

# **Booklet/Document Guide**

## **Introduction**

The Booklet/Document topic is discussed in three parts:

- Basic Guide
- Statutory/Regulatory
- Court Decisions

# Basic Guide

## In General

Ideally, the booklet should be a very brief document and the plan document should be a very extensive document. The reasons are these:

- By having the plan document extensive, all of the minutia can be put in writing and the plan document will serve as a guide, operational/administrative manual, etc. This logic is especially critical considering that the stop-loss carrier looks to the document and not the booklet as its basis for payment.
- By having the booklet as brief as possible, the potential conflicts with the plan participants are reduced. Less said, less to argue over so to speak.
- Also, the fewer pages in the booklet, the less will be the printing and distribution costs for the plan sponsor.
- The approach meets the letter and spirit of the ERISA §102 and Department of Labor Regulations §2520.102-1 *et seq.*, such as:
  1. *Understood by average plan participant.*
  2. *Sufficiently comprehensive to apprise participants of benefits.*
  3. *Consider education of, typical participant and complexity of plan terms.*
  4. *No technical jargon or long, complex sentences.*
  5. *Booklet to fairly and objectively summarize.*
- Several practical considerations must be kept in mind:
  1. The booklet, not the document, must contain the ERISA *statement of rights*.
  2. The booklet may, and should, contain special alerts to the plan participants. That is, the booklet is a suitable vehicle for presenting *do's* and *don'ts* to the participants.
  3. Certain items in the booklet may be safely eliminated (definitions, details on coordination or subrogation) while other items must be shown in some detail (COBRA, e.g.). Also there should be sameness as regard exclusions and closeness as regard covered expenses.

While the reasons for two free-standing items are compelling, these enormous difficulties remain:

- Whenever the stop-loss carrier sees the benefit in Terms X and the participants see the same benefits in Terms Y, the possibility for misunderstanding exists. The stop-loss carrier will seek justification to deny; the participant will seek justification to get the benefits paid. The argument may hinge on a word or comma.
- The administrative burden of having to prepare and maintain two independent and free-standing documents is heavy and costly.

## Possible Solutions

Three solutions are possible:

1. Let the document and booklet be the same.
2. Prepare and maintain two free-standing items.
3. Have a free-standing document text and booklet text but use a common Schedule of Benefits.

The merit of the first solution is that it has most of the best and least of the worst features of the first two solutions. The website sample document and booklet follow the third solution.

## The Website Booklet/Document

The pieces to the paperwork are these:

<u>Item</u>	<u>Description</u>
A	Document Text
B	Booklet Text
C	Schedule of Benefits (Common to both Document and Booklet)

The Website approach crafts the single Schedule of Benefits to drive both the Document and the Booklet. As will be discussed later, the Schedule of Benefits is a broad purpose document in and of itself consisting not only of benefit description but provisions for cost containment, managed care and ancillary benefits.

## Mechanics For Preparation

### In General

The choices by the user in actual preparation of the Items A, B and C are quite wide and will be reflected of the needs and capability of such user. The ranges are these:

#### Simple

Prepare C by manual means using A and B as pre-printed on-the-shelf items.

#### Advanced

Computer-to-computer or *hard disc* transfer of A and B with C being computerized as on a word processor.

### Physical Size Of Booklet

There has been over the past decade or so a movement to present the booklet in 8½ x 11 size rather than the smaller size. There are some compelling reasons to do so:

1. For the smaller plans the production costs of doing an 8½ x 11 size is less costly than doing a smaller size and generally more convenient.

2. Many employers appreciate the 8½ x 11 because it more easily coordinates with their other employee handout items.
3. With an 8½ x 11 booklet in notebook format, the need to reprint because of Booklet amendments is greatly reduced. This is because the amendments may be given to the participants in 3-ring punched form and merely added to their existing booklet.

## **The Preparation Process**

<u>Step</u>	<u>Action</u>
1	Marked up draft of the Schedule of Benefits (C) is given to word processor.
2	Final Schedule of Benefits is produced, edited, etc. and numerous clean copies made.
3	Final Schedule of Benefits is added to Booklet text and sent to printer.
4	Final Schedule of Benefits is added to Document text (three copies) with one to client, one to stop-loss carrier and one to file.

