

REPORTING AND DISCLOSURE¹

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TABLE OF CONTENTS

A. BACKGROUND 1

B. THE IMPORTANT ROLE OF REPORTING AND DISCLOSURE 1

C. THE ANNUAL REPORT (FORM 5500) 2

 1. ERISA’s Requirement 2

 2. Tax Code’s Requirement 2

 3. ERISA Title IV’s Requirement 2

 4. Form 5500 2

 5. Deadline 5

 6. Filing Exemptions 5

 a. Small Insured or Unfunded Welfare Plans 5

 b. Certain Group Insurance Arrangements 5

 c. Top-Hat Plans 6

 7. Accountant’s Report 6

 8. Actuary’s Report 7

 9. Reporting of Delinquent Contributions 7

 10. Common Defects 7

 11. Consequences of Noncompliance 7

 a. IRS Twenty-Five Dollar Per Day Penalty 7

 b. DOL \$1,100 Per Day Penalty 7

 (1) Assessment from Due Date 8

 (2) DFVC Program 8

 c. Failure to File Form SSA 8

 d. Failure to File Schedule B 9

 e. Failure to File Schedule P 9

 f. Failure to Disclose Change in Plan Status 9

 g. Criminal Sanctions 9

 h. Other Relief 9

 12. Electronic Filing 9

D. SUMMARY ANNUAL REPORT 10

 1. Exemptions 10

 2. Penalties for Failure to Provide SAR 10

 3. Electronic Disclosure 10

 4. Foreign Language Requirement 11

E. SUMMARY PLAN DESCRIPTION 11

 5. Deadline for Issuing SPD 11

 2. Updated Summary Plan Description 11

 3. Contents of SPD 11

4.	Filing With Department of Labor	11
5.	Foreign Language Requirement	11
6.	Different Summaries for Different Groups of Employees	12
7.	Penalties for Failure to Comply	12
8.	Electronic Disclosure.	12
9.	Revised Summary Plan Description Regulations.	12
F.	SUMMARY OF MATERIAL MODIFICATION	13
1.	Cases	14
2.	Group Health Plans	14
3.	Filing With Department of Labor	14
4.	Penalties	14
5.	Electronic Disclosure	14
G.	CLAIMS AND APPEALS	15
1.	Deadline for Denying Claim	15
2.	Deadline for Appealing Denial	15
3.	Deadline for Deciding Appeal	15
4.	Case Law	16
5.	Department of Labor Proposals	16
H.	PARTICIPANT BENEFIT STATEMENT	17
1.	Separated Participants	17
2.	Other Participants or Beneficiaries Requesting Statement.	18
I.	CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (“COBRA”) ...	18
1.	Initial Notice to Employee and Spouse	18
2.	Events Requiring Employer to Notify Administrator	18
3.	Events Requiring Employee or Qualified Beneficiary to Notify Administrator .	19
4.	Events Requiring Administrator to Notify Qualified Beneficiary	19
5.	Special HIPAA Notice Requirement	19
6.	Sanctions for Noncompliance.	19
J.	HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996	20
1.	HIPAA Notice Requirements	21
2.	Certificates of Coverage	21
K.	SURVIVOR ANNUITY NOTICES	23
1.	QJSA Explanation	23
2.	QPSA Explanation	24
3.	Fully Subsidized Benefit	24
4.	Consequences of Noncompliance	24
5.	IRS Sample Language for Spousal Waiver	24

L.	NOTICE TO PARTICIPANTS: ELIGIBLE ROLLOVER DISTRIBUTIONS	24
M.	WITHHOLDING TAX NOTICE	25
N.	REDUCTION IN BENEFIT ACCRUAL RATE	25
	1. Regulations on ERISA § 204(h) Notice Requirements	26
	2. Case Law	27
O.	TRANSFER OF EXCESS PENSION ASSETS TO HEALTH BENEFIT ACCOUNTS	27
P.	FAILURE TO SATISFY MINIMUM FUNDING REQUIREMENTS	28
Q.	DOMESTIC RELATIONS ORDERS	28
R.	MEDICAL CHILD SUPPORT ORDERS	28
S.	MEDICARE AND MEDICAID DATA BANK	29
T.	GENERAL DISCLOSURE	29
	1. Information Available to Participants on Request	29
	2. The Meaning of “Other Instrument”	30
	3. Nature of Requests	31
	4. Penalties for Noncompliance	32
	5. Relationship to Fiduciary Duty	32
	6. Proposed Rules on DOL Requests for Documents	33
U.	RETENTION OF RECORDS	33
V.	DUES-FINANCED EMPLOYEE ORGANIZATION PLANS	34
W.	DETERMINATION LETTER APPLICATIONS	34
	1. User Fees	35
	2. Termination of Plan	35
	3. Notice of Merger, Consolidation, or Transfer of Plan Assets or Liabilities	35
X.	PBGC PREMIUMS	35
	1. Due Date: Large Plans	35
	2. Due Date: Small Plans	35
	3. Mail Rule	36
	4. Penalties for Noncompliance	36
Y.	REPORTABLE EVENTS	36
	1. Reportable Events	36

2.	Notice of Reportable Events	37
3.	Penalties	38
Z.	REPORTS BY CORPORATE GROUPS WITH LARGE UNDERFUNDED PLANS	38
1.	Covered Pension Plans and Sponsors	38
2.	Financial and Actuarial Reports	39
3.	Due Date	39
4.	Penalties	39
AA.	NOTICE TO PARTICIPANTS REGARDING UNDERFUNDED PENSION PLANS	39
1.	Contents of the Notice	39
2.	Issuance of the Notice	40
3.	Penalties	40
BB.	TERMINATION OF DEFINED BENEFIT PENSION PLANS	40
1.	Notice to Participants	40
2.	Notice to PBGC	40
3.	Notice of Benefits	41
4.	Notice of Final Distribution	41
5.	Missing Participants	41
6.	Multiemployer Plans	41

A. BACKGROUND

The predecessor to the Employee Retirement Income Security Act of 1974 (“ERISA”) was the Welfare and Pension Plans Disclosure Act (“WPPDA”). The WPPDA became effective January 1, 1959, and imposed limited reporting and disclosure requirements on employee benefit plans. These requirements were found generally to be inadequate. The Senate Labor Committee, after conducting hearings in July 1971 concerning private welfare and pension funds, concluded that “many participants in private pension plans are forfeiting pension benefits because of inaccurate or incomplete information concerning their rights and obligations under the covering plan.” S. Rep. No. 92-634, at 101 (1971).

The need to provide a clear and careful explanation to participants and beneficiaries of their benefits was, and remains, a particular challenge. During the 1971 hearings, one employee testified, “I don’t think there’s a pension plan that I’ve looked at that two men can get the same answer out of, especially men that are not college men or lawyers.” *Id.* at 101. Much of the frustration expressed in that testimony remains today, more than 25 years after ERISA’s enactment. A 1987 GAO report concluded that a significant number of workers either do not understand their pension plans’ eligibility requirements or are not sure when they can retire with pension benefits. *Pension Plans: Many Workers Don’t Know When They Can Retire* (GAO/HRD-87-94BR).

A good portion of ERISA — all of Part 1 of Title I (29 U.S.C. §§ 1021 through 1031) — addresses the reporting and disclosure obligations imposed on employee benefit plans covered under that Act. Those obligations apply both to pension plans and welfare plans. ERISA requires not only regular reporting of information to the federal government, but also disclosure of information to participants and beneficiaries. Much of the disclosure to participants and beneficiaries is to occur automatically, without their being required to make a request. Other materials need be disclosed only on the request of a participant or beneficiary.

B. THE IMPORTANT ROLE OF REPORTING AND DISCLOSURE

The reporting and disclosure requirements imposed under ERISA--and to a lesser extent those imposed under the Internal Revenue Code and the federal securities laws — serve a variety of goals. In particular, they help:

- Make sure plan participants and beneficiaries know their rights under ERISA;
- Ensure that plan participants and beneficiaries are provided the information necessary to make informed decisions concerning their benefit options;
- Encourage employers to comply with ERISA by making public the transactions of plans and their fiduciaries and administrators; and
- Assist government agencies in meeting their enforcement obligations under ERISA.

Outlined below are the basic reporting requirements applicable to employee benefit programs, most of which serve one or more of these goals.

C. THE ANNUAL REPORT (FORM 5500)

1. **ERISA's Requirement.** An annual report must be filed for each employee benefit plan covered under ERISA. ERISA §§ 101(b)(4), 103 & 104 [29 U.S.C. §§ 1021(b)(4), 1023 & 1024]. The filing must be made for both welfare and pension plans, and is to be made by the plan administrator. *Id.* The administrator is the plan sponsor, unless the plan documents indicate otherwise. ERISA § 3(16) [29 U.S.C. § 1002(16)].

2. **Tax Code's Requirement.** The Internal Revenue Code independently requires that annual reports be filed for tax-qualified pension plans (that is, profit sharing, stock bonus, money purchase pension, defined benefit pension, and Section 401(k) plans which meet the requirements of Section 401(a) of the Internal Revenue Code). I.R.C. § 6058(a). The filing is to be made by the plan administrator or by the employer maintaining the plan. *Id.* The Tax Code also requires that employers file annual reports for cafeteria plans, qualified educational plans, and group legal services plans they maintain. I.R.C. § 6039D. Until further notice, annual reports under Section 6039D are not required for group-term life, accident and health, or dependent care plans. IRS Notice 90-24.

3. **ERISA Title IV's Requirement.** An annual report must be filed for pension plans covered under ERISA's plan termination insurance provisions (generally, tax-qualified defined benefit pension plans). ERISA § 4065 [29 U.S.C. § 1365]. The report is to be filed by the plan administrator. *Id.*

4. **Form 5500.** A single annual report satisfies all three of the requirements described above. In February 2000, the DOL, IRS, and PBGC substantially revised the Form 5500 for the 1999 reporting year. The Form 5500, Form 5500-C, and Form 5500-R have been replaced with one Form 5500 to be used by all filers. The 1999 Form 5500 is a simple main form with basic identifying information and includes a checklist that guides filers to various schedules.

The new Form 5500 series is intended to:

- Reduce the total amount of information required to be reported for many plans by eliminating information that is not useful to accomplish enforcement, research, or other statutorily mandated missions;
- Provide plans using simple tax qualification structures and financial operations with correspondingly streamlined annual reporting requirements;
- Allow large and small pension plan filers to report information on coverage requirements for qualified plans in accordance with the three-year testing cycle

permitted under Rev. Proc. 93-42, 1993-2 C.B. 540;

- Target reporting requirements so that welfare plans generally complete fewer items than pension plans and small plans complete fewer items than large plans;
- Establish the Form 5500 as the standardized reporting format for all so-called direct filing entities, common/collective trusts, pooled separate accounts, 108-12 investments entities, and group insurance arrangements;
- Eliminate redundant items and improve questions that historically produced frequent technical filing errors; and
- Reduce government and filer costs associated with filing, receiving and processing annual reports, speed government processing, and enable plans and their service providers to establish more streamlined record keeping and filing support systems.

The new form consists of a one-page main form with eight basic questions that identify: (i) the type of annual report being filed, (ii) the plan on whose behalf it is being filed, and (iii) what schedules and how many of each are being filed as attachments to the Form 5500. The form includes a total of thirteen schedules:

- Five pension schedules:
 - (1) Schedule B (Actuarial Information) (unchanged).
 - (2) Schedule E (ESOP Information) (unchanged).
 - (3) Schedule R (Retirement Plan Information). This new schedule is required for all pension plans unless the plan is neither a defined benefit plan nor subject to IRC § 412 nor ERISA § 302 and no benefits were distributed during the plan year. This schedule gathers information on plan distributions and funding. The requirement to report on non-QJSA distributions was replaced with a requirement to report the number of single sum distributions made. The participant count questions were moved to Form 5500.
 - (4) Schedule T (Qualified Pension Plan Coverage Information). This new schedule is used to report coverage data for qualified pension plans, including plans maintained by QSLOBs and employers participating in multiple-employer plans. Plans testing coverage under the three-year testing cycle of Rev. Proc. 93-42 must file this schedule for the first year in the plan's testing cycle, but not in subsequent years as long as the employer may rely on the earlier year's testing. The employer signature requirement was eliminated for Schedule Ts attached to the Plan's Form 5500 for employers participating in plans maintained by more than one employer.

- (5) Schedule SSA (Separated Vested Participant Information) (unchanged)
- Seven financial schedules:
- (1) Schedule A (Insurance Information). This schedule must be attached if any pension or welfare benefits under the plan are provided by, or if the plan has an investment contract with, an insurance company or other similar organization. The revised Schedule A is more closely aligned to GAAP on reporting investment contracts with insurance companies. The reporting on types of contracts/insured benefits and on commissions and fees was broadened. As part of the shift to computer scannable forms, a separate Schedule A must be filed for each insurance contract, but Schedule A information may be reported on an insurance contract or policy year basis.
- (2) Schedule C (Service Provider Information). This schedule must be attached by large plans if any person who rendered services to the plan received directly or indirectly \$5,000 or more in compensation from the plan during the plan year or if an accountant or actuary was terminated. Schedule C has been limited to require reporting only on the top 40 paid service providers and requires explanations of service provider terminations only for accountants, and enrolled actuaries. The requirement to file a Schedule C to identify annually plan trustees was eliminated.
- (3) Schedule D (Direct Filing Entity/Participating Plan Information). This schedule is new and consists of a standardized form for filing information on relationships between plans and master trust investment accounts, common/collective trusts, insurance company pooled separate accounts, investment entities covered under 29 C.F.R. § 2520.103-12 (103-12 IEs), and group insurance arrangements, collectively known as “direct filing entities.” A 1999 Transition rule permits DFEs with a fiscal year ending in 1999 to file 1999 DFE Form 5500s on or before October 16, 2000. Under a separate 1999 Transition Rule, the new requirement that large plans report their percentage interests in the assets of CCTs and PSAs on their Schedule H if the CCT or PSA choose not to file as a DFE was deferred until returns/reports for plan years beginning in 2000.
- (4-5) Schedules H and I (Financial Information). These new schedules essentially incorporate the financial statements from the current Form 5500. For small plan filers, Schedule I maintains simplified financial statements similar to the former Form 5500-R and adds a limited number of specific investment categories that must be separately reported. For large plan and DFE filers, Schedule H maintains financial statements similar to the former Form 5500. Additional guidance was provided in the instructions on reporting “deemed distributions” of participant loans, “corrective distributions” from pension plans, and welfare plan “incurred but not reported” claims.

- (6) Schedule G (Financial Transactions). As part of the shift to computer scannable forms, use of the Schedule G will be mandatory for 1999 Form 5500 filings by large plans and certain direct filing entities (DFEs) to report loans, leases and fixed income obligations in default or uncollectible, and prohibited transactions. The Schedules of Assets (detailed listings of investments) and Schedule of Reportable (5%) Transactions are required for large plan filers and certain DFEs; however, computer scannable forms will not be required and the limited reporting relief proposed for transactions made at the direction of participants and beneficiaries was adopted.
- (7) Schedule P (Trust Fiduciary Information) (unchanged)
 - One fringe benefit schedule:
 - (1) Schedule F (Fringe Benefit Plan Information) (unchanged).

The IRS is no longer responsible for processing Form 5500 and distributing it to other government agencies. Rather, the PWBA is now responsible for the task, since between 750,000 and 800,000 plans annually file the form and the IRS's computer processing system is antiquated and its fiscal problems serious. National Computer System has been selected as the vendor that will be responsible for designing a processing system to facilitate electronic filing and distributing the appropriate data to the pertinent agencies, under the new processing system called ERISA Filing Acceptance System (EFAST).

5. Deadline. The annual report is to be filed by the last day of the seventh month after the end of the plan year. 29 C.F.R. §§ 2520.104a-5(a)(2) & 2611.3(c); Treas. Reg. § 301.6058-1(a)(4); Form 5500 Instructions, Section 1 ("When to File"). Note that absent regulations, ERISA § 104(a)(1)(A) would have required filing within 210 days after the end of each plan year. Section 4065 of ERISA would have required filing within six months after the end of the plan year. An extension of time for up to two and one-half months may be requested on IRS Form 5558 (Application for Extension of Time). An automatic extension of time (without the need to file Form 5558) is granted until the due date of the federal income tax return of the employer, if (a) the plan year and the employer's tax year are the same, (b) the employer has been granted an extension of time to file its federal income tax return, and (c) a copy of the IRS extension of time to file the employer's federal income tax return is attached to the Form 5500. Form 5500 Instructions, Section 1 ("When to File").

