November 2011

MERCER

Legal & Regulatory Update

Important information about legislative, regulatory and compliance developments that affect the administration of your employee benefit plans

IN THIS ISSUE

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2012 Qualified Retirement Plan Limits and Other Benefit-Related Figures

The IRS recently announced that the qualified plan limits for 2012 are increasing. As a result, the major limits for 2012 will be:

401(k) annual contribution limit	$17,000.00
Catch-up annual contribution limit	$5,500.00
401(a)(17) annual compensation limit	$250,000.00
Highly compensated employee (HCE) threshold	$115,000.00
DC 415 annual addition limit	$50,000.00
DB 415 annual benefit limit	$200,000.00

As the table below shows, the adjusted gross income (AGI) thresholds for the "Saver's credit" for contributions to retirement plans increased.

Saver's credit adjusted gross income (AGI) thresholds (Section 25B)	2012	2011
50% Saver's credit if AGI is no more than:		
Married filing jointly	$34,500	$34,000
Head of household	$25,875	$25,500
Other filing status	$17,250	$17,000
20% Saver's credit if AGI is above the AGI threshold for 50% credit but no more than:		
Married filing jointly	$37,500	$36,500
Head of household	$28,125	$27,375
Other filing status	$18,750	$18,250
10% Saver's credit if AGI is above the AGI threshold for 20% credit but no more than:		
Married filing jointly	$57,500	$56,500
Head of household	$43,125	$42,375
Other filing status	$28,750	$28,250

The Social Security wage base is increasing to $110,100. The wage base increases if there is an increase in the cost-of-living adjustment (COLA) for Social Security benefits. Also tied to the Social Security benefit COLA is the maximum benefit guaranteed by the PBGC, which Mercer projects will increase by 1%. However, the flat-rate PBGC premium for single- and multi-employer DB plans will be unchanged for 2012. The premium for 2012 is $35 per participant for single-employer DB plans and $9.00 per participant for multi-employer DB plans.

The maximum contribution limits for health savings accounts (HSAs) have increased for 2012, as have the maximum out-of-pocket costs for associated high-deductible health plans (HDHPs), as shown below:

HSA/HDHP limits	2012	2011
Self-only coverage		
Maximum tax-deductible HSA contribution	**$3,100**	**$3,050**
HDHP minimum annual deductible	**$1,200**	**$1,200**
HDHP maximum out-of-pocket limit	**$6,050**	**$5,950**
Family coverage		
Maximum tax-deductible HSA contribution	**$6,250**	**$6,150**
HDHP minimum annual deductible	**$2,400**	**$2,400**
HDHP maximum out-of-pocket limit	**$12,100**	**$11,900**
Catch-up contribution limit for ages 55 and older (this value is set by statute and will not be adjusted after 2009)	**$1,000**	**$1,000**

Reminder – Participant Fee Disclosure in 2012

As we have reported in past editions and communicated in other forums – and as you have likely seen discussed in other places, including the popular media – the Department of Labor's (DOL's) new participant fee disclosure rules take effect in 2012, with the earliest due date for the first required disclosure being May 31, 2012. Given the amount of other coverage on the subject, another reminder may not seem necessary. Still, as the compliance dates near, we believe a recap of the technical detail of the rules will be helpful to Mercer's Defined Contribution clients as you work with Mercer to meet the new requirements. This article will not address the plan sponsor fee disclosure regulations, also effective in 2012, since, as of press time, those regulations have not been finalized.

Background of the New Rules

First, it's worth noting that, while the new requirement is frequently referred to as "fee disclosure," that name does not really capture the true breadth of the requirement. Certainly, it was the DOL's desire to give participants a view into the fees that impact their account balances that drove the DOL to impose this new requirement. However, the actual rule, which applies only to 401(k)-type plans in which participants direct their investments, goes further. It requires plan sponsors to provide comprehensive information about the plan's investments – beyond just investment-related fees – and specific plan provisions so participants may make investment and other decisions about their accounts on an informed basis.