## **Why The Guide Booklet/Document Method?**

1. **Legal Considerations**  
The letter and spirit of ERISA are only met with the Booklet being a summary of the plan and *not* a reproduction of the plan.
2. **Stop-Loss Considerations**  
To gain greatest comfort with stop-loss, the plan benefits should be stated in great detail. Providing the stop-loss carrier with a 200 page plan document, while extreme, illustrates the fact that the more explicitly are the benefits and terms of administration stated, the fewer stop-loss problems will there be.
3. **Administrative Considerations**  
Expanding the plan document from a recital of benefits to a *master plan for administration* gives the plan supervisor a clear roadmap by which to manage the plan. The plan document may be used to a considerable extent as an administrative guide.
4. **Economic Considerations**  
Giving the participant a *cloned* plan document is considerably more expensive than a summary booklet. Also, the loose leaf has the edge over the stapled or bound in that the problems and costs of reprints with the loose leaf may be dramatically reduced. The reason is that inserts are possible in lieu of total reprints.
5. **Communication Considerations**  
The smaller version is less threatening to the participant; the gist of the plan is given in the Schedule of Benefit pages, which are easily accessed and understood. In responding to the admonition in the regulations that the booklet be understood by the average reader, it is pointless to attempt to give in great detail the Coordination of

Benefits order of priorities-or to define all of the terms. Rather, alerts and hints to the participant as to how the plan should be used are more appropriate. That is, the booklet may be a *how to* guide and not an authoritative *encyclopedia* of benefits.

6. **Standardized Size And Format**

The 8½ x 11 size has merit for production reasons (standard size is cheaper and easier to handle). The 8½ x 11 size is usually more *integratable* with the employer's other handout items. In a pinch, the employer or plan supervisor may reproduce the booklet or copies on a copier to *get by*.

7. **Why The Website Approach Is Practical**

The website approach has merit in that the plan document can grow without limit; the booklet can remain small and practical; and the commodities of the Benefit Summary pages gives maximum security to the plan's fiduciaries. In brief, the website approach is the best of all worlds.

8. **Future**

The difficulty with the booklet and plan document being the same is that the single approach will eventually fall of its own weight; the booklet will simple be too large to be practical. The day is fast approaching with cafeteria and managed care network designs. The advantage of the booklet and plan document being separate is that the plan document can grow without limit and the booklet can remain small and *manageable*.

# Statutory/Regulatory

## ERISA

**Act Sec. 102.** (a)(1) A summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries as provided in section 104(b). The summary plan description shall include the information described in subsection (b), shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan. A summary of any material modification in the terms of the plan and any change in the information required under subsection (b) shall be written in a manner calculated to be understood by the average plan participant and shall be furnished in accordance with section 104(b)(1).

(2) A plan description (containing the information required by section (b)) of any employee benefit plan shall be prepared on forms prescribed by the Secretary, and shall be filed with the Secretary as required by section 104(a)(1). Any material modification in the terms of the plan and any change in the information described in subsection (b) shall be filed in accordance with section 104(a)(1)(D).

**Act Sec. 102.** (b) The plan description and summary plan description shall contain the following information: The name and type of administration of the plan; the name and address of the person designated as agent for the service of legal process, if such person is not the administrator; the name and address of the administrator; names, titles, and addresses of any trustee or trustees (if they are persons different from the administrator); a description of the relevant provisions of any applicable collective bargaining agreement; the plan's requirements respecting eligibility for participation and benefits; a description of the provisions providing for nonforfeitable pension benefits; circumstances which may result in disqualification, ineligibility, or denial or loss of benefits; the source of financing of the plan and the identity of any organization through which benefits are provided; the date of the end of the plan year and whether the records of the plan are kept on a calendar, policy, or fiscal year basis; the procedures to be followed in presenting claims for benefits under the plan and the remedies available under the plan for the redress of claims which are denied in whole or in part; (including procedures required under section 503 of this Act).

## **Department Of Labor Regulations §2520.102-1 Et Seq.**

Those portions of the Regulations which are commonly applied (foreign language section is excluded) and which do not relate exclusively to qualified or deferred benefit plans are set forth as follows:

**§2520.102-2 Style and format of summary plan description.**-(a) *Method of presentation.* The summary plan description shall be written in a manner calculated to be understood by the average plan participant and shall be sufficiently comprehensive to apprise the plan's participants and beneficiaries of their rights and obligations under the plan. In fulfilling these requirements, the plan administrator shall exercise considered judgment and discretion by taking into account such factors as the level of

comprehension and education of typical participants in the plan and the complexity of the terms of the plan. Consideration of these factors will usually require the limitation or elimination of technical jargon and of long, complex sentences, the use of clarifying examples and illustrations, the use of clear cross-references and a table of contents.

