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FIDUCIARY LIABILITY INSURANCE HANDBOOK

The Definitive Guide for Fiduciaries and Advisers of Employee Benefit Plans

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FIDUCIARY LIABILITY INSURANCE HANDBOOK OUTLINE

INTRODUCTION

Although not required by fiduciary law, most employee benefit plan fiduciaries realize that they need fiduciary liability insurance. But many plan officials do not pay adequate attention to the quality of their fiduciary liability insurance protection. Buying decisions are often based on the lowest premium amount or name recognition of the insurance carrier. Like the underlying liability, however, fiduciary liability insurance is complex, and deserves important consideration to ensure that the plan and its fiduciaries are protected in the event of a claim.

The purpose of this handbook is to explain the ins and outs of fiduciary liability insurance and provide a practical guide to ensure that plan officials obtain the best possible protection for their funds and to protect against their own personal liability. While it is not intended to replace the advice and representation of an experienced fiduciary liability insurance broker or outside counsel, we hope that this handbook serves as a useful reference.

Our goal is to make one thing obvious: fiduciary liability insurance is not a commodity. A quality scope of coverage from an insurance carrier with fiduciary expertise and experience is an essential component of your employee benefit and risk management portfolio.

I. THE NUTS AND BOLTS OF A FIDUCIARY LIABILITY INSURANCE POLICY:

Understanding the Basics

A. What is Fiduciary Liability Insurance?

A fiduciary liability insurance policy is a contract designed to protect plan trustees, other fiduciaries and the employee benefit plan against claims alleging breach of their fiduciary duties to the plan or claims alleging they committed an error in the administration of the plan. The insurance carrier issues the insurance contract to the plan itself or to an employer that sponsors an employee benefit plan. The policy provides two important basic benefits, **defense** and **indemnity**: (1) the policy pays for the expense of defending fiduciaries accused of violating their duties to the benefit fund [i.e., providing a lawyer to defend you]; and (2) the policy also indemnifies trustees for their alleged violations of duty and negligent administrative acts or omissions in the event of a settlement or judgment of liability [i.e., payment of covered damages you owe to the complaining party]. While fiduciary liability policies now provide coverage to the plan itself, as discussed more fully below, the primary

purpose of the fiduciary liability insurance policy is to protect against the individual liability of plan fiduciaries.

B. Why Is Fiduciary Liability Insurance Necessary?

Plan sponsors and fiduciaries may be exposed to significant liabilities. The Employee Retirement Income Security Act "ERISA" Section 409 imposes personal liability on individuals who breach their fiduciary duties, thus putting their personal assets at risk. An employee benefit plan and its fiduciaries, including the plan trustees, can be sued by several different constituencies: (1) a governmental regulator, like the Department of Labor "DOL" or the Internal Revenue Service "IRS"; (2) plan participants; or (3) another fiduciary, including other current or former plan trustees, of the plan under co-fiduciary liability.

Importantly, under fiduciary liability law, the employee benefit plan cannot use plan assets to defend a fiduciary for claims alleging negligence or wrongdoing. ERISA's anti-exculpatory clause [ERISA section 410, 29 U.S.C. section 1110] prohibits a plan from paying for or indemnifying a fiduciary for a breach of fiduciary duty. ERISA permits indemnification of a plan fiduciary by an employer or plan sponsor whose employees are covered under the plan, rather than the plan itself, so long as the fiduciary remains liable for any loss caused by a breach of that fiduciary's duty. But indemnification is never foolproof, as the employer may not have the assets to indemnify a fiduciary or is prevented by applicable law. Fiduciary insurance is thus essential to avoid personal liability for your service on behalf of an employee benefit plan.

C. What is Covered?

The modern fiduciary liability insurance policy will offer **four basic coverage grants**: (1) breach of fiduciary duty; (2) negligence in the administration of the plan; (3) voluntary compliance programs; and (4) regulatory penalties.

1. Breach of Fiduciary Duty:

The primary coverage grant in a fiduciary liability policy is for breaches of fiduciary responsibility under ERISA or other applicable fiduciary law. Depending on the nature of the breach and how many beneficiaries are involved, a claim for breach of fiduciary duty can result in significant exposure to the plan and the other policyholders. Historically, the most significant loss payments under fiduciary liability insurance policies are imprudent

investment cases in which beneficiaries or other third-parties allege that the trustees breached their fiduciary duties in investing plan assets. The Department of Labor can also allege that plan trustees breached their fiduciary duties in the administration of the plan. The damages model for imprudent investment claims is typically the loss in investment principal as well as the lost opportunity cost if the principal had been prudently invested. Other breach of fiduciary duty claims may also present significant liability potential, including allegations of 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 defined contribution plan, failing to accurately communicate relevant information to plan participants, or making misrepresentations about plan investments.

2. Administration of the Plan:

The second coverage grant is coverage for negligent errors in the administration of the plan even if the errors do not constitute breaches of fiduciary duty. In this context, administration commonly includes handling paperwork and records for the plan, providing interpretations with respect to any plan (including calculating and determining benefits), or giving advice to participants regarding the plan. For example, the plan document may allow thirty days for an employee to add a newborn child to the health insurance plan. But the plan administration office may erroneously offer advice to the employee that the employee had sixty days to add the newborn when the plan only allows 30 days. If a plan participant relies on this incorrect advice and does not timely add the newborn to the health plan until fifty days after the date of birth, the health insurer could deny any claims for medical benefits. The employee then could sue the plan, alleging that they were given improper instructions on how to enroll the newborn child in the plan. This claim could qualify as a wrongful act under the policy as an error in the administration of the plan.

3. Voluntary Compliance Programs:

Historically, fiduciary liability insurance policies would cover claims only when a third- party was alleging some type of wrongdoing, and not loss by the insured itself (first-party claims). The reason is to avoid moral hazard claims, which would involve a policy coverage that could create an incentive to take unusual risks. But that has changed in recent years with regulatory agencies encouraging employee benefit plans to proactively remedy fiduciary violations under ERISA by taking prescribed remedial actions – expenses that typically cannot be paid out of plan assets.

Both the IRS and DOL now have vibrant voluntary compliance programs. If you make mistakes with respect to your plan, for example, the IRS Employee Plans Compliance Resolution System "EPCRS" encourages plans to remedy mistakes and avoid the consequences of plan disqualification. Similarly, the DOL's Voluntary Fiduciary Correction Program "VFC" allows those potentially liable for certain specified fiduciary violations under ERISA to voluntarily apply for relief from enforcement actions and certain penalties. Although not "voluntary," the IRS also offers correction of mistakes that are discovered during an audit. This is known as the IRS Audit Closing Agreement Program "Audit CAP", which allows a plan to enter into a Closing Agreement with the IRS, allowing the plan to correct identified issues and pay a sanction negotiated with the IRS.

The cost of correction of many of the violations specified in a voluntary compliance application or pursuant to an Audit Closing Agreement Program may not be paid with plan assets, unless such cost would have otherwise been paid from the plan (and assuming the plan document permits such payment of reasonable and necessary expenses to be paid from the trust). Modern fiduciary liability insurance policies solve this problem by providing coverage for voluntary compliance program expenditures. These expenditures are subject to a policy sublimit that is part of the aggregate limit of the policy, typically ranging from $50,000 to $250,000. Under this sublimit of coverage, the insurance carrier essentially allows the insured to make a claim against themselves and seek reimbursement from the insurer.

PRACTICE POINTER: The voluntary compliance coverage should cover both the expenses of attorneys and accountants to evaluate and investigate the possible regulatory non-compliance, as well as the fees, penalties or sanctions paid to the governmental authority under an authorized voluntary compliance program.

This coverage has become the most utilized fiduciary liability insurance feature in recent years. An employee benefit plan should consult its broker or insurance adviser to ensure that its fiduciary liability policy has an adequate voluntary compliance sublimit.

4. Regulatory Penalties:

Most professional liability insurance policies are not designed to cover penalties. The typical policy will define "loss" or "damages" to exclude any taxes, fines or penalties that are not affirmatively covered in the policy. The problem for fiduciaries of employee benefit plans, however, is that they face individual liability from penalties under ERISA and several recent statutes, and these penalties cannot be paid out of plan assets. Fiduciary

liability insurance companies have filled that void by providing coverage for certain penalties faced by employee benefit plans. But note: A penalty will not be covered unless specifically stated as covered under the policy, typically by endorsement, since the policy will otherwise exclude all penalties. [Miscellaneous penalties can sometimes be covered pursuant to endorsement, which is discussed later.]

The typical fiduciary policy will provide coverage for the following types of penalties:

1) Section 502(i): Section 502(i) of ERISA permits the DOL to assess a five (5) percent civil penalty against a party in interest who engages in a prohibited transaction with respect to an employee benefit plan.

2) Section 502(l): Section 502(l) of ERISA requires that, in the event of a fiduciary breach, the DOL assess a civil penalty of twenty (20) percent of the amount of settlements or courts orders against a breaching fiduciary or any other person who participated in the breach. The DOL has increasingly interpreted Section 502(l) to afford it no discretion not to impose the penalty when its investigation reveals that there may have been a breach of fiduciary duty.

3) Section 502(c): Section 502(c) of ERISA imposes penalties for alleged failures by the plan or administrator to respond to written requests for plan information. Section 502(c) provides for penalties for an administrator's refusal or failure to supply required information. The DOL is authorized to assess penalties of at least $100 a day [now indexed for inflation every year] from the date of refusal or failure, and every violation is treated separately for purposes of calculating the penalty. 502(c) claims are common claims because many benefit claims contain a tag-along reporting allegation. Section 502(c) became even more valuable with the reporting requirements of the Pension Protection Act of 2006, as these penalties are codified to be enforced under ERISA Section 502(c). Some carriers label this coverage "Pension Protection Act" coverage, but ensuring that your plan has a sublimit of coverage for 502(c) penalties will provide the necessary cover.

4) HIPAA: In 2008, the Health Insurance Portability and Accountability Act of 1996 "HIPAA" privacy and security rules were broadened by the enactment of the Health Information Technology for Economic and Clinical Health Act "HITECH". One of the significant changes in the final rule is the expanded scope of the Department of Health and Human Services "HHS" enforcement authority, including civil monetary penalties up to an annual maximum for identical violations of $1.5 million.

PRACTICE POINTER: The key for HIPAA coverage is to ensure that your carrier provides cover for both HIPAA's privacy and security rules, as some policies only refer to the privacy rule.

Many carriers will provide $25,000 to $100,000 for HIPAA violations. This will not be adequate to cover alleged intentional violations, or multiple violations in the same calendar year. If you have a health or welfare plan, you need at least $1.5M in HIPAA coverage, and should try to secure full policy limits if possible.

5) PPACA: The Patient Protection and Affordable Care Act "PPACA," also known as "ACA," and generally referred to as Obamacare, amended and expanded ERISA and the Public Health Service Act "PHSA" by incorporating PPACA coverage mandates for individual, group, self-insured and fully insured employer-sponsored health plans into Section 715 of ERISA. Various regulatory agencies have implemented penalties for PPACA violations. For example, the IRS may assess excise taxes upon group health plans (and church plans) that do not comply with PPACA insurance market reforms. HHS also enforces PPACA insurance market reforms against non-federal governmental plans and may assess penalties. Some carriers refer to this important penalty coverage as "Health Care Reform Coverage."

6) IRC Section 4975: Section 4975 of the Internal Revenue Code "IRC" gives authority to the IRS to assess excise taxes for prohibited transactions, such as the failure to remit contributions within the prescribed time frame. Section 4975 penalty coverage is becoming more important with the increased enforcement of contribution deadlines.

7) Social Security Death Master File Penalties: Although somewhat obscure, Section 203 of the Bipartisan Budget Act of 2013 established penalties of $1,000 to $250,000 per person for improper disclosure of confidential social security and other information in the Social Security Death Master File.

D. What is Not Covered: Policy Exclusions and Other Coverage Limitations

A fiduciary liability policy is designed to cover claims against covered fiduciaries for claims brought by third parties alleging breach of fiduciary duty or negligence in the administration of the plan. With some exception [i.e., see the section on coverage for benefit overpayment miscalculations], the fiduciary policy is not designed to cover plan mistakes, but liability to third parties. This is an important distinction in understanding the liability coverage provided.

As professional liability policies have evolved, policy coverage has become more comprehensive. With this trend, the number of exclusions has declined. But that is not the only place in the policy in which coverage can be reduced or excluded. Indeed, a fiduciary liability insurance policy contains coverage limitations that can be found in the policy exclusions, the definitions section of the policy, including the policy's definitions of "wrongful act" and "loss," or even the Conditions sections of the policy.

