CHUBB

The Chubb Primary℠ Fiduciary Liability Policy Guidebook

Protecting fiduciaries and benefit plans you manage

With four decades of experience in fiduciary liability and risk management, Chubb designed The Chubb Primary[SM] policy for publicly traded companies and financial institutions. This product includes what we know as standard, reliable coverage and so much more. Paired with loss prevention services and educational material, Chubb is committed to providing long term solutions for fiduciary liability as our customers navigate the ever-changing risks inherent in employee benefit plans.

The Chubb Primary[SM]

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The Chubb Primary℠ Fiduciary Liability Insurance

DECLARATIONS

<WRITING COMPANY>
Incorporated under the laws of <STATE>, a stock insurance company, herein called the Company

<ADDRESS>
<CITY>, <STATE> <ZIPCODE>

Policy Number: <POLICYNO>

NOTICE: THIS IS A CLAIMS MADE POLICY, WHICH APPLIES ONLY TO "MATTERS" FIRST MADE DURING THE "POLICY PERIOD", INCLUDING ANY APPLICABLE EXTENDED REPORTING PERIOD. THE LIMIT OF LIABILITY TO PAY "LOSS" WILL BE REDUCED, AND MAY BE EXHAUSTED, BY "DEFENSE COSTS", AND "DEFENSE COSTS" SHALL BE APPLIED AGAINST THE RETENTION AMOUNT. THE COMPANY SHALL NOT BE LIABLE FOR ANY AMOUNT, INCLUDING "DEFENSE COSTS" OR THE AMOUNT OF ANY JUDGMENT OR SETTLEMENT, UPON EXHAUSTION OF THE APPLICABLE LIMIT OF LIABILITY. READ THE ENTIRE POLICY CAREFULLY.

Item 1. **Parent Organization:**

<ACCTNAME>
<ACCTADDRESS>
<ACCTCITYNAME>, <ACCTDOMSTATCD> <ACCTZIP>

Item 2. **Policy Period:** From: <EFFDATE>
To: <EXPDATE>
At 12:01 A.M. local time at the address shown in Item 1.

Item 3. **Limit of Liability:**

All **Loss** Each **Policy Period:** $<LIMIT>

Item 4. **Sublimits of Liability:**

(A) HIPAA/HITECH Penalties:	$<$1.5MORLOLWHICHEVERISLESS>
(B) PPACA Penalties:	$<SUBLIMITLESSTHAN250K>
(C) Section 4975 IRC Excise Tax:	$<SUBLMTLESSTHAN250K>
(D) Section 502(c) Penalties:	$<SUBLMTNOMORE250K>
(E) Canadian Penalties:	$<AMOUNT>
(F) Voluntary Program Loss and Defense Costs:	$<SUBLIMIT250KORLESS>
(G) Penalty Suite Sublimit:	$<SUBLIMIT>
(H) Failure to Enroll Loss and Defense Costs:	$<AMOUNT50KOR LESS>

NOTE: The Sublimits of Liability shown in (A) through (H) above, are part of, and not in addition to, the Limit of Liability shown in Item 3 above.

Policy Forms

Application

Marketing Materials

Item 5. **Retentions:**

(A) Section I. Insuring Clause and Section II. Elective Reporting Coverages:

(1) **Non-Indemnifiable Loss**: None

(2) Indemnifiable **Loss**: $<AMOUNT2>

(B) Section III. Voluntary Program Notice Coverage: $<AMOUNT>

Item 6. **Extended Reporting Period:**

Additional Period: <NUMBER> <ERPTIMEPERIOD>

Additional Premium: <PERCENT>% of Annualized Premium

Item 7. **Pending or Prior Proceedings Date:** <DATE>

IN WITNESS WHEREOF, the Company issuing this Policy has caused this Policy to be signed by its authorized officers, but it shall not be valid unless also signed by a duly authorized representative of the Company.

<WRITING COMPANY>

<SECSIG>	<PRESSIG>
Secretary	President
<DATE>	<AUTHREPSIG>
Date	Authorized Representative

The Chubb Primary℠ Fiduciary Liability Insurance

In consideration of payment of the premium and subject to the Declarations and the limitations, conditions, provisions and other terms of this Policy, the Company and the Insureds agree as follows:

I. INSURING CLAUSE

Fiduciary Liability Coverage

The Company shall pay, on behalf of an **Insured**, **Loss** on account of any **Claim** first made against the **Insured** during the **Policy Period**, for a **Wrongful Act** by such **Insured**, or by any **Insured Person** for whose **Wrongful Acts** the **Insureds** are legally liable.

II. ELECTIVE REPORTING COVERAGES

(A) Inquiry Coverage

(1) Pre-Claim Investigation Coverage

The Company shall pay, on behalf of an **Insured**, **Loss** on account of any **Pre-Claim Investigation** first made against the **Insured** during the **Policy Period**.

(2) Interview Coverage

The Company shall pay, on behalf of an **Insured**, **Defense Costs** incurred solely by such **Insured Person** on account of an **Interview** first made during the **Policy Period**.

(3) Written Request to Toll or Waive Statute of Limitations

The Company shall pay, on behalf of an **Insured**, **Defense Costs** incurred solely by the **Insured** in responding to a written request to toll or waive a statute of limitations, first made during the **Policy Period**, applicable to a potential **Claim**. A written request to toll or waive a statute of limitations is commenced by the first receipt of such written request by an **Insured**.

(B) Benefit Claim Denial Coverage

The Company shall pay, on behalf of an **Insured**, **Loss** on account of any **Benefit Claim Denial** first made against the **Insured** during the **Policy Period**.

(C) Failure to Enroll Demand Coverage

The Company shall pay, on behalf of an **Insured**, **Failure to Enroll Loss** and **Defense Costs** on account of any written demand, other than a **Claim**, by a participant or a participant's beneficiary to pay such **Failure to Enroll Loss**, first made during the **Policy Period**. The Company's maximum liability for all **Failure to Enroll Loss** and **Defense Costs** under this Section II(C), combined, for the **Policy Period** shall be the aggregate Sublimit of Liability set forth in Item 4(H) of the Declarations.

III. VOLUNTARY PROGRAM NOTICE COVERAGE

The Company shall pay, on behalf of an **Insured**, **Voluntary Program Loss** and **Defense Costs** on account of any **Voluntary Program Notice** first given to the Company during the **Policy Period**. The Company's maximum liability for all **Voluntary Program Loss** and **Defense Costs** under this Section III, combined, for the **Policy Period** shall be the Sublimit of Liability set forth in Item 4(F) of the Declarations.

IV. COVERAGE EXTENSION

Penalty Suite Additional Sublimit of Liability

Solely with respect to coverage for **Civil Penalties** for which Sublimits of Liability are set forth in Item 4(A) through 4(E) of the Declarations ("Individual Civil Penalty Sublimits"), the Company shall provide an additional Sublimit of Liability set forth in Item 4(G) of the Declarations ("Excess Penalty Suite Sublimit") in excess of each Individual Civil Penalty Sublimit. However, the Excess Penalty Suite Sublimit shall be an aggregate Sublimit of Liability applying to all **Civil Penalties** in excess of the Individual Civil Penalty Sublimits combined.

V. EXCLUSIONS

The Company shall not be liable for **Loss** on account of any **Matter**:

(A) Prior Notice

based upon, arising from or in consequence of any **Wrongful Act**, fact, circumstance or **Matter**, that was the subject of any notice accepted under any prior fiduciary or employee benefit liability coverage;

(B) Pending or Prior Proceedings

based upon, arising from or in consequence of any written demand first received by, or action, proceeding, **Matter**, or **Matter** that is **Related**, commenced against any **Insured** on or prior to the Pending or Prior Proceedings Date set forth in Item 7 of the Declarations;

(C) Bodily Injury/Property Damage

for bodily injury, violation of any right of privacy, mental anguish, humiliation, emotional distress, sickness, disease or death of any person or damage to or destruction of any tangible property, including loss of use thereof, whether or not it is damaged or destroyed; provided that this Exclusion (C) shall not apply to any bodily injury to, mental anguish, emotional distress, sickness, disease, exacerbation of existing illness, or wrongful death of any person resulting from: (a) selection of any **Managed Care Services** provider; or (b) denial or delay of any benefit under a health care plan, other than a **Self-Administered Plan**;

(D) Workers Compensation; Unemployment; Social Security; Disability Benefits

for any failure of any **Insured** to comply with any workers' compensation, unemployment insurance, social security or disability benefits law or any amendments to or rules or regulations promulgated under any such law, or any similar provisions of any federal, state, or local statutory law or common law anywhere in the world; provided that this Exclusion (D) shall not apply to any **Matter** for a **Wrongful Act** in connection with the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, or rules or regulations promulgated thereunder, or the Health Insurance Portability and Accountability Act of 1996, each as amended, or rules or regulations promulgated thereunder, provided such **Matter** is otherwise covered hereunder; or

(E) Conduct

based upon, arising from or in consequence of:

(1) any deliberate fraud, any deliberate criminal act, or any knowing and willful violation of any law by an **Insured**; provided that, for acts or omissions which are treated as a criminal violation in a **Foreign Jurisdiction** that are not treated as a criminal violation in the United States, the imposition of a criminal fine or other criminal sanction in such **Foreign Jurisdiction** will not, by itself, be conclusive proof that a deliberate fraud, deliberate criminal act, or knowing and willful violation has occurred;

(2) an **Insured Person** having gained any personal profit, remuneration or other financial advantage, to which such **Insured Person** was not legally entitled; or

(3) an **Organization** or **Plan** having gained any profit, remuneration or other financial advantage to which such **Organization** or **Plan** was not legally entitled,

established by a final, non-appealable adjudication in any underlying action or proceeding.

For the purpose of determining the applicability of this Exclusion (E): (i) the **Wrongful Acts**, conduct, or actual knowledge of, or facts pertaining to, one **Insured** shall not be imputed to any other **Insured Person**; and (ii) only the **Wrongful Acts**, conduct, or actual knowledge of, or facts pertaining to, any past or present chief financial officer, chief executive officer or head of benefits (or an equivalent position to any of the foregoing worldwide) of an **Organization** shall be imputed to such **Organization** and its **Subsidiaries** or **Plans**; provided that, the foregoing subparagraph (ii) shall not preclude application of Exclusion (E) if the **Organization** or **Plan** is adjudicated in its own right.

VI. LIMIT OF LIABILITY

(A) The Company's maximum aggregate liability for all **Loss** shall be the Limit of Liability set forth in Item 3 of the Declarations subject to any sublimit of liability in this Policy and excess of any applicable Retention. Any sublimit of liability in this Policy shall be part of, and not in addition to, the Limit of Liability set forth in Item 3 of the Declarations.

(B) **Defense Costs** are part of, and not in addition to, the Limit of Liability set forth in Item 3 of the Declarations and subject to any sublimit of liability in this Policy.

(C) The Limit of Liability available during the Extended Reporting Period, if applicable, shall be part of, and not in addition to, the Limit of Liability set forth in Item 3 of the Declarations.

(D) The amount of any recovery obtained by the Company less all costs incurred by the Company to obtain such recovery shall be reinstated to the Limit of Liability set forth in Item 3 of the Declarations and any applicable sublimit of liability in this Policy.

VII. RETENTION

(A) The Retentions shall apply as set forth in Item 5 of the Declarations and shall only apply to covered **Loss**. Retentions shall be borne uninsured by the **Organization** or **Plan** and at its own risk.

(B) If different parts of a **Matter** are subject to different Retentions under this Policy, then the Retention applicable to such **Matter** shall not exceed the largest applicable Retention set forth in Item 5 of the Declarations.

(C) No Retention shall apply to any **Civil Penalties** pursuant to Subsections (C) through (F) of the definition of **Civil Penalties**.

VIII. REPORTING

(A) The **Insureds** shall give to the Company written notice of any **Claim** no later than:

(1) one hundred and eighty (180) days after this Policy expires and is renewed with the Company; or

(2) sixty (60) days after: (a) this Policy expires or terminates and is not renewed with the Company; or (b) the expiration of the Extended Reporting Period, if applicable.

(B) The **Insureds**, at their discretion, may give to the Company written notice of any **Elective Matter** no later than ninety (90) days after the in-house general counsel or risk manager of the **Parent Organization** first becomes aware of such **Elective Matter**. No coverage shall be available under this Policy for **Loss** on account of any unreported **Elective Matter**. However, if an **Insured** elects not to report an **Elective Matter**, coverage for any subsequent **Matter** that is **Related** to such **Elective Matter** shall not be denied based on a failure to report such **Elective Matter** and shall be deemed first made in the **Policy Period** in which such subsequent **Matter** was first made against such **Insured** and reported to the Company.

(C) The **Insureds**, at their discretion, may give to the Company a **Voluntary Program Notice**. A **Voluntary Program Notice** shall be deemed to have been first made when such **Voluntary Program Notice** was first given to the Company. The Company may, in its sole discretion, waive such prior notice requirement and accept a **Voluntary Program Notice** that is given to the Company within thirty (30) days of the **Insured's** entry into such **Voluntary Program**, in which case the **Voluntary Program Notice** shall be deemed to have been first made on the initial date of the **Insured's** entry into such **Voluntary Program**. No coverage shall be available under this Policy for **Loss** on account of any unreported **Voluntary Program Notice**.

(D) With respect to Subsections (A), (B) and (C) above, such written notice to the Company shall be a condition precedent to coverage for any **Matter**. However, if the **Parent Organization** can prove to the Company's satisfaction that it was not reasonably possible for the **Insureds** to give such notice within the time periods set forth in Subsection (A), (B) or (C) above and that subsequent notice was given as soon as reasonably possible thereafter, the Company shall waive the foregoing time period.

(E) If, during the **Policy Period**, the **Insureds** give written notice to the Company of any circumstance which could give rise to a subsequent **Matter**, then such **Matter** subsequently arising from such circumstance shall be deemed to have been first made during the **Policy Period** in which such written notice of circumstance was first given by the **Insureds** to the Company; provided such subsequent **Matter** is reported to the Company as soon as practicable after the in-house general counsel or risk manager of the **Parent Organization** first becomes aware of such **Matter**.

(F) The **Insureds** shall give to the Company in any written notice described above a description of the **Matter** or circumstance, the nature of any alleged **Wrongful Acts**, the nature of the alleged or potential damage, and the names of all actual or potential defendants.

IX. ADVANCEMENT OF DEFENSE COSTS

(A) The Company shall advance **Defense Costs** on account of a **Matter** reported pursuant to Section VIII, Reporting, on a current basis, but no later than sixty (60) days after receipt by the Company of bills or invoices detailing such **Defense Costs** and all other information reasonably requested by the Company with respect to such bills or invoices until the Limit of Liability set forth in Item 3 of the Declarations or any applicable sublimit of liability has been satisfied. Any advancement of **Defense Costs** by the Company shall reduce the Limit of Liability set forth in Item 3 of the Declarations or any applicable sublimit of liability.

Furthermore, if an **Organization** refuses in writing, or fails within sixty (60) days of an **Insured Person's** written request for indemnification, to advance, pay or indemnify an **Insured Person** for **Defense Costs** on account of a **Matter**, then, upon reporting the **Matter** pursuant to Section VIII, Reporting, the Company shall pay or advance covered **Defense Costs** on a current basis until such time that the **Organization** accepts the **Insured Person's** request for indemnification or the Limit of Liability set forth in Item 3 of the Declarations or any applicable sublimit of liability has been exhausted, whichever first occurs.

(B) Any advancement of **Defense Costs** shall be repaid to the Company by the **Insureds**, severally according to their respective interests, if and to the extent it is determined that such **Defense Costs** are not insured under this Policy. However, the Company shall not seek repayment from an **Insured** of advanced **Defense Costs** that are uninsured pursuant to Section V, Exclusion (E), Conduct, unless a final, non-appealable adjudication has occurred.

X. DEFENSE AND SETTLEMENT

(A) With respect to any **Claim** or **Pre-Claim Investigation** covered by this Policy:

(1) The Company shall have the right and duty to defend such **Claim** or **Pre-Claim Investigation**, even if any of the allegations therein are groundless, false or fraudulent. The Company's duty to defend shall cease upon exhaustion of the Limit of Liability or applicable sublimit of liability.

(2) Notwithstanding Paragraph (A)(1) above, the **Insured** shall have the right to assume the defense of a **Claim** or **Pre-Claim Investigation**. Such right shall be exercised by the **Parent Organization** on behalf of all **Insureds** by providing notice to the Company as soon as practicable but no later than thirty (30) days after the **Insured** provides notice of such **Claim** or **Pre-Claim Investigation** pursuant to Section VIII, Reporting. Once the defense of such **Claim** or **Pre-Claim Investigation** has been assumed by the **Insured**, in no event shall the Company be obligated to reassume the defense. However, the **Parent Organization** shall select legal counsel to conduct the defense of any **Claim** that is a **Mass or Class Action** or an **ESOP Claim** from the Company's list of approved fiduciary liability defense firms ("Panel Counsel"). An **Insured** may select Panel Counsel that is different from that selected by another **Insured** if such selection is required due to an actual conflict of interest or is otherwise reasonably justifiable.

(B) Notwithstanding Subsection (A) above, it shall be the duty of the **Insured** and not the duty of the Company to defend any **Voluntary Program Notice** or **Elective Matter**, other than a **Pre-Claim Investigation**.

(C) With respect to Subsections (A) and (B) above, the **Insured**:

(1) agrees not to settle or offer to settle any **Matter**, incur any **Defense Costs** or otherwise assume any contractual obligation or admit any liability with respect to any **Matter** without the Company's prior written consent, which the Company shall not unreasonably withhold, subject to Paragraph (C)(2) below;

(2) may settle a **Matter**, including all **Matters** that are **Related**, without the Company's prior written consent if the **Matter** is reported pursuant to Section VIII, Reporting, and the amount of such settlement and **Defense Costs** does not exceed the amount of the applicable Retention; and

(3) agrees, with respect to a **Matter**, to provide the Company with all information, assistance and cooperation which the Company may reasonably require and agrees that the **Insured** shall not do anything that could prejudice the Company's position or its potential or actual rights of recovery; provided that the failure of any **Insured** to give the Company such information, assistance or cooperation shall not impair the rights of any other **Insured Person** under this Policy.

(D) The Company:

(1) shall have the right and shall be given the opportunity to effectively associate with the **Insured** and shall be consulted in advance by the **Insured**, regarding the investigation, defense and settlement of any **Matter** that appears reasonably likely to be covered in whole or in part under this Policy, including selecting appropriate defense counsel and rates and negotiating any settlement;

(2) shall not be liable for any element of **Loss** incurred in excess of the amount of the applicable Retention, for any obligation assumed, or for any admission made, by any **Insured** without the Company's prior written consent, which the Company shall not unreasonably withhold; and

(3) may, in its sole discretion, waive the consent requirement in Paragraph (C)(1) above with respect to **Defense Costs** incurred within ninety (90) days prior to the reporting of a **Matter** pursuant to Section VIII, Reporting.

XI. RELATED MATTERS

All **Matters** that are **Related** shall be deemed a single **Matter** first made on the date the earliest of such **Matters** that are **Related** was either first made, or on the date the earliest of such **Matters** that are **Related** is deemed to have been first made in accordance with the applicable reporting provisions of this Policy or any prior policy.

XII. ALLOCATION

If the **Insured** who is afforded coverage for a **Matter** incurs an amount consisting of both **Loss** that is covered and any amount that is not covered, then coverage shall apply as follows:

(A) **Defense Costs**:

(1) If it is the Company's duty to defend the **Matter**, one hundred percent (100%) of **Defense Costs** incurred by such **Insured** on account of such **Matter** shall be covered **Loss**, provided that the foregoing shall not apply with respect to any **Insured** for whom coverage is not provided pursuant to Subsection XXIV(C), Representations and Severability, or excluded pursuant to Section V, Exclusion (E), Conduct.

(2) If the **Insured** has the duty to defend or exercises its option to assume the defense of the **Matter**, the **Insured** and the Company shall use their best efforts to determine an allocation of **Defense Costs** between **Defense Costs** that are covered and any amount that is not covered based on the relative legal and financial exposures of the covered parties to the covered matters. However, if the **Insured** and the Company cannot agree on an allocation of **Defense Costs** pursuant to this Paragraph (A)(2), the Company shall advance on a current basis **Defense Costs** which the Company believes to be covered under this Policy until a different allocation is negotiated, arbitrated or otherwise determined.

(B) The **Insured** and the **Company** shall use their best efforts to determine an allocation of all remaining amounts other than **Defense Costs** incurred by such **Insured** from such **Matter** between **Loss** that is covered and any amount that is not covered; in all instances, such determination shall be based on the relative legal and financial exposures of the covered parties to the covered matters.

XIII. PRIORITY OF PAYMENTS

(A) It is understood and agreed that any coverage provided under this Policy is principally intended to protect and benefit the **Insured Persons**. Accordingly, in the event that: (1) **Loss** for which an **Insured Person** has not been paid or indemnified; and (2) any other **Loss**, are concurrently due under this Policy, then the **Loss** described in (1) above shall be paid first. Thereafter, **Loss** incurred by a **Plan** shall be paid and finally **Loss** incurred by an **Organization** shall be paid to the extent of any remaining amount of the Limit of Liability or applicable sublimit of liability.

(B) Except as otherwise provided in Subsection (A) above, the Company may pay covered **Loss** as it becomes due under this Policy without regard to the potential for other future payment obligations under this Policy.

