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ERISA FAQs for Health & 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 Plans, whether they are fully insured or self-insured:

- Medical, Surgical, Hospital, or HMO Plans
- Health Reimbursement Accounts (HRAs)
- Health FSAs (Flexible Spending Accounts)
- Dental Plans
- Vision Plans
- Prescription Drug Plans
- Sickness, Accident, and Disability (Disability Insurance)
- Death (Life and AD&D Insurance)
- Employee Assistance Plans (EAPs) (if providing counseling, not just referrals)
- Severance Pay Plans
- Business Travel Accident Plans
- Prepaid Legal Services
- Unemployment Benefit Plans
- Vacation Plans

- Apprenticeship or other Training Plans
- Daycare Assistance Plans
- Scholarship Plans
- Holiday Plans
- Housing Assistance Plans
- 419A(f)(6) and 419(e) Welfare Benefit 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 dependants),
- without prefunding or using insurance, and
- entirely from the employer's general assets, AND
- without employee contributions.

Voluntary insurance plans, in which Participants pay all of the cost, and the employer's role is limited to withholding premiums through payroll deduction and remitting them to an insurer, <u>may</u> 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 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 constitutes endorsement:
  - Selecting the insurer
  - Negotiating Plan terms/linking coverage to employee status
  - Using employer's name/associating Plan with other employee plans
  - Recommending Plan to employees
  - Saying ERISA applies
  - Doing more than permitted payroll deductions
  - Allowing use of employer Cafeteria Plan
  - Assisting employee with claims or disputes

  The following does NOT constitute endorsement:
  - Permitting insurer to publicize the Plan
  - Collecting premiums by payroll deduction
  - Remitting premiums to insurer

<u>ERISA generally does not apply to:</u>

- Cafeteria Plans, POPs (Premium Only Plans), or Premium Conversion Plans

Note—the benefits funded by them are often subject to ERISA

- Dependant Care Assistance Plans (DCAPs, or Dependant Care FSAs)
- Paid Time Off Plans (PTO)
- Adoption Assistance Plans
- Educational Assistance or Tuition Reimbursement Plans
- On-site Medical Clinics (if providing First Aid only—not treatment, e.g., flu shots)

ERISA Terminology

Health & Welfare Benefit Plan—a plan, fund, or program established or maintained by an employer to provide welfare benefits to its Participants and their Beneficiaries. It may be self-insured, partially self-insured, or fully insured.

Plan Sponsor—the name of the sponsoring employer.

Plan Administrator—is 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 reserved in writing properly. Note—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.

Participants and Beneficiaries—employees, former employees, their dependants and beneficiaries who are eligible to benefit from an ERISA plan.

Named Fiduciary—has the authority to control and manage the operation of the Plan, and generally decides benefit appeals. A fiduciary can be a person or an entity. 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). Fiduciary Liability insurance is important because a relatively benign mistake could turn into an expensive 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 enrollment form.

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.

Other Fiduciaries—anyone (even an employee, whether or not he is 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 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 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.

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

Plan Number—a three digit number assigned by the Plan Administrator. If there is one Welfare Benefit 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 Assets—there are at least three ways a Plan could be considered to have assets:

- Participant & Beneficiary Contributions—are Plan Assets by definition (even though participant contributions may be treated as employer contributions by the IRS for tax purposes). 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.
- 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.
- Amounts Attributable to Plan Assets—insurance company refunds, reimbursements, subrogation recoveries, and payments from stop-loss policies.

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

Trust Rule—Plan Assets must be held in a formal trust account for the benefit of the Plan, and deposits to the trust must be made within certain timeframes, except:

- Participant contributions made under a Cafeteria Plan.
- COBRA premium payments, regardless if they are made under a Cafeteria Plan.
- Participant contributions made for an insured benefit plan.

Therefore, most Participant pre-tax contributions will not need to be held in trust.

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.