The fiduciary policy has five key possible exclusions: (1) benefits due exclusion; (2) conduct exclusions; (3) failure to fund/contributions exclusions; (4) pending or prior litigation exclusion; and (5) insured versus insured exclusion.

1) Benefits Due Exclusion: The most common claim against trustees of benefit plans are claims for benefits, which often comes in the form of a breach of fiduciary duty claim. For example, plan participants often claim that their monthly pension payment was inaccurately calculated, or that a medical bill was improperly excluded by the plan. Benefits due to participants will be excluded from coverage in either the benefits due exclusion, or the definitions of "loss" or "damages" in the policy in which "benefits" are defined. The reason for the exclusion is that the policy is not designed to pay contractual obligations of the plan, but rather is intended to defend a plan and its officials from claims relating to alleged improper denial of benefits. Stated differently, the insurance policy will not pay the actual benefit, but will defend claims relating to benefits.

As noted above, benefits due exclusions exclude only indemnity payments for the contractual obligation to pay the benefit. 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, but the plan would have to pay any settlement or judgment awarding the retiree the underpaid portion of their distribution, which constitutes the benefits due under the plan. Although rare, the benefits due exclusion will not apply under most policies to the extent that recovery of such benefits is payable as a personal obligation of an individual insured person.

As more pensions plans offer defined contribution benefits with individualized accounts, a frequent claim is that a plan official failed to follow the investment instructions of a participant, leading to an alleged investment loss or forfeited gain. An important exception to the benefits due exclusion is required to address a drop in value of individual accounts. The exclusion should provide an exception or affirmative coverage for "loss in the actual

accounts of participants in a plan by reason of an alleged breach of fiduciary duty resulting from a change in value of the investments held by a Plan."

2) Conduct Exclusions: Like most errors and omissions or directors and officers insurance policies, the primary conduct exclusions in the fiduciary policy are the "fraud" and the "personal profit or advantage" exclusions.

Fiduciary policies typically exclude coverage for liabilities resulting from the fraudulent acts of the insured and the insured's willful statutory violations. Fraud exclusions vary widely. Some policy forms exclude claims brought about or contributed to by the "dishonest" or "fraudulent, dishonest or criminal" acts of the insureds. Other forms exclude "deliberately fraudulent" or "deliberately dishonest" conduct, a "willful violation of law" or the "intent to cause injury."

The fraud exclusions in most fiduciary policies do not apply until some triggering event evidencing guilt of the insured has taken place. In other words, the policy enforces the principle of "innocent until proven guilty." Even then, however, the triggering condition for the applicability of this exclusion varies as well, with most forms requiring a judgment or other final adjudication that first establishes that the requisite improper conduct actually occurred. Other forms, in contrast, merely require the requisite conduct to have occurred "in fact," and a small minority of forms has no explicit triggering condition at all. For those forms that require a "final adjudication," courts have consistently held that the adjudication must occur in the underlying fiduciary proceeding as opposed to the coverage action, and therefore the exclusion does not apply if the claim against the fiduciary is settled. But if the exclusion does not expressly require an adjudication, the exclusion can apply to settlements.

Some newer fiduciary policy forms adopt a third type of trigger, invoking the exclusion if there is a finding in any judicial or other proceeding or an admission or statement by the insured that establishes that requisite conduct occurred. This approach requires more proof than the "in fact" trigger, but allows the insurer to invoke the exclusion even if the underlying claim is settled.

Like the fraud exclusion, most fiduciary policies also exclude claims based on or attributable to an insured trustee or other fiduciary gaining "in fact" any "personal profit, advantage, or remuneration to which they were not legally entitled." The theory

of the personal profit exclusion is to prevent an insured from benefiting financially from a relationship with the benefit fund, such as a personal gain on an investment with the benefit fund. Typically, this exclusion applies to settlements and does not require a final adjudication in the underlying E&O litigation, although if the common "in fact" language appears, the exclusion is not triggered merely by unsubstantiated allegations.

Severability of Exclusions: Conduct exclusions are also affected by the "severability" clause, which comes at the end of the exclusion section in many fiduciary policies. Like the severability provision for the policy application, the severability provision for exclusions typically states that no fact pertaining to and no knowledge possessed by any insured person shall be imputed to another insured person. Thus, an exclusion applies to a particular insured person only if they committed the conduct or are otherwise subject to the matters described in the exclusion. In other words, an exclusion would not apply to one insured person simply because it applies to another insured person. "Severability" clauses typically do not apply to any entity coverage for the benefit fund, however, since the fund generally is considered responsible for the conduct of its trustees or employees.

3) Failure to Fund/Contributions Exclusion: A key issue for defined benefit plans is whether the plan is properly funded. For underfunded plans, the insurer may add an exclusion for "failure to fund a plan" or the inability to pay benefits because of "insufficient contributions." A failure to fund exclusion can limit coverage, and should be reviewed carefully to evaluate whether coverage can be found without this significant limitation.

4) Pending or Prior Litigation Exclusion: Fiduciary policies frequently include an exclusion that bars coverage for claims arising from pending or prior litigation or from any facts or circumstances involved in such litigation. The insurers' intent is to avoid exposure for claims that the insured knew about or should have expected at the time it purchased the policy. The pending or prior litigation exclusion generally will reference a date—frequently the inception date of the policy—that is used to determine whether the litigation is "pending or prior." [See section below on how to maintain continuity of coverage].

5) The "Insured versus Insured" Exclusion: The insured versus insured exclusion is designed to prevent the moral hazard of the trust fund or certain trustees trying to convert the fiduciary policy to cash by suing other trustees. Insured versus insured exclusions are problematic for fiduciary liability policies, because trustees have co-fiduciary liability

under ERISA, and sometimes have an obligation to bring a claim against another fiduciary to remedy a fiduciary breach. The recent trend is to eliminate insured versus insured exclusions in fiduciary policies to address this issue.

PRACTICE POINTER: The introductory or preamble language at the beginning of each exclusion often determines the scope and effect of the exclusion. For example, the exclusion for bodily injury may eliminate coverage with respect to claims either "for bodily injury …" or "based upon or arising out of bodily injury …" The former is much narrower because it excludes only claims by a person who alleges bodily injury. The "arising out of" preamble to the exclusion is broader, because it could also exclude related claims that would not exist "but for" the core bodily injury claim.

E. Understanding Claims-Made Coverage

Fiduciary policies are written on a claims-made format. Subject to other policy terms and conditions, the obligation of an insurer to pay for a claim and related expenses under a claims-made policy is triggered or activated only if a covered claim is first made against the insured during the policy period or extended reporting period. Claims-made policies contrast with the more common occurrence-basis comprehensive general liability policies, which are triggered by the date of loss or when the injury occurs, even though the claim may not be made until months or years after the policy expires. Under a "claims-made" policy, the policy will cover claims that are first made during the policy period even if the underlying alleged wrongdoing occurs prior to the policy period. Stated differently, the existence of coverage is determined based upon the policy in force when the claim is made, not the policy in force when the alleged wrongdoing occurs. This type of coverage allows the insurers to estimate with reasonable accuracy soon after the end of a policy the amount of losses likely to be paid under that policy and protects insurers against unanticipated claims first made years after the policy expires.

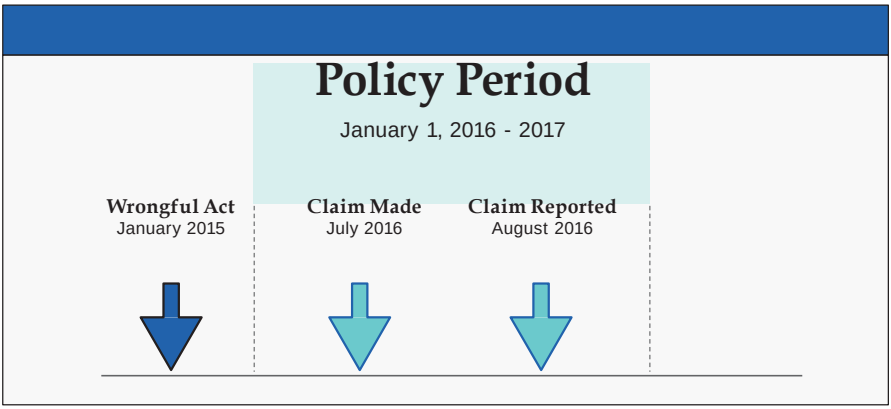
In practical terms, a fiduciary policy generally requires two things: (1) that a claim be first "made" against the insured during the policy period in order to trigger coverage; and (2) that the claim be reported to the insurance carrier within a specified time. Thus, the second key to triggering coverage is the date by which the claim must be reported to the insurer. Each policy will describe its claim reporting provisions and requirements, which can vary significantly by insurer and line of coverage.

Generally, there are two types of claims-made policies:

1) Pure Claims-Made Policy: This covers claims first made during the policy period regardless of when the wrongful act took place:

- ⇨ claim must be made against the insured during the policy period
- ⇨ wrongful act may have occurred before or during the policy period
- ⇨ allows reporting "as soon as practicable"

Under a pure claims-made policy, the insured is required to report the claim "as soon as practicable," rather than within a strict timeframe. Usually a policy will provide guidance for reporting a claim and the required timeframes.



For example, a wrongful act may have occurred in January 2015, with the claim made in July 2016 and reported to the insurer in August 2016. The 2016 pure claims-made policy would respond to the claim, even though the wrongful act took place in the prior year before the policy incepted.

2) Claims-Made-and-Reported Policy: For insurers who want more accuracy in projecting their losses and operating profitably, they will employ a claims-made-and-reported policy that place strict limitations on the time frame for reporting claims. The claims-made-and-reported policy includes specific requirements for when the claim is made and when it is reported:

- ⇨ claim made against the insured during the policy period
- ⇨ wrongful act may have occurred before or during the policy period
- ⇨ claim reported to the insurer during a designated reporting period

Both the making of a claim and the reporting of the claim are critical factors in triggering this type of claims-made policy. The reporting of the claim to the insurer must occur during a designated period, usually within a thirty (30) or a sixty (60)-day period. The designated reporting period may or may not fall within the policy period. For example, if a wrongful act took place in January 2014, with the claim made in December 2015 and reported to the insurer in March 2016, the claim would likely not be covered under the 2015 policy in force when the claim was made because of the claim reporting requirement.

F. Prior Acts Coverage and How to Maintain Continuity of Coverage

For any claims-made coverage, continuity of coverage is critical not only when switching to a new carrier, but for renewals as well if the incumbent carrier wants to limit coverage in some manner. As noted above, the policy in force when a claim is made will determine whether a claim is covered or not under the policy. Ensuring continuity of coverage involves three parts of the fiduciary policy: (1) prior acts coverage; (2) the pending or prior litigation exclusion; and (3) the "no known claims or circumstances" warranty on the application.

The **first step** to maintain continuity is to ensure that the policy provides **full prior acts coverage**. Some carriers will have a continuity date which restricts coverage for any claim relating to wrongful acts before that date. Since fiduciary decisions can be challenged years after they are made – like an investment decision made decades ago – full prior acts coverage is critical.

The **second step** is to ensure that the **Pending or Prior Litigation Exclusion** has an effective date that represents the first day on which coverage was purchased [as long as coverage has been continuously in effect]. For any event that existed prior to that date, coverage would be excluded under the pending or prior litigation exclusion even if full prior acts is provided. If higher limits are purchased, the carrier does have the right to establish a pending or prior date for the increased limits.

Finally, the **third step** is the warranty of "no known claims or circumstances" in the application. The insurer has potential grounds to void or rescind the policy if this warranty response constitutes a misrepresentation, such as if someone responsible for the plan had knowledge of something that could turn into a claim, such as a participant complaint. Most brokers advise their clients to answer a no-known-loss warranty only on the initial application and not on the renewal application. If a new business application is presented for renewal, most brokers will cross out the warranty portion of the application. Note,

however, that new warranties are still appropriate and will often be required for the purchase of new or higher limits of liability, but will only apply to those increased limits of liability.

G. Understanding Duty to Defend Coverage

The most valuable feature of a fiduciary liability insurance policy is payment of the expenses to defend a claim, which often exceeds indemnity payments under the policy. Defense coverage comes in two basic formats. "Duty to defend" coverage is the most common in modern policies. In the event a claim is made against the named insured for an alleged wrongful act, the insurance carrier providing duty to defend coverage has the duty to defend the claim, even if it is groundless, false or fraudulent. Therefore, even if the claim lacks merit, the carrier still has an obligation to defend the claim. The benefit of the duty to defend form is that an insurance carrier must pay the defense expenses incurred with respect to all allegations of a claim or lawsuit, even if only one part of the complaint involves indemnity coverage.