(b) *General format.* The format of the summary plan description must not have the effect of misleading, misinforming or failing to inform participants and beneficiaries. Any description of exceptions, limitations, reductions, and other restrictions of plan benefits shall not be minimized, rendered obscure or otherwise made to appear unimportant. Such exceptions, limitations, reductions, or restrictions of plan benefits shall be described or summarized in a manner not less prominent than the style, captions, printing type, and prominence used to describe or summarize plan benefits. The advantages and disadvantages of the plan shall be presented without either exaggerating the benefits or minimizing the limitations. The description or summary of restrictive plan provisions need not be disclosed in the summary plan description in close conjunction with the description or summary of benefits, provided that adjacent to the benefit description the page on which the restrictions are described is noted.

**§2520.102-3 Contents of summary plan description.** -Section 102 of the Act specifies information that must be included in the summary plan description. The summary plan description must accurately reflect the contents of the plans as of a date not earlier than 120 days prior to the date such summary plan description is disclosed. The following information shall be included in the summary plan description of both employee welfare benefit plans and employee pension benefit plans, except as stated otherwise in subsection (j) through (n):

- (a) The name of the plan, and, if different, the name by which the plan is commonly known by its participants and beneficiaries;
- (b) The name and address of –
  - (1) In the case of a single employer plan, the employer whose employees are covered by the plan,
  - (2) In the case of a plan maintained by an employee organization for its members, the employee organization that maintains the plan,
  - (3) In the case of a collectively-bargained plan established or maintained by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, parent, or most significant employer of a group of employers all of which contribute to the same plan, or other similar representative of the parties who established or maintain the plan, as well as:
    - (i) A statement that a complete list of the employers and employee organizations sponsoring the plan may be obtained by participants and beneficiaries upon written request to the plan administrator, and is available for examination by participants and beneficiaries, as required by §§2520.104b-1 and 2520.104b-30, or,
    - (ii) A statement that participants and beneficiaries may receive from the plan administrator, upon written request, information as to whether a particular employer or employee organization is a sponsor of the plan and, if the employer or employee organization is a plan sponsor, the sponsor's address.

- (4) In the case of a plan established or maintained by two or more employers, the association, committee, joint board of trustees, parent, or most significant employer of a group of employers all of which contribute to the same plan, or other similar representative of the parties who established or maintain the plan, as well as:
- (i) A statement that a complete list of the employers sponsoring the plan may be obtained by participants and beneficiaries upon written request to the plan administrator, and is available for examination by participants and beneficiaries, as required by §§2520.104b-1 and 2520.104b-30, or,
  - (ii) A statement that participants and beneficiaries may receive from the plan administrator, upon written request, information as to whether a particular employer is a sponsor of the plan and, if the employer is a plan sponsor, the sponsor's address.
- (c) The employer identification number assigned by the Internal Revenue Service to the plan sponsor and the plan number assigned by the plan sponsor.
  - (d) The type of pension or welfare plan, e.g., for pension plans-defined benefit, money purchase, profit sharing, etc., and for welfare plans-hospitalization, disability, pre-paid legal service, etc.;
  - (e) The type of administration of the plan, e.g., contract administration, insurer administration, etc.;
  - (f) The name, business address, and business telephone number of the plan administrator as that term is defined by section 3(16) of the Act;
  - (g) The name of the person designated as agent for service of legal process, and the address at which process may be served on such person, and in addition, a statement that service of legal process may be made upon a plan trustee or the plan administrator;
  - (h) The name, title, and address of the principal place of business of each trustee of the plan;
  - (i) If a plan is maintained pursuant to one or more collective bargaining agreements, a statement that the plan is so maintained, and that a copy of any such agreement may be obtained by participants and beneficiaries upon written request to the plan administrator, and is available for examination by participants and beneficiaries, as required by §§2520.104b-1 and 2520.104b-30. For the purpose of this paragraph, a plan is maintained pursuant to a collective bargaining agreement if such agreement controls any duties, rights or benefits under the plan, even though such agreement has been superseded in part for other purposes;
  - (j) The plan's requirements respecting eligibility for participation and for benefits. The summary plan description shall describe the plan's provisions relating to eligibility to participate in the plan, such as age or years of service requirements, and the items listed in subparagraphs (1) or (2) as appropriate:
    - (1) Omitted-pension.
    - (2) For employee welfare benefit plans, it shall also include a statement of the conditions pertaining to eligibility to receive benefits, and a description or summary of the benefits. In the case of a welfare plan providing

extensive schedules of benefits (a medical care plan, for example). Only a general description is required if reference is made to detailed schedules of benefits which are available without cost to any participant or beneficiary who so requests;