XIV. OTHER INSURANCE AND INDEMNITY

(A) If any **Loss** covered under this Policy is insured under any other valid and collectible insurance policy (other than an insurance policy that is issued specifically as excess over the Limit of Liability provided by this Policy or a personal umbrella policy or personal directorship liability policy purchased by an **Insured Person**), then this Policy shall cover such **Loss**, subject to its terms and conditions, only to the extent that the amount of such **Loss** is in excess of the applicable retention or deductible and limit of liability under such other insurance, whether such other insurance is stated to be primary, contributory, excess, contingent or otherwise.

(B) This Policy shall be specifically excess of, and shall not contribute with, any valid and collectible insurance for cyber liability or employee benefit liability, regardless of whether such other insurance is stated to be primary, contributory, excess, contingent or otherwise.

(C) Any payment by an **Insured** of a retention or deductible under any other insurance policy described in Subsection (A) or (B) above shall reduce the applicable Retention under this Policy by the amount of such payment which would otherwise have been covered **Loss** under this Policy.

XV. INDEMNIFICATION, SUBROGATION AND RECOURSE

(A) This Policy has been issued to the **Parent Organization** with the understanding and agreement that each **Organization** agrees to fulfill its indemnification obligations to each **Insured Person** to the fullest extent permitted by: (1) any United States law; and (2) any contract or agreement providing an indemnification obligation exceeding any such law. If the Company pays as **Loss** any indemnification owed to any **Insured Person** by any **Organization**, the Company does not waive or compromise any of its rights to recover such **Loss** from such **Organization**.

(B) In the event of any payment of **Loss** under this Policy, the Company shall be subrogated to the extent of such payment of **Loss** to all of the **Insureds'** rights of recovery, including any such right to indemnification from any **Organization**, other insurer or other source. The **Insureds** shall take all reasonable actions to secure and preserve the Company's rights, including any action against any **Organization** for indemnification. It is understood and agreed that the Company shall not subrogate against any **Insured Person**.

(C) No **Plan** has purchased or paid for the Policy and thus, the right of recourse that is otherwise required under ERISA Section 410(b)(1) is not applicable.

XVI. EXTENDED REPORTING PERIOD

(A) If this Policy does not renew or is otherwise terminated for a reason other than for non-payment of premium (each a "Termination of Coverage"), then an **Insured** shall have the right to purchase the Extended Reporting Period for the Additional Period and the Additional Premium set forth in Item 6 of the Declarations and the Extended Reporting Period shall become part of the **Policy Period**.

(B) The right to purchase the Extended Reporting Period shall lapse unless written notice of election to purchase the Extended Reporting Period, together with payment of the applicable Additional Premium, is received by the Company within sixty (60) days after the effective date of a Termination of Coverage.

(C) If the Extended Reporting Period is purchased, then coverage otherwise afforded by this Policy shall be extended to apply to **Matters** that are:

(1) either first made or deemed to have been first made during the Extended Reporting Period;

(2) reported to the Company in accordance with Section VIII, Reporting; and

(3) (i) with respect to **Claims**, for **Wrongful Acts** prior to the earliest of the effective date of a Termination of Coverage or the date of any conversion of coverage described in Section XIX, Acquisition of the Parent Organization; or (ii) with respect to **Elective Matters** or **Voluntary Program Notices**, arising out of facts or circumstances occurring prior to the earliest of the effective date of a Termination of Coverage or the date of any conversion of coverage described in Section XIX, Acquisition of the Parent Organization.

(D) The Additional Premium for the Extended Reporting Period shall be deemed fully earned at the inception of the Extended Reporting Period.

(E) No coverage shall be available under this Section XVI for that portion of any **Matter** covered under insurance purchased subsequent to the effective date of a Termination of Coverage.

XVII. CREATION OR ACQUISITION OF AN ESOP

Notwithstanding anything in this Policy to the contrary, if during the **Policy Period** any **Organization** creates, or directly or indirectly acquires, an employee stock ownership plan ("ESOP"), the **Organization** shall promptly give to the Company written notice thereof, together with such other information requested by the Company. The Company shall, at the request of the **Organization**, provide the **Organization** with a quotation for coverage for **Matters** based upon, arising from or in consequence of such ESOP, subject to such terms, conditions, and limitations of coverage and such additional premium as the Company, in its sole discretion, may require.

XVIII. ACQUISITION OR CESSATION OF SUBSIDIARIES OR SPONSORED PLANS

(A) Acquisition of a Subsidiary or Sponsored Plan (other than an ESOP)

(1) If before or during the **Policy Period** an **Organization** acquires voting or appointment rights in another entity, such that the acquired entity becomes a **Subsidiary**, or acquires another plan such that the acquired plan becomes a **Sponsored Plan**, then such **Subsidiary**, **Sponsored Plan** and the **Insured Persons** thereof, shall be **Insureds** only with respect to **Claims** for **Wrongful Acts**, or **Voluntary Program Notices** or **Elective Matters** arising out of facts or circumstances, first occurring after such acquisition.

(2) If a **Sponsored Plan** or a **Subsidiary** is acquired during the **Policy Period** pursuant to Subparagraph (A)(1) above and: (i) in the case of an acquired **Sponsored Plan,** the total assets of such acquired **Sponsored Plan** exceed fifteen percent (15%) of the total assets of the **Parent Organization's** comparable **Sponsored Plan** (as reflected in the most recent audited, consolidated financial statements of such **Sponsored Plans** as of the date of the acquisition), or (ii) in the case of an acquired **Subsidiary**, the total assets of such **Subsidiary** exceed fifteen percent (15%) of the total assets of the **Parent Organization** (as reflected in the most recent audited consolidated financial statements of such **Subsidiary** and the **Parent Organization**, respectively, as of the date of such acquisition), the **Parent Organization** shall, no later than sixty (60) days after the date of such acquisition, give written notice of such acquisition to the Company together with all information the Company may require. Coverage for any such acquired **Subsidiary**, **Sponsored Plan**, and its **Insured Persons** may be subject to additional or different terms and conditions and payment of additional premium as the Company may require.

If the **Parent Organization** fails to give such notice and information or does not pay any required premium in accordance with the foregoing, coverage for such acquired **Subsidiary**, **Sponsored Plan**, and its **Insured Persons** shall terminate with respect to **Matters** first made more than sixty (60) days after such acquisition. This Subsection (A) shall not apply to any ESOP.

(B) Cessation of a Subsidiary or Sponsored Plan

(1) If before or during the **Policy Period** an **Organization** ceases to be a **Subsidiary**, then with respect to such **Subsidiary** and its **Insured Persons**, coverage shall continue until termination of this Policy for **Claims** for **Wrongful Acts**, or **Elective Matters** or **Voluntary Program Notices** arising out of facts or circumstances first occurring while such **Organization** was a **Subsidiary**; or

(2) If before or during the **Policy Period** a **Sponsored Plan** is terminated or otherwise ceases to be a **Sponsored Plan**, then with respect to such **Sponsored Plan** and its **Insured Persons**, coverage shall continue until termination of this Policy for **Claims** for **Wrongful Acts**, or **Elective Matters** or **Voluntary Program Notices** arising out of facts or circumstances first occurring prior to the earlier of:

(i) the date that the **Organization** or **Insured Person** ceases to be a fiduciary of such **Sponsor Plan**; or

(ii) the date that:

1. the **Sponsored Plan** ceases to be a **Sponsored Plan**; or
2. the final distribution of the assets of such **Sponsored Plan**,

whichever occurs last.

(C) In the event the Pension Benefit Guaranty Corporation ("PBGC") becomes the trustee of a **Sponsored Plan** before or after the inception date of this Policy, coverage under this Policy with respect to such **Sponsored Plan**, shall continue until termination of this Policy, for those who were **Insureds** at the time the PBGC became the trustee of such **Sponsored Plan**, with respect to **Claims** for **Wrongful Acts**, or **Elective Matters** arising out of facts or circumstances first occurring prior to the effective date the PBGC became the trustee of such **Sponsored Plan**.

XIX. ACQUISITION OF THE PARENT ORGANIZATION

(A) If during the **Policy Period** the **Parent Organization** is acquired such that another entity, person or group of entities or persons acting in concert, acquires more than fifty percent (50%) of the outstanding securities representing the present right to vote for the election of, or to appoint, directors or **Managers** of the surviving entity, then:

(1) coverage under this Policy shall continue until the expiration of the **Policy Period**, solely for **Claims** for **Wrongful Acts**, or for **Voluntary Program Notices** or **Elective Matters** arising out of facts or circumstances, first occurring prior to such acquisition; and

(2) the entire premium for this Policy shall be deemed fully earned as of the effective date of such acquisition.

(B) If the **Parent Organization** gives the Company written notice of an acquisition described in Subsection (A) above at least thirty (30) days prior to the date of such acquisition together with all information that the Company may require, the Company shall provide the **Parent Organization** with a quote for up to a six (6) year extension of coverage solely for **Claims** for **Wrongful Acts**, or for **Voluntary Program Notices** or **Elective Matters** arising out of facts or circumstances, first occurring prior to such acquisition (the "Run-Off Quote"). Coverage offered pursuant to the Run-Off Quote may be subject to additional or different terms and conditions and payment of additional premium. If the **Parent Organization** accepts the Run-Off Quote, the extension of coverage provided pursuant to the Run-Off Quote shall replace any extension of coverage that would otherwise be available to the **Insureds** pursuant to Section XVI, Extended Reporting Period.

XX. SPOUSES, DOMESTIC PARTNERS, ESTATES AND LEGAL REPRESENTATIVES

Coverage under this Policy shall extend to **Claims** for **Wrongful Acts** of an **Insured Person** made against:

(A) the estate, heirs, legal representatives or assigns of such **Insured Person** if such **Insured Person** is deceased or the legal representatives or the assigns of such **Insured Person** if such **Insured Person** is legally incompetent, insolvent or bankrupt; or

(B) the lawful spouse or domestic partner of such **Insured Person** solely by reason of such spouse's or domestic partner's: (1) status as a spouse or domestic partner; or (2) ownership interest in property which the claimant seeks as recovery for an alleged **Wrongful Act** of such **Insured Person**,

provided that, no coverage provided by this Section XX shall apply with respect to loss arising from an act, error or omission by an **Insured Person's** estate, heirs, legal representatives, assigns, spouse or domestic partner.

XXI. NOTICE

(A) All notices to the Company under this Policy of any **Matter** or circumstance shall be given in writing to one of the following addresses:

(1) ChubbClaimsFirstNotice@Chubb.com

(2) Attn: Chubb Claims Department

Chubb
P.O. Box 55122
Scranton, PA 18505-0544

(B) All other notices to the Company under this Policy shall be given in writing to one of the following addresses:

(1) NA.FinancialLines@chubb.com

(2) Attn: Chubb Underwriting Department

Chubb
202B Hall's Mill Road
Whitehouse Station, NJ 08889

(C) Any notice described in Subsection (A) or (B) above shall be effective on the date of receipt by the Company.

XXII. TERMINATION OF POLICY

This Policy shall terminate at the earliest of the following times:

(A) ten (10) days after receipt by the **Parent Organization** of written notice of termination from the Company for non-payment of premium;

(B) upon expiration of the **Policy Period**;

(C) upon receipt by the Company of written notice of termination from the **Parent Organization**, in which case any returned premium shall be computed on a pro rata basis; provided that this Policy may not be terminated by the **Parent Organization** after the effective date of any event as described in Section XIX, Acquisition of the Parent Organization; or

(D) at such other time as may be agreed upon by the Company and the **Parent Organization**, in which case any returned premium shall be computed on a pro rata basis.

XXIII. BANKRUPTCY

(A) Bankruptcy or insolvency of any **Insured** shall not relieve the Company of its obligations nor deprive the Company of its rights or defenses under this Policy.

(B) In the event a liquidation or reorganization proceeding is commenced by or against an **Organization** under United States bankruptcy law and/or the PBGC under **ERISA**, the **Organization**, any **Plan** and **Insured Persons** hereby agree not to oppose or object to any efforts by the Company, the **Organization**, **Plan** or an **Insured Person** to obtain relief from any stay or injunction.

XXIV. REPRESENTATIONS AND SEVERABILITY

(A) The Company, in issuing this Policy, has relied upon the statements, representations and information in the **Application** as being true and accurate. The **Application** is the basis for, and considered incorporated into, this Policy and shall be construed as a separate request for coverage by each **Insured**.

(B) The knowledge of an **Insured** shall not be imputed to any other **Insured Person**, and only the actual knowledge of a past or present chief executive officer, chief financial officer or head of benefits (or equivalent thereof) of the **Parent Organization** shall be imputed to the **Organization** or **Plan**. The Company shall not be entitled under any circumstances to void or rescind this Policy with respect to any **Insured**.

(C) However, in the event that the **Application** contains any misrepresentation made with the actual intent to deceive or contains any misrepresentation which materially affects either the acceptance of the risk or the hazard assumed by the Company under this Policy, then no coverage shall be afforded for any **Matter** based upon, arising from or in consequence of any such misrepresentation with respect to:

(1) any **Insured Person** who knew of such misrepresentation (whether or not such **Insured Person** knew the **Application** contained such misrepresentation) or any **Organization** or **Plan** to the extent it indemnifies any such **Insured Person;** or

(2) any **Organization** or **Plan** if any past or present chief executive officer, chief financial officer, general counsel or head of benefits (or equivalent thereof) of the **Parent Organization** knew of such misrepresentation (whether or not such individual knew such **Application** contained such misrepresentation).

XXV. VALUATION AND FOREIGN CURRENCY

All premiums, limits, retentions, **Loss** and other amounts under this Policy are expressed and payable in the currency of the United States of America. Except as otherwise provided in this Policy, if a judgment is rendered, a settlement is denominated or any element of **Loss** under this Policy is stated in a currency other than United States of America dollars, payment under this Policy shall be made in United States of America dollars at the rate of exchange published in The Wall Street Journal on the date the judgment becomes final, the amount of the settlement is agreed upon or any element of **Loss** is due, respectively.

XXVI. ACTION AGAINST THE COMPANY

No action may be taken against the Company unless, as a condition precedent thereto, there shall have been full compliance with all the terms of this Policy. No person or entity shall have any right under this Policy to join the Company as a party to any action against any **Insured** to determine such **Insured's** liability nor shall the Company be impleaded by such **Insured** or legal representatives of such **Insured**.

XXVII.ROLE OF PARENT ORGANIZATION

By acceptance of this Policy, the **Parent Organization** agrees that it shall be considered the sole agent of, and shall act on behalf of, each **Insured** with respect to: (A) the payment of premiums and the receiving of return premiums that may become due under this Policy; (B) the negotiation, agreement to and acceptance of endorsements; and (C) the giving or receiving of any notice provided for in this Policy (except the giving of notice of any **Matter** or circumstances in accordance with Section VIII, Reporting, or the giving of notice to apply for an Extended Reporting Period as provided in Section XVI, Extended Reporting Period). Each **Insured** agrees that the **Parent Organization** shall act on its behalf with respect to the foregoing.

XXVIII.ALTERATION AND ASSIGNMENT

No change in, modification of, or assignment of interest under, this Policy shall be effective except when made by written endorsement to this Policy which is signed by an authorized representative of the Company.

XXIX. WORLDWIDE TERRITORY, APPLICATION OF LAW AND LIBERALIZATION

(A) This Policy shall apply anywhere in the world.

(B) Any reference to United States law shall include:

(1) United States federal, state and local statutory law and any rule or regulation promulgated thereunder, as amended;

(2) United States common law; and

(3) with respect to Paragraphs (B)(1) and (B)(2) above, any equivalent body of law anywhere in the world.

(C) If the **Parent Organization** requests a fiduciary liability policy for issuance to its foreign **Subsidiary** in its own country, the Company or any subsidiary or affiliate of Chubb shall provide a quote to the **Parent Organization** for a GLS policy; provided that Chubb can support or facilitate the issuance of such GLS policy to such foreign **Subsidiary** in such foreign country. Coverage offered pursuant to the issued GLS policy shall be subject to additional or different terms and conditions and payment of additional premium. Any coordination of coverage under such policy with coverage under this Policy shall be set forth in an endorsement attached to this Policy.

(D) Whether or not a policy is purchased pursuant to Subsection (C) above, where legally permissible, for **Loss** from that portion of any **Claim** maintained in a **Foreign Jurisdiction** or to which the law of a **Foreign Jurisdiction** is applied, the Company shall apply to such **Claim** those specific definitions and exclusions of the GLS policy in such **Foreign Jurisdiction** that are more favorable to such **Insured** than the comparable definitions and exclusions of this Policy. This Subsection (D) shall not apply to any provision of any policy addressing limits of liability (primary, excess or sublimits), retentions, other insurance or excess liability coverage, duty to defend, defense within or outside the limits, taxes, loss as a result of any cyber or General Data Protection Regulation related matter, conformance to law, any claims made provisions, and any endorsement to this Policy that excludes or limits coverage for specific events or litigation, or that specifically states that it will have worldwide effect.

For the purposes of determining coverage under Subsections (C) and (D), "GLS policy" means Chubb's current Good Local Standard fiduciary liability policy, including any mandatory endorsements, sold within such **Foreign Jurisdiction** that provides coverage substantially similar to the coverage afforded under this Policy with respect to such **Claim**. "GLS policy" shall not include any partnership management, cyber liability, or professional liability coverages.

XXX. STATE AMENDATORY INCONSISTENCY

If there is an inconsistency between a state amendatory endorsement attached to this Policy and any other term or condition of this Policy, the Company shall apply, where permitted by law, those terms and conditions either of such state amendatory endorsement or the Policy which are more favorable to the **Insured's** coverage; provided that, with respect to any time period relating to notice of cancellation or non-renewal provided under this Policy, the Company shall apply the applicable state law.

XXXI. HEADINGS

The descriptions in the headings and sub-headings of this Policy are solely for convenience and form no part of the terms and conditions of coverage.

XXXII. COMPLIANCE WITH APPLICABLE TRADE SANCTION LAWS

This insurance does not apply to the extent that trade or economic sanctions law or other similar laws or regulations prohibit the Company from providing insurance.

XXXIII. DEFINITIONS

When used in this Policy:

Administration means:

(A) advising, counseling, failing to provide proper or timely notice, providing interpretations to, or calculating benefits of, **Employees**, **Executives**, participants or beneficiaries with respect to any **Plan**; or

(B) handling of records or effecting enrollment, termination or cancellation of **Employees**, **Executives**, participants or beneficiaries under any **Plan**.

Application means:

(A) any application, including attachments, or any written information or representations, provided to the Company by, or on behalf of, an **Insured** during the negotiation of this Policy or for the purposes of the Company's underwriting of this Policy;

(B) all publicly available documents filed by an **Organization** with the Department of Labor or the Securities and Exchange Commission during the twelve (12) months preceding this Policy's inception date; and

(C) if applicable, any representation provided to the Company within the past three (3) years in connection with any policy of which this Policy is a renewal or replacement.

Benefit Claim Denial means an appeal of an **Insured's** adverse benefits determination pursuant to the U.S. Department of Labor's claim procedure regulation 29 C.F.R. Section 2560.503-1(h) or any similar claim procedures pursuant to applicable law.

Civil Penalties means, to the extent such penalties are insurable under the law pursuant to which this Policy is construed:

(A) the five percent (5%) or less, or the twenty percent (20%) or less, civil penalties imposed upon an **Insured** as a fiduciary under Section 502(i) or (l) of **ERISA**, respectively;

(B) civil money penalties imposed by:

(1) the Pension Ombudsman appointed by the United Kingdom Secretary of State for Work and Pensions or any successor thereto, by the United Kingdom Occupational Pensions Regulatory Authority, or the Pensions Regulator or any successor thereto, pursuant to the Pension Scheme Act 1993, the Pensions Act 1995, the Pensions Act 2004, or rules or regulations thereunder;

(2) Ireland's Pensions Board or Pensions Ombudsman; or

(3) the Pension Benefit Standards Act, R.S.C., 1985, C.32 of Canada, including any rules or regulations thereunder, as amended, or the same or similar provisions of any legislation, rules or regulations in each of the provinces or territories of Canada ("Canadian Penalties"); provided the Company's maximum liability for all such Canadian Penalties on account of all **Matters** shall be the amount set forth in Item 4(E) of the Declarations,

provided any coverage for such civil penalties applies only if the funds or assets of the pension scheme are not used to fund, pay or reimburse the premium for this Policy;

(C) civil money penalties imposed upon an **Insured** for violation of the privacy provisions of the Health Insurance Portability and Accountability Act of 1996, as amended, ("HIPAA/HITECH Penalties"); provided the Company's maximum limit of liability for all such HIPAA/HITECH Penalties on account of all **Matters** shall be the amount set forth in Item 4(A) of the Declarations;

(D) civil money penalties imposed upon an **Insured** for violation of the Patient Protection and Affordable Care Act, as amended, and any rules or regulations promulgated thereunder ("PPACA Penalties"); provided the Company's maximum limit of liability for all such PPACA Penalties on account of all **Matters** shall be the amount set forth in Item 4(B) of the Declarations;

(E) the fifteen percent (15%) or less excise tax imposed upon an **Insured** under Section 4975 of the Internal Revenue Code of 1986, as amended, ("Section 4975 IRC Excise Tax"); provided the Company's maximum limit of liability for such Section 4975 IRC Excise Tax on account of all **Matters** shall be the amount set forth in Item 4(C) of the Declarations; or

(F) civil money penalties imposed upon an **Insured** as a fiduciary under Section 502(c) of **ERISA,** including any amendments pursuant to Section 507 of Title V of the Pension Protection Act of 2006 ("Section 502(c) Penalties"); provided the Company's maximum limit of liability for all such Section 502(c) Penalties on account of all **Matters** shall be the amount set forth in Item 4(D) of the Declarations.

