Plan sponsors and administrators routinely face the important task of responding to participant requests for information and documents. This can become a challenging and frustrating process when dealing with a hostile or adversarial participant, and even more challenging when it is unclear whether the participant is legally entitled to the requested information.

In these instances, plan sponsors and administrators are in the tough position of trying to balance a participant’s legitimate need to know certain information against the plan’s interest in avoiding undue administrative burdens and the disclosure of confidential, sensitive or potentially misleading information.

It is imperative that plan sponsors and administrators understand what information must be made available to participants upon request and the limits on a participant’s right to know. By familiarizing themselves with these rules, they can comply with their statutory obligations while minimizing their exposure to penalties, fines and litigation.

The following is a summary of the rules regarding participant requests for information and the documents that must be produced in response to those requests. These rules are in addition to the various notices and documents that must be provided to plan participants automatically, such as summary plan descriptions (SPDs) and Consolidated Omnibus Budget Reconciliation Act (COBRA) and Health Insurance Portability and Accountability Act (HIPAA) notices, and various documents that must be provided in connection with benefit claims processing and appeals.
When a plan participant or beneficiary asks for information or documents relating to the plan, ERISA is fairly specific about how the plan needs to respond. Plan sponsors that understand what must be—and what should not be—disclosed can cut their risk of penalties, fines and litigation.
Note that plans always are entitled to provide more information than is legally required if the sponsor or administrator believes it appropriate and helpful. This is a business decision that should be made after considering historical practice (e.g., whether similar documents or information have been made available in the past) and the interests of the plan, and making certain that appropriate management-level staff (and, if necessary, trustees and/or plan counsel) have been consulted.

What Disclosures Must Be Made Upon Participant Request?

Participants and beneficiaries are entitled to information about their benefits and rights with respect to their employee benefit plans so they can make informed decisions. The Employee Retirement Income Security Act (ERISA), Internal Revenue Code (IRC) and other federal laws protect these rights by imposing a duty on plan sponsors and administrators to produce certain documents when participants request them.

ERISA Sections 101(k), 104(b)(4) and 105(a) set forth the principal rules governing participant requests for information. If a request falls within the categories enumerated in these sections, the plan must provide the information. If ERISA does not mandate disclosure, then the plan is not required to provide it (although the plan may do so voluntarily if staff believes it is appropriate).

Note that certain requests may fall in a gray area where there is little guidance or when courts have differed in their interpretation of these statutes. Those requests should be reviewed on a case-by-case basis with input from plan counsel to limit potential liability.

**ERISA Section 101(k)**

The Pension Protection Act of 2006 (PPA) expanded the disclosure obligations applicable to multiemployer pension plans. Specifically, PPA added ERISA Section 101(k), which requires multiemployer plan administrators to provide a copy of the following information when a participant or beneficiary, employee representative or contributing employer requests it in writing:

- Any periodic actuarial report (including any sensitivity testing) received by a plan for any plan year that has been in the plan’s possession for at least 30 days (including actuarial reports prepared in connection with the plan’s annual valuation or pursuant to the requirements for plans in endangered or critical status)
- Any quarterly, semiannual or annual financial report prepared for the plan by any investment manager or advisor or other fiduciary that has been in the plan’s possession for at least 30 days
- Any application filed with the secretary of the Treasury requesting an extension of the years to amortize any unfunded liability under ERISA Section 304 or IRC Section 431(d), and the determination of the secretary pursuant to such application.

Because of the general nature of the first bullet point (regarding actuarial reports), the plan may wish to consult legal counsel whenever there is any question about whether a particular actuarial report is covered by a participant’s request. In addition, whenever a plan receives a “blanket” or broad-spectrum request for documents, it should provide what it can and consider asking the participant to follow up with a more specific reference to any information or documents being sought.
Section 101(k) has two other limitations. First, this provision does not expressly apply to health and welfare funds. Second, Department of Labor (DOL) regulations clarify that any information or data that served as the basis for any report or application required to be disclosed under Section 101(k) does not have to be produced pursuant to a participant request.

**ERISA Section 104(b)(4)**

Section 104(b)(4) requires administrators to provide to any participant or beneficiary upon written request:

- The latest updated SPD
- The latest annual report (Form 5500)
- Any terminal report (Form 5310)
- The relevant bargaining agreement
- The trust agreement, contract “or other instruments under which the plan is established or operated.”

