SPD, a Form 5500, and an SAR for each separate component benefit plan by replacing them with one comprehensive wrap plan. The DOL acknowledges the use of a wrap document, which covers more than one plan in one document.

What Is A Plan Document?

The plan document describes the plan's terms and conditions related to the operation and administration of the plan. It is required for each welfare benefit plan an employer maintains which is subject to ERISA, and it must be in writing. An insurance company's Master Contract, Certificate of Coverage, or Summary of Benefits is not a plan document or Summary Plan Description (SPD). An ERISA plan may exist even without a written document—it is simply out of compliance.

The plan document should contain:

- Name of the plan administrator
- Designation of any named fiduciaries other than the plan administrator under the claims procedure for deciding benefit appeals
- A description of the benefits provided
- The standard of review for benefit decisions
- Who is eligible to participate, e.g., classes of employees, employment waiting period, and hours per week
- The effective date of participation, e.g., next day or first of the month following satisfaction of an eligibility waiting period
- How much the participant must pay towards the cost of coverage
- The plan sponsor's amendment and termination rights and procedures, and what happens to plan assets, if any, in the event of plan termination
- Rules restricting and regulating the use of Personal Health Information (PHI), if the plan sponsor uses PHI
- Subrogation, coordination of benefits, and offset provisions

- Procedures for allocating and designating administrative duties to a TPA or committee
- How the plan is funded, whether from employer and/or employee contributions, only if it has assets
- How insurer refunds (e.g., dividends, demutualization) are allocated to participants
- For group health plans, information regarding COBRA, HIPAA, and other federal mandates such as Women's Health Cancer Rights Act, preexisting condition exclusion, special enrollment rules, mental health parity, coverage for adopted children, qualified medical support orders, and minimum hospital stays following childbirth

Note: It is important to remember that non-ERISA plans should also have a separate written plan document.

"Wrap" Plan Document—the typical way of supplementing an insurance company's Certificate of Coverage with the missing ERISA provisions. It is a wrapper, or supplement to a Certificate of Coverage. The "wrap" document should make clear to the participants that the "wrap" document and the carrier's documents together constitute the SPD for the plan. If a Master Contract is not issued to an employer, the Certificate of Coverage may suffice. In our experience, most "wrappers" do not fully satisfy the requirements of ERISA. If a "wrap" plan document is used, it should wrap around the Master Contract or insurance policy if the plan is insured.

Wrap-Tightsm Plan Document—a single umbrella plan document and SPD provided exclusively by ERISA Pros, through which several welfare benefit plans are provided. The DOL acknowledges the use of a "wrap" document, which covers more than one plan in one document.

There are several advantages to ERISA Pros' **Wrap-Tightsm** Document. The **Wrap-Tightsm** Document establishes a common umbrella plan and plan year for all of its component benefit programs, allowing you to file a single Form 5500 and avoid the often significant costs of preparing separate Form 5500s for each plan. This also saves the time and expense of preparing a plan document and an SPD for each separate plan that may be due at different times of the year. It may also save costs on independent audit fees. Importantly, a **Wrap-Tightsm** plan provides consistent information for all of its covered plans and reduces the chances of forgetting to file a Form 5500 for any one of them. A potential disadvantage of using one document to wrap around several component benefit plans is that it may require you to report information on a plan which would have otherwise fallen into the small plan exemption from reporting (having fewer than 100 participants). We believe that our **Wrap-Tightsm** plan document approach is the best way to meet the ERISA document compliance requirements for most companies.

Summary of Material Modification (SMM)—must be furnished automatically in the same manner and to the same individuals as an SPD when a plan is amended, or "materially" modified. Examples of material modifications are changes to deductibles and eligibility, and the addition or deletion of a line of coverage. An SMM is a simple way to disclose just the changes to participants rather than drafting a new SPD. It must conform to the same understandability standards as an SPD. The SMM must be delivered within 210 days after the end of the plan year, or within 60 days after a "material reduction" in benefits of a group health plan. There is a penalty of up to \$110/day for not delivering

an SMM within 30 days after a participant or beneficiary requests it, and there is also the potential for employer liability described above, especially if a material reduction has occurred.

