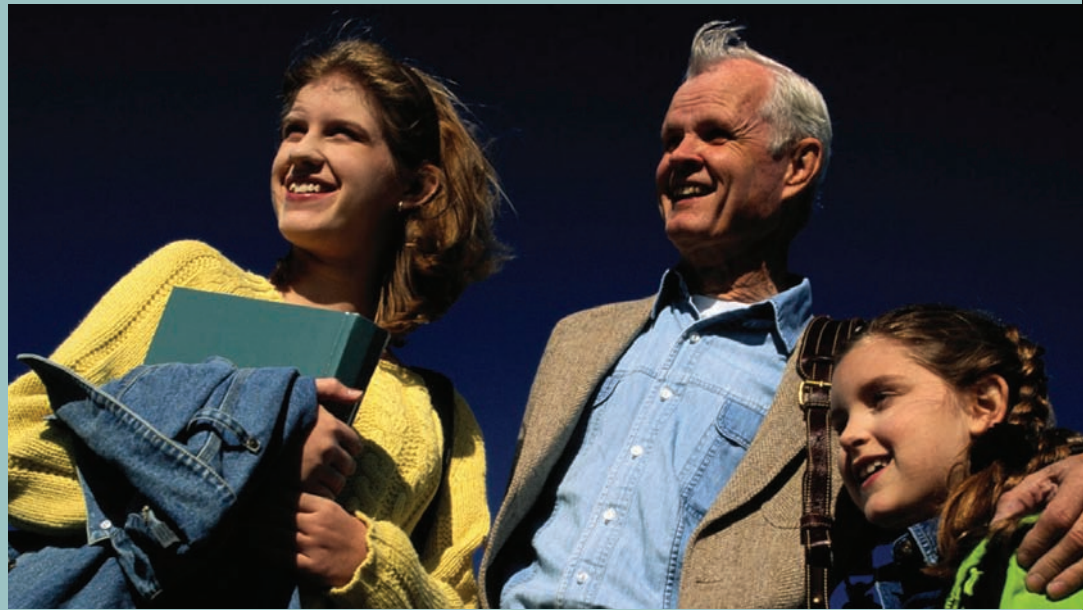




JULY-AUGUST 2008

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SUPPLEMENT YOUR CONSUMER DIRECTED HEALTH PLAN WITH VOLUNTARY BENEFITS

With the continued rise of health care costs, employers are using Consumer Directed Health Plans (CDHPs) to do more for employees while spending fewer dollars. According to Employee Benefits News, nearly 60 percent of human resources executives identify cost control as the top reason for adopting a CDHP. Now, employers are finding that voluntary health products can offer an exceptional fit with all types of CDHPs, including everything from account-based plans, such as Flexible Spending Accounts (FSAs), Health Reimbursement Arrangements (HRAs), and Health Savings Accounts (HSAs), to high deductible plans.

Examples of medical plan characteristics that may lead to a need for voluntary health products are:

- » Recent reductions in benefits within a medical plan
- » Recent increases to co-insurance, annual deductibles or out of pocket maximums
- » Only one medical plan option offered to employees
- » Plans with separate deductibles for hospital admissions

Plan design combinations can be created that incorporate voluntary health products into employee benefit programs. This has the effect of increasing employee engagement in health care costs and decision making, reducing gaps created by higher deductibles and coinsurance, and increasing overall employee satisfaction with the breadth and flexibility of benefit offerings.

MOST POPULAR SUPPLEMENTAL BENEFITS BY PRODUCT TYPE

- » Life Insurance 24%
- » Disability Insurance 20%
- » Accident Insurance 15%
- » Hospital Indemnity 15%
- » Cancer/Critical Illness 12%
- » Dental 9%
- » Long Term Care 2%

Source: Eastbridge Consulting Group, U.S. Worksite Survey, May 2006

ALLOWABLE RETIREMENT PLAN EXPENSES: WHAT CAN THE PLAN PAY?

The payment of expenses by an ERISA plan, e.g., a 401(k), defined benefit plan or money purchase plan, out of plan assets is subject to ERISA's fiduciary rules. The "exclusive benefit rule" requires a plan's assets be used exclusively for providing benefits. ERISA also imposes upon fiduciaries the duty to defray reasonable expenses of plan administration. Certain expenses (recordkeeping, compliance work, etc.) easily fall objectively within the parameters of this standard, but other expenses may be more subjective in nature. General principles of allowable expenses include:

- » The expenses must be necessary for the administration of the plan.
- » The plan's document and trust agreement must permit use of plan assets for payment of expenses.
- » The expenses must be reasonable in nature and must be incurred primarily for the benefit of participants/beneficiaries.
- » The expense cannot be the result of a transaction that is a prohibited transaction under ERISA, or it must qualify under an exemption from the prohibited transaction rules.

In light of today's plan fee environment, it is incumbent upon fiduciaries to request full disclosure of fees and expenses, how fees break down with services provided, as well as a request for a full explanation of who will be the recipient of fees. Ultimately the ability to pay expenses from a plan trust is a "facts and circumstances" determination that needs to be made by plan fiduciaries. Because it is possible that the Department of Labor may challenge such determinations, it is important that fiduciaries consult ERISA counsel prior to paying questionable expenses from a plan trust and document the decision and reasoning. If you would like more information in regards to plan expenses or help in determining how to identify proper plan expenses, please contact your plan consultant.

BENEFITS COMPLIANCE FAQs

Question: Instead of us creating a Summary Plan Description (SPD), some carriers just provide a certificate of benefits to our employees. Is that enough?

Answer: Probably not. A carrier's certificate of benefits or benefits booklet does not include all of the specific information that is required by law. According to the federal Employee Retirement Income Security Act (ERISA) §104, all employee benefit plan participants and beneficiaries must receive a Summary Plan Description (SPD) that advises them of their benefits, rights and obligations under the plan. The SPD must be written in plain language so the average participant can understand it and must include:

- » Name of the plan
- » Name and address of the plan sponsor
- » Employer identification number
- » Plan number assigned by the sponsor
- » Description and type of plan

- » Type of administration
- » Service agent and plan administrator's name
- » Address and telephone number
- » Name, title and address of each plan trustee
- » Plan's eligibility requirements for participation
- » An explanation of benefits provided by the plan
- » Circumstances that can result in ineligibility or other loss of benefits
- » Sources of contributions and the method by which the amount of contribution is calculated
- » Claims procedures
- » A statement of ERISA rights
- » Plan year dates

An SPD must be provided to all plan participants and beneficiaries within 90 days of participation in the plan, within 120 days of a new plan's effective date, every five years if it is amended or, rarely, every 10 years if it is not amended.

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