



Employee Retirement Income Security Act (ERISA) and your Welfare Benefit Plan

An overview and resource handbook
for employers and their HR professionals

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Unum: Your benefits partner



We are a company of people serving people. When you choose Unum as your employee benefits provider, you're in the hands of 10,000 people dedicated to providing better benefits to organizations of all sizes and their employees.

Rooted in a heritage of more than 150 years, employee benefits are our singular passion and focus. Our innovations have set new standards for our industry and helped us grow into one of the nation's leading providers.

Using this handbook

The Employee Retirement Income Security Act of 1974 (also known as “ERISA”) was forged at a time when high-profile abuses in the funding and administration of pension plans compelled Congress to act. From its beginning over 30 years ago, ERISA has set minimum, consistent standards for managing employee benefits, such as those benefits insured or administered by Unum. These standards generally govern benefit plan decision-making, the disclosure of information to employees and the reporting of plan information to the federal government. Today, the U.S. Department of Labor (DOL) — in particular, its Employee Benefit Security Administration (EBSA) — has primary responsibility for administering and enforcing ERISA.

While it is fair to say that most employers want to fulfill their benefit promises and provide employees with the information they need in order to take advantage of their benefits, ERISA continues to protect employees from those employers who do not.

For employers complying with many state and federal requirements, the reality is that they may take on ERISA responsibilities simply by offering benefits to employees. This happens routinely, for example, when an employer chooses to provide group health insurance or a pension plan for its employees. Once that decision is made, adding other employee benefits may simply extend an employer's responsibilities under ERISA to those new benefits being offered.

ERISA matters to you

Admittedly, there are penalties for failing to comply with ERISA requirements. These range from simple fines for each day of a violation to criminal penalties that can be imposed personally on individuals administering the plan. Plan administrators can also be required to make up losses suffered by their plans when they violate their duty to manage and administer the plan in compliance with ERISA.

Nevertheless, ERISA doesn't require that a business provide any particular type of benefit or any benefits at all. However, ERISA does set high standards for the administration of the benefit plans that a business does decide to provide.

The good news for employers is that ERISA has made employee benefit plan administration more uniform nationally, which can greatly simplify benefit administration for a geographically diverse workforce as well as help level the playing field when you're competing for qualified employees.



Helping you keep your business on track

For years, we've been helping employers like you ensure that your welfare benefits satisfy ERISA's requirements through our ERISA-compliant claims and appeal processes, the employee booklets we provide for group insurance and the assistance we offer you in your efforts to report paid premiums, commissions and fees to the federal government. Through resources such as this handbook, we try to make it easier for you to manage the employee benefits you offer by partnering with Unum. It's part of our commitment to help you get the most from your benefit plans.

Please keep in mind, though, that in this handbook we focus only on welfare benefit plans — not 401(k) plans or other retirement or pension plans.

Although this publication is designed to give you an overview of some of ERISA's most important requirements, it doesn't describe every requirement or each exception or special rule. So you'll want to seek the advice of your own professional advisors — perhaps your company's attorney, accountant or tax professional — when you have questions specific to your plan.

PART 1:

When ERISA impacts your business

While you are free to choose the type of employee benefits, if any, to provide or make available to employees, if you offer certain benefits, your business will be required to comply with ERISA. That said, understanding ERISA, with all its complexities, could easily become a full-time job. Our goal at Unum is to familiarize you with the basics and help you make sure your business is in compliance.

Because ERISA regulates employee benefit plans, the first step is to list each benefit that your business provides and figure out whether each benefit, by itself, or with other benefits, is offered as part of an employee benefit plan that Congress decided should be subject to ERISA. Doing this will help you figure out if ERISA applies to any of your employee benefit plans.

ERISA contains a rather complicated definition of the term “employee welfare benefit plan.” Generally, this definition has several elements and each must be satisfied before your benefit program would be considered an ERISA-covered welfare plan. To get a handle on this, we’ll break the definition down into its five elements, one step at a time, by asking:

FIRST STEP – Are you providing any “welfare benefits” under ERISA?

SECOND STEP – Does your welfare benefit plan have “participants” and “beneficiaries”?

THIRD STEP – Is there enough detail to show you’ve got a plan, fund or program?

FOURTH STEP – Is your benefit program “established or maintained” by an “employer” or “employee organization”?

FIFTH STEP – Are you ready to make the call?

SIXTH STEP – Have you remembered the exemptions?

FIRST STEP

Are you providing any “welfare benefits” under ERISA?

ERISA regulates a wide variety of non-retirement benefits called “welfare benefits.” These can include the following benefits:

- | | | |
|------------|-----------------|------------------------------|
| medical | death | scholarship funds |
| hospital | unemployment | prepaid legal services |
| sickness | vacation | holiday & severance programs |
| accident | training | surgical |
| disability | daycare centers | |

This means, for example, that the types of insured benefits offered by Unum — life, disability income, long term care, critical illness, hospital indemnity and accident insurance benefits — would be considered “welfare benefits” under ERISA.

On the other hand, welfare benefits under ERISA do not generally include payment of “compensation” while an employee is on vacation or out sick if benefits are paid out of an employer’s general assets as a routine payroll practice. This means that many sick pay or salary continuation programs may not be ERISA welfare plans. As an example, when Unum provides administrative services only (and no insurance) in support of an employer’s self-funded, self-insured short term disability plan, Unum is often assisting with non-ERISA plans.



Did you know?

A cafeteria plan, also known as a Section 125 plan, would technically be viewed as a mere funding vehicle that allows employees to pay for certain benefits on a pre-tax basis; it would not be considered a welfare benefit. Instead, it is the actual benefit(s) paid for through the cafeteria plan that may be considered ERISA plan(s).

SECOND STEP

Does your welfare benefit plan have “participants” and “beneficiaries”?

