

one for adoption assistance, and one “mega-plan” for all the remaining benefits (ERISA and non-ERISA alike).

5. *What Topics Should Be Addressed in the Plan Document?*

There are several topics that must be addressed in the ERISA plan document. Here is an overview of some of the more important ones.

a. What Benefits and Who Is Eligible?

ERISA requires the plan document to describe the plan’s terms and conditions. In the most basic sense, this requires a description of the benefits provided and the employees and dependents who are eligible. As noted, for an insured benefit, much of this information will be found in the insurance contract. When preparing wrap documents for such benefits, an employer must avoid restating the provisions found in the insurance contract or it may find itself promising benefits beyond those the insurer has agreed to provide. The sponsor of an insured plan should limit itself to adding only the missing items (like those listed in the earlier discussion of wrap documents).

For self-insured benefits (like Zipco’s severance benefits), the employer must draft its own description of benefits and eligibility. In doing so, employers (and their advisors) must be familiar with the increasing body of case law that has added relevant rules and requirements not found in the ERISA statute. For example, cases like the highly publicized one involving Microsoft must be consulted before drafting plan language excluding temporary workers, leased employees or other discrete groups of workers. As another example, Zipco should be aware of the line of severance plan cases holding that employees terminated in connection with a corporate acquisition are entitled to benefits even if they are hired by the acquiring company and thus never have a period of unemployment. This result can be avoided by addressing it in the severance plan document—Zipco should consider limiting severance pay to those employees who are not rehired in the event of a corporate takeover.

b. How Will Benefits Be Funded?

ERISA requires the plan document to describe the plan’s funding method and how payments are made to and from the plan. It is always wise to address how benefits will be funded, even though as a technical matter this is required only if the plan has plan assets, a subject discussed later in this Short Course.

c. How Will Insurer Refunds and Similar Amounts Be Treated?

For insured benefits that require a premium contribution from employees, it is important for the plan document to address the treatment of insurance refunds, rebates, experience returns, and similar payments (including the commonly encountered “demutualization” payments). This is because if premiums are paid in whole or part by employee contributions, ERISA treats any insurance refund as being partially attributable to employee contributions. This gives the employees a type of ownership interest in the refunds, which may require that all or part of the refunds be returned to employees. However, ERISA does not specify how to allocate refunds between the employer and employees. Instead, the employer can choose an allocation formula to be used for this purpose (subject to some general parameters imposed by the DOL), and this should be reflected in the plan document. (Indeed, one of the conditions of the

complete Form 5500 exemption for small insured plans, discussed later, is that the plan have a method for dealing with insurer refunds.)

d. Standard of Review for Benefit Decisions

When a dispute about benefits goes to court, the “standard of review” applied by the judge can have a critical impact on the outcome. There are essentially two available standards. Under the “de novo” standard, the court may substitute its judgment for the plan administrator’s, deciding for itself what plan terms mean and how factual issues should be resolved. In contrast, under the “abuse of discretion” (or “arbitrary and capricious”) standard, a court will generally respect the plan administrator’s determination (even if the court might have made a different one) unless the determination falls outside the bounds of reasonableness. This more “deferential” standard of review applies, however, only if the plan document says so. ERISA plan documents (and SPDs, discussed later) should therefore provide that the plan administrator has “discretionary authority” to interpret and administer the plan and to make factual determinations.

e. Other Items

Some of the other issues that must be addressed or should be addressed in an ERISA plan document are:

- designation of a “named fiduciary” (responsible for deciding benefit appeals under the plan’s claims procedures);
- plan amendment and termination procedures, including who has authority to amend and terminate and what happens to plan assets (if any) in the event of termination;
- required provisions for group health plans, including COBRA; qualified medical child support orders (QMCSOs); coverage of dependent children in cases of adoption; HIPAA portability, special enrollments, and access provisions; hospital stays for newborns and mothers; parity in the application of certain limits to mental health benefits; and coverage for reconstructive surgery in connection with mastectomy;
- other substantive provisions relevant for particular plans regarding, for example, subrogation and reimbursement clauses (applicable, for example, where a participant or beneficiary injured in an accident may recover from another source for expenses paid by the plan); or coordination of benefits (applicable when two plans cover the same individual);
- procedures for allocating (e.g., where the sponsor designates a committee of employees to act as plan administrator) and delegating responsibilities under the plan (e.g., where certain administrative tasks will be performed by a TPA).

I. Are You an ERISA Fiduciary? You Better Behave!

1. Who Are ERISA Fiduciaries?

Regardless of the designations that may appear in plan documents or contracts with outside entities, anyone performing ERISA fiduciary functions is a