# EXPLANATION OF ERISA

**Q/A-1 What is ERISA?**

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans.

ERISA requires plans to provide participants with plan information including important information about plan features and funding; provides fiduciary responsibilities for those who manage and control plan assets; requires plans to establish a grievance and appeals process for participants to get benefits from their plans; and gives participants the right to sue for benefits and breaches of fiduciary duty.

There have been a number of amendments to ERISA, expanding the protections available to health benefit plan participants and beneficiaries.

**Q/A-2 Which employers are governed by ERISA?**

Those employers who voluntarily establish pension and health plans in private industry are governed by ERISA. In general, ERISA does not cover group health plans established or maintained by governmental entities, churches for their employees, or plans which are maintained solely to comply with applicable workers compensation, unemployment, or disability laws. ERISA also does not cover plans maintained outside the United States primarily for the benefit of nonresident aliens or unfunded excess benefit plans.

**Q/A-3 What employee benefit plans are governed by ERISA?**

ERISA governs all claims for benefits (whether procured through insurance or otherwise) from an "employee welfare benefit plan" An employee welfare benefit plan is defined as “any plan, fund, or program . . . established or maintained by an employer or by an employee organization" which provides employee benefits such as life, health or disability.

Under "safe harbor" regulations promulgated by the DOL, the employer will "establish" a plan by arranging for group insurance for its employees, unless the employer does nothing more than (1) allow the insurer to publicize the program, and (2) allow for payroll deductions to pay for the insurance. If the employer does almost anything else, there will be sufficient involvement to show the employer "established or maintained" the plan. Any of the following types of employer activities will probably lead to the determination that a welfare plan exists:

- Paying all or even part of the policy premiums;
- Urging employees to join the plan;
- Retaining some of the deducted premium to administer the plan;
- Keeping track of who is in the plan;
- Answering questions for the plan members about their coverage.

**Q/A-4 Does ERISA require employers to offer employee benefits?**

No. ERISA does not require an employer to provide employee benefits. However, once an employer decides to provide benefits that are subject to ERISA, the employer must follow the requirements under ERISA.

**Q/A-5 What are the main compliance obligations for an employer sponsored ERISA plan?**

The main compliance obligations for an employer’s ERISA plans are as follows:

- A Plan document must exist for each plan
- Fiduciary standards must be followed
- A Fidelity bond must be purchased to cover every person who handles plan funds
- A Summary Plan Description (SPD) must be furnished automatically to plan participants

- A Summary of Material Modification (SMM) must be furnished automatically to plan participants when a plan is amended
- Copies of certain plan documents must be furnished to participants and beneficiaries on written request
- Form 5500 must be filed annually for each plan (subject to important exemptions, especially for small plans)
- A Summary Annual Report (SAR), which summarizes Form 5500 information, must be furnished automatically to plan participants for a plan that files a Form 5500 (except totally unfunded welfare plans)
- Claim procedures must be established and carefully followed when processing benefit claims and when reviewing appeals of denied claims
- Plan assets, including participant contributions, may be used only to pay plan benefits and reasonable administrative expenses
- For a few welfare plans, plan assets may have to be held in trust

ERISA provides that the assets of an ERISA-covered plan shall be held in trust by one or more trustees pursuant to a written trust agreement unless subject to one of the exceptions of ERISA. It also provides that these requirements shall not apply to plan assets which consist of insurance contracts or policies issued by an insurance company qualified to do business in a State; or to any assets of such an insurance company or any assets of a plan which are held by such an insurance company.

**Q/A-6 What are the Plan document requirements for an ERISA Plan?**

ERISA does not require an employer to provide employee benefits. But once an employer decides to provide benefits that are subject to ERISA, the benefits must be provided through a written document. In addition, the employer-sponsor is generally free to design their own plan of benefits. This is because ERISA also does not dictate the contents of the plan document, except for some general content areas discussed below. ERISA does not require any particular format of plan document. The type of plan document will be influenced in the most fundamental way by the nature of the plan benefits in question.

An employer's insured benefits will be dictated in large part by the insurance and HMO contracts under which the benefits are paid. But because insurance companies and HMOs are not directly subject to ERISA, their contracts may not have all the provisions required of an ERISA plan document. The standard way of supplementing such contracts is to use a "wrap document," which contains the missing terms and essentially wraps itself around the insurance contract (or contracts) to become a single ERISA plan document. Among the ERISA items often unaddressed in the insurance policy are the designation of a plan administrator, the designation of an ERISA named fiduciary, the plan year and plan number, the plan name, and, as discussed below, the designation of how many plans the sponsor maintains.

There are no hard-and-fast rules for determining how many plans there are. As a consequence, the employer is generally free to determine the number of plans it has for ERISA compliance purposes. Failure to address this issue can create a lot of confusion.

As part of its plan design and documentation process, an employer may choose to establish a single "bundled" plan through which all welfare benefits are provided, including non-ERISA fringes like the cafeteria plan, DCAP, etc.; or it could treat each type of benefit as a separate plan (e.g., medical, dental, health FSA, DCAP, etc.)

