Questions and Proposed Answers for the Department of Labor Staff for the 2011 Joint Committee of Employee Benefits Technical Session Held on May 6, 2011

The following questions and answers are based on informal discussions between private sector representatives of the Joint Committee on Employee Benefits (JCEB) and Department of Labor (DOL) staff. The questions were submitted by ABA members, and the responses were given at a meeting of JCEB and government representatives. The responses reflect only unofficial, nonbinding staff views as of the time of the discussion, and do not necessarily represent the official position of the DOL. Further, this report on the discussions was prepared by JCEB representatives, based on their notes and recollections of the meeting.

1. **PPACA: Rescission Question**

   **Question:** If a spouse or child loses eligibility as a result of a qualifying event, but fails to provide the required 60-day notice of the event (assuming the proper initial notice of this requirement has been provided), can the plan terminate coverage retroactive to the date coverage should have been lost, without violating PPACA’s limitation on rescission?

   **Initial Proposed Answer:** Yes. According to the DOL’s Q&As on PPACA, if there is a failure to provide notice of a divorce, the plan can treat the ex-spouse as having elected COBRA and bill him or her for the COBRA cost, but the Q&A assumes that the notice was provided on a timely basis such that the ex-spouse was eligible for COBRA. The implication of the answer is that termination of coverage retroactively under COBRA (for failure to pay premiums) is not rescission of coverage within the meaning of the PPACA provisions. Therefore, if the ex-spouse or child is not eligible for COBRA because of a failure to provide notice, retroactive termination of coverage is appropriate under COBRA and is not a rescission of coverage under PPACA, whether or not the employer can prove that the failure to provide notice was a deliberate misrepresentation.

   **DOL Answer:** The JCEB and the DOL had a discussion about health reform issues and implementation generally. Any specific questions that are appropriate for FAQ guidance will be addressed by the three Departments through that guidance process.

2. **PPACA: Rescission Question**

   **Question:** In an FAQ published jointly by the Departments, the agencies addressed a situation of administrative delay where the human resource department reconciles lists of eligible individuals with their plan once per month. According to the Q&A, if a plan covers only active employees (subject to
COBRA) and an employee pays no premiums for coverage after termination of employment, the Departments do not consider the retroactive elimination of coverage back to the date of termination of employment, due to delay in administrative recordkeeping, to be a rescission.

There are other situations that involve administrative delay where the premium is paid. For example: The employer pays 100% of the premium at the beginning of the month. The employee terminates employment mid-month and the coverage ends when employment ends, but the third party administrator does not receive notice of the termination until the end of the month, at which time the premiums for the later half of the month are refunded. Is this considered a rescission?

**Initial Proposed Answer:** The delay in administrative recordkeeping should not be considered a rescission in cases where the premium is paid and then refunded. Since the Departments do not consider a retroactive elimination of coverage back to the date of employment termination due to a delay in administrative recordkeeping to be a rescission when no premiums have been paid, it would be consistent to apply this same thinking when premiums have been paid and are then refunded.

**DOL Answer:** The JCEB and the DOL had a discussion about health reform issues and implementation generally. Any specific questions that are appropriate for FAQ guidance will be addressed by the three Departments through that guidance process.

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**3. PPACA: Rescission Question**

**Question:** During open enrollment employees were informed in written materials that only adult children that did not have coverage through another employer-sponsored health plan were eligible to enroll and receive coverage under the plan. An employee enrolled a child with coverage beginning January 1, 2011. Certification forms were sent to all children age 19 to 26 who were enrolled in the plan beginning January 1, 2011. The plan received a completed certification form indicating that an adult child had eligibility for coverage through their own employment and that the eligibility existed prior to January 1, 2011. Would this be considered an intentional misrepresentation of material fact on the part of the employee? Is retroactive cancellation permitted?

**Initial Proposed Answer:** This would be considered an intentional misrepresentation of material fact and therefore a retroactive cancellation would be permitted. Since enrolling employees were given written notification that certain children were not eligible to enroll or receive coverage under the plan, a failure to abide by this written material should constitute an intentional misrepresentation of material fact.
4. PPACA: Grandfather Status Question

Question: Will a plan lose grandfather status if the plan drops coverage of non-preferred providers?

Initial Proposed Answer: No. Dropping coverage of non-preferred providers is not one of the changes listed in §2590.715-1251(g)(1) and therefore should be permitted without triggering the loss of grandfather status.

DOL Answer: The JCEB and the DOL had a discussion about health reform issues and implementation generally. Any specific questions that are appropriate for FAQ guidance will be addressed by the three Departments through that guidance process.

5. PPACA: Grandfather Status Question

Question: A plan has a $500 deductible for all benefits on March 23, 2010, except for wellness. The plan is contemplating applying the $500 deductible to wellness. Will the plan lose grandfather status?

Initial Proposed Answer: No. Since wellness represents only a very small portion of the plan, the "maximum percentage increase" should not be calculated based on moving from $0 to $500. Plans should be permitted to determine the fraction of the plan that comprises wellness and calculate the "maximum percentage increase" based on the fraction.

DOL Answer: The JCEB and the DOL had a discussion about health reform issues and implementation generally. Any specific questions that are appropriate for FAQ guidance will be addressed by the three Departments through that guidance process.

6. PPACA: Extension of Coverage for Children

Question: Under the special rule for grandfathered group health plans, a group health plan may exclude an adult child who has not attained age 26 from coverage only if the adult child is eligible to enroll in an eligible employer-
sponsored health plan (as defined in Section 5000A(F)(2) of the Internal Revenue Code) other than a group health plan of a parent.

If a dependent goes on active duty, is his military coverage considered employer-sponsored coverage for purposes of this special rule?

**Initial Proposed Answer:** No. Prior agency thinking has not considered military coverage to be considered employer-sponsored coverage.

**DOL Answer:** The JCEB and the DOL had a discussion about health reform issues and implementation generally. Any specific questions that are appropriate for FAQ guidance will be addressed by the three Departments through that guidance process.

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7. **PPACA: Extension of Coverage for Children**

**Question:** The standard meaning of "placed for adoption" involves a child's financial dependency on the employee. Are plans now prohibited from requesting financial dependency in cases where there is a placement for adoption?