By contrast, a "duty to reimburse" or "indemnity" policy, used in some fiduciary policies, states that it is the insured's responsibility – not the insurance carriers obligation – to defend a claim when one occurs. Under a duty to reimburse policy, the insured controls the defense, but submits the claim expenses to the insurance carrier for reimbursement. The benefit of the duty to reimburse form to the insured is that the insured chooses defense counsel and controls the defense, and the insurance carrier simply reimburses the insured. But a duty to reimburse form does not provide a defense for non-covered claims, and could result in a messy allocation dispute.

Most insurers institute **litigation management guidelines** that must be followed in connection with the defense of a claim. It is important to discuss these requirements with the insurer at the inception of every claim. Details regarding documentation, billing, and routine communications as to the status of the matter should be addressed early to avoid problems and misunderstandings later. In order for the insurance carrier to properly evaluate and assess a claim, frequent and substantive communications from defense counsel are a must.

In some instances, even under a duty to defend coverage form, the insurance carrier may allow the insured to use their own defense counsel if pre-approved in advance of a claim. This is usually done at the time coverage is placed as part of the negotiation process. As

an alternative, a number of insurance carriers with duty to defend forms provide "panel counsel." Panel counsel consists of pre-approved attorneys used by the carrier to handle claims on their behalf. Panel counsel attorneys are highly experienced lawyers with particular expertise in ERISA and fiduciary liability. The insured receives the benefit of this expertise, and benefits from prearranged billing rates and reporting arrangements.

Not all expenses are covered. Fiduciary policies typically define defense costs as reasonable and necessary costs, including attorneys' fees, expert fees and other costs, incurred in defending or investigating a covered claim. But covered defense costs frequently exclude any compensation or benefits of directors, officers or employees of the company, or other overhead costs of the company. In-house lawyers cannot bill their time and be reimbursed under the insurance policy [or credited to the retention], even if they are saving the insurance carrier money. Defense costs also do not include any salaries of in-house or salaried lawyers.

Policy Retentions: Finally, it is important to note that the payment or advancement of defense expenses by the insurer is subject to any applicable retention amount or deductible. Retentions and deductibles are negotiated when the policy is procured, and are applied "per claim" such that each claim submitted during the policy term will incur a new retention or deductible. As noted later in the handbook, retentions should be minimal when applied to individual fiduciaries who would have to fund the retention out of their own pocket if they do not have an employer to reimburse them.

Defense Within Policy Limits: The payment or advancement of defense expenses under the policy will serve to reduce the applicable policy limit in most policies. So, the payment of $1,000,000 in defense costs, for example, will reduce the policy limit by this amount.

II. CUTTING-EDGE COVERAGE ENHANCEMENTS:

What new coverages do you need for your plan?

State-of-the-art fiduciary policies now cover more than just breaches of fiduciary duty and administrative errors and omissions. The most comprehensive policies now cover voluntary compliance programs, settlor and other non-fiduciary functions, and regulatory penalties not previously covered by insurance. Modern policies have expanded to cover liability involving recent privacy and health care legislation, as well as evolving cyber risks that all plans now face. With so many recent policy changes, insurance professionals and benefit funds need to evaluate what new coverages are right for their plans.

A. Settlor/Non-Fiduciary Coverage

Fiduciary liability policies are primarily designed to cover breaches of fiduciary responsibility. Policies were not originally designed to cover business expenses, such as establishing a benefit plan. Fiduciary policies, for example, would cover a claim for breach of fiduciary duty, but not a challenge to a settlor function, such as establishing or terminating a plan, choosing the plan design and plan features, or amending the plan, including changes in benefits.

But over time, the fiduciary versus settlor distinction has blurred. Indeed, a challenge to a plan amendment – a classic settlor function – nearly always includes a breach of fiduciary duty claim against trustees. And the settlor role is more problematic for multiemployer or some governmental plans in which the same trustees wear "two hats" to handle both fiduciary and settlor functions.

The solution is to seek coverage for **settlor functions** in a plan's fiduciary liability insurance policy. Settlor coverage is now being offered in two different ways. First, some carriers now expand their definition of "wrongful act" to provide defense costs for claims in which a trustee is sued in a settlor capacity. For example, the definition of "wrongful act" can be expanded to include acts "solely in such Insured's settlor capacity with respect to establishing, amending, terminating or funding a Trust or Plan." Alternatively, some carriers amend the definition of "administration" to include settlor-like activities, such as "choosing, changing or eliminating the Trust or Plan options." Policyholders should be careful to ensure that the language does not limit potential coverage for possible claims that can be brought against the plan trustees or fiduciaries. For this reason, the word "settlor" is the safest bet to ensure that all business decisions relating to the plan are covered.

Another solution is to seek coverage for non-fiduciary functions of plan officials. This covers any claim that could be brought in the capacity as a trustee (as opposed to their capacity as just a fiduciary). Non-fiduciary coverage is sometimes called **"Trustee Claims Expense Coverage."** Typical language expands defense coverage to "any negligent act, error or omission by an Insured solely in such Insured's capacity as a trustee of a Plan." This is the broadest way to expand coverage for settlor claims, because it does not limit the type of function that could be covered. The idea behind the non-fiduciary or trustee approach is that it provides broader coverage than just covering settlor functions. While claims are rare, non-fiduciary coverage would theoretically cover claims such as

a challenge to the fund's property lease or other non-plan function; or could cover an employment practices claim in which a trustee is named as an additional defendant. For these reasons, such coverage, while broader in scope, is typically restricted to a defense sublimit within the overall limit of liability. The best possible approach, therefore, is to seek full settlor coverage as well as the non-fiduciary/trustee defense sublimit of coverage.

Finally, a word of caution is appropriate. Settlor coverage represents expanded coverage for the plan sponsor under the same policy as the coverage for the individual trustees. It is essentially the equivalent of entity coverage in a directors and officers liability policy. Thus, the possibility exists that a settlor claim could exhaust the limit of liability and leave nothing left to protect individual trustees, many of whom are serving as volunteers, or for no additional compensation, with their personal assets at risk. Adding settlor coverage is not without risk, therefore, and plan trustees should consult with their professional broker or insurance advisor to ensure that they have adequate policy limits if opting for settlor coverage.

B. Pre-Claim Investigation Coverage

The Department of Labor has primary responsibility for regulating employee benefit plans. The DOL typically exercises this authority by conducting routine and targeted audits of plans, and has increased its number of audits in recent years. Most insurance policies have not treated DOL investigations as a covered claim under a fiduciary policy until the DOL issues "findings" at the conclusion of the investigation. The reason is that fiduciary liability insurance policies are issued on a claims-made basis. This means that the policy will cover "claims" that are first made during the policy period. The definition of "claim" generally requires a "wrongful act" or some allegation of wrongdoing. Any defense costs for responding to most regulatory investigations, prior to "findings" being made, are thus not covered under a standard fiduciary policy.

In recent years, however, many DOL audits have become more extensive. The DOL often interviews plan officials, and requests large volumes of documents. Many plans prudently hire an attorney to protect their rights during a DOL audit. For insurance purposes, another concern is that audits often take more than one year, and extend beyond any one individual insurance policy period. Plans thus face some uncertainty as to which policy should cover any ultimate liability assessed by the DOL – i.e. the policy in force when the audit began, or the policy in force when the notice of findings is issued at the conclusion of the audit.

To address these more intensive DOL audits, fiduciary liability insurance carriers have responded by offering **"Pre-claim investigation"** coverage. This is typically handled by expanding the definition of "claim" to include a pre-claim investigation, often defined as "a fact-finding investigation which does not contain an allegation of a wrongful act in writing" commenced by the DOL. With pre-claim investigation coverage, insurers will reimburse for the expense of an attorney to represent the plan during the investigation. This gives the plan access to an advocate to address concerns by the investigator.

PRACTICE POINTER: Check to see if your carrier's pre-claim investigation coverage covers IRS and Health and Human Services "HHS" audits, as many policies limit the pre-claim coverage to DOL-type audits.

Second, for investigations by other regulatory authorities, such as the Department of Justice, the Securities and Exchange Commission, or a state attorney general, carriers may grant **"Interview Coverage."** This provides pre-claim reimbursement for defense costs when an enforcement unit is conducting an investigation.

A third component of pre-claim investigation coverage is coverage for **"Benefit Claim Denials."** This provides coverage for an appeal of an adverse determination by the participant under the Department of Labor claim procedure regulations. This allows a plan to seek reimbursement for attorney fees if plan counsel is necessary to assist when a participant appeals a denial of benefits.

While insurance carriers will charge additional premium for adding pre-claim investigation coverage to a plan's fiduciary policy, this coverage enhancement can provide valuable coverage for a regulatory investigation or audit of your employee benefit plan.

C. Health Care Reform

The Patient Protection and Affordable Care Act amended and expanded ERISA and the Public Health Services Act by incorporating the PPACA's coverage mandates for individual, group, self-insured and fully insured employer sponsored health plans into Section 715 of ERISA. To enforce these new coverage mandates, health plan participants can file direct actions under ERISA sections 502(a)(1)(B) and Section 502(a)(3), the sections of ERISA under which beneficiaries have long brought benefit claims. And separate from beneficiary litigation, the DOL has implemented PPACA requirements in its health plan audit process. PPACA-related

litigation is possible, likely under section 510 of ERISA, which prohibits interfering with employee benefits and protects employees' rights to present and future entitlements.

These new causes of action under PPACA should be covered under the breach of fiduciary duty coverage of the fiduciary policy. But what would not be automatically covered are the new penalties from various regulatory agencies for PPACA violations. PPACA penalties will not be covered under fiduciary insurance unless penalty coverage is expressly carved back from the general penalty exclusion. For example, the IRS may assess excise taxes upon group health plans (and church plans) that do not comply with PPACA's insurance market reforms. For group health plans, the penalty upon a noncomplying plan sponsor is at least $100 per day [and indexed for future inflation each year] of noncompliance per affected individual, and such violation must be self-reported to the IRS on IRS Form 8928. The Department of Health and Human Services "HHS" enforces PPACA's insurance market reforms against health insurers and nonfederal governmental plans (such as state and municipal employee health plans), and may assess penalties of up to $100 per day, per affected individual, for each day of noncompliance. The Public Health Services Act "PHSA", which was incorporated into ERISA by reference, provides additional penalties, including up to $1,000 per day fines for failure to provide participants or beneficiaries with a summary of benefit and coverage explanations.

Like with section 502(c) penalties, employee benefit plans must review their policies to ensure that they have a sublimit of insurance coverage for penalties related to Health Care Reform.

D. HIPAA/HITECH

The privacy and security rules of the Health Insurance Portability and Accountability Act of 1996 "HIPAA" were broadened by the enactment of the Health Information for Technical Economic and Clinical Health Act "HITECH" in 2008. HITECH enhanced patient's privacy rights, provided individuals with new rights to obtain copies of their health information, and fortified the government's ability to enforce the law. In January 2013, the Office for Civil Rights "OCR" of the U.S. Department of Health and Human Services "HHS" issued a final rule under HITECH with significant amendments to the HIPAA privacy, information security and breach notification rules.

One of the significant changes in the final rule is the expanded scope of HHS's enforcement authority. In the final rule, HHS expanded liability by: (1) subjecting the

HITECH Act and implementing regulation violations to a Civil Monetary Penalty "CMP"; (2) subjecting business associates and all downstream contractors to direct liability for certain HIPAA violations; and (3) increasing the monetary penalties for such violations. HHS detailed in the final rule that it will establish penalties based on the degree of culpability for each violation of a given provision. The precise fine will depend on factors set forth in 45 C.F.R. section 160.408, such as the nature and extent of the violation, including the number of persons affected and time period during which the violation occurred, the nature and extent of the resulting harm, the history of prior compliance with the provision, the financial condition of the covered entity or business associate, and "such other matters as justice may require." The annual maximum for identical violations is $1.5 million.

Fiduciary liability insurance carriers have responded with penalty endorsements that are intended to reimburse employee benefit plans faced with HIPAA penalties. The key issue is whether the limit of the HIPAA coverage in your policy is sufficient to meet HHS's civil monetary penalty authority. HIPAA sublimits range from a low of $25,000 to the statutory maximum of $1.5 million. Some policies will even provide full policy limits for HIPAA to protect the plan in the event of multiple violations in the same policy year.