The final regulations actually expand the general fiduciary responsibility rules of ERISA and make the providing of this information, in the prescribed manner, a new fiduciary duty. A failure to do so will expose plan sponsors to claims of a breach of fiduciary responsibility under ERISA.

Detail of the Disclosure Requirements

As a starting point, the new disclosures can be separated according to when they must be provided. A notice must be delivered when a participant initially has the right to direct investments in their account, and then annually thereafter. On a quarterly basis, specific fee information must be provided to participants.

The initial and annual notices must be provided to all eligible participants, whether or not actually enrolled. The DOL believes that the annual notice will serve as a reminder to eligible, nonparticipating employees of their right to enroll in the plan. The notice must include the following:

- General plan information. A list of investment funds available in the plan (including a description of any self-directed brokerage option), how participants can provide investment instructions and what voting rights and plan-level restrictions on investment transfers may apply.
- Administrative expenses. An explanation of what fees and expenses may be charged to individual participant accounts for general plan administrative services (e.g., recordkeeping, legal, accounting) and how those charges would be allocated.

- Individual fees and expenses. Fees or expenses for specific transactions or services that may be charged to individual participant accounts, such as loan initiation fees, distribution fees, brokerage charges and short-term redemption fees.
- Comparison chart of investment information. A chart that allows participants to compare investments based on performance, fees and expense ratios, comparable benchmarks and certain other information. (A DOL model chart, which will serve as a safe harbor, can be found at www.dol.gov/ebsa/participantfeerulemodelchart.doc.)

If there are any changes in the first three categories of information, the plan sponsor must give participants notice of the change at least 30, but no more than 90, days before the change is effective. The plan sponsor may provide new participants with a copy of the last annual notice plus any notices of changes provided to participants since then, meaning the sponsor need not physically update the notice for every change or every new participant.

Once each quarter, plan sponsors must provide to each participant who has an account in the plan information regarding:

- The dollar amount actually charged to the participant's account during the previous quarter for general administrative services, as well as a general statement as to whether any administrative expenses were paid through revenue sharing from investments in the plan
- The dollar amount actually charged to the participant's account during the previous quarter for specific transactions or services, with a description of what the fee was for

The regulations specifically permit this information to be on participants' quarterly benefit statements, and the DOL has assumed that this will be the most common method for satisfying this requirement.

Other Requirements and Considerations

Information available online. In the process of crafting the new rules, the DOL has stated that it tried to strike a balance between providing additional useful information and avoiding information overload for participants. One way the DOL tried to strike this balance was by pushing disclosure of certain investment information to the Internet. The rules require the comparison chart to include, for each investment, an address for a website that provides access to specific information such as the investment's objectives, principal strategies, portfolio turnover and quarterly performance. The DOL felt that participants who wanted to know more about the investments could get information online. The regulations also require plans to provide Internet access to a glossary of investment terms relevant to the disclosures. The regulations require that participants be able to obtain on request paper copies of both the glossary and supplemental investment information that appear online.

Electronic delivery. Upon issuing the rules in October 2010, the DOL indicated that it would provide additional guidance concerning electronic delivery of the required notice. Since then, the DOL began an initiative to review and potentially revise its current standards for electronic delivery. While this initiative is not yet complete, the DOL did provide interim guidance in September on e-delivery for participant fee disclosure. On the positive side, this guidance confirmed that the DOL's current rules for e-delivery of participant statements covered the new quarterly fee notice requirement. However, like other 401(k) providers, we do not believe the new guidance is particularly helpful, since it

essentially requires affirmative consent to e-delivery from participants, as do the current DOL rules. Accordingly, Mercer will provide opportunities for electronic delivery notice, but based on the DOL's existing e-delivery rules.

Effective date. In July, the DOL finalized its extension of the effective date for participant fee disclosure. For calendar year plans (and non-calendar year plans with plan years beginning on or after November 1, 2011, through April 1, 2012), the deadline for the first comprehensive notice is May 31, 2012. For non-calendar years beginning after April 1, 2012, the deadline is 60 days after the beginning of the plan year. The participant statement for the second quarter is the first that must contain the new quarterly fee information.