Claim means any:

(A) written demand (other than an **Elective Matter**, subpoena or other investigatory instrument) for:

(1) monetary or non-monetary (including injunctive) relief; or

(2) arbitration, mediation, or other equivalent alternative dispute resolution proceeding,

against an **Insured** for a **Wrongful Act**, commenced by the first receipt of such demand by an **Insured**;

(B) proceeding, including any appeal therefrom, against an **Insured** for a **Wrongful Act**, commenced by:

(1) the service of a civil complaint or similar pleading, or any foreign equivalent thereof;

(2) the receipt of written notice of an administrative or regulatory proceeding, including but not limited to a receipt of a written notice of commencement of a fact-finding investigation, by the U.S. Department of Labor, the PBGC, or any similar governmental authority located outside the United States, including, the Pensions Ombudsman appointed by the United Kingdom Secretary of State for Work and Pensions or by the United Kingdom Occupational Pensions Regulatory Authority or any successor thereto; or

(3) an arrest, the return of an indictment, information or any foreign equivalent thereof, or the receipt of an official request for **Extradition**; or

(C) investigation by an **Enforcement Unit** against an **Insured Person**, solely in his or her fiduciary capacity with respect to any **Sponsored Plan**, for a **Wrongful Act**, commenced by the service of a written request from such **Enforcement Unit** upon an **Insured Person** compelling witness testimony or document production and identifying such **Insured Person** as a target of such investigation, including a subpoena, civil investigative demand, grand jury subpoena, search warrant, target letter or Wells notice; provided that the Company shall take into reasonable consideration all extrinsic evidence presented by the **Insured Person** when determining whether such written request identifies such **Insured Person** as a target of such investigation.

Committee means any employee benefit or pension committee established by an **Organization** with respect to a **Sponsored Plan**, provided the committee consists of at least one **Insured Person**.

Corporate Trustee Company means any entity formed and operating outside the United States of America established by the **Parent Organization** and duly appointed to act as a trustee of a **Sponsored Plan**.

Defense Costs means that part of **Loss** consisting of reasonable costs, charges, fees (including attorneys' fees, experts' fees, and the cost of **E-Discovery Specialist Services**) and expenses (other than regular or overtime wages, salaries, fees or benefits of the **Insured Persons**) incurred in:

(A) investigating, defending, opposing or appealing any **Claim** and the premium for appeal, attachment or similar bonds;

(B) a **Pre-Claim Investigation**;

(C) a **Benefit Claim Denial**;

(D) preparing and filing any entry into a **Voluntary Program**;

(E) responding to a written demand to pay **Failure to Enroll Loss**;

(F) an **Interview**; or

(G) responding to a written request to toll or waive a statute of limitations.

E-Discovery means the review, development, collection, storage, organization, cataloging, preservation or production of electronically stored information in connection with the defense of a **Claim**.

E-Discovery Specialist Services means only the following services performed by an **E-Specialist Firm**:

(A) assisting the **Insured** with managing and minimizing the internal and external costs associated with **E-Discovery**;

(B) assisting the **Insured** in developing or formulating an **E-Discovery** strategy which shall include interviewing qualified and cost-effective **E-Discovery** vendors;

(C) serving as project manager, advisor or consultant to the **Insured**, defense counsel and the Company in executing and monitoring the **E-Discovery** strategy; and

(D) such other services provided by the **E-Specialist Firm** that the **Insured**, Company, and **E-Specialist Firm** agree are reasonable and necessary given the circumstances of the **Claim**.

Elective Matter means any **Pre-Claim Investigation**, **Interview**, written request to toll or waive a statute of limitations, **Benefit Claim Denial** or written demand to pay **Failure to Enroll Loss**, if reported to the Company in accordance with Section VIII, Reporting.

Employee means any natural person whose labor or service was, is or will be engaged by and directed by the **Organization** or any **Plan**, including a part-time, seasonal, leased and temporary employee, or any volunteer. **Employee** shall not include any independent contractor.

Enforcement Unit means any federal, state, local or provincial law enforcement or governmental regulatory authority worldwide (including, the U.S. Department of Justice, the U.S. Securities and Exchange Commission and any attorney general) or the enforcement unit of any securities exchange or similar self-regulatory organization. **Enforcement Unit** shall not include the U.S. Department of Labor, the U.S. Pension Benefit Guaranty Corporation, the Internal Revenue Service (with the exception of the Criminal Investigative Division thereof), or any similar governmental authority located outside the United States, including, the Pensions Ombudsman appointed by the United Kingdom Secretary of State for Work and Pensions or by the United Kingdom Occupational Pensions Regulatory Authority or any successor thereto.

ERISA means:

(A) the Employee Retirement Income Security Act of 1974, as amended, including amendments of such Act pursuant to the:

   (1) Consolidated Omnibus Budget Reconciliation Act of 1985;

   (2) Health Insurance Portability and Accountability Act of 1996;

   (3) Newborns' and Mothers' Health Protection Act of 1996;

   (4) Mental Health Parity Act of 1996;

   (5) Women's Health and Cancer Rights Act of 1998;

   (6) Pension Protection Act of 2006;

   (7) Health Information Technology for Economic and Clinical Health Act of 2009;

   (8) Patient Protection and Affordable Care Act of 2010; and

   (9) Setting Every Community Up for Retirement Enhancement Act of 2019;

(B) the English Pension Scheme Act 1993, and the English Pensions Act 1995, the Pensions Act 2004, as such Acts are amended and any rules or regulations promulgated under such Acts,

and with respect to both Subsections (A) and (B) above, any similar statutory or common law anywhere in the world, and any rules or regulations promulgated thereunder; and

(C) the privacy provisions under the Health Insurance Portability and Accountability Act of 1996, as amended.

ESOP Claim means any **Claim** made against an **Insured** for **Wrongful Acts** in connection with any private company employee stock ownership plan sponsored or established by an **Organization** for its **Employees**.

E-Specialist Firm means any e-discovery consultant firm approved by the Company.

Executive means any natural person who was, now is or shall become:

(A) a duly elected or appointed director, officer, **Manager**, in-house general counsel, member of the Advisory Board, governor or management or committee member of any **Organization** organized in the United States of America; or

(B) a holder of a position equivalent to any position described in Subsection (A) above in an **Organization** that is organized in a **Foreign Jurisdiction**.

Extradition means any formal or written process by which an **Insured Person** located in any country is surrendered, or sought to be surrendered, to any other country for trial or otherwise to answer any criminal accusation, including the execution of an arrest warrant where such execution is an element of such process.

Failure to Enroll Loss means an amount equal to the amount of life, health or death benefits that otherwise would have been due to, or on behalf of, a participant or beneficiary of a **Sponsored Plan** that is an Employee Welfare Benefit Plan as set forth in Section 3(1)(A) of **ERISA**, but for the **Insured** negligently failing to enroll such participant or beneficiary in such **Sponsored Plan**, provided that such **Sponsored Plan** is not a self-funded **Plan**. In no event shall **Failure to Enroll Loss** include or be based on any Employee Pension Benefit Plan as set forth in Section 3(2)(A) of **ERISA** or any other type of employee pension plan.

Financial Impairment means the status of an entity resulting from:

(A) the appointment by any state or federal official, agency or court of any receiver, conservator, liquidator, trustee, rehabilitator or similar party (including a creditors' committee, if applicable) or foreign equivalent empowered to initiate the assumption of control, supervision, management or liquidation of such entity; or

(B) such entity becoming a debtor in possession under the United States bankruptcy law.

Foreign Jurisdiction means any jurisdiction, other than the United States of America.

Health Care Exchange means the American Health Benefit Exchange and the SHOP Exchange, as such terms are defined in Section 1311 of the Patient Protection and Affordable Care Act of 2010, and any other similar health care exchange, including any public or private entity established to facilitate the purchase of health insurance coverage in accordance with the Patient Protection and Affordable Care Act of 2010, as amended.

Insured means any **Organization**, **Plan**, **Committee**, **Insured Person**, and **Corporate Trustee Company**.

Insured Person means:

(A) an **Executive**;

(B) an **Employee**;

(C) a past **Employee** or **Executive** retained as a fiduciary or plan consultant to a **Sponsored Plan**; provided that for the purposes of determining an **Organization's** indemnification obligation to any such fiduciary or plan consultant, each such fiduciary or plan consultant shall be deemed a director or officer of the **Organization** and indemnified to the fullest extent permitted by statutory or common law;

(D) a duly elected or appointed natural person member of a **Committee**, solely in his or her capacity as such; or

(E) a duly elected or appointed natural person trustee of a **Sponsored Plan**, solely in his or her capacity as such.

Insured Person shall not include any natural person in his or her capacity as an employee or executive of any third party, including a service provider, other than a **Corporate Trustee Company**.

Interview means any request for an interview or meeting with, or a sworn statement or testimony from, an **Insured Person** by:

(A) an **Enforcement Unit** in connection with: (1) such **Insured Person** acting solely in his or her capacity as a fiduciary of a **Sponsored Plan**; or (2) a **Sponsored Plan's** business activities; or

(B) an **Organization** in connection with an inquiry or investigation of the **Sponsored Plan** by an **Enforcement Unit**,

commenced by the first receipt of such request by such **Insured Person**; provided that **Interview** does not include any request:

(1) for document production or discovery materials unless such documents or discovery materials are in the sole possession and control of such **Insured Person**;

(2) by an **Enforcement Unit** that is part of any routine or regularly scheduled **Enforcement Unit** oversight, compliance, audit, inspection or examination; or

(3) by an **Enforcement Unit** that is part of an employment-related investigation or claim.

Loss means the amount which any **Insured** becomes legally obligated to pay as a result of any **Matter**, including:

(A) compensatory damages;

(B) punitive, exemplary or multiplied damages, if and to the extent such damages are insurable under the law of the jurisdiction most favorable to the insurability of such damages; provided such jurisdiction has a substantial relationship to the relevant **Insured**, to the Company, or to the **Claim** giving rise to such damages;

(C) **Civil Penalties**;

(D) judgments, including pre-judgment and post-judgment interest;

(E) settlements;

(F) **Defense Costs**;

(G) claimant's attorney's fees awarded by a court pursuant to Section 502(g) of **ERISA**, as amended, against an **Insured**;

(H) reasonable fees and expenses of an independent fiduciary retained to review a proposed settlement of a covered **Claim** (including reasonable and necessary fees and expenses of any law firm hired by such independent fiduciary to facilitate that review of such proposed settlement of a covered **Claim**);

(I) solely for purposes of Subsection II(C), Failure to Enroll Demand, **Failure to Enroll Loss** and **Defense Costs**, combined; and

(J) solely for purposes of Section III, Voluntary Program Notice Coverage, **Voluntary Program Loss** and **Defense Costs**, combined.

Loss does not include any:

(1) cost incurred by any **Insured** to comply with any order for non-monetary (including injunctive) relief or to comply with an agreement to provide such relief;

(2) amount not insurable under the law pursuant to which this Policy is construed;

(3) taxes, fines or penalties, except as provided in Subsections (B), (C) and (J) above, with respect to punitive, exemplary or multiplied damages, **Civil Penalties** and **Voluntary Program Loss**.

(4) amounts incurred by an **Insured** in the defense or investigation of any action, proceeding, investigation or demand that was not then a **Matter**, even if (i) such amount also benefits the defense of a covered **Matter**, or (ii) such action, proceeding, investigation or demand subsequently gives rise to a **Matter**;

(5) (i) benefits due, or to become due, or that portion of any settlement or award in an amount equal to such benefits, under any **Plan**; or (ii) benefits which would be due, or that portion of any settlement or award in an amount equal to such benefits, under any **Plan** if such **Plan** complied with all applicable law, including loss resulting from the payment of claimant attorneys' fees based upon a percentage of such benefits or payable from a common fund established to pay such benefits, except to the extent that:

1. an **Insured** is a natural person and the benefits are payable by such **Insured** as a personal obligation, and recovery for the benefits is based upon a covered **Wrongful Act**; or

2. a **Matter** made against an **Insured**:

(a) alleges a loss to the **Sponsored Plan** or to the accounts of such **Sponsored Plan's** participants by reason of a change in the value of the investments held by such **Sponsored Plan**, regardless of whether the amounts sought or recovered by the plaintiffs in such **Claim** are characterized by plaintiffs as "benefits" or held by a court as "benefits"; or

(b) seeks amounts that would have been due to or on behalf of a participant or beneficiary of a **Sponsored Plan**, but for the **Insured** failing to enroll such participant or beneficiary in the **Sponsored Plan**, as set forth in Subsection (B) of the definition of **Administration**, unless and to the extent the **Sponsored Plan** is self-funded;

(6) costs incurred in cleaning-up, removing, containing, treating, detoxifying, neutralizing, assessing the effects of, testing for, or monitoring **Pollutants**; or

(7) any amount constituting any contribution, or that portion of any settlement or award constituting any contribution, that is owed to, or is to fund, any **Plan**, except to the extent that the contribution is **Non-Indemnifiable Loss** payable by a natural person **Insured** as a personal obligation based upon a **Wrongful Act**.

Managed Care Services means the administration or management of a health care plan utilizing cost control mechanisms, including but not limited to utilization review, case management, disease management or the use of a preferred provider network. **Managed Care Services** does not include any **Self-Administered Plan**.

Manager means any natural person who was, now is or shall become a manager, member of the Board of Managers or equivalent executive of an **Organization** that is a joint venture (other than a partnership) or limited liability company.

Mass or Class Action means any **Claim**:

(A) brought or maintained by or on behalf of five or more natural persons who are acting in concert, whether or not such natural persons are represented by one or more legal counsel;

(B) brought or maintained by or on behalf of one to four natural persons if any of such natural persons are seeking monetary relief on behalf of a class or group of complainants in order to resolve such **Claim**, whether or not such natural persons are represented by one or more legal counsel; or

(C) by a governmental entity, department, agency or authority.

Matter means any **Claim**, **Elective Matter**, or **Voluntary Program Notice**.

Non-Indemnifiable Loss means **Loss** for which an **Organization** is not permitted by common or statutory law to indemnify an **Insured Person** or is permitted to indemnify an **Insured Person** but does not do so solely by reason of **Financial Impairment**.

Organization means the **Parent Organization** and any **Subsidiary**. **Organization** shall also mean any such entity as a debtor in possession under United States bankruptcy law.

Parent Organization means the entity named in Item 1 of the Declarations.

Plan means:

(A) any **Sponsored Plan**; and

(B) any government-mandated insurance program for workers' compensation, unemployment, social security or disability benefits for **Employees** and any plan maintained to comply with applicable workers' compensation, unemployment, social security or disability laws.

Policy Period means the period of time set forth in Item 2 of the Declarations (subject to any termination in accordance with Section XXII, Termination of Policy) and the Extended Reporting Period, if applicable.

Pollutants means any solid, liquid, gaseous or thermal irritants or contaminants, including smoke, vapor, soot, fumes, acids, alkalis, chemicals, asbestos, asbestos products or waste. Waste includes materials to be recycled, reconditioned or reclaimed.

Pre-Claim Investigation means a fact-finding investigation into a possible violation of **ERISA** with respect to a **Sponsored Plan** which does not contain any allegation of a **Wrongful Act** in writing, commenced by the U.S. Department of Labor, the PBGC, or any similar governmental authority located outside the United States, including, the Pensions Ombudsman appointed by the United Kingdom Secretary of State for Work and Pensions or by the United Kingdom Occupational Pensions Regulatory Authority, or any successor thereto.

Related means based upon, arising from or in consequence of the same or related, or the same or related series of, facts, circumstances, transactions, situations, events or **Wrongful Acts**.

Self-Administered Plan means a **Plan** administered by an **Insured** and in which the employer or plan sponsor (as defined in the Employee Retirement Income Security Act of 1974) retains the right to make the final benefit determination.

Sponsored Plan means any employee benefit plan or program which is operated solely by an **Organization** or jointly by an **Organization** and a labor organization solely for the benefit of the **Employees** or **Executives** of an **Organization**, located anywhere in the world while such plan or program is being actively developed, formed or proposed by the **Organization** prior to the formal creation of such plan or program or which existed on or before the inception date of this Policy, or, subject to Section XVIII, Acquisition or Cessation of Subsidiaries or Sponsored Plans, which is created or acquired after such inception date, provided that **Sponsored Plan** shall not include any ESOP created or acquired by the **Organization** during the **Policy Period** or during a prior policy period for which this **Policy Period** is a renewal or replacement thereof (except as provided pursuant to Section XVII, Creation or Acquisition of an ESOP).

Subsidiary means:

(A) any entity while more than fifty percent (50%) of the outstanding securities or other equity ownership, representing the present right to vote for election of, or to appoint, directors, **Managers**, or the foreign equivalent of any such directors or **Managers** of such entity, are owned or controlled by the **Parent Organization** directly or indirectly through one or more **Subsidiaries**; or

(B) any entity while the **Parent Organization** has the right, pursuant to either written contract or the by-laws, charter, operating agreement or similar documents of an **Organization**, to elect or appoint a majority of the Board of Directors of a corporation or **Managers** of a joint venture (other than a partnership) or limited liability company.

Voluntary Program means any voluntary compliance resolution program or similar voluntary settlement program administered by the U.S. Internal Revenue Service, U.S. Department of Labor, or the PBGC, including the Delinquent Filer Voluntary Compliance Program, the Voluntary Fiduciary Correction Program, the Employee Plans Compliance Resolution System, and the Premium Compliance Evaluation Program, or any similar program administered by a governmental authority located outside the United States.

Voluntary Program Loss means filing fees, fines, penalties and sanctions incurred by an **Insured** pursuant to a **Voluntary Program**.

Voluntary Program Notice means prior written notice of the **Insured's** intent to enter into any **Voluntary Program** on account of any actual or alleged non-compliance of a **Plan** with any statute, rule or regulation.

Wrongful Act means any:

(A) actual or alleged breach by an **Insured** of the responsibilities, obligations or duties imposed by **ERISA** upon fiduciaries of the **Sponsored Plan,** including any actual or alleged negligent or improper selection of or monitoring of any third party service provider to the **Sponsored Plan**, including any provider of **Managed Care Services**;

(B) actual or alleged negligent act, error or omission in the **Administration** of any **Plan** by an **Insured**;

(C) matter claimed: (1) against an **Insured** solely by reason of the **Insured's** service as a fiduciary of any **Sponsored Plan**; or (2) against any **Insured Person** solely by reason of such **Insured Person's** role in any negligent act, error or omission in the **Administration** of any **Sponsored Plan**;

(D) actual or alleged act, error or omission by an **Insured** solely in such **Insured's** settlor capacity with respect to any **Sponsored Plan**; or

(E) actual or alleged breach of fiduciary duty by an **Insured** with respect to a **Health Care Exchange**.

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Click the application below to open the fillable form at chubb.com.

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The Chubb Primary℠ Fiduciary Liability Insurance

As a leader in fiduciary liability insurance, Chubb understands this exposure and is committed to providing long term solutions to our customers as they navigate the ever-changing risks inherent in employee benefit plans. Through The Chubb Primary℠ Fiduciary Liability Insurance, we've leveraged our four decades of fiduciary experience to craft a best in class policy, incorporating sought after terms with innovative new offerings to create a better customer experience - from the ease of purchasing a world-class, comprehensive policy to the flexibility of choosing how and when to use your coverage - Chubb delivers.

Tried and True Coverage Features:

Traditional Claims - Coverage for written demands for monetary damages, civil and criminal complaints and formal investigations involving breaches of fiduciary duty under ERISA and errors in administering employee benefit plans, as well as fiduciary capacity backstop coverage for claims made against a fiduciary solely because they happen to be a plan fiduciary.

Fines and Penalties - Unlimited coverage for ERISA §502(i) and 502(l) fines as well as certain penalties under English law.

Voluntary Settlement Programs - First party coverage for companies that discover an issue and want to address it by participating in a governmental correction program.

Notice of Potential Claims - Ability to preserve rights to coverage under a current policy for future potential claims that might be made after the policy expires

Former Plans and Subsidiaries - Continuing protection for terminated plans and former subsidiaries for prior conduct if the policy is renewed with Chubb.

Popular Coverage Features Added - We've designed The Chubb Primary Fiduciary Liability Insurance policy to be comprehensive, by incorporating a vast number of coverage features that customers commonly request.

Elective Reporting Coverages

We've incorporated a vast number of coverage features that customers commonly request:

- *Pre-Claim Investigations* - Department of Labor investigations that do not allege a written Wrongful Act;
- *Tolling requests* - Written requests to toll or waive a statute of limitations applicable to a potential claim;
- *Benefit Claim Denial Appeal* - Appeal of an adverse benefit determination under 29 C.F.R. §2560.503-19h);
- *Interview* - An Enforcement Unit's (including the SEC's) request for an Interview, meeting or sworn testimony from an Insured Person without alleging a Wrongful Act.