E. Cyber Liability Coverage

Because they depend on modern technology, benefit funds face data breach and cyber loss risks, including threats from hackers, thieves, third-party contractors, and employees. Moreover, benefit funds can also be affected by inadvertent misuse or loss of data. The fund's computer systems may also need to be shut down and operations interrupted. Most insurance professionals recommend that a fund purchase a separate cyber liability insurance policy, but the fiduciary policy may cover some cyber events.

When evaluating cyber exposure, the difference between third- and first-party claims is crucial. Third-party claims involve claims from participants, regulators or other third parties relating to alleged losses from a broad range of wrongdoing by a plan in connection with a computer system or breach of privacy due to theft, loss or misuse of data. By contrast, first-party claims relate to damages suffered by the policyholder itself. First-party cyber claims can include paying for the cost of providing notice to individuals whose identifying information was compromised and other expenses related to investigating a breach.

Employee benefit plans clearly have cyber liability exposure. The key question, however, is whether they need a separate cyber liability policy.

PRACTICE POINTER: While most brokers will advocate that a cyber policy is essential, smaller employee benefit plans needing to conserve resources may not necessarily need a separate cyber liability coverage if they can secure first-party coverage in their fiduciary policy. The reason is because many third-party claims are already covered under their fiduciary liability insurance policy.

The definition of "wrongful act" in fiduciary liability insurance policies can be quite broad, and arguably could cover many third-party data breach claims if alleged in the context of a breach of fiduciary duty or negligence in the administration of an employee benefit plan. The definition of "Administration" also broadly includes coverage for handling records, which would encompass cyber exposure. Finally, many fiduciary liability insurance policies expressly cover a plan's HIPAA exposure, which mandates that employers protect the privacy of employee medical and health-related information.

But while certain third-party claims could already be covered under a plan's fiduciary liability policy, or even its crime insurance policy, most first-party claims would not. Funds still have exposure for notification and content restoration expenses even if, as often happens, no third-party claim is asserted. Consequently, to the extent any additional cyber coverage is needed, funds at a minimum need first-party coverage, which can sometimes be provided as an additional coverage to a fiduciary policy. Indeed, some fiduciary policies offer first-party coverage to supplement the third-party coverage that may already be provided. This will not be a substitute for a full-fledged cyber policy with robust access to breach response professionals, but provides valuable coverage nonetheless to fill this critical first-party breach response gap.

F. Benefit Overpayment Coverage

Fund administrators of defined benefit plans have the primary responsibility to correctly calculate and pay each participant's retirement benefit on a monthly basis during the participant's lifetime. Although mistakes are rare, a fund is often in a quandary when it discovers that a participant or beneficiary's pension was calculated incorrectly or was otherwise paid incorrectly under the terms of the plan document. The problem for fiduciaries is that the fund trustees and plan administrators are required to fix incorrect pension calculations under Section 404(a) of ERISA in order to comply with plan documents. This correction must result in both the participant or beneficiary receiving the correct amount going forward, and the fund recouping all past overpayments (or paying all past underpayments) made to the individual, with interest.

The fund has limited options to correct an overpayment of plan benefits. The fund can attempt to reduce the affected individual future pension payment or ask the participant to pay the money back. But these options are not always workable, particularly for a deceased participant. The plan sponsor can make the fund whole. But this option does not work for multiemployer pans in which the plan sponsor is effectively the Board of Trustees, which does not have the assets to make the necessary contribution.

Whether the fiduciary liability insurance policy responds to benefit overpayment claims is murky at best and fiduciary carriers have historically been reluctant to commit to a position on the issue. The primary coverage problem is that a benefit overpayment issue rarely involves a third-party claim because no participant is going to complain about receiving too much money. A fiduciary liability policy is likely not triggered by a benefit overpayment, unless a third-party like the DOL comes in and asserts a breach of fiduciary duty. Without a claim, many fiduciary liability carriers would likely not respond to the problem. In other words, carriers will correctly assert that they provide third-party coverage for benefit overpayments claims when a participant or beneficiary is involved, but that does not mean they provide coverage for a first-party situation in which an overpayment occurs, but no claim has been made.

Euclid Specialty proactively responded to this dilemma by creating first-party voluntary overpayment coverage with a sublimit of coverage, which most leading carriers have now copied. The benefit overpayment coverage provides coverage for benefit miscalculations made by the plan (as opposed to a third-party administrator) that result in overpayment that would otherwise not be covered by the plan and cannot be recovered after reasonable effort. Even though no claim needs to be brought against the plan, the coverage is not a blank check. To recover against the sublimit, it must involve a miscalculation by the plan that cannot be recovered by the plan. The plan must attempt, for example, to seek reimbursement or offset the overpayment against future benefit payments to a participant or beneficiary. The coverage is also not designed to cover interest or other lost opportunity costs a plan may seek from a participant, or benefit overpayments that date back before the applicable statute of limitations.

G. 502(a)(3) Equitable Relief (Cigna v. Amara Surcharges)

In 2011, the United States Supreme Court issued the landmark ERISA decision in CIGNA Corp. v. Amara, 131 S. Ct. 1866 (2011). While the decision involved a challenge to CIGNA's conversion of its traditional defined benefit pension plan to a hybrid cash balance plan, the

case's significance is proving to be much broader, as expected, for future equitable relief claims. The Amara Court declared that a form of monetary compensation is available under the equitable relief provisions in ERISA section 502(a)(3), including a "surcharge" remedy upon a showing of "actual harm."

Since the Amara decision, courts continue to wrestle with equitable relief under section 502(a)(3). And although it will take time to sort out, the recent case law demonstrates that some courts will provide equitable relief to beneficiaries whose benefit claim is foreclosed under the normal 502(a)(1) avenue of relief. The question then becomes whether equitable relief is covered under a fiduciary liability insurance policy.

The vast majority of fiduciary liability insurance policies do not expressly address whether Amara-type equitable relief is covered, leaving policyholders with potential uncertainty. The uncertainty stems from the fact that a finding of equitable relief under Amara is technically not a benefit under the plan. A fiduciary carrier would likely defend the case under a claim for breach of fiduciary duty, but would the policy pay indemnity? This novel type of coverage issue should be addressed when negotiating your fiduciary liability coverage. For example, if a participant is told by a plan administrator that a surgery is covered, but the resulting bills are denied under the plan when the mistake is discovered, the participant may have an equitable estoppel claim. The claim would not represent a covered benefit, and thus coverage could be unclear unless specifically addressed. Plans should attempt to ensure that 502(a)(3) equitable claims are expressly covered under their fiduciary policy to remove this uncertainty.

H. Miscellaneous Penalties

Fiduciary liability policies typically only cover specifically defined penalties, often defined as **"Covered Penalties"** or a similar nomenclature. As regulation has increased, however, so have the types of penalties that can be imposed. The "band-aid" approach of adding penalty coverages to the policy when new penalties are developed can leave a plan exposed to a new penalty. For example, the Department of Labor's recently announced increased penalties that will be annually indexed for inflations. Their chart of applicable penalties first listed ERISA section 209(b) penalties, which arguably would not be covered under existing fiduciary penalty coverage grants. Similarly, a new penalty was created under the Bipartisan Budget Act of 2013 regarding improper disclosure or misuse of information in the Social Security Administration Death Master File computer database –

yet another penalty that would be excluded from coverage without an affirmative coverage grant.

Euclid Specialty responded to this void by offering the **Miscellaneous/Other Penalties Endorsement** as a safety net to cover any other penalty that can be assessed against an employee benefit plan, and other leading insurance markets have followed suit. This new coverage covers any penalty assessed against a plan that is insurable under applicable law and not already covered under the policy.

III. ERISA FIDELITY BOND:

What you need in your plan's fidelity bond

Fiduciary liability insurance and fidelity bonding are easily confused. A fidelity bond is a contract under which the issuer of the bond, typically a surety company or an insurance carrier, agrees to reimburse a benefit fund for losses caused by theft, fraud, or other dishonest acts covered by the bond. A fidelity bond covers losses due to *intentional* acts to deprive a benefit fund of fund assets. By contrast, a fiduciary insurance policy covers losses caused by negligence or other acts or omissions not intended to cause the benefit fund to lose assets. But unlike fiduciary insurance which is discretionary, *fidelity bonding is mandatory under ERISA.*

Who must be bonded? The ERISA standard is that each person who handles plan assets must be bonded. The ideal bond not only names the plan as the insured and covers the plan's trustees and employees, but also covers any natural persons employed by a vendor who would be required to be bonded. The reason is that fund assets are often handled by third parties. Euclid Specialty's coverage is even broader, expanding coverage to "… any other natural person who handles Employee Benefit Plan assets, whether or not required to be bonded …" With this language, coverage is automatic not only for the employees of a plan vendor, but also for the employees of entities typically exempt for ERISA's bonding requirements, such as banks and insurance companies. An employee of a non-fiduciary service provider would also be covered if they embezzle plan assets. The key provision to review is the definition of "Plan Official" or "Employee" to ensure that your bond meets the ERISA requirement.

What scope of coverage is required? The scope of coverage requirement under ERISA is "fraud or dishonesty." The bond is intended to protect the plan from loss by reason of fraudulent acts or dishonesty on the part of persons required to be bonded. Many bonds

sold by insurance companies use a lesser, different standard of coverage for "employee theft" that may not meet the higher "fraud or dishonesty" standard of ERISA. Indeed, the Department of Labor has issued findings that bonds with the standard employee theft coverage are deficient.

PRACTICE POINTER: Most plans choose their bond based on the lowest possible premium. This has led many plans to select bonds that only cover standard "Employee Theft," but do not meet the ERISA fraud and dishonesty standard. Given that fidelity bonds are so inexpensive, it is imperative to pay the small additional premium to ensure that your bond meets the broader ERISA standard.

Broader coverage is available, including for third-party computer fraud, wire fraud and forgery, which is becoming increasingly important for benefit funds operating in the modern era. Indeed, because many financial records are maintained and transactions conducted with computers, the risk is that third parties can hack into computer systems to steal plan assets. Fiduciaries should consider purchasing third-party **computer fraud, wire transfer fraud**, and **forgery** coverage to provide protection for these types of losses.

Payment Instruction Fraud: A growing threat to businesses is the rise of **"social engineering fraud"** or **"payment instruction fraud."** In these schemes, scammers use official-seeming email communications to induce company employees to transfer company funds to the imposters' account. Most crime insurers have taken the position that payment instruction fraud is not a covered direct loss because the schemes do not involve a "hacking" of the company's systems – rather the actual fund transfers are considered an indirect loss because they are voluntarily committed by an insured person with such person's knowledge or consent. Payment Instruction Fraud coverage is nevertheless crucial because of the growing number of social engineering schemes to trick plan officials into sending plan assets. This coverage will usually be sublimited and may require additional application disclosures to confirm plan controls to guard against social engineering scams.

What limit of liability is required? The bond limit is for each person required to be bonded and must equal ten (10) percent of the plan assets "handled," subject to a minimum limit of $1,000 and a maximum required limit of $500,000. This maximum limit of liability increases to $1,000,000 if a plan's assets are invested in securities of any sponsor or contributing employer, unless these investments are via a "pool" such as a mutual or index fund.

PRACTICE POINTER: The ERISA limit requirement is the maximum required, but not necessarily the correct amount for your plan. For plans with assets in the tens or hundreds of millions, or even billions, trustees should consider higher limits.

ERISA does not allow for a deductible on the "fraud" or "dishonesty" coverage for the required $500,000 or $1,000,000 limit of liability, however any additional third party coverages may contain a deductible.

ERISA compliant bonds should contain an **inflation guard provision** which provides for an increased bond limit should the plan grow in assets during the policy period, thus requiring a higher limit to satisfy the ERISA minimum limit requirement. For policies covering more than one plan on the same policy, a provision allocating ERISA's required limit to each plan should be included to ensure that a covered loss which affects more than one plan does not exhaust the limit.

IV. APPLYING FOR FIDUCIARY LIABILITY COVERAGE

Many policyholders do not want to take the time to fill out a long application for coverage. We understand that it takes valuable time. But quality policyholders should embrace the opportunity to fill out the application to explain how they run their employee benefit plans. The insurance application is an opportunity to tell your story and advocate for lower premiums and quality insurance coverage. And if you happen to have a prior claim or some plan issues, it is your chance to provide an explanation of the circumstances and any exigency that could help place your account in a better light.