The standard way of bundling different benefits into a single ERISA plan is through use of a mega-wrap document or umbrella document. Such a document wraps itself around a set of other documents to combine them into one legal document.

**Q/A-7 What key items must be included in an ERISA Plan document?**

There are number topics that must be addressed in the ERISA plan document. Some of the more important topics include:

- What benefits and who is eligible;
- How will benefits be funded;
- How will insurer refunds and similar amounts be treated;
- Standard of review for benefit decisions;
- Designation of a "Named Fiduciary;"
- Plan amendment and termination procedures, including who has authority to amend and terminate the plan and what happens to plan assets (if any) in the event of termination;

- Required provisions for group health plans, including COBRA; qualified medical child support orders (QMCSOs); coverage of dependent children in cases of adoption; HIPAA portability, special enrollments, and access provisions; hospital stays for newborns and mothers; parity in the application of certain limits to mental health benefits; and coverage for reconstructive surgery in connection with mastectomy;
- Other substantive provisions relevant for particular plans regarding, for example, subrogation and reimbursement clauses (applicable, for example, where a participant or beneficiary injured in an accident may recover from another source for expenses paid by the plan); or coordination of benefits (applicable when two plans cover the same individual); and
- Procedures for allocating (e.g., where the plan sponsor will designate a committee of company employees to act as plan administrator) and delegating responsibilities under the plan (e.g., where certain administration tasks will be performed by a TPA).

**Q/A-8 Who is a fiduciary under ERISA?**

Anyone performing ERISA fiduciary functions is a fiduciary under ERISA. Persons or entities become ERISA fiduciaries to the extent that they:

- Have discretionary authority or discretionary control regarding the management of an ERISA plan (e.g., the plan sponsor making plan management decisions);
- Have any authority or control respecting management or disposition of plan assets (but not all plans have plan assets, a subject discussed later);
- Render investment advice for a fee (e.g., an investment company giving advice to an ERISA plan with a VEBA); or
- Have discretionary authority or discretionary responsibility in the administration of the plan (e.g., an insurance company that has final decision-making authority over benefit claims).

Anyone can be a fiduciary; even individual employees can become fiduciaries based on the functions they perform for their company's ERISA plans.

**Q/A-9 What are the principle requirements of a fiduciary under ERISA?**

An ERISA fiduciary is held to a very high standard of behavior, which requires more careful decision-making and more disclosure to plan participants and beneficiaries than would be required in a normal business relationship. The principal duties of ERISA fiduciaries are:

- To act solely in the best interest of plan participants and beneficiaries (the duty of undivided loyalty);
- To use plan assets for the exclusive purpose of paying plan benefits or reasonable expenses of plan administration (the exclusive benefit rule);
- To act with the care, skill, prudence and diligence that a prudent person in similar circumstances would use
- To diversify the plan's investments (if any) to minimize the risk of large losses ; and
- To act in accordance with the documents governing the plan.

In addition, ERISA imposes broad prohibitions on certain transactions between ERISA plans and other identified individuals, subject to equally broad exemptions.

**Q/A-10 Are there any exceptions to a fiduciary's duties under ERISA?**

ERISA's fiduciary rules are general in nature and affect every aspect of plan administration. However, they do not apply to a plan sponsor's business decisions regarding plan design. Such business activities (including decisions about establishing, amending and terminating ERISA plans) are known as "settlor" functions, and they are treated as non-fiduciary in nature.

As a result, when an employer, which is a fiduciary with respect to its ERISA plans, considers whether to terminate one of its plans, it does not have to consider the best interest of the participants and beneficiaries as would be required under the duty of undivided loyalty.

It may instead consider how expensive the plan has become to maintain and administer.

As with so many other ERISA rules, of course, distinguishing between fiduciary and non-fiduciary activities in practice is not always so easy.

**Q/A-11 What is the liability for a fiduciary under ERISA?**

ERISA fiduciaries that violate their duties are personally liable for any damages caused to the plan or for any profit realized by the fiduciary through its breach. A breaching fiduciary may also be liable for special fiduciary penalties assessed by the DOL (equal to 20% of the amount recovered by the DOL under a settlement agreement or through an adverse court decision). Such fiduciaries may also be removed from their fiduciary positions and may even be subject to criminal penalties.

Fiduciary liability can arise in a number of different ways. A particular trouble spot involves enrollment disputes. An employer will probably have the responsibility under each of its insured arrangements to process individual enrollments. Certain reported cases have imposed fiduciary liability where an employer, for example, fails to forward a life insurance application before the affected employee dies. With no enrollment of the employee, the insurer will have no liability under its insurance policy.

**Q/A-12 What are the fiduciary bond requirements under ERISA?**

ERISA requires every fiduciary of an employee benefit plan and every person who handles plan funds or other property to be bonded under what is commonly referred to as a "fidelity bond." The bond is intended to protect the plan from losses due to fraud or dishonesty on the part of the fiduciary or other person handling funds. The required bond must be in place at the beginning of the plan year in an amount equal to at least 10% of the funds handled during the prior reporting year, subject to a minimum of $1,000 and a maximum of $500,000.