Wrongful Acts - Adds settlor conduct coverage and newly created backstop coverage for Claims against Insured Persons due solely to their involvement in plan administration.

Fines and Penalties - Coverage for certain penalties under Irish law as well as sublimited coverage for penalties under certain Canadian laws, HIPAA/HITECH, the Affordable Care Act, I.R.C. §4975 and ERISA §502(c), including §507 of the Pension Protection Act.

Exclusions:

- *Conduct* - Uses a final, non-appealable adjudication standard and is limited to profit that's personal in nature for Insured Persons and to advantage that's "financial."
- *Bodily Injury* - Carves out coverage for certain injuries resulting from the selection of a managed care service provider or the denial or delay of any benefit under a health care plan that is not Self-Administered.
- *Pollution and Liability of Others Assumed by Contract* - Removed

Liberal Claim Reporting and Notice - Up to 180 days after expiration of a policy that has been renewed, plus waiver of this time period where the Insured demonstrates that it was not reasonably possible to provide notice within 180 days.

Advancement of Defense Costs - Advancement of defense costs where an Organization refuses to indemnify an Insured Person.

Flexible Defense and Settlement - Flexible option for the Insured to assume the defense of a new claim or to let the duty to defend remain with Chubb, along with the ability to settle within the retention without Chubb's consent and the potential to obtain coverage for some Defense Costs incurred prior to submission.

Defense Costs Allocation - 100% pre-determined Defense Costs allocation where Chubb retains the duty to defend, and the use of best efforts based on financial and legal exposure otherwise.

Fully Non-Rescindable and Severable - Fully non-rescindable and non-voidable as to all Insureds, and fully severable for Insured Persons.

Subrogation - No subrogation against Insured Persons and any amounts recovered will be restored to the Limit of Liability.

Cancellation - Insured has the unilateral right to cancel the policy on a pro-rata basis.

Globalized Coverage Language and Globally Integrated Capabilities - Equivalency language for statutory and common law that globalizes the policy, along with a global network and affiliated broker relationships for procuring locally admitted policies.

New Coverage Innovations

We've added innovations that are completely new to the market:

Failure to Enroll Demand Coverage - Coverage for plan enrollment errors where the injured party has not filed a formal Claim, which empowers Insureds to quickly resolve delicate situations all in the context of Chubb's renowned coverage for benefits that would have been due but for the failure to enroll .

Penalty Suite Additional Sublimit of Liability - An additional sublimit (within policy limits) for fines and penalties which floats above all other fine and penalty sublimits for customers to use if a specific fine or penalty sublimit has been exhausted.

The Chubb Advantage

Thought Leadership - Chubb strongly encourages loss prevention through education. We provide insight into fiduciary exposures including:

- Who May Sue and Why: How to Reduce Your ERISA Risks, and the Role of Fiduciary Liability Insurance
- The War on Retirement Plan Fees: Is Anyone Safe?

Longevity – We've been protecting organizations against fiduciary risks for almost half a century; we're here to stay[1].

Global Capabilities – Our worldwide expertise and local presence enable us to solve complex global leadership protection problems that most insurers shy away from.

Superior Claims Handling – Our specialized staff attorneys partner with our insureds to provide a smooth claims experience while achieving superior results.

Financial Stability - Fiduciary claims can be expensive and protracted, so an insurer's long-term viability is critical. Our financial stability and ability to pay claims rate among the best in the industry, as attested by Standard & Poor's and A.M. Best Company[2].

[1] Source: https://www.chubb.com/us-en/_assets/doc/17010193-side-a-plus-independent-coverage-endorsements-04.17.pdf
[2] Source: https://www.chubb.com/us-en/_assets/doc/14011198-investigative-response-policy-brochure-12.16.pdf

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What Is Fiduciary Liability Insurance and Why Do You Need It?

Fiduciary Liability Insurance Policies (FLIPs) are arguably one of the least understood insurance products on the market. However, it may be the only coverage that adequately protects people against liability for managing or administering an employee benefit plan - from top corporate executives that hire investment managers to payroll clerks that process enrollment forms. With the rising frequency of expensive and time consuming litigation and regulatory efforts in today's evolving legal environment, employers and plan fiduciaries are increasingly being held accountable for their actions (or failure to act) with respect to employee benefit plans. Thus, FLIPs are an important part of any comprehensive risk management program.

Who is Considered a Fiduciary?

Any individual included in the plan document by name or title, along with anyone who has discretionary decision-making authority over the administration or management of a plan or its assets may be considered a fiduciary under ERISA. Fiduciaries commonly include the plan sponsor (which is typically the employer), the plan trustee and the plan administrator, directors and officers (including when they appoint other fiduciaries or retain third party service providers) and internal investment committees.

What is Considered to be a Plan?

Employee benefit plans fall into two broad categories - retirement plans and welfare plans. Retirement plans include a wide gamut of plans, including but not limited to defined benefit pension plans, profit sharing or savings plans such as 401(k)s, 403(b) plans, stock purchase plans, and employee stock ownership plans (ESOPs). Welfare Plans include medical, dental, life and disability plans.

Why Your Company Needs Fiduciary Liability Insurance

FLIPs protect plan fiduciaries against claims alleging that they mismanaged an employee benefit plan or plan assets. This includes, but is not limited to, making bad investment decisions, negligently handling plan records, and negligently selecting plan service providers. In addition to being an effective risk transfer tool for companies, FLIPs are a vital means of protecting fiduciaries' personal assets for the following reasons:

- The Employee Retirement Income Security Act of 1974 ("ERISA") imposes the "highest duty known to law" on employee benefit plan fiduciaries, which is arguably even higher than the standard of care placed on corporate directors and officers.
- ERISA Section 409 expressly imposes personal liability on plan fiduciaries who breach their fiduciary duties. This means that fiduciaries might have to personally pay for any losses they cause out of their own private assets.
- ERISA prohibits plans from indemnifying plan fiduciaries, which means plans cannot pay defense costs, settlements or awards on behalf of fiduciaries that have breached their fiduciary duties.
- Even if your company wishes to indemnify its fiduciaries, it may not be financially capable of doing so, or it may be barred by law from doing so.

The equation is simple: Highest duty known to law + Personal Liability + Legal and/or Financial Inability to Indemnify = Exposure of personal assets

- To compound matters, ERISA casts a wide net of liability that ensnares people by deeming them to be fiduciaries based on their conduct (i.e. functional fiduciaries), even though they are not named fiduciaries. This means you could be a plan fiduciary and not even know it.
- FLIPs are the only insurance that offers broad protection against fiduciary exposure. ERISA bonds, D&O insurance and Employee Benefits Liability coverage(offered under traditional general liability policies) are inadequate and provide little to no ERISA liability coverage, or exclude it altogether.
- By law, fiduciaries cannot escape their fiduciary duties by delegating them to third party service providers. Fiduciaries retain the duty to prudently select and monitor these service providers.

As a result, a fiduciary's personal assets may be exposed–unless they carry Fiduciary Liability Insurance.

Chubb's Superior Coverage

Chubb's Fiduciary Liability Insurance policies provide some of the broadest coverage and most favorable terms in the market:

- Coverage for all employee benefit plans sponsored by the company for its employees, including plans that aren't subject to ERISA
- Coverage for virtually all of the company's constituents, including the company and its employee benefit plans, directors and officers, and employees, and members of the company's employee benefit committees , administrative committees, and

investment management committees
- Multiple insuring clauses available for a variety of matters, including written demands, civil or criminal suits, regulatory proceedings and government investigations
- Some of the broadest inquiry coverage available on the market, including potential coverage for Interviews conducted by an the U.S. Securities and Exchange Commission (SEC)
- Coverage for voluntary settlement programs administered by the Internal Revenue Service (IRS), Department of Labor (DOL), Pension Benefit Guaranty Corporation (PBGC) or any similar program administered by a government body located outside of the United States
- Responsive to a broad array of allegations including but not limited to:
  - Wrongful denial of or improper change in benefits
  - Improper enrollment or advice
  - Fiduciaries engaging in a prohibited transaction and other conflicts of interest
  - Failure to administer the plan according to plan documents
  - Imprudent investment of assets or lack of investment diversity
  - Imprudent selection of and failure to monitor third-party service providers
  - Flexible defense arrangements under which Chubb provides a defense using expert legal counsel with extensive experience in ERISA litigation
  - Coverage for punitive damages and certain fines and penalties, including but not limited to civil penalties under 502(c), 502(i), 502(l), the Pension Protection Act (PPA), Health Insurance Portability and Accountability Act (HIPAA), and the Affordable Care Act (ACA), were applicable and where permitted by law
  - Enhanced reporting provisions when renewed with Chubb

Why Chubb?

Solid financial stability, a long tradition of unparalleled fiduciary expertise, top-rated claims service, and access to global solutions are but a few of the reasons to partner with Chubb to provide fiduciary protection.

- A promise to pay is only as good as your Insurer's ability to pay. Chubb's financial stability and ability to pay claims consistently rank among the best in the insurance industry. For more than 75 years, Chubb has maintained A.M. Best Company's highest ratings – making Chubb an easy and wise choice.
- Since 1975, Chubb has pioneered and honed fiduciary protection, becoming one of the leading fiduciary liability carriers in the world. Our depth of understanding the duties and legal exposures of fiduciaries, as well as complicated plan structures, allows us to provide bold, insightful coverage that stands out in the market.
- When you buy insurance, you're buying peace of mind, and that's what you get with Chubb. Chubb is renowned in the industry for unparalleled claims service with fair, prompt claims handling.
- Our worldwide expertise and local presence combines the best of both worlds, enabling us to solve complex global protection problems while being mindful of local needs and relationships.
- Additional fiduciary educational support (complete with Fiduciary FAQs and Loss Scenarios) is available at Chubb.com. Also, view "A Chubb Special Report: Who May Sue You and Why: How to Reduce Your ERISA Risks and the Role of Fiduciary Liability Insurance" for an in-depth analysis of fiduciary exposures and coverages.

The Myth of Coverage under ERISA Bonds and EBL Insurance

The Fiduciary Liability Insurance Policy (FLIP) is designed to protect fiduciaries against breach of fiduciary duty claims and more. It is the only type of insurance that does so. Contrary to popular belief, ERISA bonds and employee benefits liability (EBL) coverages do not fully cover fiduciary exposures.

- ERISA bonds, which are required under Section 412(a) of ERISA, differ from fiduciary liability coverage. ERISA bonds provide first party coverage that is designed to protect the plan and its participants by ensuring that any employee who handles funds or other property of the plan are bonded. This protects the plan from risk of loss due to fraud or dishonesty on the part of the bonded individuals.
- EBL coverage, which is provided via an endorsement to a general liability policy, also provides limited protection. It covers errors in plan administration only (e.g. failure to enroll or improper eligibility advice), and not breaches of fiduciary duty (e.g. imprudent investment, negligent selection of service providers, etc.). Moreover, EBL coverage for errors in administration is often more restrictive than the errors in administration coverage afforded under FLIP.

Contact Us
For more information on Fiduciary Liability solutions, contact your local agent or broker, or visit us at www.chubb.com/us/fiduciaryliability.

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CHUBB

Why Do You Need Fiduciary Liability Insurance?

Because you may not be as protected as you think.

Misconception	Reality
I don't need fiduciary liability insurance because:	**I need fiduciary liability insurance because:**
We carry Employee Benefits Liability (EBL) coverage, and it will protect me from fiduciary liability exposures.	While EBL provides some coverage for errors in plan administration, it does not cover breach of fiduciary duty claims. This is critical because fiduciary breach claims can involve personal liability, plus they are typically more severe than administrative error claims. Thus, relying solely on EBL coverage leaves individuals personally exposed to some of the most severe claims involving benefit plans.
We don't sponsor any pension or retirement plans, and those are the plans that give rise to lawsuits.	While pension and retirement plans are commonly targeted, many other types of plans, including but not limited to medical and life insurance plans, SERPs, stock option plans and top hat plans, are also sued. In fact, suits over COBRA notices in medical plans are becoming more frequent
I don't have any fiduciary risk because we hire outside professionals to administer and manage our plans, and we delegate plan responsibilities to them.	While hiring outside professionals (such as a TPA or an investment advisor) to provide services to a plan may help mitigate fiduciary liability, it does not eliminate it. The company and its executives and other fiduciaries retain responsibility for selecting and monitoring those professionals, meaning that they are exposed to liability for damages resulting from an outside professional's mistakes. It's common to see executives and plan committees sued despite the use of external professionals to administer and manage the plan.
None of our executives or employees have fiduciary exposure because we are careful not to name any of them as plan fiduciaries in any documents.	Under ERISA, people can be held liable as a plan fiduciary even when they aren't expressly named as a fiduciary. Specifically, people can legally be deemed to be "functional" plan fiduciaries based on their conduct and the decisions they make, meaning someone may be a plan fiduciary without even realizing it. Executives get sued as functional fiduciaries due to the authority they wield.
If I am sued for anything I do as a plan fiduciary, I can rely on the plan and all of its assets to indemnify me.	ERISA prohibits plans from indemnifying plan fiduciaries for a breach of fiduciary duty, so plans may not pay defense costs, settlements, or awards on behalf of fiduciaries that have breached their fiduciary duties

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Claims Scenarios That Could Implicate Fiduciary Liability Coverage

Fiduciaries of all types of employee benefit plans are increasingly exposed to claims regarding errors or mismanagement with respect to their plans or plan investments. Following are claim scenarios that depict some of these exposures.

Although these scenarios are based on actual events, facts and details have been altered for purposes of illustration and/or to protect the parties' privacy. Coverage for an actual claim depends on the specific facts of such claim. Nothing contained in these scenarios should be relied upon or used as a basis for granting or ensuring coverage.

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Claims Scenarios Involving Defined Contribution Retirement Plans

Type of Scenario	Details
Service Provider Dishonesty	A privately owned company retained a third-party administrator ("TPA") to manage the day-to-day operations of its 401(k)-retirement plan. The TPA, in turn, hired a professional investment manager to invest the plan's assets. The employer eventually discovered that the outside investment manager (who turned out to be affiliated with the TPA) was "skimming" money off the top of the employees' retirement fund contributions. The DOL accused the employer of a breach of fiduciary duty for failing to have adequate safeguards in place and demanded that the employer make the plan whole. The employer had to pay $2,000,000 to replace the funds embezzled by the investment manager, and for the lost investment income that the stolen funds should have earned but for the theft. Legal expenses topped $75,000.
Failure to Timely Follow Employee's Investment Instructions	A participant in a 401(k) plan gave instructions to change his 401(k) investments so as to decrease his investment in a fund that was heavily concentrated in sub-prime investments. The transfer was executed within the week. However, in the interim, the sub-prime market imploded, and the employee suffered investment losses of $150,000 due to the subprime investments. The employee sued for the lost principal plus lost investment income, claiming that the fiduciaries took too long to process and execute his transfer instructions, thus leaving him exposed to the losses in the sub-prime market.
Investment in a Ponzi Scheme	The fiduciaries of a 401(k) plan, seeking to shield themselves from liability for investment decisions, retained the services of a third-party investment manager. The investment manager invested the plan assets with funds that ultimately turned out to be part of a Ponzi scheme, and all of the plan assets were lost. The plan participants sued the fiduciaries for negligently selecting and failing to monitor the investment manager. The employer tendered the suit under its Fiduciary Liability Insurance, and the matter was eventually settled, costing the insurer millions of dollars in defense costs and indemnity.
Decline in Employer's Company Stock Value	A publicly traded company offered its own company stock as one of its 401(k) investment options. The company stock price declined due to a downturn in the market, resulting in a decline in the participants' plan balances. The participants sued the company's fiduciaries – including its directors and officers acting as unnamed, functional plan fiduciaries – for offering the company stock as an investment option and investing the company's matching contributions in the company stock. The plaintiffs alleged that the defendants knew or should have known (based upon nonpublic information) that the company stock was an imprudent, risky investment. After spending more than $10,000,000 in defense costs, the case settled for $7,000,000, all of which was paid for by insurance.
Use of Proprietary Funds as Plan Investment Options	An investment firm used its affiliated fund manager's mutual funds (i.e. "proprietary funds") in its own sponsored 401(k)'s plan investment lineup. The plan participants sued over the use of proprietary funds, claiming a breach of the duty of loyalty and care because the proprietary funds were expensive, underperformed their peers, and were selected in order to generate revenue for the affiliated fun manager. The Plaintiffs demanded disgorgement of the excessive fees and payment for the lost investment opportunity.

Type of Scenario	Details
Financially Unsound GIC Investment	A company that sponsored a 401(k) plan utilized Guaranteed Investment Contracts (GICs) as part of its plan investment lineup, and plan participants invested $12,000,000 in these GICs. However, the GICs were offered by an insurance company that was not AAA rated and had extensive junk-bond holdings. The GIC issuer eventually went into receivership, causing significant losses to the plan participants. The participants sued the plan investment committee, the plan administrator, the plan and the plan sponsor for a breach of fiduciary duty and for violating the Master Trust Agreement, which authorized GIC investments underwritten only by AAA rated companies. The case eventually settled for more than $4,000,000 and cost over $750,000 to defend.
Failure to Guard Against Social Engineering Fraud	A plan's recordkeeper improperly distributed a participant's entire 401(k) balance to a perpetrator who impersonated the participant via email. The recordkeeper refused to make the participant whole, causing the participant to sue its employer for breach of fiduciary duty under ERISA, for failing to properly vet and monitor the recordkeeper and the recordkeeper's online safety protocols. The result was that case settled for $140,000.
Excessive Recordkeeping Fees and Investment Expenses	A class action was filed against 401(k) plan fiduciaries for agreeing to pay the plan recordkeeper its fees based on an percentage of assets under management without any cap based on a per capita dollar amount. Plaintiff also claimed that the plan investment lineup imprudently included retail share classes, actively managed funds, and underperforming funds, and that some imprudent funds were included in the plan because they were managed by the recordkeeper's affiliated fund manager. A $10,000,000 Fiduciary Liability Insurance policy was exhausted to defend and settle the matter.
Missed Plan Contributions Discovered	A company realized that it missed certain deposits of employee salary reduction contributions for its sponsored plan, so it entered a Voluntary Fiduciary Correction Program with government regulators in order to address the issue and avoid any future claims. Fiduciary Liability Insurance paid $50,000 in filing fees and legal expenses.
Erroneous Eligibility Advice	An employee was erroneously advised that he was not yet eligible to participate in his employer's 401(k) plan, so he did not enroll or contribute to the plan. Upon learning that he should have been eligible earlier, the employee sued for lost tax advantages and investment opportunities during the time he was denied enrollment. Fiduciary Liability Insurance paid over $10,000 to defend and resolve the matter.
Maintenance of Former Parent's Company Stock in 401(k) Plan	A private company that was spun off from a public company retained the former public company parent's stock as an investment option in its 401(k) plan post-spin. (The former parent's stock was present in the plan due to profit sharing contributions that had been made by the former parent pre-spin.) Following a decline in the former parent's stock price, plan participants sued for imprudently maintaining an undiversified concentration in the former parent's stock. Result was $275,000 spent in defense costs through the motion to dismiss.

Claims Scenarios Involving Defined Benefit Pension Plans

Type of Scenario	Details
Improper Offset of Social Security Benefits	A manufacturing company maintained a defined benefit plan for its unionized labor force. This plan provided for survivor benefits for decedent employees' spouses. The surviving spouses filed a class action alleging an error in calculating their benefits under the plan because the benefit payments were reduced by the amount of social security benefits, which was allegedly contrary to the plan and the collective bargaining agreement. Result was payment of $2,000,000 in defense costs, as well as about $2,000,000 for an award of plaintiff's attorneys' fees.
Investment in High Risk Funds	An employer hired a professional investment manager to handle its defined benefit pension plan investments. The manager invested the plan assets in high-risk investments, counting on a significant return in a bull market. However, the market turned and the plan rapidly lost tens of millions of dollars, threatening the plan's viability. The employees sued the employer for negligently hiring and inadequately monitoring the investment manager. The fiduciaries faced millions of dollars in exposure, but were ultimately successful by defeating the claim for lack of standing.
Cash Balance Plan Conversion	An employer attempted to "de-risk" its pension plan by converting it into a cash balance plan. Participants sued, claiming that their benefits were reduced as part of the conversion process in violation of anti-cutback provisions. Approximately $15,000,000 was paid in defense costs.
Out-Dated Mortality Data	An employer was sued for sponsoring a pension plan that used decades old mortality data to convert the value of single life annuities to joint and survivor annuities. Result was that over $2,000,000 in Fiduciary Liability Insurance was exhausted for defense.
Improper Crediting of Years of Service	A retiree claimed that he was denied pension credit for his years of service after his employer was acquired by another company, despite verbal promises to the contrary during the acquisition process. The new employer did not recognize or credit the prior years of service. Fiduciary Liability Insurance paid $300,000 in defense costs before the case resolved.
Estranged Spouse Claim Against Pension Distribution	Pursuant to ERISA, an employer required a retiree to obtain his estranged wife's consent before honoring his request for a lump sum distribution of his pension benefits. The employee threatened to sue the employer if the benefits were not released, claiming his wife abandoned him, making it impossible to get spousal consent. Upon execution of sworn affidavits to this effect, the employer paid the lump sum to the retiree. Years later, after the retiree died, hisestranged wife's children (i.e. his stepchildren) sued the employer for releasing the pension funds to their stepfather without their mother's consent. Fiduciary Liability Insurance paid over $115,000 to resolve the matter.

