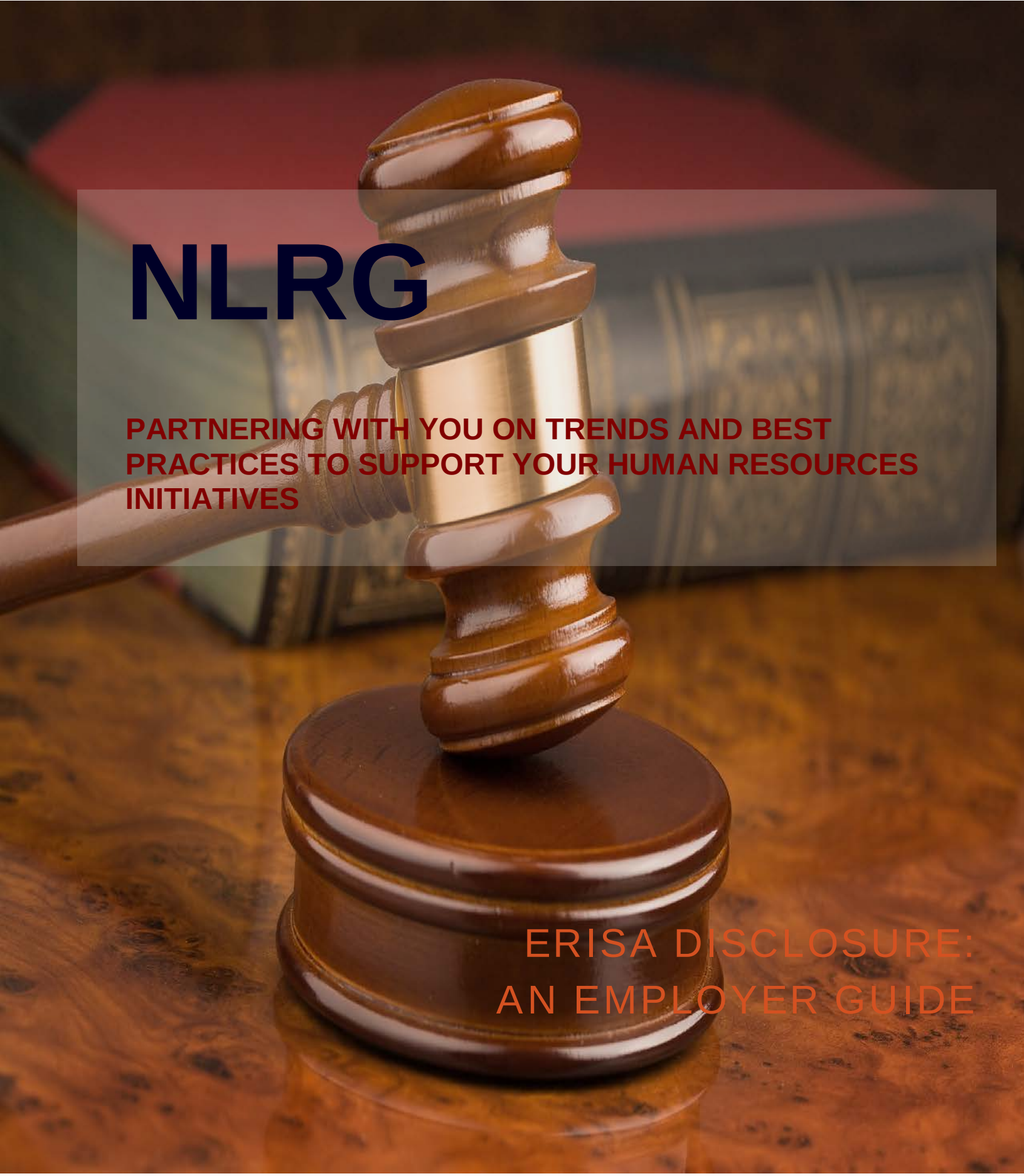

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ERISA DISCLOSURE: AN EMPLOYER GUIDE

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ERISA DISCLOSURE: AN EMPLOYER GUIDE

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- Health Care Reform: Access to Coverage and Care
- HIPAA Portability Compliance Manual
- Qualified Medical Child Support Order

Updated: August 2015

WHAT IS ERISA?

The Employee Retirement Income Security Act of 1974 (ERISA) is the main federal statute that provides the regulatory framework for employee welfare benefit plans. This Employer Guide describes the ERISA rules that pertain to welfare benefit plans only; ERISA's pension plan rules are beyond the scope of this Guide.

ERISA is divided into four Titles. Only Title I, called "Protection of Employee Benefit Rights," applies to "employee welfare benefit plans." Title I of ERISA is, in turn, divided into seven Parts—five of which apply to and impose requirements on employee welfare benefit plans.

The following Parts of Title I regulate employee welfare benefit plans:

- Part 1 (ERISA Section 101-111)—Reporting and Disclosure;
- Part 4 (ERISA Sections 401-414)—Fiduciary Responsibility;
- Part 5 (ERISA Section 501-515)—Administration and Enforcement;
- Part 6 (ERISA Sections 601-609)—COBRA Continuation Coverage and Additional Standards for Group Health Plans;
- Part 7 (ERISA Sections 701-734)—Group Health Requirements (HIPAA, Newborns' and Mothers' Health Protection Act, Mental Health Parity and Addiction Equity Act, Women's Health and Cancer Rights Act, and Patient Protection and Affordable Care Act).

Preemption of state law. A major benefit of ERISA, particularly for multistate employers, comes from ERISA's preemption of most state laws. The ERISA preemption provisions are intended to preserve flexibility for multistate employers that desire to offer a single, uniform benefit plan on a regional or nationwide basis. While the courts have given ERISA's preemption of state law a broad sweep, the exact limits of ERISA preemption continue to be heavily litigated.

Group health plan requirements. Since its enactment in 1974, ERISA has been repeatedly amended to impose an ever-increasing number of coverage standards and operational requirements on group health plans. The 2010 Health Reform Act (Patient Protection and Affordable Care Act) as amended by the Health Care and Education Affordability Reconciliation Act of 2010 has significantly added to these requirements. The scope of this Employer Guide is limited to the Reporting and Disclosure requirements of ERISA. Group health plan mandates and other ERISA compliance issues are addressed in other appropriate Employer Guides.

WHAT IS AN ERISA PLAN?

An Employee Welfare Benefit Plan has four basic elements:

- There must be a plan, fund, or program;
- That is established or maintained by an employer;
- For the purpose of providing specifically listed benefits, through the purchase of insurance or otherwise;
- To participants and beneficiaries.

Although the meaning of most of the terms found in the definition of an employee benefit plan are either self-evident or set forth in ERISA, the phrase "plan, fund or program" is not defined in the statute, but rather has been laid out in several court cases. The courts have held that a "plan, fund or program" under ERISA is established if from the surrounding circumstances, a reasonable person can ascertain the intended benefits, the class of beneficiaries, the source of financing, and the procedure to receive benefits.

No particular formalities are required to create an ERISA plan and no single action in and of itself necessarily constitutes establishment of an ERISA employee benefit plan. Thus, ERISA plans have been deemed to be "established or maintained" by a practice that would cause a reasonable employee to perceive an ongoing

commitment by the employer to provide employee benefits. This would include any contributions by the employer toward payment of benefits or by the employer simply administering the benefit.

It is easy to have a plan, fund, or program — generally any ongoing administrative scheme will satisfy this condition. Showing that an employer maintains a plan is also easy — any contribution by the employer toward payment of benefits or administration of the plan is enough (including a contribution toward insurance coverage).

Notwithstanding the above, there are several exemptions to ERISA plans which will be addressed later in this Employer Guide.

Tip: An early determination that a benefit plan is subject to ERISA is essential for the following reasons:

- ERISA creates specific duties on the part of the employer, plan fiduciaries and administrator, the breach of which may give rise to an ERISA action.
- ERISA defines and limits the available causes of action.
- ERISA gives plan participants and beneficiaries certain rights unique to actions under ERISA.

As the burden of proof is on the employer or employee organization to show that an arrangement is exempt from any ERISA provisions, an employer should review all of its practices, policies, and/or communications to ensure that an ERISA plan may not have been inadvertently "established or maintained."

ARE ALL EMPLOYEE WELFARE PLANS SUBJECT TO ERISA?

There are certain types of employee welfare benefit plans that are not covered under ERISA and are specifically excluded under the statute. Thus, the following types of benefit plans are not subject to ERISA requirements.

- Governmental plan: A plan that is established or maintained for its employees by the U.S. government, government of any state or political subdivision, or any agency of any of the foregoing, or a plan to which the Railroad Retirement Act applies. Health Care Reform amended the definition of "governmental plan" in ERISA and the Code to specifically include certain plans of Indian tribal governments. As amended, ERISA provides that plans that are established and maintained by an Indian tribal government, a subdivision of an Indian tribal government, or "an agency or instrumentality of either" are considered to be governmental plans if all of the participants in the plan are employees of such entity and substantially all of their services as employees "are in the performance of essential governmental functions but not in the performance of commercial activities (whether or not an essential government function).
- Church plan: A plan established and maintained for its employees by a church or by a convention or association of churches which is exempt from tax under Internal Revenue Code Section 501. This is sometimes a confusing exemption since the determination of whether or not a plan is maintained by a church is not always that clear. If there is any doubt about the direct connection between the plan and the employees it covers, the employer should seek additional advice from its legal counsel.
- A plan maintained to comply with state laws on workers' compensation, unemployment or mandated disability insurance.
- A plan maintained outside the U.S. primarily for nonresident aliens.
- Plans that cover only self-employed individuals which cover no "common-law employees" generally are not subject to ERISA, although Part 7 of ERISA Title I (imposing portability and other standards on group health plans) expressly applies to plans covering partners.
- Plans that cover only married shareholders of a corporation are not treated as ERISA plans.

However, these statutory exemptions are specific to ERISA. An employer should be aware that it may be required to comply with other federal laws that affect employee benefit plans, such as HIPAA or the Mental Health Parity and Addiction Equity Act. The Public Health Service Act ("PHSA") governs non-federal governmental plans and health insurance issuers. Based on the PHSA, plans that are statutorily exempt from ERISA will have other compliance issues.

EMPLOYEE WELFARE BENEFITS

An ERISA health and welfare plan provides:

- Medical, surgical or hospital care or benefits;
- Benefits in the event of sickness, accident, disability, death or unemployment;
- Vacation benefits
- Apprenticeship or other training benefits;
- Day care centers;
- Scholarship funds; and
- Prepaid legal services.

Some examples include: medical insurance, dental, vision, prescription drug plans, drug or alcohol treatment programs, health Flexible Spending Accounts (FSAs), Employee Assistance Programs, Wellness Programs, AD&D, and short and long term disability benefits.

ERISA EXCEPTIONS: EMPLOYEE BENEFIT PRACTICES AND PROGRAMS

Department of Labor ("DOL") regulations specify certain practices and programs providing benefits to employees that are not considered welfare benefit plans subject to ERISA.

Payroll Practices

The payment of an employee's normal compensation in full or in part out of the employer's general assets for periods when the employee is physically or mentally unable to work — that is, an unfunded short-term disability plan—is generally not a welfare benefit plan subject to ERISA. However, if a disability program provides more than an employee's normal compensation or is funded in any way — for example, it is provided through insurance — the program will be a welfare benefit plan subject to ERISA.

Furthermore, the DOL regulations also list additional types of payroll practices as not being ERISA plans. These would include plans where compensation is paid to an employee:

- While absent on a holiday or vacation;
- While absent on active military duty;
- While absent for the purpose of serving as a juror or as a witness in an official proceeding;
- On account of periods of time during which the employee performs little or no productive work while engaged in training; or
- Who is relieved of duties while on sabbatical leave or while pursuing further education.

Voluntary Benefits

When most people think of voluntary plans, they think of insurance coverage offered to employees on a voluntary basis, with employees paying the entire 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. While voluntary plans are often suggested to employers by their insurance agents, it has become increasingly common for employees to ask their employer to offer voluntary plans (particularly if the employer does not offer benefits, or where employees wish to supplement existing employer-sponsored benefits).

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. However, just because an employee pays for the entire cost of the coverage, the plan might not actually be a voluntary plan under ERISA. Therefore, careful consideration of the plan and its administration must be undertaken before assuming that the plan is not subject to ERISA.

DOL regulations contain a "safe harbor" from the ERISA plan definition for certain voluntary insurance arrangements, under which employees pay the full premium and the employer has minimal involvement. In order

for a voluntary arrangement to be exempt from ERISA based on the DOL safe harbor, it must meet the following requirements:

- No employer or employee organization contributions;
- Participation is completely voluntary;
- No employer consideration except for reasonable compensation for administration; and
- No employer endorsement. An employer can publicize, collect premiums, remit premiums, provide employee information to an insurance company and maintain a file on the voluntary plan. However, an employer cannot express positive normative judgment and cannot urge/encourage employee participation.

Many voluntary or “employee-pay-all" arrangements fail to qualify for this exemption because the employer directly or indirectly "endorses" the program as its own.

Several formal opinions have been published by the DOL addressing the issue of when an employer or employee organization has "endorsed" a welfare benefit plan. The exemption depends in large part on whether the insurance company or an enrollment firm offers the plan, rather than the employer. The DOL’s position is that the level of involvement by the employer or the employee organization is "the key for determining whether a plan is exempted under the regulations." The participation of the employer or employee organization should be limited to the duties specified in the regulation, none of which involve the exercise of discretionary duties. An employer hoping to rely on this exemption should also be careful not to create the impression that the benefit is part of its benefit package by, for example, including it in enrollment materials or encouraging employees to enroll. In a number of opinion letters, the DOL has described the following activities as those which exceed the limited involvement contemplated by the regulations:

- Assistance in the preparation of claims forms;
- Receipt of the contract in the employer’s name;
- Employer’s choosing of the insurance company and the coverage;
- Negotiating with the insurer;
- Sending premium notices and collecting premiums as directed by the insurer and transmitting premiums to the insurer other than through a payroll deduction or dues check-off;
- Recordkeeping;
- Sending descriptive literature under the name of the employer or employee organization;
- Administration of a fund by trustees appointed by, and subject to removal and replacement by, the union and employers who are signatory to the trust agreement;
- Involvement in the discretionary administration of the arrangement;
- Permitting payment of premiums on a pre-tax basis through the employer’s Section 125 plan.

Some court cases have approved of such activities, determining that a plan is still considered “voluntary.” To avoid confusion on the part of participants, many employers specifically disclaim status as an ERISA plan. However, plan sponsors should be mindful that merely disclaiming ERISA status may not protect the benefit from ERISA requirements if the facts and circumstances would indicate that the benefit is, in fact, subject to ERISA. The DOL warns in the final FMLA regulations that if a plan is intended to be exempt from ERISA under this provision, the employer should not pay an employee’s premium while he or she is on FMLA leave. The same warning applies for other types of unpaid leaves.