- (k) Omitted-pension.
  - (1) For both pension and welfare benefit plans, a statement clearly identifying circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture or suspension of any benefits that a participant or beneficiary might otherwise reasonably expect the plan to provide on the basis of the description of benefits required by (j) and (k) above.
- (l) Omitted-pension.
- (m) Omitted-pension.
- (n) Omitted-pension.
- (o) The sources of contributions to the plan-for example, employer, employee organization, employees-and the method by which the amount of contribution is calculated.
- (p) The identity of any funding medium used for the accumulation of assets through which benefits are provided. The summary plan description shall identify any insurance company, trust fund, or any other institution, organization, or entity which maintains a fund on behalf of the plan or through which the plan is funded or benefits are provided.
- (q) The date of the end of the year for purposes of maintaining the plan's fiscal records;
- (r) The procedures to be followed in presenting claims for benefits under the plan and the remedies available under the plan for the redress of claims which are denied in whole or in part (including procedures required under section 503 of Title I of the Act); and
- (s) (1) The statement of ERISA rights authorized by section 104(c) of the Act, containing the items of information applicable to the plan included in the model statement of subparagraph (2) of this paragraph. Items which are not applicable to the plan are not required to be included. The statement may contain explanatory and descriptive provisions in addition to those prescribed in paragraph (t)(2) of this section. However, the style and format of the statement must not have the effect of misleading, misinforming or failing to inform participants and beneficiaries of a plan. All such information shall be written in a manner calculated to be understood by the average plan participant, taking into account factors such as the level of comprehension and education of typical participants in the plan and the complexity of the items required under this subparagraph to be included in the statement. Inaccurate, incomprehensible or misleading explanatory material will fail to meet the requirements of this section. The statement of ERISA rights (the model statement or a statement prepared by the plan), must appear as one consolidated statement. If a plan finds it desirable to make additional mention of certain rights elsewhere in the summary plan description, it may do so.

The summary plan description may state that the statement of ERISA rights is required by federal law and regulation.

- (2) A summary plan description will be deemed to comply with the requirements of paragraph (e)(1) of this section if it includes the following statement; items of information which are not applicable to a particular plan may be deleted: As a participant in (name of plan) you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.

Obtain copies of all plan documents and other plan information upon written request to the plan administrator. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for plan participant, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called *fiduciaries* of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA. If your claim for a (pension, welfare) benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the plan reviewed and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the material and pay you up to \$100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

**§2520.102-4 Option for different summary plan descriptions.**-In some cases an employee benefit plan may provide different benefits for various classes of participants and beneficiaries. For example, a plan amendment altering benefits may apply to only those participants who are employees of an employer when the amendment is adopted and to employees who later become participants, but not to participants who no longer are employees when the amendment is adopted. (See §2520.104b-4.) Similarly, a plan may provide for different benefits for participants employed at different plants of the employer, or for different classes of participants in the same plant. In such cases the plan administrator may fulfill the requirement to furnish a summary plan description to participants covered under the plan and beneficiaries receiving benefits under the plan by furnishing to each member of each class of participants and beneficiaries a copy of a summary plan description appropriate to that class. Each summary plan description so prepared shall follow the style and format prescribed in §2520.102-2, and shall contain all information which is required to be contained in the summary plan description under §2520.102-3. It may omit information which is not applicable to the class of participants or beneficiaries to which it is furnished. It should also clearly identify on the first page of the text the class of participants and beneficiaries for which it has been prepared and the plan's coverage of other classes. If the classes which the employee benefit plan covers are too numerous to be listed adequately on the first page of the text of the summary plan description, they may be listed elsewhere in the text so long as the first page of the text contains a reference to the page or pages in the text which contain this information. If the plan administrator elects to prepare more than one summary plan description each such summary plan description shall be filed with the Secretary in the manner provided in §2520.104a-3(b).

**§2520.102-5 Limited exemption with respect to summary plan descriptions of welfare fare plans providing benefits through a qualified health maintenance organization.** -(a) The summary plan description of an employee welfare benefit plan under which some or all benefits are provided through membership in one or more qualified health maintenance organizations, as defined in section 1310(d) of the Public Health Service Act, as amended, 42 U.S.C. §300e-9(d), shall not be required to include, with respect to any such qualified health maintenance organization, the information described in sections 102-3(j)(2), 102-3(1), 102-3(9) and 102-3(S) of this Part 2520, provided that:

- (1) Such summary plan description contains a notice of the type described in paragraph (b) of this section;
  - (2) Any request made in the manner described in paragraph (b)(4) of this section is transmitted promptly by the plan administrator to any such organization in which the person making the request is eligible for membership as a benefit under the plan; and
  - (3) The plan administrator furnishes, in the manner described in section 104b-1 of this Part 2520, to each person to whom such summary plan description is furnished, the identity of all such qualified health maintenance organizations in which such person is eligible for membership as a benefit under the plan at a date no later than the date when the option of membership in the qualified health maintenance organization is offered to such person.
- (b) The notice referred to in paragraph (a) of this section shall indicate:

- (1) The availability of membership in one or more qualified health maintenance organizations as defined in section 1310(d) of the Public Health Service Act, as amended, 42 U.S.C. §300e-9(d), as an option under the plan;
- (2) Whether such membership is made available as the sole benefit under the plan, in addition to one or more other benefits, or as an alternative to one or more other benefits;
- (3) That each such organization is which membership is available to the participant or beneficiary will supply him or her upon request, written materials concerning (i) the nature of services provided to members; (ii) conditions pertaining to eligibility to receive such services (other than general conditions pertaining to eligibility for participation in the plan) and circumstances under which services may be denied; and (iii) the procedures to be followed in obtaining such services, and the procedures available for the review of claims for services which are denied in whole or in part.

## **Court Decisions**

### **Background**

The core issue arises-where the booklet and the document differ; which will prevail in a court review?

### **Booklet**

The booklet necessarily has some built in differences from the document:  
The booklet will summarize or omit some plan benefits and provisions.

- Some conditions or provisions of the plan are not in the booklet because they are so rarely seen.
- Timing of changes to the booklet and the document may be different.

While there has been considerable litigation on booklet-document differences, plan fiduciaries may be reasonably comfortable so long as document is clear that it governs and the booklet has a disclaimer that if any dispute arises, and the differences not a factor in any participant benefit elections a plan actions, the booklet will prevail. Courts have repeatedly shown such beliefs to be ill-founded, however.

### **ERISA**

ERISA demands that the booklet be a document to be understood by the average participant. The Department of Labor Regulations emphasize the need for simplicity. The need to be simple and yet understood and also the need to avoid a coverage/benefit gap between the booklet and the document are almost impossible to meet.

## Trend of Court Decision

Participants picked up early on the language differences and sued for benefits.

The earlier decisions were generally favorable to the plan. Later decisions tended to view a booklet discrepancy as a plan modification. This practice is now generally followed.

## Resolving Differences

**Procedural Violations.** Courts will usually hold that ERISA technical or procedural oversights do not demand that the plan pay unintended benefits. These are truly technical violations which do not directly relate to the benefit in question. However, the courts will require the plan to pay benefits where the technical oversights are flagrant or wholesale and where such oversights result in detrimental reliance and relevant harm.

**Booklet Disclaimers.** Courts view such booklet disclaimers in a mixed way. Such disclaimer has merit in and of itself.

- Such disclaimer is of merit unless the oversight was flagrant.
- Such disclaimer may be of merit if it is in large type, prominent, etc.
- Such disclaimers have no merit.

**Preemption.** Courts have been consistent in holding that any state law defenses as regards booklet-document differences are not available to the participant.

## How Participants May Recover

ERISA provides that benefits may be recovered and that rights may be enforced. Where the benefits and rights question revolve around an booklet-document difference a range of possible ways of relief are possible.

**No Relief.** This view, once deemed reasonable is no longer considered.

**Court-Provided Relief.** Court directly intends and gives equitable relief by requiring the benefit in question to be paid.

**Fiduciary Breach.** Court holds that there has been a fiduciary breach and mandates that fiduciary act as such-which corrects the problems.

**Fiduciary Held Personally Liable.** In this instance an individual fiduciary may be held by ERISA as being personally liable for the difference and made to pay for the error.

**Improper Disclosure.** The court might hold that the disclosure rules of ERISA as regards the booklet were violated and that substantive relief if possible.

What proper course should be followed is in the process of development. Clearly the conclusions which most courts will reach by whatever logic is this; if participant relied on a bad booklet to his detriment, the plan will pay.

## The Booklet-Document Difference

The difference problem is most difficult.

Some say that the booklet should govern.

- Some say that the booklet cannot modify the plan.
- Certainly the logic that the booklet is a *summary* and not a duplicate is generally accepted.

## Factors Give Cause To A Claim

For a court to review a booklet-document difference question, there must be three elements:

Booklet must be inaccurate or inconsistent with the document.

- Booklet error must have been relied upon significantly.
- As a result of such reliance, there was either harm or prejudice, or there was deliberate omission or concealment.