Fidelity Bond—must be purchased and in place at the beginning of the Plan Year for any Funded Plan. It covers anyone who handles Plan assets, and it insures against a fiduciary's fraud or dishonesty. 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 an Unfunded Plan that accepts employee contributions that are not actually segregated from the employer's general assets.

Insurance Terminology

Insurance Companies which provide benefits to Welfare Benefit Plans are generally not responsible for an ERISA Welfare Benefit Plan's compliance—that is the sole obligation of the Plan Sponsor/Administrator/employer.

Master Contract—an insurance policy or contract 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.

Certificate of Coverage (Certificate of Insurance, Certificate Booklet, or just "Cert")—a booklet describing the terms of the insurance coverage that are 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/Coverage are often incorrectly referred to as SPDs—even by experienced benefits professionals.**

Summary of Benefits (Benefit Summary)—usually a one, two, or three page handout summarizing and highlighting the features of coverage contained in the Certificate of Coverage, e.g., deductibles, copays, coinsurance, exclusions, etc.

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.

What is a Plan Document?

The Plan Document describes the Plan's terms and conditions related to the operation and administration of a 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 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 month following satisfaction of eligibility waiting period
- How much the Participant must pay towards the cost of coverage
- 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 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 are 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 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-*Tight*℠ Plan Document—a single umbrella Plan Document and SPD, 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-*Tight*[SM] Document: It establishes a common umbrella Plan and Plan Year for all of its component benefit programs. Our Wrap-*Tight*[SM] system allows you to file a single Form 5500, avoiding the often significant costs of preparing separate Form 5500s for each plan that may be due at different times of the year because of different Plan Years of the component benefit programs. This also saves the time and expense of preparing a Plan Document and an SPD for each separate Plan. It may also save costs on independent audit fees. Importantly, a Wrap-*Tight*[SM] 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-Tight[SM] Plan Document approach is often the best way to meet the ERISA document compliance requirements for most companies.

What Information Should a Summary Plan Description (SPD) Contain?

The Summary Plan Description, or SPD, is the main vehicle for communicating Plan rights and obligations to Participants and Beneficiaries. As the name suggest, 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 <u>not</u> 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 that is not used more than once.)
- 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 Plan's fiscal records (which may be different than 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 month following satisfaction of eligibility waiting period

- How insurer refunds (e.g., dividends, demutualization) are allocated to Participants. **Note: This is important to obtain the small Plan (<100 Participants) exception for filing Form 5500.**
- Plan Sponsor's amendment and termination rights and procedures, and what happens to Plan assets, if any, in the event of Plan termination
- Summary of any Plan provisions governing the benefits, rights, and obligations of Participants under the Plan on termination or amendment of Plan or elimination of benefits
- 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 Plan Administrator or authorized Fiduciary to interpret 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 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 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 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 assure you have provided an understandable summary of the Certificate of Coverage
- Language explaining that in the event of a conflict between the Plan Document and the SPD, the Plan Document controls

How Should the SPD be Delivered?

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
- dependants of a deceased retiree under a retiree medical plan

Note—insurance companies are not required to prepare or deliver an SPD.

Unless requested, an SPD does not need to be provided separately to dependants of a covered employee or to employees who are not covered, although it is a good idea to do so.
An SPD should be furnished to Participants within 90 days after becoming covered—whether they request it or not. Plan Administrators of a new Plan must furnish 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. The DOL can impose fines of up to $110/day on an employer that fails to deliver SPDs in a timely and appropriate manner.

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 electronically, 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 the SPD on an employer's website or intranet does not necessarily satisfy this requirement because it was not affirmatively delivered to the Participant.

Electronic Distribution

Requirements for employees with work-related computer access—Definition of work-related computer access: The employee has 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 furnished 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 transmittal 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 disclosure 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 furnished 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.

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 how many Participants are covered**; there is no small plan (less than 100 Participants) exemption for the SPD, like there is for Form 5500s.