A plan that does not have funds or property, of course, does not need a bond. In most cases, a plan with plan assets will need to have a bond, but the terms "plan assets" and "plan funds or property" are not synonymous.

**Q/A-13 What are the requirements for a Summary Plan Description (SPD) under ERISA?**

The SPD is probably the most important document required by ERISA—more important even than the plan document. This is because the SPD is the main vehicle for communicating plan rights and obligations to participants and beneficiaries, and it will usually be enforced over the plan document, which is typically not disclosed to covered individuals. A badly-drafted SPD (for example, one that promises more benefits than the sponsor intended to pay or that fails to disclose important limits on benefit entitlement) can result in a much-larger-than-expected benefit liability for the plan sponsor.

It should be noted that the plan administrator is the party responsible for furnishing the SPD. This is the case even where SPDs are actually drafted by outside entities (such as TPAs drafting SPDs for their client companies or insurers who provide employee booklets or "certificates of coverage" that describe the benefits provided under an insured plan).

**Q/A-14 Is a SPD required for every Plan?**

Unlike the numerous exceptions to the Form 5500 requirement, there are few exceptions to the SPD requirement. Among the plans for which SPDs are not required are employer-provided daycare centers and plans benefiting a select group of management or highly compensated employees. Significantly, there is no small plan exception. Whether a plan covers 12 employees or 2,000, a SPD is generally required.

**Q/A-15 Who must receive a SPD?**

SPDs must be furnished to participants actually covered under an ERISA welfare plan (but need not be furnished separately to covered beneficiaries like spouses and dependent children). In addition, SPDs should be furnished to COBRA qualified beneficiaries (or to the guardian of an incapacitated COBRA qualified beneficiary); to the parent or guardian of a child under a qualified medical child support order; and to the spouse (or other dependent) of a deceased retiree who remains entitled to benefits under a retiree medical plan.

Additionally, although not required, SPDs are often furnished to employees who are eligible but not yet covered by a plan because this allows them to make informed choices about enrollment.

**Q/A-16 When a participant must be given a SPD?**

A SPD should generally be furnished within 90 days after a participant first becomes covered under the plan. For new plans, the plan administrator must furnish a SPD (to covered participants) within 120 days after the plan first becomes subject to ERISA. As noted, many employers as a practical matter provide a SPD along with the plan enrollment form even before an employee becomes covered by the plan. An updated SPD must be furnished to all covered participants every five years (every ten years for a plan that had no intervening changes).

**Q/A-17 How SPDs must be given to participants?**

SPDs must be furnished in a way "reasonably calculated to ensure actual receipt of the material," using a method "likely to result in full distribution." By the nature of the rule, the determination of whether a method of delivery is satisfactory will turn on the facts and circumstances regarding the employer's workplace and workforce. Whether or not a SPD was furnished can be an important issue in benefits litigation, and a plan should be prepared to prove that it followed an acceptable method of delivering SPDs. The DOL has specifically approved certain delivery methods, including first-class mail (and second- or third-class mail, if return/forwarding postage is guaranteed and address correction is requested). The DOL regulations also approve of hand-delivery of SPDs at the worksite; however, the regulation cautions that "in no case" will it be acceptable to merely place SPDs in a "location frequented by participants." SPDs may also be furnished electronically if the workplace is one where employees have access to computers and where hard copies of the SPD can be printed easily.

**Q/A-18 What are the requirements for a SPD?**

ERISA does not require a SPD to be in any particular form, and there is no magic formula for drafting an effective and adequate SPD. (For this reason, many larger employers turn to outside professionals for assistance, especially with self-insured plan SPDs.) ERISA does, however, impose certain general format and style requirements. First, a SPD must be sufficiently accurate and comprehensive to inform plan participants and beneficiaries of their rights and obligations under the plan. Next, it must be written in a manner understandable to the average plan participant. Third, it must not have the effect of misleading, misinforming or failing to inform participants and beneficiaries. And last, any description of exceptions, limitations, reductions, and other restrictions of plan benefits must be apparent in the SPD.

SPDs come in many shapes, sizes and varieties. For example, a stand-alone SPD can summarize a separate, underlying plan document. However, where a plan's terms and conditions are simple enough, a single document could be used to satisfy both the SPD requirement and the plan document requirement. Also, although the SPD requirement under the statute applies to each ERISA plan, there would appear to be no practical reason why a single SPD couldn't summarize several underlying plans. Many employers, for example, distribute SPDs in three-ring binder format, with different sections for different benefits, allowing replacement pages to be issued when necessary.

**Q/A-19 Are there any concerns for employers using SPDs drafted by an insurance company?**

Drafting the SPD for an insured plan presents special issues because the insurance company (or HMO) normally provides an employee booklet or "certificate of insurance" for distribution to covered individuals. While an insurer's description of benefits tends to be thorough, these booklets rarely contain all the elements necessary for a SPD, and they often leave out other key information. Numerous things can be missing including:

- Required references to ERISA,
- The number of plans the employer maintains,
- The plan number(s) for Form 5500 purposes (e.g., # 501),
- The plan year (if different from the insurance policy year),
- The identity of the plan administrator and named fiduciary,
- The plan's agent for service of process in a lawsuit,
- The ERISA model statement of rights,
- COBRA, HIPAA and other health-mandate information (for group health plans),
- The fact that an employer has multiple locations, and
- The fact that the employer is a controlled group.