The courts are more lenient than the DOL in determining whether there has been "endorsement." According to the courts, an employer may select carriers and negotiate rates if the employer acts only as an honest broker and remains neutral vis-à-vis the plan’s operation. Courts have traditionally viewed any such arrangement from the vantage point of an "objectively reasonable" employee and have carefully considered whether that employee would conclude from the employer’s actions that the employer had exercised control over the program or made it appear like part of the employer’s own benefit package.

Tip: An employer offering voluntary benefits should review its practices regarding its involvement with the benefits, including the manner in which they are communicated to employees and how they are paid. The plan administrator should train any supervisors, managers, or others dealing with benefits in the proper communication of all its benefits to employees.

IMPORTANT DEFINED TERMS UNDER ERISA

PLAN ADMINISTRATOR/PLAN SPONSOR

A plan administrator is a person with statutory responsibility for ensuring that all of the required filings with the federal government are timely made and the person upon whom the statute imposes authority to make important disclosures to participants about plan benefits. Generally, the plan administrator is designated in the plan document (more about plan documents later). However, if the plan administrator is not so designated, then the responsibility defaults to the plan sponsor, which is usually the employer. Generally in a single employer situation, the employer is the plan administrator. Therefore, the employer is ultimately responsible for all reporting and disclosure requirements and should implement a process to make certain those responsibilities are being followed.

PARTICIPANT

The definition of participant has been interpreted broadly to include "employees in or reasonably expected to be in, currently covered employment." This would include employees who are eligible for a plan but who are not enrolled. However, employees in a class not eligible to participate in a plan are not "participants" under the ERISA definition. In addition, because the definition is not limited to current employees, it can include COBRA qualified beneficiaries, covered retirees, and other former employees who may remain eligible under a plan.

A participant has the rights provided under the plan in question, and the plan's fiduciaries owe fiduciary duties to plan participants. A participant may sue under ERISA Section 502 for plan benefits and to remedy violations of ERISA Title I. A participant also has the right to request and examine copies of plan documents. Welfare plan participants do not have the right to receive automatic copies of the SPD or summaries of material modifications unless they are covered by the plan in question.

Furthermore, an individual ceases to be a participant in a welfare benefit plan on the earliest date on which (1) the individual becomes ineligible to receive any plan benefit even if the contingency for which the benefit is provided occurs, and (2) the individual is not designated by the plan as a participant.

BENEFICIARY

A beneficiary is any person designated by a participant (or by the terms of an ERISA plan) who is or may become entitled to a benefit under the plan. For example, a COBRA spouse or dependent child would be treated as a beneficiary because of entitlement to benefits under a group health plan subject to COBRA, as would an assignee of benefits under a medical plan (e.g., a health care provider) or under a life insurance plan. A beneficiary has the rights provided under the plan in question, and the plan's fiduciaries owe fiduciary duties to plan beneficiaries as well as plan participants. A beneficiary may sue under ERISA Section 502 for plan benefits and to remedy violations of ERISA Title I. A beneficiary also has the right to examine and request copies of plan documents. However, most *welfare* plan beneficiaries do not have the right to receive automatic copies of the SPD or summaries of material modification.

WHAT ARE ERISA'S MAIN REQUIREMENTS?

ERISA provides significant protections for participants in employee welfare benefit plans and their beneficiaries. ERISA imposes a variety of reporting and disclosure requirements on administrators of welfare benefit plans. These requirements mandate that certain financial and other plan information be reported to the Internal Revenue Service (IRS) and the Department of Labor (DOL) and be disclosed to plan participants and their beneficiaries.

This Employer Guide is limited to the disclosure requirements under ERISA.

Disclosure Requirements	Reporting Requirements
Plan Document must exist for each plan.	Form 5500 must be filed annually for each plan (subject to important exemptions).
Summary Plan Description (SPD) must be furnished automatically to plan participants.	Summary Annual Report (SAR) must be furnished automatically to plan participants for plans required to file a Form 5500.
Summary of Material Modifications (SMM) must be furnished automatically to participants when a plan is amended.	
A four page Summary of Benefits and Coverage (SBC) must be provided to "applicants and enrollees" before enrollment or re-enrollment.	
Copies of certain plan documents must be furnished to participants and beneficiaries upon written request.	
Claim procedures must be established and followed when processing benefit claims and when reviewing appeals of denied claims.	

ERISA also mandates standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and provides appropriate remedies, sanctions, and access to the federal courts when these responsibilities have been breached.

Other ERISA Requirements
Plan assets, including participant contributions, may be used only to pay plan benefits and reasonable administration costs.
For some plans, plan assets may have to be held in trust.
Plan assets, including participant contributions, may be used only to pay plan benefits and reasonable administration expenses.
Fidelity bond must be purchased to cover every person who handles plan funds.
Group health plans must conform to applicable mandates like COBRA and HIPAA.

FOR MORE INFORMATION REGARDING GROUP HEALTH PLAN MANDATES, SEE HEALTH AND WELFARE BENEFITS: AN EMPLOYER GUIDE

WHAT IS A PLAN DOCUMENT?

ERISA requires that every ERISA health and welfare plan be established and maintained in writing and the scope of an ERISA plan is defined by the official plan document. The plan document describes the plan's terms and conditions related to the operation and administration of a plan. The written instrument should be adopted by the employer. An insurance company's master contract, certificate of coverage, or summary of benefits is usually not sufficient to serve as a legal plan document and rarely fully protects the plan sponsor.

Importance of Meeting Written Document Requirement

- Every plan participant has the right to examine the plan document.
- ERISA benefit plans must be administered strictly in accordance with the documents and instruments governing the plan.

What IS NOT a Plan Document?

- An insurance company's Master Contract.
- A certificate of coverage.
- An insurance company's summary of benefits.

INFORMATION THAT MUST BE IN A PLAN DOCUMENT

- Name of Plan Administrator;
- Designation by name, or according to a procedure contained in the plan, of one or more fiduciaries with authority to control and manage the operation and administration of the plan;
- A procedure for establishing and carrying out a funding policy and method consistent with the objectives of the plan and with ERISA requirements;
- How much the participant must pay toward the cost of coverage;
- A description of any procedure for allocating responsibilities for plan operation and administration;
- A procedure for amending the plan and for identifying those persons with authority to amend the plan;
- A statement of the basis on which payments are made to the plan, such as contributions from the employer, employee, or both;
- A description of the benefits provided, including the elective COBRA continuation of group health plan coverage benefits specifically mandated by ERISA;
- Who is eligible to participate, e.g., classes of employees, employment waiting period, and hours per week (the eligibility provision should include so-called "Microsoft" language explaining (1) that the employer's classification of individuals as employees or as non-employees at the time of an eligibility determination is conclusive for purposes of plan eligibility, and (2) that any later ruling or determination that the employer's classification was incorrect will not result in the individual becoming retroactively eligible or ineligible to participate);
- The effective date of participation, e.g., next day or first day of month following employment;
- The treatment of insurance refunds, rebates, experience returns and similar payments for benefits that are fully insured;
- The provision that the plan administrator has "discretionary authority" to interpret and administer the plan and to make factual determinations;
- 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, hospital stays for newborns and mothers, parity in the application of certain limits to mental health benefits, coverage for reconstructive surgery in connection with mastectomy, claims and appeals process, external review for self-insured non-grandfathered plans; and
- Other substantive provisions relevant for particular plans regarding, for example, subrogation and reimbursement clauses, coordination of benefits, and whether the plan is grandfathered.

What If There is No Plan Document?

An ERISA plan may still exist even if no plan document exists. A plan administrator's failure or refusal to put a plan in writing is merely a violation of ERISA and does not avoid coverage of the plan by ERISA. Failure to have a plan established in writing can be a liability to an employer in various circumstances.

- Participants and beneficiaries may bring suit to enforce ERISA's written plan document requirement. Legal action may require the preparation of a formal document where none currently exists.

- A plan document must be furnished in response to a participant's written request. The plan administrator may be charged up to $110 per day if the document is not provided within 30 days of a request.
- Criminal penalties may be imposed on any individual or company that willfully violates any requirement of Title I of ERISA, which includes disclosure rules. The penalty per conviction could be $100,000 and/or imprisonment for up to ten years. The fine can be increased up to $500,000 if it is against a company.
- Without a plan document, it can be difficult to prove plan terms and thus enforce plan provisions.
- Participants and beneficiaries who sue to enforce informal, *unwritten* plans can base their claims on past practice or other evidence outside the actual terms of a written document that is favorable to their position.
- A plan sponsor may not be able to amend or terminate an informal plan until it first adopts a written plan instrument complete with the required ERISA procedure for amending the plan and for identifying persons having authority to amend the plan.
- ERISA requires a fiduciary to act "in accordance with the documents and instruments governing the plan." This duty provides yet another incentive for careful plan drafting since, once reduced to writing as part of the plan document, plan language must generally be followed.

IS A PLAN DOCUMENT NEEDED FOR EACH BENEFIT AN EMPLOYER OFFERS?

Many of ERISA's requirements apply directly (or indirectly) on a plan-by-plan basis. There are no hard-and-fast rules for determining how many plans an employer sponsors. As a consequence, the plan sponsor is generally free to determine the number of plans it maintains for ERISA compliance purposes. Determining and declaring the number of plans is an important part of the plan design process.

Multiple benefits can be bundled in a number of ways.

Single Bundled Plan with All Benefits	Plan Bundled on Configuration			Plan Bundled According to Classification	
Plan 501	Plan 501	Plan 502	Plan 503	Plan 501 Union Employees	Plan 502 Non-Union Employees
Medical	Medical	Short Term Disability	Group Term Life	Medical	Medical
Dental	Dental	Long Term Disability		Dental	Dental
Vision	Vision	ADD		Vision	Vision
Short Term Disability	EAP			EAP	EAP
Long Term Disability				Short Term Disability	Short Term Disability
Group Term Life				Long Term Disability	Long Term Disability
ADD				ADD	ADD
EAP				Group Term Life	Group Term Life

For example, the plan sponsor may choose to establish a single "bundled" plan through which all fringe benefits are provided. Alternatively, it could bundle different groups of benefits in different configurations (e.g., health, dental, vision, and employee assistance under one plan; short-term disability and long-term disability under another plan). Where more than one option is provided for a particular type of benefit (e.g., medical benefits), each option could be treated as a separate plan (e.g., self-insured medical option as a separate plan, HMO option as a separate plan, indemnity option as a separate plan). Benefits could also be bundled according to the class (or classes) of participants who receive the benefits (e.g., one plan for benefits provided to union-represented employees and another plan for benefits provided to nonunion employees).

The plan sponsor might also treat each type of benefit as a separate plan (e.g., medical, dental, vision, life, long-term disability, short-term disability, employee assistance). Where insured benefits are involved and there is no wrapper document that bundles the benefits together into one plan, it is likely that each insurance contract will be considered a separate welfare benefit plan.

Example: Calculation of Penalties. Through separate group insurance contracts, Employer A offers its employees medical, dental, and long-term disability coverage. At some point in the history of the coverage, the number of participants under each contract exceeds the 100-participant threshold for Form 5500 filing purposes, but Employer A fails to file any Form 5500s. If the DOL later discovers this fact on audit, it will likely view Employer A as maintaining three separate plans and having several late annual filings to which separate penalties apply (as opposed to maintaining a single bundled benefit and having one late filing penalty per year).

WHAT IS A WRAPPER PLAN DOCUMENT?

A "wrapper plan document" is the typical way of supplementing an insurance company's certificate of coverage or insurance contract with the missing ERISA provisions. The "wrapper document" should make clear to the participants that its contents and the carrier's documents together constitute the plan document for the plan.

Wrapper Summary Plan Description: The same application of a "wrapper" for a plan document is also appropriate for a "wrapper summary plan description." This type of wrapper supplements an insurance carrier's benefit book or summary of benefits with the missing ERISA provisions in order to create an SPD.

WRAPPER PLAN DOCUMENT FOR A BUNDLED PLAN

If more than one benefit program is included under a single ERISA plan number (e.g., health, vision, dental, and employee assistance plan benefits), then a wrapper plan document should be prepared to evidence the bundled approach. The result will be a single plan document that lists all of the welfare benefit options under that ERISA plan number.

When multiple contracts or benefit arrangements are bundled under a single wrapper plan document, differences among the parts are inevitable. These differences should be identified and addressed at the outset as a matter of wrapper plan design.

WHAT IS A SUMMARY PLAN DESCRIPTION?

The Summary Plan Description (SPD) is the main vehicle for communicating plan rights and obligations to participants and beneficiaries. As the name suggests, it is generally a summary of the material provisions of the plan document.

ERISA provides that an SPD must be "written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan." Great care must be taken in composing the SPD language to meet these two, often conflicting, requirements. In addition, plan sponsors generally want SPDs and other communication materials to convey positive messages to employees about their benefits.

The information contained in an SPD is crucial, since some courts may rely on the SPD language if a conflict arises between the plan and the SPD in regard to the description of benefits or eligibility conditions. It is critical to assure that all plan information in the plan document is also included in the SPD and vice versa. SPDs should outline the terms of the plan as well as state that the plan document controls where there are differences between

the plan document and the SPD. Finally, an SPD should state that the plan administrator has broad discretionary authority to determine eligibility for benefits and to construe the terms of the plan.

INFORMATION THAT MUST BE IN A SUMMARY PLAN DESCRIPTION

An SPD Must Contain All of the Following Information	
Name of the plan.	Description of circumstances resulting in disqualification, ineligibility or denial or loss of benefits.
Name, address, and phone number of plan sponsor/administrator.	Amendment and termination provisions, authority and reservation of rights.
Plan sponsor's EIN, and plan number.	Rights of participants regarding termination or amendment of plan.
Type of plan (medical, dental, etc.).	Subrogation provisions.
Type of plan administration (contract, insurer, etc.).	Plan contributions and funding.
Name of insurer, HMO or Third Party Administrator responsible for plan financing, administration or claims payment.	Claims and appeals procedures. Prohibition on rescission of coverage.
Name, title and address of any trustee or trustees.	Statement of ERISA rights.
Statement that plan administrator or trustee may be served with legal process.	Offer of assistance in non-English language.
Statement that records are kept on a calendar, policy or fiscal year.	Description of the cost sharing provisions in the plan, such as premiums, deductibles, co-insurance, co-payments (out-of-pocket maximums for non-grandfathered plans on or after January 1, 2014), annual and lifetime caps with no annual limits on essential health benefits for plan years beginning on or after January 1, 2014, and a description of coverage, including, among other things, coverage of tests, devices, providers, emergency care, pre-authorization/utilization review requirements, and coverage of routine patient costs in connection with clinical trials by non-grandfathered plans on or after January 1, 2014.
Date on which the plan year ends.	HIPAA pre-existing condition and special enrollment disclosures, the need for which ends as of December 31, 2014 with the elimination of pre-existing conditions under PPACA.
Relevant provisions of any collective bargaining agreement.	Minimum hospital stays after childbirth disclosures (Newborns' and Mothers' Health Protection Act).
Requirements for eligibility to participate in the plan, including children up to age 26 to the extent the plan covers birth, adopted,	Mental health parity information.

step or foster children.	
Description of plan benefits.	Reconstructive surgery after mastectomy disclosures (WHCRA).
Description of circumstances resulting in disqualification, ineligibility or denial or loss of benefits.	Description for the procedures for a Qualified Medical Child Support Order (QMCSO) or a statement that participants and beneficiaries can obtain the procedures without cost.
Waiting period not to exceed 90 days.	Provisions of any wellness program.