**Initial Proposed Answer:** No. The statutory language of PPACA does not specifically address the definition of "placed for adoption." It does not appear that the congressional intent of the PPACA extension of dependent coverage was to circumvent the standard meaning of "placed for adoption."

**DOL Answer:** The JCEB and the DOL had a discussion about health reform issues and implementation generally. Any specific questions that are appropriate for FAQ guidance will be addressed by the three Departments through that guidance process.

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8. **PPACA: External Review Question**

**Question:** In Technical Release 2010-01, the Department of Labor permitted non-grandfathered self-insured group health plans to comply with either the standards in the Technical Release, or to comply with available state external review processes.

The federal external review process applies to all adverse benefit determinations except those based on eligibility. In contrast, the state external review process need only cover determinations based on requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.
If the self-insured plan decides to use the state external review process, can the plan refuse to send to external review any determinations that, although adverse, are not based on requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit?

**Initial Proposed Answer:** Yes, as long as Technical Release 2010-01 remains in force.

**DOL Answer:** The JCEB and the DOL had a discussion about health reform issues and implementation generally. Any specific questions that are appropriate for FAQ guidance will be addressed by the three Departments through that guidance process.

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**9. PPACA: External Review Question**

**Question:** A participant is disputing a reduction in the amount paid by a self-insured plan for out-of-network benefits, because the participant failed to obtain the requisite pre-authorization. Is this appeal a candidate for external review?

**Initial Proposed Answer:** Yes, if the self-insured plan is using the federal external review process. This is an adverse benefit determination not based on eligibility. No, if the self-insured plan is using a state external review process which is limited to determinations based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

**DOL Answer:** The JCEB and the DOL had a discussion about health reform issues and implementation generally. Any specific questions that are appropriate for FAQ guidance will be addressed by the three Departments through that guidance process.

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**10. PPACA: External Review Question**

**Question:** Assume a health flexible spending account (FSA) meets the requirements for an excepted benefit under the HIPAA portability regulations. Is the health FSA required to comply with either the external review procedures or the enhanced internal appeal procedures under the PPACA?

**Initial Proposed Answer:** No. The particular health FSA is not considered a "group health plan" subject to the external review procedures and enhanced internal review procedures. See 29 CFR §2590.732, Special rules relating to group health plans.

**DOL Answer:** The JCEB and the DOL had a discussion about health reform issues and implementation generally. Any specific questions that are appropriate
for FAQ guidance will be addressed by the three Departments through that guidance process.

11. PPACA: External Review Question

Question: A self-insured health plan provides for two levels of internal ERISA claims appeals, followed by voluntary binding arbitration. At what stage can the participant request external review?

Initial Proposed Answer A: It appears that the voluntary binding arbitration is the final level of internal appeal. Therefore, the participant can request external review if he or she loses at the voluntary binding arbitration. "Binding" simply means that the participant agrees not to bring a civil action under ERISA if he or she does not like the outcome of the arbitration. It does not affect the participant's right to external review.

Initial Proposed Answer B: Voluntary binding arbitration would be meaningless if a participant could simply move on to external review. Therefore, the sequence would be (1) first internal appeal, (2) second internal appeal, (3) external review, and (4) either voluntary binding arbitration, or suit in federal court.

DOL Answer: The JCEB and the DOL had a discussion about health reform issues and implementation generally. Any specific questions that are appropriate for FAQ guidance will be addressed by the three Departments through that guidance process.

12. PPACA: Model Notice of Adverse Benefit Determination

Question: Will the items required on the model notice of adverse benefit determination trigger a HIPAA privacy violation? This notice has fields for a diagnosis and diagnostic codes. The preamble to the December 2000 final HIPAA privacy regulations do not anticipate that medical diagnoses are placed on EOBs.

Initial Proposed Answer: No. The final HIPAA privacy regulations require that group health plans provide individuals with the opportunity to agree or object to disclosures to family members (§164.510(b)(2)). Non-minor children and spouses have the opportunity to request that the health plan withhold information from the employee. As long as the plan explains the right to request a confidential communication, the inclusion of the diagnosis and diagnostic codes on the notice of adverse benefit determination will not trigger a HIPAA privacy violation.
**DOL Answer:** The JCEB and the DOL had a discussion about health reform issues and implementation generally. Any specific questions that are appropriate for FAQ guidance will be addressed by the three Departments through that guidance process.

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**13. PPACA: Excepted Benefits Question**

**Question:** An employer has a stand alone retiree only medical plan. Historically, retirees who are rehired have stayed in the retiree only medical during their reemployment period. Will the plan no longer be considered a retiree only plan because of the rehired retirees - there is more than one actively employed period in the plan? If the answer is yes, will there be an exception made to this rule such that the retiree plan does not have to comply with the market reforms under PPACA?

**Initial Proposed Answer:** The retiree plan would lose its status as a retiree only plan because actively employed participants are participating in the plan. There is no exception from complying with the market reforms under PPACA.

**DOL Answer:** The JCEB and the DOL had a discussion about health reform issues and implementation generally. Any specific questions that are appropriate for FAQ guidance will be addressed by the three Departments through that guidance process.

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**14. PPACA: Excepted Benefits Question**

**Question:** Employer has separately insured group dental and vision policies that are bundled with other benefits. Are the dental and vision benefits considered excepted benefits and not subject to Health Care Reform Public Health Service Act (“PHSA”) provisions? The employer offers a bundled benefits package to its employees. The employees have a choice of two medical plans (a fully insured HMO and a self-funded PPO), along with self-funded prescription drug benefit, insured dental, and insured vision. There is no separate election or opt out for dental or vision. Employees either say yes to the entire package of benefits, or they waive the entire benefits package.

Would the dental and vision plans be considered excepted because each benefit has a different insurer and policy number, or would they not be considered excepted because of the bundling?

Does DOL FAQs About the Affordable Care Act Implementation Part II, Q/A 6 imply that benefits under the facts above would not be excepted because of bundling?
Initial Proposed Answer: These dental and vision benefits are provided under separate policies. Under the limited scope dental and vision exception, benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, OR are otherwise not an integral part of a group health plan. Benefits are not an integral part of a group health plan (whether the benefits are provided through the same plan or a separate plan) only if the following two requirements are satisfied:

♦ Participants must have the right to elect not to receive coverage for the benefits; and

♦ If a participant elects to receive coverage for the benefits, the participant must pay an additional premium or contribution for that coverage.