Policy Forms
Application
Marketing Materials

Claim Scenarios Involving Employee Stock Ownership Plans

Type of Scenario	Details
ESOP Valuation Expert With Conflict of Interest	Following an ESOP's purchase of all of the shares of a company, the Department of Labor filed an enforcement action against the ESOP fiduciaries for selecting a valuation expert who had a pre-existing relationship with the selling shareholder to appraise the shares, claiming that the appraiser overvalued the shares in favor of the seller. The $1.000,000 Fiduciary Liability Insurance Policy limit was exhausted on defense.
Two-Part Sale of a Company to an ESOP	A shareholder sold 50% of his shares to a new ESOP for $10,000,000 in a fully leveraged transaction. Later that same year, the shareholder sold the remaining 50% of his shares to the ESOP for the same amount. The participants sued for overpaying for the remaining 50% of the shares due to the alleged failure to account for the impact of the new leverage on the second stage transaction's purchase price. They also claimed that the ESOP purchase left the company excessively leveraged and unable to fund future capital expenditures. Result was the exhaustion of $5,000,000 in Fiduciary Liability Insurance., plus additional debt forgiveness.
ESOP Valuation Issues in Divorce Proceedings	Two sisters established and managed a privately-owned company, which was 100% owned by an ESOP. Both sisters and their husbands worked for the company and participated in the ESOP. One of the husbands eventually filed for divorce, at which time his employment was terminated. Shortly thereafter, the company paid almost $2,000,000 for 10 years of backlogged management fees to a consulting company that was separately owned by one of the sisters. The estranged spouse alleged that these payments were designed to diminish the value of his distributive share from the ESOP. Result was over $500,000 was spent to resolve the matter.
Diluted Share Value Through the Use of Warrants	When an ESOP purchased all of a company's shares for $35,000,000, the selling shareholder helped to fund the purchase by carrying some of the debt and accepting some warrants. The Department of Labor claimed that the fiduciaries breached their duties by failing to consider the dilutive effect of warrants on the share price, thus overpaying for the stock by over 20%. The carrier paid the full $1,000,000 fiduciary insurance limit to defend the matter.
Deficient Sale Price for ESOP Shares	Ten years after an ESOP purchased a company, the company's senior executives purchased the ESOP's shares, thus taking over the company. The price paid by the executives was lower than the price paid by the ESOP initially due to adverse financial developments in the interim. The fiduciaries were sued for agreeing to sell the ESOP shares at too low of a price.

Claims Scenarios Involving Health and Welfare Employee Benefit Plans

Type of Scenario	Details
Reduction in Collectively Bargained Retiree Medical Benefits	A manufacturer and a labor union renegotiated their union contract to require all participants in the union's medical plan, including retirees, to contribute towards their health insurance premiums. The retirees sued, alleging that their benefits were vested and could not be renegotiated, and they sought damages and reinstatement of the benefits. Almost $3,000,000 was paid in defense costs.
Enrollment Error	An employer offered healthcare benefits to its employees through a third-party health insurer. Under the plan, participants had 60 days to add newborn children to their medical plan. Following the birth of a child, an employee worked with his employer's HR department to add the child, but the employer failed to submit the paperwork to the carrier within the 60-day window. The child became ill and incurred significant hospital bills, which the medical insurer eventually denied due to the fact that the child wasn't enrolled in the plan. The employee sued the employer for failing to submit the enrollment forms and Fiduciary Liability Insurance paid over $200,000 to settle the matter.
Systemic Underpayment of Medical Benefits	An employer retained a third-party administrator ("TPA") for its self-funded health plan. Out-of-network medical service providers (via an assignment of benefits) claimed they were systemically underpaid for emergency medical services provided to participants. Plaintiffs alleged that the plan fiduciaries were complicit in hiring the TPA and making the underpayments. Defense costs exceeded $1,000,000.
Improper Instructions on How to Claim Benefits	An employee became ill and, in compliance with her employer's HMO processes, notified the HR department of an illness and impending hospitalization. The HR department advised the employee that it was unnecessary to provide any advance notice of her hospitalization to the HMO. This advice was erroneous as the HMO's notification rules had recently changed, so the HMO denied coverage for the hospital bills. Fiduciary Liability Insurance eventually paid more than $500,000 to settle the matter, including the Plaintiffs' attorney's fees.
COBRA Notices	An employer was sued for failing to comply with the updated legal requirements for COBRA notices, as well as for the use of forceful fraud warnings in their COBRA notices which allegedly chilled the participants' exercise of their COBRA rights. Result was the payment of $200,000 to resolve the lawsuit.
Failure to Inform of Ineligibility	An employee signed up for $100,000 in life insurance benefits offered through his employer. When the life insurance company declined the application for coverage due to ineligibility, the employer failed to notify the employee and instead proceeded to deduct premiums from the employee's paychecks. Upon the employee's death, the life insurance company denied the claim and employee's widow sued the employer. Fiduciary Liability Insurance eventually paid $100,000 to resolve the matter.

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The claim scenarios described here are intended to show the types of situations that may result in claims. These scenarios should not be compared to any other claim. Whether or to what extent a particular loss is covered depends on the facts and circumstances of the loss, the terms and conditions of the policy as issued and applicable law. Facts may have been changed to protect privacy of the parties involved.

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How to Reduce Your ERISA Risks, and the Role of Fiduciary Liability Insurance

A Chubb Special Report, by Lars C. Golumbic

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If there had been any doubt, the last few years have made clear that lawsuits against any and all parties involved with retirement and welfare plans are here to stay. Indeed, plan sponsors and fiduciaries now face increased risks of litigation on a number of fronts, and the need for comprehensive fiduciary liability insurance is greater than ever. For these reasons, Chubb commissioned the ERISA-experienced law firm of Groom Law Group, Chartered to compile this special report to help our customers and brokers understand the potential liability that fiduciaries face in today's litigious environment.

In this report, Lars C. Golumbic of Groom Law Group discusses the responsibilities of ERISA fiduciaries and the types of litigation that may be brought against them, as well as some practical suggestions on plan design and administration that may help reduce litigation risk. He then shares insights on how the role of fiduciary liability insurance and other forms of protection can mitigate against financial loss to plan sponsors and their fiduciaries when faced with a lawsuit.

Chubb is pleased to share this information and hopes it will help you raise the awareness of your company's fiduciaries about the potential risks they face and serve as a practical resource in your overall loss prevention efforts.

Introduction

Fiduciary liability in connection with employee welfare benefit plans and retirement plans is one of the most misunderstood exposures faced by directors, officers, employees, and trustees. Many fiduciaries fail to appreciate that they can be held *personally* liable for a breach of fiduciary duty, even when the breach is unintentional. Moreover, plan fiduciaries are subject to a very high standard of care ("the highest duty known to the law"), even higher than the duty imposed on corporate directors and officers. Yet, plan fiduciaries' decisions, unlike those of corporate fiduciaries, are not given the benefit of corporate law's business judgment rule. To further complicate matters, traditional Directors and Officers insurance does not cover plan fiduciary liability, and there may be limitations on the ability of a benefit plan or employer to indemnify a fiduciary who has been sued. In short, a plan fiduciary's personal wealth may be at risk, so understanding potential fiduciary liabilities, obtaining sound legal guidance, and partnering with a reputable fiduciary liability insurance carrier are crucial.

With retirement plan assets in the U.S. totaling tens of trillions of dollars and private healthcare spending edging past a trillion dollars a year, it is no surprise that litigation in the field of benefits has exploded in recent years, with no slowdown in sight. Employers have long understood that providing a well-structured employee benefits program (e.g., medical, life, disability, and retirement plans) can be an important piece of the package necessary to attract and retain an appropriately skilled workforce. And doing so has always been challenging, but today the stakes are higher than ever, as the area of law has become more regulated, the amounts at issue have soared, and the plaintiffs' class-action bar has become more sophisticated. Employers need to weigh carefully the human resource advantages of providing benefits against the significant obligations they undertake in doing so. Establishing a balance between corporate benefits and obligations is especially difficult because the legal rules governing employee benefit plans – established under the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1001, *et seq.* (ERISA) – are complex. As a result, the need for skilled and experienced ERISA defense counsel is more crucial than ever. Engaging ERISA defense counsel who understands ERISA's complexities and nuances can help provide a strong tactical advantage against these evolving types of claims.

Recent years have made clear that ERISA class action lawsuits are not confined to the largest players. Employers and plans of all sizes are vulnerable. Particularly in times of economic transition – when layoffs, workforce adjustments, and corporate mergers and acquisitions are more likely to occur – more plan participants are willing to step forward as ERISA plaintiffs. On top of that, ERISA contains a provision that almost always allows plaintiffs (but not defendants) to recover attorneys' fees when they prevail. This provision provides additional incentives to plaintiffs' lawyers to bring suit under ERISA.

Although there are no "silver bullets" to protect employers, plans, and fiduciaries from litigation, employee benefits professionals *can* improve the chances that their company's benefits programs will avoid litigation and defeat any legal challenges that may arise. The path to reducing legal exposure begins with a sound understanding of the ERISA-defined roles of plan-related personnel. ERISA does not impose liability at large. Rather, from the board of directors to the benefits manager, an individual's potential exposure, including possible individual liability, depends in significant part on his or her role with respect to the employee benefit plan in question. We address those roles and responsibilities in Section I of this report. In Section II, we provide an overview of the most prevalent (and serious) types of ERISA claims currently being filed. Section III, in turn, discusses a variety of plan-drafting and plan-administration measures that plan sponsors and fiduciaries should consider to mitigate litigation exposure. Section IV considers why fiduciary liability insurance should be deemed an integral part of any employee benefits program, providing protection to plan sponsors and fiduciaries against both personal liability and the sometimes significant costs associated with the defense of employee benefit lawsuits.

I. Understanding the ERISA Responsibilities of Plan Sponsors, Fiduciaries, and Parties in Interest

ERISA imposes special, heightened duties, called fiduciary duties, on a variety of individuals and entities that carry out certain responsibilities with respect to pension and welfare plans. ERISA's fiduciary duties apply to anyone who: exercises any discretionary authority or control over a plan; exercises any authority or control over a plan's assets; has any discretionary authority in administering a plan; or provides investment advice to a plan for a fee. Anyone who occupies such a role is deemed to function as a fiduciary under ERISA, even if not named as a fiduciary in the plan's governing documents.

In particular, ERISA requires fiduciaries to adhere to a strict duty of loyalty, which requires them (when acting with respect to a plan), to act for the exclusive purpose of administering the plan and providing benefits to participants and beneficiaries. Additionally, ERISA imposes a duty of prudence on fiduciaries, which requires them to act with the care, skill, and diligence that a "prudent man acting in like capacity and familiar with such matters would use" under the circumstances. As a related duty, ERISA requires fiduciaries to diversify plan investments unless it is "clearly prudent not to do so" under the circumstances (certain plans, called employee stock ownership plans (ESOPs), are exempt from the duty to diversify). ERISA also presumptively prohibits fiduciaries from engaging in certain activities that could pose a risk to plans' participants and beneficiaries. For example, in addition to the duty of loyalty, fiduciaries may not engage in certain prohibited transactions with "parties in interest," unless the fiduciary can prove compliance with a statutory or regulatory exemption.

While certain kinds of violations are blatant and obvious (e.g., inducing the plan to enter into a bloated contract with the fiduciary's family member), violations often arise in a number of complex and challenging situations – such that even diligent and well-intentioned professionals can find themselves as defendants in lawsuits alleging a breach of their duties under ERISA. These lawsuits can impose *personal liability* on fiduciaries, including those who may not even have known that they were ERISA fiduciaries.

Not everyone who interacts with an ERISA plan is a fiduciary, however, and even if a person is a fiduciary, he is not necessarily a fiduciary at all times and for all purposes. Instead, ERISA permits persons to wear "two hats" at separate times – a fiduciary hat and a "settlor" hat. Settlor activities are generally those that arise out of the establishment and design of the plan. Setting up or changing benefit plans is the quintessential plan "settlor" activity. On the other hand, administering the plan is a core "fiduciary" activity. Although the law draws an important distinction between settlor activities and fiduciary activities, this distinction does not always provide protection from class action litigation where, as a general rule, anyone remotely connected to an ERISA plan will be named in the lawsuit. Lawsuit targets typically include: the plan sponsor; the plan administrator; any named fiduciaries, particularly members of any investment committees; appointing fiduciaries, particularly the CEO and members of the board of directors; the recordkeeper and/or trustee of the plan; investment managers; and other service providers (e.g., accountants, consultants, investment advisors, and attorneys).

ERISA also identifies certain individuals or entities as "parties in interest." Parties in interest include not only ERISA fiduciaries and their family members but also any person providing services to a benefit plan, the employer whose employees are covered by the plan, unions whose members are covered by the plan, and various other defined parties or entities that have some relation to the plan or its fiduciaries. Although only fiduciaries are subject to ERISA's prudent man standard, both fiduciaries and parties in interest are subject to the statute's prohibited transaction provisions. This complex set of provisions is designed to prevent transactions that might pose a conflict of interest with respect to the plan or its assets. These provisions automatically bar certain enumerated transactions unless the parties involved can demonstrate that a particular statutory exemption applies.

II. Legal Actions Brought Against Employee Benefit Plans and Personnel

The types of legal actions asserted against benefits plans and associated personnel vary significantly in their frequency and potential exposure. ERISA defines two broad categories of benefit plans:

- *Welfare benefit plans*, which include medical plans, disability benefit plans, vacation benefit plans, and the like.
- *Pension benefit plans*, which include any plan designed to provide retirement income to employees or that results in a deferral of income by employees to periods extending beyond termination of covered employment. There are two main types of pension benefit plans:
  - *Defined benefit plans* are based on the traditional "pension" plan model, in which the employer guarantees to the employee a stream of payments, often based on his or her years of service, payable as an annuity throughout the employee's retirement. In defined benefit plans, the risk of providing retirement income falls on the employer, although the employer is required to insure that risk through the federal Pension Benefit Guaranty Corporation (PBGC).
  - *Defined contributions plans*, which are now far more common than defined benefit plans, include the well-known 401(k) plan, as well as any other type of plan in which the employer makes a set contribution to the plan on the participant's behalf and then the participant bears the investment risk. Some defined contribution plans are participant-directed, meaning that the participant can allocate his or her assets among some set of investment options selected by the employer. There is no insurance program to protect against investment losses or business failures for this type of plan.

The most common legal claims asserted under ERISA, by far, involve "denial of benefit" claims under medical and disability benefit plans. Typically, after having made an unsuccessful (or only partially successful) claim for coverage of a certain medical procedure under the terms of a medical plan, or for disability income benefits under a disability plan, the plan participant sues in court claiming that he or she was improperly denied coverage or reimbursement. Benefit claims litigation has become more complicated in recent years following the Supreme Court's decision in *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008). There the Court held that a plan administrator that is the payer on a benefit claim it evaluates operates under an inherent conflict of interest. As a result, courts in denial of benefit cases since this decision often permit discovery regarding whether a conflict may have impacted the benefits determination.

Other types of individual benefit claims, although somewhat less common, involve retirement plans. Upon retirement, a participant may claim that the employer miscalculated his or her retirement benefits, or that the employer improperly denied a surviving spouse the survivor benefits to which he or she was entitled.

In a defined contribution plan, participants may claim that the plan administrator failed to follow specific investment instructions (e.g., move assets from Fund A to Fund B) or took some other action that adversely affected their retirement accounts.

These types of claims are the grist of employee benefits lawsuits – raising issues that in most circumstances personally affect the participant or claimant. These participant-focused disputes often are resolved short of litigation. Once a claim is filed, it is filtered through the benefits claims procedure that ERISA requires every plan to have. The claim may be allowed, adjusted in part, or denied. Normally, it is only after the claims procedure is fully exhausted and unsuccessful that litigation ensues. As discussed later, all benefit plan personnel should understand their roles, both to ensure that participant claims are handled properly and to increase the chances that decisions made under the plan will be upheld should the dispute make its way to court. Fiduciary liability insurance can play a role in mitigating the cost of defending such claims.

Although less prevalent in terms of the number of lawsuits filed, the frequency of class action claims fueled by the plaintiffs' bar has exploded in recent years. These claims purport to be brought on behalf of part or all of the entire class of plan participants, and the aggregated financial exposure can be significant. For example, plaintiffs may claim that investments affecting all retirement plan participants as a group contained excessive expense charges, or were selected in order to confer some benefit on the employer or another party in interest, or that a medical plan or other agreement barred the plan sponsor from modifying retiree medical benefits. In addition to substantial damages, the plaintiffs may demand significant injunctive relief – to change the plan terms or long-established practices. Some of these class action cases are styled as claims to recover benefits due, but many seek to hold plan sponsors and fiduciaries personally liable for breaches of fiduciary duty.

Some of the most significant and up-and-coming litigation concerning benefits plans includes:

- Claims involving employer stock, including:
  - ESOP claims alleging that the employer's stock was improperly valued, plan fiduciaries engaged in prohibited transactions or other conflicts of interest, and/or corporate changes disadvantaged ESOP participants
  - "Stock drop" cases under defined contribution (e.g., ESOP and 401(k)) plans, alleging that plan fiduciaries acted imprudently in offering an employer stock fund or misrepresented the risks associated with investments in a plan sponsor's stock
- "401(k) fee" cases alleging that the plan fiduciaries breached their obligations to the plan and its participants by charging or permitting excessive fees and expenses for plan services provided by third parties, such as investment management, recordkeeping, and asset custody.
- "Proprietary (or affiliated) fund" cases, which often fall into the category of 401(k) fee cases, in which participants in a plan sponsored by a financial institution allege that the plan sponsor included mutual funds or other investments offered by the financial institution or its affiliates in the plan's investment lineup in order to benefit the institution, without regard to whether those investments were best for the plan. Participants may allege that they were harmed either by excessive fees in these investments or by their poor performance.
- "Church plan" cases, in which plaintiffs allege that religiously-affiliated hospitals and other not-for-profit entities do not qualify for the statutory exemption from ERISA's funding and notice requirements for church plans.
- Investigations into the plan's activities by the Department of Labor, which may or may not result in litigation.
- In the welfare plan context, litigation regarding the implementation of the new requirements imposed by the Affordable Care Act.

On the pages that follow, we discuss recent developments in these selected areas to illustrate the potential liability exposure of employee benefit plans and plan fiduciaries, recognizing that there may be additional types of risks that are outside the scope of this discussion.

A. Claims Against Retirement Plans

1. Special Issues Involving Employee Stock Ownership Plans

Employee stock ownership plans (ESOPs) are a type of defined contribution employee benefit plan created by Congress as a means of fostering employee ownership. By definition, ESOPs are designed to invest primarily in employer stock. ESOPs, particularly those established by privately-held companies, have come under increased scrutiny from the Department of Labor (DOL) in recent years. DOL began an ESOP enforcement project in 2005, and, as of December 2015, it had more than 300 open civil ESOP litigations. Private plaintiffs, too, have initiated ESOP litigation, and DOL has supported such litigants, namely by filing amicus briefs at the appellate level.

A large number of ESOP cases center around the ESOP's purchase of employer stock. Typically, these cases present a scenario in which an ESOP, represented by an independent trustee, has engaged in a so-called "prohibited transaction" – a purchase of company stock by the ESOP from company officers, directors, and/or majority shareholders. Such a transaction is exempt from ERISA's prohibited transaction rules if the stock purchase is made for "adequate consideration." Where the stock is not publicly-traded, ERISA defines adequate consideration as "the fair market value of the asset as determined in good faith by the trustee." To make this fair market value determination, the ESOP trustee generally retains a valuation expert to advise it as to the appropriate purchase price. Litigants have often challenged the value of the stock purchased in the subject transaction, claiming that it was overvalued and the purchase price too high. Common allegations regarding purported errors in the underlying transaction valuation include:

- Unrealistic projections of the company's future financial performance (e.g., "hockey stick"-shaped projections that predict growth well beyond historical levels)
- Reliance upon stale financial information
- Failure to discount appropriately for company-specific risks (e.g., customer concentration)
- Improper selection of comparable companies
- Inappropriate application of control premiums
- Improper valuation of options, warrants, or stock appreciation rights included in seller consideration
- Failure to include discount for lack of marketability
- Internal inconsistencies in valuation

ESOPs often purchase company stock in a leveraged transaction. The use of leverage may lead to claims that the company was harmed as a result of its inability to service the debt load incurred by the leveraged buyout of the selling shareholders.

DOL has also alleged various conflicts of interest in ESOP transactions, such as: where the company's board of directors appoints the trustee to represent the ESOP in connection with the proposed transaction, and the selling shareholders participate in the appointment in their capacity as directors; or where a valuation firm performs a preliminary valuation for the sellers offering their stock for sale to the ESOP, and the ESOP trustee later engages the same firm to conduct the valuation upon which it will base its fair market value determination.

In addition to probing the technical aspects of company stock valuation, ESOP litigation tends to focus on the ESOP trustee's process in arriving at a determination of fair market value. Notably, DOL entered into a settlement agreement with GreatBanc Trust Company in June 2014.[1] The parties agreed to certain process requirements to which GreatBanc would adhere going forward when serving as ESOP trustee in connection with the purchase or sale of company stock. DOL has publicly endorsed this settlement as a "template" for ESOP transactional trustees, so parties engaged in ESOP stock purchases would be well advised to review this settlement agreement.