Coordination with ERISA Section 404(c)

Though this has gotten less attention, when the DOL issued the participant fee disclosure rules, it also made changes to the regulations under ERISA section 404(c), which relieves plan fiduciaries from liability resulting from participant direction of their investments. The most important change is to make the investment disclosures that must be provided automatically to participants in order to comply with 404(c) consistent with the disclosures required under the new regulations. This means that plan sponsors will have only one set of investment disclosure requirements. As a result of this change, confirming prospectuses will no longer have to be sent following a participant's initial investment in a fund, as previously required under 404(c).

Mercer's Solution

Mercer is committed to helping its Defined Contribution clients meet the requirements of the new disclosure requirements. We have already begun – and will continue – to collect and compile the plan-specific information, including investment data, needed to prepare the disclosures. If you have not seen it yet, you will soon receive a sample of our standard templated notice along with additional information describing our fee disclosure solution and its delivery specific to you and your needs. Your relationship manager is prepared to help you through the process.

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Year End Planning for Your 401(k) Plan

Qualified defined contribution plan sponsors must complete certain administrative requirements on or near the end of each plan year. As fourth quarter begins, it is important to start planning for these requirements. Below is a summary of items you may wish to consider as you wind up your responsibilities for the 2011 plan year.

Participant Notices

Qualified Default Investment Alternative (QDIA) Notice Plans utilizing a QDIA as their default investment option must provide a notice describing the QDIA investment and default process within a reasonable period, but at least 30, and no more than 90, days prior to the start of the 2012 plan year. Generally, the notice should be provided to all participants who have been or could be defaulted into the QDIA.

Nondiscrimination Safe Harbor Participant Notices Plans utilizing a nondiscrimination safe harbor plan design must provide each eligible participant a notice of the plan sponsor's intent to be a safe harbor plan for the 2012 plan year, along with a description of the safe harbor plan design. This notice must be delivered no later than 30, and no earlier than 90, days prior to the beginning of the 2012 plan year. This notice requirement applies to:

- 401(k)/401(m) traditional safe harbor designs
- Qualified Automatic Contribution Arrangement (QACA) safe harbor designs

Eligible Automatic Contribution Arrangements (EACA) Plans with an automatic enrollment feature designed to be an EACA must provide all eligible participants with a notice describing the automatic enrollment plan design. This notice must be delivered no later than 30, and no earlier than 90, days prior to the beginning of the 2012 plan year.

Automatic Contribution Arrangements (ACA) All other automatic enrollment designs must provide an annual notice to participants indicating the participant's salary deferral percentage and his or her right to change that election within a reasonable time, but at least 30 days prior to the beginning of the 2012 plan year.

Summary Annual Report (SAR) A summary annual report of your plan's 2010 Form 5500 must be provided to your participants. Generally, the SAR should be distributed within nine months after the end of your 2010 plan year. If you received an extension to file your 2010 Form 5500, then the SAR distribution date is extended to two months following your extended Form 5500 filing date.

Administrative Matters

Delinquent Participant Loans You should review your loan delinquency reports to ensure that all loans for which participants have failed to make payment installments within your cure period are "deemed distributed" to the participants in 2011.

Application of Forfeitures Generally, all forfeitures generated in a plan year should be used as indicated in the plan document for that year. For example, if forfeitures are used to offset employer contributions, then the 2011 forfeitures should be used to fund 2011 contributions. If forfeitures are reallocated, any forfeitures remaining as of the last day of the plan year should be allocated to participant accounts as of that date.

Additionally, if your plan has accrued gains arising from transaction processing and other actions, or if you have uncashed participant checks returned to the plan, you also should determine how to best use these amounts in 2011.

Required Minimum Distributions (RMDs) All participants who are age 70½ or older and have terminated employment (or are age 70½ or older and own more than 5% of your company, regardless of employment status) in 2011 should receive their required minimum distributions on or before December 31, 2011. Participants whose first RMD is due in 2011 may delay distribution of their 2011 RMDs until April 1, 2012.