Special rule for group health plans — **A Summary of Material Reduction in Covered Services or Benefits** must be furnished in the same manner and to the same participants as an SPD when there is a material reduction in covered services or benefits for a group health plan. This summary must be provided within 60 days after the date of the adoption of the change. Alternatively, the plan administrator may furnish this summary within 90 days by a system of communication that it maintains to provide participants information about their plan and that also otherwise meets the ERISA disclosure requirements. A "material reduction" generally means any modification that would be considered by the average participant to be an important reduction in covered services or benefits. Examples include any reduction or elimination in benefits, formulas, methodologies, schedules, or service area (e.g., HMO); increase in deductibles, coinsurance, or copays; or establishment of new conditions or requirements (e.g., prior authorization).

A plan administrator must also make its documents available for inspection at his or her principal office. Upon request, the documents must also be available for inspection within 10 days at the location of the company's principal office (if different than the administrator's principal office) and at each location where at least 50 participants work. Our **Wrap-Tightsm** approach provides you with a branded system to harness these important documents and ensure they are available when needed.

Summary Plan Description (SPD) Document Requirements

The Summary Plan Description, or SPD, is the main vehicle for communicating plan rights and obligations to participants and beneficiaries. As the name suggests, it is generally a summary of the material provisions of the plan document, which is understandable to the average participant of the employer. However, in the context of health & welfare benefit plans, it is not uncommon for the SPD to be a combination of a complete description of the plan's terms and conditions, such as a Certificate of Coverage, and the required ERISA disclosure language.

Note: An insurance company's Master Contract, Certificate of Coverage, or Summary of Benefits is not a plan document or SPD.

An SPD must contain all of the following information:

- The plan name
- The plan sponsor/employer's name and address
- The plan sponsor's EIN
- The plan administrator's name, address, and phone number
- Designation of any named fiduciaries, if other than the plan administrator, e.g., claim fiduciary
- The plan number for ERISA Form 5500 purposes, e.g., 501, 502, 503, etc. (Note—each ERISA plan should be assigned a unique number.)
- Type of plan or brief description of benefits, e.g., life, medical, dental, disability

- The date of the end of the plan year for maintaining the plan's fiscal records (which may be different from the insurance policy year)
- Each trustee's name, title, and address of principal place of business, if the plan has a trust
- The name and address of the plan's agent for service of legal process, along with a statement that service may be made on a plan trustee or administrator
- The type of plan administration, e.g., administered by contract, insurer, or sponsor
- Eligibility terms, e.g., classes of eligible employees, employment waiting period, and hours per week, and the effective date of participation, e.g., next day or first of the month following satisfaction of an eligibility waiting period
- How the insurer refunds (e.g., dividends, demutualization, and medical loss ratio (MLR) refunds) are allocated to participants. **Note: This is important for obtaining the small plan (<100 participants) exception for filing Form 5500.**
- The plan sponsor's amendment and termination rights and procedures, and what happens to plan assets, if any, in the event of plan termination
- A summary of any plan provisions governing the benefits, rights, and obligations of participants under the plan on termination or amendment of the plan or elimination of benefits
- A summary of any plan provisions governing the allocation and disposition of assets upon plan termination
- Claims procedures—may be furnished separately in a Certificate of Coverage, provided that the SPD explains that claims procedures are furnished automatically, without charge, in the separate document (e.g., a Certificate of Coverage), and time limits for lawsuits, if the plan imposes them
- A statement clearly identifying circumstances that may result in loss or denial of benefits (e.g., subrogation, coordination of benefits, and offset provisions)
- The standard of review for benefit decisions (We recommend consideration of granting full discretion for the plan administrator or authorized fiduciary to interpret the plan and make factual determinations.)
- ERISA model statement of participants' rights
- The sources of plan contributions, whether from employer and/or employee contributions, and the method by which they are calculated
- Interim SMMs since the SPD was adopted or last restated
- The fact that the employer is a participating employer or a member of a controlled group
- Whether the plan is maintained pursuant to one or more collective bargaining agreements, and that a copy of the agreement may be obtained upon request
- A prominent offer of assistance in a non-English language (depending on the number of participants who are literate in the same non-English language)
- Identity of the insurer(s), if any
- Additional requirements for Group Health Plan SPDs:
 - Detailed description of plan provisions and exclusions (e.g., copays, deductibles, coinsurance, eligible expenses, network provider provisions, prior authorization and utilization review requirements, dollar limits, day limits, visit limits, and the extent to which new drugs, preventive care, and medical tests and devices are covered). A link to network providers should also be provided. Plan limits, exceptions, and restrictions must be conspicuous.