In addition to the application for coverage, many fiduciary liability insurance policies deem certain documents, such as the financials of the benefit fund or other similar documents, to be part of the application for insurance. The application or "proposal form" is the formal introduction by the prospective insured benefit fund and the trustees to the insurance carrier. It is essentially an information-gathering process by which the insurer evaluates the insured as an insurance risk. Typically, the application will request at least the following information and materials: (1) benefit fund name and address; (2) a statement of total assets; (3) number of participants; (4) annual contributions for the three prior trust or plan years; (5) details on plan amendments or any anticipated benefit reductions; (6) the total number of trustees and any employees of the trust, including the names, addresses and employer affiliation of all present and former trustees from the prior six years; (7) names and years of service for the plan's professional administrator, actuary or consultant, legal

counsel, certified public accountant, custodian of assets, and investment manager for investment decisions; (8) details on current insurance program, including the limits of liability, deductibles, and other pertinent information; (9) claims history; (10) details on any claim or circumstance that an insured knows about that may give rise to a claim against insureds under the policy, including any investigation or audit by the DOL, IRS, or other governmental agency; and (11) the most recent CPA audited financial statement, including investment schedule and portfolio, IRS Form 5500 (or 990) and all completed schedules. The information contained in the application, and any other documents submitted in connection with the application, are critical to underwriting and pricing the policy.

As noted below, the most critical question on an initial application for insurance coverage is information relating to any claim, or any circumstances that an insured knows may lead to a claim under the policy. One of the most frequent sources of friction between the insured and the insurer is the warranty statement in the application. The warranty provision states that no insured person is aware of any matter which may give rise to a future claim. A warranty provision is generally included only within the application for the initial fiduciary liability insurance policy. A warranty is generally not needed in a renewal application (but may still be requested), because the insurer is already on risk for any potential claim noticed to the insurer. But if at renewal the insurer increases its limit of liability or lowers its attachment point, the insurer may require a warranty statement for the increased limit or lower attachment. In that event, insureds should seek to have the warranty expressly limited to the amount the limit of liability is increased over the lower attachment.

Warranty provisions vary among application forms in two primary ways. First, some provisions refer to known "facts, circumstances or situations," whereas other provisions refer to known "acts or omissions." The former approach may be viewed as broader because it does not require knowledge of specific conduct by insured persons which could give rise to a claim, but rather general circumstances which could give rise to a claim even though no specific wrongdoing is then known. Second, the language describing the likelihood of a future claim varies among applications. Some provisions require disclosure of known information that "might" or "may give rise to a future claim," whereas other applications require disclosure of known information only if the information is "likely" or "reasonably likely" to give rise to a claim. Although warranty language varies from carrier to carrier, it is an insured's obligation to answer such questions truthfully, in order to avoid potential voiding or rescission of the policy based on misrepresentations.

V. THE STRUCTURE OF A FIDUCIARY LIABILITY INSURANCE POLICY

A fiduciary policy is structured in several parts: the insuring agreement that defines the scope of coverage; policy definitions; exclusions; and other terms and conditions of the policy.

A. Insuring Agreement

The key provision of every insurance policy is the insuring agreement that describes the policy's grant of coverage. The fiduciary liability insuring agreement grants coverage, like most professional liability policies, to (a) "Insureds" (b) for "claims" made during the policy period (c) that result from a "wrongful act," which will be defined as the professional negligence of fiduciaries. Although the policy language may vary, the Insuring Agreement is standard in most policies. The key to look for is what might be missing in terms of ensuring that all four possible coverage grants discussed above are included in the policy. The modern development is to offer multiple insuring clauses to provide coverage for (1) fiduciary duty and (2) administration of the plan in the first insuring agreement; (3) voluntary compliance programs and (4) penalty coverages in the second insuring agreement; and sometimes (5) non-fiduciary coverage in the third insuring agreement [note that settlor coverage can be added alternatively by expanding the definition of administration or the definition of wrongful act]. Check to see that all possible coverage grants are included in your policy. Since many policy forms are outdated, some of the coverage grants, like voluntary compliance and penalty coverages, may need to be added by endorsements.

The term "trigger" refers to the events or circumstances that actuate the policy's coverage, and whether such events or circumstances fall within the policy's insuring agreement. The insuring agreement is what outlines the coverage grant under the policy. Everything flows from the insuring agreement. Think of the policy as a funnel – the insuring agreement provides the broad coverage grant, and from there, the policy gets narrower as definitions, exclusions and conditions come into play. Thus, the first step in determining coverage is to look at the insuring agreement. If the insuring agreement is not triggered, there is no coverage under the policy.

In a claims-made policy, the insuring agreement will always contain language that a claim must be made during the policy period, and the policy conditions dictate the reporting obligations for the claim. The timing and reporting of a claim determine whether and when

coverage is triggered under the insuring agreement, because nothing happens until a claim is made during the policy term and reported to the insurer in accordance with the policy's reporting provision. **Three questions** determine whether a matter falls within the insuring agreement:

(1) Is the matter a claim and if so, when was the claim first made?
(2) What are the policy conditions that require reporting the claim to the insurer?
(3) Are there allegations of wrongful act(s) as defined by the policy?

The timing of the claim is also important. In order for the insuring agreement to be triggered, the claim must be first made during the policy period. This requirement is the key to claims-made coverage. Insurers will look to when the demand, proceeding or investigation was first made, in order to determine whether the matter was made during the policy term. Insurers will also look to the policy conditions to determine the reporting requirement under the policy. Some claims-made policies provide strict reporting requirements, such as within 60 days of receipt by the insured, or by the end of the policy period. Other claims-made policies state that reporting is to be made "as soon as practicable." It is important to understand the reporting requirements under a specific claims-made policy, since claims can be denied for late reporting or if the insurer has been prejudiced by the failure to report a claim "as soon as practicable."

B. Key Definitions

1) Who is Insured? A person or entity must be an "insured" as defined under a policy in order for coverage to apply. The first category insured under the policy is the plan or trust itself. "Plan" will be defined in the policy and includes pension plans and employee welfare plans. Under many fiduciary insurance policies, the term "plan" is not confined to traditional ERISA plans and, as such, may include plans that are not subject to ERISA, such as "top hat" plans, excess benefits plans, church plans, governmental plans, and plans that are created and maintained outside the United States. The key is to verify before accepting policy terms that any plan to be insured is listed on the policy declarations or named insured endorsement, particularly if multiple plans are included in the same policy. Some brokers ask that the definition of "Plan" include any employee benefit plan that is sponsored or will be sponsored by the named insured to ensure that every possible plan is covered.

The second category covered under the policy is the trustees and the employees of the plan. The definition of Insureds under a fiduciary policy will include the trustees of the plan.

PRACTICE POINTER: The policy should cover past, present or future trustees of the plan. The reason why past or future trustees must be covered is that alleged breaches of fiduciary duty or wrongful acts can take place years before a policy is in force.

For example, a claim can arise years after a trustee has retired, but their liability does not end when they leave the plan. A former trustee can be sued in 2017 for an investment made years earlier, but still need coverage when the actual lawsuit is filed. The broad coverage for past, current or future trustees ensures that no trustee is without potential coverage. Like the coverage for trustees, fiduciary policies will cover employees of the trust or plan. This includes the plan administrator if they are employed by the plan.

While the plan, trustees and plan employees are the key parties to be insured under a fiduciary policy, other natural persons or organization may be designated as additional insureds by endorsement to the policy. But any additions should be evaluated carefully, since these parties will share the limits of potential coverage with the key fiduciaries of the plan. A fund's third-party administrator and other service providers are not normally covered for this reason, even if they are considered to be fiduciaries under ERISA. Claims filed against third-party providers are typically covered by that third-party's own errors and omissions insurance policy because their liability arises from professional services rendered for another party's plan. Nevertheless, third-party advisors occasionally ask benefit funds to be added to their fiduciary liability insurance policy as an additional insured. This should be done only after considering the risk of diluting available coverage.

PRACTICE POINTER: Do not allow administrators to be named to the plan's fiduciary policy: Require all plan service providers to secure their own TPA E&O coverage. This approach preserves policy limits for the plan's direct fiduciaries.

2) Definition of Claim: The definition of **"Claim"** typically encompasses lawsuits and usually includes written and even verbal demands for monetary or nonmonetary relief. Policies vary on whether administrative, arbitration, or investigative proceedings are covered, including what stage of the administrative investigation is considered a claim. The typical definition of claim also includes investigations by the Department of Labor. But the intent of including investigations by the Department of Labor is not to cover the expenses of routine DOL audits, which may or may not ultimately lead to an assertion of potential liability or "findings" by the regulator. To address audits before a finding or allegation of wrongdoing, some policies offer **pre-claim investigation coverage**, which is discussed above in the Cutting-edge coverage section. Finally, many definitions of claim include

criminal proceedings, but only when commenced by the return of an indictment or similar charging document. This is an important distinction, because significant time and defense expense can be incurred before an indictment is issued.

Although policies vary, claim is typically defined as: (1) a written demand for monetary or injunctive relief; (2) a civil proceeding commenced by the service of a complaint or similar pleading; (3) a criminal proceeding commenced by a return of an indictment; (4) a formal administrative or regulatory proceeding commenced by the filing of a notice of charges, formal investigative order or similar document; and (5) a written notice by the Department of Labor, the Pension Benefit Guaranty Corporation "PBGC" or similar regulatory agency of the commencement of an investigation.

The key issue is to ensure that your policy's definition of **"Claim"** covers non-monetary claims, such as injunctions, and includes the modern expansions of coverage for pre-claims investigations, regulatory interviews, and benefit claim denials. You will also need to check the related definition of **"Enforcement Unit"** to determine which regulatory agencies are covered under the pre-claim investigation coverage: specifically, does it apply to the audits by the DOL, HHS, and/or the IRS?

3) Employee Benefit Law: The definition of **"employee benefit law"** will define the scope of potential coverage for alleged fiduciary breaches. The key is to ensure that the definition includes ERISA and any state or other provisions that might apply concerning fiduciary standards of care with respect to a plan. While each law does not need to be named specifically, the definition should be comprehensive enough to provide coverage for key fiduciary statutes, including the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Newborns' and Mothers' Health Protection Act of 1996, the Mental Health Parity Act of 1996, the Women's Health and Cancer Rights Act of 1998, the Pension Protection Act of 2006 "PPA", the Multiemployer Pension Reform Act of 2014 "MPRA", the Patient Protection and Affordable Care Act "PPACA", the Health Insurance Portability and Accountability Act of 1996 "HIPAA" and the Health Information Technology for Economic and Clinical Health Act of 2009 "HITECH". Multiemployer policies, or any other policy involving a plan sponsor with union employees should include coverage for Section 301 of the Labor Management Relations Act "LMRA" relating to alleged violations of collectively bargained contracts in connection with a Plan.

Some policies will exclude unemployment insurance, Social Security, government-mandated disability benefits or similar law, but coverage should be available under the

administration coverage grant of the policy. In other words, the fiduciary policy should not cover the actual benefits, but should provide you a defense if a participant alleges that the plan mishandled these benefits on the participant's behalf.

4) Administration: The definition of **"administration"** will determine the extent of coverage grant for claims of negligence in the administration of the plan. "Administration" should be broadly defined to include: giving advice and/or counseling to participants and beneficiaries; providing interpretations; handling records; determining and calculating benefits; eligibility for benefits; distributing or filing required notices or documents (including COBRA notices); activities relating to enrollment, termination or cancellation of participants or beneficiaries under a Plan. If settlor coverage is not already provided in the definition of "wrongful act," some policies provide settlor coverage by expanding the definition of "administration" to include "any act, error or omission committed, attempted … by an Insured solely in such Insured's settlor capacity with respect to establishing, amending, terminating, or funding a Plan."

5) Wrongful Act: The definition of **"Wrongful Act"** is the key policy definition that defines the scope of coverage for the policy. You will want to make sure that **Wrongful Act** includes coverage for (a) breaches of fiduciary duty; and (b) negligence in the administration of the plan. The definition of **Wrongful Act** is also where some policies incorporate non-fiduciary and/or settlor coverage into the policy. Finally, in order for the insuring agreement to be triggered, a wrongful act or acts allegedly committed by the insured must be alleged. In other words, the claimant must accuse the insured of having done something wrong with regard to the plan and demand some relief, typically monetary damages. Usually, a wrongful act involves a breach of the responsibilities, obligations or duties imposed upon fiduciaries by an employee benefit law, such as ERISA. A wrongful act can also involve any negligent act, error or omission in the administration of a plan, such as calculating and determining benefits under the plan.