It is important to note that while Section 104(b)(4) contains a catchall category (“other instruments under which the plan is established or operated”), regulatory guidance on what types of documents must be provided under this provision is limited.

This issue has also been the focus of much litigation, and courts have differed in their interpretation. Certain courts have interpreted other instruments narrowly to cover only formal legal documents that govern the plan, rather than the routine documents with which a plan conducts its operations. Other courts have interpreted the term more broadly to require disclosure when a document is indispensable to plan operation and would help participants understand their rights.

However, the general principle is that the documents referenced in Section 104(b)(4) are those that would enable “the individual participant to know exactly where he stands with respect to the plan—what benefits he may be entitled to, what circumstances may preclude him from obtaining benefits, what procedures he must follow to obtain benefits, and who are the persons to whom the management and investment of his plan funds have been entrusted.” Because these are fact-intensive inquiries, plans will need to make a document-by-document determination based on input from legal counsel. However, as a general guide, the other instruments have been construed by some courts to include:

- Insurance contracts under which the plan is established or administered
- The formula and figures used in benefit calculations
- Funding and investment policies
- Third-party administrator contracts that establish, amend or constitute part of an employee benefit plan
- The schedule of “usual and customary” fees used to determine the dollar amount that will be paid for health claims.

Other courts have determined that these documents do not have to be disclosed pursuant to the catchall provision:

- Trustee meeting minutes
- List of the names and addresses of plan participants
- Determination letters
- Bonding policies
- Trustee expense policies
- Lists of fund expenditures.

Recent regulatory guidance has clarified changes made by the Patient Protection and Affordable Care Act (ACA) to the existing ERISA internal claims and appeals procedures. Among other requirements, those rules require plans to disclose specific information upon the issuance of an “adverse benefit determination” for medical claims. DOL has clarified its position that when an internal rule, guideline, protocol or similar criterion serves as a basis for making an adverse benefit determination, either at the initial level or upon review, that information must be provided automatically in the notice of adverse benefit determination or provided to a claimant upon request. DOL believes these types of information constitute “instruments under which a plan is established or operated within the meaning of [ERISA] section 104(b)(4). . . .”

The same regulations also require a plan to provide a claimant, upon request and free of charge, reasonable access to and copies of all documents, records and “other information” relevant to their claim. That includes:

- The claimant’s medical records relating to the claim
- The diagnosis and treatment codes (and their meanings)
- The identity of the medical or vocational expert whose advice was obtained on behalf of the plan in connection with the claim
- Any relevant document, record or other information that:
  - Was relied upon in making the benefit determination
  - Was submitted, considered or generated in the course of making the benefit determination (regard-
less of whether it was relied upon)
— Demonstrates compliance with the plan’s administrative process and safeguards for ensuring consistent decision making, or
— Constitutes a statement of policy or guidance with respect to the denied claim (regardless of whether it was relied upon).24

In these instances, the underlying data or information used to develop any such rule, guideline, protocol or similar criterion is not required to be provided.25

As noted, whenever a plan receives a broad-spectrum request for documents, it should provide what it can and consider asking the participant to follow up with a more specific reference to any information or documents being sought.

**ERISA Section 105(a)**

ERISA Section 105(a) requires defined benefit plan administrators to provide, upon written request by any participant or beneficiary, a pension benefit statement (based on the latest available information) that indicates (1) the total benefits accrued and (2) the nonforfeitable pension benefits (if any) that have accrued, or the earliest date on which the benefits will become nonforfeitable.

### Other Limitations on a Participant’s Right to Information

**Rights Restricted to Participants or Beneficiaries**

Unless the specific ERISA section that governs the information request provides otherwise, plan administrators are required to produce these documents only upon request by a participant or beneficiary. Accordingly, the administrator should determine whether an individual is a participant or beneficiary at the time of the request.

ERISA Section 3(7) defines a *participant* as “any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any benefit.” By definition, this includes employees who are eligible to enroll in a plan, but not actually enrolled. It also covers employees who are in a waiting period but may become eligible in the future. However, the definition is not broad enough to cover employees who are excluded from participation in the plan.

