An Employer's Guide to EMPLOYEE BENEFITS

A Collaborative Effort

Minnesota Department
of Employment and
Economic Development

Briggs and Morgan, P.A.

An Employer's Guide to Employee Benefits is available without charge from the Minnesota Small Business Assistance Office, 500 Metro Square, 121 Seventh Place East, St. Paul, MN 55101-2146, (651) 296-3871 or 1-800-657-3858, Minnesota toll free; or from Briggs and Morgan, P.A., 2200 IDS Center, Minneapolis, MN 55402, (612) 977-8400 (Contact Donna Erickson).

An Employer's GUIDE TO EMPLOYEE BENEFITS

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INTRODUCTION

It is critical for businesses to attract and retain qualified employees. Because beginning or emerging businesses may have more risk attached to them, it is imperative that they provide employment packages which satisfy employees. Employee benefits play an important part in employee compensation and benefit packages. They enable an employer to provide benefits to employees on a tax-free basis and to use the pricing advantage available when pooling employees for coverage.

This Guide will discuss employee benefit plans, including both pension (*i.e.*, retirement) and welfare (*i.e.*, health, disability, death) benefit plans. There are some benefits beyond the scope of this guide. Individual retirement accounts (IRAs) and medical savings accounts (MSAs) will be discussed only in passing since they provide a benefit on an individual rather than a group basis. Employee stock ownership plans (ESOPs) will also be mentioned only briefly.

The Employee Retirement Income Security Act of 1974, as amended ("ERISA") is a federal law which regulates employee pension and welfare benefit plans. Under ERISA there is much more detailed regulation of pension benefit plans than there is of welfare benefit plans. ERISA imposes requirements as to disclosure of information to participants and the government, as well as to funding, participation, vesting and the accrual of benefits. It sets forth certain standards for fiduciaries to follow in working with plans, it prohibits certain transactions with plans and their assets, and has specific procedures for the termination of a plan. ERISA also provides participants and fiduciaries with

enforcement tools. Both the Department of Labor ("DOL") and the Internal Revenue Service have been given enforcement responsibilities under ERISA.

The Internal Revenue Code (the "Code") also regulates employee benefit plans where special tax benefits are available. Tax benefits may be deductions available to the employer or either the deferral or exclusion from taxable income of benefits to the employee. The Code sets forth certain standards for "qualified" retirement plans which must be followed to ensure this tax favored status. Similarly, the Code specifies the way in which welfare benefit plans are to be structured. This may include limits on benefits paid, discrimination rules relating to coverage of employees and other limitations. In this Guide, we hope to provide you with a framework which you can utilize in structuring employee benefit programs for employees. We will address the requirements of ERISA and the Internal Revenue Code and on the various types of retirement and welfare plans available, focusing on their individual advantages and requirements. We will also discuss the impact of a plan on plan sponsors whether those be an individual employer, a controlled group of corporations or businesses, a group of employees affiliated through the providing of services, employers joining together in a multiple employer plan or multi-employer groups which provide benefits under the terms of a collective bargaining agreement. We will also address both for-profit businesses and non-profit organizations. The rules associated with the design, implementation and administration of employee benefit plans are numerous and complicated. Consultation with legal counsel familiar with these rules is strongly advised.

While ERISA, a federal law, preempts state pension law, except for church and government plans, many state insurance laws regulate health and welfare benefits. As a result, application of Minnesota law, particularly in the area of health and welfare benefit plans, is addressed in this Guide.

This Guide will analyze general design and implementation decisions to be made in the structuring of an employee benefits program as well as ongoing administrative requirements. It will also address non-qualified deferred compensation plans and non-taxable fringe benefits.

Finally, this Guide will address the enforcement of rights by participants and fiduciaries as well as by the Internal Revenue Service and the DOL and will explain the remedies available as well as the limitations on remedies under ERISA. It will discuss who can enforce ERISA, where and how such enforcement takes place, whether federal or state law controls and what private rights of action are available to participants. Whether as a claim for benefits, a claim for breach of fiduciary duty or a claim of discrimination with respect to seeking benefits.

The goal of this Guide is to assist new employers in their determination of the best package of employee benefits to offer to their work force and to give guidance as to administrative responsibilities and potential liabilities in sponsoring such plans. In addition, throughout this Guide we will note other laws which might have an impact on employee benefits provisions.

Originally published in 1995, this book has proven itself to be a useful tool for employers as they design benefit plans intended to attract and retain quality employees in a competitive marketplace. Since 1995, business in Minnesota has continued to grow and the job market has constricted, causing employers to place more efforts and dollars into their benefit programs in order to retain a strong employee base. Also since 1995, both federal and state laws have been added and modified. We have addressed those law changes in this new edition to give the reader an up-to-date perspective on employee benefits.

This Guide has been revised to reflect changes made to the Code and ERISA by recent tax legislation. The General Agreement on Trade and Tariffs of 1994, the Uniformed Services Employment and Reemployment Rights Act of 1994, the Small Business Job

Protection Act of 1996, the Taxpayer Relief Act of 1997, the IRS Restructuring and Reform Act of 1998, the Community Renewal Tax Relief Act of 2000, the Economic Growth and Tax Relief Reconciliation Act of 2001, the Sarbanes-Oxley Act of 2002 and the Job Creation and Worker Assistance Act of 2002 are examples of recent tax legislation that had an effect on retirement plans and whose provisions are reflected in this Guide. The Health Insurance Portability and Accountability Act of 1996, the Newborns' and Mothers' Health Protection Act of 1996 and the Women's Health and Cancer Rights Act of 1998 are examples of recent tax legislation that had an effect on welfare benefit plans and whose provisions are also reflected in this Guide.

This Guide cannot and does not answer all questions relating to employee benefits. Further, the contents of this Guide are based on current laws, regulations, rulings and judicial decisions, all of which are subject to change. The reader is cautioned that this Guide should not be relied upon as a substitute for competent legal advice, but rather should be viewed as a general informational guide to a very complex area of law.

SECTION ONE: QUALIFIED RETIREMENT PLANS

GENERAL CONSIDERATIONS

Tax Treatment; Economic Structure

Retirement plans such as pension, profit sharing, stock bonus and the like are referred to as "qualified" plans because these plans must satisfy certain formal requirements under Section 401(a) of the Code. A qualified retirement plan enjoys significant tax advantages as a result of satisfying the qualifications set forth in the Code. The extremely favorable tax consequences available to qualified retirement plans provide the most significant reason for their popularity. These tax consequences are described in the next few paragraphs.

First, contributions made by an employer to a qualified plan are currently deductible when the contributions are made. In fact, contributions to a qualified plan need not be made until the date the employer's tax return is due, including extensions. The employee to whom benefits are credited in a qualified plan, on the other hand, does not recognize any income with respect to the contributions until the funds are actually distributed. In the interim, contributions to the trust or other funding vehicle are accumulated and generate earnings on a tax-deferred basis, again until distributed to the employee. In addition, neither the contributions to, nor distributions from a qualified plan are subject to Social Security and Medicare taxes. It is the deferral of income taxes which creates a very powerful savings tool for many employees and employers are rewarded by receiving an immediate deduction for contributions made to the plan.

A qualified retirement plan is represented by two "agreements." First, the employer promises to provide certain benefits to its employees who are eligible to participate under the plan. This is the "plan." Second, the employer makes contributions to a funding vehicle on behalf of those employees who are participants in the plan. The usual method of funding a pension or profit sharing plan is through a tax exempt trust. This second agreement is usually a written trust agreement between the employer and one or more trustees. In some cases an insurance contract may be used in lieu of a trust. An insurance contract is less flexible than a properly drafted trust because the arrangement limits the investments to those offered by one insurance company. The trust may either be a separate document or included as part of the plan document. The trustee of the trust holds and invests those contributions made to it by the employer for the purpose of making benefit payments to employees and/or beneficiaries upon their achieving the conditions required to receive benefits, generally termination of employment and, in some cases, attainment of the normal retirement age defined under the plan or upon disability or death. Distributions under a plan may be made in a lump sum, installment payments over a fixed number of years, or over the employee's lifetime (or the joint lives of the employee and his or her spouse). The method of distribution is a function of the type of plan, the provisions of the plan as established by the employer and the elections, if any, made by the employee.

Employer Goals; Costs

There are disadvantages in maintaining a qualified retirement plan. One of the significant requirements of a qualified plan is that it may not discriminate in favor of shareholders, officers, or highly compensated employees (the "prohibited group"). In other words, a plan must generally cover all or a nondiscriminatory cross section of the employer's employees. If the goal of the employer is to provide broad participation among employees and have benefits which do not discriminate in favor of the "prohibited group," then there are no additional costs necessitated by the

nondiscrimination requirements. Frequently, however, an employer will want to pick and choose a limited number of key employees to benefit under the plan. Providing substantially similar benefits to rank and file can be a significant additional cost to an employer wishing to provide retirement benefits to a limited number of key employees. Very often the total amount of employer contributions to a qualified plan will be greater than the cost of providing similar benefits under a non-qualified plan to a select group of employees. Essentially, ERISA and the Internal Revenue Code have imposed the cost of broader employee participation for the rights of an employer and its employees to enjoy the tax benefits of a qualified retirement plan.

There are also higher annual administrative costs associated with maintaining a qualified retirement plan because of the additional IRS and ERISA reporting and disclosure requirements and fiduciary responsibilities. These are discussed in greater detail later in this booklet.

There are various ways in which coverage, participation, contributions, plan selection and plan design can impact an employer's costs as well as the level of benefits provided to various groups of employees under a qualified plan. As the complexity of a plan increases, however, so do the costs of design, implementation and administration. An employer must determine what its goals are for providing retirement benefits to some or all of its employees and whether simplicity and the minimization of costs are overriding goals.

Finally, the Internal Revenue Code has been amended numerous times since the enactment of ERISA in 1974. These changes have generally imposed greater restrictions and costs on employers and their owners in providing retirement benefits. An employer must recognize that the rules for qualified retirement plans are likely to continue to change in the future. As those changes occur an employer must revisit its design decisions to make certain that its goals are continuing to be met through the retirement plan it has adopted.

Vendors

There are a number of services that need to be provided in connection with the design, implementation and administration of a qualified plan. These include:

- Plan selection and design services (which can also be provided as part of the legal services).
- Legal services in connection with the drafting of the plan documents, preparation of corporate documents, adoption of the plan and obtaining an IRS determination of the plan's qualified status.
- The initial and ongoing services of a trustee and/or custodian of plan assets.
- Management of investments of plan assets.
- Plan administration, including plan accounting, communication to employees and periodic reporting to the IRS, DOL and, if applicable, PBGC. This may also include the ability to implement participant instructions as to deferral amounts or investment selections made through a voice-response unit or the internet.

The foregoing services can be provided by either a single vendor (a "bundled approach"), by separate vendors (an "unbundled approach") or with the bundling of some services. Also, some services can be provided by the employer.

An example of a bundled approach would be an employer's decision to utilize a prototype plan (a prototype plan is a qualified plan whose form has been pre-approved by the IRS) offered by an insurance company, mutual fund or bank trust department. A "standardized" prototype offers very little variation in plan design, while a "non-standardized" prototype, which offers more variation in design, should receive its own determination of qualified status from the Internal Revenue Service. The vendor offering prototype

plan documents will typically assist the employer in adopting the plan (subject to the general caveat that the plan should be reviewed by the employer's legal counsel), it will hold and invest the assets contributed to the plan, and it will perform the necessary record keeping and annual disclosure and reporting requirements. Often the vendor of "bundled" services will provide some of the services "free of charge," which means they are absorbed by other fees, typically from the investment of plan assets. Such vendors may also attempt to lock the employer into the relationship with it by imposing charges or penalties upon an early termination of the arrangement.

One consideration for the employer in connection with choosing the bundled approach relates to the employer's flexibility, either in the provisions offered by the prototype plan or the ability to change certain aspects of the services (*e.g.*, investment alternatives) on other than an all or nothing basis. Often a decision to change investments will necessitate termination of the entire arrangement and will thus trigger a change in the form of plan, the recordkeeping, and the reporting responsibilities. In addition, there might be penalties or charges for early termination of the arrangement. The bundled approach does offer the significant advantage of limiting the employer's dealings to one vendor rather than coordinating the responsibilities of multiple professionals. Often turnaround time can be enhanced where a single vendor is providing all the services because they are not, for example, waiting for someone else to provide information.

With an unbundled approach, an employer has more flexibility in changing its investments, its plan administrator or its plan provisions without changing the entire arrangement. In many cases a single vendor does not provide the best service in all areas; the unbundled approach allows an employer to obtain the best services in all areas and at the most cost-effective basis overall. On the other hand, simplicity and reduced up-front costs often make it easy for an employer to choose a single vendor to provide all of the services.

The employer must in all cases make certain that it understands the structure of the plan, the contractual arrangement(s) (including penalties for termination of the contractual arrangement(s)) and all of the costs involved. The employer should also monitor the vendor's performance, including compliance with ERISA and Code requirements imposed on sponsors of qualified plans. Unfortunately, in the bundled approach there are generally no other professionals involved with the plan who may help the employers monitor the vendor's performance.

ERISA AND CODE REQUIREMENTS

The Employee Retirement Income Security Act of 1974 (ERISA) dramatically changed the law relating to qualified retirement plans. Many of the changes made by ERISA were changes to the qualification requirements under the Internal Revenue Code. In addition, the DOL was given jurisdiction over eligibility, vesting, funding, fiduciary responsibility, reporting and disclosure. ERISA provided greater remedies for plan participants and their beneficiaries and has sparked litigation by both employees and the DOL. The enforcement rights under ERISA are discussed in more detail below under **CIVIL ENFORCEMENT AND REMEDIES.** ERISA places a very high duty of care on those persons responsible for establishing, administering and managing a plan and the assets of a plan. These persons are referred to as fiduciaries of the plan. In general, ERISA requires that a plan fiduciary discharge the duties undertaken with respect to the plan solely in the interest of the plan's participants and beneficiaries. In discharging those duties, a fiduciary must act:

- for the exclusive purpose of providing benefits or defraying reasonable administrative expenses,
- with the care, skill, prudence and diligence of an expert in a similar circumstance,

- by diversifying any plan investments to minimize the risk of large losses, and
- in accordance with the plan documents.

In addition, ERISA generally prohibits most transactions such as the borrowing, exchange or transfer of assets between a plan and its fiduciaries unless the transaction is specifically permitted by statute, regulation or ruling. Participants and the DOL can bring claims for a breach of these duties. The fiduciaries of a plan covered by ERISA must be very serious about their duties and responsibilities and seek competent advice in fulfilling those responsibilities or risk potential litigation or penalties.

What follows is a list of the fundamental requirements that a retirement plan must satisfy under ERISA and the Internal Revenue Code in order to be treated as a qualified plan.

Written Plan and Trust

Every qualified retirement plan must be established and maintained pursuant to a written plan document and, except in limited circumstances, all of the assets of a qualified plan must be held in trust. The trust requirement does not extend to assets held under an insurance contract or annuity and certain qualified custodial accounts or IRAs.

Communication to Employees

The employees must be informed of the existence of a qualified plan and its basic terms. Employers should use caution in preparing a summary of the plan because courts have been willing to award damages based on what was promised in the summary even though it did not accurately reflect the terms of the plan. Summary Plan Descriptions are discussed in greater detail under **ADMINISTRATION of QUALIFIED RETIREMENT PLANS** below.

Controlled or Related Employers; Separate Lines of Business

For purposes of meeting the qualification requirements for qualified retirement plans, all commonly controlled employers must be treated as a single employer. Generally, commonly controlled corporations are those that have 80% or more common ownership or control. Also, certain affiliations between certain employers can cause those employers to be treated as part of an "affiliated service group" which means that the members of such group must be treated as a single employer for qualified plan purposes. This issue can become very significant when an employer is attempting to determine whether its retirement plan meets the minimum participation and nondiscrimination coverage tests. These rules are designed to severely limit an employer's opportunity to create multiple corporations in order to provide greater retirement benefits to highly compensated employees at the exclusion of non-highly compensated employees.

In a move to provide relief for the general rule that all commonly controlled employers are treated as a single employer, the Code provides an exception under the nondiscrimination, coverage and minimum participation rules for commonly controlled employers whose business operation can satisfy the standards set for qualified separate lines of businesses ("QSLOBs"). Each qualified separate line of business must include at least 50 employees and meet numerous requirements imposed by IRS regulations. If a separate line of business meets all of these requirements, then such separate line shall be treated as though it were an unrelated employer for purposes of applying the nondiscrimination, coverage and minimum participation requirement. Thus, larger employers may be able to provide substantially different and separate retirement plans to employees that are in distinct and separate business lines of the employer or a group of related employers. Similar relief is not, however, available to smaller employers who might also have separate and distinct lines of business with fewer than 50 employees in each separate line. To obtain QSLOB status, an employer must file a notice with the IRS.

Leased Employees

For purposes of certain coverage and nondiscrimination requirements applicable to qualified plans, a leased employee must be treated as an employee of the entity for which the services are performed. Basically, a leased employee includes any individual whose services are leased from another company, who works on a substantially full-time basis for at least one year and whose services are under the recipient's primary direction or control. Consequently, an employer must monitor those employees that it leases from a third party to determine if and when such an individual must be treated as the employer's employee and thus eligible to participate in the employer's retirement plan(s). Every qualified retirement plan must specifically state how such plan will treat leased employees. An employer may not have to cover leased employees if they accrue benefits under a money purchase pension plan provided by the leasing organization if the annual allocation to each leased employee is at least 10% of compensation and all benefits are immediately vested. This standard is seldom met.

Independent Contractors

Independent Contractors are not eligible to participate in a qualified plan sponsored by the employer for which they provide services. However, the definition of an independent contractor has been the subject of much litigation. In some cases, an individual has been held by a court to actually be a common law employee of the sponsoring employer, despite that employer having classified the individual as an independent contractor. The result of such a holding is that the individual, who was not allowed to participate in the employer's plan because he or she was classified as an independent contractor, should have been eligible for the employer's plan. Since the individual was improperly excluded from the plan, the employer was required to make the individual whole by making up the contributions and earnings the individual would have received if properly classified

as an employee. In some cases, this meant the employer had to contribute stock or qualified non-elective contributions to the individual's account.

Courts have followed the IRS guidelines, including its "20 Factor Test", in determining whether an individual is an independent contractor or an employee. The IRS looks at the degree of control the employer has over the manner and timing of the individual's performance of projects assigned, as well as at the degree to which the employer exercises financial control over the individual's pay.

In order to prevent this type of an outcome, many plan sponsors are now including language in their plans to exclude individuals who are classified by the employer as an independent contractor, even if a court later determines that such individuals are actually common law employees.

General Nondiscrimination

In general, a plan may not discriminate as to benefits or contributions in favor of highly compensated employees ("HCEs"). However, certain disparities in plan contributions or benefits are permitted. First, contributions or benefits may be determined based on a uniform relationship to compensation. Thus, a contribution based on a percentage of compensation is permitted even though an employee earning $60,000 may receive twice the contribution of an employee who is only earning $30,000.

In addition, a plan may be integrated with the benefits provided by Social Security. Because Social Security benefits, by design, discriminate in favor of lesser compensated employees, the benefits under a plan integrated with Social Security will permissibly discriminate in favor of higher compensated employees.

Current IRS regulations contain a number of design-based safe harbors which are deemed to satisfy the nondiscrimination tests. For example a contribution based on a fixed percentage of each

participant's total compensation will satisfy a design-based safe-harbor for defined contributions plans. If an employer does not use a design-based safe-harbor benefit structure, then the benefits or contributions under each retirement plan must be tested each year to see if the plan discriminates in favor of HCEs as to benefits or contributions under each retirement plan.

In addition to the general nondiscrimination rules, many provisions of the Code require a review of benefits provided to HCEs and, consequently, it is important to be able to identify an employer's HCEs. A HCE includes any employee who:

- was a 5% owner in the current or preceding year; or
- received compensation from the employer of more than $90,000 (as adjusted for cost of living increases)[1] in the preceding year and, if the employer elects, was in the employer's top-paid group.

Minimum Participation and Nondiscrimination Coverage Tests

First, a defined benefit plan must cover at least 50 employees, or if less, at least 40% of the employer's eligible employees. It does not matter if an employer maintains identical or comparable plans for different groups of employees; any defined benefit plan must satisfy this minimum participation requirement. Again, this test is determined by looking at all corporations under common control. Thus, if two separate and distinct corporations are owned by the same shareholder, a separate defined benefit plan may <u>not</u> be maintained by only one of those corporations if it covers fewer than 50 employees and fewer than 40% of the total employees of both corporations.

In addition, any qualified plan must satisfy one of two coverage tests.

- **Ratio Percentage Test.** The plan must benefit 70% or more of the employer's non-highly compensated employees ("NHCEs"). If, however, less than 100% of the HCEs are covered, then a

[1] See Appendix A for dollar limit in previous years.

reduced percentage applies. That reduced percentage is equal to 70% of the percentage of HCEs covered. For example, if a plan covers 50% of the employer's HCEs, then only 35% (70% x 50%) of the total NHCEs must be covered by the plan.

- **Average Benefits Test.** An alternative test for coverage will be satisfied if the class of employees covered is not discriminatory and the average benefit percentage for the NHCEs is at least 70% of the average benefit percentage for the HCEs. The average benefit percentage is the average contribution or benefit under the plan expressed as a percentage of compensation.

The 70% nondiscrimination coverage tests can be satisfied by combining certain separate plans for testing purposes only. Also, for purposes of these tests it is permissible to exclude those employees who are not otherwise eligible to participate under a plan because, for example, they have not completed a year of service.

The nondiscrimination test must be satisfied for each year. In order to eliminate the need to test the plan annually and avoid the risk of non-qualification, most employers cover all otherwise eligible employees. As an employer becomes larger and more diverse, it often becomes necessary to look at different plans for different groups of employees.

Eligibility

For purposes of plan eligibility, a plan may only impose up to one year of service as a condition of eligibility. (That can be increased to 2 years for non-401(k) portions of a plan if the employee is 100% vested in benefits under the plan). A year of service is the completion of at least 1000 hours of service in a 12-month period starting with the date of employment. Also, a plan may impose a minimum age requirement for eligibility, not to exceed age 21. Further, a plan may exclude union members from eligibility provided that retirement benefits were subject to good faith bargaining.

A provision to exclude a class of employees is permissible only if the plan can satisfy the minimum participation and nondiscrimination coverage tests described above. Again, a plan which excludes a class of employees will need to be monitored each year to assure compliance with the coverage and nondiscrimination tests. A plan can be disqualified for failing the coverage and nondiscrimination tests if its status is not monitored.

Vesting; Forfeitures

A qualified plan may require that employees complete a minimum number of years of service before they earn 100% of the benefit payable under the plan. This is referred to as "vesting." There are typically two types of vesting schedules. The first is a cliff vesting schedule where the employee becomes 100% vested after a certain number of years of service and is 0% vested before such time. The second schedule is a graded vesting schedule with gradual vesting over a period of time. The most restrictive vesting schedule a qualified plan can have is shown below for the two types of schedules. A plan may have a more generous vesting schedule.

Years of Service	Cliff Vesting for Non-Matching Contributions	Graded Vesting for Non-Matching Contributions
1	0	0
2	0	0
3	0	20
4	0	40
5	100	60
6	100	80
7	100	100

In addition, a participant must become 100% vested under a plan upon death or the attainment of normal retirement age, and may become 100% vested upon disability or attainment of early retirement age.

If a plan is determined to be "top-heavy," then the plan's vesting schedule for all employer contributions must be equal to or better than a three-year cliff vesting schedule or a six-year graded schedule. "Top-heavy" plans are plans that primarily benefit owner employers. See **TOP-HEAVY PLANS** discussed below.

Matching Contributions are also subject to a maximum three-year cliff vesting schedule or a six-year graded schedule.

A participant must not forfeit the non-vested portion of his or her benefit until he has incurred five consecutive one-year breaks-in-service. A one-year break-in-service is a year during which the participant is credited with fewer than 500 hours of service. Forfeitures in a defined benefit and money purchase pension plan must be used to reduce the employer's contribution. In all other plans, forfeitures may either be reallocated to current plan participants or used to reduce plan expenses or the amount which the employer must contribute to the plan.

Top Heavy Plans

A "top-heavy" plan will be subject to some additional, more strict requirements. Basically, a top-heavy plan is one in which key employees have accumulated more than 60% of the contributions or benefits under the plan. Key employees include certain officers, 5% owners and certain highly compensated 1% shareholders.