A benefit program won’t be an ERISA plan unless it provides benefits to “participants and beneficiaries.” A participant is an employee or former employee of an employer (or member or former member of an employee organization) who is eligible for (but not necessarily “receiving”) benefits under the plan. Any person designated by a participant or designated by the terms of a plan as someone who is or may become entitled to a benefit (other than the employee) is a beneficiary.

A benefit plan that only has one participant can still be an ERISA plan. Unlike some other federal laws, such as the Family and Medical Leave Act (FMLA), there is no minimum number of employees required before an employer must comply with ERISA.

A benefit plan without employee participants isn’t an ERISA plan. For example, an individual and his or her spouse are not counted as employees of the business if they own the business. So, a plan that covers only an owner and his or her spouse is not an ERISA-covered plan.

THIRD STEP



Is there enough detail to show you've got a plan, fund or program?

ERISA applies only if benefits are offered through a “plan, fund or program.” A “plan, fund or program” would likely exist if:

- your employer has identified a specific benefit to be provided, including who would be eligible for the benefit;
- your employer has determined how the benefit would be provided and paid for (such as through insurance) and has set up a mechanism for the payment; and
- there is an ongoing administrative scheme to provide the benefit.

While your purchase of insurance for employees would not, by itself, necessarily demonstrate that you have a plan, fund or program, it is an important factor to consider, along with the other actions taken and the additional documentation that exists regarding the particular benefit plan.

Interestingly, while ERISA does require that your employee benefit plan be described in a written document, you need not rely on a single document to meet this requirement. Instead, you may designate multiple documents as making up your plan documents. Those documents could include insurance policies, administrative services agreements, board of director resolutions, employer memos and employee communications. From a best practices perspective, actually designating the documents that comprise your plan will make your job easier when it's time for you to provide the ERISA-required disclosures discussed later in this handbook and when you need to explain or justify benefit plan determinations.

As an employer offering more than one welfare benefit program, your advisors may suggest that you streamline your plan documentation, administration, reporting and disclosures by structuring all your benefits as a single ERISA plan. In the event some of your programs accumulate funds, a single plan structure could make it easier for you to apply funds accumulated under one benefit program to another.

FOURTH STEP

Is your benefit program “established or maintained” by an “employer” or “employee organization”?



Only those welfare benefit programs “established or maintained” by an employer for its employees or by an employee organization for its members are regulated by ERISA. Setting aside the concept of “established or maintained” for a moment, this step requires you to identify whether an employer or employee organization is involved with your benefit plan.

Whether an employer-employee relationship exists depends on many factors. Most often, an “employer” can be identified by its compliance with U.S. Internal Revenue Service (IRS) Form W-2 income reporting requirements applicable to its employees.

An employee organization is, literally, an organization formed by or on behalf of employees to deal with employers in matters affecting their employment relationship. The most common examples include labor unions, employee representation committees and employee beneficiary associations. Employee organizations do not include associations of individuals with particular interests unrelated to their employer, such as the AARP, AMA, ABA and AAA. Without the involvement of an employer or employee organization, ERISA would not apply to that benefit program. For purposes of this handbook, we’re focusing on employers, not employee organizations.

If you have identified your employer as involved with a particular welfare benefit, your attention needs to shift to whether it has “established” or “maintains” the benefit program. To do so, you will need to keep in mind that benefits don’t automatically meet this requirement simply because they are available through the workplace. Terms like “establish” and “maintain” have particular meaning in the context of ERISA plans. Whether your employer’s actions reflect this type of effort will often depend on the unique characteristics of each benefit plan arrangement. Certain factors weigh more heavily than others. In fact, many employers believe they are so minimally involved in 100% employee-paid benefit programs that they have not “established” and do not “maintain” that program. This is not always true.

With no clear definitions in the law, the DOL and the courts have identified certain factors that employers can consider when trying to determine whether they have established or currently maintain an ERISA benefit program.

As an employer, you are more likely to be viewed as establishing or maintaining a benefit program for your employees (and be subject to ERISA) if you do one or more of the following:

- pay or reimburse employees for premium;
- offer the benefit program under a flexible benefit or cafeteria plan;
- choose insurers;
- endorse the benefit program and permit your logo to be used by the insurer in marketing the program;
- suggest or negotiate insurance policy design, terms and premium rates with the insurer;
- run enrollment meetings;
- review and approve literature to be distributed to your employees;
- limit the number of insurers soliciting business in your workplace;
- prepare claim forms for employees;
- allow your company's name to be used on the insurer's marketing materials;
- answer employee questions about the insurance policy;
- permit enrollment meetings during business hours;
- distribute certificates, enrollment forms and waiver cards; and/or
- permit employees to receive a group discount on individual policies.

Because this list is presented in order of likelihood of making your benefit program an ERISA plan, it means that, for example, the first bulleted factor (namely employer-paid premium) is the factor that most significantly could cause a benefit to be considered established or maintained by the employer.

At the same time, as an employer, you may be less likely to be seen as establishing or maintaining a benefit program if you merely do the following:

- permit employees to receive group rates on group policies;
- serve as policyholder on the group insurance policy covering employees;
- permit the insurer to advertise its policy and distribute information about the policy to employees; and/or
- deduct and remit employee premiums at the employees' direction.

Importantly, all of these bulleted factors in both of these lists aren't necessarily equal in weight. Which ones are involved and how they are combined in a particular situation can also affect whether your business will be seen as "establishing" or "maintaining" a benefit program.

FIFTH STEP

Are you ready to make the call?

It's impossible for this handbook or Unum to tell you whether or not your benefit program will need to comply with ERISA. However, using this six-step process should help you organize your thoughts about your welfare benefit program(s). Moreover, if you believe your benefit plan may not be governed by ERISA, talk with your company's professional advisors — perhaps your company's attorney, accountant or tax professional — who can address your specific concerns.