6. Filing Exemptions. The Form 5500 Instructions, in Section 2 ("Plans Excluded From Filing"), describe a number of exemptions from the requirement that an annual report be filed. The most important are as follows:

- a. **Small Insured or Unfunded Welfare Plans.** A welfare plan with fewer than 100 participants at the beginning of a plan year is not required to file an annual report, if the plan is fully insured, or entirely unfunded (with benefits paid directly from the general assets of

the employer or employee organization sponsoring the plan), or a combination of the two (with some benefits provided exclusively through insurance contracts and others wholly unfunded). Certain additional requirements set forth in 29 C.F.R. § 2520.104-20(b) must be met to enjoy the exemption. Generally, participant contributions under insured arrangements must be forwarded to the insurance company within three months, and insurance refunds to which contributing participants are entitled must be returned to them within three months of receipt by the employer or employee organization. Contributing participants must also be informed upon their entry into the plan of any plan provisions concerning the allocation of refunds. *Id.*

b. Certain Group Insurance Arrangements. No annual report need be filed for an insured welfare plan providing benefits for two or more unaffiliated employers, if an annual report is filed by the trust or other entity holding the group insurance contract under which plan benefits are provided, and the trust or other entity is the conduit for payment of premiums for those policies. This exception does not apply in the case of a multiemployer plan. 29 C.F.R. § 2520.104-43.

c. Top-Hat Plans. Unfunded pension plans that benefit only a select group of management or highly compensated employees, commonly called “top-hat plans”, need not file annual reports so long as they file a very simple statement with the Secretary of Labor within 120 days after the plan is established. The statement is described in 29 C.F.R. § 2520.104-23. Unfunded or insured welfare plans that benefit only a select group of management or highly compensated employees are also exempt from the annual report requirement. 29 C.F.R. § 2520.104-24.

7. Accountant’s Report. An accountant’s report (*i.e.*, an audit) must accompany a plan’s annual report. The required contents of the report are set forth in 29 C.F.R. §§ 2520.103-1(b)(5) & -8. There is an exception for plans with fewer than 100 participants. 29 C.F.R. § 2520.104-46.

On December 1, 1999, the DOL issued proposed amendments to 29 C.F.R. 2520.104-46. *Proposed Small Pension Plan Security Amendments*, 64 Fed. Reg. 67435 (Dec. 1, 1999). The proposed amendment would condition the waiver of the audit on enhanced disclosure of information to participants and beneficiaries, and, under certain circumstances, improved bonding requirements. The waiver would be available only to plans if, with respect to the plan year for which the waiver is claimed, (1) at least 95% of the plan assets are “qualifying plan assets,” (2) or any person who handles nonqualifying plan assets is bonded for the amount of the value of such assets. “Qualifying plan assets” include qualifying employer securities as defined by Section 407(d)(1), loans meeting the requirements of Section 408(b)(1), and assets held by a bank or similar financial institution defined in Section 2550.408b-4(c), an insurance company, an organization registered as a broker-dealer, or other organization authorized to act as a trustee for IRAs under IRC § 408.

In addition, under proposed Section 2520.104-46(B), the SAR would be required to include:

- the name of each institution holding qualified plan assets and the amount held by each institution as of the end of the plan year;
- the name of the surety company issuing the bond;
- a notice that participants and beneficiaries may, upon request and without charge, examine or receive copies of evidence of the bond, and statements received from each institution holding qualified assets; and
- a notice stating that participants and beneficiaries should contact the PWBA if they are unable to examine or obtain copies of the documents specified above.

The waiver is not available to plans that elect to file a Form 5500 as a large plan pursuant to 2520.103-1(d).

Other plans for which an accountant's opinion is not required are:

- a. Welfare plans that are unfunded, fully insured, or a combination of the two, as described in 29 C.F.R. § 2520.104-44(b)(1);
- b. Pension plans whose sole assets consist of insurance contracts which provide that, upon receipt of the premium payment, the insurance carrier fully guarantees the amount of benefit payments attributable to plan participants for that plan year, as specified in 29 C.F.R. § 2520.104-4(b)(2); and
- c. Plans that have elected to defer attaching an accountant's opinion for the first of two plan years, one of which is a short plan year of seven months or less, as permitted under 29 C.F.R. § 2520.104-50.

8. Actuary's Report. Important changes were made to the filing requirements for Schedule B, Actuarial Information, beginning in 1995. The filing requirements vary depending on the size and type of plan. All defined benefit pension plans, however, regardless of size must provide current liability information based on the GAM-83 mortality table, as required by the Retirement Protection Act of 1994.

9. Reporting of Delinquent Contributions. Starting with the 1995 forms, the Department of Labor modified items 15h and 26h on the Form 5500 C/R to ask whether, during the plan year, any participant contributions were transmitted to the plan more than 31 days after receipt or withholding by the employer and, if so, the amount. The modification does not affect administrators of plans with 100 or more participants filing on Form 5500 which, unlike former 5500 C/R filers, are currently required to disclose on Form 5500 detailed information about prohibited transactions involving delinquent participant contributions.

10. Common Defects. The failure to attach an accountant's report and the failure to attach required investment schedules are common reasons for rejection of annual reports. In 1991, roughly 40 percent of annual reports were considered deficient in some respect. Some administrators file annual reports without an audit, later mailing the audit separately. The IRS cannot match these audit reports with the appropriate Form 5500s, and cannot amend its computerized database unless the administrator submits an amended filing. All blocks on the form must be completed because the annual reports are keyed into computer databases. If an administrator offers additional explanatory material, it should nevertheless make certain to complete the blocks so that a computerized entry can be made. Another reason for rejected filings is the improper reporting of participant loans. Apparently, filers are failing to treat loans as plan assets to be reported on the balance sheet and on the schedule of assets held for investment. The Department of Labor's *Trouble-Shooters' Guide to Filing the ERISA Annual Reports* describes the IRS's "edit testing" used to flag errors. Under that process, a computerized check is made of various items on the report. *See also* Comments of Michael S. Auerbach, at 19 *Pens. Rep.* (BNA) 1903.

11. Consequences of Noncompliance. A variety of sanctions can apply in the event of a failure to file an annual report. They are described below:

a. **IRS Twenty-Five Dollar Per Day Penalty.** A person failing to file an annual report required under the Tax Code (*e.g.*, an annual report for a tax-qualified pension plan) may be assessed a \$25 penalty for each day during which the failure continues. The penalty is capped at a maximum of \$15,000 per report. The penalty is to be paid on notice and demand by the Secretary of the Treasury, and does not apply if the failure is due to reasonable cause. I.R.C. § 6652(e).

b. **DOL \$1,100 Per Day Penalty.** The Secretary of Labor is authorized to assess a civil penalty of up to \$1,100 per day for any failure or refusal of a plan administrator to file an annual report required under ERISA. The \$1,000 amount stated in ERISA § 502(c)(2) has been adjusted pursuant to the Debt Collection Improvement Act of 1996. *See* 29 C.F.R. § 2570.502c-2. An annual report rejected for failure to provide material information is treated as not having been filed. Once the PWBA's Office of Enforcement has identified that a plan has not filed an annual report, it appears a subsequent (rushed) filing will not transform the plan from a non-filer to a late filer. Under current DOL practices, failure to include an auditor's report can subject the administrator to a penalty of \$150/day up to a maximum of \$50,000. For other missing financial reporting items, a fine of \$100/day up to a maximum of \$36,500 can be assessed. Miscellaneous missing reporting items can result in a fine of \$10/day up to a maximum of \$3,650. Penalties can be reduced if plan sponsors show a good faith effort to correct their errors.

(1) **Assessment from Due Date.** Civil penalties for ERISA reporting requirements are assessed starting on the date the reports were due, not the date the plan administrator is notified of the deficiency. *Pension & Welfare Benefits Administration v. Spalding & Evenflo Cos.*, Case No. 92 RIS-19 (1994); *see* 21 *Pens.*

Rep. (BNA) No. 50, at 2386 (Dec. 19, 1994).

(2) **DFVC Program.** In 1995, the PWBA instituted the Delinquent Filer Voluntary Compliance (“DFVC”) Program for plan administrators who have not timely filed their Form 5500s. 60 Fed. Reg. 20,874 (Apr. 27, 1995). Plan administrators who utilize this program will pay a substantially lower penalty than they normally would be required to pay if the DOL discovered the failure to file. The DFVC program is available only to plan sponsors who voluntarily file a delinquent annual report. Once DOL notifies a plan sponsor of its failure to file a Form 5500 or of the assessment of a penalty for failure to file, the plan sponsor is no longer eligible to participate in the DFVC program.

Plan administrators electing to file a delinquent Form 5500 under the DFVC program must:

(a) File a completed Form 5500 or Form 5500-C (including required schedules and attachments) with the IRS. The Form must contain the notation, at the top center of the first page in red, bold print, “DFVC Program”. If a Taft-Hartley Board of Trustees is the plan administrator, at least one employer representative and one union representative must sign the Form; and

(b) Send the DOL a signed and dated copy of the first page of the Form 5500 filed with the IRS and a check payable to the “U.S. Department of Labor” in the amount of the applicable penalty (see below). Both the Form 5500 and the check should contain the notation, in bold red print, “DFVC Program” at the top center of each item.

For an annual report filed up to 12 months late (without regard to any extensions), the maximum penalty is \$2,500 for Form 5500 filers and \$1,000 for Form 5500-C filers. For an annual report filed more than 12 months late (without regard to any extensions), the maximum is \$5,000 for Form 5500 filers and \$2,000 for Form 5500-C filers. 60 Fed. Reg. at 20,875. Note that the reduced penalty paid to the Department of Labor does not relieve a plan sponsor of the late filing penalty owed to the IRS under I.R.C. § 6652(e).

c. **Failure to File Form SSA.** A person failing to file Form SSA with the annual report may be assessed \$1 for each participant with respect to whom the filing is not made, multiplied by the number of days for which the failure continues. The maximum assessment for any plan year, however, is \$5,000. The penalty is to be paid upon notice and demand by the Secretary of the Treasury, unless the failure is due to reasonable cause. I.R.C. § 6652(d)(1).

d. **Failure to File Schedule B.** The plan administrator of a defined benefit pension plan

that fails to file a Schedule B (Actuarial Information) with its annual report is subject to a penalty of \$1,000 for each failure, unless the failure is due to reasonable cause. I.R.C. § 6692.

e. Failure to File Schedule P. A penalty of \$10 per day may apply for any failure to file a Schedule P (Annual Return of Fiduciary of Employee Benefit Trust), with a maximum penalty of \$5,000. The penalty is to be paid upon notice and demand by the Secretary of the Treasury. The penalty will not apply if it is shown that the failure was due to reasonable cause. I.R.C. § 6652(c).

f. Failure to Disclose Change in Plan Status. A plan administrator that fails to notify the Secretary of the Treasury of certain changes in the plan's status, such as the plan's name, the name or address of the plan administrator, termination of the plan, or merger or consolidation of the plan with another plan (or its division into two or more plans) may be required to pay \$1 for each day during which the failure continues. This amount is to be paid upon notice and demand of the Secretary of the Treasury, unless the failure was due to reasonable cause. I.R.C. § 6652(d)(2).

g. Criminal Sanctions. Willful violations of the reporting and disclosure requirements of Title I of ERISA are criminal. A person committing such a violation may be fined up to \$5,000 (\$100,000 in the case of a person that is not an individual), or imprisoned for up to one year, or both. ERISA § 501 [29 U.S.C. § 1131]. In addition, under 18 U.S.C. § 1027, a penalty of up to \$10,000, five years imprisonment, or both attaches to the making of any false statement which was known to be false, or for knowing and concealing any fact. In *U.S. v. Harris*, 185 F.3d 999 (9th Cir. 1999), *cert. denied*, 120 S. Ct. 600 (1999), the Ninth Circuit held that 18 U.S.C. § 1027, the federal statute which makes it a crime to include false statements on pension plan reports required under ERISA, was not unconstitutionally vague. See also *U.S. v. Palumbo Bros. Inc.*, 145 F.3d 850 (7th Cir. 1998).

h. Other Relief. The Secretary of Labor, plan participants, beneficiaries, or fiduciaries may bring suit to enjoin violation of the reporting and disclosure requirements of Title I of ERISA and to obtain other equitable relief. ERISA §§ 502(a)(3) & (a)(5) [29 U.S.C. §§ 1132(a)(3) & (a)(5)].

12. Electronic Filing. The IRS permits plan sponsors to file the Form 5500 by computer modem and has approved several IBM-PC compatible software packages. If the Form is filed electronically and has an error, the IRS will fax a correction notice to the firm transmitting the information. The firm should fax back the corrections and await written confirmation of a correct filing.

Form 8453-E, Employee Benefit Plan Declaration and Signature for Electronic/Magnetic Filing, is a signature document that completes the filing of an employee benefit plan return or report transmitted via electronic or magnetic media. It is used to authenticate the form and related

schedules, transmit the signatures of appropriate plan officials, transmit any accompanying paper documents, or authorize other filings. See Form 5500 Instructions, Section 1 (“Electronic Filing of Form 5500”); IRS Publication 1507.

D. SUMMARY ANNUAL REPORT

A summary of the annual report must be provided to participants and to beneficiaries receiving benefits under the plan. ERISA §§ 101(a)(2) & 104(b)(3) [29 U.S.C. §§ 1021(a)(2) & 1024(b)(3)]. This summary annual report is to be provided in the form prescribed in Department of Labor regulations found at 29 C.F.R. § 2520.104b-10(d). (The Secretary of Labor is given authority to designate the form of the summary annual report under ERISA § 109(c) [29 U.S.C. § 1029(c)].) Although ERISA requires that the summary be provided within 210 days after the close of the plan year, Labor Department regulations relax this deadline, allowing the summary annual report to be provided within nine months after the close of the plan year. 29 C.F.R. § 2520.104b-10(c). If an extension of time to file an annual report has been granted, distribution of the summary annual report may also be delayed. In that case, the summary annual report must be provided within two months after the end of the extension period. 29 C.F.R. § 2520.104b-10(c)(2). In the case of top-hat plans described in Section C.6.c., there is no requirement that summary annual reports be distributed to participants or beneficiaries.

1. Exemptions. No summary annual report need be distributed for plans described in Sections C.6.a. and c. of this outline, nor for certain other plans catalogued at 29 C.F.R. § 2520.104b-10(g).

2. Penalties for Failure to Provide SAR. A participant, beneficiary, fiduciary, or the Secretary of Labor may bring suit to require the distribution of summary annual reports or, presumably, to obtain equitable relief for any damage suffered as a consequence of the failure to distribute summary annual reports. ERISA § 502(a)(3) & (5) [29 U.S.C. §§ 1132(a)(3) & (5)]. A willful failure to distribute a summary annual report is criminal, punishable by a fine of not more than \$5,000 or imprisonment for not more than one year, or both. In the case of a violation by a person other than an individual, the fine is instead limited to \$100,000. ERISA § 501 [29 U.S.C. § 1131].

There is no other special penalty under ERISA for failure to provide a summary annual report. Presumably, however, a participant requesting a summary annual report, who does not receive the summary within 30 days of that request, can be awarded up to \$110 per day for each succeeding day (until the summary annual report is provided). ERISA § 502(c)(1) [29 C.F.R. § 2570.502c-1].

3. Electronic Disclosure. On January 28, 1999, the Department of Labor issued proposed rules which establish a safe-harbor for plans which file summary annual reports using electronic media. *Proposed Rules Concerning Use of Electronic Communication and Recordkeeping Technologies by Pension and Welfare Benefits Plans*, 64 Fed. Reg. 4506 (Jan. 28, 1999). A plan will

fall within the safe harbor rule if the plan administrator sends an electronic copy of the SAR to a participant who has the ability to effectively access the document at the worksite, and has the opportunity at work to convert the electronic document into a paper document without cost, and:

- the plan administrator takes appropriate steps to ensure the participant actually receives the document (such as by use of a return-receipt electronic mail feature;
- the electronic document meets the style, format, and content requirements of 29 C.F.R. 2520.102-2-5 and 29 C.F.R. 2520.104b-10;
- each participant receives a notice, by electronic means or in writing, telling the participant what document will be sent electronically, the significance of the document, and the participant's right to receive a free paper copy of the document; and
- upon participant request, a paper copy of the document is furnished to the participant.

4. Foreign Language Requirement. For complete discussion of this issue, see E.5 below. In the SAR context, refer to 9 C.F.R. 2520.104b-10(e).