As a result, many employers supplement insurer booklets with a "wrap-around" SPD that supplies the missing terms. Care must be taken in preparing such a wrap-around SPD—if the SPD provides for or describes benefits or rights not addressed in the insurance contract, the plan sponsor may find itself insuring a portion of the plan by paying benefits out of its general assets.

**Q/A-20 What are the requirements for a welfare plan SPD?**

ERISA provides relatively detailed content requirements for welfare plan SPDs, particularly for group health plans. As a consequence, there is no substitute for reviewing the lists of required contents in careful detail and evaluating for each item what information about the plan in question would be required. In addition to these specifically-required items, there is also a general fiduciary duty of disclosure under ERISA that may require a description of special aspects of the plan, including how the plan might relate to other benefits.

The items to be included in a welfare plan SPD include the following:

- Basic plan-identifying information;
- A description of plan eligibility provisions;
- A description of plan benefits;
- A statement clearly identifying circumstances that may result in loss or denial of benefits;
- A description of plan amendment and termination provisions;
- A description of plan subrogation provisions (if any);
- Information regarding plan contributions and funding;
- Information regarding claims procedures (claims information may be furnished in a separate document that accompanies the SPD, provided that the SPD explains that claims procedures are furnished automatically, without charge, in the separate document);
- A model statement of ERISA rights (typically patterned after the model statement provided in DOL regulations, it informs plan participants and beneficiaries of their rights under ERISA); and
- A prominent offer of assistance in a non-English language.

Certain additional items should or must be addressed in the SPD for a group health plan. These include the following:

- A detailed description of group health plan benefit provisions, which includes a long list of items like cost-sharing provisions (premiums, deductibles, co-insurance, and copayments); annual or lifetime caps or other plan limits; provisions governing the use of network providers and the composition of provider networks; any conditions or limits applicable to obtaining emergency medical care; and any provisions requiring pre-authorizations or utilization review (some but not all of this information may be provided in a separate document if the SPD explains that a copy may be requested by participants and beneficiaries without charge);
- A description of the role of health insurers (i.e., whether a related insurer actually insures plan benefits or merely provides administrative services for the plan);
- Information regarding COBRA continuation coverage; and
- Disclosures regarding other federal mandates (including disclosures about HIPAA preexisting condition and special enrollment rules; rights to minimum hospital stays after childbirth; mental health parity; reconstructive surgery after mastectomy; qualified medical child support orders; and coverage for adopted children).

**Q/A-21 Are there any penalties for failing to provide a SPD?**

There are no specific penalties for failure to prepare or distribute a required SPD, like those imposed for Form 5500 reporting failures. The main consequence of failing to have an adequate SPD comes when participants and beneficiaries sue to enforce plan rights. An inadequate SPD (for example, one that conflicts with the plan document it seeks to summarize) will normally be enforced by the courts in lieu of the underlying plan document, if doing so will favor the participant or beneficiary involved. This can result in liability for benefits never intended by the employer.

A plan sponsor's complete failure to produce an SPD does not normally create additional rights to benefits (unless the affected participant or beneficiary can show that the lack of an SPD caused a loss of benefits, for example, because the individual was unaware of the need to pre-authorize medical treatment). But where there is no SPD, a court is more likely to enforce informal benefit summaries, enrollment materials, correspondence, and possibly oral communications, which can also result in unanticipated benefit liabilities.

**Q/A-22 What is a Summary of Material Modification?**

After a SPD has been provided to plan participants, changes may occur in the plan or in the other information required to be contained in the SPD. Under ERISA, any modification in the terms of the plan that is "material" and any change in the information required to be in the SPD must be reported to plan participants. Issuance of frequent SPDs can be expensive, so ERISA allows plan administrators to report such changes through a summary of material modifications (SMM), which limits itself to describing the modification or change.

A SMM is provided in the same manner and to the same individuals as the SPD. A SMM generally must be furnished within 210 days after the end of the plan year in which a modification or change is adopted. However, a SMM relating to a material reduction in covered services or benefits under a group health plan must be furnished no later than 60 days after the date of adoption of the reduction. Notwithstanding these relatively long statutory

deadlines, there will often be times, depending on the type of amendment, when SMMs should be furnished well before the deadline or even in advance of the effective date of the change.

**Q/A-23 What other disclosures must a plan sponsor make to Participants and Beneficiaries?**

On written request by a participant or beneficiary, the ERISA plan administrator must furnish a copy of the latest SPD and SMMs, the latest annual report, any terminal report, any bargaining agreement, any trust agreement, any contract, and any other "instrument under which the plan is established or operated." This last catch-all category of documents has been interpreted to apply to various documents, including a health plan's usual and customary fee schedules or guidelines; guidelines used to review medical claims; contracts between plans and TPAs (if they are documents under which a plan is administered); and minutes of meetings. Copies of applicable documents must be provided within 30 days of the request. Penalties of $110 per day may be assessed for each day after the deadline that the plan administrator does not respond. The requesting participant or beneficiary can sue to recover these penalties. The plan administrator may charge a reasonable amount to cover the actual cost of furnishing requested documents, not to exceed 25 cents per page.