Under ERISA Section 3(8), a *beneficiary* is “a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.” This term is also quite broad and may include an employee’s spouse, children or other permissible assignees under the plan.

With respect to requests from third parties, DOL has taken the position that any information that is required to be disclosed to a participant or beneficiary must also be disclosed to a third party (such as a doctor, hospital or other health care provider), but only when the participant or beneficiary has provided an express written authorization.26 In these cases, the plan administrator should confirm that such an authorization is on file before disclosing any requested information.

### Old Documents

ERISA also clarifies that a plan is not required to produce certain historic documents. The regulations under ERISA Section 101(k) clarify that administrators of multiemployer plans are not required to provide any reports that have been in a plan’s possession for six years or longer, or less than 30 days.27 ERISA Section 104(b)(4) also contains a similar limit by entitling a participant to only the “latest” SPD and annual report. Under this rule, a plan would not be required to provide historic Forms 5500 (although it could do so volun-
tarily without much risk, since this information generally is available online).

**Documents That Do Not Exist**

ERISA requires plan sponsors to produce only existing documents. With the exception of the pension benefit statement, there is no statutory requirement for a plan sponsor to create documents or reports specifically to satisfy a participants request for information, or to produce documents that a plan sponsor does not already have in its possession.  

**Reasonable Costs**

Plan sponsors may charge a reasonable fee for copying documents requested under ERISA Sections 104(b)(4) or 101(k). No other charges may be assessed for furnishing information, statements or documents required by other ERISA provisions, including Section 105(a), unless explicitly permitted under those ERISA sections.  

The charge cannot exceed 25¢ per page, and the plan sponsor must charge less if the actual cost to the plan sponsor is less. Further, while a plan administrator may charge for the cost of mailing or delivering documents provided under ERISA Section 101(k), those charges are not permitted for documents provided under ERISA Section 104(b)(4). Upon request, a plan administrator is also required to provide information about the charge that would be required to provide a copy of the materials requested.  

**Identifiable or Proprietary Information**

As a general matter, plan sponsors are not required to provide any information that is reasonably determined to include individually identifiable information regarding any plan participant, beneficiary, employee, fiduciary or contributing employer, or any proprietary information regarding the plan, any contributing employer or service provider. This information should not be provided upon a participant request, but the plan sponsor would need to tell the participant that the information is being withheld.

**Potential Consequences for Failure to Grant Valid Request**

Under ERISAs enforcement provisions, a penalty may be imposed for a plan administrator’s failure to comply with a valid written request for information. The amount of the penalty may vary, depending on which ERISA provisions were violated.

For example, a plan administrator that fails to furnish requested information under Section 104(b)(4) may be liable for a penalty of up to $110 per day from the date of such “failure or refusal.” Although this penalty provision is not specifically linked to Section 104(b)(4), courts often have applied it in that context. In those cases, the penalty begins to apply on the 31st day after the written request is made.

In determining whether to impose the penalty, and the appropriate amount, courts routinely have considered factors such as the length of delay, the number of requests made, the importance of the documents withheld, bad faith by plan administrator, injury and prejudice to the participant, and whether the participant had a right to the information. Generally, courts have upheld penalties where plan administrators were unable to provide a valid reason for failing to timely provide information or documents, but have declined to impose a penalty where plan administrators have acted in good faith and reasonably attempted to comply with a request. Accordingly, when responding to a participant request for information, a plan should determine in good faith what the participant is entitled to and provide those documents in a timely manner. In instances where it’s unclear whether a participant is entitled to such information, the plan should consult with its legal counsel and, if necessary, ask for additional clarification from the participant.

By responding to requests in this manner, the plan can demonstrate that it acted in good faith if the issue is ever litigated. If a court ever determines that the plan improperly withheld documents, the court may be less likely to impose a penalty, or may reduce the amount of penalty, for plans that acted in good faith.
For multiemployer plans, if a plan administrator fails to comply with a valid written request for documents under ERISA Section 101(k), DOL may assess a civil penalty of $1,000 per day for each violation. DOL has the discretion to waive all or part of the penalty based on the plan administrator’s compliance with requirements, the degree of noncompliance and other mitigating circumstances. However, even with these reductions, the penalty for a failure to comply can become substantial over a period of time.