- Information regarding COBRA, HIPAA, and other federal mandates such as the Women's Health Cancer Rights Act, preexisting condition exclusion, special enrollment rules, mental health parity, coverage for adopted children, Qualified Medical Support Orders, and minimum hospital stays following childbirth.
- Name and address of health insurer(s), if any
- Description of the role of health insurers (i.e., whether the plan is insured by an insurance company or the insurance company is merely providing administrative services)

Recommended, but not required provisions in an SPD:

- For insured arrangements, attach the Summary of Benefits provided by the insurance companies to help ensure you have provided an understandable summary of the Certificate of Coverage
- For self-insured arrangements, provide the name, address, and phone number of any Third Party Administrator (TPA) paying claims or benefits.
- Language that in the event there is a conflict between the plan document, the SPD, and a Certificate of Insurance, which document controls

Wrap SPD Document Requirements:

Group insurance Certificates of Insurance are typically not SPDs because they do not contain all of the language required by ERISA. An employer must prepare an ERISA "wrapper" to supplement the Certificate of Insurance. Together, the wrapper and Certificate of Insurance comprise a proper SPD.

An employer may wish to consolidate its various component benefit plans into a single plan for reporting and disclosure. ERISA *Pros'* proprietary **Wrap-Tightsm** plan is a multi- or mega-wrap plan, which saves the employer the time and expense of preparing an SPD, a Form 5500, and an SAR for each separate component benefit plan by replacing them with one comprehensive wrap plan.

SPD Delivery Requirements

The plan administrator/employer is responsible for preparing the SPD and affirmatively delivering it to certain persons, e.g.:

- covered employees
- terminated COBRA participants
- parents or guardians of children covered under a qualified medical support order
- dependents of a deceased retiree under a retiree medical plan

Note—It is not the insurance company's responsibility to prepare or deliver the SPD.

Unless requested, an SPD does not need to be provided separately to dependents of a covered employee or to employees who are not covered, although it is a good idea to do so.

An SPD should be delivered to participants within 90 days after they become covered, whether they request it or not. Plan administrators of a new plan must distribute an SPD within 120 days after the plan is established. An updated SPD must be furnished to all covered participants every 5 years, and every 10 years even if the SPD has not changed.

Determining whether or not an SPD was furnished to a participant or beneficiary is an important issue in litigation. An employer should be prepared to prove that it furnished one in a way "reasonably calculated to ensure actual receipt," using a method "likely to result in full distribution." Acceptable methods of delivery include: first-class mail, hand-delivery, and electronic distribution, if the employees have access to computers in the workplace and can print a copy easily. DOL regulations are quite clear that merely placing copies of the SPD in a break room or posting it on an employer's website or intranet does not necessarily satisfy this requirement because it was not affirmatively delivered to the participant.

SPD Electronic Distribution Requirements

Requirements for employees with work-related computer access—Definition of work-related computer access: Employees have the ability to access documents at any location where they reasonably could be expected to perform employment duties. In addition, access to the employer's electronic information system must be an integral part of their employment duties.