6) Loss: 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" generally includes any damages, settlements, judgments and defense costs incurred by the insureds on account of a covered claim. The seemingly broad definition of loss excludes from coverage, however, certain types of loss. For example, virtually all fiduciary policies exclude from the definition of loss fines or penalties imposed by law or matters uninsurable under the law pursuant

to which the policy is construed. Nevertheless, as discussed more fully below, the most comprehensive policies will cover certain common penalties incurred by benefit funds and Trustees, including ERISA sections 502(i), (l) and (c) and HIPAA penalties. This provision should be reviewed to ensure all newly created penalties and voluntary correction program fees are included in your policy's coverage.

C. Key Policy Terms

1) Notice Provisions: As explained above in the Understanding Claims-Made Coverage section, most fiduciary liability policies are written on a claims-made format. This means the insurance carrier pays only for claims first made against the insured during the policy period—even if the alleged wrongdoing occurred prior to the policy period. Some policies require the insurance carrier be notified no later than a defined number of days (e.g., 60 days) after the end of the policy period. Other policies are claims-made-and-reported requiring notice (1) as soon as practicable and (2) within the policy period. Claims made close to the end of the policy period may not be covered because the plan does not have sufficient time to notify the insurance carrier before the policy period ends. A better approach for the policyholder is to require notice to be "as soon as practicable." This gives the policyholder a reasonable time in which to notify the carrier, and reasonableness will vary based on extenuating circumstances for each situation.

Potential Claims: Most policies have a notice of circumstances or potential claim provision that allows a plan to report, during the policy period, circumstances that might give rise to future claims. If the claim is made later, the insurer treats it as being made at the time the notice of the potential claim was given. Importantly, the policy will require that the potential claim notice be specific and detailed in order to "lock in" future coverage. Fiduciaries considering a switch in insurance companies should evaluate whether they know of any facts or circumstances that could give rise to a future claim, and give notice of the potential claim to their current carrier before switching coverage. Otherwise, any claim that later arises could be excluded by the new carrier. The most common issue is with DOL or other regulatory audits. Other common issues are complaints by participants with respect to an alleged failure to provide plan documents or potential challenges to benefit denials. These must be noticed to the carrier to ensure that a later finding of wrongdoing is not excluded if it arises in a subsequent policy period.

Claim time limitations: The broadest fiduciary liability insurance policies provide coverage for any wrongful acts in the past – full prior acts coverage. Frequently, however, policies have a retroactive date limitation or similar language that restricts coverage to claims arising from wrongful acts occurring after a "retroactive" date. Generally, the retroactive date is:

(1) The same day that policy coverage began; or
(2) The expiration date of the expiring policy providing "prior acts" coverage.

If a policy has a provision stating that all prior wrongful acts are covered, the policy provides *full prior acts coverage*. Many policies contain no reference to the timing of prior wrongful acts, which means that these policies provide full prior acts coverage. The best practice for fiduciary policies is to require full prior acts coverage to ensure coverage for alleged wrongful acts that took place in prior years.

To prevent multiple policies from providing coverage for the same or related claims, most fiduciary policies contain *interrelated claim provisions*. These provisions provide that the same insurance policy will respond to any later claim related to or arising out of an initial claim—even if it happens years later. This prevents multiple policies from being triggered for a related incident.

2) Policy Limits: Most fiduciary liability insurance policies are subject to a single annual aggregate limit. Benefit plans need to purchase a sufficient policy limit to cover both defense and indemnity exposure. Coverage for such defense expenses normally applies in the same fashion as indemnity, that is, both are subject to the applicable deductible and any coinsurance or allocation provisions.

The overall aggregate limit of liability also applies if the insured elects the policy's **Extended Reporting Period "ERP."** The ERP is an additional period of time in which to report a claim beyond the expiration of the policy (but only for wrongful acts that occurred during the policy term.) Aggregate limits are not usually reinstated or increased by purchase of the ERP. But reinstatement of full limits may be available in limited circumstances for additional premium.

3) Retentions/Deductibles: Some fiduciary insurance policies contain a retention, deductible, or some other provision that requires an insured to bear a portion of loss before the insurer pays any portion of the loss. The clause may also provide for a single retention

applicable to claims made against several insureds for the same or related wrongful act(s). When the sum of the individual-insured retention exceeds the individual-insured aggregate deductible, only the aggregate retention applies.

The trend in modern fiduciary liability insurance policies, at least for multiemployer plans, is to eliminate any policy deductible or retention. The reason deductibles are often eliminated is that, because the plan cannot pay the deductible, fiduciaries otherwise have to pay out of their personal assets if the plan sponsor cannot or will not pay. For this reason, fiduciaries should attempt to purchase a policy without a deductible. By contrast, deductibles are more common for policies issued to for-profit plan sponsors or to governmental entities, since the deductible can be paid by the plan sponsor (or out of plan assets for the governmental plan) and is a cost-effective way to reduce premiums.

4) Defense within Policy Limits: Most policy forms clearly state that the costs and expenses associated with the defense are included in, and not in addition to, the overall limit of liability. **This means that any expenses for defending a claim come out of the overall policy limit.** Thus, it is crucial that the plan work with an experienced insurance professional or broker to evaluate the amount of coverage required, since defense costs and expenses will erode the policy limit, and can be significant when the matter involves litigation.

5) Excess Policies: Purchasing an excess policy or policies can help to ensure sufficient coverage for a plan's risk exposure. Excess policies can be purchased to create a "tower" of coverage. For example, you can start with a $10,000,000 aggregate limit primary policy, and stack additional $10,000,000 excess layers on top of the primary to create a larger available aggregate limit of coverage. A large plan with significant assets may require both a primary and several excess policies, each of which will "drop down" to provide coverage upon exhaustion of the primary policy limit. Excess policies should "follow form," which means they mirror the terms, conditions and definitions of the primary policy, except as to any terms, conditions or definitions specific to the excess policy. If the excess policy does not follow form, then the coverage of the excess policy may be more restrictive than the primary policy.

Drop-down Coverages: Excess policies can also be tailored with specific endorsements that will "drop down" to provide coverage pursuant to a sublimit if the primary policy sublimit has been exhausted. For example, if a primary policy offers a sublimit for voluntary

compliance program expenditures of $250,000, the excess policy can provide some additional sublimit of liability [i.e., a $100,000 to $250,000 excess sublimit] that will apply if the primary policy sublimit is exhausted, even before the aggregate limit of the primary policy has been exhausted. This is the primary advantage of stacking policy limits into a tower, as opposed to seeking higher limits from just one primary carrier. Stated differently, by adding an excess policy – as opposed to a higher aggregate limit from the primary carrier – the policyholder is able to increase available sublimits for penalty and voluntary compliance coverages.

6) Endorsements: Endorsements are amendments to the policy contract, and are what truly distinguish a fiduciary liability policy and make it unique to the requirements and needs of an individual plan.

PRACTICE POINTER: No plan is the same, but fiduciary liability policies can address the specific coverage needs of an individual plan by utilizing endorsements that are drafted specifically to provide coverage requested by the plan.

Common endorsements include adding penalty and voluntary compliances coverages, or other expansions of coverage. But endorsements can also remove coverage, such as when a carrier wants to restrict coverage for prior acts, a pending claim, or funding issues. The list of proposed endorsements on the policy quote should be reviewed carefully to ensure you fully understand the exact scope of coverage being provided.

VI. SELECTING THE RIGHT POLICY FOR YOUR PLAN

The two most commonly asked questions about fiduciary insurance policies are how much coverage a plan should buy, and how much should the coverage cost. Both questions should be directed to a qualified insurance broker or professional with experience in fiduciary liability insurance. Nevertheless, some general parameters are useful based on how insurance companies price benefit plan risks. The starting point for rating a fiduciary liability insurance policy is the asset size of the fund and the number of fund participants. The larger the fund and the more participants, the more insurance is needed and the more expensive the policy will be. From this initial price estimate, the insurer will increase or lower the price based on risk factors, such as the funding level and cash flow of the plan. Not surprisingly, the better funded plans will often receive premium credits based on a lower level of risk for fiduciary exposure.

A. How Much Coverage Do You Need?

The amount of insurance purchased depends predominantly on fund size and the number of participants. Funds with less than $5 million in assets generally purchase at least $1 million in coverage limits; funds between $5 and $10 million in assets generally purchase $1 to $5 million in limits; funds of $10 to $50 million in limits often purchase limits of $5 million; and funds over $50 million purchase between $5 million and $10 million. When funds reach $100 million in size, insurance professional begin to recommend $10 million in limits, and towers of excess insurance of $25 million in limits and higher for funds with $250 million and above in assets. Again, funds should seek professional advice from an experienced insurance professional.

As to pricing, insurance companies typically refer to rate per million of coverage. The rate for the initial $1 million of coverage also varies based on fund assets, the number of participants and the underwriting evaluation of risk factors, including funding level. The rate for a defined benefit or Employee Stock Ownership Plan "ESOP" plan will also be higher than a defined contribution plan, as the risk is traditionally higher (although this is changing in recent years with excessive fee lawsuits). Rates for fiduciary liability coverage range from $3,000 per million of coverage for a small fund to as high as $25,000 per million of coverage for a large fund. Again, these are only rough guidelines. In order to determine a market price, funds should retain a qualified insurance professional to seek quotes from several insurers that specialize in fiduciary liability insurance and compare results to recent benchmarking statistics.

A frequent question is whether related plans may purchase fiduciary policies in the same policy, or whether each plan needs a separate policy. Plans may either purchase insurance policies which share the limit of liability with related plans or with a dedicated limit to each plan. This decision should be made by the plan with advice from fund counsel, the administrator or the broker. The main advantage provided by sharing limits is some premium savings, however this comes with the inherent risk that the limit of liability may be exhausted by one plan leaving the related plans with no coverage. Sharing of limits is only suggested for plans with common board of trustees, or when a small single-employer plan for employees is sponsored by a covered plan on the policy.

B. How Much Penalty Coverage Do You Need?

The appropriate level of penalty coverage is complex and requires professional advice from an experienced fiduciary liability insurance broker. The Department of Labor states that the purpose of the penalties is deterrence of improper conduct. But any experienced ERISA lawyer will tell you that the DOL generally looks to the sublimit of penalty coverage in the fiduciary policy. Indeed, the DOL typically assesses a penalty no higher than the amount of the penalty coverage. Consequently, if the DOL continues to respect applicable sublimits of penalty coverage, then the risk of carrying too low of a limit is reduced for trustees facing personal liability. However, since the DOL does not publish or disclose any information on how it assesses penalties, every situation is unique and the DOL can impose any amount as a penalty. Notwithstanding, generally $100,000 to $250,000 should be sufficient penalty coverage for most funds, and $500,000 should be sufficient for large funds (with assets over $1 billion). Defense counsel should attempt to define an appropriate penalty that is not based solely on the available coverage limit. Otherwise, the DOL will continue to seek higher and higher penalties based on the available penalty coverage sublimit.

A typical fiduciary policy will cover section 502(i) and (l) penalties for the entire statutory penalty assessed by the DOL. Voluntary compliance fees and penalties under 502(c), HIPAA, PPACA and IRC Section 4975 will usually be subject to a sublimit of coverage ranging from $25,000 to $250,000, or higher when excess carriers provide additional drop-down excess sublimit coverage. HIPAA penalty coverage can vary from as low as $25,000 to the full policy limit, depending on the carrier, but any sublimit lower than $1,500,000 is not recommended.

Umbrella Penalty Coverage: Euclid Specialty offers higher limits through our unique Penalty Box Umbrella Endorsement. At least one other leading carrier has matched a limited portion of this coverage. Instead of requiring policyholders to pay for increased limits for each type of penalty coverage, the endorsement offers an umbrella of penalty coverage that sits on top of each penalty sublimit and provides additional excess coverage – up to $250,000 – when additional limits are required. The Penalty Box Umbrella Endorsement applies to voluntary compliance program expenditures, and 502(c), PPACA, and IRC Section 4975 penalties. Leading carriers also offers a Miscellaneous/Other Penalties Endorsement as a safety net to cover any other penalty that can be assessed against an employee benefit plan that is not already covered under the policy, without worrying whether or not a particular penalty is covered.

C. What Retention Should You Choose?

Most modern fiduciary liability policies covering multiemployer plans do not contain a retention amount because of individual fiduciary liability. In response to this individual liability, most fiduciary liability policies cover claims from “dollar one” with no self-insured retention or deductible. A common exception is fiduciary liability policies for governmental plans, which generally contain a self-insured retention based on the size of the plan. The rationale for imposing a retention on governmental plans is the obligation to indemnify pursuant to state law. Plan sponsors of corporate entities may also elect a retention to reduce the premium, electing to self-insure the retention layers. Importantly, when a retention is selected, the policy should specify that no retention applies to liability of natural person insureds. This means that no individual fiduciary will make a personal payment out of their own pocket when sued for their work, often on a volunteer basis, on behalf of the plan.