SIXTH STEP

Have you remembered the exemptions?

When you speak with your advisor, you might want to ask whether your benefit program qualifies for the voluntary insurance exemption — meaning that your benefit program wouldn't have to comply with ERISA requirements because it is exempt. This exemption applies to welfare benefit programs that meet all five of these conditions:



- The benefit is provided under voluntary insurance. While you are probably familiar with group insurance where a policy is issued to an employer to provide benefits for its employees, the concept of “voluntary” insurance may be new to you. This term refers to the practice of offering voluntary insurance policies to employees in the workplace. Each qualifying employee then has the opportunity to choose whether to enroll in and pay for the coverage.
- You, as the employer, make no contributions — meaning that you pay no premiums or plan expenses related to the particular benefit program.
- Employee participation in the benefit program is completely voluntary.
- Without **endorsing** the program, your sole involvement is to permit an insurer to publicize the program to employees and to pay premiums through payroll deductions.
- You receive no monetary compensation in connection with the benefit plan other than reasonable compensation for the payroll deduction administrative services you actually provide.

Interestingly, the fourth bullet — that an employer refrain from endorsing the program — is often the most difficult for employers to satisfy. Although the law is still evolving, one court has explained it by acknowledging that employers may be considered to have “endorsed” their benefit programs when an objective employee could conclude based on the employer's actions that the employer had not merely facilitated the program's availability but had exercised control over it or made it appear to be part of the employer's benefit package.

In addition to the voluntary insurance exemption, the following plans are exempt from ERISA:

- plans maintained by government entities for their employees, such as plans covering employees of the federal government, any city, county or state government and any federal or state agency (including public schools, community colleges, state universities, and city and county hospitals). Note that a plan that covers government employees might be covered by ERISA if it is not maintained by the government, but is maintained by a union;
- church plans that do not choose to be covered by ERISA;
- plans maintained solely to comply with state workers' compensation or unemployment compensation laws;
- plans put in place by an employer only to comply with the state disability laws in California, Hawaii, New Jersey, New York, Rhode Island and Puerto Rico (also called "statutory plans"); and
- non-U.S. benefit plans covering non-U.S. citizens.

This means that these types of plans, even though the first five steps might cause you to conclude the plan had to comply with ERISA requirements, have been excused from ERISA requirements and have no decision-making, reporting or disclosure obligations under ERISA.

While there are other exemptions and special rules influencing whether any particular benefit program will be considered an ERISA plan, with this part of the handbook, you now have a framework for thinking about when you may be providing benefits that trigger obligations for you under ERISA. In the next several parts, we'll cover what those obligations are and provide you with some resources to help you meet those obligations.

PART 2:

What ERISA means for you

Minimum requirements

Focusing on welfare benefit plans only, ERISA puts in place a set of minimum requirements for those tasked with administering employee benefits. In particular, these requirements address three types of activities for those with plan administrator responsibilities:

- **Disclosing** the content and provision of the benefit plan in documents such as a summary plan description (SPD), which must be delivered to employees and other plan participants; and
- **Reporting** information about your benefit plan(s) to the DOL on Annual Report Form 5500; and
- **Being** accountable as a “fiduciary” for administering the plan and handling its assets, if any.

In Parts 3, 4 and 5 of this handbook, we’ll look at these three requirements in more detail. But first, let’s identify who the key players are when it comes to these activities.



Who does what?

ERISA has some special names for those involved with benefit plans. For example, your plan has a “sponsor,” a “plan administrator” and “fiduciaries.” Here’s a description of who fulfills each role. As you’ll see, not only can one person or entity fill all of these roles, but the roles can overlap.

The **sponsor** is the employer (or employee organization) that created and maintains your benefit plan.

The **plan administrator** is the entity or individual with responsibility for complying with ERISA reporting and disclosure requirements. The plan administrator is often the plan sponsor, although a particular person or group of people (including you) is usually charged with filling the role of plan administrator. (In fact, we’ve prepared this handbook with you and others like you in mind.) Beyond reporting and disclosure duties, your plan may also ask the plan administrator to take on other administrative duties. The plan administrator is also a fiduciary, which is described next. Notably, though, service providers like payroll vendors and third-party administrators usually only carry out routine administrative tasks rather than agree to take on specific decision-making functions on behalf of plan administrators. For this reason, service providers infrequently serve as true plan administrators under ERISA.

Broadly speaking, a **fiduciary** is an individual or entity with discretionary authority or control over your benefit plan, its administration or its assets. ERISA requires that your benefit plan document actually identify a specific fiduciary, called the **named fiduciary**, with authority and responsibility for the administration of the plan and management of its assets. Even if not “named” in your plan document, others with specific responsibilities to the plan can also be fiduciaries, such as insurers (often referred to as **claim fiduciaries**), certain third-party administrators and other plan advisors such as consultants. Other advisors such as lawyers, actuaries and accountants when providing professional services to a benefit plan would not typically be considered fiduciaries since they usually lack the authority to control the plan. It’s important to remember that a person or entity will be a fiduciary when performing certain functions or having certain responsibilities for the plan, regardless of whether that person or entity was identified as a fiduciary or even understood its fiduciary responsibilities. See Part 5 of this handbook for more information about fiduciaries.

PART 3:

Providing the details of your plan to those who may benefit



Fundamental to ERISA is the recognition that when employers disclose benefit plan information, employees are in a much better position to understand, exercise and enforce their rights under the plan. With this in mind, ERISA most notably requires plan administrators to provide three disclosure documents to participants:

- Summary Plan Description (SPD);
- Summary of Material Modification (SMM); and
- Summary Annual Report (SAR) for plans with 100 or more participants (unless an exemption applies).