The separate policy, certificate, or contract of insurance condition is met for dental and vision insurance policies under these facts, so those benefits are excepted benefits. Bundling does not alter the analysis or lead to a different conclusion. (The dental and vision benefits do not provide for a separate premium for the coverage so they arguably are considered to be an integral part of the group health plan under the second prong of the definition.)

The dental and vision benefits offered under the separate policies have to be limited scope benefits.

Department of Labor FAQs About the Affordable Care Act Implementation Part II, Q/A 6 (http://www.dol.gov/ebsa/faqs/faq-aca2.html) includes the following:

Q6: What if my dental (or vision) benefits are structured as excepted benefits under HIPAA? Does that exemption except my dental (or vision) plan from the Affordable Care Act’s market reforms?

Yes. If benefits constitute excepted benefits under HIPAA, the requirements of the Affordable Care Act’s market reforms do not apply. Under HIPAA, dental (and vision) benefits generally constitute excepted benefits if they:

♦ Are offered under a separate policy, certificate, or contract of insurance; or

♦ Are not an integral part of the plan. For dental (or vision) benefits to be considered not an integral part of the plan (whether insured or self-insured), participants must have a right not to receive the coverage and, if they do elect to receive the coverage, must pay an additional premium.

Accordingly, if a plan provides its dental (or vision) benefits pursuant to a separate election by a participant and the plan charges even a nominal employee contribution towards the coverage, the dental (or vision)
benefits would constitute excepted benefits, and the market reform provisions would not apply to that coverage.

The last sentence of the FAQ was not intended to create ambiguity for a bundled plan. A bundled plan with a separate insurance policy for dental or vision could use the first prong of the limited dental/vision exception. It also does not matter whether the bundled plan is filed under one Form 5500 plan number or not.

DOL Answer: The JCEB and the DOL had a discussion about health reform issues and implementation generally. Any specific questions that are appropriate for FAQ guidance will be addressed by the three Departments through that guidance process.

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15. PPACA: Excepted Benefits Question

Question: Is a Texas voluntary injury benefit plan that (1) provides medical and income replacement benefits solely for workplace injuries and illnesses and (2) is maintained by a Texas employer that does not subscribe to the state workers' compensation system an "excepted benefit" under Part 7 of ERISA and the parallel provisions of Chapter 100 of the Internal Revenue Code?

Initial Proposed Answer: Yes. Approximately one-third of all Texas employers covering over 1.5 million Texas employees do not subscribe to the Texas workers' compensation system ("nonsubscribers"). Because Texas nonsubscriber plans provide coverage similar to workers' compensation coverage, these plans are exempt from Part 7 of ERISA and Chapter 100 of the Code. See, ERISA Section 733(c)(1)(D) and IRC Section 9832(c)(1)(D) that exempts "workers' compensation and similar insurance," and their implementing regulations under DOL Reg. Section 2590.732(c)(2)(iv) and Treas. Reg. Section 54.9831(c)(2)(iv) that exempts "workers' compensation or similar coverage."

Background: The workers' compensation system in Texas is purely voluntary. (See, Texas Labor Code §406.002.) Employers in Texas may elect whether to provide state regulated worker's compensation benefits, i.e., "subscribe" to the state program. Employers who subscribe to the state regulated workers' compensation program may either pay into the state system on an insured basis or may self-insure the state provided benefits. (See Texas Labor Code §406.003.) Alternately, an employer may elect to be a nonsubscriber. Under Texas law, a nonsubscriber is not required to provide workers' compensation benefits for its employees and may be sued for any workplace injury or illness. These employers are subject to negligence liability claims (similar to general liability claims) from injured employees that can prove that their injuries resulted from the employer failing to provide a safe workplace. To limit their liability nonsubscribers provide an occupational injury plan (referred to as a "Nonsubscriber Plan") that provides medical and salary continuation benefits for
Texas employees who experience a workplace injury or illness. Some Nonsubscriber Plans also provide death, dismemberment, income replacement and other forms of work-injury related benefits. However, no dependents participate in a Nonsubscriber Plan (except as a beneficiary of a death benefit provided by the plan), because only those employees who actually experience a workplace injury or illness are eligible to receive benefits. Similar to many other workers’ compensation programs in other states, Texas Nonsubscriber Plans are typically self-insured, with some employers obtaining stop loss coverage for both benefits and liability exposure. A Texas Nonsubscriber Plan is solely limited to workplace injury and illnesses. Thus, like other plan sponsors who desire to provide major medical coverage for their eligible employees and dependents, a Texas Nonsubscriber Plan sponsor will also provide a separate ERISA plan providing major medical coverage for non-workplace injuries and illnesses.

**Status Under ERISA**

ERISA §4(b)(3) provides that ERISA shall not apply to any employee benefit plan if the plan “is maintained solely for the purpose of complying with applicable workmen's compensation laws or unemployment compensation or disability insurance laws.” Various court decisions have held that Texas Nonsubscriber Plans are not maintained "solely to comply with" workers' compensation laws, and thus are not eligible for this ERISA exception that covers substantially all other state workers’ compensation systems. As a result, Texas Nonsubscriber Plans satisfy the definition of an "employee welfare benefit plan" under ERISA §3(1).

**Status Under the IRC**

A Texas Nonsubscriber Plan provides, in part, health care to employees. As a result, a Texas Nonsubscriber Plan is a “group health plan” under IRC Section 5000(b)(1).

**Texas Nonsubscriber Plans are Similar Insurance / Coverage to Workers’ Compensation**

Texas Nonsubscriber Plans provide coverage to Texas workers for workplace injuries and illnesses, thereby making these plans similar to workers’ compensation. The phrase “solely to comply with” under ERISA Section 4(b)(3) means that the exclusive reason to maintain the plan must be to comply with the workers' compensation system of Texas. Alternatively, the phrase “similar insurance” and “similar coverage” in the excepted benefit provisions of ERISA Part 7 and IRC Chapter 100 does not require that the exclusive purpose of the Plan be to comply with the workers' compensation system. Rather, the phrase only requires that the Plan be “similar to” or have characteristics in common with workers' compensation in order to be an excepted benefit. As noted above, Texas Nonsubscriber Plans are the functional equivalent of workers’ compensation and should be exempt from ERISA Part 7 and IRC Chapter 100. Texas courts have also held that Texas Nonsubscriber Plan benefits are “non-fringe benefits” (unlike traditional major medical coverage) and that the primary purpose of such benefits (similar to workers’ compensation) is to protect nonsubscriber employers from liability exposure. Rentech Steel v. Teel (Tex. App. – Eastland, August 13, 2009).
16. Plan Existence Question

Question: An employer offers chair massages at work as a benefit to employees. The massages are offered on a regular and ongoing basis. The employees do not have to have a specific illness or injury in order to get a chair massage. The idea is to promote general well-being and reduce stress.