Are Plans Required to Meet With Participants to Explain Documents and Plan Features?

A plan’s legal obligations are limited to disclosing certain documents to participants. ERISA does not require the plan’s staff or sponsor to engage in meetings with participants, particularly if the participant is hostile or disrespectful. In fact, technically ERISA does not require plan staff or plan sponsors to have any meetings or face-to-face conversations with participants.38

Legal requirements aside, it may be both customary in the industry and the historical practice of a plan to meet with participants from time to time and to answer in-person and telephonic questions about benefits, eligibility, retirement, claims processing and so on. For obvious reasons, and as a very important part of providing excellent service to participants, it is in everyone’s best interest for plan staff to continue doing so.

If communications with participants become hostile or unduly adversarial, or if lawyers become involved or litigation is threatened, the plan staff and plan sponsors should keep in mind that they have no legal duty to continue the conversation. There are commonsense limits as to what information plan staff should be discussing with participants, and most plans may already have directives or guidance on who is entitled to communicate directly with participants and what information they can discuss.

Because there are no statutory or regulatory guidelines in this area, the matter is almost always one of exercising discretion and using common sense. Needless to say, plan staff should carefully avoid giving any advice that could lead to potential liability for the plan, such as legal or tax advice, and plans should refer participants to their own advisors and consultants on these matters.

Conclusion

Providing helpful information and documents to plan participants is a critical function for plan administrators and sponsors. In fulfilling this function, it is essential to be equipped with a working knowledge of statutory and regulatory requirements—both as to the nature of the information and documents that must be disclosed, and the time frames for doing so. Failure to comply with these guidelines can result in significant penalties.

In addition, failure to provide information as required by ERISA can create problems in court for a plan that is trying to defend a benefit claim determination. (Judges generally are not favorable toward plans that fail to comply with statutory disclosure requirements.)

It is equally important for plan administrators and sponsors to know where they are legally entitled to draw the line. Although each plan must make its own business decisions about how to respond to information requests, not every request for information is appropriate and not every request

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must be honored. Knowing how and when to say "no" to a request can sometimes be important in avoiding undue administrative burdens and costs, especially when dealing with an adversarial or combative participant. It can also help to avoid the disclosure of inaccurate or inappropriate information or the needless escalation of a claims dispute. 

Endnotes

1. The term periodic actuarial report includes studies, tests (including sensitivity tests), documents, analyses or other information received by the plan from the plans actuary that depict alternative funding scenarios based on a range of alternative actuarial assumptions, whether or not received by a plan at regularly scheduled, recurring intervals. Therefore, under this provision, plans would be required to disclose not only the annual actuarial valuation, but also any sensitivity testing that the plan may occasionally request, such as in response to certification of critical or endangered status. Preamble to the ERISA 101(k) Regulations (75 Fed. Reg. 9334).

2. DOL regulations clarify that any information or data that served as the basis for any report or application required to be disclosed under ERISA §101(k) does not have to be produced pursuant to a participant request.

3. This type of response demonstrates good faith and can help to reduce the risk of a later claim that the plan's response was deliberately incomplete or failed to comply with statutory time frames.

4. See CWA/ITU Negotiated Pension Plan Bd. of Trs. v. Weinstein, 107 F.3d 139, 142 (2d Cir. 1997); See also Brown v. American Life Holdings, Inc., 190 F.3d 856, 861-62 (8th Cir. 1999) (holding that "other instruments under which the plan is established or operated" covers only formal documents that establish or govern the plan); Faircloth v. Lundy Packing Co., 91 F.3d 648 (4th Cir. 1996) (holding that "other documents" covered under ERISA §104(b)(4) are the formal or legal documents under which a plan is set up or managed).


11. DOL Advisory Opinion 97-11A.

12. DOL Advisory Opinion 96-14A.

13. DOL Advisory Opinion 87-10A.


16. Id.

17. Id.

18. Shaver v. Operating Engineers Local 428 Pension Trust Fund, 332 F.3d 1198 (9th Cir. 2003).

19. Under the DOL Regulations (that were updated for ACA) an adverse benefit determination is defined as a "...denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate." DOL regulations also clarify that an adverse benefit determination includes any cancellation or discontinuance of coverage (a "rescission") that has a retroactive effect. DOL Reg. Section 2590.715-2714(a)(2)(i); See also DOL Reg. Section 2560.503-1; DOL Reg. Section 2590.715-2712(a)(2).