Contributions If you want your final 2011 plan contributions to be reflected on your participants' fourth quarter statements, you should begin working with Mercer to get your contributions finalized in a timely manner.

Fourth Quarter 2011 Deadlines and Other Requirements for Defined Benefit Plans

As we approach the end of 2011, there are a number of key administrative, notice and filing deadlines that sponsors of calendar-year defined benefit plans should be aware of. Below is a brief summary of the requirements for the fourth quarter of 2011. Please keep in mind that plan sponsors should review these requirements with their pension consultants and/or actuaries to determine the appropriate action needed to ensure their plans' compliance.

Due Date	Item	Required Action
October 1	Adjusted Funded Target Attainment Percentage ("AFTAP") Certification	The plan's funding status must be certified by an enrolled actuary by the first day of the 10th month of the plan year. *Note: Plans that do not have a timely AFTAP certification for the current year are presumed to be less than 60% funded.*
October 15	Form 5500 (if an extension of the filing deadline has been obtained by filing Form 5558)	For calendar-year plans, Form 5500 and all required Schedules must be filed with the Department of Labor (DOL) by this date.
October 17	Comprehensive Premium Filing	The Comprehensive Premium Filing must be filed with the PBGC. The filing must include the required premium payment amounts: ■ For plans with more than 500 participants, this includes the reconciliation of the estimated flat-rate premium as well as the variable rate premium. ■ For plans with between 100 and 500 participants, the full flat-rate premium and variable-rate premium must be included.
October 30	Notice of Benefit Limitations and Restrictions	Plans subject to funding-based benefit restrictions must provide notice to participants and beneficiaries within 30 days after the plan has become subject to benefit restrictions.
November 1–15	Review Annual Adjustments	Update systems for 2012 plan dollar limits for annual IRS cost-of-living adjustments and updated mortality rates.

Due Date	Item	Required Action
December 31	Annual Notice of Availability of Plan Benefit Statements	Plan sponsors using the "Annual Notice of Availability" to comply with the PPA plan benefit statement requirements must distribute the notice each year.
December 31	Required Minimum Distributions	Ensure that annual required minimum distribution payments are made to terminated participants 70½ and older, 5%-or-more owners and beneficiaries.
December 31	Self-Correction of Plan Qualification Defects Pursuant to the Employee Plans Compliance Resolution System ("EPCRS")	Corrections of any eligible "significant" operational defects that occurred during the 2010 plan year must be completed no later than December 31, 2011. Contact Regulatory Support for further details regarding specific corrections.
December 31	Plan Amendments	Adopt and execute documents implementing any discretionary plan changes made during the plan year. *Note: To be valid, a plan amendment generally must be executed on or before the last day of the plan year in which the change took effect.*

IRS Prioritizes DB Guidance to Be Released in 2012

On September 2, 2011, the IRS and the Department of Treasury released the 2011–2012 Priority Guidance Plan ("Plan") listing the topics on which they intend to publish formal administrative guidance between July 2011 and June 2012.

The Plan is developed annually based on suggestions from taxpayers, tax practitioners and industry groups. As they have done previously, the IRS and Treasury intend to update and republish the Plan to reflect additional guidance to be published during the year.

Of the 317 projects listed, there are 37 Retirement Benefits projects, many of which will provide guidance on defined benefit plan administration. Much of the defined benefit plan guidance will address the significant legislation enacted over the past several years, including the Pension Protection Act of 2006 ("PPA") and the Pension Relief Act of 2010 ("PRA"). The potential IRS guidance for defined benefit plan administration includes:

1. Guidance updating the regulations for service credits and vesting under Internal Revenue Code ("Code") section 411
2. Final regulations relating to hybrid defined benefit plans, as added by the PPA (including guidance relating to conforming amendments)
3. Guidance relating to the minimum survivor annuity requirements contained in Code section 417
4. Regulations (proposed or final) on additional issues related to the funding limit requirements and related rules set forth in Code section 436, as added by the PPA
5. Guidance providing a sample amendment to reflect benefit limitations that may apply in the event that a single-employer plan does not meet the funding requirements of Code section 436
6. A Revenue Procedure updating the correction methods provided under the Employee Plans Compliance Resolution System, including guidance providing a voluntary compliance program for late filers of the Form 5500-EZ
7. Guidance on rollovers to defined benefit plans
8. Additional guidance on issues related to funding and benefit limitation relief for single-employer plans under the PRA

Over the coming months, Legal and Regulatory Support will continue to monitor the legislative landscape and will communicate any changes as they arise.