## Court Decisions

1. Plan document and certificate were correct; certificate stated effective date of coverage for the Participant to be June 1. The Participant had a hospitalization May 31. Was he covered? The court held that he was not covered.
2. Plan effective date was February 1; the booklet and enrollment card had effective date of April 1. Participant, a takeover participant, had a claim incurred March 16. Because the enrollment card date should be controlling, the claim was held to not be payable.
3. Plan's eligibility date was July 1, one month after date of hire; certificate was issued to the Participant showing an effective date of June 1. The certificate was misissued as a result of a clerical error. When the Participant put in a claim incurred in June, the court held that the plan was liable.
4. The Participant was hospitalized for asphyxiation. Confusion as to plan benefits:
  - Booklet-Asphyxiation excluded.
  - Document-Asphyxiation, whether voluntary or not, excluded.Participant's attorney's argued that booklet would permit an involuntary asphyxiation to be covered because of how the exclusion was worded. Court held that the plan document should prevail. As a result, the exclusion was allowed to hold and the benefit was excluded.
5. The certificate booklet gave the Participant disability benefits. The plan document did not. When the plan denied, Participant sued. The plan lost in court.
6. Where booklet failed to have coordination provision but it was in the master contract, the court held that the plan could not apply it. The drafting error was costly to the plan.

7. Plan document said that to be an accident there must be a visible wound or contusion; the booklet was silent on this point. The Participant had an accident but no visible wound or contusion. Plan denied; Participant, claiming the booklet language, sued. Court said the claim should be treated as an accident.
8. Participant had dental surgery which was excluded in the plan document but not in the booklet. Court held that the claim should be paid.
9. Participants booklet was silent as to either subrogation or coordination with automobile medical benefits. When the plan attempted to coordinate, Participant objected. Court held that the Participant was correct; if it was not in the booklet, it should not be done by the plan.
10. Booklet clearly set out extended benefits for total disability. Even so, the plan denied such benefits. Court held such denial was arbitrary and capricious and improper. Plan had claimed that the booklet was merely a summary and any error therein was excusable. Plan's argument did not prevail.
11. Participant terminated June 3; died October 3 without converting. Participant claimed a benefit for these reasons:
  - She had not been given a booklet, or at least a current one, as required by ERISA.
  - State law required that she be specifically notified of the right to convert.
12. Court found trustees technically in compliance with what ERISA required; participant had been given the booklet within the 120 day ERISA period. Also, participant had prior booklets telling her of her rights to convert. Also, only duty of the plan to inform her of conversion rights is by the booklet.
13. The Participant was hurt in a boating accident. Booklet made no mention of exclusionary provisions which were stated in the plan document. The Court considered this discrepancy and held that the plan should pay.
14. Certificate stated that Participant was covered march 4; the plan document would have set his effective date at April 8. The ID card showed effective date to be March 4. Court held that in a conflict, the plan booklet should be controlling. The claim was held paid.
15. Participant was unable to read or write. Plan benefits were changed. New booklets were handed out. Participant relied on the verbal explanation which his supervisor gave him. Court held that a valid explanation had been given to the participant.
16. Plan document had preexisting condition described; booklet, however did not. The Court made a factual determination and found that the Participant did *not* rely

on the booklet, in error, to his detriment. Court as a result, let the denial on preexisting ground remain.

17. The Employer self-administered a fully insured long term disability plan for the insurer. The lawsuit involved this chronology:

- Employed 8-11-80
- Hospitalized (hepatitis) 7-8-81 to 7-24-81
- Returned to work 7-31-81 to 8-8-81
- Terminated due to disability 10-5-81
- Effective date was *the first day of the month following one year of employment.*
- Correct Effective Date 9-1-81  
(meaning no coverage)
- Booklet given to Participant had incorrect Effective Date 7-23-81  
(meaning there was coverage)
- System's records and Premium payments showed the Effective Date to be 7-23-81.

18. Participant sued for benefits; Insurer denied claiming the later Effective Date.

Participant argued as follows:

- Systems acted as Insurer's agent.
- Conflicts between the policy and booklet should be resolved in favor of participant.
- Real contract is between Participant and Insurer as evidenced by the Booklet.

**Employer as Agent of Insurer.** When it assumes administrative responsibility, an Employer acts in its own selfish interests and is therefore *not* an agent of the Insurer; the Employer is merely an administrative aide. These are the tests needed to distinguish agency v. administration:

- Is task expressly delegated?
- Is task subject to insurer's supervision and audit?
- Is task clear evidence of lack of collusion?

If answers are all yes, Employer is not an agent but merely an administrative aide. In the instant case, the court held the existence of agency was a matter of fact to be decided by a jury.

**Booklet-Document Conflict.** The preponderance of opinion is that conflicts be resolved in favor of the participant. The Court held to this point of view in its decision.