E. SUMMARY PLAN DESCRIPTION

A written summary of each employee benefit plan subject to ERISA must be furnished to plan participants and to beneficiaries. ERISA § 102(a)(1) [29 U.S.C. § 1022(a)(1)]. The summary must be written in a manner calculated to be understood by the average plan participant, and must be sufficiently accurate and comprehensive to reasonably apprise participants and beneficiaries of their rights and obligations under the plan. *Id.*

1. Deadline for Issuing SPD. A summary plan description must be furnished to participants, and to beneficiaries receiving benefits under the plan, within 90 days after the individual becomes a participant (or in the case of a beneficiary, within 90 days after first receiving benefits). ERISA § 104(b)(1)(A) [29 U.S.C. § 1024(b)(1)(A)]. A grace period applies when a plan first becomes subject to ERISA's reporting and disclosure requirements (normally, when the plan is adopted). In that circumstance, the summary must be provided to participants, and to beneficiaries receiving benefits, within 120 days after the plan becomes subject to ERISA's reporting and disclosure requirements. ERISA § 104(b)(1)(B) [29 U.S.C. § 1024(b)(1)(B)].

2. Updated Summary Plan Description. Every fifth year, an updated summary plan description, which incorporates all plan amendments made within the five-year period, must be distributed. ERISA § 104(b)(1) [29 U.S.C. § 1024(b)(1)]. If there have been no amendments within the five-year period (fat chance!), an updated summary plan description need only be issued every tenth year. *Id.*

3. Contents of SPD. The information required to be included in a summary plan description is set forth in ERISA § 102(b) [29 U.S.C. § 1022(b)] and regulations at 29 C.F.R. § 2520.102-3. (The Secretary of Labor is given authority to designate the form and content of SPDs under ERISA § 109(a) [29 U.S.C. § 1029(a)].) The summary must accurately reflect the contents of the plan as of a date not earlier than 120 days prior to the date the summary is distributed. 29 C.F.R. § 2520.102-3. Participants and beneficiaries are also required to receive a statement of their ERISA rights. ERISA § 104(c) [29 U.S.C. § 1024(c)]. This statement is commonly made a part of the summary plan description, rather than distributed separately.

4. Filing With Department of Labor. The Taxpayer Relief Act of 1997 amended ERISA § 104(a) [29 U.S.C. § 1024(a)] to eliminate the requirement that a plan administrator file the summary plan description with the Secretary of Labor. The Secretary of Labor may still request the SPD at any time.

5. Foreign Language Requirement. If a significant portion of participants covered under a plan are literate only in the same non-English language, so that a summary in English would fail to inform them adequately of their rights and obligations under the plan, a special notice must be included in the summary provided to them. In that event, the English language summary provided to the participants must prominently display a notice, in the non-English language, offering them assistance and clearly setting forth in the non-English language the procedures to follow in order to obtain assistance. 29 C.F.R. § 2520.102-2(c). See also: 9 C.F.R. 2520.104b-10(e) for regulations applicable in SAR context. Although the assistance provided need not involve written materials, it must be provided in the non-English language and must be calculated to provide the participants with a reasonable opportunity to become informed as to their rights and obligations under the plan. *Id.*

These special requirements apply if the following portion of participants are literate only in the same non-English language:

- a. 25 percent of participants, in the case of plans covering fewer than 100 participants at the beginning of a plan year; or
- b. the lesser of 10 percent of participants, or 500 participants, in the case of plans covering 100 or more participants at the beginning of the plan year.

6. Different Summaries for Different Groups of Employees. If a plan provides different benefits to various classes of participants and beneficiaries, summary plan descriptions may be distributed which cover only those benefits and rules applicable to the members of the group receiving the summary. 29 C.F.R. § 2520.102-4.

7. Penalties for Failure to Comply. The consequences of failure to timely provide a summary plan description are the same as those described in Section D.2. for failure to provide a summary annual report — a penalty of up to \$110 per day under ERISA § 502(c)(1), as modified by the Debt Collection Improvement Act of 1996. See C.F.R. § 2570.502 c-1. Because the SPD is

supposed to be provided without any request, the penalty may be imposed even if a participant requests a copy orally, rather than in writing. *Crotty v. Cook*, 121 F.3d 541 (9th Cir. 1997); *Brooks v. Metrica, Inc.*, 1 F.Supp.2d 559 (E. D. Va. 1998).

8. Electronic Disclosure. In April 1997, the Department issued Interim disclosure rules to provide a safe harbor for plan administrators who meet ERISA's disclosure requirements for SPDs and SMMs through electronic media. 62 Fed. Reg 16979 (Apr. 8, 1997). In Jan. 1999, the Department issued *Proposed Rules Concerning Use of Electronic Communication and Recordkeeping Technologies by Pension and Welfare Benefits Plans*, 64 Fed. Reg. 4506 (Jan. 28, 1999), as discussed in Section D.3 above. These proposed electronic disclosure rules apply to the electronic delivery of SPDs and updated SPDs.

9. Revised Summary Plan Description Regulations. In September 1998, in conjunction with the Department of Labor's proposals to change the processing of benefit claims, DOL proposed regulations that would change the required contents of SPDs. 63 Fed. Reg. 48,376 (Sept. 9, 1998). Under the proposed regulations, group health plans would be required to disclose:

- any condition or limits on the coverage of emergency medical care;
- the extent of participants' choice of doctors and access to specialists;
- rules on the use of network providers, the composition of the provider network, and any coverage of out-of-network providers;
- any annual or lifetime caps or benefit limits;
- coverage of preventative services;
- coverage of new or existing drugs;
- coverage of medical tests, devices and procedures;
- any preauthorization or utilization review requirements;
- QMCSO procedures or a statement that such procedures may be obtained from the plan administrator; and
- a description of COBRA coverage.

Pension SPDs would be required to contain:

- a statement describing the plan's normal retirement age, and a "statement describing any other conditions which must be met before a participant will be eligible to receive benefits," including QDRO procedures or a statement that such procedures may be obtained from the administrator; and

- a revised PBGC statement.

Both pension and welfare SPDs would be required to include:

- a statement clearly identifying circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture or suspension of any benefits that a participant or beneficiary may reasonably expect the plan to provide on the basis of the SPD;
- a summary of any provisions governing the authority of plan sponsors or others to terminate the plan or amend or eliminate benefits, and the circumstances, if any, under which the plan may be terminated or benefits amended or eliminated;
- a summary of any plan provisions governing the benefits, rights and obligations of participants and beneficiaries under the plan on termination of or elimination of benefits under the plan, including, for pension plans, a summary of provisions relating to accrual and vesting of benefits on plan termination;
- a summary of any plan provisions governing the allocation and disposition of plan assets on termination;
- the procedures governing claims for benefits, applicable time limits, and remedies available under the plan for the redress of claims that are denied in whole or in part; and
- a revised statement of ERISA rights.

F. SUMMARY OF MATERIAL MODIFICATION

Whenever a material modification is made in the terms of a plan, or any change is made in the information required to be disclosed in a summary plan description, a summary of the modification must be distributed. ERISA § 102(a)(1) [29 U.S.C. § 1022(a)(1)]. The summary must be written in a manner calculated to be understood by the average plan participant. *Id.* A copy of the summary must be furnished to each participant and to each beneficiary receiving benefits under the plan. ERISA § 104(b)(1) [29 U.S.C. § 1024(b)(1)]. The summary generally must be provided no later than 120 days after the modification becomes effective. *Id.* A new participant must be provided not only with a copy of the most recent summary plan description, but also with all summaries of material modification issued since publication of the SPD, within 90 days after a person first becomes a participant. In the case of a beneficiary, these materials are to be provided within 90 days after the person first receives benefits. *Id.*; 29 C.F.R. § 2520.104b-3(c). If a revised summary plan description is issued prior to the deadline for furnishing the SMM, and the revised SPD incorporates the modification, no separate summary of material modification is required. The revised summary plan description will be adequate. 29 C.F.R. § 2520.104b-3(b).

There is no statutory or regulatory requirement to issue a summary of material modification

to participants or beneficiaries in a top-hat plan described in Section C.6.c. 29 C.F.R. § 2520.104-20(b), -23 & -24. In *Rose v. Bellsouth Corp.*, 1997 U.S. Dist. LEXIS 7680 (W.D.N.C. Apr. 30, 1997), the district court held that if an SPD has not been amended and no SMM was sent to participants, the amendment is ineffective.

1. Cases. In *Dall v. Chinnet, Co.*, 33 F. Supp.2d 26, 33-34 (D. Me. 1998), aff'd 1999 U.S. App. LEXIS 20939 (Aug. 30, 1999), the court noted that under Section 104(b)(4) a plan administrator is automatically obligated to furnish all participants with a summary of the material modifications made to a plan no later than 210 days after the end of the year wherein the changes were to go into effect. If, however, a plan participant requests that the plan administrator furnish him or her with the same information that is required to be furnished under Section 104(b)(1) automatically, the penalty provisions of ERISA Section 502(c) are triggered and an administrator has only thirty days to respond.

2. Group Health Plans. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") amended ERISA § 104(b) [29 U.S.C. § 1024(b)] to require prompter notice to participants and beneficiaries of modifications in health plan coverage or benefits. As amended, whenever there is a material reduction in covered services and benefits, a summary description of the changes must be provided to participants and beneficiaries within 60 days after the changes are adopted. Alternatively, plan sponsors may provide descriptions of changes at regular intervals of not more than 90 days. 29 C.F.R. § 2520.104b-3(d).

3. Filing With Department of Labor. The Taxpayer Relief Act of 1997 amended ERISA § 104(a) [29 U.S.C. § 1024(a)] to eliminate the requirement that a summary of material modification be filed with the Secretary of Labor. Plan administrators are still required to furnish any SMMs to the Secretary of Labor upon request.

4. Penalties. The remedies described in Section D.2 above, for failure to provide a summary annual report or summary plan description, apply as well in the case of any failure to comply with ERISA's summary of material modification requirement.

5. Electronic Disclosure. On January 28, 1999, the Department of Labor issued proposed rules which establish a safe-harbor for plans which file summary annual reports using electronic media. *Proposed Rules Concerning Use of Electronic Communication and Recordkeeping Technologies by Pension and Welfare Benefits Plans*, 64 Fed. Reg. 4506 (Jan. 28, 1999). These rules are addressed in Section E.8 above.

G. CLAIMS AND APPEALS

Each employee benefit plan subject to ERISA must provide a written notice of benefit denial to any participant or beneficiary whose claim for benefits is denied. The notice must set forth the specific reasons for the denial and must be written in a manner calculated to be understood by the participant. ERISA § 503(1) [29 U.S.C. § 1133(1)]; *see, e.g., Weaver v. Phoenix Home Life Mutual Insurance Co.*, 990 F.2d 154 (4th Cir. 1993); *Rakoczy v. The Travelers Insurance Co.*, 914 F. Supp.

166 (E.D. Mich. 1996). The plan must also afford the participant whose claim has been denied a reasonable opportunity for a full and fair review of the decision denying the claim. ERISA § 503(2) [29 U.S.C. § 1133(2)]. The review is to be conducted by the appropriate named fiduciary. *Id.* The claims procedure itself must be included in the summary plan description. 29 C.F.R. §§ 2560.503-1(b)(1)(ii) & 2520.102-3(s).

1. Deadline for Denying Claim. If a claim is to be denied in whole or in part, notice of that decision must be provided to the participant or beneficiary making the claim within a reasonable period of time after the plan receives the claim. 29 C.F.R. § 2520.503-1(e)(1). If notice of a denial of claim is not furnished within a reasonable period of time, the claim is deemed denied, and the claimant is permitted to initiate the plan's appeals procedure. 29 C.F.R. § 2560.503-1(e)(2). The time period for reviewing claims may not exceed 90 days, unless special circumstances require an extension of time. In that event, written notice of the extension must be provided to the participant or beneficiary making the claim and must be provided before the end of the initial 90-day period. The extension may not exceed a period of 90 days from the end of the initial period. 29 C.F.R. § 2560.503-1(e)(3).

2. Deadline for Appealing Denial. A plan is permitted to establish a limited period of time during which a claimant must file any request for review of a denied claim. The time limit must be reasonable and in no event may be shorter than 60 days from the date the claimant receives written notification of the denial of the claim. 29 C.F.R. § 2560.503-1(g)(3).

3. Deadline for Deciding Appeal. The appropriate named fiduciary must consider any request for review of a claim denial promptly, and ordinarily not later than 60 days after the plan receives the request for review, unless special circumstances require an extension. An example of a special circumstance permitting an extension would be the need to hold a hearing (if the plan procedures provide for a hearing). When there has been an extension, the appeal decision must be rendered as soon as possible, but not later than 120 days after receipt of the request for review. 29 C.F.R. § 2560.503-1(h)(1)(i). If a committee or board of trustees is designated as the named fiduciary to hear appeals, and it holds regularly scheduled meetings at least quarterly, a special rule applies. The appeal must then be decided no later than the date of the committee or board's next meeting, unless the review is filed within 30 days preceding the date of that meeting, in which case the decision must be made no later than the date of the second meeting following the filing of the appeal. In the case of special circumstances (such as the need to hold a hearing, if the plan procedures provide for a hearing), a further extension may be permissible, in which case the decision must be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review. 29 C.F.R. § 2560.503-1(h)(2)(ii). The decision of the named fiduciary deciding the appeal must be in writing and must specify the specific reasons for the decision, written in a manner calculated to be understood by the participant or beneficiary making the claim, and must also include specific references to the pertinent plan provisions on which the decision is made. 29 C.F.R. § 2560.503-1(h)(3). If a decision on an appeal is not made within the time frame set forth above, the appeal is considered to have been denied (that is, the claim denial is considered to have been upheld on appeal). 29 C.F.R. § 2560.503-1(h)(4).

4. Case Law. Federal courts generally hold that “substantial compliance” with the notice requirements under ERISA § 503 is sufficient — namely, that beneficiaries must be supplied with a statement (or statements) of reasons that, under the circumstances, permits a sufficiently clear understanding of a benefit denial. E.g., *Gomuluch v. Ameritech*, 48 F. supp. 2d 785 (N.D. Ill. 1999); *Bussey v. Corning Life Svcs. Inc.*, 2000 WL 91916 (N.D. Ill. Jan. 19, 2000). *Heller v. Fortis Benefits Ins. Co.*, 142 F.3d 487, 492-93 (D.C. Cir.), *cert. denied*, 119 S. Ct. 337 (1998); *Terry v. Bayer Corp.*, 145 F.3d 28, 33-34 (1st Cir. 1998); *Dade v. Sherwin-Williams Co.*, 128 F.3d 1135, 1142 (7th Cir. 1997); *Ellis v. Metropolitan Life Insurance Co.*, 126 F.3d 228, 234-36 (4th Cir. 1997); *Recupero v. New England Telephone & Telegraph Co.*, 118 F.3d 820, 840 (1st Cir. 1997) (claim will not be allowed due to inadequacy of formal notice without showing of prejudice); *Brehmer v. Inland Steel Industries Pension Plan*, 114 F.3d 656, 662 (7th Cir. 1997); *Neurological Resources P.C. v. Anthem Ins. Cos.*, 61 F. Supp. 840 (S.D. Ind. 1999) (failure to provide adequate notice in writing that the claim had been denied); *Tormey v. General American Life Insurance Co.*, 973 F. Supp. 805, 813-14 (N.D. Ill. 1997) (first denial letter was inadequate by itself, but “in combination with the reviewing process and the second letter qualif[ied] as substantial compliance with the regulations”); *Camarda v. Pan American World Airways*, 956 F. Supp. 299, 311 (E.D.N.Y. 1997) (“precise compliance with the regulations is not necessary as long as the plan administrator has substantially complied with such regulations and has provided the beneficiary with sufficient information to appeal the denial”).

Failure to provide the specific reason for a denial — but only a conclusory statement that the requested acute level of medical care is not necessary — is not substantial compliance with ERISA § 503 and the DOL regulations, particularly when the defendants’ internal communications are more detailed. *Crocco v. Xerox Corp.*, 956 F. Supp. 129, 142-43, 20 E.B.C. 2529 (D. Conn. 1997) *aff’d in pertinent part, rev’d in part*, 137 F.3d 105 (2d Cir. 1998). Where the notice of denial of benefits is insufficient, courts generally remand the benefits determination to the plan administrator for correct processing. *Crocco v. Xerox Corp.*, 956 F. Supp. at 144; *Christian v. Dupont-Waynesboro Health Care Coverage Plan*, No. 96-0011-H, 1997 U.S. Dist. LEXIS 21567 (W.D. Va. Dec. 16, 1997).