D. Selecting the Right Insurance Broker

Fiduciary Liability is a complex niche that requires experience and expertise. Just as a plan should select investment advisors, counsel and auditors that have other clients and deep experience with employee benefit plans, your insurance broker should also have experience in fiduciary liability policies. The broker who handles your commercial insurance coverage may not be suitable for your fiduciary policy if they lack the expertise and experience to ensure that you have the proper scope of coverage. An experienced fiduciary broker will also have the experience to guide you in the proper limit necessary to protect your plan and benchmarking to evaluate the quality of carrier to select and whether the premium is reasonable.

Finally, some brokers are provided an additional compensation, such as profit-sharing commissions, by insurance carriers for high volumes of business. Independent brokers do not let this factor influence their placement or recommendations of insurance carriers for particular accounts. However, it is appropriate that disclosure of any additional compensation be disclosed and provided to clients when requested. Policies should be placed with the most qualified insurance carrier, not the insurance carrier paying the highest overall compensation.

In sum, do not select a broker solely based on a personal relationship or a broker’s relationship with an insurance carrier, but on expertise and experience.

E. Selecting the Right Insurance Carrier

Your broker or insurance adviser will guide you in this selection. The key factors should be whether your insurance carrier is highly experienced in this complex fiduciary niche and provides a quality scope of coverage at a fair premium. Your fiduciary carrier should have a track record of experience in handling complex fiduciary claims with expertise and fairness. You want a carrier that is responsive and will help you resolve any claim efficiently.

Another important consideration is the financial stability of the insurance carrier. A.M. Best is the oldest and most authoritative insurance rating agency. The A.M. Best rating is an independent and objective opinion regarding an insurer's relative creditworthiness. As a word of caution, make sure that you are aware of all entities participating in the risk of an insurance policy, including any placement in which "captives" participate in the risk of a policy or "fronting arrangements" which change the risk participation on a policy or a program of business.

You also want independence, avoiding any conflict in which your judgment as a plan fiduciary could be questioned. For example, some fiduciary insurance markets also are investment companies that offer investment products for benefit plans. This is a potential conflict of interest, as you can be challenged for the prudence of any plan investment. You do not want to be insured by a carrier in which you also have a plan investment.

In sum, the lowest price is not the key to making a prudent choice of an insurance carrier. And whether you have heard of the insurer on television commercials should not be determinative: rather, independent expertise, market leading scope of coverage, financial stability, and experience handling complex fiduciary claims are more important.

F. Do You need Employee Benefit Liability Coverage?

Employee benefit liability "EBL" provides coverage for the liability of an employer for an error or omission in the administration of an employee benefit program, such as the failure to advise employees of benefit programs. This coverage can be purchased as part of an entity's general liability policy, usually by endorsement. A common question is whether the plan needs fiduciary coverage if they already have EBL coverage. Fiduciary coverage is more valuable than EBL coverage because a fiduciary policy provides the necessary coverage for negligence or errors or omissions in the administration in an employee benefit plan, but usually with a broader administration coverage [including if the fiduciary

policy also covers the settlor business decisions of amending or changing benefits]. In addition, the fiduciary policy also provides the broader breach of fiduciary duty coverage. Consequently, the EBL policy is not necessary when the plan purchases comprehensive fiduciary liability coverage. And conversely, fiduciary coverage is still necessary even if a plan has EBL coverage.

VII. UNIQUE ISSUES

A. Who Can Pay for Fiduciary Insurance?

ERISA does not require that a benefit fund or trustee purchase fiduciary insurance, but a fiduciary faces significant personal exposure without it. Importantly, ERISA generally prohibits a benefit fund from excusing a fiduciary from liability for breaches of duty or using fund assets to pay such liability, even if the breach was unintentional or in good faith. See ERISA Section 410, 29 U.S.C. section 1110 (Exculpatory Provisions; Insurance). And ERISA further prohibits benefit funds from paying for the defense of trustees who breach their duties to the fund. But the law permits the benefit fund to use fund assets to purchase fiduciary insurance coverage for its trustees and other fiduciaries, with one important limitation. Insurance can be purchased with fund assets only if the insurance policy entitles the insurance carrier to have "recourse" against a breaching fiduciary to recover amounts paid by the insurance carrier under the policy. In other words, the fiduciary insurance policy must provide that if the insurance carrier pays money to a benefit fund to restore losses caused by a trustee's breach of fiduciary duty to the fund, the insurer can proceed against the trustee to recover from his personal assets the money it paid to the fund. Importantly, the law does not restrict the plan sponsor from paying for the insurance, as the only limitation is on paying from plan assets unless recourse is provided.

B. Waiver of Recourse

The ERISA-mandated recourse provision discussed in the preceding section – which applies if the fiduciary insurance is paid out of plan assets – means that a breaching fiduciary's personal assets would still be at risk for all losses caused by the fiduciary notwithstanding the fiduciary insurance policy. To prevent the right of the insurer to recoup any payments from the individual fiduciary, therefore, the fiduciary liability insurance policy must include a **"waiver of recourse" provision**. A waiver of recourse "WOR" provision generally means that the insurance carrier agrees that it will not seek to recover from a fiduciary any payments made by the carrier under the policy to discharge the fiduciary's

liability. The insurance carrier must charge an additional premium for the WOR provision, which cannot be paid with the benefit fund's assets. Instead, the WOR premium must be personally paid by the fiduciary, or by an employer, the employer association, or a union. Typically, insurance companies charge a nominal twenty-five dollars WOR premium per individual fiduciary since it will normally be paid out of pocket by individuals. While small, this is the most important portion of the policy premium for a trustee to pay.

PRACTICE POINTER: It is very common for trustees to resign and be replaced during a policy term. The question often arises whether the replacement trustee needs to pay a new waiver of recourse premium. Most carriers charge WOR premium by the number of trustee positions or seats. Accordingly, a replacement trustee is covered by the WOR paid by the resigning trustee unless a new trustee position has been created. The new trustee, however, will have to pay the WOR premium at the next policy renewal.

Another question is whether WOR should be required for excess policies. If an excess policy is true following form to the primary policy – meaning that it follows all terms and conditions of the primary policy – then WOR should not be required by excess policies. Nevertheless, many brokers are conservative and do not want to create any possibility of personal liability, and may advise their clients to pay WOR for each excess layer.

Many benefit fund trustees are volunteers and do not get paid for their service on the plan board, or do not receive additional compensation for sitting on the plan committee of their employer. They often do not want to pay for the waiver of recourse out of their own pocket. But it is essential for this premium to be paid to eliminate personal recourse against you. If they do not want to pay, trustees should ask their employer to pay the waiver of recourse of premium. This is permitted, as the only entity that cannot pay is the plan itself.

C. Unique Issues for Multiemployer Plans

Multiemployers plans are governed by a board of management and union trustees, and technically do not have a plan sponsor like a single employer plan. This means that the fiduciary trustees, in addition to their fiduciary responsibilities, will also be making settlor or business decisions in deciding the amount of benefits or in making benefit changes. Settlor coverage is thus imperative for multiemployer plans. Eliminating retentions is also more important for multiemployer plans since there is no plan sponsor to pay the retention to avoid individual liability.

D. Unique Issues for Governmental Plans

Governmental plans raise unique liability issues because governmental employees in most states have protection for their actions under a state's sovereign immunity statute and/or state indemnification provisions, and thus many plans believe that they do not need fiduciary coverage. Many of the state immunity and indemnification provisions have significant limitations, however, as they are often discretionary and otherwise contain serious limitations. For example, many provisions will limit indemnification of a public official to actions in their scope of employment or a good faith limitation. Enterprising plaintiff lawyers can easily allege claims of bad faith or actions outside of a public official's authority to prevent indemnification. For these reasons, governmental plans need fiduciary liability insurance coverage – at least for claims in which governmental indemnification is not available.

The key coverage issue for governmental plans is to evaluate whether their policy covers non-indemnifiable claims. Several leading policies negate the duty to defend provision for what is often called "government-defended claims." These provisions do not provide defense to a claim when government immunity or indemnification provisions should apply. This could eliminate coverage when a claim could be defended by the governmental entity, and leave an individual without any coverage if the indemnification is somehow not provided and the policy presumes that indemnification is provided. The best scope of coverage for governmental plans, therefore, is to ensure that coverage applies irrespective of whether the plan official has access to governmental indemnification.

VIII. FIDUCIARY LIABILITY CLAIMS

A. Reporting a Claim

Fiduciary policies generally require insureds to give notice of a claim to the insurer "as soon as practicable." Some policies require the notice of claim be given no later than a defined number of days (e.g., 60 days) after the end of the policy period. Some fiduciary policies are claims-made-and-reported policies and require the insureds to give notice of the claim both as soon as practicable and within the policy period. Because fiduciary policies are "claims made," meaning the claim must be filed or otherwise first made during the policy period, insureds have relatively narrow coverage if the claim must be both made and reported to the insured during the policy period. Policyholders have broader coverage in a "claims-made policy" if they are allowed to report after the policy period any claim

first made during the policy period. Otherwise, claims made close to the end of the policy period will likely not be covered, because the insureds may not have sufficient time to give notice to the insurer of such claim within the policy period. Courts have generally upheld a failure to comply with the requirement to give notice during the policy period, even when the insurer has not been prejudiced by the insured's delay in giving notice. The best protection for a policyholder is to negotiate a notice provision that requires prejudice to the carrier before a claim can be denied. This is rarely offered, but would represent the best possible notice provision for a policyholder.

Many times, an insured will have knowledge that a claim may be asserted against it before that claim is ultimately made. Most policies have **"notice of circumstances"** or **"potential claim"** provisions that allow insureds to report, during the policy period, circumstances that might give rise to future claims. If that potential claim is actually made against the insureds at a later date, the policy will treat that subsequent claim as having been first made at the time the notice of potential claim is given to the insurer, even if the subsequent claim is made after the end of the policy period. In other words, insureds can "lock in" coverage for a potential future claim by giving notice of that potential claim during the policy period. Importantly, the policy will require that the notice of potential claim be specific and detailed in order to lock in coverage at a later date. If an insured is contemplating switching to another carrier, the insured should evaluate whether they have knowledge of facts or circumstances that could reasonably give rise to a future claim, and give notice of any potential claim to their carrier before switching coverage. The reason is that any claim that ultimately arises could be excluded by the new carrier under a prior acts or known claim exclusion.

B. Time Limitations on Notice to a Carrier

Many policy forms contain no reference to the timing of prior wrongful acts. When issued without language to the contrary, most fiduciary policies provide full prior acts coverage, regardless of the time between the wrongful act and the claim being made against the insured. Frequently, however, policies will contain or be endorsed with language that is sometimes referred to as a retroactive date limitation. Such provisions preclude coverage for claims arising from wrongful acts occurring prior to the stipulated retroactive date. Generally, insurers may apply retroactive dates in three different ways: (1) the insurer may impose a retroactive date that is the same as the policy inception date; (2) the insurer may impose retroactive dates that are the same as the expiring policy (the policy provides

"prior-acts" coverage); or (3) the insurer may choose to impose no retroactive date or provide provisions stating that all prior wrongful acts are covered (the policy provides "full prior-acts" coverage). As noted in earlier sections of this Handbook, full prior acts should be sought for fiduciary policies because fiduciaries can be challenged for decisions made years earlier.

Most policy forms contain extended reporting provisions "ERP" allowing the insureds to extend the policy's coverage to include claims first made after the policy expiration or cancellation for wrongful acts occurring on or after the policy's retroactive date and before the policy's expiration or cancellation. Such provisions are especially desirable in the event of policy cancellation or nonrenewal, or when a renewal policy contains a retroactive date later than the retroactive date of the expired policy. Extended reporting periods are desirable because they give insureds some protection if coverage is canceled or not renewed by the insurer, in the event of switching coverage to a new carrier, or if a plan merges with another.

To prevent multiple policies from being triggered for related claims, most fiduciary policies contain interrelated claim provisions that provide that claims that relate to or arise out of the same or essentially the same wrongful acts as those alleged in a prior claim will be deemed to have been made at the same time as the prior claim. Although policy language varies, "interrelated wrongful acts" are typically defined to mean "wrongful acts which have as a common nexus any fact, circumstance, situation, event, transaction or series of facts, circumstances, situations, event or transactions." Another approach is to provide that "more than one claim involving the same wrongful act or interrelated wrongful acts shall be deemed to constitute a single claim," deeming the claim made at the time when the first claim regarding the interrelated wrongful act was made against the insured. While these clauses have obvious benefits for insurers, insureds also benefit by avoiding additional retentions or deductibles to the extent that claims asserted after a particular policy has expired relate to a claim that was asserted during the policy period.