Samples of the various forms for the different steps in the claims and appeals process can be found in the Appendix.

Claims Procedures

One of ERISA's basic purposes is to protect promised benefits. Thus, to help accomplish this purpose, the ERISA statute and DOL requires specific claim procedures to be established in the plan's SPD under which benefits can be requested by participants and beneficiaries, and disputes about benefit entitlements can be addressed.

Health care reform law and implementing regulations have changed the existing claims procedure rules to add enhanced internal claims and appeals requirements and make external review procedures applicable for both group health plans and health insurers. Although generally effective for plan years beginning on or after September 23, 2010 (i.e., January 1, 2011 for calendar-year plans), certain health care reform requirements are subject to an enforcement grace period.

Basic Structure of Required ERISA Claims Procedures

The basic steps in an internal claims and appeal procedure are as follows:

- a claim for benefits by a claimant or authorized representative;
- a benefit determination by the plan, with required notification to the claimant;
- an appeal by the claimant or authorized representative of any adverse determination; and
- the determination on review by the plan, with required notice to the claimant.

Additional notices are required when (a) a pre-service claim is incorrectly filed (e.g., is not in compliance with the plan's procedures), and (b) an urgent care claim is filed but is incomplete. The plan may provide for additional

required or voluntary appeals, however, the DOL claims regulations limit group health claims to a maximum of two required appeals and impose certain other restrictions on additional appeals. Effective for plan years beginning on or after September 23, 2010 (i.e., January 1, 2011 for calendar-year plans), health care reform and its implementing appeals regulations make external review applicable for both group health plans and health insurers, although an enforcement grace period applies with respect to certain requirements

The timing of the claims procedure is governed by the type of claim. As previously noted, a claim may be typical post-service, pre-service or urgent. Furthermore, timing and claims procedures are determined by the type of benefit that is provided, whether it is under group health plan coverage, disability or life insurance.

When SPD Information Changes

After the original SPD has been provided to plan participants, changes will often be made to the plan. Any changes made to the information contained in the original SPD must be reported to plan participants. This can be accomplished in two ways — either the employer can prepare a new SPD or the employer can produce a Summary of Material Modifications (SMM). There is no specific format for an SMM other than the title "Summary of Material Modifications" at the top of the page.

Below is a sample format for an SMM:

Sample Summary of Material Modifications Format

[Name of employer] sponsors the [name of the plan] Plan, Plan Number ___ and hereby provides notice of the following change(s) which take(s) effect on [date].

[Describe what is happening under the plan – for example, "The plan sponsor added the following new benefit options to the plan:" It is always helpful to reference the location of the material within the SPD that is being changed by the SMM.]

In the event of a "material reduction" in covered services or benefits provided under a group health plan, the plan administrator must furnish participants with a description of the modification or change within 60 days after the adoption of the modification or change. Alternatively, the plan administrator may provide such information at regular intervals at least every 90 days.

The DOL defines a "material reduction" under a health plan as any modification or change that:

- Eliminates benefits payable under the plan;
- Reduces benefits payable under the plan (for example, from a change in formulas, methodologies, or schedules that serve as the basis for benefit determinations);
- Increases deductibles, copayments, or other amounts paid by a participant or beneficiary;
- Reduces the service area covered by an HMO; or
- Establishes new requirements (for example, pre-authorization requirements) to obtain services or benefits.

When is a New SPD Required?

At a minimum, ERISA requires employers to prepare new SPDs and distribute them to participants at least every 10 years. For many plans, however, a five-year rule applies. A new SPD must be distributed to plan participants every five years if there has been a material change in the plan during that time.

Each time a new SPD is distributed, a new 5- or 10-year clock begins to run.

Who Must Receive an SPD or an SMM and When?

The plan administrator must distribute the original SPD to participants within 120 days after the plan becomes subject to ERISA. For newly hired employees, an SPD should generally be furnished no later than 90 days after the employee becomes a participant.

- Covered employees (participants).
- COBRA participants.
- Parents or guardians of children covered under a qualified medical child support order.
- Dependents of a deceased retiree under a retiree medical plan.

When an SMM or subsequent SPD is prepared, it generally must be provided to plan participants no later than 210 days after the close of the plan year in which the material changes were made. Neither a retroactive nor a prospective effective date of the amendment will change the general SMM due date; the due date depends on the plan year and/or the adoption year.

SMMs related to a material reduction in covered services or benefits under a group health plan must be distributed within 60 days after the adoption of the modification or change (unless the plan provides a disclosure every 90 days regardless of any changes made).

Foreign-Language-Speaking Participants and Disclosure

If there is a specified number of foreign-language-speaking plan participants (see table below), the employer must follow special rules in preparing the SPD or SMM.

If a plan falls into one of these categories, a foreign language SPD or SMM can be provided. Alternatively, the employer can include a statement, prominently displayed, and in the non-English language, telling how, when, and where participants can receive an oral, non-English explanation of the plan. A sample written explanation, which could be translated into the non-English language and used in an SPD, is provided below.

Total Number of Plan Participants	Number of Participants Literate in the Same Foreign Language
Fewer than 100	25% or more
100 or more	Either 10% or 500 or more (whichever is the lesser)

Foreign Language Statement

The following is a sample written explanation, which could be translated into the non-English language and used in an SPD:

> This Summary Plan Description and booklet contain a summary in English of your plan rights and benefits under _____ Group Health Insurance Plan. If you have difficulty understanding any part of this Summary Plan Description or booklet, contact the Plan Administrator at _____. Office hours are from _____ to _____ Monday through Friday. You may also call the Plan Administrator's office at _____ for assistance.

NOTE: The Plan Administrator is responsible for preparing and delivering an SPD, SMM or a notice of material reduction in benefits.

DISTRIBUTING AN SPD, SMM OR OTHER REQUIRED ERISA NOTICE

SPDs and SMMs must be furnished in a manner "reasonably calculated to ensure actual receipt of the material." Acceptable methods include:

- In-hand delivery to employees;
- First class mail;
- Second or third class mail, but only if return and forwarding postage is guaranteed and address correction is requested; or
- Inclusion in a union or company publication, but only if the mailing list for the publication is complete and up-to-date, and notice that the information is contained in the issue is displayed prominently on the cover, and steps are taken to ensure delivery to participants not on the mailing list.

Electronic Distribution of Documents

Electronic transmission is an emerging option for plan administrators. Disclosure to participants (both employees and non-employees) may be made electronically (for example, by e-mail, an intranet or the Internet). This option is not without limit, however. The DOL issued a safe harbor rule, meaning that plans are not required to comply with its conditions; however, compliance ensures that the DOL will find a plan's electronic delivery method acceptable. As outlined in the rule, all **ERISA Title I plan documents and notices, including SPDs, SMMs, and SARs, may be furnished electronically.**

Work-Related Access

The employee has the ability to access documents at any location where they could be reasonably expected to perform employment duties. Access to the employer's electronic system must be an integral part of their employment duties.

Compliance with the safe harbor rule for electronic distribution depends on whether the plan participant has work related computer access or non-work computer related access.

EMPLOYEES WITH WORK RELATED COMPUTER ACCESS
Electronic materials must be prepared and furnished in accordance with other applicable requirements, i.e., timing, format and content requirements.
A notice must be provided to each recipient, at the time 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 a change; ■ The procedures for withdrawing consent and updating information, i.e., 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 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.
The above steps for those with work-related computer access must also be followed.

WHAT ABOUT THE FOUR PAGE SUMMARY OF BENEFITS AND COVERAGE UNDER HEALTH CARE REFORM?

ERISA's disclosure requirements have been expanded by Health Care Reform's requirement to provide a four-page "summary of benefits and coverage" to applicants and enrollees before enrollment or re-enrollment. The summary (referred to as the SBC) must accurately describe the "benefits and coverage under the applicable plan or coverage." The SBC requirement applies in addition to ERISA's SPD and SMM requirements. The requirement applies beginning with the first open enrollment period beginning on or after September 23, 2012 for participants and beneficiaries enrolling or re-enrolling through open enrollment. For individuals enrolling other than through open enrollment (e.g., newly eligible individuals or special enrollees), the requirement applies beginning on the first day of the first plan year that begins on or after September 23, 2012.

WHO PROVIDES THE SBC?

The group health plan or, if applicable, the health insurer is required to provide an SBC to plan participants and beneficiaries (as defined by the Employee Retirement Income Security Act (ERISA). This would include eligible or enrolled employees, dependents, COBRA participants and children covered pursuant to qualified medical child support orders). If the group health plan is self-insured, the plan administrator (employer) has the obligation to provide the SBC to participants and beneficiaries. If the plan is fully insured, both the plan and insurer have the obligation. In order to prevent them from duplicating efforts, the regulations provide that a responsible party can satisfy the SBC requirement if a complete SBC is provided by another party on a timely basis.

Who Provides the SBC	
Fully Insured	Plan Administrator/Insurer
Self Insured	Plan Administrator (Employer)

WHO MUST BE PROVIDED THE SBC AND WHEN?

Generally, the SBC must be distributed to all applicants (at the time of application), policyholders (at issuance of the policy), and enrollees (at initial enrollment and annual enrollment). According to the proposed regulations, the plan (including the plan administrator) and the insurer must automatically provide an SBC to participants and beneficiaries with respect to each "benefit package" for which the participant or beneficiary is eligible. In addition, the regulations propose that the insurer must automatically provide the SBC to a group health plan upon application, renewal, or request.

INSURERS PROVIDE TO GROUP HEALTH PLAN (Employer/Plan Sponsor)	
Upon an application or request for information by the plan about the health coverage:	As soon as practicable following the request, but no later than seven days after the request.
If plan subsequently applies for coverage:	A new SBC is not required unless there has been a change in the terms.
If information is changed before coverage is offered:	Provide a new SBC no later than the date of offer or first day of coverage.
Upon written application for renewal:	No later than the date materials are distributed.
Automatic renewal:	No later than 30 days prior to the first day of the new policy year.
Upon request from the group health plan:	As soon as practicable, but no later than seven days following the request.

PLAN OR INSURER PROVIDES TO PARTICIPANTS AND BENEFICIARIES			
Occurrence	SBC for currently enrolled benefit plan	SBC for all eligible benefit options	Timing
Open Enrollment (Renewal)	✓		A new SBC must be provided no later than the date the renewal materials are distributed.
Automatic Renewal	✓		No later than 30 days prior to the first day of the new plan year.
Initial Enrollment		✓	As part of any written application materials that are distributed by the plan or insurer for enrollment OR no later than the first date the participant is eligible to enroll in coverage for the participant and any beneficiaries.
Special Enrollment		✓	Within 90 days after enrollment pursuant to a special enrollment right.
Upon Request	✓		As soon as practicable, but in no event later than seven days following the request.

SBC CONTENT

The statute requires that the SBC must be presented in a uniform format, utilize terminology understandable by the average plan participant, not exceed four pages in length, and not include print smaller than 12-point font. While the health care reform law called for a four-page summary, the proposed regulations interpret the four-page limitation as four *double-sided* pages. This will give employers additional flexibility in providing the required information.

In addition, the SBC must be provided as a stand-alone document. It also must be presented in a uniform format, use terminology understandable by the average plan enrollee and not include print smaller than 12-point font.

The SBC must be presented in a culturally and linguistically appropriate manner. In general, the rules provide that, in specified counties of the United States, plans and insurers must provide interpretive services, and must provide written translations of the SBC upon request in certain non-English languages. In addition, in such counties, English versions of the SBC must disclose the availability of language services in the relevant language. The counties in which this must be done are those in which at least 10% of the population residing in the county is literate only in the same non-English language. The amended interim final regulations implementing the appeal process and external review requirements under health care reform include a chart listing U.S. counties in which the 10% threshold is met—this determination is based on U.S. Census data

The SBC must contain the following information:

- Uniform definitions of standard insurance and medical terms so that consumers may understand and compare health insurance coverage and exceptions to coverage;
- Description of the coverage, including the cost sharing, for each category of essential health benefits and other benefits identified by Health and Human Services (HHS);
- Exceptions, reductions and limitations on coverage;
- Cost sharing, including deductibles, coinsurance and copayments;
- Renewability and continuation of coverage provisions;
- Coverage examples that illustrate benefits provided under the plan for pregnancy, for serious and chronic medical conditions and for other common benefit scenarios (the examples in the proposed regulations include a normal childbirth, treatment for breast cancer and diabetes management) and related cost-sharing based on recognized clinical practice guidelines;
- For coverage beginning on or after January 1, 2014, statements of whether the coverage is minimum essential coverage (MEC) and has at least 60% actuarial value;
- Statement that the four-page summary is a summary and that other documents should be consulted to determine the coverage terms;
- Contact information (e.g., phone number, internet web address, etc.) for questions and obtaining a copy of the plan document or insurance policy;
- For plans that maintain one or more networks of providers, an internet address (or similar contact information) for obtaining a list of network providers;
- For plans that use a formulary in providing prescription drug coverage, an internet address (or similar contact information) for obtaining information on prescription drug coverage;
- An internet address for obtaining the uniform glossary; and
- Information on premiums for insured coverage or the cost of coverage for self-insured coverage.

Updating the SBC: Notice of Material Modifications

A group health plan or insurer must provide a notice of material modification if it makes a material modification in any of the terms of the plan that is not reflected in the most recently provided SBC. Only material modifications that would affect the content required in the SBC would require plans and insurers to provide this notice. In these circumstances, the notice must be provided no later than 60 days prior to the date on which such change will become effective, if it is not reflected in the most recent SBC provided and occurs other than in connection with a renewal (i.e., mid-plan year). The notice may be provided in paper or electronic form, in accordance with the requirements discussed above for providing the SBC.