SPD: Summary Plan Description

The SPD is a written document, or series of documents, often prepared by or for the plan administrator. It summarizes the important features of your benefit plan. You must distribute it to all covered participants.

The format and content of your SPD are explicitly dictated by ERISA and related DOL regulations. For example, you must use very specific language explaining participants' rights under your plan. In addition, the SPD must provide important information about your benefit plan such as:

- your plan's name, the plan year and type, the names and addresses of the plan sponsor and plan administrator, and plan funding (including the name of the insurer, if any);
- detailed information about plan eligibility requirements, plan benefits, and rights upon plan termination; and
- an explanation of claims procedures and how to appeal a claim determination.

For more information about these detailed requirements, please refer to **Appendix A** for our **SPD Content Checklist**. If you have to prepare an SPD, the checklist can help you identify and collect the information you'll need to write it.

SMM: Summary of Material Modifications

An SMM is a written document that updates or amends an SPD by summarizing any material change to that existing SPD. An SMM could take the form of the annual benefits update you provide employees at open enrollment time or the summaries of benefits you provide employees when you change insurers. It's important that you disclose in a timely fashion any material change in your benefit plan not previously reflected in your current SPD. To determine whether a plan change is "material," you might look at it from the perspective of a plan

participant. Is the change something a participant would like or need to know? Would it cause a participant to do something differently if she or he knew about the change? If so, you might need to distribute to all participants an SMM reflecting that change.

SAR: Summary Annual Report

An SAR is also a written document. It is a summary of certain information about the plan, focused on the most recent plan year. It summarizes the employer funding and financial information furnished to the DOL on the plan's Annual Report Form 5500. For a welfare benefit plan, the SAR is very short. A sample format is found in the Code of Federal Regulations, specifically 29 CFR 2520.104b-10(d)(4). These regulations are available from the DOL at http://www.dol.gov/dol/allcfr/Title_29/Part_2520/29CFR2520.104b-10.htm.

Additional disclosure obligations: Responding to requests from employees

You will want to keep your plan's disclosure documents readily available. This is because you must have available for examination and must provide upon written request copies of certain documents to participants such as:

- the most recent SPD and any SMMs issued after that SPD;
- the most recent Form 5500, including all schedules (see Part 4 of this handbook for more information about this form); and
- the current plan documents — those that established and guide the operation of your plan.

These obligations are coupled with some potential penalties. In addition to a plan participant's right to bring a lawsuit for failure to provide these documents, a plan sponsor can be fined \$110 per day for failing to provide an SPD or SMM within 30 days of a written request. Willful violations of ERISA requirements, including the SPD requirements can also result in criminal penalties of up to \$500,000 and jail time up to 10 years.

WHEN TO DISCLOSE:

A chart to keep it straight

Use this chart as you think about how ERISA disclosure requirements might apply to your insured plan. Keep in mind that different requirements may apply if your plan is self-insured or partially self-insured. Always consult your advisors with specific questions about disclosure.

Time requirements for delivery of disclosure documents	
Type of disclosure document & event	Standard delivery deadlines
SPD	
Upon creation of plan	Within 120 days
Upon admission of a new participant	Within 90 days
If any plan amendment has been made	Updated every 5 years
When no plan amendments have been made	Updated every 10 years
SMM (or a new SPD)	
Upon any material change in the plan	Within 210 days after the end of the plan year in which the change is adopted
Upon material reduction in benefits or services under a group health plan	Generally, within 60 days of adoption of any reduction
SAR	
Annually to all participants	Within 9 months after the end of the plan year

How to disclose: Can I do it electronically?

The DOL has provided guidance on acceptable techniques for providing the required disclosures. Importantly, the technique you choose to use must be reasonably calculated to result in actual receipt by, and full distribution to, all your plan participants. The DOL has indicated that, depending upon the specific circumstances, first-class mail delivery and hand delivery as well as inclusion in a company publication may meet the requirements of actual receipt and full distribution. However, with so many different ERISA disclosure requirements, it's no wonder that many plan administrators want to furnish information to plan participants electronically rather than in paper form.

To address this, the DOL developed regulatory guidelines outlining some, but not all, of the ways you can satisfy these participant disclosure requirements through electronic disclosure. If you follow these guidelines, you can make sure your electronic disclosures, including SPDs, SMMs, and SARs, meet all DOL requirements. The full text of the DOL regulations on electronic disclosure appears at 29 CFR Section 2520.104b-1(c). This document is available at

http://www.dol.gov/dol/allcfr/Title_29/Part_2520/29CFR2520.104b-1.htm.

These electronic disclosure rules can be complex; while we provide an overview below, it is important that you (or your advisors) carefully review these regulations before relying on electronic disclosures.

Making sure your employees get the required information that you distribute electronically

You'll need to make sure your plan participants actually receive the electronic versions, using the same care as you would with hard-copy materials. This could include tracking actual receipt through return receipts, notices of undelivered electronic mail or surveys to confirm the information sent was received.

In addition, your electronic delivery system will need to:

- protect the confidentiality of individual account and benefit information;
- meet all style, format and content requirements applicable to the particular document (in reality, this doesn't mean that the electronic version ends up looking identical to the paper form); and
- be accompanied by notice (electronic or paper) of the importance of the document and the recipient's right to receive, upon request, a paper version.

Simply providing disclosure through computers located in a common area workstation or kiosk will not satisfy the DOL guidelines on electronic disclosure of required documents such as SPDs and SMMs.

While it is true that electronic delivery is most often used to communicate with workplace employees who have computers at their individual workstations, it isn't restricted to worksite locations. For employees who access and use electronic information as part of their job duties, you can send ERISA disclosures electronically to the location where they are reasonably expected to perform their duties, either inside or outside the workplace, without their prior consent. Even if you have individuals who do not use electronic information systems as an integral part of their job duties, you can still deliver information electronically if those individuals give their affirmative informed consent.