- Electronic materials must be prepared and delivered in accordance with otherwise applicable requirements (e.g., timing and format requirements for SPDs as outlined under ERISA.)
- A notice must be provided to each recipient, at the time that the electronic document is furnished, detailing the significance of the document.
- The notice must advise the participant of their rights to have the opportunity, at their work site, to access documents furnished electronically and to request and receive (free of charge) paper copies of any documents received electronically.
- The employer must take appropriate measures to ensure the electronic distribution will result in actual receipt of information by the participants (i.e. return-receipt.)
- If the disclosure includes personal information relating to an individual's accounts and benefits, the plan must take reasonable and appropriate steps to safeguard the confidentiality of the information.

Additional requirements for non-employees or employees with non-work related computer access—

- Affirmative consent for electronic distribution must be obtained from the individual. Before consent can be obtained, a pre-consent statement must be furnished that explains:
 - The types of documents that will be provided electronically;
 - The individual's right to withdraw consent at any time without charge;
 - The procedures for withdrawing consent and updating information (e.g. updating the address for receiving electronic disclosure);

- The right to request a paper version and its cost (if any); and
- The hardware and software requirements needed to access the electronic document.
- The regulations permit the pre-consent statement to be provided electronically if the employer has a current and reliable e-mail address.
- If system hardware or software requirements change, a revised statement must be provided and renewed consent from each individual must be obtained.
- If the documents are to be provided via the Internet, the affirmative consent must be given in a manner that reasonably demonstrates the individual's ability to access the information in electronic form, and the individual must have provided an address for the receipt of electronically distributed documents.
- The employer must keep track of individual electronic delivery addresses, individual consents and the actual receipt of e-mailed documents by recipients.
- Steps 1, 2, 4 and 5 outlined above under **requirements for employees with work-related computer access** must also be followed.

ERISA Pros Electronic Document Delivery Package – Employers wishing to deliver their SPDs (as well as Summary Annual Reports (SARs) and Summaries of Material Modifications (SMMs) electronically should consider using ERISA Pros' proprietary Electronic Document Delivery Package. We provide a set of instructions, a checklist, fillable forms and emails, and a spreadsheet to monitor and document compliance.

There are very few exceptions to the SPD requirement. One is that an SPD is not required for an employer-provided day care center. Another is that a plan covering a select group of management or highly compensated employees (e.g., a Top-Hat Plan) is exempt from this requirement. With few exceptions, **an SPD is required regardless of how many participants are covered**; there is no small plan (less than 100 participants) exception, like there is with Form 5500s.

What happens if the employer/plan sponsor doesn't have an SPD or plan document? If a participant, beneficiary or the DOL makes a written request for a copy of either document, it must be furnished within 30 days; otherwise the employer/sponsor can face a DOL penalty of up to \$110/day in the case of a participant request or \$156/day (capped at \$1,566 per request) in the case of a DOL request.

A poorly drafted SPD, which provides greater benefits or fails to disclose exclusions in the underlying Certificate of Coverage, may result in additional liability for the plan sponsor/employer. A participant or beneficiary can sue his employer/plan sponsor/plan administrator to enforce his or her plan rights. Where an SPD has not been provided as required by law, or is inadequate or contradictory to the Certificate of Coverage, courts tend to favor the participant or beneficiary, resulting in liability for benefits never intended by the employer. Also, if the employer completely fails to produce an SPD, and a participant can show a loss of benefits resulting from not having received an SPD (e.g., he was not aware of the need to pre-authorize a hospital stay or surgical procedure), a court may find in favor of the employee, again resulting in an unexpected expense to the employer. With medical treatment often costing significant dollars, having liability without insurance coverage can be devastating to an employer. Participants and beneficiaries are entitled to

relatively wide-ranging discovery regarding their claims, and the DOL has broad powers to subpoena records in the course of an audit or investigation.

5500 Preparation, Electronic Filing, ERISA Deadline, & Penalty

Form 5500 Annual Reporting—The plan administrator must prepare a Form 5500 annually for each ERISA plan that an employer sponsors in order to report certain information to the DOL. The **deadline** for filing is 7 months after the end of the plan year. A 2-1/2 month extension is available by filing a Form 5558. Form 5500 records must be maintained for not less than six years. The DOL requires that all Form 5500s for Plan Year 2009 and later must be filed electronically.