21. Id. at D-11.


23. DOL Reg. Section 2560.503-1(h)(3)(iv) and 4; See also DOL/ERISA, "FAQs About the Benefit Claims Procedure Regulations," D-10.

24. Id. at D-12.

25. Id. at C-17 and D-12.

26. DOL Advisory Opinion 82-21A.

27. DOL Reg. Section 2520.101-6(d).

28. Certain courts have recognized a narrow exception to this rule and have required the plan administrator to create and furnish a requested SPD, in an instance where no SPD existed.

29. DOL Reg. Section 2520.104b-30(a); DOL Reg. Section 2520.101-6(b)(3).

30. Id.

31. DOL Reg. Section 2520.104b-30(b).

32. The Health Insurance Portability and Accountability Act (HIPAA) provides broad privacy protections to individually identifiable health information maintained by a plan or plan sponsor (protected health information or PHI). Generally, HIPAA prohibits the disclosure of PHI except in very narrow and limited circumstances. Further, even when HIPAA permits the disclosure of PHI, the disclosure must be limited to specific entities and situations, and only after certain procedural safeguards have been satisfied. 45 C.F.R. Section 160.103; See also 45 C.F.R. 164.500(a).

33. ERISA Section 502(c)(1); DOL Reg. Section 2575.502c-1.

34. Id.

35. McDonald v. Pension Plan of NYSA-ILA Pension Trust Fund, 320 F.3d 151, 162-163 (2d. Cir. 2003) (holding that the district court is required to consider bad faith, length of delay, number of requests made, the importance of documents withheld and prejudice to the participant in determining whether to impose the penalty); See also Byars v. Coca-Cola Co., 517 F.3d 1256 (11th Cir. 2008) (holding that it was appropriate for the district court to consider prejudice to the participant in denying a request for penalties against the plan administrator); Sullivan v. Raytheon Co., 262 F.3d 41, 52 (1st Cir. 2001) (holding that a showing of bad faith and prejudice are not required to impose penalties, but those factors can be among the reasons not to award penalties); Ramos v. Bank of Am., 779 F. Supp. 2d 1058, 1083-1084 (N.D. Cal. 2011) (holding that the district court has the discretion to impose penalties based on the administrators’ bad faith, intentional conduct, length of delay, number of requests and the prejudice or damages to the participant).

36. Bartling v. Lockheed Martin Corp., 48 F.App'x 543, 557 (6th Cir. 2002) (upholding a $7,700 penalty where there was a 154-day delay in producing documents, the plan administrator failed to inform participant he was requesting incorrect documents, the plan administrator failed to produce certain documents, and the plaintiff made multiple requests for production); See also Brown v. Aventis Pharmcs, Inc., 341 F.3d 822, 828-829 (8th Cir. 2003) (upholding penalties of $11,550 where the plan sponsor led participant to believe that documents would be provided automatically, but failed to produce those documents or replace the participant’s lost copies of plan documents. The plan sponsor later used the participant’s failure to request documents as a basis for denying benefits); Knueger Int'l, Inc. v. Blank, 225 F.3d 806, 811 (7th Cir. 2000) (upholding a $15,300 penalty where there was a 153-day delay in producing documents where the plan sponsor provided no explanation for the delay).

37. Ames v. American Nat’l Can Co., 170 F.3d 751, 758-760 (7th Cir. 1999) (refusing to impose a penalty where the plan sponsor acted in good faith and only failed to produce a grandfathered plan provision because it was not aware that the participant wanted it. Once the plan sponsor was put on notice that the participant wanted that information, the plan sponsor produced it the next business day).

38. It is important to note that under ACA, a plan must allow a claimant to “present evidence and testimony as part of the internal claims and appeals process.” (Emphasis added). There is limited guidance on the issue, and it is unclear whether a plan is required to allow all claimants to present a “testimony” in person or if plans are permitted to accept written testimonies. The issue should be decided based on the facts and circumstances of the case, and in the best interest of all parties involved. A plan may wish to consult legal counsel whenever there is any question about whether a particular participant is entitled to present testimony in connection with the appeal of a denied claim.