The DOL regulations provide many details about the information that must be provided when consent is required, as well as how the consent should be worded and how it should be delivered.

Foreign language statement: Is disclosing in English enough?

If your plan covers participants who are not literate in English but who can read and speak in a foreign language, your SPD and SAR may need to include statements in their non-English language explaining how they can get plan information.

You must provide a foreign language notice if:

- your plan covers fewer than 100 participants at the beginning of the plan year, and 25% or more of them are illiterate in English but speak and read the same foreign language; or

- your plan covers 100 or more participants at the beginning of the plan year, and the lesser of 500 or 10% or more of all participants are illiterate in English but speak and read the same foreign language.

Here is the DOL's suggested wording that should be translated into the appropriate foreign language:

This [Summary Annual Report/Summary Plan Description] contains a summary in English of your plan rights and benefits under [employer's name]'s [name of plan]. If you have difficulty understanding any part of this [Summary Annual Report/ Summary Plan Description], contact [name of plan administrator], the plan administrator, at [his or her] office at [complete address of plan administrator]. Office hours are from [time] A.M. to [time] P.M. [day of the week] through [day of the week]. You may also call the plan administrator's office at [plan administrator's telephone number] for assistance.

Helping you prepare your SPD

When your company purchases Unum group insurance, we can provide at your direction an insurance certificate with supplemental ERISA disclosure pages (together we refer to these documents as an employee "booklet") for distribution to plan participants. By delivering this booklet to your employees, you generally will have satisfied your initial ERISA SPD disclosure requirements for the benefits described in the group insurance policy.

In some cases, you may need to include additional employer-specific requirements that are not addressed in our standard Unum group insurance booklet. For example, specific requirements must be met for benefit plans with trustees or for plans that are subject to a collective bargaining agreement with a union. If you have special requirements applicable to your plan, such as a foreign language statement, you should discuss them with your Unum representative.

In addition, we provide these group insurance booklets in electronic format, which allows you to either print and distribute the booklets to your participants and beneficiaries or take steps, where appropriate, to deliver booklets electronically.

When you offer your employees benefits through Unum's individual insurance policies, booklets are not provided because employees receive their own insurance policies. However, Unum can provide materials to help you prepare your SPD for these individual policy-based benefits if ERISA applies. This may be needed if, for example, your employer maintains the plan and does not qualify for the voluntary insurance exemption. Please refer back to pages 10-11, of this handbook for more information. If that's the case for you, then ask your Unum representative about a sample "ERISA wrapper template."

PART 4:

Telling the federal government about your plan



ERISA's reporting requirements tell an employer and plan administrator what to report to the federal government and when to report it.

As plan administrator, if your plan does not qualify for a reporting exemption, you will need to file with the DOL an annual report — called the Annual Report Form 5500 or just Form 5500. Please note that:

- You do not need to complete Form 5500 for plans with fewer than 100 participants at the beginning of a plan year that are unfunded, fully insured or a combination of insured and unfunded. The term “unfunded” refers to the situation when money has not been formally set aside to fund the plan; instead, the plan is funded by the employer on an ongoing basis out of its general assets.
- You must file a Form 5500 for each benefit plan, although you're free to design your plan to include multiple types of benefits.
- Unless you request an extension in a timely manner, you must file Form 5500 within seven months of the end of each plan (not necessarily policy) year. Refer to **Appendix B** for more detail on these reporting deadlines.

Each year, the DOL posts updated forms and detailed Form 5500 filing instructions at http://www.dol.gov/ebsa/forms_requests.html. We recommend you download and print these forms and instructions as your first step. You should also pull out your forms and related files from the previous year to help make the process more manageable.

While there is no substitute for reviewing the extensive filing instructions provided by the DOL, we did want to share some tips and information that we think will be helpful to you when you are preparing to fill out and file Form 5500.

A few key points

Schedule A: Form 5500 includes many schedules, including Schedule A. Use Schedule A for plans that rely on insurance policies to provide benefits to participants. Insurers provide employers, either automatically or upon request, with some of the information needed to complete Schedule A. For most plans, Schedule A reports the type of policy, number of covered lives, total premium, and fees and commissions paid in connection with the policy during the year.

If for some reason you do not receive information from Unum that you need to complete your Schedule A, please contact us immediately at 1-800-633-7491 (option 5) so that we can assist you.

Experience-rated contracts: Additional information is included in Schedule A for “experience-rated” contracts. For employers with insured benefits, “experience-rated” means that a plan is eligible for a dividend or return of premium at the end of the policy year if the plan’s claims experience, reserves and expenses are less than expected. Unum refers to these plans as “participating.” Only a very small number of Unum policies are “experience-rated” as defined under ERISA. Most Unum plans are “non-experience-rated” for ERISA filing purposes.

Schedule C: If required to file a Form 5500, your plan may have to include a Schedule C. Schedule C reports the direct and indirect compensation paid by the plan to its service providers who receive \$5,000 or more during the plan year. Effective beginning for the 2009 plan year, Schedule C disclosure will be much more extensive than it has been, particularly as it relates to “indirect” compensation received by plan service providers. A plan service provider might include a third-party administrator (in the case of a self-insured plan), a consultant or an investment manager (in the case of a plan with assets).

Schedule C is also used to identify whether, during the plan year, your plan terminated its accountant or actuary – even if the \$5,000 threshold is not met.

Amounts reported on Schedule A would not need to be repeated on Schedule C.

Schedule agreement: Make sure that all the basic information on your Schedules A and C agrees with the Form 5500 information you provide. Don’t forget to complete the plan year line on each form where requested.