Other ESOP litigation issues have involved ESOP terminations and repurchase obligations. With respect to ESOP terminations, one court ruled that fiduciary defendants breached their duties by failing to properly liquidate certain ESOP stock as the plan required. ESOP repurchase obligations have given rise to liability where there is insufficient liquidity to purchase allocated and vested shares from terminating participants and/or participants electing diversification.

[1] *Perez v. GreatBanc Trust Co.*, 5:12-cv-01648-R-DTB (C.D. Cal. June 2, 2014) (Dkt. 166-1).

2. ERISA Retirement Plan "Stock Drop" Cases: The Supreme Court Changes the Legal Landscape.

Over the past two decades, class action "stock drop" lawsuits have become the ERISA plaintiff bar's bread and butter. These lawsuits generally allege that fiduciaries of defined contribution pension plans should not have continued to offer company stock as an investment option after a business or market event caused the company's stock price to drop. Plaintiffs often also assert that the fiduciaries misrepresented to the participants the risks associated with investing in employer stock by suggesting, for example, that the company itself would achieve X earnings or Y sales when, in reality, that was not what management actually expected. Often these cases are companion lawsuits to securities cases arising out of the same events.

Stock drop claims have long made up a large percentage of class action filings under ERISA – and for good reason. First, the market itself has been volatile and unpredictable. As a result, we saw spikes in stock drop litigation following the burst of the tech bubble in the early 2000s and during and after the economic recession beginning in 2008. Second, a number of high-profile ERISA class action attorneys actively solicit these kinds of claims from retirement plan participants. Using websites, press releases, and newspaper articles, these attorneys target particular companies that have, for example, restated corporate earnings, suffered a major stock price decline, changed or otherwise acknowledged the failure of a particular business plan or model, suffered decreased profits or revenue due to a downturn in an industry sector, or filed for bankruptcy.

Defendants and their insurance carriers often feel a great deal of pressure to settle stock drop cases for various reasons. For example, the damages plaintiffs seek in these cases tend to be high (although often inflated); fiduciary defendants face personal liability under ERISA if a court rules that they have breached their duties, driving a desire to put the matter to rest regardless of the merits of the claim; discovery, especially electronic discovery, can be extremely expensive; and, of course, litigating even a meritorious defense case carries with it inevitable costs and distractions.

It is therefore understandable that stock drop defendants routinely file motions to dismiss the complaints right away, hoping to eliminate unmeritorious claims early in litigation before costs and exposure rise – and, along with them, the pressure to settle. Until 2014, most courts applied, in one form or another, a defense-friendly "presumption of prudence" at the motion to dismiss stage. Essentially, courts started by presuming that the plan's fiduciaries had fulfilled their duties, dismissing stock drop claims unless plaintiffs overcame that presumption by alleging that the company in question faced dire circumstances or an imminent collapse – a high bar that helped keep flimsy claims from gaining traction.

In 2014, the Supreme Court eliminated this defense-friendly presumption. In its *Fifth Third Bancorp v. Dudenhoeffer* decision, the court explained that the presumption was nowhere to be found in ERISA but had rather been crafted by judges. The *Dudenhoeffer* ruling was not all bad for defendants, however, as the Supreme Court emphasized the need for lower courts to filter out dubious suits in the early stages of litigation and gave some guidance as to how to do so. The *Dudenhoeffer* decision divided stock drop claims into two buckets: public information claims and inside information claims. The public information bucket involves claims that fiduciaries should have known that company stock was overvalued based on *publicly available* information alone, like the continuous decline in the company stock's market price. The Court explained that, absent some "special circumstances" making a stock's market price inherently unreliable, which the Court left undefined, these claims should rarely survive a motion to dismiss. The inside information bucket involves claims that the fiduciaries were company insiders with access to material, *non-public* information indicating that the stock's price was about to fall. These claims fail unless they demonstrate, among other things, a specific alternative action that the fiduciaries could have taken that would not have violated securities laws, and that a reasonable fiduciary could not conclude that the defendant fiduciaries' actions – likely holding the stock, continuing to purchase it, or withholding insider information – would be to the plan's ultimate benefit.

The Plaintiffs' bar wasted little time before beginning to test *Dudenhoeffer*'s boundaries. Several cases in the lower courts have begun to explore the contours of the "special circumstances" exception to the reliability of a stock's publicly-traded price. Fortunately for plans and their sponsor companies, courts generally have been quick to limit this would-be loophole: one recent court decision applied a narrow definition of "special circumstances" limited to accounting irregularities, misuse of insider information, or fraud. Also, some post-*Dudenhoeffer* plaintiffs have questioned whether *Dudenhoeffer*'s hurdles apply at all to investments in closely-held company stock, arguing that the Supreme Court's holding is limited to publicly-traded securities. The few courts

to consider the issue so far have had mixed views as to whether *Dudenhoeffer*'s protections apply to closely-held company ESOPs. For the most part, though, lower courts have largely viewed *Dudenhoeffer*'s new standard as at least as capable of culling shaky claims as the old.

Plan fiduciaries would be wise to continue monitoring these cases as they move through the lower courts and into the appellate courts. Fiduciaries should consider what actions they might take, if any, to ensure that they are prudently managing company stock in accordance with *Dudenhoeffer*'s continually-evolving standard, particularly if the plan sponsor company is struggling financially. Possible actions could include hiring an independent fiduciary to monitor the plan's employee stock fund to ward off allegations that fiduciaries possessed material non-public information about the reliability of the stock price, or ensuring that plan fiduciaries meet regularly and consider whether a sale or freeze of company stock would cause more harm to the plan than good. The need to reconsider the plan's investment in company stock periodically is especially strong in light of the Supreme Court's recent decision in the *Tibble* case (discussed in more detail in the section on excessive fee cases) confirming a plan fiduciary's continuing duty to monitor plan investments.

The scope of "excessive fee" litigation has expanded to the point where every plan sponsor and plan service provider dealing with a 401(k) plan of significant size should be on notice.

3. 401(K) "Excessive Fee" Cases: Who's Next?

Over the last 10 years, the scope of so-called 401(k) "excessive fee" litigation – another staple of the plaintiffs' bar – has expanded to the point where every plan sponsor and plan service provider dealing with a 401(k) plan of significant size should be on notice that it may be the next defendant in this type of ERISA class action.

Indeed, since 2015, numerous other companies have been named as defendants in cases alleging "excessive fees" with regard to their 401(k) plans. Settlements in these excessive fee cases have proven to be very lucrative for plaintiffs and plaintiffs' firms[2] and, thus far, defendants have been reluctant to take these cases to trial.

Overview

In general, plaintiffs in these cases allege that the plan sponsors and the members of their benefits committees have breached their fiduciary duties under ERISA by requiring participants to pay excessive fees – either in the form of overly high expense ratios for mutual funds offered as plan investment options or overly high fees paid by the plan participants for recordkeeping services. Additionally, plaintiffs often include claims alleging some or all of the following: inappropriate use of proprietary funds; improper revenue sharing; failure to use the lowest cost share class; failure to make use of Collective Investment Trusts (CITs) or Separately Managed Accounts (SMAs) rather than mutual funds; allowing investment or transaction "drag" to occur with unitized stock funds; and claims that plans engaged in "prohibited transactions" under ERISA. Recordkeepers and other service providers to the plans have also been swept into some of these cases, particularly with respect to revenue sharing. In light of DOL's new expanded definition of the term "fiduciary" under ERISA,[3] we expect to see more fee cases encompassing a broader range of defendants.

[2] For example, Lockheed Martin Corporation agreed to a $62 million settlement of an excessive fee case; the Boeing Corporation agreed to a $57 million settlement; and Ameriprise Financial agreed to a $27.5 million settlement.

[3] *See* 29 C.F.R. § 2510.3-21 (2016). The Department's new "fiduciary rule" expands the definition of an "investment advice" fiduciary to subject more advisors and vendors to fiduciary status. This broader definition now encompasses not only ERISA plans but also advice with respect to IRAs and rollovers to IRAs, among other things, unless certain exemptions apply based on an array of new contractual standards, warranties, and disclosures. It is reasonable to anticipate that this expansion into the IRA space may subject a whole new community of professionals to the types of fiduciary litigation that ERISA fiduciaries have increasingly faced in recent years. That said, some in the incoming Trump administration have expressed an intention to attempt to repeal the fiduciary rule, so this area of law may be changing as well.

Excessive fee cases can be broken down into three broad categories: general excessive fee cases, proprietary fund cases and revenue sharing cases. And while all three categories involve many of the same claims – including the general claims of excessive fees in the form of high mutual fund expense ratios and overly costly recordkeeping services, each category raises its own unique issues.

General Excessive Fee Cases

The most straightforward type of excessive fee cases are those that involve claims against companies, their boards, executives, and officers with the general theme that less expensive investment options (with equivalent risk and return) are available in the marketplace, and the failure to provide these less-expensive options constituted a breach of a fiduciary duty under ERISA. The basis for this general claim has most often been supported by allegations that plan fiduciaries: offered the more expensive share class of an investment option; failed to take into account, and disclose to participants, revenue sharing arrangements in which the plan investment funds participated; offered the wrong type of investment option (i.e., a bank investment option instead of a stable value fund); or failed to offer CITs or SMAs rather than mutual funds.[4] Recently, plaintiffs began attacking plans offering investments previously viewed as safe due to their relatively low fees, such as Vanguard funds, alleging that plan fiduciaries could have negotiated for fees that were lower still.

In mid-2016, a number of colleges and universities across the nation became the newest targets of this type of "excessive fee" litigation by the plaintiffs' bar.

These cases against educational institutions are novel in that they expand the scope of excessive fee litigation to 403(b) retirement plans (as opposed to 401(k) plans) sponsored by not-for-profit institutions, making clear that any sponsor of a large retirement plan is at risk for an excessive fee lawsuit.

Proprietary Fund Cases

Proprietary fund cases are very similar to general excessive fee cases in many ways, but they include one very significant difference. Namely, these cases arise out of a conflict of interest or self-dealing theory. These claims involve plans sponsored by entities in the financial services industry for the benefit of their own employees. Plaintiffs allege that the fiduciaries of these plans breached their fiduciary duties by selecting investment options for the 401(k) plan that are affiliated with the plan sponsor. Plaintiffs allege that these "proprietary" funds were selected by plan fiduciaries to provide some benefit to the employer or its affiliates. For example, plaintiffs may allege that the plan sponsor included one of its new mutual funds in the plan's investment lineup in order to provide "seed money" for the new fund, or they might allege that the fiduciaries included proprietary funds simply in order to generate fees for the institution. Plaintiffs then allege that the proprietary funds underperformed the market and/or charged excessive fees, causing a loss to plan participants.

Over the last several years, many large financial institutions have been the targets of proprietary fund cases. Essentially, any financial institution operating a 401(k) plan with significant assets that includes proprietary investment options should consider itself a potential target for this type of suit.

Revenue Sharing Cases

The final general category of excessive fee cases is the "revenue sharing" case. This type of excessive fee claim rests on the assertion that financial service providers and their affiliates engage in a variety of revenue sharing arrangements with plan service providers that result in the

[4] Leading cases in this area include *Tibble v. Edison Int'l*, 2010 U.S. Dist. LEXIS 69119 (C.D. Cal. July 8, 2010), and *Tussey v. ABB, Inc.*, 746 F.3d 327 (8th Cir. 2014).

providers receiving fees that are excessive in light of the services they provide. Although general excessive fees cases often contain supplemental allegations complaining that revenue sharing is improper or should have been disclosed, these cases focus on the idea that revenue-sharing arrangements are nothing more than "kick-back" payments that improperly encourage a greater investment of plan assets in funds operated by a certain financial service provider.

These cases are sometimes called "gatekeeper" cases because the basis for the financial services provider and its affiliates' fiduciary liability is found in the claim that these providers screen what funds are available as plan investment options, thus acting as a "gatekeeper" to what funds participants are offered access.

Best Practices

While some courts have proven to be less receptive to "excessive fee" cases than others, many 401(k) fee cases have gone forward and have resulted in substantial settlements for plaintiffs. Accordingly, before becoming the target of a 401(k) fee case, employers should act affirmatively to review and, potentially, change:

- The process by which their 401(k) plan adds, reviews, and removes plan investment options – focusing, if applicable, on review of the inclusion of proprietary funds
- The procedure in place for review of plan recordkeeping services and any use of revenue sharing
- The internal understanding of who constitutes a fiduciary under ERISA with regard to the 401(k) plan and what exactly that obligation entails

4. The Plaintiffs' Bar's Latest Attack: The Church Plan Exemption

In 2013, the plaintiffs' bar initiated a wave of putative class action lawsuits challenging what had long been an uncontroversial notion: that benefit plans sponsored by church-affiliated not-for-profits, such as hospitals or schools, are exempt from ERISA's coverage. Plans that qualify as church plans may elect to, but are not required to, comply with ERISA's requirements, such as funding standards, notice and disclosure requirements, and coverage under the federal retirement insurance program run by the PBGC. During the past few years, some dozens of lawsuits targeting religious health care systems have challenged that long-standing legal proposition.

The pivotal legal issue in these cases has been whether a plan must be established by a church to qualify for the church plan exemption, or whether it is sufficient that a church-controlled or church-affiliated organization maintain the plan. For decades, courts had understood that maintenance by a church-controlled or church-affiliated organization was sufficient. This understanding was in line with the fact that the Internal Revenue Service (IRS) and DOL had always interpreted the church plan exemption in that manner. In the recent wave of litigation, though, plaintiffs had some initial success in convincing courts that the decades-old statutory interpretation was incorrect. In the district courts, decisions were mixed, with the only decision on the merits coming down on the side of defendants. In the appellate courts, the Third, Seventh, and Ninth Circuits agreed with the plaintiffs that every church plan must be established by a church. On June 5, 2017, however, the Supreme Court reversed the three appellate courts and held unanimously that ERISA does not require a church plan to be established by a church.[5]

Although the defeat in the Supreme Court was a major blow to the plaintiffs' firms bringing these suits, the ruling ultimately does not resolve the pending lawsuits or prevent future litigation. This is because ERISA contains several other requirements for a plan to qualify as a church plan, and the scope of these requirements was not before the Supreme Court. For example, plaintiffs have typically alleged that the hospitals sponsoring the church plans failed to be "controlled by" or "associated with" a church, as the statute requires. They have also alleged that the entities maintaining the church plans did not have as their principal purpose the administration or funding of the benefit plans. As a last resort, plaintiffs have claimed that the church plan exemption is an unconstitutional accommodation under the First Amendment's Establishment Clause. At least for the time being, these unresolved issues are left to the lower courts to decide.

The stakes will be high as the parties litigate these remaining issues in the lower courts. This is because plaintiffs often style these cases as breach of fiduciary duty cases, which allows for personal liability to be imposed on plan fiduciaries. Plaintiffs typically allege that the plans at issue are underfunded (often by millions or hundreds of millions of dollars) when funding is calculated under ERISA's rules, and they seek rulings that the plan sponsors must adequately fund the plans on an ERISA basis. Plaintiffs also argue that defendants owe significant civil penalties for failing to follow ERISA's reporting and notice requirements, including failing to send participants and beneficiaries pension benefit statements, annual funding notices, and notices of their failure to meet minimum funding. Significantly, ERISA provides that a court, in its discretion, can award civil penalties of up to $110 per day to each participant and beneficiary for each day that he or

[5] Advocate Health Care Network v. Stapleton, 581 U.S. ___, Nos. 16-74, 16-86, 16-258, 2017 WL 2407476 (U.S. June 5, 2017).

A finding against defendants...could result in millions or even billions of dollars in penalties, if a court decided to impose penalties to the fullest extent of the law.

she did not receive certain notices and disclosures required by ERISA. Other penalties may be imposed for failing to file documents with the Secretary of Labor. Therefore, a finding against defendants on this issue could result in millions or even billions of dollars in penalties, if a court decided to impose penalties to the fullest extent of the law. In addition, if a court finds that a plan previously operated as a church plan must comply with ERISA, the plan could be required to pay significant amounts in premiums to the PBGC.

That said, there remains a weapon in the defense arsenal that has not been substantively addressed by any court in the recent wave of church plan lawsuits. ERISA includes a provision permitting retroactive correction of a plan's failure to meet the requirements to qualify as a church plan. In the recent church plan cases, no court has yet determined that any of the plans at issue do not qualify as church plans. Thus, it remains to be seen how a court would interpret the retroactive correction provision and whether it could be applied to correct a plan's failure to satisfy any requirement under the church plan definition.

5. Navigating Department of Labor Investigations, Audits, and Settlements

Thousands of times each year, fiduciaries of ERISA-covered plans and service providers receive an unexpected letter or phone call from DOL noticing an investigation "to determine whether any person has violated or is about to violate" any provision of Title I of ERISA. These investigations, sometimes called audits, can drag on for months or years at great expense.

Though it shares enforcement authority with a number of different agencies, DOL has primary responsibility for enforcing violations of Title I of ERISA, such as breaches of fiduciary duty and prohibited transactions. DOL's Employee Benefits Security Administration (EBSA) is charged with investigating ERISA violations, while DOL's Office of the Solicitor of Labor acts as DOL's in-house counsel with respect to litigating any such ERISA violations. EBSA investigates compliance with employee benefits law through ten regional and three district offices throughout the country. Most EBSA investigations are civil, but EBSA also has the authority to conduct criminal investigations.

In recent years, EBSA has focused its enforcement resources in certain areas and has developed a set of National Enforcement Projects – areas on which each EBSA Regional Office focuses investigative resources. These include: ESOPs, Plan Investment Conflicts, Contributory Plans Criminal Project; Rapid ERISA Action Team; Abandoned Plan Program; Health Benefits Security Project; Consultant/Adviser Project; and Reporting and Disclosure Enforcement. A detailed explanation of these enforcement projects is available on EBSA's website, www.dol.gov/ebsa/erisa_enforcement.

EBSA has extremely broad investigative authority with respect to ERISA violations. An investigation may be initiated for a variety of reasons. For instance, an employee/participant may lodge a complaint with EBSA, EBSA may identify unusual information reported on a Form 5500, an investigation may arise out of a national or regional office enforcement priority, the matter may be referred to EBSA by another agency, or EBSA may even initiate a random investigation (a theoretical but unlikely possibility).

The subjects of an investigation may include, but are not limited to, various types of employee benefit plans (retirement, health, welfare, apprenticeship), plan sponsors, plan

trustees, named fiduciaries, functional fiduciaries, plan administrators, and plan service providers (consultants, custodians, investment advisors, and directed trustees).

Phases of an EBSA investigation

- EBSA investigations typically begin with an initial contact from the Investigator (or Auditor), either by a letter or a preliminary phone call followed by a letter. The letter usually includes a request for documents and information that should be made available to the Investigator. There is no requirement that DOL identify the target, scope, origin, or end of an investigation. The document request could ask for copies to be sent to the Investigator or could ask for permission to do an onsite review.
- After receiving the Notice of Investigation, it may be advisable to contact the fiduciary insurance carrier covering the plan or provider (if any) and retain counsel. Experienced ERISA counsel can coordinate with the Investigator at the outset of the investigation to narrow, or at least prioritize, the requested information. Further, because the turnaround deadline for producing documents and information is relatively short (usually a matter of weeks from the date of the initial letter), ERISA counsel may be able to modify the response deadline.
- If the subject fails to cooperate with the request for documents, DOL will most likely issue a subpoena. In rare instances, DOL will begin the investigation with a subpoena rather than a document request. Either way, experienced ERISA counsel will typically submit formal written objections to preserve their clients' rights.
- Typically after reviewing at least some documents, DOL may request to interview plan sponsors, plan administrators, trustees, named fiduciaries, functional fiduciaries, and/or service providers. Although such interviews are "voluntary," not recorded by court stenographers, and not taken under oath, they should still be considered a formal procedure before a government agency, and adequate preparation in conjunction with ERISA counsel is necessary. At other times, DOL will issue subpoenas for testimony and conduct formal depositions on the record and under oath. These, too, of course, warrant extensive preparation with ERISA counsel.
- In the days and weeks after the interview or deposition concludes, the Investigator may follow up with additional questions and requests.
- Once the Investigator has gathered and analyzed the information obtained from the investigation, the Investigator writes an internal "Report of Investigation" to his/her supervisors. The EBSA regional office director will then decide whether to take further action.
- The closing of an investigation, like the opening of an investigation, takes place with a letter. EBSA regional offices issue a number of types of closing letters:
  - No Findings/No Action Closing Letter: Where the investigation detected no ERISA violations, a letter closing the investigation and indicating that no further action will be taken is usually provided.
  - Findings but No (or Possible) Further Action Letter: When any potential violations that are identified are *de minimis* or have been adequately corrected, the closing letter may note the potential violations but will also state that no further action will be taken. EBSA may also choose to refer a potential violation to the IRS. Under these circumstances, the IRS may impose excise taxes, if applicable.
  - Voluntary Compliance or 10-Day

Letter: When EBSA concludes an investigation and determines that violations of ERISA may have occurred, the regional office issues a Voluntary Compliance Letter. A sample letter is available on the EBSA website. In general, the letter:

- Provides a description of facts identified during the investigation and the Department's position with respect to violations that may have occurred based on the Department's understanding of the facts;
- Invites discussion regarding correction of the identified potential violations;
- Advises that, without correction, the matter may be referred to the Solicitor of Labor for possible legal action;
- Advises that the Secretary of Labor may furnish information to parties affected by the investigation and notes that the target of the investigation remains subject to suit by private parties, even if the Secretary takes no further action;
- Discusses the Secretary of Labor's rights and obligations with respect to assessing civil penalties;
- Requests a written response within 10 days. ERISA counsel typically requests an extension of the time to reply in order to properly prepare a response that addresses all issues raised, explains any defenses to claims, describes voluntary compliance actions, and includes supporting documentation. On the other hand, if the target does not wish to negotiate the findings of the letter, it may take the steps set forth in the letter to correct issues the identified in the investigation (e.g., change procedures, adopt policies, restore assets, repay monies, correct prohibited transactions).

