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JANUARY 2012

ERISA/EMPLOYEE BENEFITS ALERT

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Rebecca focuses her practice in the area of Employee Benefits & Executive Compensation. She provides counsel to private, not-for-profit and public corporations on all aspects of employee benefits and ERISA matters, including plan design and implementation, plan administration and compliance, and employee benefits issues arising out of mergers and acquisitions and other corporate transactions, as well as group health plan issues including COBRA and HIPAA.

EMPLOYEE BENEFITS & EXECUTIVE COMPENSATION PRACTICE RINGING IN THE NEW YEAR - BENEFITS STYLE

Happy New Year! Ready or not, it is time for sponsors of employee benefit plans (including both retirement and welfare benefit plans) to begin paying close attention to the administrative practices and procedures that plan sponsors will need to implement throughout the year in order to comply with changes in reporting and notice requirements. Below is a summary of these changes which, include the following:

- COLA Increases for Dollar Limitations on Benefits and Contributions
- Second Five-Year Determination Letter Cycle
- Internal Claims and Appeals Process
- Summary of Benefits and Coverage, Effective March 23, 2012
- Fee Disclosure Requirements, Effective May 31, 2012
- Enhanced Disclosures for Target Date Funds

We recommend that plan sponsors allow ample time to both understand these requirements and facilitate their implementation. Of course, we will update you as compliance deadlines approach and will keep you informed of additional guidance as it is released.

COLA INCREASES FOR DOLLAR LIMITATIONS ON BENEFITS AND CONTRIBUTIONS

The Internal Revenue Service ("IRS") has announced cost-of-living adjustments affecting dollar limitations for pension plans and other retirement-related items for 2012. In general, many of the pension plan limitations will change for 2012 because the increase in the cost-of-living index met the statutory thresholds that trigger their adjustment.

Plan Limits for Plan Year	2012	2011
401(k), 403(b), 457 Elective Deferral Limit	$17,000	$16,500
Annual Compensation Limit	$250,000	$245,000
Defined Contribution Limit	$50,000	$49,000
Defined Benefit Limit	$200,000	$195,000
Key Employee	$165,000	$160,000
Definition of Highly Compensated Employee	$115,000	$110,000

SECOND FIVE-YEAR DETERMINATION LETTER CYCLE

Under the determination letter program, every individually designed plan has a regular, five-year filing cycle (A-E). The cycles are staggered and spread over five-year periods, so that different plans have different cycles. Under this system, plan sponsors need to submit their plans only once for a determination letter that rules on all amendments adopted and made effective within the applicable five-year filing cycle. Special rules apply to multiple employer plans, multiemployer plans, governmental plans, some plans of employers on controlled groups, and plans for which there has been a spinoff, merger, or acquisition.

A plan's five-year filing cycle is generally determined by reference to the last digit of the employer identification number ("EIN") of the employer that sponsors the plan. The chart below identifies how a plan's five-year cycle is determined.

Last Digit of Plan Sponsor's EIN	Plan's Cycle	Plan's Five-Year Filing Cycle
1 or 6	A	February 1, 2011 - January 31, 2012
2 or 7	B	February 1, 2012 - January 31, 2013
3 or 8	C	February 1, 2013 - January 31, 2014
4 or 9	D	February 1, 2014 - January 31, 2015
5 or 0	E	February 1, 2015 - January 31, 2016

If you are a sponsor of a qualified plan that falls within Cycle A (EIN ends with a one or a six), your five-year filing cycle is about to end and immediate action is required. Please contact Rebecca Alperin for assistance with preparing an application. Plan sponsors whose EIN ends with a two or a seven should get ready, as we will be preparing your application for a favorable determination over the course of the next year.

INTERNAL CLAIMS AND APPEALS PROCESS

Currently, non-grandfathered group health plans covered by ERISA must have an internal claims and appeals process for adverse benefit determinations that complies with existing regulations. In June 2011, the Department of Labor ("DOL"), Department of Health and Human Services ("HHS") and IRS jointly issued amendments to the interim final rules addressing internal claims and appeals requirements under health care reform. The non-enforcement grace period for changes required by these amendments expires with plan years beginning on or after January 1, 2012. Accordingly, internal claims and appeals processes should be amended to include the following changes:

- Restoring to 72 hours (from 24 hours) the period by which a plan must notify a claimant of a benefit determination with respect to an urgent care claim, provided that the plan defers to the attending provider as to whether the claim is for urgent care.
- Eliminating the requirement to automatically provide diagnosis and treatment codes as part of a notice of adverse benefit determination, and instead requiring the notice to state that the codes (and their meanings) are available upon request.
- Limiting a claimant's ability to seek immediate external or judicial review because of a plan's failure to strictly adhere to the claims procedure rules when the failure is very minor and meets certain other requirements.
- Allowing a plan to meet its obligation to furnish culturally and linguistically appropriate notices by including a statement, in the relevant non-English language, about the availability of language services (and making those services available), and providing that this requirement applies when it has been determined that 10 percent of the residents in the applicable county speak a particular non-English language.