Some courts have ruled that plan administrators have no duty to advise participants what additional information is needed to prove their claims, provided that the denial notice contains the basic reasons for the denial. *Ellis v. Metropolitan Life Insurance Co.*, 126 F.3d at 234-36 (fiduciary has no “duty to affirmatively aid claimants in proving their claims”); *Brehmer v. Inland Steel Industries Pension Plan*, 114 F.3d at 661. In contrast, one district court held that the plan fiduciaries had a duty to describe the additional medical information needed to perfect a participant’s claim. *Crocco v. Xerox Corp.*, 956 F. Supp. at 143-44, *aff’d in pertinent part, rev’d in part*, 137 F.3d 105 (2d Cir. 1998). *See also Schleibaum v. Kmart Corp.*, 153 F.3d 496 (7th Cir. 1998) (stating that “the ERISA claims process is not designed to be an endurance contest where an employer must continue to appeal, without knowing what information the employer requests or whether the employer will even consider the appeal”).

5. Department of Labor Proposals. In September 1998, the Department of Labor proposed a sweeping overhaul of its rules under ERISA § 503 requiring that plans maintain

reasonable claims procedures. 63 Fed. Reg. 48,389 (Sept. 9, 1998). Under the proposed regulations, a plan's procedures will be deemed reasonable only if the following requirements are met:

- the SPD contains a description of all claim procedure timeframes including procedures for obtaining authorization review decisions;
- the claims procedures may not require that an adverse benefit determination be submitted to arbitration. The plan cannot require the participant to file more than one appeal as a prerequisite to litigation;
- the claims procedures may not contain any provision, nor may they be administered in a way, that unduly hampers the filing or processing of claims;
- the procedures must allow a representative, such as the participant's physician, to act on the participant's behalf;
- the procedures must provide that if the participant fails to comply with the plan requirements, the plan must notify the participant of the failure to comply and of the correct procedures for filing a claim. When a claim for urgent medical care is incomplete or fails to follow the plan's procedures, the plan administrator must notify the claimant within 24 hours and must tell the claimant what additional information is required to process the claim. For non-urgent care, claimants must be told of deficiencies in the claim form within five days;
- group health care claims involving urgent care must be decided within 72 hours of receipt of the claim; and
- non-urgent health care claims must be decided within 15 days.

A notification of a denial of benefits must include references to "any internal rules, guidelines, protocols, etc., that have been used by the initial decision-maker as a basis for denying the claim." Also, the plan must disclose the existence of any documents that were created or received in the review process, including reports and identities of experts consulted by the plan during the review. Claimants must have access to pertinent documents used to deny the claim. The claims denial must also contain a full description of the plan's review process, and must state that the claimant may sue under ERISA § 502(a) to recover benefits.

Claims appeals must be handled by "an appropriate named fiduciary" who is neither the party who made the initial determination nor that person's subordinate. The appeal must be independent of the determination of the initial appeal and must not give deference to the initial adverse determination. All relevant documents must be reviewed, regardless of whether they were considered in the initial denial. Appeals of health care decisions must be based on medical judgment conducted through consultation with an independent health care professional "who has appropriate training and experience in the field of medicine involved in the medical judgment."

In its explanation of the proposed regulation, the Department of Labor stated that a claimant should be entitled to litigate without further exhaustion of administrative remedies if the claims procedure fails to comply with the DOL regulation.

H. PARTICIPANT BENEFIT STATEMENT

1. Separated Participants. The plan administrator of a plan subject to ERISA’s vesting requirements (generally, any pension plan other than a “top-hat” plan), and the plan administrator of any tax-qualified plan, must provide an individual benefit statement to each participant who has separated from service. ERISA § 105(c) [29 U.S.C. § 1025(c)]; I.R.C. § 6058(e). The statement must include the name of the plan; the name and address of the plan administrator; the amount and taxpayer identification number of the participant; the nature, amount, and form of deferred vested benefit to which the participant is entitled; and a description of benefits which are forfeitable if the participant dies before a certain date. ERISA § 105(c) [29 U.S.C. § 1025(c)]; I.R.C. § 6057(a)(2). The notice must be provided to a separated participant no later than the due date for filing the Schedule SSA covering the participant (Schedule SSA is filed with the plan’s Annual Report). ERISA § 105(c) [29 U.S.C. § 1025(c)]; I.R.C. § 6058(e).

2. Other Participants or Beneficiaries Requesting Statement. A plan administrator of a pension plan (as opposed to a welfare plan) is required to furnish any participant or beneficiary making a written request with a statement of the total benefits accrued by the participant and the nonforfeitable pension benefits, if any, which have accrued (or the earliest date on which the benefits will become nonforfeitable). ERISA § 105(a) [29 U.S.C. § 1025(a)]. The plan administrator is not required to provide more than one such statement during any 12-month period. ERISA § 105(b) [29 U.S.C. § 1025(b)].

I. CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (“COBRA”)

As part of the Consolidated Omnibus Budget Reconciliation Act of 1985, both the Tax Code and Title I of ERISA were modified to provide certain health plan participants with the right to continue their health coverage (at their own expense) for a period beyond the time their coverage would otherwise terminate. Similar rules apply to federal, state, and local governmental group health plans. *See* 5 U.S.C. § 8905a (federal); 42 U.S.C. § 300bb-I (1985) (state and local). A variety of notice requirements are associated with these rights.

1. Initial Notice to Employee and Spouse. Each covered employee, and if the employee is married, his or her spouse, must be provided with a notice describing the COBRA rights of participants and beneficiaries at the time their coverage under the plan commences. I.R.C. § 4980B(f)(6)(A); ERISA § 606(a)(1) [29 U.S.C. § 1166(a)(1)]. In Advisory Opinion 94-17A, the Department of Labor stated that group health plans are not required to give employees’ spouses initial notice of their COBRA rights until they have commenced coverage under a plan. The purpose of the initial notice requirement would not be served by requiring that notice be given to a person who is not eligible for coverage under a plan and thus would not be entitled to make a COBRA election as a qualified beneficiary. Attempted delivery by certified mail constitutes a good faith

effort to comply with COBRA's notification requirement, even if the notice is not actually retrieved or otherwise received by the employee. *DeGruise v. Sprint Corp. Benefit Mgmt. Systems, Inc.*, 23 E.B.C. 1277 (E. D. La. 1999).

2. Events Requiring Employer to Notify Administrator. In the event an employee covered under the group health plan (1) dies, (2) has his or her employment terminated (other than by reason of the employee's gross misconduct), (3) has his or her hours reduced, or (4) becomes entitled to Medicare benefits, or (5) if a proceeding is instituted with respect to the employer under Title 11 of the United States Code, the employer must notify the plan administrator of the event if it would cause a "qualified beneficiary" (generally, the employee or a member of his or her family covered under the plan at the time of the event) to lose coverage. I.R.C. § 4980B(f)(6)(B); ERISA § 606(a)(2) [29 U.S.C. § 1166(f)(6)(B)]. The employer must give notice within 30 days of the event. *Id.* A multiemployer plan may, however, adopt a provision extending the 30-day period to the extent it wishes. *Id.* A plan (whether or not multiemployer) may provide for measuring the notice period from the date the qualifying beneficiary would lose coverage, rather than from the (earlier) date of the qualifying event. I.R.C. § 4980B(f)(8)(B); ERISA § 607(5)(B) [29 U.S.C. § 1167(5)(B)]. A multiemployer plan may provide that the determination of whether one of the events listed in (1) through (4) above has occurred will be made by the plan administrator (rather than by the employer). I.R.C. § 4980B(f)(6)(D); ERISA § 606(b) [29 U.S.C. § 1166(c)].

3. Events Requiring Employee or Qualified Beneficiary to Notify Administrator. If a qualified beneficiary would lose coverage by reason of a divorce or legal separation of the employee from his or her spouse, or a dependent child has ceased to be a dependent under the rules applicable under the plan, the covered employee or qualified beneficiary must notify the administrator that such an event has occurred. I.R.C. § 4980B(f)(6)(C); ERISA § 606(a)(3) [29 U.S.C. § 1166(a)(3)]. The covered employee or qualified beneficiary must provide that notice within 60 days after the date of the qualifying event. *Id.* Any qualified beneficiary who is determined to be disabled for Social Security purposes at the time of the employee's termination of employment or reduction in hours which triggered the qualified beneficiary's COBRA rights, must notify the plan administrator of the Social Security Administration's disability determination within 60 days after that determination is made. *Id.* If a qualified beneficiary is later determined by the Social Security Administration no longer to be disabled, the qualified beneficiary must give the plan administrator notice within 30 days after the date of any such final determination. *Id.*

4. Events Requiring Administrator to Notify Qualified Beneficiary. The plan administrator must notify all qualified beneficiaries of their COBRA rights within 14 days after receiving notice of a qualifying event from an employer, covered employee, or qualified beneficiary. I.R.C. § 4980B(f)(6)(D); ERISA § 606(a)(4) & (c) [29 U.S.C. §§ 1166(a)(4) & (c)]. Notice to a covered employee's spouse will be treated as notice to all other qualified beneficiaries (other than the covered employee) residing with the spouse. *Id.* An employee's spouse, however, has an independent right to receive notice of ability to elect COBRA continuation coverage, so that failure to provide the spouse notice may allow a belated election of COBRA coverage. *McDowell v. Krawchison*, 125 F.3d 954 (6th Cir. 1997). A multiemployer plan may adopt a provision extending

the 14-day period to the extent it wishes. *Id.*

5. Special HIPAA Notice Requirement. Section 421 of HIPAA made changes to three areas in the COBRA continuation rules applicable to group health plans. These three areas relate to disability extension, the definition of qualified beneficiary, and the duration of COBRA continuation coverage. HIPAA required group health plans subject to COBRA to notify, by November 1, 1996, all individuals who had elected COBRA continuation coverage of these three changes. Providing such individuals a copy of Department of Labor Technical Release 96-1 constitutes compliance with this notice requirement.

In Notice 98-12, 1998-5 I.R.B. 12, the IRS provided supplemental information that plan administrators can provide qualified beneficiaries. The three-part notice covers background information on the interaction between COBRA and HIPAA, the availability of other group health plan coverage, and courses of action available when no other group health coverage is available. The IRS issued final COBRA regulations on February 3, 1999 at 64 Fed. Reg. 5160 (Feb. 3, 1999).

6. Sanctions for Noncompliance. Failure to comply with COBRA, including its notice requirements, causes an employer to become subject to an excise tax. I.R.C. §§ 4980B(a)-(c) & 4980B(e)(1)(A)(i); 29 C.F.R. § 54.4980B-2, Q-9. In the case of a multiemployer plan, it is the plan which becomes subject to the tax (rather than the contributing employers). I.R.C. § 4980B(e)(1)(A)(ii); 29 C.F.R. § 54.4980B-2, Q-10. Any person responsible for administering or providing benefits under the plan (other than in his or her capacity as an employee), and whose act or failure to act caused (in whole or in part) the failure, may also become subject to the penalty, but only if the person (1) assumed, under a legally enforceable written agreement, responsibility for performance of those duties, or (2) in the absence of a written agreement, provides coverage for similarly situated beneficiaries with respect to whom there has been no qualifying event and receives a written request for coverage of the qualifying beneficiary. I.R.C. § 4980B(e)(1)(B) & (e)(2); 29 C.F.R. 54.4980B 2, Q-10; 54.4980B-3, Q-3 (defining “similarly situated nonCOBRA beneficiaries.”)

In general, the excise tax is \$100 per day from the date the failure first occurred through the date the failure is corrected. I.R.C. § 4980B(b)(1) & (2). Calculation of the tax will not, however, extend beyond six months after the maximum period of COBRA coverage for the employee or qualifying beneficiary. The penalty period for persons liable only because they provide coverage for similarly situated beneficiaries does not begin until the 45th day after a written request for coverage is made. *Id.* The tax does not apply where the failure was not known and would not have become known by the exercise of reasonable diligence. I.R.C. § 4980B(c)(1). The tax also will not apply if the failure was a consequence of reasonable cause and not due to willful neglect, and the failure is corrected within 30 days after it becomes known (or would have become known had simple diligence been exercised). I.R.C. § 4980B(c)(2).

In *Vincent v. Wells Fargo Guard Services, Inc. of Florida*, F. Supp. (S.D. Fl. 1999), the court held that employer was not liable for failing to notify administrator of a qualifying event since the employee did not incur medical expenses during the period that would have been his COBRA

continuation coverage. The court refused to award damages of up to \$100 per day since the employer was not the administrator and civil penalties are “reserved for plan administrators.”

In general, the liability for unintentional failures is capped at the lesser of (1) 10 percent of the total amount paid or incurred by the employer during the preceding taxable year for its group health plans, or (2) \$500,000. I.R.C. § 4980B(c)(4)(A). In the case of a multiemployer plan, the 10 percent limitation is applied to the amount paid or incurred by the trust for medical care during the taxable year (whether on a self-insured or fully insured basis). I.R.C. § 4980B(c)(4)(B). Where a person becomes subject to the COBRA excise tax by reason of the person’s administering or providing benefits under the plan (and the person is not an employer or a multiemployer plan), the tax imposed with respect to all plans for any single taxable year is capped at \$2,000,000. I.R.C. § 4980B(c)(4)(C).

The Secretary of the Treasury has the power to waive part or all of the excise tax, to the extent the payment of tax would be excessive relative to the failure involved. I.R.C. § 4980B(c)(5). The Secretary may exercise this power only where the failure is due to reasonable cause and not to willful neglect. *Id.* In addition, the sanctions described in Section D.2 above (for failure to distribute a summary annual report) would apply in the event of a violation of the COBRA notification requirements.

Plan administrators that fail to provide COBRA notices required by part 6 of Title I of ERISA may also be subject to a penalty of up to \$110 per day under ERISA § 502(c)(1)(A) [29 U.S.C. § 1132(c)(1)(A)]. *See* 29 C.F.R. § 2570.502c-1.

J. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

Under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), any period of exclusion from medical coverage due to a preexisting condition must be reduced by an individual’s periods of creditable coverage. Coverage under a group health plan, health insurance and Medicare and Medicaid is considered creditable coverage. HIPAA and temporary regulations issued in April 1997 create new notice and certification requirements.

1. HIPAA Notice Requirements. Before imposing a preexisting condition exclusion, a plan must give the participant a written notice that discloses the existence of the terms of the exclusion and the right of the participant to demonstrate credible coverage for him or herself and his or her dependents. Treas. Reg. § 54.9801-3T; 29 C.F.R. § 2590.701-3; 45 C.F.R. § 146.111.

If a plan elects to credit coverage based on prior coverage for particular benefits (as opposed to coverage generally) — the so-called “alternative method” — the plan must state that it is using the alternative method and describe the effect of using the method, including an identification of any categories used, in all disclosure statements concerning the plan, including disclosure to each enrollee at the time of enrollment. Treas. Reg. § 54.9801-4T; 29 C.F.R. § 2590.701-4; 45 C.F.R. § 146.113.

Plans are required to make determinations regarding individuals' period of creditable coverage and to notify the individuals of the determination within a reasonable period of time upon receiving a certification of creditable coverage, disclosure of information relating to the alternative method, or other evidence of creditable coverage. If the plan seeks to impose a preexisting condition exclusion, it must notify the individual to that effect and set forth any appeal procedures available to the individual to establish creditable coverage. Plans may modify initial determinations of creditable coverage, but must provide notice of any modifications. Treas. Reg. § 54.9801-5T(d); 29 C.F.R. § 2590.701-5(d); 45 C.F.R. § 146.115(d).

Plans must provide employees with a description of any special enrollment rules on or before the time when an employee is offered the opportunity to enroll in a group health plan. The regulations provide model language that may be used for this notice. Treas. Reg. § 54.9801-6T(c); 29 C.F.R. § 2590.701-6(c); 45 C.F.R. § 146.117(c).

Health insurers providing coverage to small employers must make a reasonable disclosure in its solicitation and sales materials of: (1) the provisions of the coverage relating to the insurer's right to change premium rates and the factors that may affect changes in premium rates; (2) the provisions relating to the renewability of coverage; (3) any preexisting condition exclusion, including the use of the alternative method of counting creditable coverage; (4) any affiliation periods applied by HMOs; (5) the geographic areas serviced by HMOs; and (6) the benefits and premiums available under all health insurance coverage for which the employer is qualified under applicable state law. The information must be described in a language understandable by the average small employer and will be sufficient if it contains an outline of the coverage, the rate or rating schedule that applies to the product, the minimum employer contributions and group participation rules that apply to any particular type of coverage, a map or listing of counties served (for network plans), and any other information required under state law. 45 C.F.R. § 146.160.