In addition to providing documents on written request, a plan administrator must also make these same documents available for inspection by participants and beneficiaries at the principal office of the plan administrator. According to applicable DOL regulations, documents must be "current, readily accessible, and clearly identified, and copies must be available in sufficient number to accommodate the expected volume of inquiries." The documents must be available at all times at the principal office of the plan administrator. In addition, within 10 calendar days after notice by a participant or beneficiary, the documents must also be made available at the following locations: (a) the principal office of the employer (if different from the principal office of the plan administrator); and (b) each employer establishment where at least 50 participants covered by the plan in question customarily work. The plan may impose reasonable procedures for participants and beneficiaries wishing to examine documents.

**Q/A-24 What is a Summary Annual Report (SAR)?**

A summary annual report (SAR) summarizes key information from an ERISA plan's annual Form 5500. If a plan is not required to file Form 5500, then there is nothing to summarize—plans exempt from the Form 5500 requirement are therefore also exempt from the SAR requirement. (In addition, under the DOL's SAR regulations, a totally unfunded welfare plan, regardless of size, need not provide SARs.) Plan administrators that file Form 5500 must provide SARs to participants covered under the plan and to others receiving SPDs. The SAR for any given year must generally be furnished within nine months of the close of the plan year. If the time to file the Form 5500 is extended, the SAR may be furnished within two months of the end of the extension period. A SAR must be furnished even in the year a plan is terminated.

**Q/A-25 What is an annual Form 5500?**

Subject to several important exemptions, the plan administrator of an ERISA plan must report specified plan information each plan year. Form 5500 is used for this purpose and is filed with the DOL. The reporting obligation applies to each ERISA plan an employer sponsors (this is one of the main reasons it is so important to address in the plan document how many plans are maintained).

**Q/A-26 Are there any exemptions from the Form 5500?**

Small plans are exempt from the annual Form 5500 for any year in which they satisfy certain conditions. To be a small plan, a plan must have fewer than 100 covered participants at the beginning of the plan year in question. For this purpose, only participants (employees or former employees) actually covered under the plan is counted. This would include COBRA qualified beneficiaries and retirees covered under a retiree plan, but would not include covered spouses or other dependents. Individuals who are eligible but not enrolled are also excluded. Under the regulations, this complete Form 5500 exemption is available to (1) small unfunded plans (benefits paid from the employer's general assets); (2) small insured plans (benefits paid through policies of insurance other than stop-loss insurance); and (3) small combination plans (benefits paid through a combination of general assets and insurance).

Under DOL regulations, a large unfunded, insured or combination plan is exempt from providing some of the information otherwise required by the Form 5500 (namely, the financial information required by Schedule H and the audited accountant's opinion required as an attachment). Just as with the small unfunded plan exemption (discussed directly above), a large plan that accepts participant contributions under a cafeteria plan will be treated as being unfunded for purposes of this partial Form 5500 exemption, provided that the presence of cafeteria plan contributions is the sole reason that the plan would otherwise be considered funded. Similarly, a large insured plan that accepts participant contributions can remain eligible for this partial exemption, provided that it satisfies certain other requirements (discussed later under the topic of exclusive benefit and trust).

There are several other complete or partial exemptions to the Form 5500 requirement. These include, for example, plans benefiting a select group of management or highly compensated employees; employer-sponsored daycare centers; and plans exclusively providing apprenticeship or other training benefits (subject to certain notice requirements).

**Q/A-27 What are the requirements for the annual Form 5500 Reporting?**

An annual Form 5500 must be filed for each ERISA welfare plan that is subject to the reporting obligation. A plan sponsor is free to bundle multiple welfare benefits into a single plan for Form 5500 and other ERISA compliance purposes; this will control how many Form 5500s need to be filed (provided that the plan document clearly reflects the sponsor's intent, as discussed earlier). Benefits bundled together in this way, however, should all operate on the same plan year so that one plan number may be used in the Form 5500 report. (Plans maintained by members of a "controlled group"—e.g., a group consisting of a parent corporation and several subsidiaries each owned at least 80% by the parent—are generally considered one employer for Form 5500 reporting and other compliance purposes, but special rules apply when determining how many Form 5500s such groups should file.)

The format for the Form 5500 is determined each year by the responsible government agencies. The deadline for filing Form 5500 is the last day of the seventh month after the end of the plan year— for calendar-year plans that is July 31 of the following year. A 2-1/2 month extension may be automatically obtained by filing Form 5558. The Form 5500 is filed with the DOL. It may be completed by hand or by computer and may be filed by mail or through the DOL's new computerized filing system called EFAST.

The plan administrator is responsible for signing and filing the Form 5500.