IRS Notice 2011-85 Delays Certain Hybrid Plan Rules

On October 12, 2011, the Internal Revenue Service issued IRS Notice 2011-85, which postponed the effective date for a number of items relating to cash balance and other hybrid plans. Below is a brief summary of the notice's impacts:

- **Effective Date Extension for 2010 Hybrid Plan Regulations:** The effective date of the proposed and final hybrid plan regulations issued in October 2010 has been postponed to a future date, no earlier than the 2013 plan year. These regulations were originally slated to be effective on January 1, 2012.
- **Market-Rate Requirements:** In order to align with the 2010 hybrid plan regulations above, the notice also postpones the required effective date for hybrid plans to adopt the new interest crediting and market rate of return requirements. These rules require that the rate of any interest credit for a plan year provided under the terms of a hybrid plan not exceed certain "market rates" of return. Although the notice does specify this, this postponement could be a sign that the market rate definition could be under review by the IRS. As a result, plans that are currently crediting interest at rates that do not satisfy the new market-rate rules need not make changes to their rates. The new effective date has not been finalized but will be no earlier than the 2013 plan year.
- **Plan Amendment Deadlines and § 411(d)(6) Anti-cutback Relief:** The notice also provides relief for certain accrued benefit reductions and associated amendments, provided the amendment to reduce benefits is done solely to comply with the age discrimination and interest credit rules for hybrid plans under § 411(b)(5). These amendments now must be adopted before the last day of the plan year prior to the effective date of the final hybrid plan and market-rate regulations above.
- **§ 204(h) Notice Relief:** The notice formally provides timing relief to hybrid plans for certain plan amendments previously adopted during 2009 plan years. (This relief was originally announced in IRS Announcement 2009-82 but was not formalized until now.) Plan sponsors were granted up to 30 days following the effective date of these amendments to provide the required 204(h) notice. Amendments affected are those that:
  - Changed an interest crediting rate under a statutory hybrid plan
  - Were adopted after November 10, 2009, and on or before the last day of the first plan year beginning on or after January 1, 2009
  - Were effective no later than the first day of the first plan year beginning in 2010

Notice 2011-85 serves as an announcement that the Treasury and the IRS intend to amend the final hybrid plan regulations under § 411(b)(5). Until the 2010 final hybrid plan regulations are formally amended, plan sponsors may rely on this notice with respect to the postponement of the effective dates.

Current indications are that revised final regulations will not be issued until sometime in 2012. As mentioned earlier, this notice could be a sign that certain portions of the regulations, particularly the market rate of return requirements, could be under review by the IRS, so additional changes could be forthcoming.

Guidance on the New "Summary of Benefits and Coverage"

The **Patient Protection and Affordable Care Act (PPACA)** added a number of reporting and disclosure requirements for health plans, including a mandatory four-page summary of the benefits and coverage available under a group health plan. The stated goal of the standardized notice is to provide individuals a uniform document with which to compare the cost and coverage of various benefit options. PPACA mandated that guidance on the notice be provided by March 23, 2011, but proposed regulations were not issued by the Departments of Health and Human Services, Labor and Treasury until August 22. Under the regulations, the new disclosure document, known as the **Summary of Benefits and Coverage (SBC)**, has three essential components:

- A *summary of plan features* highlighting the key features of a plan's benefits and coverage to help enrollees make health coverage decisions. A template SBC has been issued.
- *Coverage examples* illustrating the expenses that would be covered by the plan under common scenarios. Similar to the nutritional information panels on food packages, these examples would be designed to allow participants to compare costs under different benefit options.
- A *uniform glossary* defining common medical and insurance terms. A separate four-page template that satisfies the glossary requirement has been issued.