Under a top heavy plan a number of additional qualification requirements are imposed. First, special vesting rules apply (see discussion of **VESTING**, above). In addition, a top-heavy plan must provide either minimum benefits or a minimum contribution. These rules essentially limit the permitted disparity that might otherwise permit a plan to make higher contributions or benefits available to key employees. Finally, certain employees

who are employed at the end of the plan year must be provided a minimum benefit even though they might not otherwise be entitled to receive a contribution because of failure to complete 1,000 hours of service or make a mandatory or elective contribution to the plan.

Anti-Alienation

In general, a plan must provide that a participant's benefits may not be assigned or alienated while they are held by the plan. This includes voluntary and involuntary assignments. There is a significant exception, however, for certain domestic relations court orders requiring payments for the support of the participant's children or for the benefit of the participant's ex-spouse. These orders are referred to as "qualified domestic relation orders" ("QDRO"). A plan must make payments required under a QDRO subject to the plan's general provisions regarding the distribution of benefits. A plan may also include an exception which allows it to recover losses caused by a fiduciary's breach of fiduciary duty from that fiduciary's account or benefit.

Limit on Compensation that may be Taken into Account

The maximum amount of an employee's annual compensation that a plan may take into account for any purpose can not exceed $200,000, as adjusted for cost of living increases (in increments of $10,000 only)[2].

Limits on Benefits, Contributions and Deductions

Plans must limit the amount of benefits or contributions on behalf of participants. Under a defined contribution plan each plan year a participant's account may not be credited with "annual additions" which are in excess of the lesser of 100% of the participant's compensation or $40,000 (as adjusted for cost of living increases). For this purpose "annual additions" include both employer and employee contributions (both pre-tax and after-tax contributions) and forfeitures under the plan which are reallocated

[2] See Appendix A.

to the other participants. Investment earnings, however, are not counted as annual additions. This limitation will generally only affect the highly compensated employees. There is also an annual limit on the amount an employer may deduct when contributing to a defined contribution plan. Generally, contributions to a defined contribution plan may not exceed 25% of the total compensation of all participants. A defined benefit pension plan may not fund an annual retirement benefit which exceeds the lesser of 100% of a participant's final average compensation or $160,000 (subject to cost of living increases)[3].

Required Distributions

A plan must provide that unless a participant elects otherwise, benefit payments must begin following the participant's attainment of normal retirement age under the plan (no later than age 65) and termination of employment. With respect to an ESOP, distributions must generally commence within five years of the employee's termination of employment.

The plan must also satisfy certain minimum distributions for participants who have terminated and attained age 70 1/2 regardless of whether they wish to defer receipt of the distribution. These rules essentially require that a participant take distribution of all of his retirement benefits over his life expectancy, or the joint life expectancy of the participant and his beneficiary, with those benefits commencing at age 70 1/2, or termination of employment, whichever is later. Failure to make or commence distributions on a timely basis will subject the employee to a 50% excise tax.

Direct Transfer of Eligible Rollover Distributions

Every qualified retirement plan must give participants the option of transferring any rollover eligible distribution directly to an IRA, other qualified retirement plan, a 403(b) plan or a government-sponsored 457(b) plan. In the event a participant does not elect a rollover of an eligible distribution to either an IRA, other qualified plan, 403(b) plan or governmental 457(b) plan, then the plan must

[3] See Appendix A.

withhold income tax from the distribution at the rate of 20%, with the balance paid to the participant. At the time the employer provides a participant with notice of his option to make a direct rollover, the employer must also provide the participant with a notice explaining the tax consequences of the various distribution options. This tax notice is required by Section 402(f) of the Code. The IRS has published a model notice which employers may use.

ANNUITIES AND SURVIVOR BENEFITS

Congress was concerned about protecting survivor retirement benefits for spouses of participants under qualified plans and thus enacted special survivor benefit rules for spouses. Generally, qualified retirement plans which are considered pension plans (this includes both defined contribution money purchase pension plans and defined benefit pension plans) are required to provide benefits to married participants and their spouses in the form of a qualified joint and survivor annuity (and a qualified pre-retirement annuity for the surviving spouse of a participant who dies while still in active employment) unless the participant, with the consent of the spouse elects otherwise. A qualified joint and survivor annuity provides benefit payments to the participant for life with benefits continuing to the surviving spouse for life following the death of the participant. Plans which are not pension plans must either provide the foregoing annuity benefits or provide that a married participant's balance (if not distributed prior to death) will be paid to the surviving spouse, unless the spouse consents to an alternate beneficiary. An employer must notify plan participants of these requirements and generally must provide participants with the ability to elect out of their otherwise automatic application, if the plan provides optional benefit forms, such as a lump sum.

TYPES OF PLANS

There are two primary categories of qualified retirement plans, defined benefit pension plans and defined contribution plans.

A defined contribution plan provides individual accounts for each participant. A participant's retirement benefits are based entirely on the amount in the account, which consists of contributions to the plan, forfeitures (if any) of other accounts, and earnings on such amounts. The employee is at risk with respect to the investment gains or losses attributable to sums in his account. Defined contribution plans include profit sharing plans (including "401(k) plans"), stock bonus plans (including ESOPs) and money purchase pension plans (including target benefit plans).

A defined benefit pension plan provides by formula a definitely determinable benefit at retirement. The annual contributions to the plan are determined actuarially as the amount necessary to fund benefits for all of the participants at retirement. Thus, actuarial and investment gains or losses are borne by the employer and do not affect a participant's retirement benefit. As discussed below, certain defined contribution plans are structured to perform more like a defined benefit pension plan and vice versa.

Defined Contribution Plans

- **Profit Sharing Plans**
    - **Definition.** A profit sharing plan is established and maintained by an employer to allow employees to participate in company profits. The plan must designate itself as a profit sharing plan, however, the employer need not have profits in order to make a contribution and contributions need not be made out of profits. A non-profit organization can sponsor a profit-sharing plan.
    - **How it Works.** The employer makes an annual contribution, typically but not necessarily from the company's profits or retained earnings, to a profit sharing

trust. The contribution can be based on a formula relating to the employer's profits, however, contributions are generally made at the sole discretion of the employer. A separate account is maintained for each participant in the profit sharing plan. The employer's contribution is allocated to each participant's account based on a pre-determined ratio. Generally, the plan provides that the allocation be made in proportion to the basic compensation of each participant. Although less common, an employer may use an allocation formula which takes into account years of service and/or age in addition to compensation. The trust invests the entire amount of the employer's contribution, with individual participant accounts sharing pro rata in the investment gains and losses. Each participant is entitled to a distribution from his or her account upon the happening of a specified event, such as the lapse of a fixed number of years, the attainment of a certain age, a layoff, illness, disability, retirement, death or severance of employment.

- **Advantages and Disadvantages.**
  - The employer determines each year whether or not it shall make contributions to the trust. Although contributions need not be made every year, they must be "recurring and substantial" over time.
  - The company receives a deduction for contributions to the trust, up to a maximum of 25% of all participants' compensation (up to $200,000, adjusted for inflation) for the year.
  - A profit sharing plan may require or permit employees to contribute to the plan.
  - The profit sharing plan may provide for the withdrawal of a participant's contributions while the participant is still employed, for example under certain defined "hardship" circumstances.

- A profit sharing plan may, subject to certain limitations, permit loans to participants.

- A profit sharing plan may provide for incidental benefits such as life, accident or health insurance.

- A married participant's benefit must, in the event of death, be payable to his or her spouse, unless the spouse has consented in writing to an alternate beneficiary.

- **401(k) Plans**

  - **Definition.** A 401(k) plan is really a type of funding arrangement which can be part of either a profit sharing or stock bonus plan. Pursuant to a qualified 401(k) arrangement, employees may choose whether to have certain amounts contributed (pre-tax) to the plan or paid to them in cash. The right to receive the amounts in cash is not subject to the general constructive receipt rule which subjects to tax any amounts which may currently be received in cash.

  - **How it Works.** There are two types of 401(k) arrangements. First, there is a "salary reduction" 401(k) plan, under which each participant selects the amount of his or her compensation to defer. This is the most common type of 401(k) plan. The company contributes this amount to the plan on the employee's behalf, which amount is then allocated to the employee's account. Typically, as an inducement for employees to make salary reduction contributions (often referred to as "elective deferrals" or "elective deferral contributions"), an employer will provide a matching contribution on at least a portion of the employee's elective deferral contributions. For example, an employer could provide a 50% match on a participant's elective deferrals up to four percent of the participant's compensation. Second, there is a "cash option" 401(k) plan, under which each participant may elect to receive as a cash

bonus a certain portion of the company's year-end contribution to the profit sharing or stock bonus plan. The amount the employee receives in cash is taxable, and the remaining amounts are contributed to the plan on a pre-tax basis.

The IRS has recognized "negative elections." This allows an employer to automatically enroll all new employees who meet the eligibility requirements in the 401(k) plan at a predetermined salary deferral rate, provided that adequate communication is made to them about their option to elect out of participation and they are given an opt-out or "negative election" form. This approach can be used to significantly increase participation among the non-highly compensated group. However, some states, including Minnesota, require that payroll deductions for 401(k) plans be authorized in writing by an employee. While these state laws may be preempted by ERISA to the extent that they relate to an ERISA plan, an employer who wants to establish a "negative election" 401(k) plan may want to proceed with caution. A problem with negative elections is that contributions are invested in a default investment fund chosen by the employer. Unless the participant makes an investment election, the employer is then a fiduciary as to the money invested in the default fund.

- **Advantages and Disadvantages.**

  - The employee is sharing in the cost of providing his or her retirement benefit. The employee can decide whether and how much to contribute towards his retirement benefit. The employee's elective deferral contributions are "pre-tax" contributions, so the employee is not subject to state or federal income tax currently on the contributed amount. This amount, however, is considered to be "wages" for FICA and FUTA withholding purposes.

- The employer can deduct all contributions to the plan, subject to the 25% aggregate compensation deduction limit for profit sharing and stock bonus plans.

- The employees who are interested in saving for their retirement are rewarded by their employer's matching contribution.

- A special nondiscrimination test must be met each year to ensure that elective deferral contributions and matching contributions are not disproportionately greater for highly compensated employees than for lower paid participants. If there is inadequate participation by the lower paid participants, then the amount which higher paid employees may contribute is reduced. This annual nondiscrimination test imposes on the employer an additional annual administrative cost for maintaining a 401(k) plan. These tests are sometimes called the average deferral percentage test and the average contribution percentage test, or the ADP and ACP tests.

- The employer may set up a "safe-harbor" or "simple" 401(k) plan which allows an employer to avoid certain non-discrimination testing that is unique to 401(k) plans. However, the plan must meet special notice, funding, distribution and vesting requirements. In addition, a safe-harbor or SIMPLE 401(k) plan must provide a statutorily prescribed minimum non-elective contribution or matching contribution to all eligible employees. A SIMPLE plan may also be established using IRA accounts, rather than a trust. Most, but not all, of the advantages and disadvantages associated with a SIMPLE 401(k) plan also apply to a SIMPLE IRA plan.

- There is a limit on the maximum dollar amount that any participant may defer to a 401(k) plan during a calendar year. In 2004 this amount is $13,000. This limit is set to

increase by $1,000 each year until 2006. It will then be subject to cost of living increases[4].

- Catch-up contributions are permitted for participants who have attained at least age 50. Catch-up contributions can be made to a 401(k) plan even though it may cause the participant to exceed other limits. For 2004, the maximum catch-up contribution is $3,000. This limit is set to increase by $1,000 each year until 2006. It will then be subject to cost of living increases.

- Participants may be able to receive a tax credit for some or all of their 401(k) contributions under the Retirement Savings Tax Credit. The Credit is available to taxpayers with Adjusted Gross Income under $50,000 and equals 50% of eligible deferrals, up to a maximum credit of $1,000. The credit is set to expire in 2006.

- A 401(k) plan must prohibit withdrawals prior to age 59 1/2 while the participant is still an employee, except for financial hardship. A 401(k) plan may provide for loans to participants.

- Because of the prevalence of 401(k) plans and their popularity with employees, many employees who have worked at other companies may strongly urge their new employer to adapt and maintain a 401(k) plan.

- A 10% tax is imposed on contributions that are not deductible. There are two exceptions:

    1) It does not apply to contributions to one or more defined contribution plans that are non-deductible because they exceed the combined plan deduction limit, to the extent that the contributions do not exceed 6% of compensation paid to beneficiaries under the plans in the year for which the contributions are made.

[4] See Appendix A for prior year limitations.

2) The excise tax does not apply to contributions to one or more defined contribution plan that are not deductible because they exceed the combined plan deduction limit to the extent the contributions do not exceed the sum of: (a) the elective deferral contributions to a 401(k) plan, plus (b) the employer's matching contributions.

- **Stock Bonus Plans**

  - **Definition.** A stock bonus plan is similar to a profit sharing plan, except that under a stock bonus plan distributions to participants may be made in the form of employer stock.

  - **How it Works.** As with a profit sharing plan, contributions to a stock bonus plan are discretionary. The only significant difference is that a stock bonus plan is designed to be invested primarily in employer stock and distributions may be made in the form of employer stock.

- **Advantages and Disadvantages.**

  - See rules applicable to **Profit Sharing Plans.**

  - Participants can demand that distribution be made in the form of employer stock, and such stock must be provided with a "put" option obligating the employer to repurchase the stock from the participant following distribution of the stock.

  - Because stock is a security, federal and state securities laws may be applicable, especially if the plan includes a 401(k) arrangement.

  - An annual independent appraisal is required of employer stock contributed to and held under the plan. This is an additional administrative burden and cost for an employer maintaining a stock bonus plan.

- Certain voting rights appurtenant to stock may pass through to participants if more than 10% of the total assets of the plan are securities of the employer.

- Distributions generally must begin no later than five years after the close of the plan year in which the participant separates from service.

- **ESOPs**

  - **Definition.** An employee stock ownership plan ("ESOP") is a stock bonus plan, or combination stock bonus plan and money purchase pension plan, which is designed to invest primarily in qualifying employer securities. An ESOP must be formally designated as an ESOP in the plan document.

  - **Advantages and Disadvantages.**

    - See rules applicable to **Stock Bonus Plans.**

    - An ESOP may only invest in "qualifying employer securities." Such securities are limited to either readily tradable common stock or the employer's common stock with the greatest voting and dividend rights. Under certain circumstances an ESOP may acquire noncallable convertible preferred stock.

    - An ESOP may be "leveraged," that is, it may borrow to acquire employer securities. In addition, the employer may guaranty such indebtedness. One who sells employer securities to an ESOP holding at least 30% of the company's stock after the purchase may reinvest the proceeds in "qualifying securities" and defer tax on investment gains until they are ultimately sold. This special tax treatment is not available to shareholders of S-corporations who sell shares to an ESOP.

- Contributions to a leveraged ESOP are subject to a 25% of total compensation deduction limit. Contributions for interest on the ESOP loan are not subject to the 25% limit.

- An ESOP may not be considered with any other plan for purposes of applying the nondiscrimination and minimum coverage rules.

- An ESOP may not be integrated with Social Security.

- ESOPs are required to offer participants who have attained age 55 and completed 10 years of participation with a right to diversify up to 25% of their account out of employer stock. At age 60 that percentage increases to 50%.

- Dividends paid an employer stock held by an ESOP are deductible if the dividends are used to repay an ESOP loan, are distributed directly to the participants, or if participants may make an election to have the dividends distributed in cash or re-invested.

- An ESOP may prevent a participant from demanding a distribution in the form of employer securities if the employer's corporate charter (or bylaw) restricts the ownership of substantially all outstanding employer securities to employees or to a trust under a qualified plan, as long as participants entitled to distribution have a right to receive the distribution in cash. As an alternative, the ESOP may distribute employer securities subject to a requirement that they may be resold to the employer under terms meeting the fair valuation.

- A subchapter S corporation may sponsor an ESOP. Special rules apply.

- **Money Purchase Pension Plan**

  - **Definition.** A money purchase pension plan is a type of defined contribution plan with certain pension plan characteristics. The employer's contribution to the plan and the allocation to participant accounts are typically based on a certain percentage of each employee's compensation. The plan must designate itself as a money purchase pension plan.

  - **How it Works.** The employer obligates itself under the plan to contribute a specific amount to the plan, generally equal to a fixed percentage of each participant's compensation. These contributions are required annually whether or not the company has profits. The amounts contributed are credited to each individual participant's account, similar to a profit-sharing plan. Adjustments are made each year based on the plan's investment experience. The participant eventually (typically upon retirement) receives distributions from the plan based on the vested percentage of the amounts credited to his or her account. Unless waived by the participant (and spouse, if married) the normal form of benefit is a life annuity (or joint and survivor annuity if married) to be provided by acquiring a single premium annuity with the funds held in the participant's account.

  - **Advantages and Disadvantages.**

    - The employer can deduct all contributions made to the plan, subject to a 25% aggregate compensation limit.

    - Investments accumulate in the trust tax-free for participants. Distributions will be taxed to the employee, but at that time may qualify for favorable tax treatment or be rolled over into an IRA.

    - The employer is required to contribute a fixed amount each year, based on the contribution formula set forth

in the plan. There are penalties for not making the contributions on a timely basis. The employer may, however, simply terminate the plan to cut off its obligation to contribute to the plan.

- In-service distributions are not permitted; early withdrawals may disqualify the plan. There is an exception, however, for required minimum distributions to participants who attain age 70 1/2 and are 5% owners.

- Now that the employer's deduction limit is 25% of aggregate compensation for profit sharing plans, many employees have decided to terminate or merge their money purchase pension plans into a profit sharing plan.

- The employer must provide benefits in the form of a life annuity (joint and survivor annuity if married) unless the participant (and spouse, if any) waive the right to receive the participant's account in the form of an annuity. This requirement creates additional administrative burdens and greater fiduciary responsibility in selecting an appropriate annuity provider. As a practical matter most participants waive the annuity requirement.

- **Target Benefit Plans**

  - **Definition.** A target benefit plan is a money purchase pension plan form of defined contribution plan with contributions to a participant's account determined based on actuarial tables.

  - **How it Works.** The amount of the employer's contribution is actuarial determined by reference to a fixed retirement benefit for each participant. As with a typical money purchase pension plan, the contributions for each

participant are credited to the participant's individual account. The IRS has issued interest rate tables which apply so that an actuary need not be hired to perform these calculations.

The actual amount of retirement benefits received by a participant depends on the value of the assets of the participant's account at the time of retirement. This type of plan is generally used where the employer wishes to provide greater benefits to older employees with more years of service and higher compensation.

- **Advantages and Disadvantages.**
    - Upon termination of the plan, the employer is not entitled to a refund of any "excess" funding.
    - A participant's ultimate benefit is limited to the amount of the participant's account balance upon termination of employment; the employee assumes all investment risk.
    - Target benefit plans are subject to an overall corporate deduction limit of 25% of the aggregate amount of the participants' compensation.

- **SEPs**
    - **Definition.** A simplified employee pension ("SEP") is an arrangement whereby an employer makes contributions to an individual retirement account ("IRA") maintained for each participant.
    - **How it Works.** The employer makes contributions in accordance with a written plan on a non-discriminatory basis to all covered employees. The contributions are then funneled to IRAs maintained for each employee. Each IRA is a separate SEP, although its provisions may simply be those of the trustee's standard IRA. The document under

which the employer makes its contributions is referred to as the SEP arrangement.

- **Advantages and Disadvantages.**
  - Simple to establish and administer. Plan document can be an IRS published form.
  - Limited to employers with 25 or fewer employees.
  - Unlike a qualified plan, the plan must cover all employees who are age 21 or older and who have performed service for the employer during three of the last five calendar years.

- **IRAs**
  - **Definition.** An individual retirement account ("IRA") is an arrangement whereby an employee or self-employed person makes contributions directly to a custodial account, which is maintained for that person. The three general types of IRAs that may be established by an individual for his or her retirement are: deductible IRAs, nondeductible IRAs and Roth IRAs.
  - **How it Works.** Almost anyone under the age of 70 1/2 who receives compensation can establish an IRA (there are restrictions as to who can establish a deductible IRA or Roth IRA). In order to adopt or create an IRA, Form 5305 (Individual Retirement Trust Account) of Form 5305-A (Individual Retirement Custodial Account) should be completed. An individual may then contribute up to $3,000, or, if less, 100% of compensation. This limit is set to increase periodically, until it reaches $5,000. It will then be adjusted for cost of living increases. Under a Form 5305 an outside institution serves as the trustee of the IRA, while under a Form 5305-A, the IRA is set up with an outside financial institution as a custodian of the account but not as the trustee.

- **Advantages and Disadvantages.**

  - Easy to establish and administer.

  - Can be established as a supplement to other qualified retirement plans or as an individual's sole retirement savings vehicle.

  - Completely portable. Since the IRA is established by the individual, it stays with the individual at all times.

  - Subject to withdrawal restrictions similar to those for qualified plans.

  - Catch-up contributions are also permitted (see "401(k) Plans" for an explanation of catch-up contributions). The catch-up contribution limit for 2004 is $1,500 and is set to increase periodically.

Defined Benefit Pension Plans

- **Generally.**

  A defined benefit pension plan is established and maintained by an employer primarily to provide for the payment of defined benefits for his or her employees over a period of years (typically for life) after retirement. The main purpose of a pension plan is to provide retirement or pension benefits, rather than deferral of present compensation. Retirement benefits are typically measured by and based on factors such as years of service and compensation received by the employees. A plan which provides benefits upon retirement is considered a pension plan if the contributions by the employer can be determined actuarially on the basis of definitely determinable benefits.

  A pension plan can be funded by employer contributions, employee contributions, or both, but are generally limited to employer contributions. One of the advantages of a defined

benefit pension plan is the fact that, unlike defined contribution plans, contributions substantially in excess of 25% of the plan participants' compensation may be deductible.

A pension plan contains a formula which determines the specific amount each participant will be entitled to upon attainment of normal retirement age under the plan. This benefit will be paid, regardless of the plan's investment experience, or the size of contributions to the plan. Based on the plan's formula for a defined benefit for each participant, an actuary predicts, factoring in variables such as life expectancy, employee turnover and investment experience, how much money must be contributed on a regular basis to meet the plan's obligations to make benefit payments. Employers are liable to make additional contributions to the plan if assets are insufficient to fund plan benefits.

In addition to retirement or pension benefits, a qualified pension plan may also provide incidental benefits such as disability income, Social Security supplements, and incidental death and medical benefits.

Pension benefits are generally paid as monthly amounts for the life of the participant (or for the joint lives of the participant and the participant's spouse). Benefits may, however, be provided in an alternate form if the participant (and, if married, the participant's spouse) consents to such alternate form. In such case, benefits may be distributed in the form of a paid-up annuity contract, as equal installments over a term certain, or, in a lump sum distribution. Pension benefits can only be distributable on death, retirement, disability, or termination of employment. Unlike defined contribution plans, in-service withdrawals are not allowed and typically distributions do not commence until the participant attains a normal retirement age (generally age 65).

Finally, pension benefits under a defined benefit pension plan are guaranteed by a federal agency, the Pension Benefit

Guaranty Corporation (PBGC). As a consequence, employers who sponsor pension plans are charged annually a per participant fee to cover the cost of this insurance coverage.

- **Traditional Pension Plan Formulas.** Under most defined benefit pension plans, participants are provided benefits based on a percentage of their average compensation and a minimum period of service in order to receive full benefits. There are various methods to average out compensation.

    - **Career Average Pay.** This type of plan bases benefits on an employee's actual compensation earned during each year of service. For example, the plan may provide that a participant will receive a benefit at normal retirement age equal to 1% of the participant's compensation for each year of service. A participant who receives $50,000 of compensation one year would be credited with $500 for that year of service. If the participant's compensation increases to $60,000 the next year, the participant would be credited with another $600 for that year. This benefit accrual would continue until the participant terminates employment.

    - **Final Average Pay.** This type of plan bases benefits on an employee's compensation averaged over a short period of years, such as the last five years before retirement or the highest five consecutive years during the last ten years of service. For example, the plan may provide that the annual retirement benefit will equal 1% of an employee's average compensation based on the last five years of service, for each year of service up to 30 years. A participant whose average pay the last five years of service was $100,000, and had accumulated 30 years of service, would receive an annual pension at retirement of $30,000 (30 years x 1% x $100,000).