The main body of the Form 5500 consists of ten general questions requiring identifying information about the plan, its sponsor and administrator, and information on the number of plan participants and the type and funding of benefits. (This part of the Form 5500 requires, among other things, the plan number—welfare plans sponsored by an employer are numbered consecutively starting with # 501.) Some of the Schedules commonly required for welfare plans are noted below.

- Schedule A (Insurance Information)
- Schedule C (Service Provider Information)
- Schedule F (Fringe Benefit Information): No Longer Required
- Financial Schedules and Accountant's Opinion

Extensive recordkeeping will be a practical necessity for ERISA welfare benefit plans of any size or complexity. ERISA also imposes a specific recordkeeping rule, which is tied to the Form 5500 obligation.

Under the rule, sufficient records must be maintained to document information that is required (or would be required in the absence of a reporting exemption) by the plan's Form 5500. The recordkeeping requirement applies not only to plan administrators but to others with reporting or certification requirements (e.g., an insurer required to provide a Form 5500 Schedule A; a TPA processing benefit payments; or an accountant providing Form 5500 audited financial statements). ERISA requires records to be kept and made available for examination for a period of not less than six years after the filing date of the Form 5500; this produces a rule of thumb to retain records for at least eight years.

**Q/A-28 What are the penalties for failing to file a Form 5500?**

In addition to possible criminal penalties for willful Form 5500 failures, the plan administrator is also subject to penalties of up to $1,100 for every day a Form 5500 is missing or incomplete (participants and beneficiaries are not entitled to sue for imposition of these penalties; only the DOL may assess these penalties). The penalties are cumulative (i.e., they are assessed separately for each missing or incomplete Form 5500), and there is no statute of limitations. While it is unusual to see full penalties assessed, imposition of even reduced penalties can make the cost of non-compliance very high. For this reason, the DOL offers a program for voluntary correction of Form 5500 problems.

**Q/A-29 What are the claims procedures requirements under ERISA?**

Claims procedures have been a required part of ERISA plans since ERISA was first enacted. Claims procedures are important because ERISA claimants are required to "exhaust" the procedures before bringing a lawsuit against the plan. Therefore, plan decision makers act in a quasi-judicial role when making claim determinations. In addition, the courts generally give a great deal of deference to decisions made under claims procedures complying with the law. And courts will also generally confine their review of such decisions to the record created by the plan (e.g., not

allowing a claimant to submit additional doctor's opinions once the matter is in court). These judge-made rules benefit the plan by making it more likely that claim decisions will be upheld.

The rules for claims procedures apply based on the type of claim involved: group health, disability or other (severance, life, AD&D, etc.). However, the basic structure of claims processing under the "old" requirements (effective until the dates described in the box under Q/A-29) remains the same under the new rules. In the first step, a claimant (plan participant or beneficiary) or authorized representative (including an attorney or doctor) files a claim. Next, the plan provides a benefit determination. Then the claimant, if denied, files an appeal. And last, the plan provides a benefit determination on review.

Insurers under insured plans remain subject to any state law procedures that are not inconsistent with the ERISA rules.

Once a claim is filed (the plan's claims procedures should define what constitutes a claim under the plan), it must be processed within certain timeframes, which differ based on the kind of claim. For this purpose (and a few others), group health claims are broken into four subcategories: pre-service claims (those requiring pre-approval by the plan); urgent care claims (essentially a subset of pre-service claims, where the claimant's life, health or ability to regain maximum function is "seriously jeopardized"); post-service claims (after-the-fact reimbursement claims including all claims under a health FSA); and concurrent care decisions (a special category of decisions where a plan pre-approves of a series of medical treatments: special timeframes apply to the appeal of a plan decision to reverse pre-approval before treatments are complete and, where urgent care is involved, special timeframes apply to certain requests by the patient to extend the preapproved treatments).

**Q/A-30 What are the timing requirements under the claims procedure rules?**

The DOL claims procedure regulations impose different deadlines, depending on the type of claim and paperwork item involved.

| Claim Processing Deadlines | | |
|---|---|---|
| **Type of Claim** | **Initial Benefit Determination** | **Appeal of Adverse Benefit Determination** |
| Group Health Plan - Urgent Care | 72 hours | 72 hours |
| Group Health Plan - Non-Urgent Pre-Service Claims –Pre-Service | 15 days (with a 15-day extension in limited circumstances) | 30 days |
| Group Health Plan - Non-Urgent Post-Service Claims –Post-Service | 30 days (with a 15-day extension in limited circumstances) | 60 days |
| Disability Plan | 45 days (with up to two 30- day extensions in limited circumstances) | 45 days (with up to a 45-day extension in limited circumstances) |
| All other types of welfare plans and all pension plans | (same as above) | (same as above) |

In addition to the benefit determinations required within the above timeframes, certain other notices are required for group health urgent care and pre-service claims. Notice must be given when an urgent care or pre-service claim is filed incorrectly under the plan's procedures (for example, when filed with an immediate supervisor instead of with the human resources manager). Incorrectly-filed claim notices must be given as soon as possible (but not later than 24 hours) in the case of urgent care claims; as soon as possible (but no later than five days) in the case of pre-service claims. A group health plan must also give notice as soon as possible (but not later than 24 hours) after an incomplete urgent care claim is filed. Special notice is not required for other incomplete claims, but if the plan provides an extension notice due to the incompleteness of a claim, the applicable decision period stops' running until the missing information is supplied.