Form 5500 Exemptions—the rules are complicated, but generally, unfunded plans and fully insured plans which cover fewer than 100 participants on the 1st day of the plan year are not required to prepare and file a Form 5500 with the DOL for that year. **Note—this exemption may be lost if a plan sponsor does not disclose how insurer refunds are allocated. This can be problematic because many small employers do not prepare and distribute an SPD containing this language, nor do they file a Form 5500, relying on the small plan exemption. However, failure to prepare and file Form 5500 by the deadline can result in a DOL penalty of up to \$2,194 per day.**

Even though dependents may be considered participants for other purposes, only participating employees are counted for this purpose. Former employees covered under COBRA and Severance Pay Plans are also counted. Employees who waive coverage are not counted. Also, unfunded plans to which employees do not contribute are not required to prepare and file a Form 5500 with the DOL. Other Form 5500 filing exemptions include employer-sponsored day care centers, apprenticeship and certain other training programs, and plans benefitting a select group of management or high-level employees.

A funded plan that accepts participant contributions is generally not eligible for a complete exemption. However, there is a special rule for a cafeteria plan that accepts participant contributions. It will be treated as unfunded for Form 5500 purposes, provided that (1) plan assets from participant contributions would be the sole reason the plan would otherwise be considered funded, and (2) if participant contributions are made for an insured plan, they are forwarded directly to the insurer as soon as they can be segregated from the employer's general assets, and the employer has a policy governing the allocation of insurer refunds.

DOL Penalties—The plan administrator is subject to DOL penalties of up to \$2,194/day for each ERISA plan Form 5500 which is late, incomplete, or not prepared and filed at all. The responsibility for filing cannot be contracted away. To put this penalty into proper perspective, assume an employer has four separate plans (e.g., a life, a medical, a dental, and a disability plan), and it prepared and filed a Form 5500 for each plan 45 days late. This employer could face a DOL penalty of \$394,920! (\$2,194/day x 45 days x 4 plans)

A willful violation may result in a criminal penalty of \$100,000 or imprisonment for 10 years, or both. Knowing misrepresentation or concealment of facts required to be disclosed by the plan

administrator are punishable by a fine up to \$10,000 or imprisonment for up to 5 years. A DOL penalty cannot be treated as a plan administrative expense.

Fortunately, the DOL does have a [Delinquent Filer Voluntary Compliance Program](#) that offers a reduced penalty, but this program cannot be used once the DOL finds the employer's error through an audit or investigation. Thus, it is easy to see how having a **Wrap-Tightsm** document is extremely helpful in mitigating a potential deadline penalty.

Summary Annual Report (SAR)—a summary of the Form 5500 information which must be furnished automatically to participants each year that an annual Form 5500 is filed (except for totally unfunded plans, regardless of size). The SAR must be prepared and delivered to participants and beneficiaries who receive SPDs. The deadline is 9 months from the close of the plan year, plus two months extension, if the Form 5500 was extended. The DOL can impose a penalty of \$156/day (capped at \$1,566 per request) for failure to respond to a request for an SAR, and there could also be a criminal penalty for willful violations.

Note: A DOL Form 5500 deadline penalty applies to each benefit plan. Each penalty is cumulative and there is no statute of limitations for these violations.

Erisa Pros will prepare and file Form 5500s electronically utilizing approved software through the DOL's EFAST2 system.

Form 5500 Annual Report Delinquent Filer Voluntary Compliance Program

The Delinquent Filer Voluntary Compliance Program (DFVCP) is designed to encourage voluntary compliance with the annual reporting requirements under the Employee Retirement Income Security Act (ERISA). The DFVCP gives delinquent plan administrators a way to avoid potentially higher civil penalty assessments by satisfying the program's requirements and voluntarily paying a reduced penalty amount.