2. Certificate of Coverage. Group health plans must provide a certificate of coverage to former participants and beneficiaries at three times:

- a. When the individual ceases to be covered under the plan, even if the individual thereafter acquires COBRA continuation coverage under the plan;
- b. When the individual's COBRA coverage ends; and

Upon the individual's request within 24 months after the later of the dates in a. or b. above.

The certificate must state the individual's period of creditable coverage under the plan or under COBRA, and the waiting period (if any) that was imposed on the individual for any coverage under the plan. Treas. Reg. § 54.9801-5T; 29 C.F.R. § 2590.701-5; 45 C.F.R. § 146.115.

The certificate of creditable coverage must be provided to each participant and dependents. A single certificate may be provided for the participant and dependents if the information is identical. If the information is not identical, a single certificate may be provided only if the certificate sets forth

all the information for both and states that the information is not identical. The certification must be in writing; however, if a participant requests that his or her certificate be sent to another plan or insurer, the recipient may agree to accept the information by other means, such as by telephone. Treas. Reg. § 54.9801-5T(a)(3); 29 C.F.R. § 2590.701-5(a)(3); 45 C.F.R. § 146.115(a)(3).

The certificates are required to contain seven specific items: (1) the date of issuance of the certificate; (2) the name of the group health plan that provided the coverage; (3) the name of the participant and dependents for whom coverage was provided and any identification numbers; (4) the name, address and telephone number of the plan administrator or insurer issuing the certificate; (5) the telephone number to call for further information regarding the certificate; (6) either a statement that the individual has at least 18 months of coverage, or the date on which a waiting period (and affiliation period) began and the date creditable coverage began; and (7) the date creditable coverage ended, unless creditable coverage is continuing at the time the certification is issued. Plans may request insurers using the alternative method of counting creditable coverage to provide them with additional information, such as an identification of the categories of benefits under which the participant had coverage, as well as any specific information that is needed to determine the participant's creditable coverage with respect to such categories. Insurers may charge for providing such additional information. The interim regulations contain a model certification and form that satisfy these requirements. Treas. Reg. § 54.9801-5T(a)(3); 29 C.F.R. § 2590.701-5(a)(3); 45 C.F.R. § 146.115(a)(3).

The certification must be sent by first-class mail to the participant's last known address. Certificates to spouses who live in a different address than the participant must be sent to the spouse's last known address. The certificates must be provided automatically at the time coverage under the plan ceases. A plan or insurer must provide the certification no later than the time a notice is required to be furnished for a qualifying event under COBRA or no later than the time a notice is required to be furnished under state law. If the certificate is for an individual not entitled to COBRA coverage, then the plan must provide the certificate within a reasonable time. Certificates must also issue automatically within a reasonable time for individuals who have elected COBRA coverage upon cessation of such coverage. Similarly, when an individual requests a certificate within 24 hours of coverage cessation, a certificate must issue within a reasonable time. Treas. Reg. § 54.9801-5T(a)(3); 29 C.F.R. § 2590.701-5(a)(4); 45 C.F.R. § 146.115(a)(4).

With respect to events occurring through June 30, 1998, a plan or insurer that cannot provide the names of dependents on an automatic certification may provide the name of the participant and specify that the type of coverage is for dependent coverage. For certificates issued upon request, the plan or insurer must make a reasonable effort to obtain and provide the names of any dependents. Treas. Reg. § 54.9801-5T(a)(5); 29 C.F.R. § 2590.701-5(a)(5); 45 C.F.R. § 146.115(a)(5).

An entity required to provide a certificate will be deemed to have satisfied the requirement if another party provides the certificate, provided that the certificate given includes the required information. Plans that are not self-funded satisfy the certification requirement when the insurer provides the certification, provided that the plan and the insurer enter into an agreement obligating

the insurer to provide the certification. Insurers are not responsible for providing information regarding coverage under other entities. When a participant's coverage ends because an insurance policy ceases, but the participant's coverage continues under the health plan, the insurer is required to provide sufficient information to the plan to enable the plan to provide a certification to the participant. Issuers of group and individual insurance policies are required to provide the certification even if not subject to the group market provision of the Internal Revenue Code, ERISA, or the Public Health Services Act. Treas. Reg. § 54.9801-5T(a)(1) & (6); 29 C.F.R. § 2590.701-5(a)(1) & (6); 45 C.F.R. § 146.115(a)(1) & (6).

Certificates of coverage apply to events (*e.g.*, termination of non-COBRA coverage, termination of COBRA continuation coverage) occurring after June 30, 1996, although certificates were not required to be furnished until June 1, 1997. In the case of events occurring after June 30, 1996, but before October 1, 1996, a certificate is required only if the individual otherwise entitled to the certificate requested it in writing. Certificates were required to be distributed not later than June 1, 1997 to individuals who experienced such an event between October 1, 1996 and May 31, 1997, even if no request was made.

K. SURVIVOR ANNUITY NOTICES

Defined benefit and money purchase pension plans are required to provide benefits in the form of qualified joint and survivor annuities and qualified pre-retirement survivor annuities, except in certain circumstances. I.R.C. § 401(a)(11)(B)(i) & (ii); ERISA §§ 205(b)(1)(A) & (B) [29 U.S.C. §§ 1055(b)(1)(A) & (B)]. The same requirements apply to other defined contribution plans, unless the following conditions are met: (1) the plan provides that a participant's nonforfeitable accrued benefit will be payable, on the death of the participant, to the participant's surviving spouse (unless there is no surviving spouse or the surviving spouse consents to the naming of another beneficiary); (2) the participant does not elect a life annuity form of payment; and (3) with respect to the participant, the plan is not a direct or indirect transferee from a plan to which the rules apply. I.R.C. § 401(a)(11)(B)(iii); ERISA § 205(b)(1)(C) [29 U.S.C. § 1055(b)(1)(C)]. Several notice requirements apply in connection with the qualified joint and survivor annuity and qualified pre-retirement survivor annuity rules:

1. QJSA Explanation. A plan subject to the survivor annuity rules must provide each participant with a written explanation of the terms and conditions of the qualified joint and survivor annuity, as well as the participant's right to make, and the effect of, an election to waive that form of benefit. I.R.C. § 417(a)(3)(A); ERISA § 205(c)(3)(A) [29 U.S.C. § 1055(c)(3)(A)]. The written notice must also explain the rights of the participant's spouse with respect to the election and the right to revoke the election. *Id.* The written explanation must be provided within the 90-day period ending on the annuity starting date, but (under pre-1996 law) at least 30 days before that date. Treas. Reg. § 1.417(e)-1(b)(3).

The Small Business Job Protection Act of 1996 ("SBJPA") added I.R.C. § 417(a)(7). The subsection, which took effect in plan years beginning after December 31, 1996, made two relevant

changes to the QJSA rules. First, plans may provide the written explanation of the QJSA after the annuity starting date, but if a plan does so, the participant's and spouse's election period is extended to 30 days after the explanation is provided. Second, plans may permit participants and spouses to waive any requirement that written explanations be provided at least 30 days before the annuity starting date, if the distribution commences more than 7 days after the explanation is provided. These amendments codify the regulatory relief accomplished by temporary amendments to the REA regulations issued in September 1995. *See* Treas. Reg. § 1.417(e)-1T(b).

2. QPSA Explanation. The plan must also provide to each participant a written explanation relating to the qualified pre-retirement survivor annuity. I.R.C. § 417(a)(3)(B)(i); ERISA § 205(c)(3)(B)(i) [29 U.S.C. § 1055(c)(3)(B)(i)]. The required explanation is comparable to the explanation required with respect to the qualified joint and survivor annuity. *Id.* Notice is required to be provided between the first day of the plan year in which the participant attains age 32 and the last day of the plan year preceding the year in which the participant reaches age 35. I.R.C. § 417(a)(3)(B)(ii)(I); ERISA § 205(c)(3)(B)(ii)(1) [29 U.S.C. § 1055(c)(3)(B)(ii)(1)]; Treas. Reg. § 1.401(a)-20 Q&A-35(a)(1). Alternatively, the explanation may be provided to eligible participants within a reasonable period after the individual becomes a participant or the plan first becomes subject to the QPSA rules. I.R.C. § 417(a)(3)(B)(ii)(11) - (IV); ERISA § 205(c)(3)(B)(ii)(II) - (IV) [29 U.S.C. § 1055(c)(3)(B)(ii)(II) - (IV)]. In the case of a participant who separates from service before attaining age 35, the explanation must be provided within a reasonable period after that separation. I.R.C. § 417(a)(3)(B)(ii) (flush language at end of section); ERISA § 205(c)(3)(B)(ii) [29 U.S.C. § 1055(c)(3)(B)(ii)].

3. Fully Subsidized Benefit. A plan need not provide the explanations described above if the plan fully subsidizes the cost of those benefits (so there is no reduction in a participants' periodic payments as a consequence of eligibility for the survivor annuity benefits) and the benefits may not be waived. I.R.C. § 417(a)(5); ERISA § 205(c)(5) [29 U.S.C. § 1055(c)(5)].

4. Consequences of Noncompliance. For qualified plans, provision of the written explanations described above is a condition of the plan's tax qualification. A plan failing to do so therefore risks disqualification. Because the notice requirements are also imposed under ERISA, ERISA's general sanctions for reporting and disclosure noncompliance (set forth in Section D.2 above) would also be available for any failure to provide the required information.

5. IRS Sample Language for Spousal Waiver. In Notice 97-10, I.R.B. 1997-2 (Dec. 30, 1996), the Internal Revenue Service provided sample language that can be included in a form used for a spouse to consent to the waiver of a qualified joint and survivor annuity or a qualified preretirement survivor annuity or to the participant's choice of a non-spouse beneficiary. Plan administrators are not required to use the sample language, and those that do are free to incorporate part or all of it in their spousal consent forms.

L. NOTICE TO PARTICIPANTS: ELIGIBLE ROLLOVER DISTRIBUTIONS

The plan administrator of a qualified plan must, within a reasonable period of time before making an “eligible rollover distribution,” provide a written explanation to the recipient of the tax consequences of that distribution. I.R.C. § 402(f). The notice must be designed to be easily understood, and must explain the following:

- The rules under which the distributee may elect a direct rollover;
- The tax withholding rules for distributions not paid in a direct rollover;
- The regular rollover (as opposed to direct rollover) rules;
- Where they apply, other special tax rules, such as the favorable tax treatment available for lump sum distributions and net unrealized appreciation in employer securities; and
- If the plan administrator intends to treat a distributee’s direct rollover election with respect to a payment in a series of periodic payments as applying to all subsequent payments (unless the distributee subsequently changes his or her election), an explanation of this rule.

Treas. Reg. sec. 1.402(f), Q&A-1. The IRS issued a model notice plan administrators may use to satisfy this requirement, IRS Notice 92-48, 1992-2 C.B. 377 (Oct. 20, 1992), and recently updated the model notice, IRS Notice 2000-11, 2000-6 I.R.B. 1 (Jan. 21, 2000). See Treas. Reg. 1.401(a)(31)-1, Q&A-1; 1.402(f), Q&A-1. In proposed regulations issued in December 1998, the IRS suggested that direct rollover notices could be provided electronically or telephonically, provided that participants have previously received a complete Section 402(f) notice (*e.g.*, in an SPD), are informed where that explanation can be found, and are advised where they can obtain another written copy on request. 63 Fed. Reg. 70,071 (Dec. 18, 1998).

Final regulations, applicable to distributions made on or after October 19, 1995, retain the time frame in which a participant must receive a rollover notice (no more than 90 and no less than 30 days prior to the date of distribution), but permit a participant to elect affirmatively a distribution before the expiration of the 30-day grace period. Treas. Reg. § 1.402(f)-1, Q&A-2. Where a series of periodic payments that are eligible rollover distributions is made, the plan administrator need not provide notice prior to each payment. Instead, it may provide notice prior to the first payment in the series, and once each year thereafter. *Id.*, Q&A-3.

A person failing to provide the written rollover explanation is subject to an excise tax equal to \$10 per failure, unless the failure is due to reasonable cause and not to willful neglect. I.R.C. § 6652(i). The tax is to be paid on notice and demand of the Secretary of the Treasury, and the total imposed on any one person for all failures during a calendar year is not to exceed \$5,000. *Id.*

In *Fraser v. Lintas*, 56 F.3d 722 (6th Cir. 1995), *cert. denied*, 116 S. Ct. 477 (1995), the court

held that there is no cause of action under ERISA § 502(a)(1)(B) for a participant who suffers adverse tax consequences due to the plan administrator's failure to provide her with timely notice of a "rollover option," because such notice does not constitute a "benefit due under the terms of the plan." *Accord, Mouly v. E.I. DuPont de Nemours Co.*, 1998 U.S. Dist. LEXIS 15041 (W.D. Va. Sept. 11, 1998).

M. WITHHOLDING TAX NOTICE

In the case of an "eligible rollover distribution," the notice described in Section L above must be provided. This notice is to include a description of the mandatory 20 percent withholding rules applicable to eligible rollover distributions not transferred in a direct rollover. As to distributions that do not constitute eligible rollover distributions, the withholding of income tax may also be required. In particular, when periodic pension payments (which are not eligible rollover distributions) are made, a notice explaining the recipient's right to make a withholding election must be provided. I.R.C. § 3405(d)(10). Treas. Reg. § 35.3405-1 includes model language for the withholding notices. Where a notice is not provided in a timely fashion, the Secretary of the Treasury may assess a tax on the person failing to provide the notice, in an amount equal to \$10 for each failure. The tax is to be paid on notice and demand of the Secretary of the Treasury, and the total amount imposed on a person for all failures during a single calendar year may not exceed \$5,000. I.R.C. § 6652(h).

N. REDUCTION IN BENEFIT ACCRUAL RATE

Defined benefit and money purchase pension plans (but not profit sharing plans) may not significantly reduce the rate of future benefit accruals, unless a special notice is first provided. After adoption of a plan amendment significantly reducing the rate of future benefit accruals, and not less than 15 days before the effective date of the plan amendment, the plan administrator must provide a written notice describing the amendment and its effective date to each plan participant, each beneficiary who is an alternate payee under a qualified domestic relations order, and each employee organization representing participants in the plan. ERISA § 204(h) [29 U.S.C. § 1054(h)].

1. Regulations on ERISA § 204(h) Notice Requirements. In December 1998, the IRS, which has regulatory and interpretive (but not enforcement) authority over ERISA § 204(h), issued final regulations that replaced temporary regulations the IRS had issued in December 1995. The final regulations apply to plan amendments adopted on or after December 12, 1998.

The final regulations confirm that an amendment affecting the rate of future benefit accrual is: (a) in the case of a defined benefit plan, an amendment that is expected to change the amount of the annual benefit at normal retirement age, or (b) in a money purchase plan, an amendment that is expected to change the amounts allocated to participants' accounts. Treas. Reg. §1.411(d)-6, Q&A 5. The Treasury Department declined a request to extend the regulations to cover plan amendments that eliminate or reduce early retirement subsidies or optional forms of benefit.

A § 204(h) notice needs only to contain an understandable summary of the plan amendment; a copy of the actual amendment is not necessary. *Id.*, Q&A 10. Notice may be provided by hand delivery or by mail, with the postmark counting as the date of delivery for notices given by first-class mail. *Id.*, Q&As 11 & 12.

The regulations provide that if a plan administrator fails to notify more than a *de minimis* percentage of participants and alternate payees to whom a § 204(h) notice is required to be given, ERISA § 204(h) is still satisfied with respect to those individuals who were actually given a notice. *Id.*, Q&A 13. An amendment will not be effective with respect to those participants or alternative payees who do not receive a § 204(h) notice, unless (i) the number of participants or alternative payees who did not receive a § 204(h) notice is *de minimis*, (ii) the plan administrator provided a § 204(h) notice to each required labor organization, and (iii) the plan administrator promptly provides a § 204(h) notice to those participants and alternative payees upon discovering the oversight. *Id.*, Q&A 14.

Despite some suggestions, the final regulations adopt no bright-line standards for determining whether an amendment results in a significant reduction in the rate of benefit accrual or what constitutes a *de minimis* percentage of participants for purposes of the rules concerning the failure to provide a § 204(h) notice to all participants and alternative payees.