SUMMARY OF BENEFITS AND COVERAGE, EFFECTIVE MARCH 23, 2012

On March 23, 2012, another requirement under the Patient Protection and Affordable Care Act (the "Act") will become effective. Insurers and group health plan administrators will be required to distribute to applicants, enrollees, and policy holders a "Summary of Benefits and Coverage" ("SBC") for each coverage option offered by the insurer or plan. The SBC is intended to provide clear and consistent information that will enable employers and participants to compare and understand the costs and benefits of different health coverage options.

The SBC must accurately describe the benefits and coverage under the applicable plan or coverage and include a glossary of terms used in health insurance coverage (such as "deductible," "co-payment," and "preferred provider"). Guidance and proposed regulations issued jointly by the Department of the Treasury, HHS, and DOL include an SBC template document along with instructions, samples, and a guide for coverage example calculations to be used in completing the SBC template. Under the currently proposed regulations, health insurance issuers will be required to also provide this type of information to group health plan sponsors at the time of application or request for information regarding coverage, within seven days of the request (including an obligation to update such information should it change); this information must also be provided upon renewal (30 days in advance of a new policy year in a case of an automatic renewal).

It is important to start preparing for these requirements now and to coordinate efforts with plan service providers and insurers to properly organize and present this information to participants and beneficiaries. Plan sponsors will need to ensure that these documents are provided to eligible employees when required and that they meet the specific needs and characteristics of the employer's workforce.

Who is responsible for providing the summary?
For self-insured group health plans, the plan sponsor or designated plan administrator must provide the SBCs. For insured plans, either the plan sponsor or the insurer is responsible for providing SBCs. If one entity, either the plan sponsor or the insurer, provides an SBC, the requirement is met for all entities, provided that the timing and content requirements are satisfied.

What must be in the summary?
The SBC may be no longer than four double-sided pages in 12-point font. The SBC must summarize key features of the coverage option, such as covered benefits, coverage limitations and exceptions, cost-sharing provisions, renewability and continuation of coverage provisions, and contact information for questions, including a website where the uniform glossary of terms may be found.

The SBC must also contain three coverage examples that illustrate what the plan will cover for common benefits scenarios. The template includes coverage examples for having a baby, treating breast cancer, and managing diabetes. The template and glossary can be viewed online (at http://www.dol.gov/ebsa/pdf/SBCtemplate.pdf.) The template may be expanded to cover additional examples in future years.

The SBC must be presented in a "culturally and linguistically appropriate manner." The proposed regulations state that this requirement will be satisfied by following the rules set forth in earlier guidance issued with respect to claims and appeals, which requires the provision of interpretive services and written translations in certain non-English languages in specified counties, based on U.S. Census Bureau data.

Any state laws that impose on health insurance issuers requirements that are stricter than those required by the SBC will not be superseded. The proposed regulations also clarify that material modifications to plans or coverage terms that are not reflected in the SBC must be communicated no later than 60 days prior to their effective date.

Who must receive the summary and when?
Insurers must provide consumers (including employer plan sponsors) with the SBC for a particular health coverage option upon an application or request for information about the coverage. The SBC must be provided as soon as possible, but not later than seven days following the application or request.

Group health plans, and insurers in the case of insured group health plans, are obligated to provide an SBC to participants and beneficiaries with respect to each benefits package for which they are eligible. The proposed regulations also state that if either the insurer or the plan administrator provides an SBC that meets the applicable timing and content requirements, the obligation will be considered satisfied for both.

The SBC must be provided

- With any written enrollment materials distributed by the plan or, if no written enrollment materials are distributed, no later than the first day the individual is eligible to enroll.
- During open enrollment each year; however, only the SBC for the coverage option in which a participant is already enrolled must be provided automatically. SBCs for other coverage options must be provided upon request.
- Not more than seven days following a request for special enrollment during a plan year.
- To participants and beneficiaries (or to an employer plan sponsor in the case of an insured plan) upon request at any time, within seven days.