A material modification could be an enhancement of covered benefits or services or other more generous plan terms. It includes, for example, coverage of previously excluded benefits or reduced cost-sharing. A material modification could also be a material reduction in covered services or benefits, or more stringent requirements for receipt of benefits. As a result, it also includes changes or modifications that reduce or eliminate benefits, increase premiums and cost-sharing, or impose a new referral requirement.

This requirement for an advance notification could be satisfied either by a separate notice describing the material modification or by providing an updated SBC reflecting the modification. Note that, for ERISA-covered group health plans, this notice is in advance of the timing required for providing an SMM (generally, not later than 210 days after the close of the plan year in which the modification or change was adopted, or, in the case of a material reduction in covered services or benefits, not later than 60 days after the date of adoption of the modification or change). In situations where a complete notice is provided in a timely manner under these rules, an ERISA-covered plan will also satisfy the requirement to provide an SMM under ERISA.

ARE THERE ANY PENALTIES?

There are no specific monetary penalties for failure to distribute SPDs, SMMs or Summary Annual Reports (SARs addressed below). However, a plan sponsor may be charged $110 per day if it does not provide a plan participant with an SPD or SMM within 30 days of an individual's request. In addition, the DOL may assess penalties if SPDs or SMMs are not provided to the agency upon request.

Many courts look to the SPD and other plan descriptive material as important evidence of the benefits employees have been promised by the employer. For this reason, a clearly worded SPD is an important line of defense for employers in benefit disputes.

In addition, if an SPD or SMM is not provided, the plan may be forced to provide benefits described in any other written documents describing the plan.

Participants and beneficiaries may also bring a civil action in federal district court to enforce any provision of ERISA. In addition, criminal penalties may be imposed against any individual or company that willfully violates any ERISA reporting and disclosure requirements. The penalty per conviction could be $5,000 and/or imprisonment for up to one year. The fine can be increased to $100,000 if imposed upon a company.

Finally, failure to distribute SPDs or SMMs could be used against the plan sponsor, in actions brought by the government or plan participants and beneficiaries, to argue that the sponsor has engaged in a pattern of non-compliance or violations of ERISA. (A pattern of non-compliance usually would cause the DOL or the court to be less sympathetic to any arguments the plan sponsor may use.) In certain situations it might give the government impetus to initiate an audit of the sponsor's benefit programs in order to look for other ERISA violations.

However, as to SBCs, a penalty of up to $1,000 per failure can be assessed on insurers (for insured health plans) and plan administrators (for insured and self-insured health plans) that "willfully fail" to timely provide the SBC. A failure with respect to each participant or beneficiary constitutes a separate offense.

SUMMARY ANNUAL REPORT (SAR)

A Summary Annual Report (SAR) is considered a plan disclosure requirement under ERISA. However, since the Summary Annual Report is based on what is reported on the Form 5500 information it is being included in this Employer Guide. An SAR is a summary of certain information contained in a Form 5500, along with notification to participants of their rights under ERISA to receive additional information. ERISA requires that an SAR be given to each participant, including former employees who are still covered by a plan (for example, COBRA participants or retirees with plan coverage), in an ERISA welfare benefit plan.

It is not necessary to file an SAR with the DOL, because the SAR contains information already reported to the DOL on the Form 5500 (the Annual Report).

See the Appendix for a Sample Summary Annual Report

ARE THERE ANY PLAN EXEMPTIONS FOR SAR DISTRIBUTIONS?

In addition to the plans and programs discussed in the section entitled "Programs Exempt from ERISA Filings" in ERISA Reporting: An Employer Guide, an SAR does not have to be provided if the plan is a totally unfunded welfare plan under which benefits are paid solely from the general assets of the employer or employee organization maintaining the plan.

WHEN TO DISTRIBUTE SARs

The SAR (or the notice of availability discussed above) must be furnished to plan participants within nine months after the close of the fiscal year of the plan which files the Form 5500 (Annual Report). If an extension of time to file an Annual Report (Form 5500) was granted by the IRS, the SAR must be furnished within two months after the close of the period for which the extension was granted.

INFORMATION INCLUDED IN AN SAR

The DOL has provided a model SAR. The SAR contains some of the Form 5500 information, and charts are available which cross-reference lines in the Form 5500 with blanks in the SAR. If a provision in the model SAR is irrelevant, a plan sponsor may delete it.

HOW TO DISTRIBUTE SARs

Like SPDs, SARs can be distributed in a number of different ways.

FOREIGN-LANGUAGE-SPEAKING PARTICIPANTS AND SARS

If there is a specified number of foreign-language-speaking plan participants (see table below), the employer must follow special rules in preparing the SAR.

If a plan falls into one of these categories, a foreign language SAR can be provided. Alternatively, the employer can include a statement, prominently displayed, and in the non-English language, telling how, when, and where participants can receive an oral, non-English SAR.

Total Number of Plan Participants	Number of Participants Literate in the Same Foreign Language
Fewer than 100	25% or more
100 or more	Either 10% or 500 or more (whichever is the lesser)

RECORDKEEPING

Regardless of the ERISA welfare benefit plan size or complexity, recordkeeping is a practical necessity. The need to maintain records is a feature of the "plan, fund, or program" that must exist before a fringe benefit program will be considered an ERISA plan. Thus, many of the choices about recordkeeping will not be based on legal rules, but defined by the nature of the plan in question, the size of the plan sponsor's workforce, and other factors. There are several relevant legal rules in this area, ranging from specific rules that dictate what records

must be kept for how long, to more general rules such as ERISA fiduciary requirements, and to statutes of limitations dictating the time limits in which ERISA and other lawsuits must be filed (and imposing indirect requirements for records that may be relevant in litigation).

Although this Employer Guide focuses on the disclosure requirements of ERISA, recordkeeping requirements are so closely intertwined with ERISA's reporting requirements (addressed in ERISA Reporting: An Employer Guide) that those requirements need to be mentioned. The recordkeeping rule of ERISA is based on the obligation to file the Form 5500 annual report which requires retention of records sufficient to document information that is required by the Form 5500 (or would be required in the absence of a reporting exemption). ERISA has a blanket record retention requirement of six years for information relating to plan documents, SPDs, annual reports, SARs, individual benefit statements, and all other certifications and reports that are required to be filed under ERISA's reporting and disclosure rules (or would be required to be filed but for an exemption). Employers are required to keep sufficiently detailed information and data necessary to verify, explain, clarify or check such documents for accuracy and completeness, including vouchers, worksheets, receipts, and applicable resolutions. Note that other laws may require record retention for longer periods.

Below are several charts addressing the various documents that are applicable to ERISA health and welfare plans and the time frame for retaining those documents.

ERISA Health and Welfare Plans Governing Documents	
Plan documents, including insurance contracts for insured plans:	As long as document is applicable, plus longer of 8 years or benefits statute of limitations.
Plan amendment and "restated" plan documents:	As long as document is applicable, plus longer of 8 years or benefits statute of limitations.
Formal adoption of plan and plan amendment:	As long as document is applicable, plus longer of 8 years or benefits statute of limitations.
Trust agreements:	As long as document is applicable, plus longer of 8 years or benefits statute of limitations.
SPDs, summaries of material modifications or material reduction in benefits, including compliance with distribution:	As long as document is applicable, plus longer of 8 years or benefits statute of limitations.
Delegation of fiduciary responsibility:	As long as fiduciary exercises delegated authority plus 6 years.

ERISA Health and Welfare Plans Enrollment, Election and Eligibility Records	
Records identifying which individuals are employees:	As long as document is applicable, plus longer of 8 years or benefits statute of limitations.
Records supporting service and other plan requirements for employee eligibility, spouse eligibility, dependent child eligibility or domestic partner eligibility:	As long as individual is eligible under the plan, plus longer of 8 years for plans that file or would file claims information on Form 5500 or benefits statute of limitations.
Employee enrolment forms and enrollment materials:	The longer of 8 years for plans that file or would file claims information on Form 5500 or benefits statute of limitations. (Statute of limitations would not apply to enrollment materials.)
Insurance applications for eligible individuals:	As long as the employee is enrolled under the plan,

	plus the longer of 8 years for plans that file or would file claims information on Form 5500 or benefits statute of limitations.
Beneficiary designations and effective court orders:	Until payment of all plan benefits with respect to employee are made, plus longer of 8 years for plans that file or would file claims information on Form 5500 or benefits statute of limitations.
Any insurer communication regarding definition of eligible employee:	Term of contract, plus longer of 8 years for plans that file or would file claims information on Form 5500 or benefits statute of limitations.

ERISA Health and Welfare Plans Form 5500	
Form 5500 and attachments:	8 years or permanent.
Substantiation of number of plans maintained:	8 years or permanent.
Summary Annual Report:	Reasonable time after distribution.
Substantiation of exemption for non-filing of Form 5500:	8 years or permanent.
Delinquent Filer Voluntary Compliance Program information:	8 years or permanent.

ERISA Health and Welfare Plans Claims and Appeals	
Claims procedures complying with DOL regulations, including forms, rules, guidelines, protocols, decision period documentation, and administrative processes.	Permanent or as long as document is applicable, plus longer of 8 years for plans that file or would file claims information on Form 5500 or benefits statute of limitations.
Benefit claims, representative authorizations, ERISA decision making process, claim approval and payment, benefit denial, appeals (including decision making process), levels of reviews and appeals, and claims substantiation for health FSAs.	Longer of 8 years for plans that file or would file claims information on Form 5500 or benefits statute of limitations.

ERISA Health and Welfare Plans Financial Records	
Insured plan premium payments:	8 years.
Plan benefit payments including health FSA:	Longer of 8 years for plans that file or would file claims information on Form 5500 or benefits statute of limitations.
Plans with no participant contributions and no trust:	8 years.
Participant contributions and no trust:	8 years.
Funded welfare plans with trusts:	8 years.
Insurance rebates, refunds, dividends,	Longer of 8 years for plans that file or would file

demutualization and similar payments:	Schedule H or I with its Form 5500 or 6 years (ERISA fiduciary statute of limitations) or according to the employer's normal business records retention (if plan assets are not involved).
Stop loss policy payments:	Longer of 8 years for plans that file or would file Schedule H or I with its Form 5500 or 6 years (ERISA fiduciary statute of limitations) or according to the employer's normal business records retention (if plan assets are not involved).
Subrogation/reimbursement recoveries:	Longer of 8 years for plans that file or would file Schedule H or I with its Form 5500 or 6 years (ERISA fiduciary statute of limitations) or according to the employer's normal business records retention (if plan assets are not involved).
Recovery of overpaid benefits:	Longer of 8 years for plans that file or would file Schedule H or I with its Form 5500 or 6 years (ERISA fiduciary statute of limitations) or according to the employer's normal business records retention (if plan assets are not involved).
Administrative expenses:	Longer of 8 years for plans that file or would file Schedule H or I with its Form 5500 or 6 years (ERISA fiduciary statute of limitations).
Plan assets in plan terminations:	6 years (ERISA fiduciary statute of limitations) after filing final Form 5500.
Plan asset issues in mergers and acquisitions:	Longer of benefits statute of limitations or 6 years (ERISA fiduciary statute of limitations) following completion of business reorganization.
Fidelity bond:	As long as bond is applicable, plus 8 years.
Fiduciary insurance and premium payment records:	As long as policy is applicable, plus 6 years.

ELECTRONIC RECORDKEEPING

DOL regulations permit the use of electronic media to comply with ERISA's rules regarding the maintenance and retention of plan records. The thrust of the final regulation is to ensure that electronic records are as secure, legible, and usable as their paper counterparts would be. In this regard, several requirements are imposed, including the following:

- The system has reasonable controls to ensure the integrity, accuracy, authenticity, and reliability of the recor records kept in electronic form.
- The electronic records are maintained in reasonable order, in a safe and accessible place, and in such a manner that they may be readily inspected or examined. For example, the record keeping system should be capable of indexing, retaining, preserving, and reproducing the records.
- The electronic records can be readily converted into legible and readable paper copy as may be needed to satisfy reporting and disclosure requirements or any other obligations under ERISA.
- Adequate records management practices are established and implemented, such as procedures for labeling electronically maintained records, providing a secure storage environment, creating backups, observing quality assurance through regular evaluations, and retaining paper copies of records that cannot be adequately transferred to the electronic system.

The regulations provide that paper original records generally may be discarded once they have been transferred to an electronic system that complies with all record maintenance requirements, unless the electronic record would not constitute a duplicate or substitute record under the terms of the plan and federal or state law. The preamble to the final regulations reiterates that the duty to maintain records as required by ERISA cannot be

avoided by contract, delegation or otherwise. Thus, the use of a third party to provide an electronic recordkeeping system does not relieve the person responsible for maintaining and retaining records under ERISA of those duties. For example, the preamble states that when a plan administrator contracts with a service provider for the preparation, maintenance, and retention of the plan's records, it nonetheless remains the plan administrator's obligation to ensure that the records are properly maintained and retained under ERISA. In addition, in the event of a DOL investigation, the plan administrator would be required to provide the necessary equipment and resources (including software, hardware, and personnel) for inspecting, examining, and converting electronic records into legible and readable paper copies.

APPENDIX

GLOSSARY OF ABBREVIATIONS

AD&D:	Accidental Death and Dismemberment
ADEA:	Age Discrimination in Employment Act
CHIPRA:	Children's Health Insurance Program Reauthorization Act
COBRA:	Consolidated Omnibus Budget Reconciliation Act
DCSA:	Dependent Care Spending Account
DMO:	Dental Maintenance Organization
DOL:	Department of Labor
EBSA:	Employee Benefit Security Administration (formerly PWBA)
EFAST:	ERISA Filing Acceptance System
EIN:	Employer Identification Number
EOB:	Explanation of Benefits
ERISA:	Employee Retirement Income Security Act
FMLA:	Family and Medical Leave Act
FSAs:	Health Flexible Spending Accounts
GINA:	Genetic Information Nondiscrimination Act
HCE:	Highly Compensated Employee
HCI:	Highly Compensation Individual
HCSA:	Health Care Spending Account
HDHP:	High Deductible Health Plan
HHS:	Health and Human Services
HIPAA:	Health Insurance Portability and Privacy Act
HMO:	Health Maintenance Organization
HRA:	Health Reimbursement Arrangement
HSA:	Health Savings Account
IRS:	Internal Revenue Service
LTD:	Long Term Disability
MEC:	Minimum Essential Coverage
NMHPA:	Newborns' and Mothers' Health Protection Act
MHPAEA:	Mental Health Parity and Addiction Equity Act
MSP:	Medicare Secondary Payer
PPACA:	Patient Protection and Affordable Care Act
PHI:	Private Health Information
PHSA:	The Public Health Service Act
PPO:	Preferred Provider Organization
QMCSO:	Qualified Medical Child Support Order
SAR:	Summary Annual Report
SBC:	Summary of Benefits and Coverage
SMM:	Summary of Material Modifications
SPD:	Summary Plan Description
STD:	Short Term Disability
USERRA:	Uniformed Services Employment and Reemployment Rights Act
VEBA:	Voluntary Employee's Beneficiary Association
WHCRA:	Women's Health and Cancer Rights Act

LIST OF INFORMATION WHICH MUST APPEAR IN A SUMMARY PLAN DESCRIPTION (SPD)

ERISA and the regulations do not present a standard format to be used in preparing the SPD. They do, however, specify the information which must be included in an SPD. Other content requirements are simply suggested. On November 21, 2000, the Department of Labor issued final regulations that modify the information which must be included in an SPD. The regulations were effective on January 20, 2001, and were generally applicable to plans on the first day of the second ERISA plan year beginning on or after January 22, 2001. For calendar year plans, the effective date was January 1, 2003. Employers complying with the requirements were required to issue new SPDs or amendments prior to the regulations' applicability date for each plan. The DOL maintains that many of the requirements were implicit under existing law before the final regulations.