**Q/A-31 What are the requirements for adverse benefit determinations?**

All adverse benefit determinations must be furnished to the claimant in writing (pre-service and urgent care determinations must be in writing even if non-adverse). The written notification for an adverse determination must be understandable and must address certain things:

- The specific reasons for the denial and the plan provisions relied on;
- A description of any additional information required from the claimant;
- A description of the appeals process;
- A statement of the claimant's right to bring civil action under ERISA after adverse benefit determination on review;
- For group health and disability claims, a statement that a copy of "internal rules or guidelines" relied on in denying the claim may be obtained on request and without cost; and
- For group health and disability claims, a statement that a written explanation of any "scientific or clinical judgment" relied on in denying the claim may be obtained on request and without cost.

Group health and disability claimants must be given at least 180 days in which to decide whether to appeal an adverse benefit determination; other claimants must be given at least 60 days. A claimant who fails to appeal within the required times generally loses his or her right to pursue the claim any further with the plan or in court. (But note that an inadequate notification of benefit determination does not start the appeal time running, which means that the time for filing suit may not start to run either thus, allowing a denied claim to remain open for an indefinite time.)

**Q/A-32 What are the requirements for a benefits appeal?**

Once an appeal is filed, it must receive "full and fair review" by a named fiduciary of the plan (This is why the plan document is required to designate a named fiduciary.) The insurer making final claim decisions under an insured plan will be the named fiduciary for that plan (or, where multiple benefits are bundled together, for that part of the plan that is insured). The named fiduciary under a self-insured plan will most often be the plan sponsor. Many self-insured plans use managed-care companies, TPAs or similar outside entities to assist with benefit claims. However, unless the outside entity has agreed to be the named fiduciary, its recommendations must be actively reviewed by the named fiduciary—it is not sufficient for such recommendations to be "rubber stamped" by the employer. As part of the appeal process, the claimant must be permitted to submit written comments and must be given access to relevant documents or other information (including material considered in connection with the initial claim, even if not actually relied on in making the denial). When an appeal involves medical judgment, the named fiduciary must consult with a medical or vocational expert with relevant experience and must disclose the identity of the expert.

All adverse benefit determinations on review must be furnished to the claimant in writing (pre-service and urgent care determinations must be in writing even if they are not adverse). The written notification for an adverse determination must be understandable and must address certain things:

- The specific reasons for the denial and the plan provisions relied on;
- A description of any additional information required from the claimant;
- A statement of the claimant's right (discussed earlier) to obtain relevant documents and other information;
- A description of any additional required or voluntary appeals and a statement of the claimant's right to sue;
- A statement of the claimant's right to bring civil action under ERISA after adverse benefit determination on review
- For group health and disability claims, a statement that a copy of "internal rules or guidelines" relied on in denying the claim may be obtained without cost upon request; and
- For group health and disability claims, a statement that a written explanation of any "scientific or clinical judgment" relied on in denying the claim may be obtained on request and without cost.

**Q/A-33 Does the participant have the right to seek a review of a denied claim to an external third party?**

If the health plan is non-grandfathered, a participant has the right to an external review of the plan administrator's denial of his or her appeal unless the denial was based on the participant's (or his or her spouse's or dependent's) failure to meet the plan's eligibility requirements.

A participant must follow the procedures provided by the plan administrator to request a review of the denied claim by an external third party. The plan administrator must provide the participant with information to what information he or she must provide to file for the review, deadlines that apply and the third party conducting the review.

The external appeal must be filed by the participant with the external reviewer within 4 months of the date that he or she is served with the plan administrator's response to his or her appeal request. If the participant does not file your appeal within this 4-month period, he or she will lose his or her right to appeal. For example, if a participant received the internal appeal decision on January 3, 2014, you must appeal the decision by May 3, 2014 (or, if that is not a business day, the next business day thereafter).

The external reviewer must notify the participant and the plan administrator of its decision on his or her external appeal within 45 days after its receipt of his or her request for external review. The external reviewer's decision is binding upon the parties unless other State or Federal law remedies are available. Such remedies may or may not exist. Therefore, unless another legal right exists under the participant's claim, use of the external review process may terminate his or her right to bring a lawsuit on the claim.

**Q/A-34 What are voluntary benefits?**

Voluntary benefits can be any type of additional benefit that is added to an employer's menu of benefit options whose cost is paid by the employee. When most people think of voluntary plans, they think of insurance coverage offered to employees on a voluntary basis, with employees paying the whole premium. Voluntary plans are quite common, particularly with small employers that might not otherwise be able to offer their employees basic welfare benefits such as health, life insurance or disability coverage.

Voluntary plans sometimes involve group-type insurance coverage, where the employer signs the insurance contract but employees participate on a voluntary employee-pay-all basis. Dental insurance, for example, may be offered in this manner. Such arrangements can be useful for supplementing basic benefit coverage already in place (e.g., supplemental long-term or short-term disability, and supplemental group term life insurance).