- **Cash Balance Pension Plan Formula.** An alternative form of a defined benefit pension plan formula is to define benefits for each employee by reference to a hypothetical account maintained for each employee. This hypothetical account is determined by reference to hypothetical annual allocations and crediting with interest at a rate determined in accordance with the plan. This is analogous to allocations of contributions and earnings to an employee's account under a defined contribution plan and is communicated to employees in that manner. On distribution, the value of the hypothetical account must be offered to a participant in the form of a life annuity (or a joint and survivor annuity if the participant is married) unless the participant (and the spouse, if the participant is married) waives the annuity and, as is often permitted, elects a cash lump sum distribution. Although this plan looks like a defined contribution plan, no individual account is maintained for each participant and the employer rather than the employee is at risk for the investment return.

Multi-Employer Plans

Employers are prohibited under the Taft-Hartley Act from making payments to union officials or to any unions. Clearly a provision enacted to prevent bribery, the law contains an exception which allows employers to make payments to a jointly sponsored and administered employee benefit trust provided that it have equal representation by employer and employee representatives.

- Known as Taft-Hartley trusts, these trusts can sponsor retirement plans for employees represented by a union as well as health and welfare plans for the same group.
- The Board of Trustees is the named fiduciary with the authority to make decisions about investment of plan assets, and entitlement of participants and beneficiaries to benefits.

- Each employer or employer group appoints its trustees. The union appoints union trustees. The two trustee groups have equal votes and the trust provides for arbitration in the event of a deadlock.

- Typical retirement plans made available through a Taft-Hartley trust would include defined benefit pension plans and money purchase pension plans. A multi-employer defined benefit pension plan would typically provide a retirement benefit at a certain dollar amount multiplied by the number of years of service an employee has worked for the period during which contributions were made by the employer to the trust fund. Money purchase pension plans are typically funded through a specified hourly contribution for each hour each employee works.

- Multi-employer retirement plans must use the same vesting schedules available to single employer plans.

- Many discrimination rules are waived for these plans both as they apply to coverage and to discrimination in favor of highly compensated employees.

- Retirement Plans which cover employees who are not members of the bargaining unit, such as union officials, are subject to separate discrimination rules.

- The primary purpose for multi-employer plans is portability. In industries where employees represented by a union frequently change employers within the industry, these employees can continue to accrue service despite changing from one employer to another.

- Multi-employer plans frequently enter into reciprocity agreements with other multi-employer plans to pass on credit for service and contributions to the "home" plan to enhance benefit levels in one plan.

- **Pension Withdrawal Liability.** When an employer ceases to make contributions to a multi-employer plan or because of a change in a bargaining agreement no longer has an obligation to contribute to a multi-employer plan, that employer experiences a withdrawal from the plan. The withdrawal can either be complete or partial.

    - When a withdrawal occurs, the employer is assessed a pension withdrawal liability determined by allocating a portion of the unfunded liability of the Plan for the vested benefits of all plan participants to the withdrawing employer.

    - The portion allocable to the withdrawing employer will be determined based upon its contribution rate, the number of employees for whom contributions were made and the time period of those contributions. The "presumptive method" for allocating liability is favored.

    - Liability is determined as of the end of the plan year preceding the date of withdrawal. Once withdrawal liability is assessed an employer has the right to receive an explanation and may seek arbitration of withdrawal liability issues within a sixty day period.

    - Withdrawal liability payments will be scheduled at quarterly intervals (for a period not to exceed 20 years), based upon the employer's previous contribution levels.

    - An employer selling its business in a stock sale can pass that liability on to the purchaser.

    - In the case of a sale of a business' assets, the seller will be assessed its allocable share of withdrawal liability unless the parties agree to certain specific assumption of liability requirements by the purchaser. The seller will be contingently liable.

- Special withdrawal liability rules apply to employers working in the entertainment industry, the building and construction industry and the trucking industry.

ESTABLISHMENT OF THE PLAN

To establish a qualified plan an employer must formalize the action by executing the appropriate legal documents. The first step in this process is for the board of directors of the company to approve the establishment of the plan and to adopt the plan and trust documents presented to them. This action may be in the form of a resolution or a written consent action.

After the board of directors has approved the plan, the corporate officer(s), authorized and empowered by the board, must execute the appropriate plan documents. The legal documents to be executed generally include a plan document and a trust agreement. These documents may be combined into one document or may be maintained as two separate documents. If the employer is adopting a prototype plan, the execution of the adoption agreement will establish the plan.

As mentioned above, a trust agreement must also be established along with the plan. All assets of a qualified plan are required under ERISA to be held in a separate trust by one or more trustees. The trustee(s) should be named in the trust agreement (or referenced as the individual appointed by the named-fiduciary). A trustee may be either a corporate officer (or employee), or an institutional trustee. It is also recommended that an initial contribution be made to the trust to formally establish its existence by the end of the first plan year.

If the sponsor does not adopt a prototype or "volume submitter" plan with no modifications of the basic plan document, the plan sponsor should seek a favorable determination from the Internal Revenue Service with respect to the plan's qualification. Although not required by law, a favorable determination letter from the IRS assures the employer that the plan satisfies the current legal

requirements of the Internal Revenue Code and qualifies for the favorable tax treatment offered to qualified plans. If a prototype or volume submitter plan is adopted with no changes to the plan, the plan need not apply for an individual determination letter but rather can rely on the opinion letter for the prototype or volume submitter as evidence of its qualified status. The IRS assesses a user fee for a determination letter, but the fee is nominal and is waived for new plans of small employers.

Small employers may be eligible for a tax credit in connection with certain of the costs of establishing a new plan.

In addition to the formal documentation of the plan, the employer should also establish a recordkeeping system for administering the plan and should communicate the plan to its employees. These issues are discussed in greater detail under the following section ("Administration").

ADMINISTRATION

Application for Determination

The Plan Administrator is responsible for the details relating to plan establishment and ongoing plan operation. When the plan is established, it is prudent, although not required by law, to submit the plan for review by the IRS. (See "Establishment of the Plan"). Upon review the IRS will issue a determination letter to the employer on the qualified status of the plan. A favorable determination letter offers formal assurance that the plan meets all the requirements necessary to allow the plan to receive the favorable tax treatment permitted for "qualified" retirement plans and that the IRS will not challenge its provisions.

You can request a determination on your plan by submitting an application for determination to the IRS (Form 5300 Series). There is no specific deadline for filing an application for determination on the plan's qualified status. However, it must be submitted by the due date of the employer's tax return for the year in which the

plan was first established in order for the determination letter to be retroactive to the plan's effective date.

Notice to Interested Parties

Prior to submitting the plan to the IRS for a favorable determination letter, the employer is required to provide notice to all "interested parties" of its intentions. "Interested Parties" include all present employees eligible to participate in the plan, and any employee who works at the same principal place of business as the eligible classification of employees.

Notice may be provided by mail, in person, or by posting. The Notice to Interested Parties must be mailed or posted not less than 10 days nor more than 24 days prior to the date on which you intend to submit the application to the IRS. It may also be distributed electronically to those who have access to a computer at their place of employment.

The Notice to Interested Parties contains relevant information concerning the plan and determination letter request. It also details the rights of "interested parties" in regard to making comment on the plan prior to the issuance of a determination letter. ERISA provides that "interested parties" have a right to submit comments or concerns to the IRS and/or Department of Labor (DOL) in regard to the plan.

Summary Plan Description

The plan administrator is also responsible for distributing the Summary Plan Description (SPD) to each participant and beneficiary of the plan. The SPD is a description of the plan's provisions written in a manner to be understood by the average participant. ERISA requires that an SPD include a description on each of the following topics:

- benefits offered under the plan,
- participation requirements,

- the plan's vesting schedule, and
- any other provisions relating to a participant's rights.

ERISA prescribes the following time requirements for distributing the SPD. Participants must be provided with a copy of the SPD within 120 days after the plan's effective date or date of the plan's adoption, whichever is later. As new participants become eligible under the plan, the plan administrator shall distribute a copy of the SPD to them within 90 days after the date the employee becomes eligible to participate in the plan.

When a plan is amended in a material way, the plan administrator is required to furnish a Statement of Material Modification describing the change to plan participants within 210 days following the end of the plan year in which the change was effective.

The plan administrator must also furnish each participant and beneficiary with an updated SPD every 5 years, incorporating into it all amendments made to the plan during such 5 year period. If no amendments have been made, a new SPD need only be distributed every 10 years.

Electronic Communication of Summary Plan Description

In response to the ever-increasing advances in technology, the Department of Labor has issued a proposed regulation addressing the communication of employee benefits material through electronic media. The proposed regulation establishes a safe harbor to which all covered pension and welfare plans under Title I of ERISA may satisfy their obligation to provide a Summary Plan Description (SPD), a Summary of Material Modification (SMM), updated Summary Plan Descriptions and Summary Annual Reports using electronic media. Under the proposed regulation, in absence of a final regulation or other guidance on this issue, a good faith compliance with the standards set forth in the proposed regulation will constitute compliance with the disclosure requirements.

The proposed regulation requires that when choosing to disclose employee benefits information to employees electronically, the employer must take "appropriate and necessary measures to ensure that the system for furnishing documents results in actual receipt by participants of transmitted information." Suggestions for ensuring that information is actually received include using a return-receipt electronic mail feature or through periodic reviews or surveys by plan administrators to confirm the integrity of the delivery system. It is also necessary that electronically delivered documents are prepared and provided in "a manner consistent with the style, format and content requirements applicable to the disclosure."

In order to ensure that an employee who receives a SPD or SMM through an email attachment or through an internet site is aware that the communication contains important information, the proposed regulation imposes a notification requirement on employers. Employers are required to notify the employee through electronic means or in writing that such documents (whether SPD or SMM) are being distributed electronically. Furthermore, the employer is also required to inform employees that they are entitled to a paper copy of each document free of charge.

Because participants are entitled to a paper copy of each document free of charge, the proposed regulation requires that employers provide employees a means by which to obtain a paper copy of the documents free of charge. For example, accessibility to a printer at each employee's worksite location ensures that a free paper copy of the disclosure documents is readily accessible. Worksite location has been defined as "any location where an employee is reasonably expected to perform his or her duties and where access to the employer's electronic information system is an integral part of those duties." As a result, for purposes of the safe harbor, the actual location of the worksite, be it at home or a client's office, is less important than the employee being "reasonably expected to access the employer's information system in the course of performing his or her duty."

Bonding

Generally, every fiduciary with respect to the plan and every other person who handles funds or other plan property must be bonded. The bond protects the plan against losses due to fraud and dishonesty. The amount of the bond must be at least 10% of the funds and other plan property handled. In addition, the bond must be at least $1,000 but need not exceed $500,000.

Participant Eligibility

After establishing the plan, the plan administrator's next step should be to determine which employees are eligible to participate and when their participation will become effective. A current schedule should be maintained to provide notification of when employees are expected to become eligible. In order to maintain a current schedule it will be necessary to include employee information such as date of birth, date of hire, and hours of service for each employee.

Upon meeting the eligibility requirements which are provided in the plan, employees should be notified of their eligibility to participate in the plan. Eligible employees must be entered into the plan on the first entry date following the date the eligible employee satisfies the requirements for participation. The plan must specify the entry date. A common entry date provision would be the first day of the plan year and the first day of the seventh month of the plan year with a service requirement of one Year of Service (1,000 hours of service in a twelve month computation period). An age requirement is also common. However, this age requirement may not exceed age 21. As employees enter the plan each employee should be provided with the following:

- a copy of the SPD;
- a beneficiary designation form;
- an elective deferral agreement (for a 401(k) plan);

- an investment election form or information about making investing elections by telephone or internet; and
- any other administrative forms which may apply.

Beneficiary Designation

Each employee, upon initial entrance into the plan, should be furnished with a notice to participants and beneficiary designation form for completion. The plan administrator will keep on file all effective beneficiary designation forms and applicable spousal consent forms. In the event of a participant's death, the effective beneficiary designation form will determine to whom the plan administrator will distribute the participant's account.

Elective Deferral Agreement

If the plan contains a cash or deferred arrangement, more commonly known as a 401(k) arrangement, the plan administrator shall provide each participant with an elective deferral agreement upon entering the plan, or within a reasonable period prior to the beginning of each election period upon request. A participant may enter into an elective deferral agreement after satisfying the eligibility requirements specified in the plan. The participant's elective deferral agreement must be kept on file with the plan administrator until amended or revoked. Such agreement will be applicable to each payroll period for which it is in effect and on file.

Plan Loans

If the plan provides that participants may receive a loan from the plan's funds, the board of directors must adopt a written policy and procedure outlining the specific rules which the plan administrator must follow in making loans from the plan. The Department of Labor requires that the loan policy be in writing and that it be non-discriminatory in nature. You should consult with your benefits attorney to create a loan policy.

The loan policy must give the procedure for the application and decision process for loans and specify that loans cannot exceed the lesser of $50,000 or one half of the present value of the non-forfeitable accrued benefit of the employee under the plan (unless that amount is less than $10,000, in which case $10,000 may be permitted if other security for the loan is provided). The $50,000 limit is reduced by the participant's highest outstanding loan balance for the year prior to the loan's origination

The loan must be made in conjunction with an enforceable written agreement (usually a promissory note) which specifies the loan amount, terms, and repayment schedule. Also, the loan must provide for repayment within 5 years, unless the loan is for the purchase of a primary residence. Repayment must be in substantially equal payments and must occur at least as frequently as quarterly, with many plans opting to require automatic payroll deductions to repay the outstanding loan balance. This repayment schedule can be suspended if the terms of the plan so provide for employees on a qualified military leave.

Regulations were issued in 1998 which discussed loan default issues. The new regulations stated that a loan must be called in default in the quarter following the quarter in which missed payments are not cured (unless the loan policy or note provides for earlier default). Once a loan is defaulted, the plan does not need to continue to accrue interest for the loan, which makes plan administration more simple. Once a loan is defaulted, the participant should be issued a distribution (or a deemed distribution, if an active employee) for the amount of the loan default (unpaid principal and interest accrued as of the date of default) and the participant will have income tax on that amount in the year of the default.

Hardship Withdrawals

If provided under the plan, participants may receive a distribution of their elective deferral contributions, without any earnings, provided they are 100% vested in their account, for a hardship brought on by an immediate and heavy financial need. Upon receiving an application for hardship withdrawal from a participant, the plan administrator must review each request in accordance with the provisions of the plan documents. Such determination by the plan administrator of the existence of an immediate and heavy financial need and of the amount necessary to meet that need must be made in a non-discriminatory and objective manner.

Qualified Domestic Relations Orders (QDROS)

Plans must provide that a participant's account may not be assigned or alienated. The Retirement Equity Act of 1984 (REA) created an exception to this rule. A Qualified Domestic Relations Order permits the plan administrator to assign a participant's account to an "alternate payee". A QDRO is an order, issued by a state court, that gives a spouse, former spouse, child or other legal dependent of the participant the right to any part of the participant's interest in the plan. Upon receiving a QDRO, the plan administrator should seek legal advice to determine the validity of the QDRO. It is highly advisable that you adopt a procedure for administering such orders.

Distributions

Distribution of a participant's account can be triggered by the participant's termination of employment, death, disability, early retirement, if provided in the plan, or normal retirement as specified in the plan. Upon the occurrence of one of these events, the plan administrator should provide the participant (or the participant's beneficiary) with a distribution notice, election of form of distribution and any other applicable forms. Also, the plan administrator must provide a special tax notice regarding plan

distribution which advises the participant of ways in which the participant can reduce or defer taxes on the distribution which is about to be made. This notice is required by federal law. If a participant asks you as plan administrator about the tax consequences of a distribution, you should advise him/her to consult with his/her own personal tax advisor.

Tax Withholdings from Plan Distributions

The plan administrator is required to make tax withholdings from certain distributions made from the plan. Under recent legislation, most distributions from a plan which are made to a participant are subject to 20% backup withholding.

As an alternative, a participant may elect to have an "eligible rollover distribution" transferred directly to a trustee or custodian of an IRA, another qualified plan, a 403(b) plan or governmental 457(b) plan ("eligible retirement plan"). The plan administrator must notify the recipients of distributions of their election rights no earlier than 90 days prior to the date of payment and no later than 30 days prior to the date of payment.

Some distributions such as installments or annuity payments over a period of more than five years are not "eligible rollover distributions" but are subject to tax. In these cases the mandatory withholding rule described above does not apply. A participant may elect not to have withholding applied to an ineligible distribution, or may elect to have withholding apply, in which case the withholding rate is 10%.

Amendments to the Plan

After the plan has been established, the employer from time to time may wish to make amendments to it. Amendments may vary in scope. Some amendments may make only minor changes whereas others may greatly change the plan. Periodically amendments may be prescribed by the Internal Revenue Code to maintain a plan's qualified status, or the employer may wish to implement changes in design.

When significant changes are made to the plan, participants and beneficiaries must be provided with a Summary of Material Modifications (SMM). This SMM, written in language similar to the SPD which can be understood by the average participant, explains the amendment's effect on the plan and on the participant's rights. A SMM must be furnished to plan participants and beneficiaries within 210 days after the end of the plan year in which the amendment was adopted.

Plan Termination

In the event that the employer decides and takes formal action through its board of directors to terminate the plan, the plan administrator should be given proper authority to take the appropriate actions to terminate the plan. The plan's termination will trigger the distribution of participants' accounts.

Record Keeping

As a plan administrator you are required to prepare within specific time periods numerous and sometimes lengthy reports and forms. To assist in your accurate completion of these filing requirements the following records must be maintained on an annual basis:

- A List of Current Employees and Participants;
- Participant Information:
  _____ Date of Birth
  _____ Date of Hire
  _____ Date of Termination
  _____ Marital Status
- Hours of Service for Each Employee and Participant;
- Each Participant's Compensation;
- Each Participant's Elective Deferral Percentage;
- Each Participant's Account and Earnings; and
- Investment Activities.

By keeping all records accurate and complete you will simplify the reporting procedures and will allow necessary forms to be filed with government agencies on a timely basis. Since the failure of meeting specified deadlines can result in costly penalties and fines, maintaining current records is a critical responsibility.

Employee Plans Compliance Resolution Systems (EPCRS)

In 1998, the IRS implemented a program that allowed employers to correct certain errors incurred in their qualified plans. The program was, and still is, voluntary, meaning a plan sponsor can decide whether to participate in the program or not. For plan sponsors who choose to participate, the IRS has prescribed a set of specific rules and procedures for correction of the errors. The program is reviewed and updated by the IRS, usually annually. The program is known as the Employee Plans Compliance Resolution System (EPCRS). In Rev. Proc. 2003-44, the IRS updated EPCRS to include three sub-programs. The sub-programs include the Self Correction Program (SCP), the Voluntary Compliance Program (VCP), and the Audit Closing Agreement Program (Audit CAP). The purpose of EPCRS is to allow an employer whose plan does not meet the requirements of a qualified plan to correct these qualification failures and "thereby continue to provide their employees with retirement benefits on a tax-favored basis."

EPCRS offers employers relief for certain qualification failures. A qualification failure is one which adversely affects the qualification of the plan under Code section 401(a) or Code section 403(b) and can arise out of an operational defect, a demographic defect or a plan document defect. Operational failures arise when there is a failure to follow the plan's provisions. An example of an operational failure is one that occurs as a result of miscalculation of benefits or distributions. The plan itself may otherwise comply with the Code's requirements, however, the failure is in the operation of the plan. A demographic failure occurs as a result of failing to satisfy the non-discrimination requirements of the Code. A plan document failure involves qualification violations in the

plan document itself. Because some of the qualification failures are more serious than others, only particular programs may be used to correct some of these failures, as follows:

- **Self Correction Program.** This is a self-correcting program that allows employers to correct operational failures discovered in their retirement plans. The employer need not report to the IRS or disclose the operational failure when using this form of correction. In order to use this method, the employer must have established a procedure designed to promote and facilitate overall compliance with the required Code sections prior to committing the operational error. Under this procedure, the employer needs to have a favorable determination letter from the IRS and the correction needs to be corrected within a certain period of time if the failure is "significant". If the failure is deemed "significant", the correction is must be completed by the end of the second plan year in which the failure occurred. The correction is deemed complete within the required correction period if a) the plan sponsor is prompt in identifying the operational failure and formulating the correction plan, and b) corrections are made for at least 85% of the affected participants. Insignificant failures may be corrected under this method beyond the two year correction period. What constitutes an "insignificant" failure is still not clearly defined by the IRS.

- **Voluntary Compliance Program (VCP).** This program involves a voluntary disclosure of operational failures by the plan sponsor to the IRS. Upon disclosing to the IRS the operational failure, the plan sponsor may obtain IRS approval of its correction proposal for a fee of $750 -- $25,000 (depending on number of participants) payable to the IRS. This program requires IRS approval and is available for operational, demographic and plan document failures but is not available for major defects. If the IRS determines that the submission is acceptable, the IRS will contact the plan sponsor to go over the proposed correction

and administrative procedure. Once an agreement has been reached the IRS will issue a compliance statement.

- **Audit Closing Agreement Program (Audit CAP).** This program allows plan sponsors to negotiate the monetary penalty for qualification failures discovered during an IRS audit of the plan. Under an Audit CAP the plan must pay the sanction, correct the failure and enter into a closing agreement with the IRS. Operational, demographic and plan document failures all apply under this program.

Department of Labor Voluntary Corrections Programs

EPCRS, which was discussed in the previous section, is an IRS program and only addresses Code violations. Other ERISA requirements for qualified plans are enforced by the Department of Labor. Like the IRS, the DOL has also implemented Voluntary Compliance Programs for certain other ERISA violations. The Department of Labor programs are known as the Voluntary Fiduciary Compliance Program (VFCP) and the Delinquent Filers Voluntary Program (DFVP). Both programs are described below.

- Voluntary Fiduciary Compliance Program (VFCP). This program only applies to fifteen specific breaches of fiduciary duty. The breaches that can be corrected under the program include:

  — failure to timely remit 401(k) contributions

  — failure to timely remit loan repayments

  — offering a loan to a party-in-interest

  — offering a loan at a below-market interest rate

  — sale of an asset to a party-in-interest

  If a plan fiduciary violates any of the above duties, and the fiduciary wishes to participate in the VFCP, the fiduciary must fully correct the error, as outlined in the program,

and explain the error and correction to the DOL. In addition, in the case of the failure to timely remit 401(k) contributions and loan repayments, the plan may avoid paying an excise tax if the error is corrected within 180 days of when the contributions were due and affected participants are properly notified of the error and the plan's participation in the program. If the DOL agrees with the proposed correction method, the DOL will issue a No Action letter, which means the DOL will not assess a penalty for such error.

- **Delinquent Filers Voluntary Program (DFVP).** This program only applies to plans that failed to file a Form 5500 in the time prescribed by law. If that happens, the plan sponsor may pay a fee and submit the late Form 5500 with a cover letter to the DOL.

TAX-EXEMPT EMPLOYERS

Qualified Plans

The use of qualified plans for tax-exempt employers is less restricted than in the past.

- Effective January 1, 1996, non-profit employers may sponsor 401(k) plans or any other type of pre-tax salary deferral arrangements under a qualified retirement plan. As noted below, certain non-profit employers may also utilize 403(b) annuities funded by employee salary deferral.

- Non-profits may not be willing to take on the liability for funding a defined benefit plan, given their sometimes weak financial support.

- Profit-sharing plans are a misnomer for organizations which do not have profit; they may, however, be a useful form of qualified plan.

- Money purchase pension plans have traditionally been commonly used by non-profits since they provide a predictable contribution for employees.

403(b) Annuities

For those tax-exempt employers which are charitable, religious or educational (Section 501(c)(3)) organizations, Section 403(b) tax-deferred annuities (known as TDAs or TSAs) are available to provide salary deferral opportunities for employees, with employers able to make matching contributions.

- TDAs must be invested in annuities or in regulated investment company stock. Strict disclosure rules (including the furnishing of prospectuses) apply to TDAs.

- TDAs are protected from current taxation under Section 403(b) of the Code which requires several things:

- The employee must own the 403(b) annuity or account. It cannot be owned by the employer or a separate trust.

- In addition, salary deferral contributions to TDAs are subject to an annual limit of $13,000[5], statutorily increasing to $15,000 by 2006 regardless of what percentage of compensation that is. This limit may be exceeded if an employee is eligible to make catch-up contributions. There are special additional catch-up contributions available to an employee who hasn't maximized contributions in prior years. Also, employees who will be at least age 50 by the end of a calendar year may make catch-up contributions for that calendar year. The maximum catch-up contribution for 2004 is $3,000, but that limit will increase in future calendar years.

[5] See Appendix A for prior years' limits.