Is this benefit subject to ERISA as an employee welfare benefit plan under ERISA Section 3(1)? (Assume it would not qualify as a group health plan under the definition of medical care under ERISA Section 733.)

Initial Proposed Answer: The definition of an employee welfare benefit plan providing “medical, surgical, or hospital care or benefits” under ERISA Section 3(1) is different from the definition for a group health plan under ERISA Section 733. This chair massage benefit would be subject to ERISA as a welfare benefit plan even if it did not qualify as a group health plan under ERISA Section 733. It does not matter whether the masseuse is licensed or not. Massage for general wellness can be a medical benefit under ERISA Section 3(1). Medical benefits do not have to be of a medically remedial nature to qualify as medical benefits under ERISA Section 3(1). (See, e.g., Letter to Joseph S. Dunn dated Nov. 17, 1993.)

DOL Answer: The JCEB and the DOL had a discussion about health reform issues and implementation generally. Any specific questions that are appropriate for FAQ guidance will be addressed by the three Departments through that guidance process.

17. Plan Existence Question

Question: An employer decides to offer its employees the opportunity to take a voluntary health risk assessment. The health risk assessment asks questions about the employee’s health, age, weight, exercise habits, diet, and medication. The employee is asked to provide blood pressure and cholesterol measurements if known, but no actual biometric screening is done (the employee answers the questions on-line at the provider’s web site). The employer hires a provider to conduct the health risk assessment. As part of the agreement, (i) the employer agrees to pay provider $50 for each employee who takes the health risk assessment, (ii) the provider will provide employer aggregated data based on the employees who take the health risk assessment, but not the names of the
employees or other individually identifiable information, and (iii) the provider states it will give a $25 gift card to each employee who takes the health risk assessment. Is the health risk assessment a group health plan for purposes of ERISA?

**Initial Proposed Answer:** The health risk assessment is not a group health plan. The definitions under ERISA Section 3 includes a definition for an employee welfare benefit plan but do not define a group health plan. An employee welfare benefit plan includes any plan:

established or maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise . . .
medical, surgical, or hospital care or benefits . . .

See 29 U.S.C. §1002(1) (2006) (ERISA §3(1)). Although a health risk assessment evaluates an employee’s general health, it does not provide medical care. The employee has additional information, but it is more similar to an employee reading a web site that explains health risk than to visiting a doctor for a physical exam. Therefore, the health risk assessment is not an employee welfare benefit plan.

For purposes of Part 7 of Title I of ERISA, ERISA defines a group health plan as follows:

The term “group health plan” means an employee welfare benefit plan to the extent that the plan provides medical care (as defined in paragraph (2) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

See 29 U.S.C. §1191b(a)(1) (2006) (ERISA §733(a)(1)). See also 29 C.F.R. §2590.732(a)(1) (stating, "A group health plan means an employee welfare benefit plan to the extent that the plan provides medical care (including items and services paid for as medical care) to employees (including both current and former employees) or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.").

For purposes of Part 6 of Title I of ERISA, a health reimbursement arrangement is not a group health plan.

**DOL Answer:** The JCEB and the DOL had a discussion about health reform issues and implementation generally. Any specific questions that are appropriate for FAQ guidance will be addressed by the three Departments through that guidance process.
18. Plan Existence Question

**Question:** An employer has ten facilities. As the flu season approaches, the employer determines to work with a nurse association to offer a flu clinic to its employees at four of its facilities. Employees are eligible to sign up for a time for a flu shot at the nurse association web site. The employer will pay for the full cost of the flu shot (which is $25 per shot multiplied by the number of employees who have registered). The employer does not receive the names of the employees who have registered. The flu clinic will be held on one day and, given the number of employees, there is not time to give a flu shot to each employee (employees receive the flu shot based on first come, first served with respect to registration). Is the flu shot clinic a group health plan for purposes of ERISA?

**Initial Proposed Answer:** The flu clinic is a group health plan. The definitions under Section 3 of ERISA contains a definition for an employee welfare benefit plan but do not define a group health plan. An employee welfare benefit plan includes any plan:

- established or maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise . . . medical, surgical, or hospital care or benefits . . .

See 29 U.S.C. §1002(1) (2006) (ERISA §3(1)). Because the employer pays the cost of the flu shot, the flu shot is an employee welfare benefit plan and is also a group health plan.

For purposes of Part 7 of Title I of ERISA, ERISA defines a group health plan as follows:

The term “group health plan” means an employee welfare benefit plan to the extent that the plan provides medical care (as defined in paragraph (2) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

See 29 U.S.C. §1191b(a)(1) (2006) (ERISA §733(a)(1)). See also 29 C.F.R. §2590.732(a)(1) (stating, “A group health plan means an employee welfare benefit plan to the extent that the plan provides medical care (including items and services paid for as medical care) to employees (including both current and former employees) or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.”). Again, the flu shot is a group health plan for purposes of this definition.

For purposes of Part 6 of Title I of ERISA, a flu shot is a group health plan.
DOL Answer: The JCEB and the DOL had a discussion about health reform issues and implementation generally. Any specific questions that are appropriate for FAQ guidance will be addressed by the three Departments through that guidance process.

19. Fiduciary: Plan Expenses Question

Question: The employer (who also is the plan administrator) moves its defined contribution retirement plan to a new service provider. The administrative services agreement provides that the service provider will charge a $40 benefit distribution fee against participant accounts. Incident to the move, the Employer amends the Plan to raise the cash-out limit from $1,000 to $5,000, and issues an SMM to Plan participants with the change. The new service provider sweeps the accounts and involuntarily cashes out approximately 35 participants. Can these participants be charged the $40 benefit distribution fee?