- EBSA will not seek voluntary compliance for certain matters, such as those involving a lengthy proposed correction of a violation, potential fraud or criminal misconduct, the removal of a fiduciary, particularly novel or complex violations, or violations of other laws. Rather, the agency will refer those cases to the Solicitor of Labor's Office. Together, EBSA and the Solicitor of Labor will determine which cases are appropriate for litigation, considering the ability to obtain meaningful relief through litigation, the cost of litigation, the viability of other enforcement options, and the agency's enforcement priorities. Note that EBSA cases referred to the Solicitor's office for litigation are often resolved through monetary settlements on the eve of litigation.
- The vast majority of EBSA investigations are resolved without litigation. Serious violations of ERISA may require a written settlement agreement with DOL. Before considering this option, it is important to note that, under ERISA Section 502(I), DOL is required to assess a 20 percent penalty on amounts recovered by a settlement agreement or court order.

6. A Special Note About Public Entity Exposure

Public-entity plans are typically created by statute and are subject to the laws of the jurisdiction where the plan was created, meaning that the standard of conduct imposed on these plan fiduciaries is dictated by state law, as are the remedies for any breach. These plans are not subject to ERISA's fiduciary requirements.[6] However, the fact that these plans are not subject to ERISA does not relieve the fiduciaries of liability exposure and may even broaden the scope of potential liability. This is because ERISA sets forth clear, tightly-drafted statutory conduct requirements and limitations on liability, as well as the specific causes of action and remedies that plaintiffs may pursue. For example, plaintiffs cannot recover consequential or punitive damages under ERISA. ERISA also contains an exclusivity provision that dictates that ERISA preempts all other laws regarding fiduciary liability. This means that, with respect to nonexempt, qualified ERISA plans, plaintiffs cannot make any state law claims or unrelated federal law claims against fiduciaries regarding an alleged breach of duty. Because public entity plans are exempt from ERISA, they do not get the benefit of the limitations that ERISA imposes on claims. As a result, fiduciaries of public entity plans could face liability for state law claims, such as common law breach of fiduciary duty, violation of traditional trust law, and negligence.

[6] See ERISA § 401(b)(1), 29 U. S. C. § 1101(b)(1).

B. Claims Against Welfare Plans

1. Observations on Welfare Benefits Claims

The types of welfare benefits claims that might be made in litigation are extremely varied. Claims may be made for medical benefits, life insurance benefits, disability benefits, or severance benefits. Most of these cases are highly individualized, turning on the particular circumstances of the claimant and often on difficult-to-apply plan provisions. If the claimant is successful, exposure is generally limited to the benefits provided under the plan, but the claimant can seek a statutory attorney's fee.

ERISA requires that every plan provide a benefits claim procedure to facilitate administrative (non-judicial) consideration of claims by fiduciaries who must consider the claim in light of what the plan requires. In a number of cases, the Supreme Court has made it clear that the plan administrator functions as a fiduciary when resolving a benefits claim. Thus, in making the claim decision, the fiduciary owes a duty of loyalty to the plan participant and a parallel duty to enforce the plan as the settlor intended it to be enforced.[7] If the plan is written to give the plan administrator discretion in construing the terms of the plan and the plan administrator complies with his/her duties in construing and administering the plan, the administrator's decision may be entitled to some measure of deference in the event the claimant is not satisfied and brings a claim to court.[8] These rules also apply to retirement plan claims in most instances.

2. Affordable Care Act[9] - Litigation Trends

As employer responsibilities under the Affordable Care Act (ACA) have been phased in over the past several years, health plan participants are beginning to file suits that reflect a variety of litigation risks to employers and health care coverage providers. Notably, courts have recently allowed cases to go forward under ACA section 1557.

Section 1557 incorporates four civil rights statutes – Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, and section 504 of the Rehabilitation Act of 1973 – and prohibits a member of a protected class (race, gender, age, and disability, respectively) from being excluded from participating in, being denied the benefits of, or being subjected to discrimination under a "health program or activity" that is receiving federal financial assistance. The frequency of Section 1557 filings may be expected to pick up, especially since final rules were promulgated by the Department of Health and Human Services (HHS) in May 2016. The final rules reflect the wide scope of Section 1557 by broadly defining "health program or activity" as all of the operations of an entity principally engaged in providing or administering health services or health insurance coverage or other health coverage, which includes a hospital, health clinic, group health plan, health insurance issuer, physician's practice, community health center, nursing facility, residential or community-based treatment facility, or other similar entity.

Litigation risk exists to the extent participants are excluded from participating in health coverage, are denied the benefits thereof, or are otherwise discriminated against with respect to health coverage because of race, gender, age, or disability. In addition, the prohibition of discrimination on the basis of gender includes gender identity, on which several provisions of the final rules are focused. HHS' final rules also have significant notice and access (language, physical/sensory, and electronic) requirements. Failure to comply or to provide reasonable modifications where appropriate also poses litigation risk.

Courts have already found a private right of action under Section 1557, which the HHS final rules confirmed, although the procedures associated with that right are unsettled. For instance, in *Rumble v. Fairview Health Services*, No. 14-2037 (D. Minn. filed June 20, 2014) the district court observed that Congress intended to create a new, health-specific, anti-discrimination cause of action that is subject to a singular standard, regardless of a plaintiff's protected class status. Conversely, in *Southeast Pennsylvania Transp. Authority v. Gilead Sciences, Inc.*, 102 F.Supp.3d 688 (E.D. Pa. 2015), the district court concluded that Congress intended to import into Section 1557 the various standards and burdens of proof from each of the four civil rights statutes, depending upon the protected class at issue.

[7] See, e.g., Metropolitan Life Ins. Co. v. Glenn, 554 U.S. 105 (2008); Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989)
[8] *See Met. Life Ins. Co, supra* (holding that the measure of deference can vary depending on reviewer's financial interest in outcome and possible conflicts).
[9] At the time of this publication, the incoming Trump administration and the Republican-controlled 115th Congress had taken steps toward repealing the Affordable Care Act. To say the least, the future applicability of the analysis in this section is seriously in question.

One can anticipate future litigation challenging coverage options ranging from gender transition to specialty medications. For instance, the final rules prohibit categorical exclusions of treatments sought by transgender patients, as well as failing to cover particular treatments for gender dysphoria.[10] In addition, with respect to specialty drugs, plaintiffs are already beginning to challenge what had previously been considered elements of routine plan design, such as formularies and drug cost-sharing tiers, when drugs such as those prescribed to treat HIV are all assigned to a higher cost-sharing tier or are only available by mail-order pharmacy.

To minimize the risk of Section 1557 claims, it will be incumbent on employers and health care providers to work closely with experienced counsel when crafting policies and coverage options to prevent discriminatory distinctions on the basis of protected classes.

III. Practical Suggestions for Plan Design and Administration

There is no one "best" plan design for all plan sponsors and all purposes. At the same time, although standardized plans offered in the marketplace might be useful starting points, it is important to have a plan structure that is (1) thoughtfully and intentionally designed; and (2) well-administered and consistently followed. Although no one plan provision or combination of provisions can eliminate the risk of litigation, employers may want to consider the following suggestions in consultation with their benefits counsel.

A. Overall Administrative Structure and Design

The following overall administrative structure and design features should be considered:

- *Avoid naming the plan sponsor as a fiduciary.* Plan sponsors should not name the sponsoring employer as the fiduciary of an ERISA plan. Instead, consider whether a committee structure is more appropriate, creating an Employee Benefits Committee to be named as the fiduciary. The committee structure may help differentiate the fiduciary functions from the non-fiduciary (i.e., business or settlor) functions and may also help to avoid attribution of knowledge from the sponsoring employer's executives to the fiduciaries.
- *Avoid naming key corporate officers as fiduciaries.* CEOs and CFOs often possess inside information that plaintiffs may claim prevented them from fulfilling their duty of loyalty. The general counsel often possesses privileged information about the sponsor that plaintiffs may claim must be divulged if the general counsel wears "two hats" and the privileged information is arguably relevant to plan administrative matters.
- *Carefully craft delegation authority.* Consider allowing the named fiduciaries to designate a person who is not a named fiduciary to carry out fiduciary responsibilities without being liable for the latter's acts or omissions. However, in order to do so, DOL requires that the plan provide a procedure for such delegation. If procedures are included in the plan, a named fiduciary will not be liable for the acts or omissions of delegated fiduciaries, provided the named fiduciary acts prudently in the delegation of responsibility *and* periodically reviews the performance of the delegated fiduciaries.
- *Define the roles of plan sponsor and fiduciaries.* In order to differentiate fiduciary functions from non-fiduciary functions, the fiduciary structure should clearly define the different roles; that is, it should clearly identify the individuals who act as "appointing fiduciaries," with the duty to appoint, monitor, and remove delegated fiduciaries.
- Plans should be created or amended to include *reasonable time limits* within which claims must be filed or they will be denied as untimely.
- Plans should be created or amended to *give the claims fiduciary discretion* to construe the terms of the plan, make benefit eligibility determinations, and make factual findings.
- Plans should *warn participants that their failure to exhaust the internal claims procedures will result in a motion to dismiss* for failure to exhaust those procedures in the event a participant or beneficiary files a lawsuit.
- Plans should advise participants that *the plan has the right to correct and recoup any overpayments*.

[10] In fact, at the time of this publication, a federal judge in the U.S. District Court for the Northern District of Texas has issued a nationwide preliminary injunction preventing enforcement of the rule's prohibition against discrimination on the basis of gender identity or termination of pregnancy. *See Franciscan Alliance, Inc. v. Burwell,* No. 7:16-cv-00108-O, Dkt. 62 (N.D. Tex. Dec. 31, 2016). The legal landscape in this area is likely to\ change rapidly over the coming years.

B. Retirement Plan Design

The following retirement plan design features should be considered:

- *Include a Section 404(c) provision in defined contribution plans.* Compliance with ERISA Section 404(c) may relieve the fiduciaries from liability for damages for "any loss or any breach" where a participant exercises control over assets allocated to his or her account in a defined contribution plan. This language should explain that the participants are responsible for managing the decision to invest or not invest in particular funds. That is, assuming the plan allows for investment diversification among various investment funds as provided in Section 404(c) regulations, the plan document and summary plan description should be clear that the participants have the full authority and responsibility to manage their investments from among the options available under the plan, and that the fiduciaries are not liable for resulting losses. The fiduciaries will also need to ensure that they provide all of the information to participants required by Section 404(c).
- *Hire an outside fiduciary.* Consider engaging a third-party, independent fiduciary to be responsible for and exercise authority over any employer stock investment fund. If an independent fiduciary is appointed, the plan sponsor may consider granting the fiduciary the authority to remove the employer stock investment fund as an option if prudence requires. At the very least, should the sponsor opt against a third-party fiduciary, consideration should be given to removing corporate officers (insiders) and directors from membership on the fiduciary committee responsible for overseeing the employer stock investment fund. Be aware, however, that the company will continue to have ongoing fiduciary obligations even after the delegation (e.g., to monitor whether the delegation itself is prudent, to correct/prevent fiduciary breaches, etc.).

Plans that include investment in employer stock should consider:

- *"Hard-wiring" the investment.* Consider designing the plan so that the investment in employer stock is locked into the plan document instead of being selected by the plan's investment committee. The plan document and summary plan description should clearly state that offering the stock investment is required under the terms of the plan. No language should be included that suggests that offering such an investment account is optional or discretionary. At the same time, some plan sponsors include language that participants have the option of directing their investments elsewhere.
- *Converting the employer stock fund into an ESOP.* This may trigger a higher standard for plaintiffs to prove claims related to the prudence of employer stock and will generally require relatively small changes in most plans that already offer employer stock as an option.
- *Encouraging diversification outside of company stock.* Remove restrictions on the sale or diversification of company stock. Offer employer stock through either a match or an employee-directed investment, but not both. Place a cap on the amount of company stock that participants can hold in their accounts.

C. Medical Plan Design

The following medical plan design features should be considered:

- *Include a strong, clear reservation-of-rights clause.* Ensure that all plan documents include an express reservation of rights to terminate or amend the plan at any time and for any reason. Be sure to include a description of the clause in the summary plan description.
- *Explain the plan's reimbursement rules.* Clearly explain how the plan reimburses or pays for benefits, especially out-of-network services and services for which the participant fails to get precertification for treatment, and make the plan's payment schedules accessible to participants and providers. In-network providers are typically paid according to a contractual fee schedule, so the participant has limited financial exposure. Most plans encourage participants to get precertification of treatment, which means (among other things) that they will know before the procedure exactly what it will cost. Because out-of-network providers have not agreed to be bound by the plan's provider-reimbursement agreements, however, plans typically pay a much smaller portion of bills for out-of-network services than for in-network services. These limitations are a frequent source of litigation because participants are commonly surprised by the size of their liability for out-of-network service bills. Similarly, it is important to alert participants to the penalties, and unexpected liabilities, they will face if they fail to comply with the plan's precertification requirement.

D. Plan Administration

With respect to plan administration, "procedural prudence" is vital. Therefore, set up a procedure in consultation with benefits counsel to help meet fiduciary obligations and to ensure that these procedures are followed.

General procedures may include the following:

- *Have regular, structured meetings.* The plan administrative committee should meet regularly, in person, with agendas and binders of relevant materials, and should keep minutes.
- *Read the plan documents.* Every administrator and fiduciary of a plan should be familiar with the documents that govern the plan, such as the plan document itself, its trust instruments, its summary plan description, any underlying collective bargaining agreements and insurance policies, and the like. The first question DOL or a plaintiff's attorney is likely to ask is whether the defendant has read the plan.

With respect to the duty to monitor:

- *Identify point person(s).* Clearly identify the individuals who act as "appointing fiduciaries" with the duty to appoint, monitor, and remove fiduciaries. Appointing fiduciaries should not themselves be plan fiduciaries (i.e., they cannot monitor themselves). Ensure that your ERISA fiduciary liability insurance policy covers those who are responsible for appointing fiduciaries.
- *Appoint with care.* Follow a clearly defined process for appointing fiduciaries, carefully evaluating possible fiduciary candidates and documenting the selection process. When reviewing applicants, ensure that candidates' qualifications are consistent with duties assigned to that individual.
- *Keep fiduciaries informed.* Consider providing training to fiduciaries, especially as ERISA case law evolves and changes.
- *Keep at arm's length for decisions.* Avoid involvement in fiduciaries' decision making.
- *Review performance.* Meet at least annually with appointed fiduciaries to review investment performance, fees and costs, and other significant events. These meetings should be documented. Replace non-performing fiduciaries!
- *Review agreements with outside fiduciaries.* Ensure that the acceptance of fiduciary status is documented, and that the parties' agreements include a clear statement of duties. Also review indemnities and limitation-of-liability clauses for compliance with ERISA Section 410, and require that corporate fiduciaries and other service providers are adequately capitalized and insured.

With respect to selecting and managing investment options:

- *Consider establishing an investment policy.* If one is already established, review it at least annually.
- *Review investment performance (e.g., consider hiring an outside investment consultant).* Periodically review investment performance of all options against relevant benchmarks. Have and follow "watch list" standards for underperforming funds, and consider retaining an independent advisor to provide assistance in monitoring fund performance and in identifying new managers, asset allocation strategies, and new asset classes. Identify and interview potential replacement managers for underperformers. Document all decisions.

- *Remember diversification.* Consider periodically whether the investment menu has the right number of options. Too few may limit ability to diversify appropriately, but too many may lead to "paralysis by analysis." In a defined benefit plan, be open to changing asset-allocation strategies and testing new asset classes.
- *Be educated about fees.* Know what you are paying and to whom. Demand full disclosure from all vendors, and include disclosure of fees in contracts. Compare with benchmarking data. Consider requesting proposals from vendors periodically (DOL has a strong bias against "perma-vendors," although change just for the sake of change may not be prudent). Make sure to periodically review and document fund choices that affect fees and why they make sense (e.g., active vs. index funds, optimal share classes, mutual funds vs. managed accounts, etc.).
- *Educate participant investors about the risks of company stock.* The employer should make clear that a concentrated holding in one stock (such as employer securities) is a very aggressive investment. This language should be included on all participant communications, and any language suggesting any prospective degree of return on company stock or encouraging company stock investments should be avoided.
- *Enhance disclosure to participants about fees.* Consider providing an annual "all-in" fee summary to participants to avoid claims that participants were not aware of fees and expenses. Consider providing a link to available DOL disclosure regulations.
- Periodically review regulatory requirements for the safe harbor of ERISA Section 404(c) to ensure that issues or concerns are addressed.

With respect to privately held ESOPs:

- *Hire help.* Ensure that the ESOP has an independent valuation advisor (appraiser), who is required by law to be independent. Consider whether the trustees should engage legal counsel; this is especially important if the trustee is not independent or not experienced.
- *Monitor the trustee's performance.* Consider whether the trustee has retained independent financial and legal counsel. Consider whether the trustee has conducted a thorough investigation of the transaction. Review how the trustee negotiated on behalf of the ESOP. Consider the trustee's review and understanding of any valuation report.
- *Understand the importance of a proper valuation*. Ensure that the appraiser is independent and qualified, a full valuation report is prepared and delivered to the trustee each year, the valuation opinions are dated appropriately, and the valuation reports follow the format specified in the DOL's proposed adequate-consideration regulation.
- *Sell company stock with care.* For related-party transactions, bring in an independent trustee to address any conflicts of interest, and ensure that the trustee receives independent financial and legal advice. For sales to unrelated parties, consider obtaining a fairness opinion for the ESOP. Ensure that all sales are supported by independent valuations.
- *Watch executive compensation.* Consider monitoring executive compensation to minimize the risk of participant claims alleging improper dilution, and ensure that appropriate safeguards are in place (e.g., a compensation committee comprising outside directors and/or independent compensation consultants).

IV. The Role of Fiduciary Liability Insurance for Protecting Plan Sponsors, Fiduciaries, and Parties in Interest

A. The Pivotal Role of Insurance in Protecting Insureds Against Fiduciary Liability

1. Personal Liability and Indemnification Issues

It should be apparent by now that plan sponsors and fiduciaries may be exposed to significant liabilities. This should be of particular concern to plan fiduciaries because ERISA Section 409 imposes personal liability on individuals who breach their fiduciary duties, thus putting the personal assets of the fiduciary at risk.

To make matters worse, ERISA's anti-exculpatory clause prohibits a plan from paying for or indemnifying a fiduciary for a breach of fiduciary duty.[11] Specifically, ERISA § 410, 29 U.S.C. § 1110 provides that "any provision in an agreement or instrument which purports to relieve a fiduciary from responsibility or liability for any responsibility, obligation, or duty under this part shall be void as against public policy."

A DOL regulation explains, however, that ERISA permits indemnification of a plan fiduciary by an *employer* whose employees are covered under the plan, rather than by the plan itself, so long as the fiduciary remains liable for any loss caused by a breach of that fiduciary's duty. Thus, as between the plan sponsor and the plan fiduciaries, the plan document, trust agreement, and/or an operative engagement agreement may provide for indemnification of the fiduciary by the corporate plan sponsor.

[11] Contribution and indemnification issues may arise in ERISA litigation, either between the plan sponsor and plan fiduciaries or among co-defendants. As between co-defendants, ERISA does not include a statutory right to contribution or indemnification. Courts that have decided the issue are split on whether there is a federal common law right of indemnification and contribution under ERISA.

Such indemnity may have limits, however. Even assuming an employer/plan sponsor is willing to indemnify a fiduciary for such a claim, there is a risk that the employer/plan sponsor may not have sufficient funds or liquidity to do so or that it may be prohibited from doing so by law. This concern is especially present during any economic downturn, when insureds are often faced with insolvency and bankruptcy.

Even when an employer/plan sponsor is willing and financially able to indemnify plan fiduciaries, it may be prohibited from doing so by applicable law. For example, plaintiffs may make the argument to a court to hold that the employer/plan sponsor is prohibited from honoring its agreement to indemnify the plan fiduciaries, when such agreement to indemnify is conditioned on the plan fiduciaries following instructions provided them without exercising independent judgment. Plaintiffs will contend that courts should prohibit indemnification in such situations to dissuade fiduciaries from not questioning whether the instructions that they were given were in the best interests of the plan and plan participants because of their fear of losing their rights to indemnification. Courts have also suggested that public policy underlying ERISA's anti-exculpatory provision may prohibit indemnity that absolves fiduciaries of responsibility for their breaches of duty.

A special note of concern surrounds multiemployer plans because there is no sponsor present to indemnify fiduciaries as there is with a traditional single employer plan. Instead, the plan is established under a collective bargaining agreement and then a board of trustees is assembled, comprising representatives from both labor and management. As such, the Labor Management Trust policy, which is described later in this report, is the only available source of protection for the trustee fiduciaries.