This exhibit reflects the elements required under the regulations following the 2001 amendments.

Required SPD Content

Name — The name of the plan (and, if different, the name by which the plan is commonly known).

Sponsor — The name(s) and address(es) of one of the following:

- The single employer who sponsors the plan.
- The employee organization that sponsors the plan.
- In the case of a collectively bargained plan, a list of all employers and unions involved in sponsoring the plan and:
  - A statement that a complete list of participating employers and employee organizations may be obtained by written request to the plan administrator (and is available for examination); or
  - A statement that participants and beneficiaries may receive (after written request to the plan administrator) information regarding whether a particular employer or employee organization is a sponsor of the plan (and the sponsor's address).
- In the case of a plan established or maintained by two or more employers, the representative of a group of employers who sponsor a plan and:
  - A statement that a complete list of participating employers sponsoring the plan is available for examination by participants and beneficiaries and may be obtained by written request to the plan administrator; or
  - A statement that participants and beneficiaries may receive (after written request to the plan administrator) information regarding whether a particular employer or employee organization is a sponsor of the plan (and the sponsor's address).

EIN — The plan sponsor's employer identification number (assigned by the IRS).

Plan Number — The 3-digit plan number (assigned by the plan sponsor). Welfare plans begin with 501 and are numbered consecutively

Plan Year — The date of the plan's fiscal year selected for ERISA purposes.

Type of Plan — The type of welfare benefit plan (for example, group health plan, disability, pre-paid legal services, etc.).

Administration — The type of administration (for example, contract administration, insurer administration, etc.).

Plan Administrator — Name, business address, and telephone number of the plan administrator.

Service of Process — Name and address of the person designated as agent for service of legal process, and a statement that service can be made on a plan trustee or the plan administrator.

Trustee — Name, title and address of the principal place of business of each trustee.

Collective Bargaining Agreement — For collectively bargained plans, a statement referencing the collective bargaining agreement, and a statement that the collective bargaining agreement is available for examination and that a copy may be obtained by written request to the plan administrator.

Eligibility — A description of the plan's requirements for eligibility to participate and to receive benefits. For example, the SPD might describe a waiting period (such as three months) before a participant is eligible to participate and the class or classes of eligible participants (such as all full-time, salaried employees).

Description of Benefits — Welfare benefit plans must also include a general description of the benefits provided under the plan. For welfare plans providing extensive schedules of benefits, only a general description is required if reference is made to detailed schedules of benefits which are available without cost to any participant or beneficiary who so requests.

As mentioned in the introduction to this checklist, the DOL's position is that all SPDs should already contain the information below, and that the DOL's outline of the following information was merely a clarification of existing law under ERISA. (The DOL is already auditing for some of the managed care-related disclosures.)

- Plan benefits and exclusions;
- The impact of discount arrangements with providers, insurers or administrators on a participant's copayments, deductibles, annual and lifetime maximum benefits, and subrogation provisions;
- Any cost-sharing provisions, including premiums, deductibles, coinsurance, and co-payment amounts for which the participant or beneficiary will be responsible;
- Any annual or lifetime caps or other limits on essential health benefits or other benefits under the plan;
- A description of a medical plan's procedures governing qualified medical child support order (QMCSO) determinations, or a statement indicating that participants and beneficiaries can obtain, without charge, a copy of such procedures from the plan administrator;
- The extent to which preventive services are covered under the plan;
- Whether, and under what circumstances, existing and new drugs are covered under the plan;
- Whether, and under what circumstances, coverage is provided for medical tests, devices, and procedures, including clinical trial coverage;
- Provisions governing the use of network providers, the composition of the provider network and whether, and under what circumstances, coverage is provided for out-of-network services (in the case of plans with provider networks, the listing of providers may be furnished as a separate document, provided that the SPD contains a general description of the provider network and indicates that provider lists are furnished automatically, without charge, as a separate document);
- Any conditions or limits on the selection of primary care providers or providers of specialty medical care;
- Any conditions or limits applicable to obtaining emergency medical care; and
- Any provisions requiring pre-authorizations or utilization review as a condition to obtaining a benefit or service under the plan.

Subrogation — A plan description must include language describing subrogation and other plan terms and conditions that may reduce benefits. Note: many commentators have become confused because of a Supreme Court decision and have stated that plans no longer have a right of subrogation. This is not the case, and employers may retain “subrogation” rights if those rights are outlined in the plan materials. In addition, to assure those rights, employers may find that they need to be more diligent in their attempts to recover financial awards/settlements rather than waiting until the employee has already settled or received a recovery.

Cessation of Benefits — A statement identifying the circumstances which can lead to disqualification, ineligibility, or denial, loss, forfeiture or suspension of benefits. In addition, SPDs must include the following:

- A summary of any plan provision governing the authority of the plan sponsors or others to terminate the plan or amend or eliminate benefits under the plan and the circumstances, if any, under which the plan may be terminated or benefits may be amended or eliminated.
- A summary of any plan provision governing the benefits, rights, and obligations of participants and beneficiaries under the plan upon termination of the plan or amendment or elimination of benefits under the plan; and
- A summary of any plan provision governing the allocation and disposition of assets of the plan upon termination.

COBRA Continuation Rights — In the case of a group health plan subject to the COBRA benefit continuation provisions, the regulations require a description of the rights and obligations of participants and beneficiaries with respect to continuation coverage, including, among other things, information concerning qualifying events, premiums, notice, and election requirements and procedures, and duration of coverage.

Contributions — The SPD must identify the source of contributions (for example, employer, employee, union) and the method by which the amount of contribution is calculated. A plan might include the following language: "You contribute toward the cost of your insurance coverage. You will be informed on an annual basis about the level of your contributions and your actual employee contribution cost. Please refer to your latest enrollment form for your present employee contributions."

Funding Medium — The SPD must disclose the identity of the funding medium used to accumulate assets and pay benefits, along with the name of any insurance company, trust fund, or other institution which maintains the fund. If a health insurance issuer is responsible, in whole or in part, for the financing or administration of a group health plan, the SPD must note the name and address of the insurer, whether and to what extent benefits under the plan are guaranteed under the policy or contract, and the nature of any administrative services provided (for example, contract administrator or claims payer).

Claims Procedure — While most employers disclose claims rules in their SPDs, the **DOL regulations allow claims procedures to be provided separately to employees, rather than in the SPD**. When plan sponsors do not include the procedures in the SPD, a statement must appear in the SPD alerting participants and beneficiaries that the claims procedures will be provided separately automatically and without charge. The SPD still must generally describe the procedures by reference. The procedures governing claims for benefits include:

- Procedures for obtaining pre-authorizations, approvals, or utilization review decisions in the case of group health plan services or benefits
- Procedures for filing claim forms, notifications of benefit determinations, and review of denied claims in the case of any plan; and
- Applicable time limits and remedies available under the plan for the redress of claims which are denied in whole or in part.

Medical Claims Appeal Procedures — In July 2010, the DOL released final regulations, reflecting enhanced internal claims and appeals requirements and external review procedures for group health plans and insurers offering individual coverage. The final rules applied to group health plan claims filed in the first plan year that began on or after September 23, 2010, but in any event, no later than January 1, 2011.

Medical claim appeal procedures apply to benefit claims filed by participants in “top hat” plans, which are unfunded plans maintained primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees.

Disability Claims Appeal Procedures — In November 2000, the DOL released the final regulations relating to claims procedures. These procedures apply to disability plans. The final rules first applied to disability plan claims filed on or after January 1, 2002.

Maternity or Newborn Coverage — For a group health plan that provides maternity or newborn infant coverage, the SPD must contain a statement describing the federal or state law requirements applicable to the plan (or any health insurance coverage offered under the plan) relating to hospital length-of-stay in connection with childbirth for the mother or newborn child. If state law only applies in some areas due to certain portions of the program being insured, the SPD must describe the federal and state law requirements that apply in each area covered by the plan.

Foreign Language Statement — An employer subject to a foreign language disclosure requirement should include a statement, prominently displayed and in the appropriate, non-English language, telling how, when, and where participants can receive an oral, non-English explanation of the plan.

HIPAA Special Enrollment Rights — For medical and other plans subject to HIPAA, the SPD must include an explanation of events that trigger a special enrollment right and the time limits that apply to such enrollment rights.

Mastectomy Reconstruction — Health plan SPDs must contain a statement regarding the limits of the mastectomy reconstruction benefit.

Qualified Medical Child Support Orders (QMCSOs) — Health plan SPDs must contain either the procedures for handling QMCSOs or a statement indicating that participants and beneficiaries can obtain, free of charge, a copy of the procedures.

ERISA Rights — All SPDs must include the statement of ERISA rights. This statement changed for plan years beginning on or after January 22, 2001.

HIPAA Privacy — Group health plans must provide covered employees with a Notice of their Privacy Practices. Plan sponsors may use a shorter explanation of the privacy rules and the plan's responsibilities in the SPD.

When there is a change in any of the above information, a Summary of Material Modifications can be sent to employees rather than immediately updating the SPD. When the plan sponsor reprints an SPD, the new SPD must contain information included within any interim SMMs.

SUGGESTED SPD LANGUAGE REGARDING
PLAN ADMINISTRATOR DISCRETIONARY AUTHORITY

Discretionary Authority — the following statement is not an SPD requirement under ERISA, but should be included in an SPD to protect the exercise of discretionary authority by the plan administrator:

> The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall interpret, construe and apply all Plan provisions and make all determinations (including factual determinations) as to whether any particular Participant or beneficiary is entitled to receive any benefit under the terms of this Plan and the amount of such benefit, which interpretation, construction or application shall be made by the Plan Administrator in its sole discretion. Any interpretation, construction or application of the Plan or the terms of the Plan that is adopted by the Plan Administrator shall be final and legally binding on all parties. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review and shall be entitled to the maximum deference permitted by law.

SAMPLE PROVISIONS TO INCLUDE IN A SUMMARY PLAN DESCRIPTION (SPD)

The following pages provide sample provisions for SPDs and are a combination of model Department of Labor wording and NLRG-developed language.

Subrogation

Right of Subrogation

The Plan will be subrogated to any and all rights of recovery that the person, his heirs, guardians, executors, agents, or other representatives (hereafter individually and collectively "Injured Person") may have as a result of the loss. In no case will the amount subject to subrogation exceed the amount of medical or other benefits paid for the injuries under the Plan and the expenses incurred by the Plan in collecting this amount. The rights of recovery (from whatever source) to which the Plan will be subrogated include, without limitation, the Injured Person's rights of recovery against:

- Any person or entity (third party) that caused, contributed to, or is in any way responsible for the injury by act or omission. The Plan's right of subrogation applies not only to those expenses of which the Plan Sponsor or Plan Administrator is aware at the point of the initial claim, but also to any and all eligible expenses which are or may be compensable by a third party as a result of the loss.
- Any person, insurance company, health care provider, or other entity that is in any way responsible for providing indemnification, coverage, compensation or other payment as a result of the injury.
- Any no fault, personal injury protection, financial responsibility, uninsured/underinsured motorist insurance.
- Any motor vehicle medical and wage loss reimbursement insurance.
- Any homeowners, renters, premises and owners, landlords, and tenants insurance, including medical reimbursement coverage.
- Any group accident and health insurance, athletic team, sporting event, school, club, and other specific risk insurance coverage or accident benefit plans.
- Any third party, any plan, or any fund liable as a result of a judgment or settlement.

By accepting Plan coverage for injuries or other charges, the injured person acknowledges the Plan's right to subrogation. **[Note to Plan Sponsor: At its option, the Plan may also require a written acknowledgment of the Plan's Right of Subrogation. The Plan might decide to include language stating that, either by accepting Plan coverage or by signing the Plan's Subrogation Agreement (please ask your Willis consultant to contact the National Legal & Research Group for a copy of such an Agreement), the injured person acknowledges and agrees that this Plan will recover in full before any amounts (including attorney fees incurred by the injured person) are deducted from the policy, proceeds, judgment or settlement.]**

The amount of the Plan's subrogation interest shall be deducted first from any recovery by or on behalf of the injured person. Any recovery shall mean any recovery (regardless whether a settlement or judgment is allocated as to the injured person's actual medical expenses, pain and suffering, loss of wages, etc.) received by the injured person, even though the amount of settlement or judgment does not provide full satisfaction for any damages suffered by the injured person. The Plan reserves the right to reduce the amount of its recoverable subrogation interest where, in the discretion of its Fiduciaries, a reduction is in the best interests of the Plan and its participants and warranted by the circumstances.

In addition, this Plan will be subrogated for attorney's fees incurred in enforcing its subrogation rights under this section. The Plan may, if the Plan agrees in writing, pay for some or all of the expenses or attorney fees incurred by the injured person in connection with any recovery. The Plan also reserves the right to initiate an action in the name of the Plan or in the name of the injured person to recover its subrogation interest.

The injured person specifically agrees to do nothing to prejudice this Plan's rights to subrogation. In addition, the injured person agrees to cooperate fully with the Plan and the Plan Administrator in asserting and protecting the Plan's subrogation rights. The injured person agrees to execute and deliver all instruments and papers (in their original form) and do whatever else is necessary to fully protect this Plan's subrogation rights. The injured person shall notify the Plan in writing when there is a proposed settlement; further, the injured person must obtain the Plan's written consent before signing any release or agreeing to any settlement.