Currently, plan sponsors must comply with ERISA-mandated disclosures, such as a summary plan description (SPD), and most plan sponsors also provide employees with extensive (and expensive) health benefit informational materials, both electronically and in print. Under the proposed rules, the SBC must be provided in addition to the other communications that plans provide.

Effective date. The SBC requirements are scheduled to take effect on March 23, 2012. At present, it appears that on that date, plan sponsors must be prepared to provide SBCs to newly eligible individuals automatically and to others upon request, and, during 2013 Open Enrollment, SBCs must be distributed to the employee population at large.

What's a plan sponsor to do? Plan sponsors and their advisors are in a dilemma. The August 2011 regulations are still only proposed. They have generated extensive controversy, and it is expected that regulators will need to consider voluminous public comments. Still, it is not known when regulations will be finalized or what changes they will contain. Because complying with the proposed rules will require great effort by employers, service providers, insurers and others, waiting for final guidance before taking action would make it impossible to meet the March 23, 2012, effective date (if it survives). Regulators have requested comments on the feasibility of complying with the effective date, but it is much too early to know if the effective date will be extended.

Next steps. Time is not on the employer's side. Mercer is analyzing how to best help plan sponsors meet their obligation to provide the SBC under the rules as they stand now and will keep our clients updated on new developments. For now, here is a summary of the key elements of the SBC rules, to provide you with a head start in the compliance process:

Issue	Requirements	Comments/Action Items
Who must provide the SBC?	The party responsible for providing the SBC depends on the type of plan: ■ Self-insured plans: plan sponsor (or designated plan administrator) ■ Insured plans: The insurer and plan sponsor both are responsible for providing the SBC. The delivery requirement is satisfied if either party provides the notice.	**Determine who will provide the SBC.** Plan sponsors should coordinate with carriers to determine who is responsible for providing the SBC. Even where vendors will be responsible, the employer probably will be involved, since it is unlikely that one entity will have all the data needed to create and provide an SBC.
Which plans must provide the SBC?	All group health plans – insured and self-insured, grandfathered and nongrandfathered – are subject to the requirement. As with other health care reform requirements, certain benefit plans fall outside the definition of a "group health plan" and are not required to provide the SBC. These include: ■ Retiree-only plans ■ Stand-alone dental and vision plans ■ Employee assistance plans (EAPs) not considered a group health plan ■ Health care FSAs funded exclusively with employee contributions	**Determine which plans must provide the summary.** Plan sponsors should work with their benefits advisors to determine which plans will require an SBC. **Determine how many SBCs are needed.** A separate SBC is needed for each "benefit package." For complex plan designs, a separate SBC may be needed not only for each plan, but for each benefit variation within the plan.
Who must receive the SBC?	The SBC must be provided to each eligible participant or beneficiary. If participants and beneficiaries reside at the same address, providing a single SBC will be sufficient. However, if a beneficiary's last address of record differs from the participant's, then a separate SBC must be sent to that beneficiary.	**Identify who must receive the summary.** Spouses living apart and covered children with an address different from the covered employee, of which the plan is aware, must receive a separate mailing.