Initial Proposed Answer: Yes. In DOL Field Assistance Bulletin 2003-03, the Department of Labor condoned the imposition of benefit distribution charges on the participant to whom the distribution is being made. Assuming the $40 benefit distribution fee is reasonable, it makes no difference whether the distribution is pursuant to an involuntary cash-out or a voluntary distribution request.

DOL Answer: Staff declines to answer this question pending the Supreme Court's decision in CIGNA Corp. v. Amara, U.S., No. 09-804, oral argument 11/30/10. The question does not address whether the $40 charge was appropriately disclosed in an SMM or updated SPD. See 29 CFR 2520.102-3(l). While the facts in CIGNA are not the same as the ones presented in this question, CIGNA raises analogous issues, including the remedy when there is a question of whether adequate notice has been provided. Because the Supreme Court decision may impact the Department's position, we decline to answer this question. See also CIGNA Corp. v. Amara, 131 S.Ct. 1866, 50 EBC 2569 (2011).

20. Fiduciary: Plan Expenses Question

Question: An employer's welfare benefit plan provides employees with a health FSA administered by a third-party administrator and a choice between a self-insured PPO administered by a third-party administrator or a fully insured HMO. All three of these programs are provided through a single welfare benefit plan which includes a tax-exempt IRC §501(c)(9) VEBA trust.

The cost of this coverage will exceed the threshold value triggering the excise tax on high-cost coverage under IRC §4980I beginning in 2018. Consequently, under IRC §4980I the excise tax on high-cost coverage will cause the TPA to pay excise tax on its allocable share of the self-insured PPO and health FSA.
coverage, while the HMO will pay excise tax on its allocable share of the insured
HMO coverage (see Joint Committee on Taxation, JCX-18-10, pps 62 and 65).
If, as expected, the TPA and the HMO include the cost of these excise taxes in
the fees that each of them collect from the plan, will the pass-through of the
excise tax on high-cost coverage be a properly payable administrative expense
to be paid from the plan assets held by the VEBA or, a reasonable expenses
incurred in connection with the implementation of a settlor decision?

**Initial Proposed Answer A:** Yes, to the extent that a health insurer (or a TPA
with respect to self-insured coverage it administers), incurs excise tax liability
under IRC §4980I and passes that cost along to the VEBA-funded welfare benefit
plan to which the coverage relates, that element of cost is a reasonable expense
of administering the plan and would generally be payable by the plan.

**Initial Proposed Answer B:** Yes, to the extent that a health insurer (or a TPA
with respect to self-insured coverage it administers), incurs excise tax liability
under IRC §4980I and passes that cost along to the VEBA-funded welfare benefit
plan to which the coverage relates, that element of cost is a reasonable expense
incurred in connection with the implementation of a settlor decision and would
generally be payable by the plan.

**DOL Answer:** The JCEB and the DOL had a discussion about health reform
issues and implementation generally. Any specific questions that are appropriate
for FAQ guidance will be addressed by the three Departments through that
guidance process.

21. **Fiduciary: Plan Expenses Question**

**Question:** May a trustee who is receiving a pension benefit from a
multiemployer pension plan receive reasonable compensation for services
provided as a trustee from such plan where he is not receiving full-time pay from
a contributing employer or employer association whose employees are
participants in the plan or from an employee organization whose members are
participants in the plan,?

**Initial Proposed Answer:** Yes, per ERISA 408(c)(2).

**DOL Answer:** EBSA staff is considering this issue in an unrelated context and
declines to answer the question at this time.

22. **Fiduciary: Indirect Compensation Question**

**Question:** An ERISA lawyer provides services to its client, the retirement plan
sponsor, with regard to the client’s retirement plan. The services pertain to plan
administration and compliance and do not involve settlor functions. The retirement plan sponsor pays the lawyer, and then seeks reimbursement from the plan. Has the ERISA lawyer received "indirect compensation"?

**Initial Proposed Answer:** No. DOL Regulation §2550.408b-2(c) defines "indirect" compensation as "compensation received from any source other than the covered plan, the plan sponsor, the covered service provider, an affiliate, or a subcontractor." In this case, the ERISA lawyer has either received payment from the plan sponsor or from the covered plan (through the plan's reimbursement to the plan sponsor).

**DOL Answer:** Staff agrees that, for purposes of the Department’s amended regulations under ERISA section 408(b)(2), as contained in its interim final rule (IFR) published in July 2010 [29 CFR § 2550.408b-2(c)], the lawyer in question would not have received “indirect compensation” as defined therein. Thus, the lawyer would not be considered a “covered service provider” under paragraph (c)(1)(iii)(C) by virtue of receiving such compensation. However, staff notes that the compensation mentioned in the question would have to be disclosed as “direct compensation” if other compensation constitutes “indirect compensation” to that lawyer.

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**23. Fiduciary: Reasonable Contracting Question**

**Question:** ERISA 408(b)(2) provides: “Contracting or making reasonable arrangements with a party in interest for office space, or legal, accounting, or other services necessary for the establishment or operation of the plan, if no more than reasonable compensation is paid therefor.” Congress chose to modify the word "arrangements" and the word "compensation" with the adjective "reasonable." Congress did not choose to modify the word "contracting." Nonetheless, the Department has promulgated an “Interim Final Rule on Reasonable Contract or Arrangement Under Section 408(b)(2).” In the preamble to the Interim Final Ruled, the Department has written: “This rule amends the regulation under ERISA Section 408(b)(2) to clarify the meaning of a "reasonable" contract or arrangement for covered plans.” What is the basis for the Department’s amending a term that is not in ERISA, especially where Congress chose not to use the term.

**Initial Proposed Answer:** The Department referred to “reasonable contract” in its original regulation under ERISA §408(b)(2) and that reference has gone unchallenged. Therefore, the Department anticipated that no one would challenge its rewriting the legislation in its new regulation, despite the risk of invalidation of the regulation. See, e.g., United States v. Vogel Fertilizer Co., 455 U.S. 16 (1982).
DOL Answer: Section 408(b)(2) refers to "contracting or making reasonable arrangements . . . for . . . services". The Department interprets this phrase as providing an exemption for reasonable arrangements, whether they are made through contracting or otherwise.

24. Fiduciary: Exemption Application Question

Question: ERISA §408(b) provides: “The prohibitions provided in §406 shall not apply to any of the following transactions . . . “ Is there any basis for asserting that the exemptions in ERISA §408(b) apply only to the prohibitions in ERISA §406(a), not ERISA §406(b)?