The injured person specifically agrees to notify the Plan Administrator, in writing, of whatever benefits are paid under this Plan that arise out of any injury or illness that provides or may provide the Plan subrogation rights under this section. Also, the Plan may provide a notice of lien regarding a subrogation claim to any person,

insurer, attorney, or other responsible party, and the notice is sufficient to protect the Plan's subrogation rights and, except as required by ERISA, the Plan may not be compelled to initiate or to intervene in any legal action in order to establish or maintain its right of subrogation. Failure to comply with the requirements of this section by the injured person may, at the Plan Administrator's discretion, result in a forfeiture of benefits under this Plan.

The covered person specifically agrees that:
[Note to Plan Sponsor: If the Plan includes a requirement to execute a written Subrogation Agreement, then the Plan could include a note stating that, at the option of the Plan, the injured party shall sign a Subrogation Agreement acknowledging and agreeing to the rights of subrogation before any benefits are paid under the Plan.]

- The covered person shall complete an Incident Report prior to the payment of claims.
- The covered person shall, at all times, cooperate with the Plan and provide further information as requested.
- The covered person acknowledges that failure to comply with any terms and conditions may, at the sole discretion of the Plan Administrator, result in one or more of the following:
    - Denial of payment of claims; and/or
    - Termination of coverage under the Plan.

If a court shall, at any time, find any part of this section unenforceable, the remaining terms and conditions shall remain in full force and effect. If there is a conflict between the Plan Document and the SPD, the Plan Document will control.

Cessation of Benefits

The Employer intends for the Plan to continue indefinitely; however, the Employer reserves the right to alter, amend, or terminate this Plan at any time and for any reason, in whole or in part, provided that no amendment shall authorize or permit any part of the Trust Fund (if such a Fund exists) to be used or diverted to any purpose other than to the exclusive benefit of the Participants. Notwithstanding the foregoing, the Plan may be amended at any time to conform its provisions to the requirements of ERISA, the Internal Revenue Code, and other applicable laws.

Allocation and Disposition of Plan Assets upon Termination

If the Plan is terminated, Plan Participants and Beneficiaries will have no further rights other than payment of benefits for eligible covered expenses incurred before the Plan was terminated. The amount and form of any final benefit will depend on any contract provisions affecting the Plan.

OR

As provided in the SPD and the legal Plan document, the Employer shall have the right to terminate this Plan at any time for any reason. Upon a complete termination, no part of the Trust Fund shall be used or diverted to any purpose other than to the exclusive benefit of the Participants, unless otherwise permitted by law.

SAMPLE OF SUMMARY OF MATERIAL MODIFICATIONS

After an SPD has been provided to plan participants, plan changes may be made that necessitate changes to the information in the SPD. Those changes must be disclosed to plan participants. This can be accomplished in one of two ways. The employer can prepare and distribute either a new SPD with the updated information or a Summary of Material Modifications (SMM) that describes the change made to the plan. There is no specific required format for an SMM, but employers may find the following sample helpful.

Sample Format for Summary of Material Modifications

[Name of employer] sponsors the [name of the plan] Plan, Plan Number ___ and hereby provides notice of the following change(s) which take(s) effect on [date].

[Describe what is happening under the plan – for example, "The plan sponsor added the following new benefit options to the plan:" It is always helpful to reference the location of the material within the SPD that is being changed by the SMM.]

SAMPLE WELFARE PROGRAM CLAIMS PROCEDURES

General

For purposes of determination of the amount of, and entitlement to, benefits of an insured Welfare Program provided under a Policy provided by an Insurance Company, the respective Insurance Company is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable Policy.

For purposes of determining the amount of, and entitlement to, benefits under a self-funded Welfare Program provided through the Company's general assets, the Plan Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-funded arrangement.

To obtain benefits from an insured or self-funded Welfare Program, the Participant must follow the claims procedures prescribed under the applicable Welfare Program. In the event that (i) the Welfare Program does not prescribe a claims procedure for benefits that satisfies the requirements of Section 503 of ERISA, or (ii) the Plan Administrator determines that the claims procedures described in the Welfare Program shall not apply, and the Welfare Program is subject to PPACA and is not grandfathered, the claims procedure applicable to such Welfare Program is described in the section entitled "Claim Procedures for Non-Grandfathered Health Plans." If the Welfare Program is grandfathered or is not subject to PPACA, the claims procedure applicable to such Welfare Program is described in the sections entitled "Claim Procedures for Grandfathered Health Plans," "Disability Plan Claim Procedures," and "Non-Health Plan Claim Procedures," as applicable.

Claim Procedures for Non-Grandfathered Health Plans

(a) Pre-Service Claim Determinations

When a covered person requests a medical necessity determination prior to receiving care, the Claims Supervisor will notify the covered person of the determination within 15 days after receiving the request.

However, if more time is needed due to matters beyond the Claims Supervisor's control, the Claims Supervisor will notify the individual within 30 days after receiving the request. This notice will include the date a determination can be expected. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the covered person must provide the specified information to the Claims Supervisor within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Supervisor sends such a notice of missing information, and the determination period will resume on the date the covered person responds to the notice.

If the determination periods above involve urgent care services, or in the opinion of a physician with knowledge of the covered person's health condition, would cause severe pain which cannot be managed without the requested services, the Claims Supervisor will make the pre-service determination on an expedited basis. The Claims Supervisor will notify the covered person of an expedited determination within 24 hours after receiving the request. However, if necessary information is missing from the request, the Claims Supervisor will notify the individual within 24 hours after receiving the request to specify what information is needed. The covered person must provide the specified information to the Claims Supervisor within a reasonable amount of time (at least 48 hours), taking into account the circumstances. The Claims Supervisor will notify the individual of the expedited benefit determination within 48 hours after the individual responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

If the covered person fails to follow the Claims Supervisor's procedures for requesting a pre-service medical necessity determination, the Claims Supervisor will notify the individual of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless the covered person requests written notification.

(b) Concurrent Claim Determinations

When an ongoing course of treatment, to be provided over a period of time or number of treatments, has been approved for a covered person and there is a reduction or termination of such course of treatment (other than by the amendment or termination of the Welfare Program), such reduction or termination is considered an adverse benefit determination. The Claims Supervisor shall notify the claimant of such reduction or termination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review before the benefit is reduced or terminated.

When an ongoing course of treatment has been approved for a covered person and the person requests to extend the course of treatment, such a request is a claim involving urgent care. The covered person must request a concurrent medical necessity determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When the covered person requests such a determination, the Claims Supervisor will notify the covered person of the determination within 24 hours after receiving the request.

(c) Post-Service Claim Determinations

When a covered person requests a claim determination after services have been rendered, the Claims Supervisor will notify the covered person of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond the Claims Supervisor's control, the Claims Supervisor will notify the individual within 45 days after receiving the request. This notice will include the date a determination can be expected. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and the covered person must provide the specified information to the Claims Supervisor within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Supervisor sends such a notice of missing information, and the determination period will resume on the date the individual responds to the notice.

(d) Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically in a culturally and linguistically appropriate manner calculated to be understood by the claimant, and will include all of the following that pertain to the determination: (1) information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific Plan or Welfare Program provisions on which the determination is based; (4) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (5) a description of the Plan's internal review procedures and time limits applicable to such procedures, available external review procedures, as well as the claimant's right to bring a civil action under Section 502 of ERISA following a final appeal; (6) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit; (7) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim; and (8) the availability of and contact information for an applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793.

(e) Appeal of Denied Claim

(1) First Level of Appeal

If a covered person's claim is denied in whole or in part, then the claimant may appeal that decision directly to the Claims Supervisor. A request for reconsideration should be made as soon as practicable following receipt of the denial and in no event later than 180 days after receiving the denial. If a covered person's circumstance warrants an expedited appeals procedure, then the covered person should contact the Claims Supervisor immediately. The claimant will be asked to explain, in writing, why he or she believes the claim should have been processed differently and to provide any additional material or information necessary to support the claim. Following review, the Claims Supervisor will issue a decision on review.

The Claims Supervisor's review will be processed in accordance with the following time frames: (a) 24 hours in the case of an urgent care claim; (b) 15 days in the case of a pre-service claim; (c) before a treatment ends or is reduced in the case of a concurrent care claim involving a reduced or terminated course of treatment; (d) 24 hours in the case of a concurrent care claim that is a request for extension involving urgent care; or (e) 30 days in the case of a post-service claim.

(2) Second Level of Appeal

If, after exhausting the first level appeal with the Claims Supervisor, a claimant is still not satisfied with the result, he or she (or the claimant's designee) may appeal the claim directly to the Employer.

Appeals will not be considered by the Employer unless and until the claimant has first exhausted the claims procedures with the Claims Supervisor. The appeal must be initiated in writing within 180 days of the Claims Supervisor's final decision on review.

As part of the appeal process, a claimant has the right to submit additional proof of entitlement to benefits and to examine any pertinent documents relating to the claim. In the normal case, the Employer will make a determination on the basis of the supporting file documents and written statement as submitted. However, the Employer may require or permit submission of additional written information. After considering all the evidence before it, the Employer will issue a final decision on appeal.

The Employer's decision on appeal will be conclusive and binding on the claimant and all other parties. Claims appeals will be processed in accordance with the same timeframes as set forth in subsection (e)(i) above. After exhaustion of the claims procedures provided under this Plan, nothing shall prevent any person from pursuing any other legal or equitable remedy otherwise available. In the event the Plan fails to strictly adhere to the requirements set forth in this Article VI, a claimant will be deemed to have exhausted the Plan's internal claims and appeals process. The claimant may then initiate any available external review process or remedies available under ERISA or under state law.

(f) Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific Plan or Welfare Program provisions on which the determination is based; (4) a statement that the individual is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined below; (5) a statement describing any voluntary appeal procedures offered by the Plan and any claimant's right to bring an action under ERISA Section 502(a); (6) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit; and (7) a statement that claimant may have other voluntary alternative dispute

resolution options such as mediation and that one way to find out what may be available is to contact the local U.S. Department of Labor office and state insurance regulatory agency. Any action under ERISA Section 502(a) may be filed only after the Plan's review procedures described above have been exhausted and only if the action is filed within 90 days after the final decision is provided.

Relevant Information is any document, record, or other information which (a) was relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

(g) Review Procedures on Appeal

In the conduct of any review, the following will apply:

(1) No deference will be afforded to the initial adverse determination;
(2) The review will be conducted by an appropriate named fiduciary who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
(3) In deciding an appeal that is based in whole or in part on a medical judgment, the fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
(4) Any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse determination will be identified, without regard to whether the advice was relied upon in making the determination;
(5) Any health care professional consulted in making a medical judgment shall be an individual who was neither consulted with in connection with the adverse determination that is the subject of the appeal, nor the subordinate of any such individual;
(6) In the case of a claim involving urgent care, an expedited review process will be available pursuant to which (a) a request for an expedited appeal may be submitted orally or in writing by the claimant, and (b) all necessary information, including the Plan's determination on review, shall be submitted between the Plan and the claimant by telephone, facsimile or other available similarly expeditious method; and
(7) The claimant will be provided with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim, as well as any new or additional rationale for denial. The claimant will have a reasonable opportunity to respond to such new evidence or rationale.

(h) External Claims Procedure. After receiving notice of an adverse benefit determination or a final internal adverse benefit determination, a claimant may file with the Plan a request for an external review. A claimant may request from the Plan Administrator additional information describing the Plan's external review procedure.

Claim Procedures for Grandfathered Health Plans

The following provision is drafted to be included in self-insured medical Summary Plan Descriptions (SPDs). (Carriers providing fully-insured benefits must produce their own claims appeal procedures.) If an updated claims appeal provision is not included in an SPD, it must be furnished to participants as a Summary of Material Modifications (SMM). The following language was written to anticipate either single employer plans or multiple employer plans with TWO levels of appeal after the initial claim decision. Special claims appeal rules may apply

where a multiemployer and/or a collectively bargained plan exists. Medical plans may have up to two levels of review of a claim decision, but only one level of appeal is required.

When You Have a Complaint

Only employees may submit claims for benefits (for themselves and on behalf of their covered dependents), and benefits will be paid only to the employee or the actual provider of services. Therefore, under the following complaint and claims appeal sections, the words "you" and "your" will mean an employee of [name of employer]. You and your covered dependents have the right to elect group health care benefits (including any combination of medical, dental, and prescription benefits) [as offered by the Plan] under the [name of health plan] (the "Plan"), and your and their rights will be determined under the Plan's provisions and in conjunction with the complaint and claims procedures outlined below. Claims will also be considered filed by you if communications and requests for benefits come from an individual that you have designated as your authorized representative to act on your behalf with respect to a claim. In the event that you designate an authorized representative to act on your behalf, the Plan will send all notifications, requests for further information, appeal decisions, and all other communications to your authorized representative.

For the purposes of the complaint and claims appeal sections, any reference to "days" will refer to calendar days, not business days we are here to listen and help. Because we want you to be completely satisfied with the member services assistance you receive, we have established a process for addressing your concerns and solving your problems. If you have a concern regarding a person, a service, the quality of care, or you want to inquire about what benefits are covered under the Plan, please call the phone number on your Benefit Identification card, the Explanation of Benefits, or the Claim Form and explain your concern to one of our member services representatives. You may also express that concern in writing. We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days. We will not consider any of these communications to be a "claim" for benefits. A formal claim for benefits must meet certain other standards which are described in the section titled "When You File a Claim."

When You File a Claim

When you file a "claim," you have the right to a speedy decision. "Claim" status also gives you the option of appealing any adverse decision regarding your claim. You will have filed a "claim" when you submit one of the Plan's Claim Forms or if you take one of the actions listed below. In the case of the submission of a Claim Form, a "claim" will be considered filed when it is received by the appropriate person/department listed below.

The Plan also recognizes the following actions and submission of forms as "claims:"

- A request by you for benefits through preauthorization or a utilization review determination in cases where use of either preauthorization or utilization review is required in order to obtain a particular benefit. (Preauthorization requirements are outlined elsewhere in Plan materials.)

- Requests by your formally designated authorized representative for preauthorization or a utilization review determination in cases where use of either preauthorization or utilization review is required in order to obtain a particular benefit. (Preauthorization requirements are outlined elsewhere in Plan materials.) The Plan will take reasonable steps to determine whether an individual claiming to be acting on your behalf is, in fact, validly empowered to do so under the circumstances, and the Plan will require that you complete and file a form identifying any person you authorize to act on your behalf with respect to a claim. However, when inquiries by a health care provider relate to payments due to the provider — rather than due to you — under managed care contracts (where the health care provider has no recourse against you for the amounts) such inquiries by a health care provider will not be considered "claims" by the Plan.

- Requests for benefits (in the case of a claim involving urgent care) by a health care provider with knowledge of your medical condition. For urgent care claims, you are not required to complete a form and formally designate a health care provider as your representative with respect to a claim.