- Finally, TDAs are also subject to annual limitations (in combination with all contributions by employer and employee on behalf of a particular individual) under Section 415 of the Code. That limit restricts total contributions to $40,000 or, if less, 100% of compensation.

- TDAs offered by employers are subject to discrimination rules which prohibit contributions which favor the highly compensated. Matching employer contributions must pass the actual contribution percentage test (the same test which applies to matching contributions in 401(k) plans).

- TDAs may be rolled over into other TDAs, IRAs, governmental 457(b) plans or into qualified retirement plans.

Section 457 Plans

Any other type of deferred compensation made available to employees of tax-exempt employers is subject to Section 457 of the Code. Section 457 of the Code sets forth certain requirements which apply to all non-qualified deferred compensation plans sponsored by tax exempt employers. If the requirements of Section 457 of the Code are not met, immediate taxability of deferred compensation results. The following requirements apply:

- The plan must be unfunded. That is, no annuities or accounts must be established in the name of particular employees (as would be the case with 403(b) annuities), but rather, any assets which the employer sets aside in order to pay deferred compensation when due must be held in the name of the employer.

- Deferral of compensation cannot exceed the lesser of $13,000, statutorily increased[6] or 33-1/3 percent of taxable compensation for a participant per year. In calculating the percentage, compensation is the "net" amount that remains after the deferral. So, for example, an employee earning $30,000 who defers $8,000 has deferred 33-1/3 percent of taxable compensation, calculated as $8,000

[6] See Appendix A for earlier limits.

divided by $22,500, the net after-deferral amount. Cafeteria plan contributions are also deducted to determine the "net" amount.

- Employees who will be at least age 50 by the end of a calendar year may make additional catch-up contributions. The limit on catch-up contributions is $3,000 for 2004, but that limit will increase in later calendar years.

- Deferral agreements must be entered into before the month in which the compensation is earned.

- The value of deferrals, including earnings, must not be available for distribution until termination of the employee's employment or an unforeseeable emergency is experienced by the employee. The standard for an unforeseeable emergency is stricter than that for a hardship withdrawal and would include:

    - a casualty loss which is extraordinary and unforeseeable and beyond the control of the participant, or

    - severe financial hardship resulting from a sudden and unexpected illness or accident;

    - to qualify for such a withdrawal, it must be shown that the hardship could not be relieved through insurance, liquidation of the participant's assets without causing even more severe financial hardship, or cessation of deferrals; and

    - the purchase of a home or the college education of a child are not unforeseeable emergencies which would justify a distribution.

- Plans that meet the requirements above are "eligible" Section 457(b) plans. It is possible to establish an "ineligible" Section 457(f) plan which permits deferrals in excess of $13,000. To do so, the plan must include a substantial risk of forfeiture if

the individual fails to perform substantial services for the employer in the future. The IRS (in Revenue Procedure 71-19) has provided additional guidance on this concept by saying that no substantial forfeiture provision will be recognized unless its conditions impose upon the employee a significant limitation or duty that will require a meaningful effort on the part of the employee to fulfill and there is a definite possibility that the event which could cause forfeiture will occur.

- Allocations to a Section 457 plan made though salary deferral or employer contributions are subject to withholding tax at the time they are paid.

- Payments made to, or on behalf of, an employee or an employee's beneficiary under a Section 457 plan, generally are not exempt from FICA taxes, unless the Section 457 plan is an exempt government deferred compensation plan or the benefits are exempted from wages because of another specific provision of the Internal Revenue Code. For eligible Section 457 plans, the only issue is when FICA tax is imposed. An amount deferred from income is not required to be taken into account for FICA purposes until the amount is reasonably ascertainable. For ineligible Section 457(f) plans, FICA applies when the amount is reasonably ascertainable and upon the later of when the employee has performed the services upon which the contribution is based and when the employee has a nonforfeitable right to benefits. Therefore, even though benefits under a Section 457 plan may be wages for income tax withholding purposes, the benefits will not be subject to FICA taxes until they are actually or constructively paid.

- It is also worth noting that:

  - Section 457 plan distributions are not eligible for IRA rollovers, unless the plan is an eligible 457(b) plan and is sponsored by a governmental employer.

- Distributions from Section 457 plans are not subject to the 10% penalty tax on premature distributions; and
- Deferrals may be transferred from one employer's Section 457 eligible plan to another, provided that each employer is a tax-exempt entity or governmental institution which can sponsor a Section 457 eligible plan.

ERISA Impact

Since ERISA applies to deferred compensation plans and would require them to cover 70% of the employer's non-highly compensated workforce, to be funded and to have limited vesting schedules, Section 457 plans can only work if they come within an ERISA exception to these pension plan requirements. Such an exception is available to "top hat plans."

A "top hat plan" must be unfunded and maintained by the employer primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees. There is inadequate guidance for determining who is in such a select group. ERISA Opinion 90-14A identifies the group as smaller than those who would be "highly compensated" under the Internal Revenue Code standard; rather, it includes only those individuals who because of their position or compensation "have the ability to affect or substantially influence, through negotiation or otherwise, the design and operation of their deferred compensation plan."

It should be noted that governmental and church plans are exempt from ERISA, so need not be limited in coverage to a "top hat" group.

SECTION TWO: HEALTH AND WELFARE BENEFIT PLANS

INTRODUCTION

While retirement plans are an important part of an employer's benefit package, the benefits employees most frequently ask about when beginning employment are in the health and welfare area. Given the ever increasing health care costs and the risks that an individual without medical coverage can face, both as to health and financial stability, medical benefits become an immediate concern. Therefore, one of the first issues a start-up employer faces is what kind of health coverage to provide to employees. As this guide will show there are numerous possibilities, particularly in the State of Minnesota, whether they relate to insured or self-funded plans, pooled funds, plans available through the State, particular plans for small employers, union plans and plans sponsored by a coordinated group of employers. State regulation in the area of health coverage is very strict. Health plans can also include other types of medical benefits, such as dental and vision benefits, medical reimbursement arrangements, health maintenance organizations and the like.

Of equal importance to a beginning employee are other current benefits. These might include life insurance, accidental death and dismemberment coverage, short and long term disability plans, severance benefits, business accident coverage, employee assistance programs, cafeteria plans or flexible spending arrangements. In sum, any of the benefits which can be provided to employees on a pooled basis are addressed in this section on health and welfare benefit plans.

This chapter will discuss federal law requirements for such benefits. The following chapter will discuss the unique aspects of Minnesota law which apply to health and welfare plans.

Such plans may be subject to Title I of ERISA which imposes fiduciary duties on the plan administrator, the claims administrator in some cases, and requires certain reporting and disclosure. In other instances, plans may not be subject to ERISA. It is important to make this determination since it affects the manner in which the plan is designed and administered. Further, it is important for employers to know whether or not its funding of a plan is eligible for a deduction and whether there are limits on that employer deduction. It is also of importance for withholding tax purposes to know whether or not benefits under the plan are taxable to the employee or are subject to an exclusion from income.

ERISA AND CODE CONSIDERATIONS

ERISA contains a rather extensive list of what constitutes a welfare benefit plan, including:

- Health coverage;
- Reimbursement of medical costs;
- Life insurance;
- Disability benefits;
- Accidental death and dismemberment coverage;
- Dental and vision benefits;
- Day care centers;
- Prepaid legal services;
- Employee assistance programs ("EAPs");
- Vacation benefits; and
- Severance benefits.

The foregoing list excludes retirement plans and, through regulations issued by the Department of Labor, certain "payroll practices." Despite some uncertainties, most administrators are able to determine whether or not a program is a welfare plan covered by ERISA.

ERISA imposes a number of obligations on administrators of covered welfare benefit plans. These include:

- Reporting and disclosure obligations;
- Rules covering the conduct of plan fiduciaries;
- Implementation of a claims procedures; and
- Compliance with certain administrative rules.

Also, a plan's status as a welfare benefit plan will often determine the laws that are applicable to the enforcement of benefits under the plan. Subject to some exceptions allowing states to regulate insurance, welfare benefit plans subject to ERISA are governed by federal laws. State laws regulating benefits of ERISA covered plans are preempted by federal law.

The taxation of benefits provided by welfare benefit plans are generally subject to very specific rules under the Internal Revenue Code. Most welfare benefit plans can provide tax-free benefits to employees while still providing a tax deduction to the employer, however, each type of plan must be reviewed to determine whether income exclusion is available and whether the plan satisfies the applicable tax law requirements.

TYPES OF PLANS

Health Plans

- **Definition.** Health plans provide a variety of medical benefits, ranging from basic coverage for routine items such as wellness programs and health screening prescription drugs, and vision and dental care, to hospital and surgical benefits. The provision of medical benefits is the most prevalent type of welfare benefits provided by employers, with up to 98% of employers providing some form of medical benefits to employers. Health plans serve a number of purposes, including (1) ensuring employees have access to medical care at reasonable costs; (2) improving efficiency through a healthier work force; (3) attracting and retaining qualified employees; and (4) responding to union or employee demands.

- **How it Works.** A health plan may provide benefits through an insurance company, through a community service organization such as Blue Cross-Blue Shield, through a Health Maintenance Organization ("HMO"), or on a self-funded basis (often out of the employer's general assets). Blue Cross-Blue Shield is an association of independent organizations that provide medical services; member hospitals and participating physicians are paid by Blue Cross-Blue Shield. A Health Maintenance Organization is an arrangement through which participants receive a full range of medical services for a predetermined fee, and the organization itself is the medical provider. In a self-funded plan, there is no outsider insurer of benefits, rather the employer is the insurer and is liable for the expenses incurred by the participants for medical care, up to the limits stated in the plan.

  The gross income of an employee does not include contributions made by the employer to an accident or health plan for health coverage provided to the employee, a spouse or dependents. Nor does gross income include amounts received

through accident or health coverage if such amounts are paid for the medical care expenses. Likewise, benefits paid by the employer under a self-funded plan are generally excluded from income if they are medical expenses under the definition of the Code.

- **Plan Design.** The means through which benefits under a health plan are provided impacts the terms and conditions of the health plan. Insurance companies, Blue Cross and Blue Shield and HMOs are regulated by the State of Minnesota. The laws affecting these benefit providers are discussed in the next chapter. Self-funded health plans are not generally regulated by the State of Minnesota. However, self-funded health plans are subject to non-discrimination requirements regarding eligibility for coverage and benefits. Things to consider when designing a health plan include:

  - **Who will pay the claim?** The employer may pay all the claims directly, through a self-funded program, or may shift the liability to an insurance company.

  - **Will the plan's coverage be broad or narrow?** Cost, nature of the work involved and employee demands will influence this decision.

  - **Who will pay for the program?** The employer may fund all or part of the plan, after sharing with employees the cost of dependent coverage, a higher level of coverage or even single coverage.

- **Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).** The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) was signed into law in 1986. The purpose of COBRA is to provide certain employees, former employees, spouses and dependent children with the right to temporarily continue coverage under a group health plan at group rates. "Group health plans" include fully insured health plans, self-insured health plans, HMOs, medical

reimbursement features of cafeteria plans, dental plans, vision plans and many employee assistance programs ("EAPs"). The provisions of COBRA apply when specific criteria are met.

Medical Savings Accounts

The Code was amended in 1996 to allow individuals to establish Medical Savings Accounts (MSAs). Recent legislation renamed these as "Archer MSAs." An Archer MSA (hereinafter "MSA") is a tax-exempt trust or custodial account established to pay medical expenses in conjunction with a high-deductible health plan. The MSA is meant for the benefit of the individual and therefore is "portable". As a result, if an individual with an MSA changes employers, the MSA stays with the individual instead of the employer.

- **Eligibility.** Two types of individuals are eligible for the MSA. The first type is employees or spouses of employees who work for "small employers" that maintain high deductible health plans. The second type is self-employed people or their spouses who are covered under a high-deductible health plan. An individual may become ineligible for an MSA if such individual is covered under another plan that is not a high-deductible health plan, including Medicare coverage. However, an individual remains eligible for an MSA if in addition to an MSA, such individual's other coverage is not for medical expenses in general, but rather for accidents, disability, dental care, vision care, disease-specific insurance, insurance paying a fixed amount per day for hospitalization, or liability insurance.

  For purposes of MSA eligibility, the IRS defines a "small employer" as an employer who for a calendar year employed an average of 50 or fewer employees on either of the two preceding calendar years. The IRS defines "high-deductible health plan" as a health plan that either has an annual deductible of at least $1,500 but not more than $2,250 for individual coverage or has an annual deductible of $3,000 but

not more than $4,500 for family coverage. High-deductible health plans may be offered through any entity including insurance companies and Health Maintenance Organizations.

- **Contributions.** Contributions to the MSA may be made in one of two ways. Contributions may be made to the MSA by the eligible employee or the employee's spouse, whichever person is the account holder. In the alternative, the employer of the eligible employee may contribute to the MSA. However, if a contribution is made by the employer for a given year, the account holder is prohibited from contributing to any MSA account for that year.

  The maximum amount a person who has an individual high-deductible coverage health plan may contribute to the MSA is 65% of the deductible. For high-deductible family coverage, the annual contribution limit is 75% of the deductible.

  Contributions to an MSA made by an eligible person are tax-deductible without regard to whether the eligible person itemizes his or her deductions, up to the person's compensation attributable to the employer sponsoring the high-deductible plan. For self-employed persons, the contribution may not exceed the person's earned income from the business from which the high-deductible plan established. Contributions made on behalf of an employee by an employer are excluded from gross income and are not subject to income tax withholding or subject to employment taxes. Contributions made to an MSA that exceed the limitations or that are made by ineligible individuals are not tax deductible.

- **Distributions.** Distributions can be made from an MSA at anytime. MSA distributions are not included as gross income if used to pay for medical expenses provided the individual incurring the expense was covered by a high-deductible plan and did not have other medical coverage. If the distribution is used for non-medical expenses then such distribution will be includible in gross income and generally subject to an

additional 15% excise tax. However, this tax will not apply to distributions made after the account holder turns 65, becomes disabled, or dies. MSA distributions cannot be used to pay premiums for COBRA-type health care continuation coverage, premiums for health care coverage while an individual receives unemployment compensation or other medical premiums.

- **Establishing an MSA.** Eligible individuals may establish an MSA with a qualified MSA trustee or custodian such as a bank or insurance company. There is no requirement of authorization or permission from the IRS to establish an MSA. Furthermore, an eligible individual may establish an MSA without any employer involvement.

Health Reimbursement Arrangements (HRAs)

- **Definition.** An HRA is an arrangement that: (1) is paid for solely by the employer and not provided pursuant to salary reduction election or otherwise under a cafeteria plan; (2) reimburses the employee for medical care expenses incurred by the employee and the employee's spouse and dependents; and (3) provides reimbursements up to a maximum dollar amount for a coverage period and any unused portion of the maximum dollar amount at the end of a coverage period may be carried forward to a future year to increase the maximum reimbursement amount in subsequent coverage periods.

- **How it Works.** To the extent that an HRA is an employer-provided accident or health plan, coverage and reimbursements of medical care expenses of an employee and the employee's spouse and dependents are generally excludable from the employee's gross income.

- **Plan Design.** To qualify for the exclusion from income, an HRA may only provide benefits that reimburse expenses for medical care incurred during the current taxable year and each expense must be substantiated. An employee cannot have the

right to receive cash or any other taxable or non-taxable benefit under the arrangement, and contributions to the HRA cannot consist of salary deferrals.

Disability Plans

- **Definition.** Disability plans protect employees against the risk that illness or injury will interrupt or terminate their ability to work or earn a living. The term "disability" may include the inability to perform any work at all, or the inability to engage in the employee's usual occupation.

- **How it Works.** Typically, the employer provides coverage for disability under an accident or health plan. The employer's contribution to the plan is excludable from the employee's gross income, and is deductible as an ordinary and necessary business expense to the employer. In the event of disability, amounts received by the employee are then included in income to the extent the amounts are attributable to the employer's contribution. To the extent any portion of the cost of the coverage was paid by the employee out of after-tax dollars, benefits received are not included in the employee's income. For purposes of these rules, amounts paid by an employee on a pre-tax basis through a cafeteria plan are considered "employer" contributions. However, payments received for permanent loss or loss of use of a body part or function, or for disfigurement, are not includible in income if such payments are computed without regard to absence from work.

- **Plan Design.** A disability plan should take into account short term benefits, which, for example, run a maximum of six months to a year, and long term benefits. Short term disability plans are often funded out of an employer's assets and may have a more inclusive definition of disability. Because of the significant cost potential involved, long term disability plans are often funded through insurance and may have a more restrictive definition of disability. For example, disability may

be the inability to work at the employee's normal occupation for the first two years after onset, and be limited to the inability to work at any occupation after the first two years. Consideration must also be given to the levels of benefits. If too generous, individuals who could be working may attempt to claim benefits. For this reason most insurance companies limit benefits to 70% of pre-tax earnings from all available sources.

Group Term Life Insurance

- **Definition.** Group term life insurance is an insurance policy carried directly or indirectly by an employer to provide death benefits to employees and retirees. The coverage is available only for a specified period (the term), with no cash value, loan value, or other permanent benefit under the policy.

- **How it Works.** Insurance companies underwrite group term life insurance with coverage based on the mortality experience of the group. (Alternatively, the employer can self fund benefits out of its own assets but with different tax consequences.) If a group term life insurance plan meets the requirements under Section 79 of the Code, the covered employee generally has excluded from taxable income the cost of up to $50,000 of employer-provided coverage, and in the event of death the beneficiary is not taxed on the death benefits received. The employer may deduct the premiums paid to purchase the coverage.

- **Plan Design**. A group life insurance policy is an agreement between an insurance company and an employer to pay benefits upon the death of a covered employee. The premium is based on the insurer's actuarial assumptions of the group of covered persons. The provisions of each plan vary, and the employee may be allowed to independently purchase additional coverage.

Accidental Death and Dismemberment

- **Definition.** Accidental death and dismemberment insurance provides death benefits only if the employee dies or is dismembered as a result of accidental bodily injury incurred while covered under the policy.

- **How it Works.** Insurance proceeds are excludable from the employee's income.

- **Plan Design.** The insurance is provided by a policy or rider issued by an insurance company to pay certain benefits in the event of accidental death and dismemberment. The provisions of each plan vary. The plan is generally designed as an additional benefit under a group term life plan.

Dependent Care Assistance Program

- **Definition.** Dependent care assistance programs ("DCAP") provide benefits to employees who require child care or related services for the care of qualifying dependents in order to work. Most frequently offered as a Cafeteria Plan component, a DCAP may offer direct payments or reimbursements in the form of flexible spending accounts or vouchers for the cost of caring for dependents, or may be in the form of an employer-sponsored dependent care center. Qualifying dependents are children under 13 and spouses or other dependents who are incapable of taking care of themselves.

- **How it Works.** The employee's gross income does not include amounts paid or incurred by the employer for dependent care assistance furnished pursuant to a DCAP which qualifies under the Code. Dependent care assistance is the payment for or provision of services that are employment related. The amount excludable is limited to $5,000 per tax year. This amount may not exceed the employee's earned income for the taxable year or, if the employee is married, the lesser of the employee's or the employee's spouse's earned income. In

order to qualify for the exclusion, the employee must report the provider's name, address and taxpayer identification number on their federal income tax returns.

- **Plan Design.** A DCAP must be a separate written plan for the exclusive benefit of employees, but need not be funded. A DCAP may not discriminate in favor of highly compensated employees in regard to contributions, benefits or eligibility, not more than 25% of benefits paid may go to shareholders or owners of more than 5% of the company, and the average benefits paid to non-highly compensated employees must be at least 55% of the average benefits paid to highly compensated employees. In addition, there are various notification and reporting requirements.

Cafeteria Plans

- **Definition.** A cafeteria plan offers participants a choice between one or more qualified benefits and cash. Participants can tailor certain benefits such as medical, group term life, disability and child care on a pre-tax basis or take cash instead (and be taxed currently).

- **How it Works.** A cafeteria plan is a plan under which (i) all participants are employees, and (ii) the participants may choose among two or more benefits consisting of cash and qualified benefits. Qualified benefits are certain benefits which are expressly excludable from gross income, including group term life insurance up to $50,000, accident or health plans, dependent care assistance, and group legal programs. Participants may also be given the choice under a cafeteria plan to use, sell, or buy additional vacation days. Generally, a cafeteria plan may not provide for deferred compensation, except through salary deferral contributions to a 401(k) plan.

  The typical cafeteria plan is a pre-tax premium plan where the amount of premium or other expenses paid in after-tax dollars by the participant is instead paid through a salary reduction.

The employer adopts a plan under which the employee elects prior to the beginning of the year to have his or her compensation reduced; the amount of the reduction is then applied to the employee's share of the insurance premium or to cover other expenses such as child care. A cafeteria plan could also provide for a flexible or reimbursable spending account for the deduction and payment of other expenses.

- **Plan Design.** The formal requirements of a cafeteria plan are:
  - It must offer the participants a choice between cash and one or more qualified benefits.
  - All participants must be employees.
  - The availability of benefits may not discriminate in favor of highly compensated employees, and actual benefits paid to key employees may not exceed 25% of the aggregate of such benefits provided to all employees for the year.
  - An election to take a qualified benefit in lieu of cash must be made prior to the beginning of the year and not changed during the year except for certain changes in status. The changes in status which the IRS has approved are listed in Appendix C.
  - It must contain certain restrictions with respect to health benefit flexible spending accounts.
  - The plan must also be written and must not discriminate in favor of highly compensated individuals as to participation or highly compensated participants as to benefits.

Severance Plans

- **Definition.** Severance compensation refers to payments made by an employer to an employee of a specified amount upon termination of that employee's employment. Benefits provided under severance plans serve two purposes. First,

they can reward an employee's past service to the company, which in turn can act as a recruiting tool. Second, they provide the employee with economic protection by helping to make ends meet while retraining or looking for another position. Severance plans may be written or informal, but may in either event constitute a plan under ERISA.

- **How it Works.** Severance plans vary from employer to employer, with some adopting a "one week's pay for each year of service" policy, to others adopting a "golden parachute" policy, which is typically reserved for executives and triggered by a change in control of the company. Eligibility for severance pay and the amount of benefits received often depend on the position of the employee and the employee's length of service.

  With certain limitations, severance benefits may be paid in a lump sum, in periodic payments or a combination of the two. Periodic payments may be tied to the employee's active search for replacement employment. Severance benefits are generally included in an employee's gross income, although a small payment in recognition for years of service may qualify as a gift or a *de minimis* fringe benefit. Severance plans may be funded, but benefits are generally paid out of the employer's general assets. Severance pay is deductible by the employer if it is an ordinary and necessary business expense.

- **Plan Design.** The design of a severance plan depends on the employers objective. Some employers wish to formalize their severance plans in a formal, written document and may include in an employee handbook. Others only verbalize their severance plan, sometimes only to key employees and sometimes on a case-by-case basis. However, if ERISA applies, a severance plan must be written and communicated to employees.

  Generally, the provision of severance benefits is accomplished through a welfare plan. However, if an employer provides severance pay which too closely resembles retirement benefits,

such severance may be treated as having been provided through a pension plan. If provided through a pension plan, the employer would be subject to the more burdensome participation, vesting and funding requirements under ERISA. Among other things, being subject to the funding requirements would prohibit an employer providing benefits out of its general assets. The plan would have to be funded and the assets held in trust.

To avoid being characterized as a pension plan, (1) payments must not be contingent, directly or indirectly (*e.g.*, eligibility limited to persons attaining a certain age or having completed a certain number of years of service) upon an employee's retiring; (2) the total amount of the payments must not exceed twice the employee's annual compensation during the year immediately preceding termination; and (3) payments must be completed (a) in the case of a window plan, within 24 months after the later of termination or normal retirement age; or (b) in all other cases, within 24 months after termination.

Courts have not always found severance arrangements to be subject to ERISA. They look to the complexity of an on-going administrative scheme in determining whether the arrangement rises to the level of a plan under ERISA.

Educational Assistance Programs

- **Definition.** Educational assistance programs arise when employers provide educational assistance to employees through in-house seminars or by reimbursements for attending outside educational programs.

- **How it Works.** Educational expenses paid for by an employer can be excluded from an employee's gross income under a written educational assistance program under Section 127 of the Code.

- **Plan Design.** An educational assistance plan must be nondiscriminatory in coverage, it must be limited to

reimbursement of tuition and fees, it must cover only employees, and benefits to participants must not exceed $5,250 per year. Courses taken need not be related to a person's work and a graduate course of study can be covered.