**Conclusion.** Court held the case to be a triable one, thereby overruling a lower court's decision favoring the insurer. That is, the insurer lost and the Participant won.

Plan was ambiguous:

Hospital defined: short-term, acute care, general hospital.

Benefits provided: major medical in excess of insured plan.

Court took ambiguity and held that hospital definition would include long-term and non-acute care. As a result, plan had to pay permanent, semi-intensive care in a chronic disease hospital.

19. Claim was submitted where date of service was after date of plan termination; such claim was denied. Claim was contested by participant on these points:
  - Scheduling of care occurred prior to plan termination.
  - Booklet was an implied contract whereby employer provided coverage.Note: Booklets nearly always have language which caveats them as *not* constituting an employment agreement of any type. Court held that claim was not payable.
20. Conflict arose as to the plan and the booklet. Where differences are germane, the booklet should prevail because it would defeat the purpose of the booklet to do otherwise; also it would put the participant at a distinct disadvantage to not be able to rely on the booklet.
21. Plan document had benefit at 25% of \$150,000.  
Plan booklet had benefit at \$150,000.  
Participant was entitled to collect the \$150,000. The difficulty arose where the plan document was amended by rider but the certificate booklet remained unchanged.
22. Certificate booklets, meeting ERISA summary plan description standards, set forth the retiree's benefits. Participant believed plan should have done something more and, as a failure thereto, had breached its fiduciary responsibilities. Court said that stating retiree benefits clearly in the booklet was sufficient. Most certainly, plan administrator did not act in an improper manner.
23. Plan had these confusing terms:
  - Mental illness-covered.
  - Mental condition-excluded.Neither of these two terms were defined. The diagnosis in question was organic brain syndrome with obsessive-compulsive features. The court agonized over the meanings and concluded the plan's language was ambiguous. As such, the court held the plan to be liable.
24. On the Insurer's own plan it had:
  - Booklet and Document  
Gave the Insurer right to amend, and charge employees for coverage.
  - Employee Handbook  
Offered *lifetime* benefits and *at no cost*.Class action to prevent the Insurer from reducing its lifetime maximum or to increasing the participant contributions. The Insurer was within its right to follow the plan and booklet. ERISA gives exclusive government of plan to booklet and document.

25. Booklet and plan document were correct and consistent. Employee handbook language was correct and inconsistent. Plan followed the correct, ERISA documents. The Participant took exception in court. Court held for the plan. Participant's handbook was substantially correct. Employer was not arbitrary and capricious. That employer did not distribute the booklet did not work against the Employer because Participant was not harmed by such oversight. Reliance by participant on language of handbook was not reasonable.
26. Certificate indicated on its face that the master contract was controlling. The master said that only nonoccupational deaths were payable; on this point the booklet was silent. Beneficiary wanted to collect accident death benefit on an occupational death. Court held that the claim was not to be paid. The certificate alert was a satisfactory defense.
27. Plan clearly stated that reparative damages from an accident must be performed within six months of such accident. When a TMJ was done more than six months after the accident, it was properly denied.
28. Booklet omitted the exclusion but the plan document included it. Court followed the majority practices and held that the claim should be paid.
29. Booklet of health care plan clearly gave the participants notice that employee contributions could be increased and the plan benefits could be amended or otherwise modified or terminated. Employer elected to increase Participant contributions for those who were in the retired status; plan benefits were also decreased. The Participant and other retirees, sued claiming they had been led to believe benefits were vested. Participants claim of plan vesting has no standing because plan is a welfare plan and not a pension plan. Wish of the participant to apply *Firestone Tire & Rubber Co. v. Bruch*, is of no avail; this case dealt with standards of review and not plan benefits vestings. ERISA also preempts any common law relief the Participant might have had. The court stressed that the SPD is the statutory approved way of communicating benefits; oral assertions have no standings. Instances where federal common law on estoppel, based on *outside* statements, might apply are of no avail in this case because:
- Plan terms are *not* ambiguous but rather very clear.
  - The outside statements were *oral* and not written as a non-ERISA document.
30. Plan booklet was in dispute with plan document. Employee agreed that the booklet's language was clearly different from plan's long established practice and that the Participant had failed to sign that he had read the booklet. Context covered both a severance and a vacation plan. The court distinguished between severance pay plans (ERISA) and vacation plans (non-ERISA plans). Since ERISA plan was put in writing in the form of the booklet, it had to be the plan-even if contrary to established employer practices. Court held that booklet could be used for the severance but not for the vacation plan.