Who is Eligible

Eligibility for the DFVCP is limited to plan administrators with Form 5500 filing obligations who comply with the provisions of the program and who have not been notified in writing by the DOL of a failure to file a timely Form 5500 annual report.

Program Criteria

Participation in the DFVCP is a two-part process. First, the plan administrator must file a complete Form 5500 Series Annual Return/Report, including all schedules and attachments, with the Employee Benefits Security Administration (EBSA) for each year for which relief is requested. To ensure proper processing, box "D" on the 5500 must be marked and a statement labeled "DFVCP" must be attached. Second, the plan administrator must submit a copy of the 5500, without the schedules and attachments and with the applicable penalty amount, to the DFVCP. The plan administrator is personally liable for the applicable penalty amount, and, therefore, amounts paid under the DFVCP cannot be paid from the assets of an employee benefit plan.

Penalty Structure

"Per day" penalty – The basic penalty under the program is \$10 per day for delinquent filings.

"Per filing" cap – The maximum penalty for a single late Form 5500 annual report is \$2,000 for a large plan (100 or more participants on the 1st day of the plan year).

"Per plan" cap – The DFVCP also includes a "per plan" cap. This cap is designed to encourage reporting compliance by plan administrators who have failed to file a Form 5500 annual report for a plan for multiple years. The "per plan" cap limits the penalty to \$4,000 regardless of the number of late Form 5500 annual reports filed for the plan at the same time. There is no "per administrator" or "per sponsor" cap. If the same person is the plan administrator or plan sponsor of several plans required to file Form 5500 annual reports, the maximum applicable penalty amounts would apply for each plan.

Caution – A plan sponsor that adopts a "wrap" or "mega-wrap" plan retroactively, in order to decrease late Form 5500 filing penalties that would otherwise apply, should proceed with caution. Changing employer sponsored plans should generally be done on a prospective basis only.

Program Participation Procedures

The procedures governing participation in the DFVCP program are intended to make the program easy to use:

- Plan administrators may use the Form 5500 for the year relief is sought or the most current form available at the time of participation. This option allows administrators to choose the form that is most efficient and least burdensome for their circumstances;
- Box D of the Form 5500 must be checked and a statement labeled "DFVCP" must be attached;
- The program conforms to the annual reporting procedures under the computerized ERISA Filing Acceptance System (EFAST); and

An online calculator is available to assist filers in computing the penalty. Additionally, after completing the calculator, located at www.efast.dol.gov, filers may choose to file electronically. However, if filing through the mail is preferred, the FAQs, located at the same site, provide the addresses and detailed information.

Contacts for Additional Information

Questions about the DFVCP should be directed to EBSA by calling 202.693.8360 or www.dol.gov/ebsa. For additional information about the Form 5500 Series, visit the EFAST Internet site at www.efast.dol.gov, or call the EBSA help desk at 1.866.463.3278.

Why Should an Employer Comply With ERISA?

First of all, compliance is not optional; it's the law! Second, employers who comply can avoid costly DOL penalties. Third, many states allow participants and beneficiaries to bring "bad faith" claims

against insurers and administrators who deny benefits. In a state court, plaintiffs can collect the benefits that were denied plus compensatory damages, such as punitive or treble (triple) damages. Trials in state courts are decided by juries, which often favor the individual participant over a corporation or insurance company.

However, ERISA is a federal law which preempts state law. ERISA limits damages to the unpaid benefits and does not provide for jury trials. Having a plan that is in compliance with ERISA will help an employer avoid a lawsuit in a state court, and perhaps several different state courts. Being out of compliance creates exposure in either state or federal court.

In state court, every aspect of a case is subject to a "de novo" review, which disregards any previous decisions made in the matter, including issues that were not even in dispute. However, ERISA has a higher standard of review for overturning decisions of a plan administrator. In federal court, an administrator's decision to deny a claim must be "arbitrary and capricious" before it can be overturned.

Many employers think "It's not going to happen to me." However, it happens a lot. In fact, there are a substantial number of cases where employers have been penalized by hundreds of thousands of dollars or more.

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