The final regulations add an example illustrating the application of ERISA § 204(h) to a situation where a defined benefit plan cannot be terminated on a proposed termination date due to a failure to satisfy all of the requirements of Title IV of ERISA. Benefit accruals will still cease if a plan amendment has been adopted that ceases accruals as of a specified date, and the § 204(h) notice includes this specified date. *Id.*, Q&A 16.

Lastly, the regulations address the application of ERISA § 204(h) to the sale of businesses. Whether a § 204(h) notice is needed generally depends on whether a plan is amended, not merely on whether a participant suffers a lower rate of benefit accrual. Suppose, for example, a company that maintains a pension plan sells all of the assets of a division and the division's employees are transferred to the new owner, which has a less generous plan, or no plan at all. No § 204(h) notice is required if the employees leave the first company's plan merely by operation of their ending employment with the first company and leaving that company's control group. No plan amendment was adopted in this example. In contrast, suppose a subsidiary is sold, that subsidiary's pension plan is transferred to the purchaser, and, in accordance with the sale agreement, the plan is amended to reduce or eliminate benefit accruals. In this case, even though the effect on participants may be the same as in the former example, a § 204(h) notice is required because a plan amendment was adopted. *Id.*, Q&A 15.

2. Case Law. In cases decided before the December 1995 issuance of the IRS regulations, courts had generally interpreted § 204(h) strictly, holding that the failure to give a proper § 204(h) notice precludes application of the plan amendment reducing benefit accruals. For example, in *DiCioccio v. Duquesne Light Co.*, 911 F. Supp. 880 (W.D. Pa. 1995), a plan

administrator's internal memorandum changed the type of compensation that would be used to calculate pension benefits, excluding income received from the exercise of stock options and stock appreciation rights. The court held the memorandum was a de facto amendment, even though it affected relatively few employees. Because the amendment had not been published or provided to the employees before it was applied to the calculation of the employees' pension benefits, the court refused to give effect to the change. In *Normann v. Amphenol Corp.*, 956 F. Supp. 158 (N.D.N.Y. 1997), the court held that early retirement benefits and the actuarial factors applied to them are subject to the notice requirements of Section 204(h), notwithstanding the IRS regulations stating otherwise. Because actual notice of new early retirement reduction factors was not provided until February 1991, when the employer distributed a new summary plan description, the employer could not apply the new reduction factors for early retirement benefits between January 1989 and February 1991. *But see Scott v. Administrative Committee of the Allstate Agents Pension Plan*, 113 F.3d 1193 (11th Cir. 1997) (defendants provided satisfactory notice of suspension of benefit accruals under Model Amendment 3 of IRS Notice 88-131).

O. TRANSFER OF EXCESS PENSION ASSETS TO HEALTH BENEFIT ACCOUNTS

When a defined benefit pension plan transfers excess assets to a health benefit account that is part of the same plan (under I.R.C. § 420), advance notice must be given by the plan administrator to each participant and beneficiary. The notice must be given not later than 60 days before the date of the transfer and must indicate the amount of the excess pension assets, the portion to be transferred, the amount of the health benefit liabilities expected to be provided with the assets transferred, and the amount of pension benefits of the participant which will be nonforfeitable immediately after the transfer. ERISA § 101(e)(1) [29 U.S.C. § 1021(e)(1)]. In addition, not later than 60 days before any such transfer, the employer maintaining the plan from which the transfer is to be made must give the Secretary of Labor, the Secretary of the Treasury, the plan administrator, and each employee organization representing participants under the plan a written notice of the transfer. ERISA § 101(e)(2) [29 U.S.C. § 1021(e)(2)]. A copy of the notice must be available for inspection in the principal office of the plan administrator. *Id.* The notice must identify the plan from which the transfer is made, the amount of the transfer, a detailed accounting of assets projected to be held by the plan immediately before and immediately after the transfer, and the current liabilities under the plan at the time of the transfer. *Id.*

Failure to provide the proper notice to a participant can result in the plan administrator being personally liable to the participant for a penalty of up to \$110 per day. ERISA § 502(c)(1) [29 U.S.C. § 1132(c)(1)], as modified by the Debt Collection Improvement Act of 1996. *See* 29 C.F.R. § 2570.502c-

1. Failure by an employer to provide notice to the Secretary of Labor, Secretary of the Treasury, plan administrator, or employee organization may, in a court's discretion, cause the employer to be liable to the party not receiving the notice in an amount of up to \$110 per day from the date of the failure. ERISA § 502(c)(3) [29 U.S.C. § 1132(c)(3)]; *see* 29 C.F.R. § 2570.502c-3.

P. FAILURE TO SATISFY MINIMUM FUNDING REQUIREMENTS

If an employer is 60 days late in making a minimum funding contribution to a defined benefit or money purchase pension plan, the employer must give notice of that failure to each participant and beneficiary, including alternate payees under qualified domestic relations orders. ERISA § 101(d)(1) [29 U.S.C. § 1021(d)(1)]. The notice requirement does not apply in the case of a multiemployer plan or where the employer has filed a minimum funding waiver request with respect to the plan year to which the missed payment relates. ERISA § 101(d)(1) & (2) [29 U.S.C. § 1021(d)(1) & (2)]. An employer failing to provide the required notice may, in a court's discretion, be held liable to the participant or beneficiary in an amount up to \$100 per day from the date of the failure. ERISA § 502(c)(3) [29 U.S.C. § 1132(c)(3)]. The normal ERISA penalties for failure to satisfy the reporting and disclosure requirements, as described in Section D.2 above (dealing with noncompliance with the summary annual report requirement), apply as well.

Q. DOMESTIC RELATIONS ORDERS

A pension plan (as opposed to a welfare plan) which receives a domestic relations order must promptly notify the participant and each alternate payee named in the order of the plan's receipt of the order and the plan's procedures for determining the qualified status of the order. Within a reasonable period after receipt of the order, the plan administrator must then notify the participant and each alternate payee of its determination whether the order is qualified. ERISA § 206(d)(3)(G)(i) [29 U.S.C. § 1056(d)(3)(G)(i)]; I.R.C. § 414(p)(6)(A).

In Notice 97-11, I.R.B. 1997-2 (Dec. 30, 1996), the IRS addressed certain issues that should be considered when drafting a qualified domestic relations order and provided sample language for QDROs. Drafters who use the sample language will need to conform it to the terms of the retirement plan to which the order applies. A domestic relations order is not required to use the sample language in order to satisfy the requirements for a QDRO.

R. MEDICAL CHILD SUPPORT ORDERS

A "group health plan" (within the meaning of ERISA Section 607(1)) which receives a medical child support order must promptly notify the participant and each alternate recipient named in the order of the plan's receipt of the order and the plan's procedures for determining the qualified status of the order. Within a reasonable period after receipt of the order, the plan administrator must then notify the participant and each alternate recipient of its determination as to whether the order is qualified. ERISA § 609(a)(5)(A) [29 U.S.C. § 1169(a)(5)(A)].

The original definition of a QMCSO included the requirement that it be an order entered by a "court of competent jurisdiction." Despite this specific requirement, many plans received orders from state administrative agencies purporting to be QMCSOs. In the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104-193, § 381, 110 Stat. 2105, 2257, Congress clarified that a QMCSO need not be issued by a court, but may also be issued "through an administrative process established under State Law" which has the force and effect of law in that State. ERISA § 609(a)(2)(B) [29 U.S.C. § 1169(a)(2)(B)].

On November 15, 1999, the DOL and HHS proposed rules on informing employee benefit plans about MCSOs, 64 Fed. Reg. 62053 (Nov. 15, 1999). The Child Support Performance and Incentive Act of 1998 (CSPIA) amended ERISA to require State agencies to enforce medical child support obligations of non-custodial parents by issuing to their employers a National Medical Support Notice. CSPIA amended ERISA by adding Section 609(a)(5) which provides that if a plan is maintained by the employer of a noncustodial parent of a child, or to which such employer contributes, receives an appropriately completed Notice, and the Notice satisfies the conditions of Section 609(a)(3) and (4), the Notice will be deemed to be a QMCSO. Within 40 business days of receipt of the Notice, the administrator must notify the State agency issuing the Notice whether the coverage is available under the plan, and if so, the effective date of coverage, or the steps necessary for the custodial parent to effectuate coverage, and provide to the custodial parent a description of the coverage and any forms required to be completed to effectuate coverage. A Notice is appropriately completed if it contains the name of the issuing agency, the name and address of the employee-participant, the home and mailing address of one or more alternative recipients, and whether family group health care coverage required by the CSO is identified and available. § 2590.609-2. The Notice must include a separate and easily severable employer withholding notice informing the employer of the noncustodial parent of applicable laws relating to any necessary withholding of employee contributions that may be required by the plan to extend coverage to any child named in the Notice. The proposed rules simplify the issuance and processing of MSCOs, provide standardized communication between State agencies, employers, and plan administrators, and create a uniform and streamlined process for enforcement of medical child support.

S. MEDICARE AND MEDICAID DATA BANK

The Omnibus Budget Reconciliation Act of 1993 directed the Secretary of Health and Human Services to establish a Medicare and Medicaid Coverage Data Bank which would be used to identify third parties responsible for paying expenses under the Medicare and Medicaid secondary payer rules. 42 U.S.C. § 1320b-14. The statute required employers that maintain or contribute to a “group health plan” covering at least one of the employer’s employees to report annually regarding the identification of all persons who were eligible to receive benefits under the plan.

The Medicare and Medicaid Data Bank was never implemented. Congress refused to appropriate funds for its operation and in October 1996 repealed the Medicare and Medicaid Data Bank legislation. Pub. L. 104-226, 110 Stat. 3033 (1996). The 1996 legislation did not repeal ERISA §§ 101(f) & 502(c)(4) [29 U.S.C. §§ 1021(f) & 1132(c)(4)], which had been added by OBRA ’93 to implement the Data Bank reporting requirements, but those sections no longer have any application.

T. GENERAL DISCLOSURE

1. Information Available to Participants on Request. In addition to ERISA’s requirement that certain materials be disclosed to participants and beneficiaries automatically (i.e., without their request), participants and beneficiaries can also obtain additional plan-related materials

upon request. In particular, in response to the written request of any participant or beneficiary, a plan administrator must “furnish a copy of the latest updated summary plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated.” ERISA § 104(b)(4) [29 U.S.C. § 1024(b)(4)].

These materials must be mailed to the address provided by the requesting participant or beneficiary, or personally delivered to the participant or beneficiary. 29 C.F.R. § 2520.104b-1(b)(2). The plan administrator may impose a reasonable charge, up to 25 cents per page, to cover the cost of copying. No charge may be imposed for certain materials that are required to be disclosed without the participants’ request, and the charge for copies must be for the least expensive means of acceptable reproduction. 29 C.F.R. § 2520.104b-30. Copies of these documents must also be available for examination by any participant or beneficiary in the principal office of the administrator and in such other places as may be necessary to make available all pertinent information to all participants. ERISA § 104(b)(2) [29 U.S.C. § 1024(b)(2)].

2. The Meaning of “Other Instruments.” In recent years the Courts of Appeals have given a narrow reading to ERISA § 104(b)(4) and limited the type and scope of documents required to be disclosed. While the section clearly requires a plan administrator to issue the listed documents – *e.g.*, the latest summary plan description, the latest annual report, any trust agreement, etc. – it is less obvious what documents are subject to mandatory disclosure as “other instruments under which the plan is established or operated.”

In *Faircloth v. Lundy Packing Co.*, 91 F.3d 648, 653 (4th Cir. 1996), *cert. denied*, 519 U.S. 1077 (1997), the Fourth Circuit held that “other instruments under which the plan is established or operated” encompasses formal or legal documents under which a plan is set up or managed.” Applying this standard, the court ruled that ESOP participants were not entitled to: (i) a copy of the IRS determination letter regarding the plan’s tax qualification, (ii) a copy of the bonding policy insuring the plan against fiduciary misconduct, (iii) appraisal or valuation reports from which the value of the company’s stock in the ESOP was derived, or (iv) the trustee expense policy. The court did not decide whether minutes of trustees’ meetings are required to be disclosed under Section 104(b)(4), because the plaintiffs’ document request did not clearly specify the information sought. The Fourth Circuit held that participants were entitled to copies of the ESOP’s funding and investment policies. *Id.* at 654-66.

In *CWA/ITU Negotiated Pension Plan v. Weinstein*, 107 F.3d 139 (2d Cir. 1997), the Second Circuit similarly held that the word “instruments” in Section 104(b)(4) refers to “formal legal documents that govern or confine a plan’s operation, rather than routine documents with which or by means of which a plan conducts its operations.” Based on this statutory interpretation, the court held that the administrator of a defined benefit pension plan was not required to provide a copy of the plan’s actuarial valuation report, even though ERISA § 103(d) requires an actuarial valuation to be made every third year. (Participants are, of course, entitled to a copy of Schedule B to the plan’s annual report, which contains a summary statement of the plan’s actuarial information). *See also*,

Hughes Salaried Retirees Action Committee v. Administrator of Hughes Non-Bargaining Retirement Plan, 72 F.3d 686 (9th Cir. 1995) (en banc) (no duty to disclose list of retirees' names and addresses).

In the last two years, at least four other Courts of Appeals have adopted similarly narrow interpretations of ERISA § 104(b)(4). The Sixth Circuit held that “‘other instruments’ refers to documents that provide or contain information concerning the terms and conditions of the participant’s policy,” and ruled that Section 104(b)(4) does not require the plan administrator to provide a claim form. *Allinder v. Inter-City Products Corp.*, 152 F.3d 544, 549 (6th Cir. 1998). The First Circuit ruled that “Medical Necessity Guidelines” to which an insurance company referred, but was not bound, in making benefit decisions, did not have to be disclosed because they are not “formal legal documents that underpin the plan.” *Doe v. Travelers Insurance Co.*, 167 F.3d 53, 60 (1st Cir. 1999). The Seventh Circuit held that ERISA does not require a plan administrator to provide copies of a sales agreement for a business division, board resolutions, or the names of individual plan fiduciaries, because they are not the “formal legal documents governing a plan.” At the same time, the court noted that these same documents would likely have to be produced in discovery. *Ames v. American National Can Co.*, 170 F.3d 751, 758-59 (7th Cir. 1999). The Eighth Circuit ruled that Section 104(b)(4) does not require furnishing copies of employer actions changing the members of the ESOP Administrative Committee, resolutions and minutes of the Administrative Committee, or written communications between the employer or Administrative Committee and the ESOP trustee. *Brown v. American Life Holdings, Inc.*, 190 F.3d 856, 861 (8th Cir. 1999) (“we agree with the circuits that have construed ‘other instruments’ as meaning, not any document relating to a plan, but only formal documents that establish or govern the plan”).

In another example of strict statutory construction, the Seventh Circuit ruled that ERISA § 104(b)(4) – which expressly refers to “the latest summary plan description” – did not require a plan administrator to produce copies of the pension plan document from 1967 or 1989. *Shields v. Local 705, International Brotherhood of Teamsters Pension Plan*, 188 F.3d 895, 903 (7th Cir. 1999).

A handful of earlier cases took a more generous view of the disclosure obligation under Section 104(b)(4). Most notably, the Sixth Circuit ordered disclosure of the plan’s actuarial valuation, based largely on a perceived presumption in favor of disclosure under ERISA. *Bartling v. Fruehauf Corp.*, 29 F.3d 1062, 1070 (6th Cir. 1994) (“all other things being equal, courts should favor disclosure where it would help participants understand their rights”). *See also, Mauro v. Federal Express Corp.*, 843 F. Supp. 935, 942 (D.N.J. 1994) (holding a participant is entitled to all documents that would help him determine his rights, eligibility or interest in the plan); *Lee v. Dayton Power & Light*, 604 F. Supp. 987, 1002 (S.D. Ohio 1985) (participant entitled to charts pursuant to which benefits were calculated because they would assist him in determining his rights).

The Department of Labor also takes a more generous stance toward disclosure. A DOL advisory opinion states that a welfare plan must provide a copy of the fee schedules under which the plan determines what medical claims will be paid. According to the Department, “any document or instrument that specifies procedures, formulas, methodologies, or schedules to be applied in

determining or calculating a . . . benefit entitlement under an employee benefit plan would be an instrument under which the plan is established or operated,” as would any “studies, schedules or similar documents that contain information and data [that] serve as the basis for determining or calculating . . . benefit entitlements.” DOL Op. 96-14A (Jul. 31, 1996). Similarly, the Department has opined that a plan’s contract with a third-party administrator must be furnished on request to the extent it “establishes or amends the plan in question, establishes a claims procedure, [or] specifies procedure, formulas, methodologies, or schedules to be applied in determining or calculating a participant’s or beneficiary’s benefit entitlement.” DOL Op. 97-11A (Apr. 10, 1997).