Other voluntary plans involve individual policies that are issued to employees who sign up and pay for the coverage. Examples of such individual policy arrangements (sometimes called worksite benefits) include hospital indemnity, cancer and other disease-specific coverage. With individual policy arrangements, the employer might allow insurance representatives to contact employees at work, to explain the offering and to help interested employees sign up for the coverage. The insurer then sends the employer a bill each month listing the employees who have signed up for the insurance and the monthly premium each employee owes. The employer collects premiums from the employees through payroll deductions (sometimes made on a pre-tax salary reduction basis under a cafeteria plan). The employer typically sends one premium check to each insurer on behalf of all employees who have purchased that insurer's product. Sometimes the insurer will reimburse the employer for the administrative costs of the payroll-deduction and premium-payment service.

**Q/A-35 Are voluntary benefits subject to ERISA?**

Generally, voluntary benefit plans are ERISA plans, unless they fall within the Department of Labor (DOL) exception. Under the DOL exception, a plan must satisfy four conditions in order to be exempted from ERISA:

1. No contributions are made by an employer or employee organization;
2. Participation in the program is completely voluntary for employees or members;
3. The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues check offs and remit them to the insurer; and
4. The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues check offs.

In addition to the employer functions specifically detailed under the safe harbor, the following "ancillary" functions have also been allowed:

- Selecting the effective date of the policy;
- Verifying the full-time employment status of employees to the insurer;
- Maintaining a list of covered employees or tracking employee eligibility status;
- Providing employee information to the insurance company;
- Maintaining a file on the voluntary plan policy (containing informational materials, policy change request forms and claim forms) and then submitting coverage change forms to the insurer;
- Issuing certificates to enrolled employees confirming the commencement of coverage; and
- Selecting certain plan options in completing an insurance application (e.g., requiring that employees work for 30 days before reaching eligibility) from a list dictated by the insurer.

One of the critical inquiries in determining whether a voluntary plan will be governed by ERISA is the employer endorsement of the plan. The employer is required to be neutral. Employers have been found to have endorsed a plan where they selected the insurance company or the coverage to be provided, were involved in various aspects of plan design (plan terms, benefits, eligibility rule, etc.), associated its name with the plan, recommended a plan, said ERISA applied to the plan, did more than just collect and remit premiums, paid premiums through a cafeteria plan,

or assisted employees with claims disputes. Additionally, employee perception of the employer's endorsement of a plan is another key inquiry. Therefore employers should ensure that they fully satisfy all of the conditions above before determining that a voluntary plan meets the safe harbor requirements.

**Q/A-36 Are voluntary plans subject to group health plan laws?**

An employer that is not at first concerned about avoiding ERISA's application should consider whether its voluntary plan arrangement involves health benefits. Such an arrangement might be considered to be a group health plan for purposes of HIPAA, COBRA, and other laws that are part of ERISA. For instance, if ERISA applies to the voluntary plan arrangement, then HIPAA's rules will apply if the arrangement provides health benefits other than certain HIPAA-excepted benefits (e.g., certain dental insurance). If HIPAA applies, the employer must ensure that the arrangement complies with HIPAA's special enrollment, nondiscrimination and other requirements. As this may be easier said than done, employers might wish to consider not offering voluntary products providing health benefits that are subject to HIPAA. (While certain dental insurance could be offered on a voluntary basis without violating HIPAA, other laws such as COBRA would apply if the arrangement were found to be an ERISA plan.) Incorrectly assuming that a voluntary health plan is exempt from ERISA may make it impossible to comply with COBRA and HIPAA; first, because the plan's insurance policy is likely to be inconsistent with both COBRA and HIPAA obligations, and second, because the premium structure or other features might violate HIPAA's health-status nondiscrimination rules.

**Q/A-37 What are the consequences for an employer if its voluntary plans fail to satisfy the safe harbor?**

If an employer's voluntary plan fails to meet the requirements of the safe harbor, an employer may be subject to statutory penalties for failing to file annual Form 5500 s (unless a Form 5500 exemption applies), or not responding to participant requests for documents. An employer otherwise subject to the Form 5500 requirement might choose to make a protective Form 5500 filing for the voluntary plan just in case (although this would defeat much of the reason for relying on the safe harbor in the first place). An employer could also respond to participant requests as if ERISA applied.

General fiduciary obligations would apply to the plan under ERISA, which would require a higher standard of conduct by the employer. In addition, the voluntary plan will be out of compliance with the DOL claims procedure requirements, although the consequence—stricter review of benefit denials in court—will fall on the insurer obligated to pay the benefits, as opposed to the employer. On the other hand, ERISA's plan document and SPD requirements will be largely satisfied by the insurance policy and the descriptive booklets provided by the insurer to covered employees, although, as discussed above, insurer-provided booklets and certificates of insurance may not fully comply with ERISA's requirements.

If ERISA applies and the voluntary arrangement provides health benefits that are subject to HIPAA, COBRA and other laws, then the arrangement must comply with those laws or face considerable penalties for noncompliance (in some cases, up to $1,100 per day).