Group Legal Services Plan

- **Definition.** Group legal services plans offer employees low-cost legal services such as referrals, advice, and representation. These plans allow a group to use its collective purchasing power to negotiate lower rates from legal providers. They also may reduce the anxiety and stress often associated with contacting an attorney.

- **How it Works.** The employer and/or employee pays for the cost of the plan through union dues or payroll deductions. Group legal benefits are no longer excludable from the employees' income. Participation may be automatic or voluntary, and a plan may be offered on a stand-alone basis, or in a cafeteria plan. Employers may deduct contributions to a legal services plan.

- **Plan Design.** The simplest type of legal services plan is one which provides referrals and discounts to the group members. Plan members are referred to an attorney who provides certain services and advice free or at a low cost, and may offer additional services on a fee structure negotiated between the attorney and employee. Another type of plan provides prepaid, unlimited legal advice by telephone and mail, with limited other services. Once the prepayment fee or premium is paid, services are available at no additional cost to the employee.

Employee Assistance Programs

- **Definition.** Employee Assistance Program ("EAP") is a generic phrase which covers an employer's provision of a variety of services in a variety of ways to its employees and their

families. Typical problems addressed by an EAP includes drug and alcohol abuse, stress, anxiety, depression, family problems, money and credit problems, and legal problems.

- **How it Works.** Under a typical EAP, the employer contracts with a third party to provide counseling and referral services. The services are generally provided by a person with professional training (*e.g.*, social worker, family counselor, doctor or nurse, financial planner, attorney). They may be provided over the phone or in person. Additional services may include an emergency hotline.

- **Plan Design.** Whether an EAP is subject to the requirements of the Employee Retirement Income Security Act of 1974 ("ERISA") depends upon what benefits the EAP offers and the way in which the program provides benefits. An EAP is subject to ERISA if it provides a benefit within the meaning of ERISA. Benefits for the treatment of drug and alcohol abuse, stress, anxiety, depression and similar health and medical problems are "medical" benefits or "benefits in the event of sickness" and, therefore, are benefits within the meaning of ERISA. In general, EAP referral services are not subject to ERISA, but an EAP which offers counseling for mental, emotional or physical problems is.

Leave Sharing Programs

- **Definition.** A leave sharing program permits an employee with accrued but unused paid leave to donate all or part of that leave for use by another employee. Typically, the recipient employee must have a particular type or degree of need (*e.g.*, family emergency, seriously ill child or spouse) and have exhausted his or her own paid leave.

- **How it Works.** There is no special Code section that permits this type of benefit to be received by the employee on a tax favored basis. Absent such a special provision, the amount received by the recipient employee is included in that

employee's gross income under Section 61 of the Code as compensation. The employee donating the paid leave does not experience a taxable event with respect to that paid leave. In short, the employee who actually uses the paid leave is the employee who experiences a taxable event, and that taxable event is the inclusion in the recipient's taxable income of the amount actually received.

Regardless of which employee "receives" the benefit of the paid leave (the donor or the recipient), the tax consequences to the employer are the same. The leave payment is compensation and is deductible by the employer in the same way other compensation provided to employees is deductible. The amount of the deductible expense must match the amount that is received by the recipient under the leave sharing plan.

- **Plan Design.** An employer has a wide degree of flexibility regarding the terms and conditions of such a plan. Depending upon the way in which the leave sharing arrangement is operated, it may or may not be a welfare benefit plan within the meaning of ERISA. A leave sharing plan may be a payroll practice and, therefore, exempt from ERISA. However, there may be reasons an employer wants to be covered under ERISA. By providing certain benefits in certain ways, it is possible to create a leave sharing plan that does not fall within the payroll practice exemption (*e.g.*, create a trust to fund the program).

Split Dollar Life Insurance

- **Definition.** Split dollar life insurance is not a type of insurance but rather it is a method by which an employer and employee can split the premium payments and benefits of a life insurance policy on the life of the employee.

- **How it Works.** Generally, the employer pays a substantial portion of the premium and acquires an interest in the policy equal to the premiums it has paid, while the employee contributes an amount equal to the value of the economic

benefit as measured by the "P.S. 58 rates" or, the insurance company's term rates. Because the employer is a beneficiary of the policy and is reimbursed for premiums advanced, the employer is not entitled to an income tax deduction for premiums paid (for tax-exempt employers the lack of a deduction is inconsequential).

- **Plan Design.** The employer can choose from a wide range of economic splits on the payment of premiums. The typical arrangement involves the employee as owner of the policy with a collateral assignment of the policy's cash value, including death proceeds, to the employer to secure the employee's obligation to repay the employer for the premiums it has advanced.

FUNDING OF BENEFIT PLANS

"Funding" refers to the source or sources from which benefits under a plan are paid. Plans may be fully insured, partially insured, or not insured. To the extent a plan is not insured, the plan may be funded or unfunded. If funded, a plan may use a tax exempt trust or a taxable trust to hold plan assets. Contributions from which benefits are provided may come from the employer, the employee, other sources, or a combination of the above. The Code determines whether and to what extent an employer may take a deduction for its contributions. Nothing under ERISA requires welfare benefit plans to be funded. However, if an ERISA plan is funded, there are additional requirements to meet.

- **Insurance.** An employer may choose to fully insure a plan by purchasing one or more insurance contracts (including HMO contracts) to provide plan benefits. One advantage of providing benefits through insurance is the predictability of cost. The employer's cost for providing benefits under the plan is the insurance premiums. The independent third party (*e.g.*, insurance carrier, HMO) receives premiums. In return, the provider pays the benefits and accepts the risk that the benefits paid will exceed the premiums collected.

A plan may be fully insured, in which case all benefits are provided through the third party in return for the payment of premiums. Alternatively, a plan may be partially insured, in which case only part of the benefits provided under the plan are provided through the third party. To the extent benefits are not insured, an employer may provide the other benefits out of its general assets. Alternatively, the employer may provide the other benefits by establishing a trust and setting aside funds to provide such benefits.

- **Unfunded.** If a plan is not insured, or is only partially insured, the non-insured benefits may be paid from the employer's general assets. When benefits are paid from the employer's general assets, the plan, or that portion of the plan, is considered unfunded. Benefits are paid out of the employer's general assets on a pay as you go basis. No monies are set aside for the payment of claims. There is no shifting of risk to a third party insurance carrier. The employer bears the risk that actual claims will exceed anticipated claims.

- **Plan Assets and Employee Contributions.** ERISA requires that plan assets be held in trust. For purposes of ERISA, "plan assets" generally include participant contributions plus tangible and intangible property in which the plan has a beneficial ownership interest. With respect to amounts an employee pays to the employer or has withheld from pay for purposes of contribution to a plan, such amounts become plan assets upon the earliest date the amounts can reasonably be segregated from the employer's general assets. In no event may this period of time exceed 15 business days following the end of the month in which such amounts are received by the employer (when the employee pays the employer), or would have been payable to the employee in cash (when such amounts are withheld from the employee's compensation). It is important to recognize that this 15 day period is not a safe harbor. Rather, it is an outside limit upon what is considered reasonable.

This rule applies regardless of whether the withholding from an employee's pay is done on an after-tax basis or on a pre-tax basis through a cafeteria plan (under Section 125 of the Code). The Department of Labor issued a Technical Release clarifying that amounts withheld from an employee's pay on a pre-tax basis through a cafeteria plan are plan assets for purposes of ERISA and would normally be required to be held in trust. However, until further notice, the Department of Labor also indicated it would not enforce the trust requirement with respect to amounts withheld from an employee's compensation pursuant to a cafeteria plan.

- **Funded.** Rather than pay non-insured benefits out of general assets, the employer may fund all or a portion of the plan by segregating monies from its general assets to pay benefits. Segregated amounts, which may or may not include employee contributions, are plan assets for purposes of ERISA. As described above, plan assets must be held in trust. Any earnings on the assets must also be held in trust. plan assets held in trust are not subject to claims by the employer's creditors. They must be used exclusively for the purpose of providing benefits and may not inure to the benefit of the employer. The employer is generally entitled to a tax deduction for contributions made to a trust, subject to the maximums permitted under Sections 419 and 419A of the Code described below. To the extent a plan has assets that must be held in trust, an employer may hold such assets in a tax exempt trust or a taxable trust.

- **Tax Exempt Trust.** A tax exempt trust, such as a Voluntary Employee Benefit Association ("VEBA") under Section 501(c)(9) of the Code, is a separate legal entity that holds and accumulates assets on a tax free basis. The employer receives a tax deduction for contributions made to the trust subject to the maximums permitted under Sections 419 and 419A of the Code described below. The trust holds those contributions. Any earnings on the contributions are also plan assets and accumulate in the trust on a tax free basis.

In order to be a tax exempt trust, certain requirements must be met. Among other things, assets (contributions and earnings) may only be used to provide certain types of benefits. A VEBA may provide death benefits, sickness and accident benefits (*e.g.*, disability, medical, hospital), and other benefits intended to enhance or protect health and well-being (*e.g.*, vacation, supplemental unemployment, severance, legal services, child care). Within 15 months of the establishment of a VEBA, an application for a determination letter must be filed with the IRS. In addition, the VEBA may not discriminate with respect to eligibility to participate or benefits.

- **Taxable Trust.** As described above, if there are plan assets, they must be held in trust. However, nothing requires an employer to establish a tax exempt trust (*i.e.*, a VEBA). The employer may establish a taxable trust. Monies are still segregated from the employer's general assets, may only be used to provide benefits under the plan, and may not inure to the benefit of the employer. The employer is still entitled to a deduction for contributions up to the maximums permitted under Sections 419 and 419A of the Code described below. The primary difference is that a taxable trust must pay taxes on the amounts remaining in the trust at the tax year end. Contributions and earnings thereon do not accumulate on a tax free basis. In addition, a taxable trust does not require an IRS determination letter.

- **Welfare Benefit Fund.** In addition to the ERISA requirements described above, the Code also may impact plan funding. Sections 419 and 419A of the Code limit the deduction available to employers who contribute to a welfare benefit fund. A welfare benefit fund includes any trust that is part of a plan (whether taxable or tax exempt) that provides benefits to employees and their beneficiaries. A welfare benefit fund also exists when an account is held for an employer by another person. Examples of this type of welfare benefit fund include, administrative services arrangements where the administrator

holds funds and certain insurance arrangements under which the employer makes contributions and has a contractual right to a dividend or refund based upon the contract year's claims experience of just that employer. Typical group insurance arrangements reflect the risk of more than just a particular employer and therefore are not considered welfare benefit funds.

For fully insured plans where the contributions are paid by the employer directly to the carrier, the limitations under Sections 419 and 419A of the Code generally do not have an impact. The employer can deduct the cost of premiums charged by the third party insurer in the tax year in which the premiums are paid. For plans that are not fully insured, the impact of Sections 419 and 419A of the Code depends upon whether the portion of the plan which is not insured is funded (*i.e.*, has a trust) or unfunded (*i.e.*, paid out of employer's general assets). If the plan, or the non-insured portion of the plan, is unfunded, Sections 419 and 419A do not impact the deduction available to the employer. When the benefits are paid out of the general assets of the employer, the employer may take the deduction at the time of payment.

When the non-insured benefits are funded, Sections 419 and 419A of the Code do apply. In general, contributions to a trust are deductible by an employer only to the extent they do not exceed the maximums under Sections 419 and 419A of the Code.

Sections 419 and 419A of the Code limit the deduction available to the contributing employer thereby limiting the extent to which advanced funding for the future can be accomplished. In general, an employer's deduction is limited to the deduction to which it would have been entitled had the benefits been provided directly by the employer plus a limited reserve.

ADMINISTRATION

The administration of an employee health or welfare benefit plan is the responsibility of the plan's sponsor, the employer or employee organization establishing the plan. The plan administrator's duties include: enrolling new participants, handling employee claims, maintaining plan records, and operating the plan in compliance with the governing plan documents and regulations. These responsibilities require that the plan administrator has a working knowledge of applicable tax laws, the fiduciary standards, and the reporting and disclosure requirements of ERISA.

A small employer may wish to delegate some of the administrative responsibilities to a benefit consultant (*i.e.*, attorney, accountant, or third-party administrator). An employer's decision to delegate specific duties may be based on cost efficiency and its ability to perform the required administrative functions of the plan. It is important to remember that for many purposes under ERISA, ultimate responsibility remains with the plan administrator.

Annual Reporting and Disclosure Requirements

ERISA was enacted by Congress to protect the rights and interests of employees and their beneficiaries with respect to employee benefits. Title I of ERISA provides safeguards and standards for the establishment, operation, and administration of such employee benefit plans. In addition, Title I of ERISA sets out the standards by which plan fiduciaries are to operate.

- **Covered Employers.** All employers including corporations, partnerships, sole proprietorships, and certain tax-exempt organizations are subject to Title I of ERISA. In addition, employee organizations which establish and maintain welfare benefit plans for a group of employees are also subject to Title I of ERISA. An exemption is provided under ERISA for government organizations and churches.

- **Covered Plans.** The requirements and standards of ERISA apply to all "employee welfare benefit plans". Section 3(1) of ERISA defines "employee welfare benefit plan" as:

> "any plan, fund, or program which was heretofore or hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care center, scholarship funds, or prepaid legal services, or (B) any benefit described in Section 302(c) of the Labor Management Relations Act, 1947 (other than pensions on retirement or death, and insurance to provide such pensions)."

An employer may find that in addition to its so called "plans", certain programs, policies and practices, whether formal or informal (written or verbal), may also fall into the definition of an employee benefit plan. If there is any uncertainty as to which plans, programs, policies or practices are subject to ERISA, the employer should consult with an attorney familiar with employee benefit matters. The term "employee welfare benefit plan" does not include general payroll practices.

Although a plan may be subject to ERISA, there are certain employee welfare benefit plans which are exempt from the ERISA reporting and disclosure requirements. Exemptions are provided for the following types of plans:

- "unfunded" plans with fewer than 100 participants;
- fully insured plans with fewer than 100 participants;

- combination of "unfunded" and insured with fewer than 100 participants;
- plans for a select group of management or highly-compensated employees (known as "top-hat" plans); and
- plans established to solely comply with workers' compensation, unemployment, or disability insurance laws.

An "unfunded" plan is a plan which has no plan assets. Benefits are paid as needed solely from the general assets of the employer. An employer whose intent is to establish an "unfunded" plan, in order to take advantage of this exemption, should be careful that benefits are truly paid from the general assets of the employer. The DOL has determined that a separate account with the name of the plan would be considered a "funded" plan. However, the DOL has also determined that a separate account in the name of the employer would be considered an "unfunded" plan.

- **Annual Reporting Requirements.** Both the DOL and the IRS require that certain plans file annual reports. This requirement is a coordinated effort on the part of the two government agencies. Therefore, if applicable, a plan that files the appropriate forms (Form 5500 Series) will satisfy the filing requirement for the DOL and IRS since the report is transmitted to both agencies. Filings are due by the last day of the seventh month following the end of the plan year. An extension of this filing deadline may be granted under certain situations as described in the Form 5500 Series. Below are the reporting requirements for the DOL and the IRS.
- **DOL Requirements.** ERISA requires that the plan administrator of an employee welfare benefit plan which is subject to ERISA, report certain information to the DOL on an annual basis. Certain plans are exempt from this annual filing requirement. Plans which are exempt for the DOL's requirements include (i) unfunded or fully insured welfare

benefit plans with less than 100 participants at the beginning of the reporting period, and (ii) apprenticeship and training plans. Other plans have special filing requirements which are much easier to meet. For example, pension plans for a select group of management or highly compensated employees ("top-hat plans") need only file a one-time statement within 120 days of the date the plan is established. If the statement is timely filed, no annual 5500 forms need be filed.

- **Penalties.** Both the IRS and the DOL are authorized to assess penalties for the failure to satisfy the annual reporting requirements described above. Both civil and criminal penalties may be assessed against the plan administrator for neglecting to file annual report, filing reports on a timely basis, or failure to provide critical information. Such penalties are described below, in greater detail:

    - The IRS is authorized to assess a civil penalty up to $25 per day for any late filing (not to exceed $15,000). Criminal penalties may also be brought against the plan administrator or employer for failure to file annual reports. Under the Internal Revenue Code criminal penalties may be assessed against an individual (up to $25,000) or against a corporation (up to $100,000), along with a potential 3 year imprisonment.

    - The DOL is authorized to assess a civil penalty up to $1000 per day beginning on the date of the plan administrator's failure to file the required annual report. Currently, the DOL assesses penalties under its enforcement program. Penalties are being assessed at $50 per day for failure to file an annual return on a timely basis. After the DOL has taken some enforcement action, the penalty is increased to $300 per day, up to $30,000 per plan year until the filing is submitted. Criminal penalties may also be assessed by the DOL. The plan administrator or the employer may be fined up to $5,000 and be sentenced to a maximum of 1 year of imprisonment.

- If a Form 5500 is not filed on time, the DOL has established a Voluntary Delinquent Filer Program, which allows a plan to fix this error. A nominal fee is charged to participate in the Program.

- **Summary Annual Report (SAR).** A plan administrator must provide each participant and beneficiary under a welfare benefit plan covered by Title I of ERISA with a summary annual report (SAR). An alternate recipient pursuant to a qualified medical child support order is also treated as a participant for this reporting requirement. Alternate recipients are discussed in greater detail below under **QUALIFIED MEDICAL CHILD SUPPORT ORDER.**

  This SAR must be provided within nine months following the close of the employer's fiscal year. If an extension was granted by the IRS for the annual report, the SAR must be provided within two months of the deadline granted under the extension.

  No specific form or style is required by the DOL in furnishing SARs to participants. However, guidelines have been issued as to the information which employers must include in a SAR and a sample SAR for pension and welfare plans is provided in the regulations.

  SARs must be delivered to participants and beneficiaries either by hand, by mail, by inserting in employee periodicals, or by electronic means. The method used must be likely to result in full distribution of such materials. If sent by mail, forwarding postage and address corrections must be guaranteed. Any materials returned must be sent again by first class mail or delivered in person. If distribution is by electronic means (*e.g.* e-mail), certain requirements must be met to ensure that all participants actually receive the SAR.

  If the employer is exempt under the small plan exemption from the ERISA reporting requirements, the employer has no Annual Report to summarize.

- **Summary Plan Description (SPD).** The plan administrator is also responsible for distributing a summary plan description (SPD) to each participant and beneficiary of a welfare benefit covered under Title I of ERISA. The SPD is a description of the rights and benefits under the plan.

  ERISA does not prescribe a specific format for the SPD, however, it does require that it be written in a manner understandable to the average participant and that it must include (but is not limited to) descriptions with respect to rights and benefits, participation requirements, and general plan information. The Department of Labor (DOL) regulations include a specific list of items which should be described in a SPD. Simply labeling a descriptive piece of information a summary plan description does not satisfy the SPD requirements.

  A SPD must be provided to each participant within 120 days following the later of the plan's effective date or the date of its adoption. New participants must be provided with a SPD within 90 days following the date the employee becomes eligible under the plan. SPDs may be provided electronically, subject to certain requirements discussed earlier under "ADMINISTRATION".

  In prior years plan sponsors were required to file SPDs with the Department of Labor. That requirements was eliminated in 1996.

  Every ten years, an updated SPD must be furnished to each participant and beneficiary if no amendments have been made to the plan. If amendments are made to the plan, an updated SPD must be furnished every five years. This updated SPD must be provided within 210 days following the end of the plan year during which the 5th or 10th year occurs since the last SPD was provided.

- **Summary of Material Modification (SMM).** A plan subject to Title I of ERISA, must also provide participants and beneficiaries with a copy of any summary of material modifications (SMM) made to the plan. A SMM describes any changes made to the

plan which materially effect the plan. This SMM must be provided within 210 days following the end of the plan year during which the modification or amendment was adopted, or if later becomes effective. It should describe the plan amendments and modify the information provided in the SPD. However, any material benefit reduction of a group health plan must be disclosed within 60 days of the effective date of the change.

Recent Federal Law Changes

Several recent federal laws have imposed additional requirements upon health plans. These laws are of universal application, to self-funded, insured and HMO-types plans. The **Family and Medical Leave Act** requires that eligible employees who take a family and medical leave are entitled to keep their medical coverage during their leave under the same terms as apply to coverage for active employees. They are required to pay the employee's share of the medical plan contribution, but the taking of a family and medical leave act is not an event which precipitates COBRA continuation coverage. If they fail to pay their share of contributions during the leave, with 15 days advance notice their coverage can be discontinued, but upon return to active work, their coverage must be reinstated under the same conditions. The **Mental Health Parity Act** requires health plans to set annual and lifetime limits on mental health benefits at the same level as those for medical or surgical benefits. The level cannot be lower for mental health benefits. This requirement does not apply to benefits for substance abuse or chemical dependency. Plans can still establish cost-sharing and limits on the numbers of visits or days of coverage for mental health benefits, provided they are not offered through an insurance policy issued in Minnesota, where such restrictions are prohibited. Small employers (between 2 and 50 employees) and those where the cost of this benefit provision increases one percent or more due to these requirements are exempted.

The **Newborns' and Mothers' Health Protection Act** mandates the time of a hospital stay after and in connection with childbirth. Following a normal vaginal delivery coverage for a hospital stay

may not generally be limited to less than 48 hours for both mother and newborn child. In the case of a cesarean section the minimum stay is increased to 96 hours.

The **Health Insurance Portability and Accountability Act (HIPAA)** protects employees changing health plans from the imposition of preexisting condition limitations and exclusions. In general, if an individual has had prior coverage for at least 12 months, and has not had an intervening break in coverage of 63 days or more, a new plan cannot impose preexisting condition limitations upon her/his coverage. When an employee's coverage ceases, the employer is required to furnish a statement certifying the length of time the employee has had medical coverage. This certificate can then be furnished to the new employer to provide for continuity of coverage without preexisting conditions. HIPAA also imposed certain privacy requirements on covered entities, which includes most group health plans. Pursuant to the privacy requirements, plan sponsors must implement safeguards to ensure that protected health information is not used except for treatment, payment or health care operations, unless the patient consents to its use for some other purpose. Large plans must have complied with HIPAA's privacy rule by April 14, 2003. Small plans must comply by April 14, 2004. See Appendix D for a more complete overview of HIPAA's privacy requirements.

The **Women's Health and Cancer Rights Act** requires health insurers and group health plans that cover mastectomies to provide coverage for breast reconstruction following mastectomies. Plan sponsors are also required to provide participants with written notice of the availability of this coverage.

COBRA Continuation Coverage Rules

Generally, the COBRA provisions apply to employers with 20 or more employees. This is determined in the previous calendar year and must be true for at least fifty percent of the working days in that year. The law does not apply to plans sponsored by certain church related entities and the plans of the federal government.

Governmental entities other than the Federal government are subject to parallel continuation requirements under the Public Health Services Act.

Employees covered under the group health plan are considered qualified beneficiaries if they are covered by the group health plan on the day before a qualifying event occurs. This includes any employee, spouse, dependent children, and in certain cases retired employees, their spouses and their dependent children. For purposes of COBRA, a "qualifying event" may be any of the following:

- Voluntary or involuntary termination of employment for reasons other than "gross misconduct";
- Reduction in the employee's number of hours;
- Enrollment in Medicare (as to a spouse and dependents);
- Divorce or legal separation;
- Death;
- Loss of "dependent child" status; and
- Bankruptcy filing by the plan sponsor, as to retired employees receiving health benefits.

Participants and beneficiaries in a group health plan are required to be provided a notice of initial rights. In 2003, the Department of Labor released a new Model Notice, which may be used to satisfy this requirement.

Self-funded plans are not regulated by the state and, therefore, the state continuation requirements generally do not apply. Certain self-funded health plans sponsored by local government entities (*e.g.*, county, city, school districts) are required by state law to provide benefits as if they were provided through insurance, Blue Cross and Blue Shield, or an HMO. This includes state continuation requirements.

Qualified Medical Child Support Order (QMCSO)

- **Federal Law.** Group health plans are required to provide benefits in accordance with qualified medical child support orders (QMCSOs). An employer and health plan administrator must deal with a QMCSO in a manner similar to the way employers and plan administrators deal with QDROs for pension plans. See **QUALIFIED RETIREMENT PLANS - ADMINISTRATION - QUALIFIED DOMESTIC RELATIONS ORDERS,** above. Group health plans were required to be amended to recognize QMCSOs by the beginning of the 1994 plan year.