In addition, a revised SBC will be required at least 60 days in advance of the effective date of any midyear change to a plan (whether positive or negative) that affects the information provided in the most recent SBC.

What are acceptable methods of delivery?
The SBC may be provided to participants and beneficiaries in paper form, or electronically if the requirements of the electronic disclosure safe harbor for ERISA plans under DOL regulations are met.

Many ERISA plans and insurers currently employ electronic disclosure methods that do not necessarily fall within the DOL's safe harbor (e.g., posting on a website) but arguably still comply with ERISA's electronic disclosure rules. The new proposed regulations suggest that only a safe harbor electronic delivery method is acceptable for SBCs. The electronic disclosure rules are currently under review by the DOL and the safe harbor might be expanded to encompass more electronic delivery options.

What are the penalties for noncompliance?
Failure to adhere to these rules results in penalties: $1000 for any willful failure to provide this information including a separate fine for each individual or entity for whom there is a failure to provide an SBC (with more guidance concerning the enforcement of these penalties against group health plans to be issued by the DOL), as well as potential $100 per day per individual excise taxes.

FEE DISCLOSURE REQUIREMENTS, EFFECTIVE MAY 31, 2012

In 2010, as part of its initiative to increase transparency in plan-related fees and expenses, the DOL issued final regulations that expanded the requirements relating to the disclosure of plan fees and expenses to participants under 401(k) plans and other defined contribution plans that allow participants to self-direct the investments under their individual accounts. The DOL recently extended the effective date of these regulations.

Under this extension, the initial annual disclosure must be provided by the later of (i) May 31, 2012, or (ii) 60 days after the first day of the first plan year beginning on or after November 1, 2011. The initial quarterly disclosure must be provided within 45 days after the end of the quarter in which the initial annual disclosure is provided (generally, August 14, 2012).

We anticipate that many service providers will prepare the participant disclosures for their clients. We recommend that one of the Hinckley Allen attorneys listed on the last page review any participant disclosure prepared by your service provider to ensure compliance with the regulations. If your service provider is not providing the disclosure notices to you, we are happy to prepare one for you.

What is the background behind these rules?
These rules are under ERISA §404(a)(1), which sets out the basic ERISA fiduciary requirement to act prudently and solely in the interest of plan participants and beneficiaries. The DOL is of the opinion that, where participants and beneficiaries are permitted to direct the investment of their retirement accounts, the plan fiduciary has a duty to "take steps to ensure that participants and beneficiaries are made aware of their rights and responsibilities with respect to managing their individual plan accounts and are provided sufficient information regarding the plan, including its fees and expenses and designated investment alternatives, to make informed decisions about the management of their individual accounts." The DOL notes that satisfying these disclosure rules does not relieve the plan fiduciary of the duty to prudently select and monitor service providers or designated investment alternatives.

What plans are subject to the new rules?
Only participant-directed individual account plans (i.e., 401(k) plans) are subject to the new rules. Plans involving IRAs, such as simplified employee pensions (SEPs) and SIMPLE IRAs, are not subject to the rules. Also excluded are non-ERISA 403(b) plans, governmental plans, church plans, and 457 plans. The rules do not apply to brokerage windows or brokerage accounts, where participants and beneficiaries are able to select investments outside of those designated by the plan. However, a plan must disclose any costs associated with using a brokerage window.

Who is responsible for providing the disclosures?
The Plan Administrator (or its designee) is responsible for providing the disclosures. However, the regulations provide plan administrators protection from liability for the completeness and accuracy of information provided to participants if the plan administrator reasonably and in good faith relied on information supplied by service providers or investment funds.

What information must be disclosed?
The regulations require a plan administrator to provide to each participant or beneficiary certain plan-related information and certain investment-related information.

The **plan-related information** generally consists of three categories:

- **General Plan Information.** General plan information consists of information about the structure and mechanics of the plan. This may include an explanation of how to give investment instructions under the plan, a current list of the plan's investment options, and a description of any "brokerage windows" or similar arrangement that enables the selection of investments beyond those designated by the plan.
- **Information about Administrative Expenses.** These are expenses for general plan administration that are charged against or deducted from individual accounts (and that are not included in the operating expenses of a particular investment such as a mutual fund). Examples include fees and expenses for legal, accounting, and recordkeeping services.
- **Information about Individual Expenses.** These are expenses and fees that may be charged to or deducted from the individual account of a specific participant or beneficiary based on the actions taken by that person. These include, for example, fees related to plan loans, fees related to qualified domestic relation orders (QDROs), or sales charges.