2. Special Considerations for Indemnification of ESOP Fiduciaries

Likewise, courts may preclude indemnification by ESOP plan sponsors. ESOPs are designed to invest in the stock of the participants' employer (i.e., the plan sponsor). Some courts have determined that plan sponsors whose shares are owned by an ESOP plan are not permitted to indemnify the ESOP plan's fiduciaries because to do so would be detrimental to the ESOP plan. In essence, the ESOP plan and its participants would gain nothing by attempting to recover from an ESOP fiduciary for a breach of duty only to have that fiduciary turn to the plan sponsor for indemnification. Ultimately, the value of the company stock held by the ESOP depends on the value of the plan sponsor, so any liabilities incurred by the plan sponsor, including indemnification liabilities, decrease the value of the plan sponsor and, consequently, the value of the ESOP shares. Thus, these courts reason that requiring the plan sponsor to pay for damages to a plan that are caused by an ESOP fiduciary simply moves money from the coffers of the plan sponsor into the plan itself, while depressing the value of the ESOP shares so that no real value inures to the benefit of ESOP participants. As the owner of the employer company that sponsored the plan, the ESOP would, in essence, be paying damages to itself if the employer/sponsor company indemnified fiduciaries for the damages caused to the plan by their breach of duty. This is arguably a violation of ERISA's anti-exculpatory clause. The DOL and some courts have supported this prohibition on indemnification.[12] At least one court has rejected it, however, citing regulations providing that, absent certain circumstances, assets of the corporate plan sponsor are not treated as assets of the ESOP.[13] In addition, in ESOP stock purchase transaction litigation where the selling shareholder defendants, but not the trustee defendants, have reached settlements with DOL, several courts have recently entered settlement bars preventing the non-settling defendant trustee from seeking indemnification or contribution from the selling shareholder.

3. State Restrictions on Indemnification

State corporate indemnification laws may also prevent or limit a plan sponsor's ability to indemnify plan fiduciaries. Some state statutes permit indemnification only when the fiduciary serves at the employer's request (e.g., not *de facto* fiduciaries). Also, state corporate law may preclude indemnification unless the fiduciary was acting in good faith and in the best interests of the *employer* (not necessarily the best interest of the *plan)*. This corporate law standard of conduct could be at odds with ERISA's requirements that all acts be undertaken in the exclusive interests of the plan participants. Thus, there is a potential disconnect between a fiduciary's standard of conduct for purposes of indemnification and ERISA's standard of conduct for fiduciaries. One obvious area where this disconnect could become acute is when the fiduciary is required to pursue his or her employer (the plan sponsor) to contribute funds to the plan.

[12] *See Johnson v. Couturier*, 572 F. 3d 1067 (9th Cir. 2009), and Fernandez et al v. K-M Industries Holding Co., 646 F. Supp. 2d 1150 (N. D. Cal. 2009)
[13] *See Harris v. GreatBanc Trust Co.*, No. EDCV12-1648-R (DTBx), 2013 WL 1136558 (C.D. Cal. March 15, 2013).

4. Other Constraints on Indemnification

Also, fiduciaries should keep in mind that even if an employer/plan sponsor is legally capable of indemnifying fiduciaries, it must be sufficiently capitalized and liquid to do so. Even if the sponsor has the financial wherewithal to indemnify fiduciaries, it may not be *required* to indemnify fiduciaries, absent some undertaking in the corporate documents.

Fiduciary liability insurance should not be subject to the same legal and financial restrictions that limit corporate employer indemnification of fiduciaries. Fiduciary liability insurance from a reputable, highly rated insurer provides fiduciaries with the added comfort that adequate funds will be available for their defense even when their employers are illiquid or financially troubled. In many instances, a fiduciary liability insurance carrier's decision to defend and/or indemnify a fiduciary may be independent of a plan sponsor's decision to defend and/or indemnify a fiduciary.

B. Types and Terms of Fiduciary Liability Insurance

This report has demonstrated the complexity of ERISA and the types of litigation that can ensue. No one wants to be placed in the position of defending against an ERISA claim, but by recognizing the potential fiduciary exposures and purchasing fiduciary liability insurance, insureds may mitigate against unnecessary inconvenience and personal loss should they be subjected to such a claim.

This section is designed to explain, in simple terms, the purpose and function of fiduciary liability insurance in protecting fiduciaries against ERISA claims.

A good starting point is an explanation of what a fiduciary liability insurance policy does. Put simply, a fiduciary liability insurance policy can be issued either to the plan itself or to an employer that sponsors an employee benefit plan. It is designed to protect insureds against claims alleging the breach of their fiduciary duties to the plan or alleging they committed an error in the administration of the plan.

It goes without saying that every insurance policy has its own particular terms, conditions, limitations, and definitions. Each claim is unique and policy terms vary, so care should be taken to review the specific policy against the specific claim. However, it is helpful to understand some of the more common policy provisions.

1. What Is A Claim?

Definition of Claim

In order to trigger coverage under a fiduciary liability insurance policy, a claim must be made against an insured for a wrongful act allegedly committed by the insured. In other words, the claimant must accuse the insured of having done something wrong with regard to the plan and demand some form of relief.

Generally, a claim may be a written demand for monetary damages or injunctive relief, a civil complaint, a formal administrative or regulatory proceeding commenced by the filing of a notice of charges or formal investigative order, or a written notice by DOL or the PBGC of an investigation against an insured for a wrongful act.

A common misconception is that fiduciary liability insurance can be used to restore losses to an employee benefit plan when a plan sponsor or employer discovers that it made an error. That is not the case. Fiduciary liability insurance is "third-party" coverage, meaning that someone must make a claim against an insured for a wrongful act. In turn, the fiduciary liability insurance policy will provide a defense against the claim (assuming that the policy includes a duty to defend provision, as discussed further on) and then pay for any covered award entered against the insured up to the policy's limit of liability. Fiduciary liability insurance is not "first-party" coverage, meaning that the insured cannot draw on the policy to restore losses to the plan. Likewise, fiduciary liability insurance should not be confused with the mandatory ERISA bond that is required for all persons handling plan assets.

Optional Coverage for Voluntary Correction Programs in Absence of a Claim

Many carriers offer optional coverage for costs associated with an insured's voluntary effort to bring its plan into compliance with certain requirements of ERISA and/or the Internal Revenue Code (IRC) without requiring that a claim be made against an insured. Such correction programs typically carry a filing fee and/or fine or penalty, which cannot be paid out of plan assets on behalf of fiduciaries.

An insured can pursue several different compliance actions depending on the circumstances. When an insured has discovered that its retirement plan is out of compliance with IRC requirements, it can correct such inadvertent non-compliance without risking plan disqualification through the Employee Plans Compliance Resolution System (EPCRS), which is administered by the Internal Revenue Service.[14] The EPCRS is made up of several components, including the Self-Correction Program, the Voluntary Correction Program, and the Audit Closing Agreement Program. Similarly, the Employee Benefits Security Administration of the Department of Labor administers the Voluntary Fiduciary Correction Program and the Delinquent Filer Voluntary Compliance

[14] *See* Rev. Proc. 2003-44, 2003-1 C. B. 1051.

Program.[15] These programs are designed to encourage employers to voluntarily comply with ERISA, including ERISA's annual reporting requirements, by self-correcting certain violations of law. And lastly, the PBGC administers the Premium Compliance Evaluation Program.

This type of coverage is often subject to a sublimit, meaning that there is a lower limit of liability applicable to this type of coverage as compared to the overall limit of liability for the policy. The sublimit is usually part of, and not in addition to, the limit of liability. Also, any grant of coverage will usually not cover the actual costs of bringing a plan into compliance (e.g., the policy will not pay for the funding obligations of the plan sponsor).

Optional Coverage for Department of Labor Investigations, Benefit Denial Appeals, and Interviews

An innovation in the fiduciary liability insurance market is the broadening of the definition of Claim to include DOL investigations that have not yet risen to the level of a Claim against an Insured for Wrongful Act. This extension of coverage goes by various names and is sometimes called "Pre-Claim Investigation" coverage. As of the date of this article, this coverage is not routinely offered. Coverage to pay the costs of litigating an appeal of benefit denials is another coverage innovation currently available from some carriers. Of course, in the event it is determined that that the insured owes the benefits sued for, fiduciary liability insurance will not pay out the actual benefits due.

Oftentimes, this Pre-Claim Investigation coverage and Benefit Denial Appeals coverage provides for discretionary reporting, meaning that insureds do not have to report the investigation or appeal unless the insured wants coverage for same. Accordingly, the failure to report investigation or denial will not result in a late reporting coverage issue should the Insured decide to report a subsequent Claim (e.g., civil or criminal complaint, formal investigation, etc.) arising from the same or similar facts or circumstances.

Finally, some policies provide for interview coverage, meaning insurance may cover fees and expenses incurred by an Insured Person in responding to a request for an interview by certain governmental regulatory authorities. This coverage should assure that individual fiduciaries do not have to pay out-of-pocket for legal fees incurred in responding to interview requests.

2. Who Is An Insured?

A person or entity must be an insured as defined under the policy in order for coverage to apply. Insureds may include the plan sponsor(s); that is, the entity or group that creates and funds the plan (typically the employer(s) of the plans' participants). Insureds under fiduciary liability policies typically include the sponsoring organization's officers, directors, and employees acting as fiduciaries or as members of any employee benefit committee, investment management committee, or administrative committee for the plan, as well as natural person employee trustees of the plan.

The plan itself, as defined under the policy, is also an insured. "Plan" often includes employee welfare plans and pension plans and can be sponsored by for-profit organizations or not-for-profit organizations.[16] Under many fiduciary liability insurance policies, the term "plan" is not confined to traditional ERISA plans and, as such, may include plans that are not subject to ERISA (e.g., "top hat" plans, excess benefit plans, church plans, government plans, and plans that are created and maintained outside the United States).

[15] *See* 67 Fed. Reg. 15052, 15058 (March 28, 2002).
[16] Note that defined contribution plans that are sponsored by not-for-profit organizations or by educational organizations may be known as "403(b) plans," referring to the applicable provision of the IRC addressing these organizations' plans.

Just as important as understanding who is an insured is knowing who is not an insured under the policy. Third- party service providers (such as investment advisors, investment managers, and third-party administrators) who are hired by the plan or plan sponsor, but who are not employees of the insured, are typically not insureds under the fiduciary liability insurance policy, even if they are considered to be fiduciaries under ERISA.[17] Fiduciary liability insurance policies typically cover only plan fiduciaries who are employed by the entity that purchases the policy, and not other fiduciaries, particularly those employed by outside providers. This approach is important because it preserves policy limits for the plan sponsor's employee and director fiduciaries.

3. What Is A Wrongful Act?

Another important policy provision is the definition of the term "wrongful act." The definition varies from carrier to carrier and from policy to policy but, generally speaking, most fiduciary liability insurance policies cover, at a minimum, breaches of fiduciary duties and errors in the administration of the plan.

Depending on the nature of the breach and how many beneficiaries are impacted, a claim of breach of fiduciary duty can result in a significant exposure to the plan and other insureds. Many such claims have resulted in significant loss payments under fiduciary liability insurance policies (e.g., employer stock drop claims). In addition, numerous other breach of fiduciary duty claims may also present significant liability potential, such as allegations involving misinterpretation of a plan document, wrongful administration of a plan in a way that is not in compliance with the plan documents, providing imprudent investment options to participants in a pension plan, failing to accurately communicate relevant information to plan participants, or making misrepresentations about plan investments.

Fiduciary liability insurance coverage may also be triggered by an insured's error in the administration of the plan. In this context, administration commonly includes handling paperwork for the plan, providing interpretations with respect to any plan, or giving advice to participants regarding the plan. Such claims are common. For example, say a company's human resources department manager tells an employee that the employee is eligible to add his/her newborn child to the health insurance plan as long as he/she does so within 60 days after birth. However, the plan terms allow only 30 days to do so. The child becomes ill a few months later and the health insurance carrier denies the claim for medical benefits because the child was not added to the insurance plan until 40 days after the date of birth. The employee sues the plan, alleging that he/she was given improper instructions on how to enroll the newborn child in the plan. That claim could constitute a claim for a wrongful act in that it involves an error in the administration of the plan.

More recently, many carriers have been offering a form of coverage for "settlor conduct." Settlor conduct includes actions taken by a plan sponsor in the creation, amendment or termination of an employee benefit plan. It does not include fiduciary conduct. Claims of settlor misconduct may accompany breach of fiduciary duty claims, especially where the plan sponsor has amended a plan to change or reduce benefits. For example, where a sponsor decides to de-risk a defined benefit plan by amending the terms of the plan, the sponsor's decision to de-risk the plan would likely be considered settlor conduct. However, any subsequent conduct by fiduciaries in carrying out the de-risking, such as hiring experts to assist with possible annuitizations, could be considered to be fiduciary conduct.

4. Loss and Benefits Due Provisions

Once a claim has been made against an insured for a wrongful act, the relief sought must constitute loss that is covered by and not specifically excluded from the fiduciary liability insurance policy. The definition of "loss" and the "benefits due" exclusion are really two sides of the same coin. Both are approaches that carriers use to address the nature of the requested relief in order to come to a coverage result. These policy provisions may be used to preclude coverage for indemnity payments that constitute benefits that are payable to participants or their beneficiaries under the terms of a plan, or that would have been payable under the terms of the plan had it complied with ERISA.

[17] Claims filed against third-party providers are typically covered by that third-party provider's own errors and omissions insurance (not fiduciary liability insurance) policy because their liability arises from professional services rendered for another party's plan.

Note that even when the relief sought is not a loss or constitutes benefits due, the insureds may still have coverage for defense costs. For example, if a retiree sues a pension plan for erroneously calculating an underpayment of a lump sum distribution, fiduciary liability insurance would pay to defend against the retiree's claim, whereas the plan would have to pay any settlement or judgment awarding the retiree the underpaid portion of his/her distribution (i.e., the benefits due under the plan).

5. Defense Provisions

Most fiduciary liability insurance policies include a "duty -to-defend" provision, which means that the insurance carrier has the right and duty to defend the claim against an insured, including the right to select defense counsel. Policies that do not include a duty to defend provision often require insureds to choose from a panel of pre-approved defense counsel for select claims including class action claims.

The duty-to-defend provision is sometimes met with resistance from insureds, and for this reason, many insurers are now giving insureds the option to assume the duty to defend at the outset of a claim. However, before doing so, insureds should consider the benefits to be gained by the exercise of this duty. The right and duty-to-defend provision includes the insurance carrier's right to select defense counsel. Fiduciary liability insurance carriers, who regularly provide the defense of fiduciary liability claims, are familiar with experienced ERISA defense counsel. Accordingly, fiduciary liability insurance carriers play a pivotal role in providing insureds with appropriate defense counsel to mount the best defense possible.

Moreover, due to the volume of the claims they handle, fiduciary liability insurance carriers commonly negotiate lower rates with the defense firms. Thus, insureds receive the benefit of a defense by accomplished ERISA defense counsel at reduced rates, preserving available policy limits for any covered loss that may arise either in settlement or judgment. These experienced ERISA defense counsel have familiarity with relevant law, which is constantly evolving. Fiduciary liability carriers also typically have litigation management guidelines in place that help to ensure that the costs of defense are reasonable and necessary. These defense provisions are important because fiduciary liability policies typically pay for defense costs within the limits of liability, meaning that every dollar spent by the carrier on defense costs erodes the available limit of liability by that same amount. These types of policies are commonly referred to as "eroding limits" policies.

Another benefit of the duty-to-defend provision is the management of discovery costs, which can be significant. In today's electronic age, a large portion of defense costs may comprise electronic discovery efforts, such as harvesting information from obsolete databases, gathering years' worth of email traffic, and cataloguing all discovery information. Fiduciary liability carriers continue to create solutions to deal with this electronic discovery in an efficient, cost-effective manner, such as negotiating vendor agreements with third-party providers to provide these services at reduced rates.

6. Other Forms of Insurance Protection

In addition to the more commonly known fiduciary liability insurance policies that cover traditional, single employer plans, there are other types of fiduciary liability policies designed to cover certain multiemployer plans, commonly referred to as "Taft-Hartley" plans. Established to address collective bargaining agreements in accordance with the Taft-Hartley Act, these plans provide benefits for people who are members of a specific union (e.g., a local chapter of the Teamsters) but are employed by different employers. A Taft-Hartley multiemployer plan is characterized by provisions that allow its participants to continue to earn benefits based on work with multiple employers, as long as each employer contributes to the plan. Policies insuring these plans, sometimes called Labor Management Trust (LMT) policies, are constructed differently than the traditional fiduciary liability insurance policy because such LMT policies cannot be issued to a single employer as a plan sponsor. Instead, they are issued to the plan itself.[18] Such LMT policies typically cover wrongful acts similar to those that are covered by fiduciary liability insurance.

Public entity plans (i.e., governmental plans) are similar to Taft-Hartley/ multiemployer plans in that insureds are often public employees who work for a variety of different public agencies or governmental divisions (e.g., a plan may cover all teachers employed by public schools within the state, even though they are employed by several different school districts). Accordingly, these policies, like LMT policies, are usually issued to the plans themselves.

[18] ERISA Section 410 permits plans to purchase fiduciary liability insurance.

There are also optional Employee Benefit Liability (EBL) endorsements that may be endorsed onto commercial general liability policies.[19] These EBL endorsements should not be confused with the coverage afforded by the fiduciary liability insurance policies; as such EBL endorsements are usually far more restrictive in scope of coverage. They typically do not provide coverage for breach of fiduciary duty claims, and instead cover only errors in the administration of a plan, which fiduciary liability insurance also covers, and, even then, may often be subject to more restrictive terms and conditions than those of a fiduciary liability insurance policy. One notable exception, however, is that defense costs under an EBL endorsement may not deplete policy limits because this endorsement is appended to a general liability policy, which is typically a policy in which defense costs do not erode limits. Fiduciary liability insurance limits, on the other hand, are generally eroded as defense costs are paid.

Fiduciaries should not rely on the fact that they have executive liability insurance, commonly referred to as Directors and Officers (D&O) liability insurance, in the event a fiduciary liability claim is made against them. As discussed previously, the same person may serve as both a plan fiduciary and as a director and/or an officer. A person's capacity depends on the nature of the activity in which he/she is engaged. If he/she conducts business on behalf of the employer, then he/she may be acting as a director and/or officer. If he/she administers the plan or deals with plan assets, then he/she may be acting as a plan fiduciary. Even when a director is also a plan fiduciary, D&O liability policies typically cover directors and officers only for activities performed in their capacity as directors or officers, not as plan fiduciaries. Furthermore, D&O liability insurance policies typically exclude from coverage any claims based on or arising from an ERISA violation.

Finally, a fiduciary liability policy will not satisfy any bonding requirements under ERISA for theft of plan assets, although the fiduciary liability policy could pay for the defense of a fiduciary who was sued by a plan participant for breach of fiduciary duty for allegedly failing to prevent or detect the theft of funds.

C. Partnering with the Insurance Carrier

Any discussion of fiduciary liability insurance would not be complete without including some best practices for insureds when a fiduciary claim is made against them.

Report a claim. The most fundamental best practice is to tender any claim to the carrier in a timely fashion. Many policies specify the reporting requirements for tendering a claim for coverage. Establishing point persons (e.g., human resources, benefits department, and general counsel's office) who are trained to recognize claims and report them timely through the employer's broker/agent to the carrier will help to ensure that the policy responds as intended. Remember that many policies may define a "claim" as constituting not only civil and criminal complaints, but also verbal or written demands and investigations. Insureds imperil coverage if they tender a claim belatedly, because late notice, or late reporting as it is often called, may serve as the basis for denial of coverage, even where there is no prejudice to the insurer.

Cooperate with your carrier. Once the claim is submitted, insureds should make every effort to cooperate with the carrier to provide all information necessary to evaluate the claim. Also, insureds should not incur any liability, including defense costs, engage in any settlement discussions, or enter into any agreements that could impact the claim without first getting the carrier's consent, because many policies have consent provisions that prohibit this type of activity. Just as an insured needs to cooperate and keep lines of communication open with the carrier, an insured is entitled to expect timely and forthright communication from the carrier, be it on coverage issues or questions about the claim in general. Prominent fiduciary liability insurance carriers employ experienced fiduciary claim examiners, many of whom are attorneys. These examiners can provide meaningful collaboration both with defense counsel and insureds as the claim progresses on such matters as defense arguments, case valuations, and selection of mediators.

Conclusion

Plan sponsors and fiduciaries need to be proactive to insulate themselves in an ever-changing legal environment. Well-designed, well-executed, and well-administered benefit plans are an important foundation for limiting litigation exposure moving forward. Likewise, fiduciary liability insurance should be considered in any comprehensive corporate risk management program.

[19] Commercial general liability insurance covers all liability exposures of a business that are not specifically excluded. Coverage typically includes advertising and personal injury liability, product liability, completed operations, premises and operations, and medical payments.

Policy Forms

Application

Marketing Materials

About the Author

Lars C. Golumbic is a Principal at Groom Law Group, Chartered, and Chair of Groom's litigation practice group. Lars is a nationally recognized ERISA litigator, and is listed by *Chambers USA, The Legal 500, Best Lawyers*, and *Super Lawyers* as one of the top ERISA litigators in the country.

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