3. Nature of Requests. Other cases have addressed what steps are necessary to request documents under ERISA § 104(b)(4). In *Anderson v. Flexel, Inc.*, 47 F.3d 243 (7th Cir. 1995), several requests for information were made by attorneys and a relative of the alleged beneficiary of a life insurance policy. Both companies involved (the employer and the insurer) had notice that there was a dispute regarding the participant’s beneficiary designation. The court ruled that a letter from an attorney requesting information about “any group life insurance that Harry may have had,” compounded by the employer’s knowledge of the underlying problem, was sufficient notice as to what information the attorney was seeking. Accord, *e.g.*, *Sam v. Creare, Inc.*, 1994 U.S. Dist. LEXIS 12142 (D.N.H. 1994) (duty exists under § 104(b)(4) if employer knew or should have known that participant’s request for information could be answered by furnishing one of the specified documents).

In contrast, in *Bartling v. Fruehauf Corp.*, 29 F.3d 1062 (6th Cir. 1994), the court held that when a third party, including an attorney, requests documents on behalf of a participant, a plan may require written authorization from the plan participants. The Fourth Circuit, however, found that the fact a request came from an attorney does not excuse an administrator from furnishing plan documents. If the plan administrator is “genuinely concerned” about the participant’s authorization or privacy, “it would [be] a simple matter to verify the attorney-client relationship.” *Sedlack v. Braswell Services Group, Inc.*, 134 F.3d 219, 226 (4th Cir. 1998); accord, *e.g.*, *Jandek v. AT&T Corp.*, 1996 U.S. Dist. LEXIS 3854 (N.D. Ill. 1996).

4. Penalties for Noncompliance. The normal ERISA penalties for failure to make required disclosures, described in Section D.2, apply to a failure to comply with the general disclosure requirement just described. An additional – and important – penalty may also apply. If a plan administrator receives a request for plan documents and then fails to mail the material to the last-known address of the requesting participant or beneficiary within 30 days after the request, a court may, in its discretion, make the administrator personally liable to the participant or beneficiary in the amount of up to \$110 per day from the date of the failure. The penalty is to be waived if the administrator’s failure results from matters reasonably beyond the administrator’s control. ERISA § 502(c)(1) [29 U.S.C. § 1132(c)(1)]; see 29 C.F.R. § 2570.502c-1.

Even though many earlier court decisions denied penalties to participants absent demonstrable “prejudice,” several circuits recently have held that a court may, but does not have to, consider provable injury to the participant. See, *e.g.*, *Sedlack v. Braswell Services Group, Inc.*, 134

F.3d 219, 226 (4th Cir. 1998) (“[a]lthough prejudice is a pertinent factor, it is not a prerequisite to imposing a penalty”); *Moothart v. Bell*, 21 F.3d 1499 (10th Cir. 1994) (awarding statutory penalties against participant’s former employer, who may have acted in bad faith by refusing to provide plan documents after several written requests); *Bartling v. Fruehauf Corp.*, 29 F.3d 1062 (6th Cir. 1994) (upholding district court award of \$100/day per document, for a total of \$25,200 to be split among 78 plaintiffs despite finding of no prejudice). *See also, e.g., Brooks v. Metrica, Inc.*, 1 F. Supp. 2d 559 (E.D. Va. 1998) (penalty warranted where participant was required to hire attorney and sue to obtain requested documents); *Almonte v. General Motors Corp.*, 1997 U.S. Dist. LEXIS 9271 (S.D.N.Y. 1997) (administrator failed to provide documents because it lost request; court awarded \$10 per day for 253-day delay); *Tait v. Bardknecht & Tait Profit Sharing Plan*, 1997 U.S. Dist. LEXIS 21089 (N.D. Tex. 1997) (withholding documents because participant is not vested or already has them is not good faith; court awarded \$100 per day for 136-day delay).

Other courts have refused to award penalties in the absence of prejudice to the participant. *E.g., Wilson v. Moog Automotive, Inc. Pension Plan*, 193 F.3d 1004 (8th Cir. Oct. 8, 1999) (affirming failure to award penalties, where documents were eventually produced and participants were not prejudiced); *Rodriguez-Abreu v. Chase Manhattan Bank*, 986 F.2d 580, 588 (1st Cir. 1993); *Paris v. Profit Sharing Plan*, 637 F.2d 357, 362 (5th Cir. 1981); *Celi v. Trustees of Pipeline Local 537 Pension Plan*, 975 F. Supp. 23 (D. Mass. 1997) (no penalty where delay was caused by “bureaucratic sloth” rather than bad faith).

5. Relationship to Fiduciary Duty. If certain documents do not need to be furnished pursuant to ERISA § 104(b)(4), the question arises whether they must be provided under a more general disclosure obligation implicit in the fiduciary duties under ERISA § 404(a) [29 U.S.C. § 1104(a)]. In *CWA/ITU Negotiated Pension Plan v. Weinstein*, 107 F.3d at 146-47, and *Faircloth v. Lundy Packing*, 91 F.3d at 656-58, the courts held that the general fiduciary duties under ERISA § 404 do not create additional obligations for a plan administrator to provide copies of plan documents. In *Hughes Salaried Retirees Action Committee*, 72 F.3d at 694, the Ninth Circuit suggested that ERISA § 404(a) might provide an independent disclosure duty in appropriate circumstances, but ruled that such a duty did not apply to the requested disclosure of retirees’ names and addresses. Most recently, the Fifth Circuit pointed to the absence of any specific disclosure requirement regarding HMOs’ physician reimbursement policies as persuasive argument that a duty to disclose these reimbursement policies should not be implied under ERISA’s general fiduciary duties. *Ehlmann v. Kaiser Foundation Health Plan*, 198 F.3d 552 (5th Cir. 2000).

These holdings contrast, and arguably are inconsistent, with decisions holding that ERISA fiduciaries have an affirmative obligation to disclose information to individual participants that may be useful to the participants. *E.g., Bins v. Exxon Company U.S.A.*, 189 F.3d 929 (9th Cir. 1999), vacated pending rehearing en banc, 198 F.3d 1191 (9th Cir. 2000); *Shea v. Esensten*, 107 F.3d 625 (8th Cir.), cert. denied, 522 U.S. 914 (1997); *Eddy v. Colonial Life Insurance Co.*, 919 F.2d 747 (D.C. Cir. 1990). One way of reconciling the two lines of cases – albeit not completely satisfying – is that Section 104(b)(4) defines a plan administrator’s duty to furnish certain plan documents to any participants who request them, while Section 404(a) creates (at most) an implicit duty to provide

information a fiduciary knows to be relevant to participants in their individual circumstances.

6. Proposed Rules on DOL Requests for Documents. When Congress eliminated the requirement that plan administrators file summary plan descriptions and summaries of material modifications with the Department of Labor in the Taxpayer Relief Act of 1997, it enacted ERISA § 104(a)(6) [29 U.S.C. § 1024(a)(6)], which requires plan administrators to furnish “any documents relating to the employee benefit plan” to the Department on request. These documents include, but are not limited to, the latest SPD and any SMMs. Congress also added a corresponding penalty provision, ERISA § 502(c)(6) [29 U.S.C. § 1102(c)(6)], authorizing the Secretary of Labor to assess a civil penalty of \$100 per day, with a maximum penalty of \$1000, for a plan administrator’s failure to furnish material requested under Section 104(a)(6).

In August 1999, DOL issued proposed rules to implement Sections 104(a)(6) and 502(c)(6). Notice of Proposed Rule-making on Furnishing Documents to the Secretary of Labor Under ERISA Section 104(a)(6) and Assessment of Civil Penalties Under ERISA Section 502(c)(6), 64 Fed. Reg. 42797 (Aug. 5, 1999). Under the proposed DOL regulations, the penalty period starts on the date of the plan administrator’s refusal or failure to furnish the documents but not earlier than 30 days after the request. 29 C.F.R. § 2520.502c-6(b) (proposed). The penalty is payable upon notice and demand by the DOL. *Id.* § 2520.502c-6(c). The Department will set the amount of the penalty taking into account the willfulness of the failure or refusal to furnish documents, *id.*, § 2520.502c-6(b), and may waive all or part of the penalty on a showing that the failure was a result of matters beyond the plan administrator’s control. *Id.* §§ 2520.502c-6(d) to -6(g). The proposed regulations also specify detailed procedures for assessing civil penalties under Section 502(c)(6). 29 C.F.R. § 2570.110 to .121.

U. RETENTION OF RECORDS

Any person required to provide information under Title I of ERISA (or who would be required to do so but for an exemption or simplified reporting requirement) must maintain records concerning the matters required to be disclosed. The records must be maintained for a period of at least six years after the filing date for the documents which are based on that information. ERISA § 107 [29 U.S.C. § 1027]. The material to be retained must be in sufficient detail to permit verification, explanation, or clarification of the materials required to be disclosed, and must be adequate to enable the documents to be checked for accuracy and completeness. *Id.* The materials to be retained must include vouchers, worksheets, receipts, and applicable resolutions. *Id.* The records are to be available for examination during the six-year period. A VEBA (a health and welfare benefit fund exempt from tax under I.R.C. § 501(c)(9)) must maintain records indicating the amount contributed by each employee (or other member) and by each contributing employer, as well as the amount and type of benefits paid by the VEBA to or on behalf of each employee (or other member). Treas. Reg. § 1.501(c)(9)-5(a). Pension plans subject to Part 2 of Title I of ERISA (virtually all pension plans subject to ERISA) must maintain records sufficient to calculate employees’ benefits, and must retain employees’ names and addresses. Prop. DOL Reg. § 2530.209-2(a); Prop. DOL Reg. § 2530.209-3(a).

The Department of Labor has issued proposed regulations authorizing the retention of record by electronic means if certain safeguards and controls are maintained. 64 Fed. Reg. 4506 (Jan. 28, 1999).

V. DUES-FINANCED EMPLOYEE ORGANIZATION PLANS

Certain dues-financed pension and welfare benefit plans maintained by an employee organization, and paid out of the organization's general assets, are exempt from ERISA's reporting and disclosure obligations if certain disclosures are made in the organization's constitution and bylaws and on the organization's LM-1 and LM-2s. 29 C.F.R. §§ 2520.104-26 & -27.

W. DETERMINATION LETTER APPLICATIONS

A plan seeking a ruling from the IRS on the initial or ongoing tax qualification of a plan must submit a determination letter application on the appropriate form listed below. These forms may also be used to seek a ruling on whether an affiliated service group exists under I.R.C. § 414(m) and whether a partial termination has occurred. No plan is required to seek a determination letter from the IRS. Determination letters are sought primarily for the plan sponsor's comfort. A notice to interested parties must be provided, under rules described in Treas. Reg. §§ 1.7476-1 & -2, prior to filing an application with the IRS. Those regulations describe the time for providing the notice prior to the filing. The forms to be used are as follows:

- Form 5300 — for both defined benefit and defined contributions plans;
- Form 5303 — for collectively bargained plans;
- Form 5306 — for prototype or employer-sponsored individual retirement accounts;
- Form 5306-SEP — for prototype simplified employee pension plans;
- Form 5307 — for adopters of master or prototype, regional prototype, or volume submitter plans;
- Form 5309 — for employee stock ownership plans (used in conjunction with Form 5300); and
- Form 6406 — short form application for determination with respect to a minor amendment to a plan that already has a favorable determination letter.

The (complex) procedures for requesting determination letter applications are set forth in Revenue Procedure 2000-6 (Jan. 13, 2000).

1. User Fees. The IRS charges a user fee for processing determination letter

applications. The current fee schedule is described in Revenue Procedure 2000-8 and may be found on Form 8717. (The fee schedule is found on Form 8718 for a VEBA's or other exempt organization's application for recognition of tax-exempt status.) The current fee for Form 5300 for a single-employer plan is \$700 or \$1250, depending on whether the plan requests a ruling on the average benefit test or any of the general tests for nondiscrimination (if not, \$700; if so, \$1250). The fee for collectively bargained plans, including multiemployer plans, is the same. The fee for multiple employer plans depends on the number of employers participating and ranges from \$700 (2 to 10 employers) to \$5,600 (more than 499 employers).

2. Termination of Plan. IRS Form 5310 may be used to seek a determination letter from the IRS on plan termination. Again, no determination letter application is required. The IRS, however, reportedly has begun targeting for review plans which terminate without requesting a determination, and Question 9 on Form 5500 asks whether a terminated plan has sought or received a final determination letter. Form 6088 is used in conjunction with Form 5310 to describe the benefits which become distributable upon plan termination.

3. Notice of Merger, Consolidation, or Transfer of Plan Assets or Liabilities. Section 6058(b) requires that the IRS be given notice at least 30 days prior to any merger, consolidation, or transfer of plan assets or liabilities. The notice is to be provided on IRS Form 5310-A.

X. PBGC PREMIUMS

The plan administrator of each plan covered under Section 4021 of ERISA (generally, any tax-qualified defined benefit plan) must file a PBGC Form 1 each year. That report is used to determine the plan's annual premium payment for Pension Benefit Guaranty Corporation insurance protecting participants' benefits. Plans reporting 500 or more participants on their prior year's Form 1 must also file a Form 1-ES (Estimated Premium Payment Form). Schedule A, used in calculating the variable-rate portion of the PBGC premium, must be attached to Form 1 for single-employer plans.

1. Due Date: Large Plans. Plans required to report 500 or more participants on a preceding year's Form 1 generally must file Form 1-ES by the last day of the second full calendar month following the close of the preceding plan year ("First Filing Due Date"). In the case of a calendar year plan, the Form 1-ES is therefore due by March 1. For plan years before 1999, Form 1 was required to be filed by the fifteenth day of the ninth full calendar month following the month in which the plan year began ("Final Filing Due Date") — by September 15 in the case of a calendar year plan. As of the 1999 filing year, the deadline for filing Form 1 has been moved to October 15 for calendar year plans, with a similar extension for non-calendar year plans. For single-employer plans, only the flat-rate portion of the PBGC premium is due on the First Filing Date; the variable-rate portion is due by the Final Filing Due Date. For multiemployer plans (which have no variable premium liability), the entire premium is due by the First Filing Due Date.

2. Due Date: Small Plans. Before 1999, plans reporting fewer than 500 participants on

the preceding year's Form 1 must file Form 1 and pay their entire PBGC premium by the fifteenth day of the ninth full calendar month following the month in which the plan year began (i.e., September 15, for a calendar year plan.) As of the 1999 filing year, the deadline for filing Form 1 has been moved to October 15 for calendar year plans, with a similar extension for non-calendar year plans.

3. Mail Rule. The PBGC considers the forms to be filed, and premium payments made, on the date on which the mailing envelope is postmarked by the U.S. Postal Service. If there is no legible Postal Service postmark, the PBGC considers the form and payment to have been filed three days before the date on which the PBGC receives it. The PBGC disregards private postage meter dates.

4. Penalties for Noncompliance. A penalty applies to late payments of PBGC premiums equal to the greater of (a) 5 percent per month (or fraction thereof) of unpaid premiums, or (b) \$25. The penalty will not, however, exceed 100 percent of the unpaid premiums. 29 C.F.R. § 4007.8(a). For 1996 filings or later, the penalty is lower for premium underpayments that are self-corrected: 1% of the late premium payment per month if the payment is made on or before the PBGC issues written notice of a delinquency. The PBGC has issued a proposed rule on self-correction of premium underpayments, 64 Fed. Reg. 22589 (Apr. 27, 1999). The PBGC will consider waiving the late payment penalty charge, if the administrator can show substantial hardship and that it will be able to pay the premium within 60 days after the filing due date. Waivers may also be granted based on a demonstration of good cause. *Id.* § 4007.8(b). A late payment interest charge also applies, which the PBGC will not waive. *Id.* § 4007.7. It is established periodically and is published at 29 C.F.R. § 4007, Appendix A.

Y. REPORTABLE EVENTS

ERISA requires that certain events affecting plans subject to Title IV (generally, tax-qualified defined benefit plans) be reported to the Pension Benefit Guaranty Corporation. These events are catalogued in ERISA § 4043(c) [29 U.S.C. § 1343(c)]. They are generally events which might give the PBGC cause for concern, because they may tend to increase the PBGC's potential liability for benefits or increase the likelihood that an underfunded pension plan will be terminated and the PBGC will be required to pay benefits. The Retirement Protection Act of 1994 added certain reportable events and granted the PBGC authority to prescribe by regulation additional events "that may be indicative of a need to terminate the plan." ERISA § 4043(c)(13) [29 U.S.C. § 4043(c)(13)].