- Submission of a medical bill for reimbursement or payment under the terms of the Plan.

You may request the Plan's Claim Form from the plan administrator by contacting [name of benefits contact]. After you have completed the Claim Form, you must submit it to the following address:

[Name of Department]
[Name of Employer]
[Address]
[Address]
Attention: [Claims Decision maker]

All submitted claims and appeals will fall into one of the three categories described below. The handling of your initial claim or later appeal will be governed, in all respects, by the appropriate category of claim or appeal, and each time your claim or appeal is examined, a new determination will be made regarding the category into which the claim or appeal falls at that particular time.

- An urgent care claim is one that involves serious jeopardy of life or health of the patient, or the ability of the patient to regain maximum function or, in the opinion of a physician with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be managed without the treatment at issue. Determination of "urgent care" status requires that the judgment of a prudent layperson with average knowledge of health and medicine be applied, except where a physician with knowledge of the patient's medical condition determines that the claim involves urgent care.

- A non-urgent pre-service claim is one that, under the terms of the Plan, requires approval of the particular benefit or procedure prior to obtaining medical care.

- A post-service claim is a claim that is neither an urgent care claim nor a non-urgent pre-service claim.

Initial Claim Decision

After you submit a claim, the Plan must make a decision on your claim within a prescribed period of time.

Urgent Care Claims

For urgent care claims, the plan administrator must notify you of the benefit determination (adverse or favorable) as soon as possible, but not later than 72 hours after receipt of the claim by the Plan. The notification will be given orally, and the Plan will send you written or electronic notification within three (3) days after the oral notification.

If your claim is incomplete but is properly filed, an employee of the plan administrator will notify you, orally, as soon as possible (but not later than 24 hours) after the receipt of the claim, of the specific information necessary to complete the claim. [The Plan must provide written notice if requested by the claimant.] You will have at least 48 hours [The Plan may provide a more generous time period.] to provide the specified information necessary to complete your claim submission. The Plan's time limit for making a determination will be suspended from the time that it provides notice to you of the incomplete claim until the date on which you respond to the request for additional information. You will be notified of the Plan's decision as soon as possible, but no later than 48 hours after the earlier of either the time the Plan receives the specified information or the expiration of the time given to you to provide the specified information.

If you fail to follow the Plan's filing procedures because your request for benefits does not: 1) identify the patient; 2) note a specific medical condition or symptom; 3) describe a specific treatment, service, or product for which approval is requested; or 4) arrive in the correct department and is not sent to the correct person, YOU WILL NOT HAVE SUBMITTED A CLAIM. An employee of the plan administrator will notify you, orally, within 24 hours, that you have failed to follow the filing procedures, and you will be reminded of the proper filing procedures. [The Plan must provide written notice if requested by the claimant.]

Requests for Extension of Urgent Care Treatment

Your request to extend a course of treatment beyond a particular period of time or number of treatments is a claim, and the Plan will decide your claim as soon as possible, taking into account the medical exigencies (the particular circumstances and requirements). The Plan will notify you of its benefit determination (adverse or favorable) within 24 hours after receipt of the claim by the Plan (as long as the claim is submitted to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments). But, if your request is not made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, your request will be treated as a claim involving urgent care and will be decided as soon as possible, taking into account the medical exigencies (the particular circumstances and requirements), but not later than 72 hours after received by the Plan. The Plan will notify you, orally, of its decision, and the Plan will send you written or electronic notification within three (3) days after the oral notification.

Non-Urgent Pre-Service Claims

For non-urgent pre-service claims, the plan administrator must notify you (in writing or electronically) of the benefit determination (adverse or favorable) as soon as possible, but not later than 15 days after receipt of the claim by the Plan. One 15-day extension of this time period is possible under certain circumstances.

[Optional Document Usage: The following two paragraphs may be used by the Plan if it elects to pursue an extension of time where the Plan has received an incomplete claim and the reason for the extension is because of circumstances beyond the control of the plan. (A Plan can instead immediately deny the incomplete claim and allow the claimant to advance to the next stage of the claims process.)]

If your claim is incomplete but is properly filed, an employee of the plan administrator will notify you (in writing or electronically) as soon as possible after the receipt of the claim, of the specific information necessary to complete the claim. If the Plan needs more time to make a decision on the claim because of the incomplete filing, the Plan may claim a 15-day extension of time, and the Plan will send you a notice specifically describing the circumstances requiring the extension, the date the Plan expects to make a decision, and a description of the information it requires to decide the claim.

The notice of extension will be sent to you before the initial 15-day period ends, in which case the Plan's time limit for making a determination will be suspended from the time that it provides notice to you of the incomplete claim until the date on which you submit the missing information. You will have 45 days from the receipt of the notice of incompleteness in which to complete the filing by supplying the specified information. [The Plan may increase this time period to a more generous number of days to give claimants more time to submit information.] The Plan will then have the benefit of the 15-day extension of time after it receives the specified information.

[Optional Document Usage: If a Plan elects to pursue an extension in order to obtain additional information from the claimant, the plan administrator may also include in the extension notice a reminder of the adverse benefit determination that will apply to the incomplete claim if the claimant fails to provide the missing information within the time limit prescribed by the Plan (at least 45 days). The following two paragraphs are an optional statement that the Plan may include in the notice to the claimant.]

If you fail to submit the missing information to complete your claim, your claim will be denied. The period for appealing your denied claim (denied because you did not supply the missing information) will begin to run at the end of the 45 days within which you are required to supply the missing information.

The Plan's time limit for making a determination will be suspended from the time that it provides notice to you of the incomplete claim until the date on which you submit the missing information. You will have 45 days from the receipt of the notice of incompleteness in which to complete the filing by supplying the specified information. [The Plan may increase this time period to a more generous number of days to give claimants more time to submit information.] The Plan will then have the benefit of the 15-day extension of time after it receives the specified information.

[Optional Document Usage: The following two paragraphs may be used by the Plan if it elects to immediately deny all incomplete claims when they are received (as stated above, a Plan can instead elect to pursue an extension of time where the Plan has received an incomplete claim).]

If your claim is incomplete but is properly filed, your attempted claim will be denied by the Plan. You will be notified in writing or electronically of the adverse benefit determination within the time limits that apply to non-urgent pre-service claims, and you will have the right to appeal the Plan's adverse benefit determination.
If you fail to follow the Plan's filing procedures because your request for benefits does not: 1) identify the patient; 2) note a specific medical condition or symptom; 3) describe a specific treatment, service, or product for which approval is requested; 4) arrive in the correct department and is not sent to the correct person, YOU WILL NOT HAVE SUBMITTED A CLAIM. An employee of the plan administrator will notify you, orally, within five (5) days, that you have failed to follow the filing procedures, and you will be reminded of the proper filing procedures. [The Plan must provide written notice if requested by the claimant.]

<u>Pre-Service Request for Extension of Treatment of Non-urgent Care</u>

Your request to extend a course of treatment beyond a particular period of time or number of treatments is a claim, and the Plan will decide your claim as soon as possible and within the time limits applicable to non-urgent pre-service claims.

<u>Post-Service Claims</u>

For post-service claims, the plan administrator will notify you in writing or electronically of the benefit determination as soon as possible, but not later than 30 days after receipt of the claim by the Plan. One 15-day extension of this time period is possible under certain circumstances.

[Optional Document Usage: The following two paragraphs may be used by the Plan if it elects to pursue an extension of time where the Plan has received an incomplete claim and the reason for the extension is because of circumstances beyond the control of the plan. (A Plan can instead immediately deny the incomplete claim and allow the claimant to advance to the next stage of the claims process.)]

If your claim is incomplete but is properly filed, an employee of the plan administrator will notify you (in writing or electronically) as soon as possible after the receipt of the claim, of the specific information necessary to complete the claim. If the Plan needs more time to make a decision on the claim because of the incomplete filing, the Plan may claim a 15-day extension of time, and the Plan will send you a notice specifically describing the circumstances requiring the extension, the date the Plan expects to make a decision, and a description of the information it requires to decide the claim.

The notice of extension will be sent to you before the initial 30-day period ends, in which case the Plan's time limit for making a determination will be suspended from the time that it provides notice to you of the incomplete claim until the date on which you submit the missing information. You will have 45 days from the receipt of the notice of incompleteness in which to complete the filing by supplying the specified information. [The Plan may increase

this time period to a more generous number of days to give claimants more time to submit information.] The Plan will then have the benefit of the 15-day extension of time after it receives the specified information.

[Optional Document Usage: If a Plan elects to pursue an extension in order to obtain additional information from the claimant, the plan administrator may also include in the extension notice a reminder of the adverse benefit determination that will apply to the incomplete claim if the claimant fails to provide the missing information within the time limit prescribed by the Plan (at least 45 days). The following two paragraphs are an optional statement that the Plan may include in the notice to the claimant.]

If you fail to submit the missing information to complete your claim, your claim will be denied. The period for appealing your denied claim (denied because you did not supply the missing information) will begin to run at the end of the 45 days within which you are required to supply the missing information.

The Plan's time limit for making a determination will be suspended from the time that it provides notice to you of the incomplete claim until the date on which you submit the missing information. You will have 45 days from the receipt of the notice of incompleteness in which to complete the filing by supplying the specified information. [The Plan may increase this time period to a more generous number of days to give claimants more time to submit information.] The Plan will then have the benefit of the 15-day extension of time after it receives the specified information.

[Optional Document Usage: The following paragraph may be used by the Plan if it elects to immediately deny all incomplete claims when they are received (as stated above, a Plan can instead elect to pursue an extension of time where the Plan has received an incomplete claim).]

If your claim is incomplete but is properly filed, your attempted claim will be denied by the Plan. You will be notified in writing or electronically of the adverse benefit determination within the time limits that apply to non-urgent pre-service claims, and you will have the right to appeal the Plan's adverse benefit determination.

Post-Service Requests for Extension of Treatment

Your request to extend a course of treatment beyond a particular period of time or number of treatments is a claim, and the Plan will decide your claim as soon as possible and within the time limits applicable to post-service claims.

Submission of a Medical Bill for Payment—If your claim is in the form of a medical bill that is submitted to the Plan for payment, the Plan will pay the benefit according to Plan provisions. This may mean that less than 100% of your medical claim is payable by the Plan. In each case where the Plan pays benefits or determines that it is not responsible for your medical claim, you will receive an Explanation of Benefits which will outline the basis for the Plan's payment. You will receive a written or electronic "denial" notification. In addition, the Plan's payment of less than 100% of your submitted claim (under the terms of the Plan) will entitle you to appeal the decision under the rules governing adverse claim determination.

If Your Claim Is Denied

If your claim is denied, the Plan will notify you in writing or electronically (oral notification followed by written notification in the case of urgent care claims) why your claim was denied, and the plan will provide additional information that will help you pursue your right to appeal the adverse determination. If you choose to appeal the Plan's adverse benefit determination, your appeal will be governed by rules that assure you a "full and fair" review.

If you are denied benefits based upon the Plan's finding that you are/were ineligible for benefits, the denial of benefits gives you the opportunity to appeal the Plan's decision.

Termination or Reduction of Benefits

If the Plan decides to reduce or terminate your previously-approved course of treatment, the Plan's decision will be treated as an adverse benefit determination, and the Plan will provide you reasonable advance notice of the reduction or termination to allow you to appeal the Plan's decision before the benefit reduction or termination takes place. If you decide to appeal the Plan's decision, you must follow the rules for appealing a Plan's decision.

Appealing Your Initial Claim Decision

You must submit a written request (An oral request for review is acceptable for urgent care claims and may be made by calling the toll-free number on your benefits identification card, your Explanation of Benefits, or your Claim Form and asking the Plan to register your oral appeal.) to the Plan within 180 days of receipt of a denial notice in order to initiate an appeal. [The Plan may allow a longer period of time.]

When you appeal an adverse determination, the Plan will provide a "full and fair review" which will include the following features:

1. You will have the opportunity to submit written comments, documents, records, and other information related to the claim.
2. At your request (and free of charge), you will be provided with reasonable access to (and copies of) all documents, records, and other information relevant to your claim for benefits. Included in this category are any documents, records or other information in your claim file, whether or not those materials were relied upon by the Plan in making its adverse determination. You also have the right to review documentation showing that the Plan followed its own internal processes for ensuring appropriate decision making.
3. The review of your claim will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
4. Any appeal of an adverse determination will not afford deference to the initial adverse determination, and the review will be conducted by a designated Plan representative who did not make the original determination and does not report to the Plan representative who made the original determination.
5. In deciding an appeal of any adverse benefit determination that is based on a medical judgment (including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the particular field of medicine involved in the medical judgment. This health care professional will not be the same professional who was originally consulted in connection with the adverse determination; neither will this health care professional report to the health care professional who was consulted in connection with the adverse determination.
6. The Plan will identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination of your claim, whether or not that advice was relied upon in making the benefit determination.

After you submit the claim for appeal, the Plan must make a decision on your claim within a short period of time.

Urgent Care Claims

The Plan's expedited appeal process for urgent care claims will allow you to request (orally or in writing) an expedited appeal, after which, all necessary information, including the plan's benefit determination on review, will be transmitted between the Plan and you by telephone, fax, or other expeditious method. The plan administrator will notify you (in writing or electronically) of the benefit determination as soon as possible, but not later than 72 hours after the Plan receives the request for review of the prior benefit determination. [However, in the case of a Plan that provides for two appeals of an adverse determination, the Plan's determination must be provided, with

respect to any one of the two appeals, not later than 36 hours after receipt by the Plan of the claimant's request for review of the adverse determination. The regulations do not specify 36 hours for each review, but the Department of Labor has stated that both reviews must be completed within the 72 hours, and the Department's view of other (non-urgent) appeals is that, where there is a two-appeal procedure, each appeal must be conducted in equal portions, and both within the maximum time period.]

Non-Urgent Pre-Service Claims

For non-urgent pre-service claims, the plan administrator must notify you (in writing or electronically) of the benefit determination within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days. [However, in the case of a Plan that provides for two appeals of an adverse determination, the Plan's determination must be provided, with respect to any one of the two appeals, not later than 15 days after receipt by the Plan of the claimant's request for review of the adverse determination.]

Post-Service Claims

For post-service claims, the plan administrator must notify you (in writing or electronically) of the benefit determination within a reasonable period of time, but not later than 60 days. [However, in the case of a Plan that provides for two appeals of an adverse determination, the Plan's determination must be provided, with respect to any one of the two appeals, not later than 30 days after receipt by the Plan of the claimant's request for review of the adverse determination.]