Requesting information: Unum automatically provides a report to group policyholders listing some of the important information needed to complete their Schedule As, including premiums, commissions and service fees as well as the recipients of those amounts. For similar information regarding other types of coverage, including individual policies offered in your workplace, contact your Unum representative. If you have questions about letters from Unum with Schedule A information, or to request Schedule A or C information, call 1-800-633-7491 to be connected to Unum’s broker compensation department. Choose option 5.

Schedule H: Some plans — those with assets — must also file Schedule H, which summarizes financial information about the plan. This requirement is discussed more fully in the DOL’s instructions for the Form 5500.

Independent audit: Some plans must include an independent auditor’s report with Form 5500. This requirement is discussed more fully in the DOL’s Form 5500 filing instructions described earlier. Keep in mind, though, that obtaining an audit and final audit report takes time. The auditor must be engaged many months before the Form 5500 filing deadline. In addition, each time the plan is changed, particularly if its funding method is changed from insured to self-insured, you’ll need to review the requirements again to determine whether an audit will be needed.

Other documents: In addition to filing the Form 5500 each year, if requested, you'll need to provide the DOL with copies of any documents related to your plan, including the plan documents, the SPD, and any applicable SMM, trust agreement, bargaining agreement or insurance contract.

Penalties for non-compliance: If you fail to file a Form 5500 or file it late, you risk incurring some very significant penalties. The DOL can fine you up to \$1,100 per day if you fail to file your Form 5500, you file an incomplete Form 5500, or you file your Form 5500 late. If you discover that you've missed a deadline, consider using the voluntary DOL correction program instead of waiting to see if you will be fined. For more information about this program, go online at http://www.dol.gov/ebsa/compliance_assistance.html#section8. If you receive a notice in the mail from the DOL indicating that your filing is incomplete, it is important to respond to that notice by providing the missing information within the timeframes indicated in the letter. If you do that, you may avoid penalties.

PART 5:

Meeting specific standards of conduct that help protect your employees' rights under your plan

In addition to disclosure and reporting, ERISA makes sure that individuals and entities (including plan administrators and employers) are held accountable as fiduciaries for administering the plan and handling its assets, if any. To better understand this aspect of ERISA, you must first understand what a “fiduciary” actually is.

Generally, a *fiduciary* is a person or entity responsible for handling matters for another through a special relationship of confidence and trust. A fiduciary must act in the interests of the other person when addressing matters of business, trust or finance. There are many kinds of fiduciary roles. In this handbook, we are only concerned with the fiduciaries associated with employee welfare benefit plans governed by ERISA.

Who are the plan fiduciaries under ERISA and what are their duties?

Although some “roles” or titles in an ERISA plan automatically confer fiduciary status (for example, a “trustee” or “plan administrator” named in your plan document), ERISA’s definition of “fiduciary” extends beyond these specific roles and titles to identify as a fiduciary basically any person or entity who performs any of the following activities or has any of the following types of authority:

- exercises any authority or control regarding the disposition or management of plan assets;
- provides investment advice concerning a plan asset for compensation; and/or
- exercises any discretionary authority or responsibility in the administration of the plan.

Under this broad definition, a final claims decision-maker is likely to be a fiduciary. It might not be that obvious but the person or entity (such as the employer) who selects the insurer and negotiates the premiums for its plan is acting as a fiduciary. In addition, an insurance broker, third-party administrator, payroll vendor or other service provider could be a fiduciary depending upon whether or not she or he has the discretionary authority to make a final decision on a matter. You can even become a fiduciary if you merely exercise control over the management of the plan or its assets, whether or not you have actually been given the authority or responsibility to do so.

Under ERISA, those who fall into the category of “fiduciary” are generally required to:

- perform their plan duties in the interest of, and for the exclusive benefit of, participants and their beneficiaries for the purpose of providing benefits and defraying reasonable expenses in administering the plan;
- make plan decisions with the care, skill and prudence that someone familiar with such decisions would use; and
- follow the documents and other written materials governing the plan (assuming they are in compliance with ERISA).

This does not mean, for example, that a fiduciary is required to award benefits to everyone who applies — the fiduciary must simply follow the plan provisions in evaluating claims and deciding whether or not to award benefits. It does mean that, when selecting an insurer and insurance policy, the employer fiduciary must perform appropriate “due diligence” and must make its decision taking into account only the best interests of the participants in the plan.

An obvious example of a fiduciary breach in a welfare benefit plan would be improper use of policy refunds from a partially or fully contributory plan. Because at least part of those refunds come from employee contributions, it would be improper for the employer, acting as a fiduciary, to use the employees’ portion of the money to pay off a company debt or buy office supplies. Such use would not be for the exclusive benefit of participants and their beneficiaries as is required by ERISA.

The use of the policy refund would also violate ERISA’s prohibited transaction rules which strictly regulate transactions involving the assets of a plan. In a plan, there are limited plan assets, but it’s important to keep in mind that contributions (premiums) paid by employees are considered “assets” of your plan and must be handled consistent with your fiduciary duties. This handling obligation includes the responsibility, when taking payroll deductions from employees, to promptly forward those premium amounts to an insurer as soon as the withheld amounts can reasonably be segregated from the employer’s accounts — but keep in mind that under ERISA this really can’t take longer than three months from the date the funds were deducted from the employee’s payroll check.

Although many of your duties in administering the plan are considered fiduciary duties, not every role or function relating to an ERISA plan is a fiduciary function subject to ERISA’s strict rules and liability. For example, the decision to offer a plan in the first place and the selection of a specific design or eligibility rules for the plan is not a fiduciary decision and need not be made with only the employee’s interests in mind. Another non-fiduciary decision relating to a plan is how much the employer will contribute toward the cost of the benefits and how much participants will be asked to contribute.



What is the liability of a fiduciary?