  For purposes of QMCSOs, a "group health plan" is an employee welfare plan under ERISA that provides medical care through insurance, reimbursement, or otherwise (*e.g.*, medical coverage, health reimbursement plans, vision plans, dental plans). In general, a QMCSO is a court or administrative order relating to the support of a child. The QMCSO provisions generally ensure that group health coverage be made available to noncustodial, out-of-wedlock, or non-dependent children of a plan participant when required under a court and/or administrative order. Such an order is typically from a state court applying state domestic relations laws, including laws which states must enact under Section 1908 of the Social Security Act.

  To be "qualified," the court order must contain certain elements. It must clearly state, (1) the name and last known mailing address (if any) of the participant and of each alternate payee covered by the order, (2) a reasonable description of the type of coverage to be provided by the plan to each such alternate recipient, or the manner in which such type of coverage is to be determined, (3) the period to which such order applies, and (4) each plan to which such order applies. The court order may not require a group health plan to provide any type or form of benefit that the plan would not otherwise provide. For

example, if the group health plan only covers employees, a court order cannot require that group health plan to cover a dependent child. It is also important to note that a QMCSO only relates to the child. A court or administrative order, or portion thereof, that attempts to also require a group health plan to provide coverage to the ex-spouse is not a QMCSO.

Employers are required to develop reasonable written procedures to determine when a court or administrative order is a QMCSO. This written procedure should include a notice to participants and each alternative recipient. Written procedures must also include a description of coverage and benefits and how those benefits are provided under a QMCSO.

In general, the written procedure for determining when a court or administrative order is a QMCSO must be followed. The order must include the four elements described above and it cannot require the group health plan to provide a form or type of benefit that the plan would not otherwise be required to provide.

Claims Procedure

All plans subject to ERISA are required to establish a reasonable benefit claims procedure and an appeals procedure for the review of denied benefit claims. A claim is a request for a plan benefit by a participant or a beneficiary. A claim is considered to have been filed when made according to the claim procedure established for the plan. If the claim procedure is not reasonable or does not exist, a claim is considered to have been filed, whether written or oral, when it is brought to the attention of an authorized representative of the plan. An employer may avoid oral claims, by requiring in the plan's procedure that all claims be made in writing.

A claim procedure is considered to be "reasonable" if it satisfies each of the following requirements:

- Complies with specific requirements for filing a claim, notification of claimant of decision, content of notice, review procedure, and decision on review;

- Is described in the summary plan description;
- Does not contain any provision, and is not administered in a way which unduly inhibits or hampers the initiation or processing of plan claims; and
- Provides for informing participants in writing, in a timely fashion, of the time limits for filing and appealing claims.

After a claim is filed, the plan administrator or insurer must provide notice to the claimant whose claim is partially or entirely denied. The timeframe within which the notice must be furnished depends on the type of claim. A participant with an urgent claim under a group health plan must receive notice within 24 hours. A participant with a claim under a retirement plan must receive notice within 90 days after the claim is received. Other types of claims are subject to timeframes between these two extremes. However, under certain circumstances the decision period may be extended. If an extension is required, the claimant must be notified of the special circumstances and of the date by which a decision will be made. Notice of a denied claim must include:

- The specific reason for the denial;
- Reference to the specific provision of the plan which the denial is based;
- A description of additional information, if any, which the claimant would need to provide to perfect the claim and an explanation as to why; and
- The steps to take if the claimant wishes to resubmit the claim for review.

A plan is also required to establish a procedure for reviewing denied claims. All review procedures must, at a minimum, provide for the following:

- Rules to request a review of the claim by filing a written application;

- Rules to review pertinent documents; and
- Rules for submitting issues and comments in writing, to the appropriate named fiduciary.

The review procedure may establish a time period for filing a request for review. This time limit must be reasonable and may not be less than 60 days after the claimant receives the notice of a denied claim for a pension plan or less than 180 days for a group health plan or disability plan. Generally, a review of the claim must be completed within 60 days from the date the request is received, but the time period is reduced for certain types of claims, including certain group health plan claims and disability claims. Special circumstances, however, may extend the review period after the request for review is received.

Only after the plan procedures have been exhausted may a participant or beneficiary seek action through the courts. Therefore, the above procedures result in a less costly resolution for all parties involved.

UNION PLANS

Multi-employer pension plans were discussed earlier in this Guide. Like multi-employer plans, union plans can be made available for only those employees of one or more employers who are represented by a bargaining representative. Often multi-employer plans are established in order to make health and welfare benefits available to employees of several employers, all of whom have entered into collective bargaining agreements with the same union.

- Multi-employer health and welfare plans are established under Section 302(c)(5) of the National Labor Relations Act (the Taft-Hartley Act).
- Contributions are made to a Taft-Hartley trust, jointly trusteed and administered by a Board on which there is equal representation by representatives of labor and management.

- The Joint Board establishes either the benefits provided under the plans it sponsors or sets the contribution level required to provide benefits specified in a collective bargaining agreement.

- There is no statutorily imposed employer withdrawal liability to a health plan or other non-pension plan in the event an employer ceases to make contributions to the plan or bargains out of the obligation to contribute to the plan. Some Joint Boards have, however, established their own rules imposing their own liability for employer withdrawal from a health plan.

- Multi-employer health and welfare plans are exempt from discrimination rules, except to the extent that they cover non-bargaining unit employees.

MINNESOTA LEGAL REQUIREMENTS FOR HEALTH AND WELFARE PLANS

Though ERISA governs employee benefit plans, those plans that provide benefits through an insurance policy are also subject to state law. Thus, the requirements of ERISA must be met and, in addition, state laws governing insurance policies, whether as to the benefits which must be offered under a certain policy, the requirements a carrier must meet to be licensed or the provisions that apply upon policy or participant termination, must be followed. This section will focus on Minnesota's requirements for group health, disability and life insurance and sets forth requirements in effect as of January 2004.

Health Plans

Minnesota regulates insured or indemnity health plans as well as health maintenance organizations licensed under Mn. Stat. Chapter 62D, preferred provider organizations licensed under Mn. Stat. Chapter 62A and nonprofit health service corporations such as Blue Cross Blue Shield of Minnesota licensed under Mn. Stat. Chapter 62C.

Insured Plans

The following minimum requirements are applicable to insured health plans offered to Minnesota residents:

- The minimum benefit standards for qualified medical care plans are set out in Minnesota Statute 62E.06. There are three levels of qualified health plans. Employers who offer insured health coverage to their employees must offer a plan or a combination of plans that has been certified or qualified as a number two qualified plan. The **number three qualified plan** must meet or exceed the following minimum standards:

    - The minimum benefit must be equal to at least 80 percent of the cost of covered services in excess of the annual deductible, which must not exceed $150 per person. There must be a limitation of $3000 per person for out-of -pocket expenses for services covered and a maximum lifetime benefit of at least $1,000,000.

    - Covered expenses must include the "usual and customary" charges for the following services when prescribed by a physician: hospital services; professional services for diagnosis or treatment of injuries, illnesses, or conditions other than dental, which require a physician's direction; drugs requiring a physician's prescription; services of a nursing home for not more than 120 days annually if such services would qualify as reimbursable under Medicare; use of radium or other radioactive material; oxygen; anesthetics; prostheses other than dental but including hair prostheses worn for hair loss suffered as a result of alopecia areata; rental or purchase, as appropriate, of durable medical equipment other than eyeglasses and hearing aids; diagnostic X-rays and laboratory tests; services for physical and occupational therapists; transportation provided by licensed ambulance services to nearest facility or reasonable mileage kidney dialysis center for treatment;

- A **number two qualified plan** offers all the coverage above except that the deductible may not exceed $500 per person. Employers who offer health coverage must offer a plan or a combination of plans that at least qualifies as a number two plan. A **number one qualified plan** is the same as a number three plan except that the deductible may not exceed $1000 per person.

- Insurers and health providers are barred from making certain agreements. Minnesota Statute Section 62A.64 bars agreements between insurers and health care providers that "prohibit or grant the insurer an option to prohibit the provider from contracting with other insurers or payors to provide services at a lower price than the payment specified in the contract." Providers are also protected from any agreements that require them to accept a lower payment in the event that the provider agrees to provide services to other insurers at a lower price. Agreements between insurers and providers requiring termination or renegotiation of existing contracts in the event that the provider agrees to provide service to other insurers at a lower price are also prohibited.

Coverage for Alcohol and Drug Abuse Treatment

All group health insurance plans must provide coverage for alcohol and drug abuse treatment. Minnesota Statute § 62A.149 mandates that such plans offer a minimum yearly inpatient coverage of "at least 20 percent of the total patient days allowed by the policy." In no event "shall coverage be for less than 28 days in each 12-month benefit year" for inpatient alcohol and drug abuse treatment. In addition, group health plans must offer a minimum of 130 hours of outpatient coverage for drug and alcohol abuse treatment. This requirement does not apply to policies that are "designed primarily to provide coverage payable on a per diem, fixed indemnity or nonexpense incurred basis or policies that provide accident only coverage."

Coverage for Mental Health Treatment

Group health insurance policies must under Minnesota Statute § 62A.152 offer coverage for outpatient mental health treatment if inpatient treatment is covered under the policy. The minimum yearly outpatient coverage is eighty percent (80%) of the first ten (10) hours of mental health treatment and seventy-five percent (75%) for any additional hours if the mental illness is serious or persistent. A parity rules is also imposed, requiring insurers to impose the same limitations of treatment whether he condition is a mental or physical condition. Thus, for example, a policy could not cover hospitalization for cardiac surgery at an 80% level and inpatient treatment of depression at a 60% level.

Dependent Coverage

Health insurance policies must offer coverage to newborn infants at the moment of birth and thereafter. The definition of "newborn infant" includes grandchildren "who are financially dependent upon a covered grandparent and who reside with the covered grandparent continuously from birth." Similar coverage must be provided to the adopted children of the insured. Further, all health insurance policies that offer coverage to full-time students must include in the definition of full-time student "any student who by reason of illness, injury, or physical or mental disability ...is unable to carry... a full-time course load." Under this statute, such students need only carry 60% of what otherwise is considered by the institution to be a full-time course load. Plans that offer coverage of dependent children until a specified age must also provide that the attainment of the limiting age will not work to terminate the coverage of the dependent child who continues to be both a) incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder or physical handicap and b) chiefly dependent upon the policyholder for support.

Health Maintenance Organizations (HMO)

Minnesota Statute § 62D.02 applies to HMOs. HMOs are required to offer a number two qualified plan. An HMO is defined as a "nonprofit corporation...which provides, either directly or through arrangements with providers or other persons, comprehensive health maintenance services...to enrollees on the basis of a fixed prepaid sum without regard to frequency or extent of services furnished." The statute defines "comprehensive health maintenance" as including, but not limited to emergency care, emergency ground ambulance transportation services, inpatient hospital and physician care, outpatient health services and preventive care. All HMOs must be granted a certificate of authority to establish and operate an HMO by the state commissioner of health. A certificate of authority will be issued only upon satisfaction of factors including, but not limited to, whether the applicant has shown a willingness and ability to assure health care services in a manner that would enhance and assure the availability and accessibility of adequate personnel and facilities; ongoing evaluation of quality health care; the monitoring and assessment of the cost of operations and patterns of service utilization; and a showing of the ability to meet financial obligations

NonProfit Health Service Plan Corporations

The Minnesota state legislature passed Minnesota Statute § 62C with the intent of promoting a "wider, more economical and timely availability of hospital, medical-surgical, dental and other health services for the people of Minnesota, through nonprofit, prepaid health service plans." Under this statute, a service plan corporation may be developed to establish and operate a service plan that provides health services or payment therefor for covered individuals of a service plan in exchange for periodic prepayments. A service plan corporation must be incorporated and its articles and bylaws must be approved by the commissioner of commerce. A service plan corporation must secure from the commissioner of commerce a certificate of authority before it can enter into any subscriber contracts or solicit applications for such contracts.

Dental Insurance Plans

Health plans that provide only dental or vision coverage are not subject to many specific provisions of Minnesota Statute § 62A, including maternity benefits, children's health supervision services and prenatal care services, benefits for alcoholics and drug dependents, coverage for emotionally handicapped children, ambulatory mental heath services, for DES-related conditions, conversion privileges for insured former spouses and children, phenylketonuria treatment, coverage for scalp hair prostheses and coverage for diagnostic procedures for cancer.

Third Party Administration License

All third party administrators unrelated to an employer sponsoring a self-insured health plan who do claims administration for the plan must be licensed by the state in order to transact business in the state. (Minnesota State § 60A.23(e)(3)) License approval is based on whether the applicant possesses "the necessary organization, background, expertise, and financial integrity to supply the services sought to be offered." The statute allows the commissioner to issue licenses subject to limitations or restrictions.

In addition, insurers or HMOs are prohibited from discriminating in coverage on the basis of DES or fibrocystic breast conditions. Insurers must offer preventative care to children to the age of 6 and immunizations to age 18. Postdelivery maternity stays conform with the federal law, but fertility treatments need not be covered. Coverage of cleft palate or cleft lip treatments is mandatory, as is coverage of reconstructive breast surgery, mammograms, pap smears and other cancer screening procedures. A policy must cover the costs of optometrists, chiropractors, psychologists and nursing services, including those of both registered nurses and nurse practitioners.

When an employee's employment in terminated, Minnesota law requires the employer to maintain health coverage for that

employee through the last day of the month of termination. Continuation of coverage rights would apply after that date. Insured policies must make individual conversion policies available after continuation rights have expired.

Continuation Coverage for Group Health Insurance

In addition to the requirements of federal COBRA continuation coverage, which applies to all group health plans covering more than 20 employees, Minnesota law imposes requirements for all **insured** group health policies and **HMOs** providing benefits to employers with at least 2 employees. Many plans may be subject to both COBRA and Minnesota continuation coverage, in which case the longer period of coverage is available for the qualified beneficiaries. Self-funded medical plans are not subject to the Minnesota continuation coverage requirements. There are no exemptions for insured church or governmental plans.

Many of the qualifying events are similar to that of federal COBRA:

- The required coverage periods for the qualifying events of termination of employment, reduction of hours, and loss of dependent status of a dependent child are the same as required under federal COBRA. These rules provide for a shorter notice period of 10 days for employers to notify qualified beneficiaries of their right to elect continuation coverage following a termination of employment or layoff.

- Spouse and dependent coverage resulting from a divorce or the death of the covered employee are not limited to the 36 months required by federal COBRA. For such qualified beneficiaries (former or surviving spouses and dependent children), Minnesota law provides that their coverage shall continue until the earlier of when the qualified beneficiaries enroll in other group coverage or until the coverage would otherwise terminate (*i.e.* the plan is discontinued for all employees). Also, prior to termination of continuation

coverage to a surviving spouse or surviving dependent child for non-payment, the employer must notify the qualified beneficiary of the payment due at least 30 days before termination (which cannot be completed until the payment is at least 90 days late).

- Retiree coverage provided under federal COBRA is not available under state law, but Minnesota law does provide for continuation coverage for Chapter 488 early retirees (for political subdivisions) until such retirees enroll in other group coverage or the coverage would otherwise cease.

- An employee who becomes totally disabled is entitled to continuation coverage under Minnesota law for a period of 24 months (as opposed to the 29 months granted under federal COBRA), but if at the expiration of that 24 months the employee is unable to engage in any paid employment or work for which the employee may (through rehabilitation) become qualified, then the coverage is available until the coverage would otherwise cease or the qualified beneficiaries enroll in other group coverage. Minnesota law does not allow the amount of premium which can be charged for coverage based on disability to be increased to 150%, as allowed under federal COBRA. Unlike federal COBRA, this Minnesota special rule for disability applies only when the covered employee (and not any other qualified beneficiary) is disabled.

- **Coordination of Minnesota Continuation Rules and COBRA.** When an employer is subject to COBRA and provides benefits through a means that is regulated by the state, the continuation requirements of each must be met. Although the requirements are similar, they are not exactly the same.

  To coordinate the continuation rules under Minnesota law and COBRA, an employer must be familiar with the areas in which the two laws differ. Although these differences are too numerous to describe in great detail in this format, some of the important issues are highlighted below. Equally important is

the manner in which these differences are applied. As a general rule, the individual entitled to continuation coverage should receive the benefit of the most generous continuation provisions.

Minnesota law generally differs from COBRA in the following situations:

- A former spouse and dependent children of a covered employee who were covered at the time of a marriage dissolution;
- A surviving spouse and dependent children with coverage at the time of the covered employee's death; and
- A covered employee, spouse and dependent children of the covered employee who were covered at the time the covered employee became totally disabled.

In each of these situations, there may be state continuation coverage that is more generous than the COBRA coverage. For example, the period of continuation coverage may be longer or the cost may be less under state continuation requirements.

- **Minnesota Law.** The child support laws of Minnesota were also expanded in 1993. Effective August 1, 1993, the state child support law requires automatic income withholding for all new and modified support orders (including child support, medical support and spousal maintenance), and additional disclosure requirements for new employees. One of the expanded disclosure provisions requires employers to ask all new hires if they are required to withhold from income child support or medical support for their dependents, and, if so, the terms of the court order. This must be done at the time of hire. However, just because there is a court order, does not mean the group health plan must, or can, recognize it. As described above, a court or administrative order based upon these expanded state law provisions must be recognized by the

group health plan if it is a QMCSO. Absent a QMCSO, the group health plan must be administered in accordance with the plan terms. If the court or administrative order requires the group health plan to do something that is not permitted or not addressed under the terms of the group health plan, following such an order may be breach of fiduciary duty under ERISA.

Small Employer Health Insurance

Minnesota regulates insurance policies offered to employers of 49 or fewer employees where the majority of them are located in the state under Mn. Stat. Chapter 62L. Coverages must be similar to those under a number 2 plan. Preexisting condition limitations may be applied, but no employer of the appropriate size may be denied coverage and the health experience of the group may only have a limited impact on premium rates. There are restrictions on the insurer's right to cancel the coverage.

Group Life Insurance

Minnesota also regulates group term life insurance and the carriers who issue or renew such policies to residents of Minnesota under Minnesota Statute Chapter 61A. The law requires that each person insured under a group life insurance policy receive a certificate of insurance issued by the insurer containing the following information:

- Name and location of the insurance company;
- A statement as to the insurance protection;
- A statement regarding the termination or reduction of protection;
- A statement that the group life insurance policy may be examined at a reasonably accessible place;
- The maximum rate of contribution to be paid;
- Beneficiary and method to change such beneficiary; and

- A statement that alternative methods for the payment of group life policy proceeds of $15,000 or more must be offered to beneficiaries in lieu of a lump sum distribution, at their request.

- A statement as to the right to continue coverage after termination of employment.

Insurance companies underwrite group life insurance with coverage based on the mortality experience of the group. All rights and privileges incident to the ownership of a group life insurance policy may be assignable if certain conditions are met.

No employer who offers group life insurance that provides life insurance benefits to more than five (5) employees of that employer may require an employee to participate in the life insurance plan as a condition of employment unless the employer pays the full cost of the plan. Similarly, no employer may discharge, discriminate or otherwise retaliate against an employee who refuses to contribute to a group life insurance plan.

Continuation Coverage for Group Life Insurance

Unlike federal COBRA requirements, Minnesota continuation coverage laws apply not only to group health plans, but also to group life insurance plans. Under state law, every group insurance policy offered by employers to their employees must allow employees who terminate employment to continue their group life insurance coverage for up to 18 months. Minnesota Statutes § 61A.092 outlines the notice requirements and 60 day election period which mirror those of federal COBRA continuation coverage. If the employer fails to notify a covered employee of the option to continue coverage and the coverage is terminated, then the employer is liable for the coverage to the same extent as the insurer would have been if the coverage were still in effect.

This statute also requires that group life insurance policies provide for conversion to an individual policy without any further

evidence of insurability at the expiration of the 18 months of continuation coverage, but the rates for this conversion coverage are not limited to the 102% of active employee premiums allowed for the 18 months of continuation coverage.

Disability Insurance

Minnesota regulates disability insurance under its requirements for an accident or health policy. Such policies provide for wage continuation payments in the event of a prolonged illness or injury. Policies and carriers are regulated under Mn. Stat. Chapter 62A.

The employer's contribution to the plan is excludable from the employee's gross income, and is deductible as an ordinary and necessary business expense to the employer. In the event of disability, amounts received by the employee are then included in income to the extent the amounts are attributable to the employer's contribution. To the extent any portion of the cost of the coverage was paid by the employee, benefits received are not included in the employee's income. For purposes of these rules, amounts paid by an employee on a pre-tax basis through a cafeteria plan are considered "employer" contributions. However, payments received for permanent loss or loss of use of a body part or function, or for disfigurement, are not includible in income if such payments are computed without regard to absence from work.

DOMESTIC PARTNER BENEFITS

There is a recent trend among many private employers and governmental bodies to offer domestic partner benefits within their health insurance plans. In order for an employee to cover his or her domestic partner, most plans that permit such benefits require the employee to certify that he or she is in a committed relationship with the person for whom he or she is requesting coverage as a domestic partner. The following are some examples of what plans are requiring an employee to certify to, as proof of a committed relationship, in order to receive domestic partner benefits: the employee and domestic partner are in a long-term

committed relationship with each other and intend to remain together indefinitely, the employee and domestic partner share a residence and intend to do so indefinitely, the employee and domestic partner are not related by blood or adoption such that would prohibit marriage in the state of their residence, documentation of a partnership ceremony, the employee and domestic partner share financial resources and have agreed to jointly assume financial liabilities of the other partner, etc.

The gross income of an employee who receives domestic partner benefits includes as imputed income the value of the employer contribution attributed to the domestic partner's health plan coverage. However, gross income generally does not include amounts received by the employee or domestic partner through an accident or health plan (whether insured or self-insured) if such amounts are paid for medical care expenses.

Domestic partner benefits take another twist in the context of an employers cafeteria plan. In order for an employee's domestic partner to be covered through an employee under a cafeteria plan, in addition to whatever conditions the employer may place on receiving such benefits, the IRS also requires that the employee must be able to claim the domestic partner as a dependent on the employee's federal income tax return.

SECTION THREE: NON-QUALIFIED RETIREMENT PLANS

GENERALLY

A non-qualified deferred compensation ("NQDC") plan or arrangement is a contractual promise by an employer to make payment of a portion of the employee's compensation in the future upon the happening of a specific event, such as termination of employment or retirement. These plans are designed to defer the receipt of compensation by an employee until some future date. For this purpose a plan can include an agreement with an employee.

A NQDC arrangement must meet several criteria in order to avoid the current taxation of income to the employee.

- First, any election to defer the receipt of compensation must be made before the employee performs the services for which the compensation is payable.

- Second, the plan must define the time and method for payment of deferred compensation for each event that entitles a participant to receive benefits. The employee will be taxed on his benefit(s) under the plan when he is entitled to receive them, whether or not he actually receives the benefits.

- Third, the plan must be unfunded, that is, it must provide that participants have the status of general unsecured creditors of the employer and that the plan is a mere promise by the employer to make benefit payments in the future.

- Fourth, the plan must specifically prohibit the transfer of any rights of participants, including the sale, transfer or

assignment to the participant's creditors. The plan may not create a trust or other beneficial interest (other than create a contractual promise to pay) for the participant or his beneficiary).

- Fifth, the plan must specify that it is the parties' intent that the arrangements are to be unfunded for purposes of the IRS and ERISA.

- NQDCs must also comply with the economic benefit doctrine and the constructive receipt doctrine.

TAX TREATMENT OF NON-QUALIFIED DEFERRED COMPENSATION (NQDC)

Unlike qualified retirement plans, the employer can deduct the contributions relating to a NQDC arrangement only when the employee recognizes them as income. This occurs in a NQDC arrangement when the employee receives (or is entitled to receive) distributions.

Since the purpose of a NQDC arrangement is to defer the recognition of income, employers do not fund the plans since that would cause immediate taxation to the employee. An employer may, however, invest its funds in anticipation of its payment obligation under the NQDC arrangement without accelerating the employee's tax liability, provided: (i) the employer is not obligated under the plan to make the investment; (ii) investments are held in the name of the employer or the trustee of a grantor trust of the employer; (iii) the employee receives no economic benefit from the investment; and (iv) investments are subject to the claims of the employer's general creditors upon insolvency or bankruptcy.

An employer's investment (if any) might depend on the commitment under the plan for the crediting of earnings to participants. In other words, the employer may attempt to match its funding obligation (*e.g.*, the interest rate on certain treasury obligations) by purchasing those investments. If, however, assets are held by the employer, income on the investments is taxed to the

employer. Corporate owned life insurance is a common form of internal funding, particularly if the NQDC arrangement also provides a death benefit.