1. Reportable Events. A listing of the reportable events is found in ERISA § 4043(c)(1)-(13) [29 U.S.C. § 1343(c)] and in the PBGC's regulations, 29 C.F.R. §§ 4043.21 to 4043.35. The PBGC has waived the notice requirement for a number of otherwise reportable events. In particular, it has waived notice for the reportable events described in Sections 4043.21 (tax disqualification), 4043.22 (plan amendment decreasing benefits), 4043.24 (partial termination), and 4043.28 (plan merger, consolidation or transfer of assets), leaving the following reportable events:

- a. Certain reductions in the number of active plan participants, if the plan does not meet certain funding levels (§ 4043.23);
- b. Failure to meet the minimum funding standards under ERISA § 302 [29 U.S.C. § 1082] or I.R.C. § 412 (§ 4043.25);
- c. The plan is unable to pay benefits when due (§ 4043.26);
- d. Certain large distributions to a “substantial owner,” if the plan does not meet certain funding levels (§ 4043.27). A substantial owner is a person who owns at least 10 percent of a contributing sponsor of the plan. ERISA § 4022(b)(5)(A) [29 U.S.C. § 1322(b)(5)(A)];
- e. A transaction resulting in one or more persons ceasing to be members of the contributing sponsor’s controlled group, if the plan does not meet certain funding levels (§ 4043.29);
- f. Liquidation or dissolution of a member of the contributing sponsor’s controlled group (waived if the plan is also maintained by other members of the controlled group and either (i) the liquidating company is a *de minimis* member of the controlled group, or (ii) the plan meets certain funding levels) (§4043.30);
- g. An extraordinary dividend or stock redemption by the contributing sponsor or a member of its controlled group, if the plan does not meet certain funding levels (§ 4043.31);
- h. Transfer of more than 3 percent of a plan’s benefit liabilities to a person who is not a member of the contributing sponsor’s controlled group or to a plan not maintained by a member of the contributing sponsor’s controlled group (waived if (i) the transferor and transferee plans are fully funded, or (ii) the transfer complies with Code § 414(l) using PBGC valuation assumptions) (§ 4043.32);
- i. Application to the IRS for a minimum funding waiver under ERISA § 303 [29 U.S.C. § 1083] or I.R.C. § 412(d) (§ 4043.33);
- j. Default by a member of the plan’s controlled group on a loan of \$10 million or more, if the default results in certain adverse consequences and the plan does not meet certain funding levels (§ 4043.34); and
- k. An employer’s bankruptcy, insolvency, or a related settlement with creditors (§ 4043.35).

In Technical Update 97-6 (Nov. 3, 1997), the PBGC waived the reportable event requirement for small employers that miss quarterly contributions to their defined benefit pension plans. The waiver applies to employers that: (i) have 100 or fewer participants in their defined benefit plans, or (ii) have 500 or fewer participants in their defined benefit plans and do not need to provide a

participant notice under ERISA § 4011 because the plan was at least 90 percent funded. The waiver does not apply to missed annual contributions or any other reportable event.

2. Notice of Reportable Events. The PBGC's regulations describe, in 29 C.F.R. § 4043.3, how to give notice to the PBGC of a reportable event. Generally, the plan administrator and each contributing sponsor are obligated to file the notice within 30 days after they learn (or have reason to know) of a reportable event. 29 C.F.R. § 4043.20. Section 4043.3(b) describes the required contents of the notice. A filing is treated as having been made (i) when mailed, if postmarked by the U.S. Postal Service, (ii) when delivered to a private delivery service, if received by the PBGC within 2 days, or (iii) when received by the PBGC in an electronic filing. 29 C.F.R. § 4043.6.

The Retirement Protection Act amended ERISA § 4043(b) [29 U.S.C. § 4043(b)] to create advance notice requirements for contributing sponsors that are not a company or a subsidiary of a company subject to the reporting requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934 or members of a controlled group with such a company. Under these rules, contributing sponsors must notify the PBGC at least 30 days in advance of the occurrence of any of four reportable events: (i) a change in contributing sponsor or members of its controlled group, (ii) liquidation of a member of the contributing sponsor's controlled group, (iii) payment of an extraordinary dividend or stock redemption, or (iv) transfer of benefit liabilities. *See* 29 C.F.R. § 4043.61 to .65. Non-public companies are also required to file reportable event notices within 10 days after the occurrence of three other reportable events: (v) application for a funding waiver; (vi) a significant loan default, or (vii) bankruptcy, insolvency or settlement with creditor. *Id.* §§ 4043.66 to .68. These advance and accelerated notice requirements apply only if, as of the close of the preceding plan year, aggregate unfunded vested benefits of plan maintained by the contributing sponsor (or controlled group members) exceeded \$50 million and the funded vested benefit percentage for such plans was less than 90 percent.

3. Penalties. A penalty of up to \$1,100 per day may be assessed for failure to provide notice of a reportable event. ERISA § 4071 [29 U.S.C. § 1371], as modified by the Debt Collection Improvement Act of 1996. *See* 29 C.F.R. § 4071.3. In 1995, the PBGC announced a revised policy on penalties. *See* "PBGC Statement of Policy on Assessment of Penalties for Failure to Provide Required Information", 60 Fed. Reg. 36837 (July 18, 1995). Generally, the PBGC will consider the facts and circumstances of each case to assure that the penalty fits the violation. Among the factors PBGC will consider are the importance and time-sensitivity of the information, the extent and willfulness of the omission, the length of delay in providing the information, and the size of the pension plan. A penalty of \$35 per day for the first 90 days of delinquency and \$50 per day thereafter will be assessed. In the case of a plan with fewer than 100 participants, the penalty will be reduced depending on the number of participants, subject to a minimum penalty of \$5 per day.

The total penalty for any violation generally will not exceed \$100 times the number of plan participants, but all or part of the penalty may be waived where reasonable cause is shown. A larger penalty of up to \$1,100 per day may be assessed where there is willful failure to comply, a pattern

or practice of failure to report, or if the lack of information causes substantial harm to participants or the pension insurance program. PBGC generally will also assess the full \$1,100 per day penalty for failure to report a missed pension contribution of \$1 million or more for failure to provide advance notice about a major corporate transaction that may pose a risk to the pension plan.

Z. REPORTS BY CORPORATE GROUPS WITH LARGE UNDERFUNDED PLANS

1. Covered Pension Plans and Sponsors. The Retirement Protection Act of 1994 added ERISA § 4010 [29 U.S.C. § 1310], which authorizes the PBGC to require certain contributing sponsors of underfunded single-employer defined benefit plans and their controlled group members to submit annual financial reports to the PBGC. The financial reporting requirements apply to employers:

- a. that sponsor defined benefit pension plans with aggregate unfunded vested benefits of more than \$50,000,000 (under the PBGC's regulations, sponsors may use the 30-year Treasury rate and the fair market value of assets (instead of 80% of the 30-year rate and the actuarial value of assets) to calculate the level of under-funding, *see* 29 C.F.R. § 4010.4(b));
- b. which are subject to a lien under ERISA § 302(f) [29 U.S.C. § 1802(f)] or I.R.C. § 412(n) for missing minimum contributions of more than \$1,000,000; or
- c. that have minimum funding waivers of more than \$1,000,000, any portion of which is still outstanding.

The PBGC regulations exempt reporting for plans with fewer than 500 participants and plans with no unfunded benefits liabilities (using the PBGC's termination assumptions), other than plans with funding waivers or missed contributions. 29 C.F.R. § 4010.8(c). Controlled groups are not required to submit information for *de minimis* entities ("exempt entities") — entities that do not sponsor a nonexempt plan and whose revenue, annual operating income and net assets are not more than 5 percent of the controlled group's revenue, net assets and annual operating income (or, if larger, \$5 million of income or net assets). *Id.* § 4010.4(d).

2. Financial and Actuarial Reports. Employers falling within the ambit of Section 4010 and all members of their controlled groups are required annually to submit certain actuarial and financial information regarding the pension plan and the sponsor, as defined in 29 C.F.R. §§ 4010.8 & .9. To ease the reporting burden, the PBGC generally seeks information that is already available. For example, the regulations may substitute its tax return for the audited or unaudited financial statements required by the statute. *Id.* § 4010.9(a)(3). If certain information is publicly available from other federal agencies, the PBGC has eliminated the reporting requirement. *Id.* § 4010.9(d).

3. Due Date. Reports under Section 4010 are generally due by the 105th day after the close of the filer's information year (*i.e.*, by April 15 for corporate groups that prepare their financial

reports on a calendar year basis), but the reporting of actuarial information may be deferred until 15 days after the deadline for filing the plan's annual report on Form 5500. *Id.* §§ 4010.8(b)(1), .10(b). The information is exempt from public disclosure. *Id.* § 4010.12.

4. Penalties. The PBGC may assess penalties under ERISA § 4071 [29 U.S.C. § 1371] of up to \$1,100 per day against the contributing sponsor and each member of its controlled group for failure to submit the information required under ERISA § 4010. *Id.* § 4010.13. The PBGC plans to issue a policy statement providing guidance on waivers of penalties. 26 Pens. & Ben. Rep. 2552 (Nov. 1, 1999).

AA. NOTICE TO PARTICIPANTS REGARDING UNDERFUNDED PENSION PLANS

The Retirement Protection Act of 1994 also added a new reporting requirement regarding underfunded defined benefit pension plans in ERISA § 4011 [29 U.S.C. § 1311]. This section requires the administrator of a defined benefit pension plan that (due to its funding level) pays a variable PBGC premium to report to plan participants and beneficiaries regarding the plan's funding status and limits on the PBGC's guaranty if the plan should terminate while it is underfunded. The notice must be "written in a manner as to be understood by the average participant." ERISA § 4011(a) [29 U.S.C. § 1311(a)].

Plans that are not subject to the additional funding requirements under ERISA § 302(d) [29 U.S.C. § 1082(d)] — the so-called "deficit reduction contribution" — are exempt from this notice requirement. ERISA § 4011(b) [29 U.S.C. § 1311(b)]; 29 C.F.R. § 4011.3(b). However, in determining whether a plan is exempt, a plan's funded current liability percentage is determined without subtracting any credit balance in the plan's funding standard account from assets.

1. Contents of the Notice. PBGC regulations contain a Model Notice designed to comply with ERISA § 4011 and to notify employees and retirees of the funding status of their plans and the limits on the PBGC's guarantee if the plans were to terminate while underfunded. 29 C.F.R. § 4011, Appendix A. This Model Notice was updated by Technical Update 99-1 to reflect the PBGC's 1999 maximum guaranteed benefits. Plan administrators are not required to use the Model Notice, but if they do not, the notice they do give must contain the information described in 29 C.F.R. § 4011.10(b) — including the plan's funded current liability percentage - *i.e.*, the percentage of retirement liabilities are actually covered by plan assets - for that plan year or the prior plan year. *Id.* §§ 4011.10(b)(3), (c). The Notice must also include information on funding waivers, unless fully repaid as of the end of the prior plan year, and missed contributions, if a plan had a funding deficiency at the end of any prior plan year or was more than 60 days late with a quarterly contribution or other payment. The Notice must also inform employees and retirees that the PBGC may not guarantee full replacement of their monthly pension checks, should the plan be terminated while it is underfunded. *Id.* § 4011.10(b).

2. Issuance of the Notice. Plan administrators must provide the Notice to each person who is a participant, a beneficiary of a deceased participant, an alternate payee under a QDRO, and

any employee organization that represents any group of participants for purposes of collective bargaining. *Id.* § 4011.7. The deadline for issuing the Notice is two months after the filing of the plan's Form 5500. *Id.* § 2627.8. Mailing the Notice to the participant's last known address is permissible, as is forwarding the document with the SAR or other documents, provided that the Notice is on a separate document. *Id.* § 2627.9.

3. Penalties. Failure to comply with the notice requirement of ERISA § 4011 and the PBGC regulation may subject the plan administrator to a penalty under ERISA § 4071 [29 U.S.C. § 1371] of up to \$1,100 for each day that the failure continues. 29 C.F.R. § 4011.3(c).

BB. TERMINATION OF DEFINED BENEFIT PENSION PLANS

Special reporting and disclosure requirements apply when a single-employer pension plan subject to Title IV of ERISA (generally, a tax-qualified defined benefit plan) is to be terminated. The termination procedures are described in ERISA § 4041 [29 U.S.C. § 1341]. The PBGC's regulations on terminations, found in 29 C.F.R. § 4041, were revised in late 1997 to include less stringent deadlines for standard terminations begun on or after January 1, 1998. 62 Fed. Reg. 60,423 (Nov. 1997). The instructions accompanying the PBGC forms also set out in detail the PBGC's positions on applicable termination procedures.

1. Notice to Participants. The plan administrator of the terminating plan must give each affected party (which includes plan participants) a written notice of intent to terminate the plan at least 60, and no more than 90, days prior to the proposed termination date. 29 C.F.R. §§ 4041.23 & .41. The rules require plan administrators to inform participants that each participant will receive a written notification regarding plan benefits and that the PBGC will not guarantee benefits following the distribution of plan assets.

2. Notice to PBGC. The PBGC must also be given notice as soon as practicable after the date on which the notice of intent to terminate is given to affected parties, and no later than 180 days after the proposed termination date for a standard termination (and 120 days for a distress termination). *Id.* §§ 4041.25, .41 & .43. PBGC Form 500 (Standard Termination Notice, including Schedule EA-S, and Enrolled Actuary Certification) is used to give notice to the PBGC in the case of a standard termination (generally, a termination where the plan's assets are adequate to provide benefits). PBGC Form 600 (Distress Termination Notice of Intent to Terminate) is used in the case of a distress termination (generally, when a plan is terminated without assets adequate to pay all benefits; such terminations are rare because a plan with insufficient assets may be terminated only in limited circumstances). In a distress termination the plan administrator must also file PBGC Form 601 (Distress Termination Notice) with Schedule EA-D, the enrolled actuary's certification.

3. Notice of Benefits. The plan administrator must notify each participant, beneficiary, and alternate payee of his or her benefits under the plan. This notice must be issued no later than the time the Form 500 is filed with the PBGC (in the case of a standard termination) and must be written in a manner likely to be understood by the individual receiving it. The new standard termination

regulations include a model notice that plan administrators may use to inform plan participants of the intended termination and the effect it will have on their benefits. As part of the new rules, the benefit notice must inform participants who might receive a lump sum of the mortality and interest rate assumptions that will be used to calculate the lump sum. *Id.* § 4041.24(d)(4), (e)(4). The rules require plan administrators to inform participants about state guarantees that apply to their benefits in the event an annuity provider encounters financial problems. *Id.* § 4041.27(b).

4. Notice of Final Distribution. Plan administrators have 120 days to distribute plan assets after they have received approval of the termination from the PBGC. *Id.* § 4041.28. A notice must be filed with the PBGC within 30 days of final distribution of assets, certifying that distribution has occurred. The plan administrator must identify the insurance company from which annuities were purchased and certify that all plan assets were distributed properly. This filing is made on Form 501 in the case of a standard termination (Post-Distribution Certification for Standard Termination), *id.* § 4041.27(h). Under revised regulations, the PBGC will impose a penalty for a late post-distribution certificate only to the extent it is filed more than 90 days after the distribution deadline. *Id.* § 4041.29(b).

5. Missing Participants. The Missing Participants Program under ERISA § 4050 is effective for distributions from terminating plans in plan years beginning after December 31, 1995. The purposes of the program are to assist plan administrators in closing out plans and to help participants in these plans obtain their benefits. The plan administrator of a single-employer plan covered by Title IV of ERISA that is terminating in a standard termination, or in a distress termination in which plan assets are sufficient to provide all guaranteed benefits, must file Schedule MP if the plan has any missing participants. Attachment A (Annuity Purchase Information) and Attachment B (Individual Information) may also be required. The PBGC uses the information to direct missing participants for whom annuity contracts were purchased to the appropriate insurance company, to locate and pay missing participants for whom benefits were paid to the PBGC, and to monitor and audit compliance. The due date for filing Schedule MP and payment of the designated benefits is the same as for the Post-Distribution Certification on Form 501. *See* 29 C.F.R. § 4050.

6. Multiemployer Plans. Special rules, set forth in ERISA § 4041A [29 U.S.C. § 1341A], apply to the termination of multiemployer plans.