The information in these three subcategories must be given to participants on or before the date they can first direct their investments, and annually thereafter. Additionally, participants must receive statements, at least quarterly, showing the dollar amount of the plan-related fees and expenses actually charged to or deducted from their individual accounts, along with a description of the services for which the charge or deduction was made.

The **investment-related information** required under the rules is comprehensive and includes for each investment a description of its features, the different types of fees that are charged, websites where participants can find additional information, and information about investing in general. Additionally, a glossary must be provided to aid in the participants' understanding of the information provided in the report.

Investment-related information must be furnished to participants or beneficiaries on or before the date they can first direct their investments, and annually thereafter. This investment-related information must be provided in a format that allows participants to compare alternatives within investment types. To accomplish this, the DOL regulations provide model tables for these disclosures. One table relates to "variable-rate" investments such as mutual funds and requires disclosure of the 1-year, 5-year, and 10-year return of each of those investments offered under the plan, as well as the return over the same periods for an applicable broad-based benchmark for each investment. Another table discloses the fees that are charged with regard to each investment. Specifically, the table sets forth the annual operating expenses of each investment (expressed as a percentage of assets and a dollar amount per $1,000 of investments), in addition to any loads and charges with regard to each investment alternative. Use of the model tables is not required but provides a safe harbor for plan administrators, and their use will be deemed to satisfy the format requirement if accurately completed. The rules require the plan administrator to provide additional tables and information for other types of investments where the investment returns and fees are not easily quantifiable in a comparison chart.

Does the use of electronic media satisfy the distribution requirements?
Plan administrators may furnish the required information electronically if the rules under the DOL's electronic disclosure safe harbor are met. Under the current DOL electronic delivery rules, posting information to a company intranet does not by itself constitute delivery.

If a plan offers immediate eligibility, how will a new hire receive the fee disclosure information prior to enrollment?
The initial notice must be provided prior to the participant's ability to first direct their investments. A best practice would be to include the annual notice with other new hire materials such as an enrollment kit or health care information.

How are these rules related to the disclosure rules under ERISA §404(c)?
Much of the information required to be disclosed under the new rules is also required in order to comply with the requirements of §404(c). However,

compliance with §404(c) is voluntary, whereas a plan administrator has a fiduciary duty to comply with these new participant fee disclosure regulations.

Are these rules different from the DOL regulations for disclosing hidden fees?
These rules are in addition to the DOL regulations relating to the disclosure of hidden fees, that require companies that provide services to employee retirement plans to disclose all fee information, including hidden fees, relating to those services.

What are the consequences for failure to comply with these rules?
There are no specific tax or monetary penalties for failing to provide fee disclosure notices. However, the disclosure requirements are a fiduciary obligation under ERISA. Failure to meet the requirements would be a breach of fiduciary duty, and plan administrators could be liable for remedies under ERISA. Of course, the DOL or the participant still would need to prove damages. For a plan that intends to be 404(c) compliant, a plan that fails to comply with the participant fee disclosure regulations will cause the plan fiduciary to lose 404(c) protection.

ENHANCED DISCLOSURES FOR TARGET DATE FUNDS

The DOL recently issued proposed regulations that would require enhanced disclosures for target-date funds in the disclosures required for participant-directed plans and in the notice for plans with a qualified default investment alternative ("QDIA notice"), regardless of whether a target-date fund is the default investment. The proposed effective date of the regulations would be 90 days after publication of the final regulations in the Federal Register.

The additional disclosures include, with respect to a target-date fund, explanations of

- How the target-date fund's asset allocation will change over time, in both narrative and graphic form; and
- The meaning of the date mentioned in the fund's name, including the age group for which it was designed and any assumptions regarding contributions and withdrawals.

The disclosures also would have to contain, if applicable, a statement that the participant might lose money near and after retirement by investing in the fund and that there is no guarantee that the fund will meet retirement income goals.

If you have any additional questions regarding this Alert or have any other Employee Benefits & Executive Compensation Law needs, please contact any member of the Employee Benefits & Executive Compensation Law Group.

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