The IRS issued guidance in 1996 as to FICA and FUTA tax treatment of nonqualified deferred compensation arrangements. Generally, contributions or benefits are subject to FICA and FUTA when the services have been performed and contributions or benefits are nonforfeitable and readily ascertainable in amount. Thus, FICA is often paid during employment, not when distributions are made.

TYPES OF NON-QUALIFIED PLANS

Supplemental Executive Retirement Plans (SERPS)

Supplemental executive retirement plans (SERPs) provide additional pension benefits to a select group of employees. In order to avoid the application of ERISA's funding, participant, vesting and fiduciary rules, a SERP (as with all non-qualified plans) must be unfunded and it must be maintained primarily to provide deferred compensation for a select group of management or highly compensated employees (*i.e.*, a "top hat" plan).

SERP benefit formulas vary:

- The formula for determining benefits might increase the final average pay monthly benefit percentage payable under the employer's qualified plan, *e.g.*, from 60 to 75%.
- The plan might commit to pay the difference between actual years of service and the full benefit under a 30 year funding period for executives who have not been employed for the full accrual period.
- The plan might agree to set aside a specific dollar amount or percentage of full compensation or the annual bonus.
- The plan might commit the employer to pay whatever amount is required to restore the executive to the profit sharing benefit

the participant would have received if a specified return on investments had been achieved.

- The plan might permit a "top-hat" employee to make salary deferrals which exceed the 401(k) plan limits into this plan.

Excess Benefit Plans

An excess benefit plan is a plan maintained by an employer solely for the purpose of providing benefits for certain employees in excess of the limitations imposed on contributions and benefits by Section 415 of the Code.

- Unfunded excess benefit plans are exempt from all ERISA provisions.
- A funded excess benefit plan is exempt from the participation, vesting and funding rules, but not from reporting, disclosure, fiduciary and enforcement provisions of ERISA.
- An excess benefit plan could cover lower paid employees who participate in other plans and thus find their reduced compensation lowering their benefits.
- A problem with excess benefit plans is that they do not cover other limiting factors, such as the employer's deduction limits or the 401(k) limit on elective deferrals.

SECTION FOUR: STOCK-RELATED LONG-TERM INCENTIVE PROGRAMS

Stock-based forms of compensation can be an element of an overall compensation program. The use of stock-based compensation is a method of incorporating a plan which pays people in proportion to the success achieved by the company. If an employee's performance can impact the value of the company's stock, then the employee will be rewarded by the increase in the value of the stock.

RESTRICTED STOCK

- **Description.** The term "restricted stock" means capital stock issued, pursuant to a plan or agreement, to an executive in connection with the performance of services. The shares are generally issued without cost or for a nominal price, and the ownership of the stock is subject to certain conditions or "restrictions" preventing the executive from having all of the rights and privileges available to an owner of unrestricted stock. Typically, the employee's rights to ownership are subject to a "vesting" schedule and, thus, ownership of some or all of the shares of the stock is made contingent upon the executive's continued employment by the employer for a certain period. Forfeiture of unvested shares occurs upon the participant's termination of employment during the restriction period. In addition, vested shares may be subject to repurchase at book value, fair market value determined by the Board of Directors, or some other agreed upon price.

  An executive who has received restricted stock has a stronger identification with a company in which he is an actual shareholder than with a company in which he is only a

potential shareholder, which would be the case if the executive is merely granted an option. In addition to meeting the employer's objectives, it is possible to structure restricted stock to allow the executive the opportunity to defer being taxed on the receipt of restricted stock.

- **Taxation.** An executive receiving a beneficial interest in stock by reason of the performance of services is taxed on the value of the stock at the time of receipt unless his interest is subject to substantial risk of forfeiture and cannot be transferred free of such risk. Income from stock is includible in gross income in the first taxable year in which the property becomes substantially vested, that is, when either the rights of the executive with the beneficial interest in the stock are not subject to a substantial risk of forfeiture or are transferable free of substantial risk of forfeiture by the transferee, whichever occurs earlier.

  However, an executive has the option of electing to report compensation income in the year the stock is transferred to him, even though it would be deferred under the above rules if the election were not made. This is referred to as a Section 83(b) election. If the election is made to report compensation income in the year of receipt, but the stock is subsequently forfeited, no deduction is allowed in respect of such forfeiture and there may not be a refund of tax previously paid.

  An employer may take a compensation deduction for the transfer of stock to the executive, provided it is "reasonable compensation" within the requirements of Section 162 of the Code. The amount that may be deducted is, however, limited to the amount includible as compensation in the income of the executive. This compensation is subject to the employer's obligation to withhold.

STOCK OPTIONS

Stock options often constitute an important part of the compensation and incentive program of a corporation. They may be offered pursuant to a plan applicable to one or more executives, or they may represent part of the premium offered to attract new executives or retain the services of valued, existing executives. By possessing the right to acquire an equity interest in the corporation, the participant's financial interest is ultimately dependent upon the long-term financial developments of the corporation. An equity plan participant is financially encouraged to work harder toward achieving success for the corporation.

- **Non-qualified (Nonstatutory) Stock Options.** As used in the context of an executive compensation program, a stock option means a right granted to one or more employees by a corporation to acquire shares of the corporation's stock at a fixed price for a specified period of time. Non-qualified or nonstatutory stock options ("NSOs") derive their name from the fact that neither the options nor the shares issued upon exercise of the options satisfy the criteria of, or "qualify" for, the special, and heretofore generally favorable, income tax treatment provided under the Code for incentive stock options.

  The exercise price of non-qualified stock options may be equal to the fair market value of the corporation's stock at the time of the grant of the option or may be a price substantially below market price at the time of the grant of the option. Most stock options require that a certain period of employment be satisfied before the option may be exercised.

  NSOs generally follow a pattern of taxation common to many employer-provided compensatory benefits, that is, they trigger gross income to the employee at some point in time, generally when they are exercised, and produce a compensation deduction to the employer.

- **Incentive Stock Options.** An incentive stock option ("ISO"), like other stock options, is a right granted an executive to purchase shares of the capital stock of the issuing corporation. The right so granted is exercisable for a specified period of time and at a fixed price, thus enabling the executive to delay exercise until the fair market value of the stock is greater than the fixed exercise price, giving the executive at the time a bargain price. In the interim, the executive has not been at risk if the value of the stock declines. If the value of the stock does decline the executive simply forgoes the exercise of the option without making any cash outlay. As in the case with nonstatutory stock options, SARs, and certain other programs, an incentive stock option accomplishes its goals by offering the potential for an equity interest in the corporation, thereby encouraging the executive to use her or his greatest efforts to promote the growth of the corporation. ISOs can be issued on a selective and discriminatory basis.

  The special status accorded ISOs does not come without cost. First, there are numerous qualification requirements that an incentive stock option program must satisfy-requirements designed to prevent abuse of the status. Second, the employer is denied any compensation deduction.

  Like a non-qualified stock option, the participant is not taxed at the time of the grant. Unlike a non-qualified stock option, the participant is also not taxed on the exercise of the option. The participant is taxed at the time of sale of the stock, and, if all requirements have been satisfied, taxation will be at the capital gains rates.

  A stock option granted to an employee will qualify as an ISO only if it meets the following qualification requirements:

  - **Written plan.** An ISO plan must be a written document which specifies the aggregate number of shares of employer stock that may be issued pursuant to the plan and the employees (or class of employees eligible to receive

the ISOs). Individual agreements must be in writing and contain the restrictions placed on the exercise of the ISOs and the subsequent transfer of the ISO stock.

- **Shareholder Approval.** An ISO plan must be approved by the shareholders of the adopting corporation within 12 months before or after the plan is adopted. Only a change in the number of shares of stock subject to the ISO plan or the employees eligible to participate will be treated as a new plan requiring shareholder approval.

- **Ten-Year Duration of ISO plan.** An ISO plan must expire within 10 years from the earlier of adoption or shareholder approval. An employee may exercise an option beyond this time, provided the grant was made within the 10 years.

- **Ten-Year Duration of the Option.** An ISO cannot be exercised after the expiration of 10 years from its grant.

- **Option Price.** The option price must be no less than the fair market value of the underlying ISO stock at the time the option is granted.

- **Restrictions on Transfer.** The ISO agreement must specifically state that the ISO cannot be transferred by the option holder other than by will or by the laws of descent and the option cannot be exercised during his lifetime by anyone other than the option holder.

- **Limitations on Options to be Exercised.** The value of shares of employer stock that can be exercised *for the first time* by a taxpayer in any one year under an ISO cannot exceed $100,000, based on the fair market value of the stock at the date of the ISO grant. Other options exercised in excess of this cap receive NSA treatment.

- **Special Rule for 10% Owners.** An ISO can be granted to a greater-than-10% owner only if the option price is at least 110% of the fair market value of the stock at the time of the

grant and the option is not exercisable after five years from the date of its grant.

- **Taxation of Stock Options.** When analyzing the tax treatment of stock options, there are three significant events: the grant of the option, its exercise, and the disposition of the stock acquired by exercising the option. The Code contains two alternate and mutually exclusive tax analyses for dealing with the three events. Section 83 of the Code governs the taxation of nonstatutory stock options, whereas statutory stock options are governed by Sections 421 and 422A of the Code.

    - **Taxation of NSO.** As noted earlier, Section 83 is the critical Code provision governing the tax treatment of non-statutory stock options. Section 83(e) of the Code contains two fundamental rules affecting all NSOs. First, Section 83 of the Code will apply to the grant of a NSO only if the option has a "readily ascertainable fair market value" at the time of the grant. Second, Section 83 of the Code will apply to the transfer of property pursuant to the exercise of a NSO only if the option did not have a readily ascertainable fair market value at its grant.

      Thus, if the option is a NSO without a readily ascertainable fair market value at the date of grant, there is no taxable event as a result of the grant. The compensatory aspects of the NSO are not taxed until the option is exercised. This delay has the effect of treating the appreciation in value of the underlying stock as compensation income rather than capital gain income.

      If the NSO did have a readily ascertainable fair market value at the time of the grant, then that value (less any amount paid for the NSO) will be taxed in the taxable year of the grant, and treated as compensation income. If the NSO is taxed at the time of the grant, then there is no tax consequences upon exercise of the grant. If the stock is held as a capital asset, then any gain realized upon a

subsequent disposition will be taxed as long-term capital gain. For this purpose, the employee's basis will include the amount of income included in income upon the grant of the option.

Options that are not actively traded on an established market do not have a readily ascertainable fair market value unless the value can otherwise be measured with reasonable accuracy.

- **Taxation of ISO.** The employee does not recognize taxable compensation income at either the grant of the ISO or the exercise of the option. However, at exercise the spread between the option price and the stock's fair market value is a preference item for alternative minimum tax purposes. The employer receives no compensation deduction upon grant or exercise of an ISO.

  Within an ISO, the employee has a taxable event only at the later sale or distribution of the stock acquired pursuant to the ISO. In this case, the employee's basis in the stock is the original option price. Gain over the employee's basis is eligible for capital gain treatment.

  In the event an employee engages in a "disqualifying disposition" of the stock, then the tax treatment changes. The employee will recognize as income the bargain purchase element of the option and the employer may deduct that amount as compensation expenses. This compensation amount is not subject to any withholding obligations. A disqualifying disposition of ISO stock occurs if the stock is disposed of within the later of two years from the date of the granting of the ISO to the employee or one year form the date that the shares were transferred to the employee upon exercise.

EMPLOYEE STOCK PURCHASE PLAN

- **Description.** Employee stock purchase plans are stock option plans primarily intended for rank and file employees. For this reason, the requirements of these plans are generally more liberal than those governing ISOs. Employees may set aside money from their paycheck in order to purchase employer stock at the end of an offering period, which may be 6, 12 or 18 months from the date of the grant. When the offering period ends, such employees may use the money they have set aside to purchase stock at the lower of two prices: the fair market value on the first day or the last day of the offering period. The purchase price can be as low as 85% of the lower of those two values. Purchasers avoid brokerage costs on purchase.

- **Taxation.** The taxation rules are very similar to those applicable to ISOs: there is no tax on either the grant or the exercise of an option, the employee is taxed at the time of sale of the stock treating the stock as a capital asset, and the employer generally has no compensation deduction. The employee has purchased this stock with after-tax dollars.

SECTION FIVE: OTHER BENEFITS

FRINGE BENEFITS

The general concept of taxable compensation under the Internal Revenue Code is that any payment of cash or "in-kind" property by an employer to or on behalf of an employee is subject to income and withholding taxes. Certain exceptions apply, including exceptions for "nontaxable fringe benefits." Nontaxable fringe benefits are generally excluded from income if they meet the requirements set out in Section 132 of the Code. The five general types of fringe benefits that are excluded from income under Section 132 of the Code are:

- No-additional-cost services;
- Qualified employee discounts;
- Working condition fringes;
- De minimis fringes; and
- Qualified Transportation fringes.

The first two types of fringe benefits, no-additional-cost benefits and qualified employee discounts, are subject to nondiscrimination rules and must be made available on substantially the same terms either to all employees of the employer or to a reasonable classification of employees which does not discriminate in favor of highly compensated employees. Such a classification might, for example, include all salaried employees (excluding hourly and union employees) or all employees working in a specific facility. Highly compensated

employees include owners, officers and certain of the highly-paid. (See the more detailed description under Qualified Retirement plans æ General Nondiscrimination, above.)

The requirement that the fringe benefit be available to a non-discriminatory group on "substantially the same terms" would preclude an airline, for example, from offering highly compensated employees free seats on its airplanes without restrictions while requiring its other employees to fly standby subject to space availability and on a first-come first-serve basis.

A plan which discriminates in favor of the highly compensated group strips all income exclusions from the highly compensated so that their benefits are **all** includible in their taxable income. That is, all fringe benefits of each highly compensated employee under the program would be subject to income tax, not simply the portion of the benefit that is discriminatory. Non-highly compensated employees in that situation continue to maintain the exclusion of their benefits from taxable income. Each of the four types of benefits programs identified above is tested separately.

- **No Additional Cost Services.** These are services made available to employees by an employer who generally offers the same services for sale to its customers in the ordinary course of the employer's line of business, provided that the employer incurs no substantial additional cost (including foregone revenue) when it provides such service to the employee. Any amount paid by the employee for the service is disregarded when measuring whether there was any substantial additional cost to the employer.

  In other words, the employer must have excess capacity that cannot be filled. Examples include free airline transportation, free hotel rooms, and free long distance telephone use. The service offered must normally be sold to customers. Thus only the airline could offer a program of free air transportation. If a hotel had extra airline seats it was unable to use, giving those to employees would not be a "no-additional-cost service"

because the hotel is not generally in the business of selling air tickets to its customers. Similarly if a seller of real estate has a 1-800 telephone number, use of the number by its employees would not be a "no-additional-cost" service to its employees, while free long distance telephone service by a long distance telephone company at non-peak times would be such a service.

- **Qualified Employee Discounts.** A qualified employee discount is an employee discount on property or services which are offered for sale to customers in the ordinary course of the employer's line of business in which the employee works. The discount must not be greater than the employer's gross profit percentage when the product is sold to customers. For services, the discount must not be greater than twenty percent of the price at which it is offered to customers.

  Thus an appliance store might offer employees a discount on refrigerators and stoves, up to the gross profit it makes on customer sales.

- **Working Condition Fringe Benefits.** Any property or service which could be provided to an employee and deducted by the employer under Section 162 or 167 of the Code can be excluded from an employee's income as a working condition fringe benefit. Any substantiation requirements required for a deduction would apply. The benefits must be received because of employee status.

  Commonly provided working condition fringe benefits include employer-paid parking, use of company cars, travel cost reimbursement, employee security devices and protections and tuition reimbursement arrangements.

  Certain specific rules apply to testing of consumer products and to overall personal security programs.

- **De Minimis Fringe Benefits.** If the value of an item of property or of a service is so small, considering its frequency, that accounting for it is unreasonable or administratively

impractical, it can be given to an employee as a de minimis fringe benefit. Examples include employee picnics or cocktail parties, traditional holiday gifts (if not cash), occasional tickets to sporting events or to the theater, coffee and doughnuts, lunch, and occasional personal typing or use of the copy machine. Gift certificates may be de minimis fringes, but specific rules apply to them.

The frequency of such employee gifts is measured person by person, not as to all employees as a group. If one employee is given a free meal every day, and other employees receive them only occasionally, that individual could not have the value of the meals excluded as a de minimis fringe benefit, though other employees who received them only occasionally could. Employer provided eating facilities may be de minimis fringes if certain standards are met.

- **Qualified Transportation Fringe Benefits.** The employer may also assist employees in transportation to and from work and exclude the value of such a benefit from the employees' taxable income. A **qualified transportation fringe** includes a transit pass for the use of mass transit facilities such as bus, rail or ferry. It also includes transportation in a commuter highway vehicle (*e.g.* a commuter van) and parking for employees at or near the employer's workplace or near a location from which the employee commutes to work by mass transit (up to a monthly maximum of $195. Cash reimbursements can be used for parking costs, commuter van costs, and for transit passes. Transit passes and commuter van transportation is limited to a monthly value of $100. Effective since January of 1998 qualified transportation benefit plans can be offered on a salary reduction basis, so that employees pay the cost of the benefit with pre-tax dollars.

  Self-employed individuals, partners and Subchapter S shareholders cannot take the exclusion from income for the qualified transportation fringe benefit.

- **On-premises Athletic Facilities.** An employer may provide athletic facilities on site for use by its employees. The value of that facility is not includible in gross income by the employees. This might include a gym, a tennis court, a golf course and/or a running track. Several conditions must be met including the following:

  - The facility must be located on the employer's premises;
  - The facility must be operated by the employer; and
  - Substantially all of the use of the facility must be by employees, spouses and dependents.

  Former employees who have retired or become disabled as well as surviving spouses of deceased employees may also use the facility. Further, partners are considered employees.

  The employer may operate the facility either through its own employees or by an independent contractor. More than one employer may operate the facility provided that its usage is limited to employees of all of the employers participating. The premises may either be owned or leased. Discrimination rules do not apply to the use of on-premises athletic facilities.

ADDITIONAL FRINGE BENEFITS

Employer Provided Meals

Section 119 of the Code excludes from an employee's income the value of meals or lodging for the convenience of the employer. Excludable meals must generally be furnished on the employer's premises. To be excludable the employer must require as a condition of employment that employees eat on-site. For example, the staff in a group home for physically disabled or mentally retarded individuals might be required to eat at the facility for the protection and assistance of its residents. Meals provided by the employer under this requirement would be excludable from the employee's income.

Employee Awards

Generally, gifts made by an employer to an employee are deemed to be compensation and subject to tax. However, there is an exception for certain achievement awards. Awards are not includible in income if a deduction is available to the employer for such achievement or safety awards. An award must not exceed the limits of certain annual limits per year per employee and must be items of tangible property (no cash permitted) which is awarded in a meaningful presentation. It must not give the appearance of being disguised compensation. A $1,600 limit per employee applies to an award that is part of a written program which is subject to nondiscrimination rules. Awards of up to $400 need not be part of a written plan and are not subject to discrimination rules. In either case, the award must be a regular practice and must recognize particular achievement.

Educational Assistance Programs

Section 127 of the Code allows an employer to provide educational assistance to its employees up to $5,250 per employee per year. It can also cover education of spouses and dependents. Several conditions apply to educational assistance programs under Section 127 of the Code:

- The plan must not discriminate in favor of highly compensated employees;
- Educational assistance programs may pay directly, or more commonly, reimburse, an employee for the cost of tuition, fees, books and supplies. However, supplies such as tools or computers which are retained by the employee after completion of study which are used in employment are not covered under this program;
- Meals, lodging or transportation for educational programs cannot be reimbursed;

- No more than 5% of the amounts paid by the employer for educational assistance may be paid to shareholders of the company;
- The program may not offer a choice of cash or educational assistance or be part of a flexible benefit plan; and
- The plan must be a separate written document and employees who are eligible must be given reasonable notice of the plan's availability and terms.

Tuition Reimbursement

Even when not part of an educational assistance program, an employer may reimburse employees for the costs of education which can enable an employee to better perform his or her job. This can cover tuition fees, books and expenses for transportation, lodging and meals. Tuition reimbursements under Section 162 of the Code must be ordinary and necessary business expenses and may not cover courses which equip or train an employee for a different job. Tuition reimbursement programs are not subject to discrimination rules.

Adoption Assistance

An adoption assistance program established under Code Section 137 can be offered as a flexible spending account through a cafeteria plan, or it can be offered outside a cafeteria plan arrangement. An adoption assistance flexible spending account may be funded by the employer, by the employee, or by both on a pretax basis. Through an adoption assistance program, employees may exclude from gross income reimbursements made for their expenses relating to adopting a child.

Long Term Care Insurance

A qualified long term care insurance contract is treated just like an accident and health insurance contract. In other words, eligible long-term care insurance premiums that do not exceed specified

limits will be treated as medical expenses for purposes of the medical expense deduction under Section 213 of the Code. In addition, an individual who is covered by a qualified long-term care insurance contract is not taxed on employer premiums for insured long-term care coverage. Amounts received under a long-term care insurance contract, up to certain limits, will be excluded from an individual's income as amounts received for injury or sickness. No restrictions on discrimination as to highly-compensated employers apply.

Accountable Plans

Reimbursement of expenses incurred in the performance of services for the employer are excludable from income provided that the employee is required to account to the employer for such expenses. For example, in the case of use of a personal automobile for work an employee may exclude from income any monthly allowance for automobile expenses, provided that the employee has accounted for actual expenses. If there is no requirement that the employee account for expenses in order to receive an allowance, the employee must declare it as subject to income tax.

SECTION SIX: CIVIL ENFORCEMENT AND REMEDIES

For employer plans subject to ERISA, ERISA dictates many aspects of enforcement. ERISA provides for criminal penalties, fines and/or imprisonment, however, this section focuses upon civil enforcement and remedies available under ERISA.

PREEMPTION

The first step in reviewing the enforcement of a claim is to determine whether or to what extent state law claims are preempted by ERISA. The starting point of the ERISA preemption analysis is to determine whether a state law "relates to" an employee benefit plan. For preemption purposes, state law includes all laws, decisions, rules, regulations and state actions having the effect of law. In general, ERISA preempts any state law which relates to an employee benefit plan. "Relates to" is interpreted in the normal sense of the phrase. A law relates to an employee benefit plan if it has a connection with or reference to such a plan. Preemption does not depend upon whether the law specifically mentions ERISA or is directed at benefit plans (*e.g.*, wrongful discharge, fraud, emotional distress, misrepresentation, unjust enrichment, conversion). ERISA's preemption is not without limits. There are a number of state laws which the courts have found to be too remote and, therefore, not preempted (*e.g.*, state surcharge taxes on medical services, professional negligence, criminal law).

In addition, certain state laws are "saved" from preemption under the ERISA itself (*i.e.*, the savings clause). State laws that regulate the insurance, banking and securities industries are not preempted (*i.e.*, saved). ERISA also provides that an employee benefit plan

cannot be "deemed" to be an insurance company, bank, trust company or investment company or to otherwise be in the business of insurance or banking for purposes of state laws which regulate those industries.

CAUSES OF ACTION

The class of persons entitled to sue, the available causes of action, and the available remedies are fairly narrow.

Benefits Claims

ERISA provides that only a participant or beneficiary may sue to receive benefits due, to enforce rights, and to clarify rights to future benefits.

Breach of Fiduciary Duty Claims

A fiduciary is personally liable for breaches of its fiduciary duties, including prohibited transactions. ERISA authorizes participants, beneficiaries, plan fiduciaries and the Secretary of Labor to bring actions for breach of fiduciary duty.

Actions to Enjoin ERISA Violations

ERISA generally provides that a participant, beneficiary, or fiduciary may bring an action to enjoin any act or practice that violates ERISA or the terms of a plan, to obtain other appropriate equitable relief, or to ensure the terms of the plan.

Actions for Disclosure

ERISA allows a participant, beneficiary or the Secretary of Labor to pursue an action for appropriate equitable relief when a plan administrator does not disclose information it is required to disclose. In addition, the court has discretion to impose up to a $110 per day penalty upon the plan administrator for failing to provide required information (*e.g.*, latest summary plan description) within 30 days of a written request, and may award that amount to the participant or beneficiary.

Costs and Attorney Fees

ERISA generally provides that the court, in its discretion, may award costs and reasonable attorneys' fees. Historically, when courts have awarded costs and fees they have tended to be awarded to the prevailing party. However, who gets costs and fees is also in the discretion of the court. However, in an action by a multi-employer plan to collect delinquent contributions the award of attorneys' fees to the plan, if it prevails, is mandatory.