31. Plan document said one thing; booklet said another. Only the booklet was filed with the Department of labor; only the booklet was distributed to the participants. The court held that the wording of the booklet would prevail.
32. Employer wrote the Participant a letter stating that it would pay Participant's group medical premiums and keep him on the plan *until your death or when you have no further use from them*. When the Employer fell in bad economic times, it cut back on some of the Participant's benefits but continued the group health benefits. When Employer sold out to a successor employer, it discontinued the Participant's group health benefits. The Participant relied on *Donovan v. Dillingham*, and held that an ERISA plan had been established. The employer noting that the funding was general asset only, believed the arrangement was merely an individual employment contract. The appeals court found that just because the plan was funded by general assets would not deny it ERISA status. While the Participant's arrangement did not have the usual ERISA administrative structure, the plan benefits were readily ascertainable. While troublesome to the court, the fact that the Participant's arrangement had a single participant would not deny it ERISA status; ERISA rules and regulations are extensive in their reference to a plan of one person.
33. The court concluded that the arrangement was a plan as contemplated by ERISA. As such, any state laws which might be useful in establishing damages or awards are preempted.
34. Essential facts involved what benefits were due. Employer, in course of plan administration, had committed several ERISA technical violations:
- Amendments to booklet were not made and/or not distributed.
  - Booklet was not filed with Department of Labor.
- Because of these omissions, the Participant wished to be provided a benefit, not otherwise due. Employer's ERISA errors, if they did not directly relate to the benefits, would not be used against the employer. While the Participant had an old and out-dated booklet, e.g., he could have obtained a current copy of the plan by simple asking for one.
35. Disability plan demanded that Participant be under the regular care of a physician. The plan specifically referred to a legally qualified physician. This definition would exclude a chiropractor.
36. Plan had an alcohol exclusion which was applicable if the tests exceeded the *legal limit*. The court said there was no *legal limit* as such. The plan should have used *numbers* or referred to the *motor vehicle operation legal limit*.
37. The Participant had a group medical policy which was fully insured. Participant's spouse shot her husband rendering him a paraplegic; the large hospital bills were submitted as assigned. The Insurer turned them back claiming the Participant's

- application had been materially misrepresented; the Insurer sought policy rescission. The hospital, as assignee, sought recovery with a third part beneficiary even though policy had been rescinded. The hospital's claim failed, however because the Plan expressly said that it would pay only the insured without reference to any assignees. That is, the Plan *could* but did not have to agree to an assignment.
38. Claim from an acupuncturist was submitted. Plan listed licensed doctors of medicine to include: medical doctor, doctor of osteopathy, podiatrist, ophthalmologist and dentist. Claim was held to be denied. The acupuncturist was not a licensed doctor as defined in the plan.
  39. Participant received an employee manual which did not accurately describe the benefit; it failed to state that the Employee had to be actively-at-work in order to qualify for certain benefits. The booklet was accurately written; the manual and the booklet were not consistent. When Participant's group life benefit was not paid, the beneficiary sued, claiming that the manual should be used and the benefit paid. Brochure, accurately composed, should be followed. The manual was not the ERISA Summary Plan Description and had, in effect, no standing. Had manual been properly written, the evidence was strong against the Participant that he could have met the actively-at-work requirement. Court agreed that claim was not payable.
  40. The Plan's conversion provision stated that the conversion policy could be on a *form customarily issued by it*. The Insurer, with a \$1,000,000 group plan, issued a *barebones* conversion policy. The Participant wanted a broader-coverage policy. The court held the plans language was ambiguous and made the insurer issue an individual policy with comprehensive-type medical benefits.
  41. Plan denied coverage by revising its interpretation of plan document language. The court said that the denial was not effective because it changed its long-standing procedure for determining the 12-month period during which employees were required to give notice of a disability, without changing the ambiguous plan provision on which it based its procedure.
  42. Employer froze pension plan accruals prior to the announcement date. Employer faced a class action in which its actions were challenged. Employer erred in two ways the court found:
    - Such accruals could not be frozen retroactively.
    - Bulletin board announcements fail as valid communication and disclosure.
  43. The Participant, a truck driver, was not eligible for his employer's long-term disability plan. Due to a computer glitch, Participant's individualized benefit summary indicated that he was eligible for the employer's long-term disability plan. The personalized benefit statement did not purport to be an ERISA SPD; also the benefit statement had adequate disclaimers. Because the Participant was

not a member of the disability plan, he did not receive a SPD for such plan; and properly so. When a claim arose, the Participant sued for benefits. Since the personalized benefit statement did not abide by the required format of an ERISA SPD, it could not be deemed to be one. Therefore, the court held that the Participant was not eligible for benefits under the long-term disability plan.