A fiduciary (whether an individual or entity) can be personally liable for failing to fulfill its fiduciary duties when administering the plan or managing its assets. A fiduciary can go to jail, be fined or incur penalties from the DOL. A fiduciary may also be required to make up any losses that the plan might suffer as a result of the fiduciary's failure to fulfill its duties. A fiduciary can also be liable for the ERISA violations of another fiduciary of the plan when that fiduciary:

- knew of the violation by the other fiduciary and did not try to correct it;
- participated in or concealed the violation; or
- by failing to conduct itself properly, enabled the other fiduciary to commit a violation.

A plan fiduciary may be investigated and sued by the DOL and may be sued for an ERISA violation by any one of the participants in the plan or by another plan fiduciary.

Is Unum a plan fiduciary?

Because Unum has the sole and final authority to decide all claims for benefits, it is considered the claims fiduciary for all ERISA benefit plans that are fully insured through Unum.

Unum is typically not a fiduciary when it provides services (and not insured benefits) to a self-insured ERISA plan. This is because Unum doesn't exercise discretionary control over the plan's assets or its administration. It simply provides support to the employer who retains the overall authority for the plan's administration.

How does Unum help you with your claim decision-making responsibilities under ERISA?

Whether Unum is providing insurance to fund your benefit program, or just claims administration services, our claims process is designed to meet the ERISA regulatory requirements for processing and adjudicating claims and appeals. According to the DOL, the purpose of these regulations is to make the claims process "fuller, faster and fairer."

For your plan's claims procedures to be considered reasonable by the DOL, you must include a clear and complete summary of the claims and appeal procedures in the SPD.

Unum helps with this by providing summaries of our claims and appeals procedures with all group policies and booklets. In addition, Unum makes claim and appeal procedures part of the individual policy or makes them available for distribution to plan participants when employers sponsor multi-life individual benefit plans or voluntary benefits.

Please note that these ERISA claims process requirements vary depending upon the type of benefit at issue. Special rules apply for disability-related benefits and for medical benefits. In addition, the timeline for processing and review of initial determinations varies depending on whether the benefits are disability or non-disability related and when a claim is filed.

In addition to special disability deadlines, Unum's claim administration process also complies with ERISA's other special requirements for the review of disability claims. For example:

- additional information must be provided or made available to claimants when a disability claim or appeal is denied;
- disability appeals must be determined anew without regard to how the initial decision was made; and
- a healthcare professional reviewing a disability appeal may not have been consulted on the original determination nor may she or he be a subordinate of a prior reviewer.

The full detail of the claims procedures required under ERISA can be found in the DOL regulations at 29 CFR Section 2560.503-1. These regulations are available at http://www.dol.gov/dol/allcfr/ebsa/Title_29/Part_2560/29CFR2560.503-1.htm.

Unum helps you with your compliance needs in this area by tailoring our claims and appeal review process to comply with ERISA claims regulations. If you have a plan that does not follow ERISA's claims procedure requirements, you may be subject to enforcement action by the DOL. There could be other consequences as well. For example, a court could penalize you by deciding that you waived the requirement that claimants exhaust their administrative remedies before filing suit on a claim. Also, the plan's initial claims determination may not be accorded full deference by the courts. In such a case, the court would make a brand-new claim determination using all the information the claimant presents to the court rather than, for example, limiting its review to the materials available at the time the final claim determination was made by the claim fiduciary.

PART 6:

Where to get more information



We hope this handbook has given you a helpful overview of ERISA requirements. For more information, consult:

- **Your Unum representative.** While Unum cannot provide legal advice, we want to help as much as we can. Just ask your Unum representative if you have follow-up questions about the information in this handbook. For example, if you're a plan administrator offering Unum's voluntary workplace benefits or individual disability policies to your employees, you may wish to request Unum's "ERISA wrapper template" to help you draft your SPD.
- **BenefitsAnswersNow.**TM This web-based resource provides answers to thousands of benefits questions and is available with selected Unum insurance offerings. The site is organized in a question-and-answer format that's easy to use. It even allows you to receive your choice of several monthly newsletters and access, modify and use hundreds of sample benefit policies and plans. BenefitsAnswersNowTM is provided by CCH, a Wolters Kluwer company, one of the top information providers in the legal, tax and regulatory markets in the U.S. and Europe.
- **The DOL website.** The DOL maintains an extensive website dedicated to ERISA. It includes compliance assistance, forms, FAQs, text of the laws and regulations, directions on how to file forms electronically, and information on how to get additional assistance. Just go to http://www.dol.gov/ebsa/compliance_assistance.html. For example, the DOL website includes the forms, schedules, instructions and tips for filing Form 5500 at http://www.dol.gov/ebsa/forms_requests.html as well as the Trouble Shooter's Guide to Filing ERISA Annual Reports, available online in two parts at:
 - http://www.dol.gov/ebsa/pdf/troubleshootersguide_pt1.pdf
 - http://www.dol.gov/ebsa/pdf/troubleshootersguide_pt2.pdf

In addition, DOL benefit advisors can help you understand federal requirements, including ERISA. Contact a DOL benefit advisor via email at http://askebsa.dol.gov/contact_form_1.asp or call toll-free at 1-866-444-EBSA (1-866-444-3272).

The DOL's EBSA website also includes the address and telephone number for your local regional EBSA Office at

http://www.dol.gov/ebsa/aboutebsa/org_chart.html#section13.

Appendix A: SPD content checklist



The full details of the required contents of an SPD are set forth in the DOL regulations at 29 CFR Section 2520.102-3, which can be found online at http://www.dol.gov/dol/allcfr/EBSA/Title_29/Part_2520/29CFR2520.102-3.htm.