Initial Proposed Answer: No, unless ERISA expressly states to the contrary. For example, in ERISA §408(b)(17), ERISA only provides an exemption for certain transactions otherwise prohibited under certain subsections of ERISA §406(a)(1). ERISA has no such limitation on the exemption under ERISA §408(b)(2).

DOL Answer: Staff believes that, in the absence of specific statutory provisions limiting relief provided by Congress to either section 406(a) or (b), the answer to this question about the scope of the 408(b)(2) exemption depends upon an analysis of the particular transactions being exempted and whether the particular transactions, when they occur, require an element of fiduciary self-dealing or recognition of conflicts of interest to accomplish the result intended. As explained in the Department’s regulation at 29 C.F.R. 2550.408b-2(e), the Department regards an act described in section 406(b) as a separate transaction which is not exempt under section 408(b)(2). Several court decisions have upheld this position. Credit Union v. Salmi, 262 F.3d 897, 911 (9th Cir. 2001); Whitfield v. Tomasso, 682 F. Supp. 1287, 1304 (E.D.N.Y. 1988); Donovan v. Daugherty, 550 F. Supp. 390, 404, n.3 (S.D. Ala. 1982); Gilliam v. Edwards, 492 F. Supp. 1255, 1262-63 (D.N.J. 1980); Marshall v. Kelly, 465 F. Supp. 341, 353-54 (W.D. Okla. 1978).

25. Disclosure: Failure to Provide Plan Documents

Question: If the Plan Administrator of a group health plan fails to provide documents required by the ERISA claims procedures (such as internal rules, guidelines, and protocols and other information relevant to the claimant’s claim for benefits), does the ERISA penalty of up to $110 per day apply?
Initial Proposed Answer: Yes. ERISA §502(c)(1) provides that "any administrator … who fails or refuses to comply with a request for any information which such administrator is required by this title to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) … within 30 days after such request may in the court’s discretion be personally liable to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal." This "title" refers to Title I of ERISA, including the claims procedures mandated by ERISA §503. (For a contrary view, see Jordan v. Tyson Foods, Inc., 312 Fed.Appx. 726 (6th Cir. 2008).)

DOL Answer: The JCEB and the DOL had a discussion about health reform issues and implementation generally. Any specific questions that are appropriate for FAQ guidance will be addressed by the three Departments through that guidance process.

26. Disclosure: Coordination of Guidance Question

Question: Back in 2007, the DOL provided informal guidance indicating that a summary annual report (SAR) must be distributed to each participant who was a participant covered under a plan at any time during the year to which the SAR relates and also to each pension plan beneficiary receiving benefits at any time during the year to which the SAR relates. Has the position of the DOL regarding which participants and beneficiaries must get a SAR changed since 2007? In particular, the DOL's annual funding notice (AFN) proposed regulations issued in 2010 state that participants covered under a plan on the last day of the notice year and beneficiaries receiving benefits under the plan on the last day of the notice year are entitled to the AFN. Does the DOL have any intention of coordinating its guidance regarding who is entitled to a SAR with its guidance regarding who is entitled to an AFN?

Initial Proposed Answer: Yes, in light of the position taken in the AFN regulations regarding which participants and beneficiaries are entitled to an AFN, the DOL believes that its makes sense to use the same "last day" rule with respect to SARs.

DOL Answer: The DOL has not issued guidance changing its view that a SAR must be distributed to each participant who was a participant covered under the plan at any time during the year to which the SAR relates and to each pension plan beneficiary receiving benefits at any time during the year to which the SAR relates. In light of the position taken in the AFN proposed regulation, however, staff intends to review the public comments they have received on the “last day” rule and will consider whether the SAR rule regarding to whom a SAR must be distributed should be revised.
27. Disclosure: Terminated Participants Question

**Question:** Section 209(a) of ERISA, as amended by the Worker, Retiree and Employer Recovery Act of 2008 (P.L. 110-458) (“WRERA”), requires, among other things, that a plan administrator shall make a report, in such manner and at such time as may be provided in such regulations as the Secretary may prescribe, to each employee who is a participant under the plan and who terminates his service with the employer. Section 209(a)(1) further requires that this report shall be in the same form, and contain the same information, as periodic benefit statements under Section 105(a) of ERISA. While Section 105(a) of ERISA provides that the administrator of a defined benefit plan shall furnish a pension benefit statement at least once every three years to each participant with a nonforfeitable accrued benefit and who is employed by the employer maintaining the plan at the time the statement is to be furnished, and to a participant or beneficiary of the plan upon written request, we are having difficulty reconciling the Section 105(a) requirements with the Section 209(a) requirement to provide a report to each participant who terminates service (without regard to his or her nonforfeitable benefit status).

A pension benefit statement under ERISA Section 105(a) is required to indicate, on the basis of the latest available information, (i) the total benefits accrued, and (ii) the nonforfeitable pension benefits, if any, which have accrued, or the earliest date on which benefits will become nonforfeitable, (iii) an explanation of any permitted disparity under Section 401(l) of the Internal Revenue Code of 1986 or any floor-offset arrangement that may be applied in determining any accrued benefits, (iv) shall be written in a manner calculated to be understood by the average plan participant, and (iv) may be delivered in written, electronic, or other appropriate form to the extent such form is reasonably accessible to the participant or beneficiary.

In the absence of further regulatory guidance, are reports under Section 209(a) of ERISA required for participants who terminate their service with the employer without a vested benefit and, if so, what information must be included in such report?

**Initial Proposed Answer:** Prior to the amendment to Section 209(a) of ERISA by the Worker, Retiree and Employer Recovery Act of 2008 (P.L. 110-458) (“WRERA”), Sections 2520.105-1(a) and 2520.105-2(b)(ii) and (f) of the Department of Labor’s 1980 proposed regulations (29 CFR 2520.105-1 through 2520.105-2) addressed reports that must be furnished to participants and their beneficiaries of single pension plans regarding benefits to which they are entitled or will become entitled at retirement. More specifically, the Preamble to the 1980 proposed regulations noted that, in the case of participants who have no vested benefits,
The new proposal, like the 1979 proposal, would permit plan administrators of single employer plans to satisfy the requirements to furnish individual benefit information upon termination by furnishing a statement of non-vested status. The statement of non-vested status informs the participant that he has no nonforfeitable benefits. It does not, however, provide information regarding accrued benefits. Thus, the statement of non-vested status does not require extensive calculations and may be presented to all participants entitled to it in a standardized form, with no need for preparation of an individual statement for each. However, the statement of non-vested status must inform the participant that he may request a benefit statement with more detailed information regarding his individual accrued (non-vested) benefits. Such a request must be treated as a request for a benefit statement. (45 Fed. Reg. 5123, August 1, 1980).