If a Participant or Beneficiary makes a written request for a copy of the Plan Document or SPD, it must be furnished within 30 days; otherwise the employer/Sponsor can face a DOL penalty of up to $110/day.

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 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.

Other Disclosure Requirements

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 furnished and delivered to Participants and Beneficiaries who receive SPDs within 9 months from the close of the Plan Year, plus 2 months extension, if the Form 5500 was extended. The DOL can impose fines of $110/day for failure to respond to a request for an SAR, and there could be criminal penalties for willful violations.

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, 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 draft 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 a 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.

A Plan Administrator must also make its documents available for inspection at his principal office. Documents must also be available for inspection within 10 days at the location of the company's principle office (if different than the Administrator's principal office) and at each location where at least 50 Participants work. Our "Wrap-Tight" approach provides you with a branded system to harness these important documents to be available when needed.

Who is Required to File Form 5500?

Form 5500 Annual Reporting—The Plan Administrator must report certain information to the DOL on a Form 5500 annually for each ERISA Plan that an employer sponsors. The deadline for filing it is 7 months after the end of the Plan Year. A 2 ½ month extension is available by filing a Form 5558. Form 5500 records must be maintained for not less than six years.

Form 5500 Exemptions—the rules are complicated, but generally, small unfunded plans, small insured plans and small partially unfunded/partially insured plans are not required to file a Form 5500. A "small" plan is one which covers fewer than 100 participants on the 1st day of the plan year. An "unfunded" plan is one which is not insured, which pays benefits from non-segregated assets and which either does not accept participant contributions or accepts participant contributions under a cafeteria plan and those contributions are not segregated from the employer's general assets.

Note—the exemption for small insured plans may be lost if a Plan Sponsor does not disclose how insurer refunds are allocated. It is 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 file Form 5500 can result in employer fines of up to $1,100/day.

Even though dependants 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. 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.

DOL Penalties—The Plan Administrator is subject to DOL penalties of up to $1,100/day for each ERISA Plan Form 5500 which is late or incomplete. This responsibility cannot be contracted away. To put this penalty into proper perspective, assume an employer has four separate Plans (e.g., a life, medical, dental, and disability plan), and filed a Form 5500 for each 45 days late. This employer could face penalties of $198,000! ($1,100/day x 45 days x 4 Plans)

A willful violation may result in criminal penalties up to $5,000 in fines and one year imprisonment for individuals, or $100,000 for corporations. 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. Penalties cannot be treated as a Plan administrative expense.

Fortunately, the DOL does have a Late Filer Voluntary Compliance Program that offers reduced penalties, 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-Tight℠ document is extremely helpful in mitigating these potential penalties.

Note: These penalties apply to each separate Benefit Plan. They are cumulative and there is no statute of limitations for these violations.

Why Should an Employer Comply With ERISA?

First of all, compliance is not optional; it's the law! Second, employers 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, they 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 pre-empts state law. ERISA limits damages to the unpaid benefits and does not provide for jury trials. Having its Plan in compliance with ERISA will help an employer avoid a lawsuit in a state court, and perhaps several different state courts. However, 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, including matters 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 all the time. Here is a brief list of actual court cases, awards, and DOL fines related to employers not being in compliance with ERISA laws pertaining to Welfare Benefit Plans:

$4,540 - Employer indifference and irresponsibility led to disclosure violations[1]

$5,215 - Employer inattentive in providing Life Insurance Plan Document and refused to furnish copy of Form 5500 to Participant until ordered to by court[2]

$9,800 - Failure to provide LTD Plan Document; employer only provided SPD[3]

$10,220 - Excessive delay in providing Severance Pay Plan Document[4]

$17,475 - Employer did not have SPD; only provided certificate of insurance to Participant; repeatedly insisted they were the same thing[5]

$17,550 - Failure to provide requested Plan Document and SPD to Participant[6]

$26,100 - Failure to respond to document request over very long time[7]

$32,850 - Delay, indifference, disregard in failure to provide copy of requested Plan Document to Participant[8]