INTERFERENCE WITH PROTECTED RIGHTS

A participant or beneficiary may also sue any person, including an employer, for interfering with rights to which the participant or beneficiary is or may become entitled. For example, an employer may not terminate an employee in order to avoid paying benefits (*e.g.*, immediately prior to vesting). Factors considered by the courts include timing, manner, and the economic impact to the person doing the interfering. An action for interference of protected rights may be brought under Section 502(a)(3) of ERISA by a participant, beneficiary or fiduciary. Among the remedies available under "appropriate equitable relief" are back pay, reinstatement, restitution of lost benefits and other relief necessary to make the participant or beneficiary whole.

DETRIMENTAL RELIANCE

ERISA really does not address mistakes, inaccuracies, etc. contained in a summary plan description ("SPD"). Because state laws (*e.g.*, breach of contract, misrepresentation, fraud) are preempted, many participants and beneficiaries would have no recourse if they relied upon and were harmed by the "faulty" SPD. In response, a number of courts adopted a detrimental reliance rule. Under this court- created rule, ambiguities, discrepancies, or errors in a SPD may be construed in favor of the participant or beneficiary if the participant or beneficiary (1) reasonably relied upon the SPD, and (2) was harmed as a result. SPDs should be periodically reviewed and, if necessary, adjusted. Further, if the

plan document and the SPD contradict each other, courts will often rely on the SPD language, since the SPD is what is given to plan participants for their information and reliance.

HOW LONG IS THERE TO BRING SUIT

The "statute of limitations" determines the window of time in which a suit must be brought. Suits brought after the statute of limitations has expired are barred and cannot be heard by the court. ERISA provides a specific statute of limitations for breach of fiduciary duty claims. Actions for breach of fiduciary duty may be brought no later than the following:

- Six years after the last action constituting the breach or violation; or, with regard to an omission, the last day on which it could be cured;
- Three years after the first day on which plaintiff learned of the breach or violation or a report was filed with the Secretary of Labor form which knowledge of the breach or violation could reasonably be expected to be obtained; or
- Six years after discovery of the breach in cases involving fraud or concealment.

ERISA also provides a specific statute of limitations for certain multi-employer claims.

For other types of ERISA claims (*e.g.*, benefits due, interference with protected rights, equitable relief), ERISA does not provide a statute of limitations. The courts have generally borrowed the statute of limitations that applies to the most analogous state cause of action. In many cases involving claims for benefits, this has been the state statute of limitations for general contract claims. However, some courts have borrowed more specific state statute of limitations. In Minnesota, courts have applied both the two year statute of limitations which applies to wage and hour claims when an ERISA claim for benefits due is brought, as well as the six year statute of limitations for general contract claims. Some courts will

also look to the plan documents and enforce limitations contained in the plan documents that are reasonable.

WHERE THE SUIT MUST TAKE PLACE

With the exception of claims solely for benefits due, federal courts have exclusive jurisdiction over civil ERISA causes of action as federal questions. There is no requirement of diversity or a specific amount in controversy. When claims are solely for benefits due, state courts have concurrent jurisdiction with federal courts. ERISA's requirements regarding venue, the geographic location of where a cause of action may be brought, are liberal. A cause of action may generally be brought where the plan is administered, where the breach took place, or where the party being sued resides or may be found.

VARIOUS PROCEDURAL ISSUES

Claims Procedures

ERISA requires that plans maintain a claims procedures. In general the procedures must provide that within a certain period of time from the date a claim is received, a plan must inform a claimant if his or her claim is upheld or denied and, if denied, the specific reasons for denying the claim. The specific time period depends on the type of claim involved. The time periods range from as short as 24 hours to as long as 90 days. The claimant must be provided with reference to the specific plan provisions upon which the denial is based and the description of any additional information that may be required to perfect the claim. Information describing the plan's appeal procedure must also be provided at the same time.

The claimant or claimant's representative has the right to review pertinent documents as well as to submit written issues and comments in challenging the denial of a claim. The challenge must usually be decided again within a certain period of time of the plan's receipt of the request for review, again depending on the

type of claim involved. If the challenge is denied, in whole or in part, the plan must notify the claimant in writing of the specific reasons and plan provisions upon which the denial is based. The Department of Labor Regulations provide that when benefits are provided through insurance, the insurance carrier is the appropriate named fiduciary for purposes of claims decisions.

Exhaustion of Administrative Remedies

Requiring a plan participant or beneficiary to work through the administrative procedures (*i.e.*, exhaust administrative remedies) is a court generated rule. It is not required by or even mentioned in ERISA or the Department of Labor Regulations. Nevertheless, it is a rule that, with limited exceptions, most courts require in ERISA cases. In most cases, the court will not hear the case until the administrative procedures have been followed. Recognized exceptions include futility, irreparable harm, and failure on the part of the plan to inform the participant or beneficiary of the administrative procedures.

Standard of Review

Once in court, one of two standards of review generally applies. If the plan grants the decision- making fiduciary the discretionary authority to interpret plan terms (*e.g.*, eligibility, benefits), and to make final and binding decisions, the standard of review used by the court is "abuse of discretion." The types of factors considered by the court include whether the interpretation is consistent with the goals of the plan, whether the interpretation renders any language in the plan meaningless or internally inconsistent, whether the interpretation conflicts with the substantive or procedural requirements of ERISA, whether the interpretation is consistent, and whether the interpretation is contrary to the clear language of the plan.

If action is mandatory under the plan (*i.e.*, no discretion) or if the plan is silent regarding the fiduciary's authority to interpret plan terms, the standard of review used by the court is "de novo." This

standard is much broader than the "abuse of discretion" standard. Under the "de novo" standard, the court can reexamine the facts and review the decision without providing any deference to the fiduciary's decision. This standard clearly favors those individuals making claims against a plan. Because the "abuse of discretion" standard is preferable, employers should review their plan documents and make sure the necessary language is present.

Jury Trail

ERISA does not specify whether there is a right to trial by jury. However, the majority of the circuit courts have held that only equitable relief is available under ERISA since their review of a plan's action is done according to the common law of trusts. Generally, with the exception of a few cases, courts have not recognized any right to a trial by jury under ERISA.

APPENDIX A: 2004 COST-OF-LIVING ADJUSTMENTS

The Internal Revenue Service has issued the inflation-adjusted amounts which affect qualified retirement plans and Social Security benefits for the year 2004.

	2001	2002	2003	2004
§ 401(k)/403(b) Deferral Limit	$10,500	$11,000	$12,000	**$13,000**
§ 457 Deferral Limit	8,500	11,000	12,000	**13,000**
SIMPLE Deferral Limit	6,500	7,000	8,000	**9,000**
Catch-Up Contribution Limit to a 401(k), 403(b) or 457 plan	NA	1,000	2,000	**3,000**
Catch-Up Contribution Limit to a SIMPLE plan	NA	500	1,000	**1,500**
Compensation Cap[7]	170,000	200,000	200,000	**205,000**
§ 415(b) Defined Benefit Annual Pension Limit	140,000	160,000	160,000	**165,000**
§ 415(c) Defined Contribution Annual Addition Limit	35,000	40,000	40,000	**41,000**
Highly Compensated Employee - Compensation Threshold	85,000	90,000	90,000	**90,000**
Key Employee - Compensation Threshold for Officers	70,000	130,000	130,000	**130,000**

[7] The Compensation Cap for grandfathered participants in certain governmental plans is $305,000 for 2004.

	2001	2002	2003	2004
Social Security Wage Base	80,400	84,900	87,000	**87,900**
- OASDI Rate	6.20%	6.20%	6.20%	**6.20%**
Medicare Wage Base	Unlimited	Unlimited	Unlimited	**Unlimited**
- Medicare Hospital Insurance Rate	1.45%	1.45%	1.45%	**1.45%**
FICA Rate	7.65%	7.65%	7.65%	**7.65%**
Maximum Disparity for Integration	5.70%	5.70%	5.70%	**5.70%**
Limit on Outside Earnings to Avoid Social Security Offset				
Under Full Retirement Age[8]	10,680	11,280	11,520	**11,640**
Over Full Retirement Age[8]	Unlimited	Unlimited	Unlimited	**Unlimited**

[8] For persons born in 1939, Full Retirement Age is age 65 and 4 months.

APPENDIX B: OTHER LAWS AFFECTING EMPLOYEE BENEFIT PLANS

- **Age Discrimination in Employment Act (ADEA)** protects employees who are 40 years of age and older against certain reductions in employee benefit plans which may be age-related as well as preventing certain employment practices. The ADEA generally protects employees in this classification against discrimination which might occur in hiring, compensation, discharges and other terms, conditions or privileges of employment. Clearly, those terms and conditions would include employee benefit plans, including benefits provided pursuant to a bona fide employee benefit plan. Former employees are also protected if discrimination that is alleged arises out of or is related to the employment relationship. Independent contractors do not have ADEA protection. The ADEA covers employers in interstate commerce with at least 20 employees on each working day in at least 20 calendar weeks in the current year. State law is not preempted by the ADEA.

  The Older Workers Benefit Protection Act enacted in 1990 which includes a limited exception to the ADEA for employee pension benefit plans which require the attainment of a certain age as a condition of eligibility for normal or early retirement benefits. In addition, a defined benefit plan which provides differing benefit payment schedules dependent on whether an employee is yet receiving social security benefits is excluded from the ADEA. The Older Workers Benefit Protection Act permits execution of releases of ADEA claims provided the releases meet certain criteria.

- **Title VII of the Civil Rights Act of 1964** prohibits discriminatory practices in employment relationships on the basis of an individual's race, color, sex or national origin. Of particular focus under Title VII have been welfare plans which discriminate on the basis of sex, pregnancy, child birth, or related medical conditions. As a general rule, the employer must provide benefit plans which treat pregnancy related medical conditions in a manner similar to other medical conditions. If the same benefits that are provided to spouses and dependents of male employees are also provided to female employees or their spouses and dependents there is no Title VII discrimination on the basis of sex.

- **Americans With Disabilities Act** prohibits discrimination in hiring and employment practices against disabled persons. An employer cannot use a benefit plan's exclusions as an excuse to refuse to hire or to terminate an individual with a disability; nor can an employer claim that the anticipated cost increases of benefits would be a legitimate defense to refusing to hire such an individual. Disabled individuals must be provided equal access to employee benefits available to other employees. Coverage cannot be denied or limited to disabled employees nor can the cost be increased simply because of a disability.

- **Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)** requires employers after the occurrence of certain qualified events to offer employees covered by an employer sponsored group health plan to elect to continue their health coverage on a self-pay basis. COBRA is described more fully in Section III(e)(2).

- **Veterans Reemployment Rights Act** requires employers to re-employ veterans upon return provided that the employee applies for reinstatement within 90 days after release for seniority status and pay he would have had but for the military service.

- **Labor Management Relations Act (LMRA)** regulates employer relations with employees represented by a labor union or other organization representing employees. One provision of the LMRA restricts financial transactions between employers, employees or their representatives. The LMRA prohibits employers from paying, lending or offering money or cash equivalents or other items of value to a representative of any of its employees, or to a labor organization or its officers or employees unless such money is paid to a separately established trust fund which is solely and exclusively for the benefit of employees, their families and dependents. Trust assets must be used to pay for medical care, pension or retirement benefits, compensation for illness or injury resulting from the job, unemployment benefits, life insurance, disability and sickness or accident insurance. Certain specific provisions apply to the way such trust funds must be established. See 29 USCA 186(c)(5).

- **Uniformed Services Employment and Reemployment Rights Act of 1994** requires employers to credit an employee who serves in the armed services, upon return from the service, for purposes of avoiding a break-in-service, accruing benefits, and for purposes of vesting.

- **Sarbanes-Oxley Act of 2002** was enacted in response to the corporate scandals that resulted in the bankruptcy of high profile public companies such as Enron and WorldCom. Sarbanes-Oxley requires employers to provide notices to employees in the event of any pension plan "black-out" and prohibits certain officers and directors of public companies from selling company stock during a pension plan "black-out."

APPENDIX C: CHANGES IN STATUS WHICH MAY PERMIT A CHANGE IN BENEFIT ELECTIONS

- **Changes in Status Affecting Premium Conversion Elections**

  If the cost of coverage under a medical plan which is funded by salary reduction increases or decreases, salary reductions may automatically be modified on a reasonable and consistent basis in proportion to the changes in the cost of the party's benefit funded by salary reduction to the extent permitted by law.

  If the coverage under a Medicare plan is significantly curtailed, an election may be revoked and a participant may receive coverage under another Medicare plan with similar coverage, if offered by the employer. Changes in coverage also includes mid-year changes in coverage of a spouse or dependent under another employer plan due to differing enrollment periods of the spouse's or dependent's employer plan. Any election change made under the exception must be made on account of and corresponding to the actual election made by the participant's spouse or dependent.

- **Changes in Status Affecting Health Benefit Elections**

  A participant may change or revoke his or her previous election concerning medical insurance premium payments or health care reimbursement benefits at any time during the plan year if there is one or more of the following, significant changes in a participant's status. A revocation of a plan election during a period of coverage and a new election for the remaining portion of the period must be consistent with the change in status. In order to be consistent, the change in status must result in the participant or the participant's spouse or dependent gaining or

losing eligibility for accident or health coverage under his or her plan or an accident or health plan of his or her spouse's or dependent's employer, and the election change must correspond with that gain or loss of coverage. The following events are considered status changes for this purpose:

- change in legal marital status such as death, marriage, divorce, legal separation, or annulment;

- change in number of dependents because of birth, death, adoption, or placement for adoption of the participant's child;

- change in employment status such as:

    1) termination or commencement of the participant's employment or his or her spouse's or dependent's employment;

    2) reduction or increase in hours of employment by the participant or the participant's spouse or dependent (such as a change from full-time to part-time, or vice versa);

    3) commencement or return from an unpaid leave of absence by the participant or the participant's spouse or dependent;

    4) changes that would affect eligibility for benefits such as changes from hourly to salaried;

    5) a change in residence or worksite;

    6) a strike or lockout;

    7) changes in eligibility rules for an employer-sponsored plan which result in a change in the participant's eligibility;

- the participant's dependent satisfies or ceases to satisfy the requirements for unmarried dependents due to attainment of age, student status, or similar circumstance provided in the accident or health plan under which the participant receives coverage;

- issuance of a court order, judgment or decree (such as a Qualified Medical Child Support Order) requiring the participant or the participant's spouse or former spouse to provide accident or health coverage to the participant's child; or

- other events as may be permitted under regulations of rulings of the Internal Revenue Service.

- **Changes in Status Affecting Dependent Care Elections**

  The rules are slightly different if a participant wishes to change his or her election concerning the dependent care reimbursement benefit. In that case, any revocation and new election must be on account of and consistent with one of the following significant changes in the participant's status:

  - marriage, separation or divorce;

  - death of a spouse or child;

  - birth or adoption of a dependent;

  - termination or commencement of the spouse's employment;

  - commencing an approved unpaid leave of absence by the participant or the participant's spouse;

  - a dependent reaching age 13 and no longer coming within the definition of dependent; or

- certain changes in cost or coverage of dependent care such as changes in cost if imposed by a dependent care provider who is not a relative or changes in cost due to reduction or increased hours.

If a change in status occurs, the participant must inform the plan administrator of his or her new election within 30 days of the occurrence. The participant's election change will take effect on the latest of (i) the date the change in status occurs, (ii) the date evidence of insurability is approved, or (iii) the first day of the payroll period after the plan administrator has received his or her request for election change.

- **Changes in Status Related to FMLA Leave**

A participant may also revoke his or her election relating to medical insurance premium payments or health care reimbursements for the plan year if the participant takes an unpaid FMLA leave. FMLA leave is a leave of absence provided for by the Family and Medical Leave Act of 1993. The participant's election may be revoked for the period of his or her FMLA leave. Upon returning, the participant's election will be reinstated to the same level of coverage as the participant had before his or her FMLA leave. The participant may change that election if a return from FMLA leave is considered a change in status. In addition, if a change in status occurs during the participant's FMLA leave, the participant may change or revoke an election as described above. The participant must revoke his or her election relating to dependent care reimbursement if he or she takes an FMLA leave. Upon the participant's return from leave, he or she may reinstate such election to the same level of coverage as he or she had before the FMLA leave. The participant may change such election if his or her return from FMLA leave constitutes a change in status.

- **Changes in Status Related to Medicare and Medicaid Eligibility**

  A participant may reduce or cancel his or her election relating to medical insurance premium payments if the participant or the participant's spouse or dependent becomes enrolled in Medicare Parts I or II or Medicaid (other than coverage consisting solely of distribution of pediatric vaccines.) Further, the participant may increase or add his or her election relating to medical insurance premium payments if the participant or the participant's spouse or dependent loses eligibility to coverage under Medicare Part I or II or Medicaid (other than coverage consisting solely of distribution of pediatric vaccines.)

- **Changes in Status Related to Key Employees**

  The plan administrator may modify a participant's election downward during the plan year if the participant is a 5% owner of the employer, a highly compensated officer or employee, or a member of the "highly paid" group of employees (as defined by the Internal Revenue Code), if necessary to prevent a plan from becoming discriminatory within the meaning of federal income tax law. The plan administrator may also adjust a participant's election if the cost of insured benefits changes during the Plan Year.

APPENDIX D: OVERVIEW OF HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) PRIVACY REQUIREMENTS

Many businesses and employers need to stop and consider what preparations they need to make in order to prepare for the April 14, 2003 compliance date (April 14, 2004 for small group health plans) for the Privacy Rule under HIPAA, or the Health Insurance Portability and Accountability Act of 1996. The U.S. Department of Health and Human Services (HHS) released final changes to the privacy regulations which were published in the Federal Register on August 14, 2002.

Covered entities (health care providers, health care clearinghouses, and group health plans) that conduct certain electronic transactions, such as claims submissions, must meet each of HIPAA's dozens of different privacy safeguards and recordkeeping requirements that are intended to protect patient confidentiality. The HIPAA Privacy Rule protects Protected Health Information (PHI), which is any individually identifiable health information that is created by or received from a health care provider, health plan, or health care clearinghouse and relates to the past, present, or future physical or mental health of an individual or payment for health services. HIPAA also provides other requirements which are not addressed in this Appendix, including security and electronic transmission requirements.

Group Health Plans Sponsored by Employers

An employer which sponsors a group health plan is a covered entity and may have to comply with various HIPAA requirements as the plan sponsor of the group health plan (including a health care reimbursement account plan) and most employee assistance plans. HIPAA compliance is not required if the employer's group

health plan is fully insured and the employer's access and use of individually identifiable health information is limited to participant data used for enrollment and disenrollment purposes and/or summary information for purposes of underwriting and determining whether to amend or terminate the group health plan.

De-identified summary health information is not PHI and thus forces no employer/plan sponsor compliance. However, if the employer as plan sponsor has access to PHI from the plan, has the responsibility for ruling on benefit appeals under the plan, or otherwise has access to PHI, the group health plan will need to be amended for HIPAA to comply with the Privacy Rule, and the employer as plan sponsor will need to certify that they will only use the PHI that they receive in accordance with the Privacy Rule. Self-funded group health plans which are administered by the employer (including FSAs and medical reimbursement plans) will need to adopt many of the HIPAA administrative and data security requirements imposed on covered entities, including clarifying job descriptions and company policies to designate which employees have access to PHI for purposes of operating the group health plan and imposing firewalls to prevent this access to PHI from being used for other purposes, such as decisions regarding employment status. Many smaller employers (who may have fully funded health plans) are currently making arrangements for outside administration and claims and appeals processing of their health care flexible spending accounts to reduce HIPAA compliance duties.

Not all individually identifiable health information that an employer receives would be considered PHI subject to the Privacy Rule, only that created by or received from a covered entity. For example, information that a supervisor receives about an employee's health related absence or FMLA leave status is not PHI unless it is information received from the group health plan or it is being used for health plan operations. Disability plans and workers' compensation arrangements are not covered entities, so information received for these purposes is not subject to the

HIPAA Privacy Rule unless or until it is later used for purposes of administering the group health plan. The implications of this rule on integrated disability/health plan arrangements are complex.

Use and Disclosure of PHI by a Covered Entity

Covered entities may not use or disclose any PHI except for treatment, payment, or health care operations without the authorization of the patient unless the Privacy Rule allows or requires such disclosure, for example the mandatory reporting of child abuse. The final regulations no longer require a covered entity to obtain a patient's consent prior to treatment, payment, or health care operations, and have instead substituted a requirement that direct health care providers make a "good faith effort" to obtain a written acknowledgement of receipt of the provider's Notice of Privacy Practices. Health plans now have the discretion to obtain this acknowledgement, but it is not required. The final amendments make the written consent optional for all covered entities, including providers with direct treatment relationships, but "more stringent" state laws will still apply, such as the Minnesota law requiring a patient's written consent prior to the disclosure of health information to unrelated entities.

Patients must sign an authorization prior to the use or disclosure of PHI for any purpose other than treatment, payment, and health care operations (unless the disclosure is otherwise provided for in the Privacy Rule, which primarily addresses public safety disclosures). There are special more restrictive rules for authorizations for use of the PHI regarding the release of psychotherapy notes, as well as special rules which apply to authorizations for use of PHI for research or marketing. Generally the new changes have simplified the authorization requirements so that an effective authorization must have the following:

- Description of the PHI to be disclosed
- Identity of the user and/or sender
- Identity of the desired recipient

- Purpose of the use or disclosure
- An expiration date or event for the authorization
- An explanation that the authorization can be revoked
- A description of the consequences (if any) should the patient refuse to sign, and
- The patient's signature and date

In many cases the changed regulations would allow authorizations for multiple purposes of uses or releases to be combined into a single authorization form.

Business Associates

While HIPAA applies directly only to covered entities (health care providers, health plans, and health care clearinghouses), it also requires entities to address privacy issues with their "business associates." Any other entity which receives or has access to PHI from a covered entity must incorporate mandatory contractual provisions requiring business associates to maintain safeguards against unauthorized uses or disclosures. In some instances the covered entity may be liable for the privacy violations by business associates. If no contract currently exists between the covered entity and the business associate, a contract which includes HIPAA Privacy Rule provisions must be entered into by April 14, 2003. Covered entities which already have a current written contract with their business associates have until the earlier of the expiration of the term of their current contract or April 14, 2004.

Administrative Requirements

Covered entities must implement a number of administrative requirements. These include naming a privacy officer, creating a compliance process, training the workforce regarding the security of PHI, implementing policies to assure that the information disclosed (in most cases, but not for treatment) is limited to the

minimum necessary for the purpose of the disclosure and must mitigate unauthorized uses and disclosures, creating sanctions against those who fail to comply with the Privacy Rule, maintaining and retaining documents regarding the medical record, enabling patients to be able to request a copy of their medical records, implementing a process for patients to submit proposed amendments to their medical record (with a review and denial procedure for the covered entity to follow), and keeping an accounting of the disclosures of PHI to be released upon request by the patient or the HHS. The administrative requirements of HIPAA are complex and will require time and resources to implement. Here are some first steps towards HIPAA compliance:

- Designate a Privacy Officer with the authority and obligation to ensure compliance with the HIPAA Privacy Rule by April 14, 2003
- Review current data collection and disclosure practices and modify as needed
- Identify employees with access to PHI
- Draft HIPAA-compliant policies and procedures for handling individually identifiable health data and adjust job descriptions of affected employees to include HIPAA compliance responsibilities
- Ensure that only staff needing to look at data about an individual have access to the PHI, that PHI received or maintained on individuals is only shared with others who need to have access to this information, and that the minimum necessary data is disclosed when disclosure is warranted (except for treatment purposes)
- Develop a tracking system to allow patients to receive an accounting of the disclosures of their PHI (except for uses for payment, treatment, or health care operations)

- Implement procedures for patients to be able to access, and when appropriate, amend their health data
- Verify that all business associates are also in compliance with the HIPAA Privacy Rule by incorporating HIPAA provisions into contracts and agreements
- Provide a Notice of Privacy Practices to all patients concerning their rights under HIPAA
- Develop due process protections, including a complaints process for patients and sanctions for non-compliance

HIPAA violations are subject to both civil and criminal penalties, so it is important that the Privacy Officer be someone with the authority and resources to assure that the company will meet the rapidly approaching compliance date. Whether you are an employer sponsoring a group health plan wondering what (if any) steps you must take to assure HIPAA compliance or a health care provider attempting to apply the newly revised hybrid entities rules for your various business groups, professional assistance with this tricky compliance task is highly recommended.

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