Although the Department of Labor issued a Field Assistance Bulletin in 2006 (DOL Field Assistance Bulletin 2006-03) in connection with periodic pension benefit statements, that Field Assistance Bulletin did not address the 1980 proposed regulations or provide any additional guidance regarding the issuance of statements to terminated participants who do not have a vested benefit. In the absence of regulations that say otherwise and in the interest of good faith compliance, employers should only be required to provide a statement of non-vested status without having to calculate accrued benefits or provide an explanation of permitted disparity or other variables under the plan formula.

**DOL Answer:** Section 209(a)(1)(B) of ERISA requires the furnishing of a benefit report upon an individual’s termination of service with his or her employer. In the absence of regulations, staff believes that good faith compliance with the statute is required. In addition, section 209(a)(1) provides that a benefit report shall contain the same information as is required in an individual benefit statement under section 105(a) of ERISA. Neither section 105 nor 209 contains special rules for non vested participants. Thus, in the absence of guidance under either ERISA 105 or 209 by the Department to the contrary, staff is of the view that plan administrators must furnish benefit reports to non vested participants upon termination of service. For other guidance on information required under section 105, see the EBSA Field Assistance Bulletin 2006-03.

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**28. Disclosure: Updated Prospectuses**

**Question:** Under the prior provision of ERISA Section 404(c) as now integrated under the new provisions of ERISA Section 2550.404a-5, are updated prospectuses required to be delivered automatically to any participant who previously made an affirmative investment election and had received timely delivery of the initial prospectus?
**Initial Proposed Answer:** No; the participant only needs to be alerted that updated prospectuses are available upon request. Moreover, the participant does not to be alerted that the prospectus has been updated.

**DOL Answer:** The ERISA section 404(c) regulation recently was amended in conjunction with publication of the Fiduciary Requirements for Disclosure in Participant-Directed Individual Account Plans Rule (“404(a) regulation”) (29 CFR 2550.404a-5). These amendments become applicable on the first day of the plan year beginning on or after November 1, 2011. As amended, the 404(c) regulation now requires that participants and beneficiaries receive the information required under the 404(a) regulation. The 404(a) regulation requires, under paragraph (d)(4)(i), that the plan administrator furnish to each participant or beneficiary a copy of a prospectus or (for non-registered investments) a similar document. These documents may be furnished either in accordance with the rule’s general timing requirements for investment-related information (on or before the date a participant or beneficiary can first direct investments and at least annually thereafter), or upon request. Without regard to prospectus disclosure, the 404(a) regulation requires that certain core investment-related information (e.g., historical performance, benchmark information, fee information, and glossary) for each designated investment option under the plan be presented to participants, in a chart or similar format, on or before the date a participant or beneficiary can first direct investments and at least annually thereafter.

**Subsequent Event:** On July 13, 2011, the Department of Labor issued a final rule extending the applicability date of the 408(b)(2) rule to April 1, 2012, and, although not altering the timing of 404a-5’s applicability date, gave plans a flexible transition period for the participant level disclosure regulation of the later of 60 days after the April 1, 2012 applicability date of the 408(b)(2) rule, or 60 days from the first day of the first plan year beginning on or after November 1, 2010 (which for some fiscal years plans may be later than 60 days after April 1, 2012).

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**29. Disclosure: Annual Notice Question**

**Question:** Is the annual notice under 29 CFR 2550.404c-5(c)(3)(ii) to be sent only to those participants who have not directed the investment of the assets in their accounts, or to all plan participants regardless of whether they have directed investment of assets in their accounts?

**Initial Proposed Answer:** Only to those who have not directed the investment of assets in their accounts. See 29 CFR 2550.404c-5(c)(2). Notice must also be issued to all new participants under 29 CFR 2550.404c-5(c)(3)(i).

**DOL Answer:** The annual notice required to comply with the Department’s qualified default investment alternative (QDIA) regulation, at 29 CFR 2550.404c-
is not required to be furnished to all plan participants. Both the initial and annual notices required under 29 CFR 2550.404c-5(c)(3) must be furnished to each participant or beneficiary “on whose behalf an investment in a [QDIA] may be made.” Fiduciary relief under the QDIA regulation will not be available with respect to assets invested in a QDIA on behalf of a particular participant or beneficiary unless both the initial and annual notice requirements have been satisfied with respect to that participant or beneficiary.

30. Disclosure: Fund Strategy Change Question

**Question:** Is a participant required to receive written notification at least 30 days, but not more than 90 days, in advance of the effective date of a change in an investment fund’s strategy under the prior provision of ERISA Section 404(c) as now integrated under the new provisions of ERISA Section 2550.404a-5?

**Initial Proposed Answer:** No, the change in fund strategy will be reflected in the updated prospectus.

**DOL Answer:** No, neither the 404(c) regulation nor the new participant-level disclosure regulation requires advance notice of the effective date of a change in investment strategy. However, in addition to performance, benchmark and fee information, the participant-level regulation, at paragraph (d)(1)(v)(C), requires that a plan administrator provide an Internet Web site address sufficiently specific to enable participants and beneficiaries to access certain supplemental information about the plan’s designated investment alternatives (DIAs). Among the supplemental information that must be made available at such Web site address is a DIA’s “principal strategies” and “principal risks” (disclosed in accordance with specified Securities and Exchange Commission standards, as appropriate).

The Internet Web site address containing such supplemental information must be made available to participants and beneficiaries in accordance with the rule’s general timing requirements in paragraph (d)(1) for investment-related information (on or before the date a participant or beneficiary can first direct investments and at least annually thereafter). The rule does not provide a specific timeframe for updating this supplemental information, for example should there be a change to a DIA’s principal strategies. However, in the Supplementary Information contained in the preamble to the final rule (75 FR 64910), the Department explains its expectation that, because participants will have continuing access to the Web site, the available information will be accurate and updated by the plan administrator, a service provider, or the issuer of the DIA as soon as reasonably possible following a change, or notification thereof.