[Special Rule: In place of making a decision within 60 days, as noted above, there is an exception in the case of a multiemployer plan with a committee or board of trustees with regularly–scheduled meetings (at least quarterly). The following is a sample provision that must govern the appeals process for post-service claims under multiemployer plans.]

The named fiduciary shall make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the Plan's receipt of a request for review — unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the Plan's receipt of the request for review. (The plan administrator will notify you, in writing, of the need for the extension. The notification will describe the special circumstances and the date when the benefit determination will be made.) The plan administrator will notify you of the benefit determination as soon as possible, but not later than five (5) days after the benefit determination is made.

If Your Appealed Claim is Denied

If your appealed claim is denied, the Plan will send you written or electronic notification that will tell you why your appealed claim was denied. The Plan will provide additional information that will help you pursue your right to appeal the adverse determination. An adverse benefit determination also includes a denial of benefits based on a finding that you were ineligible for benefits at the time; such adverse benefit determination of your eligibility will allow you the opportunity to appeal the Plan's decision.

Final Appeal *[Optional Document Usage: Include this section if the Plan provides two levels of appeal.]*

[Optional Document Usage: The following language would be included in a Plan's provisions if it provides a second appeal instead of mandatory non-binding arbitration.]

If you are dissatisfied with the outcome of your first appeal, you may request a second appeal review. To initiate a second appeal review, you should follow the same process required for your first appeal. You must submit a

request for appeal within 180 days. [Observation: The regulations give no formal guidance on the time period by which claimants must appeal; rather, the regulations state that a Plan must provide claimants with a reasonable opportunity to pursue a full and fair review at the second review level. Presumably, 180 days would be the most generous time period that a Plan must allow a claimant. Any time limit less than 180 days must stand up to the "reasonable opportunity" requirement.]

Urgent Care Claims

For urgent care claims, the plan administrator must notify you (in writing or electronically) of the benefit determination as soon as possible, but not later than 36 hours after the Plan receives your request for review of the Plan's prior adverse benefit determination. [The regulations do not specify 36 hours for each review, but the Department of Labor has stated that both reviews must be completed within the 72 hours, and the Department's view of other, non-urgent appeals is that, where there is a two-appeal procedure, each appeal must be conducted in equal portions, and both within the maximum time period.]

Non-Urgent Pre-Service Claims

For non-urgent pre-service claims, the plan administrator must notify you (in writing or electronically) of the benefit determination within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Plan receives your request for review of the Plan's prior adverse benefit determination.

Post-Service Claims

For post-service claims, the plan administrator must notify you (in writing or electronically) of the benefit determination within a reasonable period of time, but not later than 30 days after the Plan receives your request for review of the Plan's prior adverse benefit determination.

[Special Rule: Where there is a multiemployer plan with a committee or board of trustees with regularly-scheduled meetings (at least quarterly), the plan must operate under the following provision in place of the second appeal for a post-service claim.]

The named fiduciary shall make a benefit determination no later than the meeting date of the committee or board that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. If the review request is filed within 30 days preceding such meeting, a benefit determination may be made by no later than the date of the second meeting following the Plan's receipt of the review request. If special circumstances require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the Plan's receipt of the review request (the plan administrator will notify you, in writing, of the need for the extension – and describing the special circumstances and the date as of which the benefit determination will be made). The plan administrator will notify you of the benefit determination as soon as possible, but not later than five (5) days after the benefit determination is made.

Denial of Claim on Second Appeal *[Include this section if the Plan provides two levels of appeal.]*

If your appealed claim is denied, the Plan will send you written or electronic notification that explains why your appealed claim was denied.

Disability Plan Claims Procedures

Carriers providing fully-insured benefits must produce their own claims appeal procedures. If an updated claims appeal provision is not included in an SPD, it must be furnished to participants as a Summary of Material Modifications (SMM).

What You Should Do and What You Should Expect If You Have a Claim

To claim benefits under the Plan, you* must first complete the Insurance Company's claim form according to the Insurance Company's requirements. You may request the claim form from the Insurance Company by calling [XXX-XXX-XXXX] or from the Plan Administrator by contacting [your benefits coordinator]. If the Insurance Company's claim form or instructions for completing it are not available, you must submit to the Insurance Company a written statement of the reasons you are entitled to benefits, and you must include your name, address and contact information, and your employer's name, address and contact information. After you have completed the claim form or written statement, you must submit it to the Insurance Company at the following address:

[Insurance Company Name]
[Address]
[Address]
Attention: [Claims recipient]

For purposes of the Plan's claims procedures, you will be considered to have filed your claim under the Plan when your claim form or written statement is received at this address.

The Plan Administrator has appointed the Insurance Company as a named fiduciary of the Plan for adjudicating claims for benefits under the Plan and for deciding any appeals of denied claims. The Insurance Company shall have the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All benefits decisions made by the Insurance Company shall be final and binding to the full extent permitted by law.

The Insurance Company has 45 days from the date your claim is filed to determine whether or not benefits are payable to you in accordance with the terms and provisions of the Plan, and, if so, the amount of benefits. If more time is needed to review your claim due to circumstances beyond the Plan's control, the Insurance Company must notify you in writing that the review period has been extended. The extension notice will describe the circumstances requiring the extension, the expected date of a decision, the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on your claim, and the additional information needed to resolve those issues. This extension may be for up to 30 days beyond the end of the normal 45-day review period. A second 30-day extension may apply if, for reasons beyond the Plan's control, additional time, beyond the first 30-day extension, is needed to review your claim. In this case, the Insurance Company will notify you in writing that the review period has been further extended. The Insurance Company will provide the same information required in the first notice of extension.

If an extension of the review period is made because you must furnish additional information in order for the Insurance Company to decide your claim, the Insurance Company will specify the additional information that is needed in the extension notice. You will have at least 45 days to return the specified information to the Insurance Company. Until you return that information (or the time to provide the information expires), the review period will be "tolled," further extending the review period beyond the normal 45-day period or the extended 75- or 105-day period. For example, if the Insurance Company advises you on the 20th day after your claim was filed that your claim is incomplete because it lacks a physician's statement regarding your ability to perform various tasks, the number of days from the date of the Insurance Company's request for the physician's statement until you provide the physician's statement will not count as part of the review period. In this example, the day you provided the physician's statement will be treated as the 21st day of the review period.

If needed in order to decide your claim, the Insurance Company may require you to submit to a medical examination, at the Insurance Company's expense. If a medical examination is required, the Insurance Company will notify you of the date and time of the examination and the physician's name and location. This will be treated as a request for additional information, as described above, and the review period will be tolled until the Insurance

Company receives the results of the examination. It is important that you keep any appointments made for you by the Company, since rescheduling examinations will delay the claim process.

If your claim is approved, you will receive the appropriate benefit from the Insurance Company.

If your claim is denied, in whole or in part, you must receive a written notice from the Insurance Company within the review period (which may have been extended beyond 45 days, as described above). The Insurance Company's written notice of an adverse benefit determination must include the following information:

1 The specific reason(s) the claim was denied.
2. Specific reference to the Policy provision(s) on which the denial was based.
3. A description of any additional material or information necessary to perfect your claim, and the reason this material or information is necessary.
4. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the written notice will include the specific rule, guideline, protocol, or other similar criterion. (Alternatively, the written notice will state that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge upon request.)
5. If the adverse benefit determination is based on a medically-related exclusion or limit, the written notice will include an explanation of the scientific or clinical judgment for the determination and will apply the terms of the Plan to the claimant's medical circumstances. (Alternatively, the written notice will state that the determination was based on such an exclusion or limit and that a copy of such explanation will be provided free of charge upon request.)
6. A statement informing you of your right to appeal the decision, and an explanation of the appeal procedure, as outlined below.

Appeal Procedure for Denied Claims

Whenever a claim is denied in whole or in part, you have the right to appeal the decision. You (or your duly authorized representative) must make a written request to appeal the Insurance Company's decision within 180 days from the date you receive the denial. If you do not make this request within that time, you will have waived your right to appeal. This request for review should be directed to the Insurance Company at the address given above for claims submissions. When requesting a review, you should state the reasons you believe the claim denial was improper, and you should submit any additional information, material, or comments which you consider appropriate. You may also review and, upon request, obtain copies of any documents that have a bearing on the claim, including the documents which establish and control the Plan.

Once your request has been received by the Insurance Company, a full and fair review of your claim must take place. This review will give no deference to the original claim decision and will not be made by the person who made the initial claim decision, nor a subordinate of that person. Any medical or vocational experts consulted by the Insurance Company in making the adverse benefit determination will be identified. If the adverse benefit determination was based in whole or in part on a medical judgment, the Insurance Company, in deciding your appeal of that determination, will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. In no case will such health care professional be an individual who was consulted in connection with the prior adverse benefit determination, nor the subordinate of such and individual. You may also submit issues and comments that you feel might affect the outcome of the review. In conducting the review, the Insurance Company will take into account all comments, documents, and other information that you submit, whether or not it was submitted at the time of the initial determination.

The Insurance Company has 45 days from the date it receives your request to review the adverse benefits determination for your claim and notify you of its decision. Under special circumstances, the Insurance Company may require more time to review your claim. If this should happen, the Insurance Company must notify you, in

writing, that its appeal review period has been extended for an additional 45 days, noting the special circumstances requiring the extension and the date by which a decision on the appeal is expected.

If an extension of the appeal review period is made because you must furnish additional information in order for the Insurance Company to decide your appeal, the Insurance Company will specify the additional information that is needed in the extension notice. You will have at least 45 days to return the specified information to the Insurance Company. Until you return that information (or the time to provide the information expires), the review period will be "tolled," further extending the review period beyond the normal 45-day period.

Once its review is complete, the Insurance Company must notify you, in writing, of the results of the review and must include in its notice the following information:

1. The specific reason(s) the appeal was denied.
2. Specific reference to the Policy provision(s) on which the denial was based.
3. A statement that you are entitled to receive, upon request and free of charge, all documents, records, and copies of all documents, records, and other information relevant to your claim for benefits under the Plan.
4. If an internal rule, guideline, protocol, or other similar criterion was relied upon in deciding the appeal, the written notice will include the specific rule, guideline, protocol, or other similar criterion. (Alternatively, the written notice will state that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge upon request.)
5. If the adverse benefit determination is based on a medically-related exclusion or limit, the written notice will include an explanation of the scientific or clinical judgment for the determination and will apply the terms of the Plan to the claimant's medical circumstances. (Alternatively, the written notice will state that the decision on appeal was based on such exclusion or limit and that a copy of such explanation will be provided free of charge upon request.)
6. The written notice will include a statement regarding a participant's right to file suit in federal or state court to recover benefits due to the participant under the terms of the Plan pursuant to ERISA Section 501(a). The written notice will also include the following statement: "You and the Plan may have other voluntary alternative dispute resolution options such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

* You may have an authorized representative, such as a guardian or an individual having a valid power of attorney from you, act on your behalf in pursuing a claim for benefits under this Plan. The Plan will take reasonable steps to determine whether an individual claiming to be acting on your behalf is, in fact, validly empowered to do so under the circumstances. Throughout this description of the Plan's claims and appeals procedures, the word "you" is used to refer to you and/or any representative acting on your behalf in claiming benefits under the Plan.

Non-Health Plan Claims Procedures

(a) A claim shall be filed in writing with the Plan Administrator and decided within 90 days (45 days in the case of a disability claim) by the Plan Administrator (unless special circumstances require an extension of up to 90 additional days [up to 30 additional days in the case of a disability claim]). Written notice of the decision on such claim shall be furnished promptly to the claimant. If the claim is wholly or partially denied, such written notice shall: (1) set forth an explanation of the specific findings and conclusions on which such denial is based, making reference to the pertinent provisions of the Plan or Welfare Program documents; (2) describe any additional information or material needed to support the claim and explain why such information or material, if any, is necessary; and (3) describe the review procedures in subsection (b).

(b) A claimant may review all pertinent documents and may request a review by the Plan Administrator of such decision denying the claim. Any such request must be filed in writing with the Plan Administrator within 60 days (or 180 days in the case of a disability claim) after receipt by the claimant of written notice of the decision. Such written request for review shall contain all additional information that the claimant wishes the Plan Administrator to consider.

Written notice of the decision on review shall be furnished to the claimant within 60 days (45 days in the case of a disability claim) (or 120 days [90 days in the case of a disability claim] if special circumstances warrant an extension) following the receipt of the request for review. The written notice of the Plan Administrator's decision shall include specific reasons for the decision and shall refer to the pertinent provisions of the Plan or Policy on which the decision is based. Such suit may be filed only after the plan's review procedures described above have been exhausted and only if filed within 90 days after the final decision is provided, or if a later date is specified in a booklet, certificate or other documentation for a particular Welfare Program, such later date with respect to a claim arising out of that Welfare Program.

SAMPLE SUMMARY ANNUAL REPORT

SUMMARY ANNUAL REPORT FOR [NAME OF PLAN]

This is a summary of the annual report of the *[name of plan, EIN and type of welfare plan]* for [*period covered by this report*]. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

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[*If any benefits under the Plan are provided on an uninsured basis:*]
[*Name of sponsor*] has committed itself to pay ***[all, certain] [state type of]*** claims incurred under the terms of the plan.

[*If any of the funds are used to purchase insurance contracts:*]

Insurance Information

The plan has (a) contract(s) with **[*name of insurance carrier(s)]*** to pay ***[all, certain] [state type of]*** claims incurred under the terms of the plan. The total premiums paid for the plan year ending ***[date]*** were **[$_____]**.
[*If applicable, add:*]
Because (*it is a*) (*they are*) so called "experience-rated" contract(s), the premium costs are affected by, among other things, the number and size of claims. Of the total insurance premiums paid for the Plan year ending **[*date*]**, the premiums paid under such "experience-rated" contract(s) were **[$_____]** and the total of all benefit claims paid under the(se) "experience-rated" contract(s) during the plan year was **[$_____]**

[*If any funds of the plan are held in trust or in a separately maintained fund:*]

Basic Financial Statement

The value of plan assets, after subtracting liabilities of the Plan, was **[$_____]** as of **[*the end of the plan year*]**, compared to **[$_____]** as of **[*the beginning of the plan year*]**. During the plan year the Plan experienced an **[*increase*] [*decrease*]** in its net assets of **[$_____]**. This **[*increase*] [*decrease*]** includes unrealized appreciation or depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. During the plan year, the Plan had total income of **[$_____]** including employer contributions of **[$_____]**, employee contributions of **[$_____]**, realized **[*gains*] [*losses*]** of **[$_____]** from the sale of assets, and earnings from investments of **[$_____]**.

Plan expenses were **[$_____]**. These expenses included **[$_____]** in administrative expenses, **[$_____]** in benefits paid to participants and beneficiaries, and **[$_____]** in other expenses.