Issue	Requirements	Comments/Action Items
When must the SBC be provided?	The SBC must be provided on several different occasions. ■ ***At initial enrollment:*** Participants and beneficiaries must receive a separate SBC for each benefit option for which they are eligible. The SBC(s) must be provided as part of enrollment materials (such as new-hire kits). If the employer doesn't distribute written enrollment materials, the SBC must be provided no later than the first date on which the participant is entitled to enroll. For electronic enrollments, the proposed rules appear to require that receipt of the SBC(s) be acknowledged, as a prerequisite to enrollment. Finally, if there are any changes to the SBC before the first day of coverage, the plan must provide an updated SBC no later than the first day of coverage. ■ ***HIPAA special enrollments:*** A special enrollee must receive the SBC within seven days of the request for HIPAA special enrollment. ■ ***Open Enrollment:*** In plans with multiple benefit options, only the SBC for the option that the participant is currently enrolled must be provided. *When the participant is defaulted* into current coverage, if the participant doesn't change benefit coverage, an SBC must be provided no later than 30 days prior to the first day of the new plan year. *When the participant must elect coverage*, an SBC must be provided along with the Open Enrollment materials, no later than the date those materials are distributed. ■ ***Upon request:*** A participant or beneficiary must receive an SBC, upon request, for any "benefit package" for which he or she is then eligible. The requested SBC must be delivered as soon as possible, but no later than seven days following the request.	**Review enrollment process.** Employers may need to revise their paper and/or electronic enrollment practices to ensure that SBCs are delivered timely (and possibly to design a means of acknowledging SBC receipt for electronic enrollments). **Short timeframes.** Employers will need to be prepared to make distributions of SBCs onsite, whenever timely distribution of SBCs by plan service provider is not feasible. **Disconnect.** The proposed regs do not take into account the fact that HIPAA special enrollments are often effected by participants online, with no special "request" and, therefore, no notice to the plan that an SBC is needed. **Initial enrollees during Open Enrollment period.** Some confusion exists about the means of providing the correct SBC(s) to individuals who are hired or become eligible during an Open Enrollment period. **Seven-day deadline.** Many employers and service providers will find that seven days is not a sufficient time to process and fulfill requests for appropriate SBCs.

Issue	Requirements	Comments/Action Items
What must be included in the SBC?	**Content of SBC.** The SBC must contain a lengthy list of information items: ■ Uniform definitions of medical and insurance terms ■ Description of coverage ■ Description of plan's exceptions, reductions and limitations of coverage ■ Cost-sharing provisions, including deductibles, coinsurance and copayments ■ Renewability and continuation of coverage provisions ■ Beginning in 2014, statement whether the plan provides "minimum essential health coverage" and whether the plan's share of total allowed costs of benefits meets applicable requirements ■ Statement that SBC is a summary only and that plan document should be consulted to determine governing provisions ■ Contact information to submit questions or obtain copy of plan or insurance contract ■ For plans with more than one network of providers, contact information for the listed network providers ■ Internet address for "uniform glossary" ■ Coverage examples for common scenarios ■ Information on cost of coverage ■ For plans with a prescription formulary, contact information on prescription drug coverage	**Consult with benefits advisor.** Plan sponsors should work with their benefits counsel and other advisors on the number and contents of various SBCs. **Determine if state disclosure requirements apply.** For insured plans, the proposed regulations allow states to impose stricter disclosure requirements, so plan sponsors must determine whether states impose additional participant reporting requirements.

Issue	Requirements	Comments/Action Items
What are the formatting requirements for the SBC?	The proposed regulations require that an SBC be presented in a uniform format, using terminology understandable by the average enrollee. The SBC must be provided as a stand-alone document, in a specified format, with no changes permitted to the order or content of the information. Unlike other employee benefit notices that plan sponsors are accustomed to providing (SPDs, SARs, etc.), even the font size and number of pages of the notice are specified by law – i.e., no more than four double-sided pages in at least 12-point font. (The instructions to the SBD templates even specify required colors, bolding and shading.) The template SBC provides text blanks for plan-specific information, and only limited changes may be made to the template, as necessary to accommodate some plan designs. The "uniform glossary" is also required to be provided, in the exact format detailed in the guidance, without modification.	**Review communication strategies.** Managing employee communications has become more critical, as the law prohibits any inconsistency between the language of any employer communications and the language of the mandatory SBC and the uniform glossary. At least initially, employers and their counsel should carefully review their existing enrollment materials, forms, brochures and other communications, to ensure that there are no such conflicts. **Review SPD.** Similarly, SPDs and other legally required notices should be reviewed to make sure their terminology matches that in the SBC and the uniform glossary.
How must the SBC be provided?	The SBC must be provided in paper form, unless the plan sponsor can satisfy the DOL's existing electronic delivery safe harbor rule. (In general, employees whose employment includes regular access to a company computer network can be notified electronically without consent. All others must give consent to electronic delivery or must receive notice in paper form.)	Determine method to provide the notice. Many employers have difficulty satisfying the DOL electronic delivery safe harbor requirements, so most plan sponsors will at least need to be prepared to provide the SBC in paper form. DOL is currently considering an update to its electronic delivery regulations, but it is unknown when revised rules might be issued.