Finally, staff notes that there may be extraordinary situations when fiduciaries, under their duties of loyalty and prudence under section 404 of ERISA, will have
a disclosure obligation beyond those addressed in the participant level regulation. See 75 FR 64910, footnote 17.

31. Disclosure: Fund Merger Question

**Question:** Is a participant required to receive written notification 30 days, but not more than 90 days, in advance of the effective date of a fund family merger under the prior provision of ERISA Section 404(c) as now integrated under the new provisions of ERISA Section 2550.404a-5?

**Initial Proposed Answer:** No, the change will be reflected in the updated prospectus and in the following year’s required disclosure under ERISA Section 2550.404a-5.

**DOL Answer:** As indicated above, the ERISA section 404(c) regulation recently was amended in conjunction with publication of the Fiduciary Requirements for Disclosure in Participant-Directed Individual Account Plans Rule (“404(a) regulation”) (29 CFR 2550.404a-5). These amendments become applicable on the first day of the plan year beginning on or after November 1, 2011. As amended, the 404(c) regulation now requires that participants and beneficiaries receive the information required under the 404(a) regulation.

The new 404(a) regulation, in paragraphs (c)(1)(i)(D) and (E), requires that plan administrators disclose, among other plan-related information, identification of the plan’s designated investment alternatives (DIAs). Paragraph (c)(1)(ii) of the rule also requires that the plan administrator must furnish a description of any changes to this plan-related information to each participant and beneficiary at least 30 days, but not more than 90 days, in advance of the effective date of such change. If, for example, a fund family merger will result in a change in the identity of a DIA offered by the plan, then the plan administrator must disclose such a change in accordance with these timing requirements. If, however, a fund family merger will have no impact on the identity of a DIA, notification is not required under this provision.

**Subsequent Event:** On July 13, 2011, the Department of Labor issued a final rule extending the applicability date of the 408(b)(2) rule to April 1, 2012, and, although not altering the timing of 404a-5’s applicability date, gave plans a flexible transition period for the participant level disclosure regulation of the later of 60 days after the April 1, 2012 applicability date of the 408(b)(2) rule, or 60 days from the first day of the first plan year beginning on or after November 1, 2010 (which for some fiscal years plans may be later than 60 days after April 1, 2012).
32. Disclosure: Fund Blackout Notice

**Question:** Is a participant required to receive written notification 30 days, but not more than 90 days, in advance of the effective date of the change in a fund’s blackout period under the prior provision of ERISA Section 404(c) as now integrated under the new provisions of ERISA Section 2550.404a-5?

**Initial Proposed Answer:** No; the change is not a plan imposed limit. The change will be reflected in the following year’s required disclosure under ERISA Section 2550.404a-5.

**DOL Answer:** It is not entirely clear what is meant by a “fund’s blackout period” in this context. If the term means a fund-based restriction on, for example, the ability to immediately withdraw an investment (e.g., 6-month waiting period), then the advance notice requirements in paragraph (c) of § 2550.404a-5 do not apply. Such restrictions, instead, are covered under paragraph (d) of this regulation. This paragraph, in relevant part, requires the disclosure of “any restriction or limitation that may be applicable to a purchase, transfer, or withdrawal of the investment in whole or in part” at least on or before the date a participant can first direct investments and annually thereafter. See (d)(1)(iv)(A)(1). This paragraph also requires Web site disclosure of the same restrictions, see (d)(1)(v)(F), with respect to which it is expected that such information will be accurate and updated as soon as reasonably possible following a change.

33. Reporting: Form 5500 Record Retention Question

**Question:** According to the instructions to the 2009 Form 5500, the Plan Administrator now must file the Form 5500 electronically but keep a copy of the Form 5500, including all required signatures, on file and make a paper copy available upon request. Does the paper copy require manual signatures, or is confirmation of the electronic signature sufficient?

**Initial Proposed Answer:** Confirmation of the electronic signature is sufficient.

**DOL Answer:** “Confirmation of the electronic signature” or a typed name on a printout is not sufficient to meet the requirement that the plan maintain a copy of the Form 5500/Form 5500-SF with all required signatures. The Department’s regulations provide with regard to electronic filing that “the plan administrator must maintain an original copy, with all required signatures, as part of the plan’s records.” See, e.g., 29 CFR 2520.103-1. A manually signed copy of the Form 5500/Form 5500-SF (whether the records are maintained as paper records or electronically in accordance with the Department of Labor’s regulations) must be kept as part of the plan’s records.
34. Participation: Working Owners Question

**Question:** In footnote 2 of the U.S. Supreme Court’s opinion in *Yates v. Hendon*, 541 U.S. 1 (2004) wrote:

The Courts of Appeals are also divided on whether working owners may qualify as “beneficiaries” of ERISA-sheltered employee benefit plans. . . The United States, as amicus curiae, urges that treating working owners as “beneficiaries” of an ERISA-qualified plan is not an acceptable solution. Brief for United States as Amicus Curiae 9 (The beneficiary approach “has no logical stopping point, because it would allow a plan to cover anyone it chooses, including independent contractors excluded by [Nationwide Mut. Ins. Co. v. Darden, 503 U.S. 318 (1992)]” and “fails to resolve participation questions for pension plans which, unlike welfare plans, tie coverage directly to service as an employee.”); id., at 24–25.

The U.S. Supreme Court then wrote: “This issue is not presented here, and we do not resolve it.” Is the position expressed in the brief still the position of the Department of Labor?

**Initial Proposed Answer:** Yes.

**DOL Answer:** In the Brief for the United States as Amicus Curiae, the Department of Labor stated that “[a] number of courts have tried to avoid treating working owners and their employees differently under ERISA by covering the owners as “beneficiar[ies]” under 29 U.S.C. 1002(8) rather than “participant[s]” under 29 U.S.C. 1002(7).” Because *Yates* held that a “working owner” may be a participant in an ERISA-covered employee benefit plan that “covers one or more employees other than the business owner and his or her spouse [emphasis added],” the question of whether a “working owner” could instead qualify as a beneficiary under the plan is no longer relevant in the context presented above.