$34,540 - Failure to provide participation agreement between employer and LTD carrier prejudiced Participant's ability to establish enrollment date[9]

$37,650 - Requested documents provided at widely spaced intervals[10]

$50,000 - Failure to file Form 5500[11]

$55,760 - Incompetence and neglect delivering insurance contracts to Participants[12]

$62,250 - Failure to deliver SPD to Participant in manner required by DOL[13]

$64,900 - Provided SPD, but failed to provide requested full Plan Document[14]

$105,840 - Plaintiff's attorney's fees in LTD claim case; award unknown[15]

$241,000 - Failure to provide SPD to Participant[16]

$5,000,000 - Cancer treatment claim wrongfully denied as experimental. State court jury trial, punitive damages[17]

$8,692,000 - Bad faith claim denial. Punitive damages. State court jury trial[18]

10 Mo.'s Prison - Plus $46,844 fine; failure to file 5500; diverting employee contributions.[19]

Award N/A - Court reversed Administrator's decision to terminate disability payments based on a *de novo* review of the facts.[20]

Footnotes:

[1] *Estate of Fields v. Provident Life &Accident Ins. Co*., 26 EBC 2401 E.D. Pa. 2001)

[2] *Neuma, Inc. v. AMP, Inc.,* 27 EBC 1983 (N.D. Ill. 2002)

[3] *Pisek v. Kindred Healthcare, Inc. Disability Ins. Plan*, 2007 WL 2068326 (S.D. Ind. 2007)

[4] *Reddy v. Schellhorn*, 38 EBC 1312 (N.D. Ill 2006)

[5] *Sunderlin v. First Reliance Std. Life Ins. Co*., 235 F. Supp. 2d 222, 29 EBC 2227 (W.D.N.Y. 2002)

[6] *Stegelmeier v. Doug Andrus Distributing Employee Health Benefit Plan*, 40 EBC 2811 (D. Utah 2007)

[7] *Daniels v. Thomas &Betts Corp*., 263 F3d 26 EBC 2132 (3rd Cir. 2001)

[8] *Lampkins v. Golden*, 1996 WL 729136 (6th Cir. 1996) (collecting cases from 1st, 3rd, 4th, 6th, 10th, and 11th Circuits)

[9] *Logan v. Unicare Life &Health Ins., Inc*., 2007 WL 1875943 (E.D. Mich. 2007)

[10] *Hemphill v. Pers. Rep. of Estate of Ryskamp*, 2008 WL 789894, as modified, 2008 WL 1696722 (E.D. Cal. 2008)

[11] *PWBA v. Compgraphix, Inc.,* 199-RIS-52 (ALJ Oct. 14, 1999)

[12] *Amschwand v. Spherion Corp.,* 37 EBC 1842 (S.D. Tex. 2006)

[13] *Leyda v. AlliedSignal, Inc*. 322 F.3d 199 (2d Cir. 2003)

[14] *Keogan vs. Towers, Perrin, Forster & Crosby, Inc.,* 30 EBC 2641 (D. Minn 2003)

[15] *Alfano v. CIGNA Life Ins. Co. of New York*, 2009 U.S. Dist. LEXIS 28118 (S.D.N.Y. Apr. 2, 2009).

[16] *Gorini v. AMP Inc.,* 117 Fed. Appex. 193 (3d Cir. 2004)

[17] *Fox v. HealthNet*, 1993 Westlaw (Riverside County Super. Ct/Central Cal.Dec. 23, 1993).

[18] *Fisher v. Aetna,* No. 3AN97-291, Alaska Super., 3rd Jud. Dist 1998.

[19] *U.S. v. Persons*, Criminal Number 6:09-cr-00012; DOL News Release No. 09-875-ATL (220), July 28,2009., (August 14, 2009)

[20] *Lundquist v. Continental Casualty Company*, No.CV 02-9602-FMO, United States District Court, Central District of California, Sept 30, 2005.