Issue	Requirements	Comments/Action Items
How must the "uniform glossary" be provided?	Unlike the SBC, the "uniform glossary" of insurance terms that is part of the SBC need not be delivered automatically to participants and beneficiaries. Rather, the plan sponsor or insurer can make the glossary available to participants and beneficiaries by providing: ■ An Internet address where it can be accessed ■ A paper copy, if requested by participants and beneficiaries. The glossary must be provided within seven days of the request.	**Determine how to provide the glossary.** Plan sponsors must be prepared to post the uniform glossary on the Internet as well as have a process to provide a paper copy to participants and beneficiaries who request a copy. The government has provided a model glossary for this purpose.
What are the SBC foreign language requirements?	Like some other federally mandated notices, the SBC must be provided to participants and their beneficiaries "in a culturally and linguistically appropriate manner." Employers can satisfy this requirement by following the similar rules contained in the recently expanded ERISA claims and review procedures. Under the rules, foreign language assistance is required for participants and beneficiaries who live in any of the U.S. counties in which the U.S. Census Bureau has determined that at least 10% of the population is literate only in the same non-English language. The list of counties and languages is updated periodically; currently the relevant non-English languages are Spanish, Mandarin, Navaho and Tagalog, and the rules affect 255 counties nationwide. Plan sponsors impacted by the foreign language requirement because they have plan participants in these counties are required to: ■ Include in the SBC a statement, in the relevant non-English language, that translation services are available ■ Provide a translated SBC upon request	**Determine if the foreign language requirements apply.** Plan sponsors should assess their covered populations to determine whether the foreign language mandate applies, and to which benefit packages. To minimize the possibility that a translated SBC will be required for participants and beneficiaries living in the affected counties, a statement on the availability of translation services should be included in all SBCs. **Mercer support.** Plan sponsors affected by the foreign language rules should notify Mercer of that need and of the languages required. Sponsors may provide their own translated documents for mailing by Mercer, or Mercer can obtain translation services, as desired.

Issue	Requirements	Comments/Action Items
What if benefits change?	If a "material modification" in any of the terms of a plan occurs that would impact the contents of the most recent SBC, a notice of that change must be provided to all affected participants and beneficiaries, at least 60 days prior to the date on which the modification is to become effective. A "material modification" can consist of any significant change to the terms of the plan, especially any increase or decrease in benefits or services or an increase in cost. NOTE: If the "material modification" is made in connection with the renewal of coverages during an Open Enrollment period, the SBC(s) provided during Open Enrollment will satisfy the requirement. This requirement can be met by sending a separate notice describing the "material modification," or by providing an updated SBC.	**Plan ahead for changes.** Although plan changes outside of Open Enrollment are not common, any mid-year changes will need to be coordinated with the effective date of the change and timely provision of the notice no more than 60 days before the change takes effect. **Review ERISA disclosure requirements.** A timely SBC will also satisfy the summary of material modification (SMM). As a result, plan sponsors may not need to provide separate SMMs when health plan changes are adequately described in an SBC.
What happens if the SBC isn't provided timely?	If any SBC is not timely delivered, plan sponsors can face significant penalties, including: ■ A fine of up to $1,000 for each willful failure to provide the SBC (with each enrolled individual a separate offense) ■ An IRS excise tax penalty equal to $100 per individual, per day of the failure (which must be reported to the IRS on Form 8928 and paid without assessment)	**Be prepared.** Given the potential drastic cost of failing to comply with the SBC rules, plan sponsors should begin to put processes in place to comply. The complexity, ambiguity, expense and difficulty that these proposed regulations entail may suggest they will be changed substantially, or their effective date and enforcement delayed. However, March 23, 2012, remains the deadline to comply with the entire notice regime.

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