Directory information

- Name of your plan:** The name of the plan and, if different, the name by which the plan is commonly known by your employees, participants and beneficiaries.
- Name and address of sponsor** (often the employer): In the case of a plan maintained by an employee organization, collectively-bargained plan, or a plan established or maintained by two or more employers, different requirements apply. These are fully detailed in the DOL regulations, specifically subsection (b) of 29 CFR Section 2520.102-3 referred to above.
- Employer tax ID number** (or EIN number): This is a number assigned to your business by the IRS for tax reporting purposes. Be sure to include it on all correspondence and reports to the DOL. If your company is small, you probably have just one EIN. A large company with subsidiaries may have several EINs. You need only refer to the EIN of the entity sponsoring your plan. If you have questions about which EIN to use, your tax professional should be able to help.
- Plan number:** This is assigned by you. It can be any three-digit number from 501 to 998 (except 888). Do not choose a number that is used by another plan at your company. For insured plans, this number will not change even if you change insurers. Each plan you have needs its own number. A single plan that provides different benefits will have only one plan number. If these benefits are provided under different plans, however, each plan must have its own number. If a plan is terminated, its number should not be reused.
- Type of welfare plan:** Identify the type of benefit offered such as disability, life, AD&D, long term care, etc.
- Type of administration:** Usually this will be insurer administration, contract administration or third-party administration. "Insurer Administration" is appropriate when a Unum subsidiary insures and administers your plan.
- Date your plan year ends:** The reporting period for your plan ends each year on the same date. If the date shown is December 31, your plan year is from January 1 to December 31 each year. Your plan year can coincide with a calendar year, your company's fiscal year or an insurance policy year.

- Name, business address and telephone number of plan administrator** (a person or entity): The plan administrator is the person or entity identified as such in the plan’s governing documents. If no plan administrator is named in your plan document, the plan sponsor will be considered the plan administrator. Plan participants must be kept informed of the plan administrator’s identity. This section may include a statement that the plan administrator may delegate duties to others.
- Name and address of person (or entity) who serves as agent for service of legal process:** The term “service of legal process” refers to the way formal court-related documents — such as a subpoena, warrant or complaint — are delivered to a person or an entity. Normally, the plan administrator is designated to receive these documents on behalf of the plan. The SPD must also contain a statement that service of legal process may be made upon a plan trustee or plan administrator.
- Source and method of financing for your plan and identity of entity that provides benefits:** Where your plan is insured, this would include identifying the method as “insurance” and the name of the insurer along with the actual policy number.
- Source of contributions to the plan:** For example, indicate if the employer, employee and/or others make contributions to, or otherwise fund, the plan.
- Collective Bargaining Agreement Information:** Include a description of any agreement applicable to the plan, note that a copy is available for inspection and will be provided upon written request, and include the statement that *“This plan is maintained pursuant to the [bargaining agreement’s name]. You may obtain a copy of the agreement by writing to the plan administrator. Copies are also available for your examination.”*

Employer-specific provisions:

Other provisions may need to be included in your SPD depending on your specific plan and situation. The Unum-provided employee group insurance booklet (also called a “certificate”) would not address these employer-specific requirements, such as:

- Trustees of the Plan: If a trust agreement is involved, the name, title and address of the principal place of business for each trustee must be included.
- Foreign language statement: In some cases, the SPD must contain a statement written in a language other than English. For information concerning this requirement, turn to page 16 of this handbook.
- How your plan handles Qualified Domestic Relations Orders (QDROs) and Qualified Medical Child Support Orders (QMCSOs).

Benefit terms

This part of the SPD needs to include information about:

- ☑ The plan’s benefit provisions, including a statement of conditions pertaining to eligibility and a description or summary of benefits;
- ☑ Events which result in forfeiture, ineligibility, loss, denial, suspension, offset, reduction or recovery (such as subrogation) of any benefits;
- ☑ Authority of the plan, sponsor or others to modify or terminate the plan, and the circumstances under which the plan may be terminated or benefits (including those provided under an insurance policy) may be modified or eliminated and the benefits, rights and obligations of participants and beneficiaries upon termination of the plan or amendment or elimination of benefits;
- ☑ Plan provisions governing the allocation and disposition of assets upon termination of the plan; and
- ☑ Plan provisions that may result in the imposition of a fee or charge to a participant or beneficiary, the payment of which is a condition for receipt of benefits under the plan.

For insured plans, plan administrators often satisfy the “Benefit Terms” portion of the SPD content requirements by giving plan participants a copy of the insurance policy or certificate (or booklet) prepared by their insurer.

Administration of benefit claims & appeals

- ☑ Procedures and time limits for handling claims and appeals as well as the remedies available. In addition to the SPD provisions required under ERISA, many SPDs include a statement that the plan administrator and its designees (for example, the insurer) have full discretionary authority with regard to making claim decisions.

Statement of ERISA rights

- ☑ Standard ERISA notices describing participants’ rights and identifying the DOL office through which assistance may be sought.

Appendix B: Reporting deadlines

Event	Reporting	Time period (unless extension granted)
For annual reporting:		
If your plan has 100 or more participants at the beginning of the plan year or is funded	File Annual Report Form 5500 annually with the DOL, including Schedule A	Within seven months of the end of each plan year
If your plan has fewer than 100 participants at the beginning of the plan year and is unfunded, fully insured, or a combination of insured and unfunded	No annual reporting requirements	
When you file Form 5500:		
If you are terminating your plan (this includes when you change from one insurance carrier to another and have adopted a new plan)	File final Form 5500 for your prior plan	Within seven months after the end of the final plan year
If your plan uses a service provider (see instructions that come with Schedule C for more information)	File Schedule C	When you file Form 5500
If you need more time to file Form 5500	File Form 5558 with the IRS for up to a 2½-month one-time extension of the filing deadline; or check the Form 5500 instruction to see if your employer's federal income tax filing extension qualifies your plan for a Form 5500 filing extension	Before the filing deadline for Form 5500

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