Further, most fiduciary policies also contain an exclusion for a claim that is based on or arises out of wrongful acts alleged in a claim reported to a previous fiduciary insurer. Thus, the "interrelated" claims language may preclude coverage under a later fiduciary policy that has unimpaired limits of liability in favor of coverage under a prior policy whose limit of liability may be impaired or exhausted.

The key issue for determining whether claims are "interrelated" is whether the claim made after the policy expires is "causally connected" to the initial claim made during the policy period. Similarly, broadly drafted interrelated wrongful acts language may trigger application of a retroactive date exclusion if a claim involves allegations of wrongful conduct occurring both before and after the retroactive date.

C. Reservation of Rights Letters

When an insurer first receives notice of a claim or suit against its insured, the insurer must promptly do one of the following: (1) acknowledge receipt of the notice and advise the insured that it will provide coverage; (2) advise the insured that it will defend the insured subject to a reservation of its right to deny coverage on one or more specified grounds; (3) enter into a Non-Waiver Agreement with the insured; (4) deny coverage on the grounds that the claim is either not covered under the policy, or that the insured has breached a policy condition; or (5) rescind the policy if it appears that the policy was procured through fraud, mutual mistake of fact, or the insured's misrepresentation or concealment of material facts in the application.

When a policyholder's claim appears to be within the scope of coverage under the policy, the insurer may acknowledge the claim and indicate to the insured that coverage will be provided. Because an insurer who defends an insured without raising any defenses to coverage may later be estopped from asserting any defenses to coverage, the most prudent course of action for an insurer in cases in which coverage is questionable is to defend the insured or reimburse defense costs subject to a reservation of rights and, if appropriate, seek a declaratory judgment determining the obligations of the insurer. A reservation of rights letter should fairly inform the insured of the insurer's coverage position and will enable the insurer to fulfill its duty to defend (or reimburse, depending on the policy) the insured while preserving the insurer's rights to assert defenses to coverage in a declaratory judgment action.

A reservation of rights letter should either quote or make specific reference to the policy provisions that are the basis for the insurer's reservation or the right to assert that there is no coverage for the claim. Potential defenses known to the insurer that are omitted from the reservation of rights letter may be waived. If further investigation is required to ascertain whether coverage is available, the reservation of rights letter should state that the insurer reserves the right to disclaim coverage based on further factual development. And if

additional grounds for a potential denial of coverage come to light either during the course of discovery in the underlying lawsuit or during the insurer's investigation of a claim, the insurer may supplement its reservation of rights letter to add newly discovered coverage defenses.

D. Understanding Consent to Settle: The "Hammer Clause"

Most policy forms require the insurer's consent for the settlement of claims, with the caveat that such consent shall not be unreasonably withheld. Many fiduciary policies also contain language giving the insurer the right to recommend settlement, with refusal by the insured to settle resulting in restrictions on the amounts recoverable under the policy. These **consent to settle provisions** are commonly referred to as **"hammer" clauses**. These provisions provide that if the insured rejects the insurer's recommendation to settle a claim and instead chooses to continue to litigate, the insurer's liability is "capped" at the amount for which the claim could have been settled, including defense costs incurred prior to the date such a settlement is refused. Some policies, for example, will cap the insurer's liability at seventy or eighty percent of potential liability. The idea is to encourage the insured to settle when the opportunity is presented.

Although the rationale for refusing to settle is often asserted as wanting to avoid "copycat" claims or to achieve "vindication" at trial, such rationale is misplaced. "Copycat" suits are almost always a non-issue, and trials come with the risk of placing the outcome of the matter into the hands of a jury, where the outcome is unknown and is public record when a judgment is entered. In contrast, settlement provides finality, and can be achieved with confidentiality provisions drafted into the settlement agreement. Nevertheless, hammer clauses can be problematic in benefit claims, because a benefit plan may have an interest in litigating an individual benefit claim beyond the value of the claim to set helpful precedent and to avoid other participants from pursuing a similar claim.

IX. CHECKLIST OF KEY COVERAGE PROVISIONS:

What you need in your Fiduciary Liability Policy

The following is a helpful checklist to use as a guide in reviewing your fiduciary policy or any fiduciary proposal.

Policy Terms and Provisions

- ⇨ **Limit of Liability**: Do you have an adequate limit of liability? If settlor or entity coverage for the plan is included, have you increased your limit to ensure that individual liability is protected? Have you considered an excess policy with another insurer to create additional limits and maybe even drop-down coverage for coverages that have a sublimit, such as penalty coverages or voluntary compliance coverages?

- ⇨ **Retention:** Do you have a retention for individual liability of natural person insureds?

- ⇨ **Who is Insured:** Do you have coverage for all sponsored plans? Do you have coverage for past, present and future trustees and fiduciaries? Do you have coverage for the benefit plan committee?

- ⇨ **Definition of Claim:** Is your definition of claim broad enough to cover non-monetary claims and criminal proceedings?

- ⇨ **Duty to Defend Provision:** The duty to defend will ensure that you have defense coverage for the entire lawsuit even if only part of the lawsuit is covered under the policy.

- ⇨ **Selection of Counsel:** Do you have the right to select your own counsel, or will you have to select from an insurer panel counsel list? Many of these attorneys are experienced and have fiduciary expertise, but they have less experience with your plan. The benefit is that many of these law firms have negotiated lower rates in exchange for the promise of a volume of business. Some carriers will allow both duty to defend and choice of counsel. Others will allow you to negotiate for your preferred counsel in the policy proposal, but not typically after the claim has been tendered.

- **ERISA Section 502(c)(3) Relief:** Does your policy affirmatively cover equitable relief or surcharges based on claims of estoppel?

- **Definition of Administration:** Is your policy's definition of **Administration** broad enough to cover giving advice and plan interpretations to participants; determining and calculating benefits; providing plan notices, including COBRA notices; and activities related to enrollment, termination or cancelation of participants and beneficiaries?

- **Definition of Employee Benefit Law:** Does your policy cover ERISA and any other fiduciary law, including state law for governmental plans, as well as other statutes that include fiduciary responsibility, like the Pension Protection Act, COBRA, the Mental Health Parity Act, PPACA, etc.?

- **Definition of Loss:** Does your definition carve back fines and penalties enumerated above? Does your **Loss** definition provide coverage for punitive damages if allowed by applicable law?

- **Definition of Wrongful Act:** Does your definition of **Wrongful Act** include the key coverage grants of breach of fiduciary duty and negligence in the administration of the plan? Check to see if any non-fiduciary defense coverage or settlor coverage is included in this definition. Does your policy cover voluntary compliance programs?

- **Are Claims Expenses in the Policy Limit?** Defense expenses are usually part of the aggregate limit, but it is sometimes possible to seek a defense limit outside the policy's aggregate limit of liability.

- **Cooperation Clause:** Review what will be required to cooperate with your insurer in the event of a claim.

- **Consent-to-Settlement/Hammer Clause:** Does your policy include a hammer clause? If it does, what percentage does your insurer require you to pay of any eventual settlement or verdict if you do not agree to a proposed settlement?

- **Spousal Coverage Extension:** Usually standard, but make sure your policy coverage extends to spouses of insureds.

- **Extended Reporting Period:** ERISA has a six-year statute of limitations. If you have a severe claim, it may be difficult to continue with broad fiduciary coverage. That is when you will want to purchase an extended reporting period for an additional period of time in which to provide notice of claims. Find out whether you have a right to an ERP, and if you can negotiate upfront a longer period than one year.

- **Right of Termination or Rescission:** Does your insurer have the right to terminate the policy for anything other than non-payment of the premium? If the policyholder terminates the policy early, do they have to pay short-rate penalties? Finally, what right does the insurer have to rescind the policy?

- **Severability:** Do you have a severability provision providing that any misrepresentation or knowledge possessed by an insured will not be imputed to any other insured for purpose of determining whether coverage is available?

- **Policy Warranty:** What warranty or representation did the plan provide in applying for the insurance policy or renewal?

- **Notice of Claim Provisions:** How long do you have to report a claim? Are you limited to claims reported within the policy period?

- **Related Claims:** Will claims that are related, even if brought in subsequent years, be consolidated and considered one claim for purposes of coverage? How is **"Related Claims"** defined?

- **Coverage Territory:** Does your policy apply to claims brought anywhere in the world?

- **Other Insurance Clause:** This clause is more typically a separate condition, stating that if loss is insured under any other valid policy, then no coverage exists under the fiduciary policy. The intent is to defer to the other insurance as the primary insurance for that risk, or not cover at all risks typically covered by other forms of insurance. Some policy forms apply this exclusion only to the extent of payment under the other policy, only to other "valid and collectible" insurance, or only up to the amount of such other insurance. The intent of this other insurance provision is to render the fiduciary policy in excess of the other insurance available to the insured.

- **Allocation:** How will coverage for non-covered claims be allocated in the event of any settlement or verdict?

- **Waiver of Recourse:** If premium is paid out of plan assets, does the Insurer have the right of recourse required under ERISA? Have you included a waiver of recourse premium to remove the right of recourse by the insurer against individual insureds?

Policy Enhancements

- **Pre-Claim Investigation Coverage:** Do you have affirmative coverage for your attorney fees in assisting with an audit or investigation commenced by an Enforcement Unit such as the DOL, HHS, IRS or PBGC which does not allege any wrongdoing or breach of fiduciary duty? Do you have coverage for interviews or other requests for statements brought by Enforcement Units?

- **Penalty Coverages:** Check to see if your policy covers key penalties that can be assessed against the plan: ERISA 502(c) reporting penalties, including penalties under the Pension Protection Act [included separately or as part of 502(c) penalties]; HIPAA penalties, including the HITECH amendment to HIPAA [make sure both privacy and security rules of HIPAA are covered]; Health Care Reform/ PPACA; IRC Section 4975. Do you have the new coverage for miscellaneous penalties that can be assessed against the plan? What about umbrella coverage for additional limits for applicable penalties?

- **Voluntary Compliance Program Coverage:** Do you have coverage for IRS and DOL voluntary compliance programs? Are you covered for attorney fees in handling voluntary compliance program applications? Do you have an adequate sublimit? Can this sublimit be reinstated during the policy period if otherwise exhausted by one claim?

- **Non-Fiduciary/Settlor Coverage:** Do you have defense coverage for non-fiduciary claims? What about settlor coverage: check the definition of **Wrongful Act** and **Administration** to see if settlor coverage is included.

- **Benefit Overpayment Coverage:** Do you have a first-party sublimit of coverage for benefit miscalculations that result in an overpayment to participants?

- **Cyber Coverage:** Although likely silent, most policies will have some cyber coverage for claims brought by third parties, but check to make sure cyber events are not excluded from coverage. The most critical cyber coverage is first-party coverage for notification to plan participants: check to see if your fiduciary carrier will offer this coverage.

Policy Exclusion Terms

- **Prior Acts/Continuity:** Do you have full prior acts coverage and continuity of coverage? Check for any prior acts date, continuity date or retroactive date.

- **Pending or Prior Litigation Exclusion:** To ensure full continuity of coverage, is the pending or prior litigation date back-dated to the first issued fiduciary policy?

- **Conduct Exclusions [Personal Profit/Dishonesty Exclusions]:** Are these exclusions limited by the requirement to be established by a final, non-appealable adjudication in the underlying proceeding [and not a coverage action by the insurer]?

- **Bodily Injury Exclusion:** Does it preserve defense coverage for the defense of a claim for violation of an employee benefit law by an insured?

- **Benefits Due Exclusion:** Does the benefit due exclusion provide for defense coverage for benefit claims? Does the policy include coverage for drops in value of individual accounts of defined contribution plans?

- **Severability of Exclusions:** Does your policy provide that no facts pertaining to or knowledge possessed by an insured will be imputed to any other insured?

X. CONCLUSION

Sponsors face increasing risk for providing quality employee retirement and health benefits, and plan officials face personal liability under fiduciary responsibility law. The most effective way to protect the plan and its officials is with a quality fiduciary liability insurance policy. This Handbook can guide you in ensuring that your policy provides the quality protection you need.

ABOUT EUCLID SPECIALTY MANAGERS, LLC

Euclid Specialty is an insurance underwriting company that specializes in providing the highest quality fiduciary liability insurance and crime coverage for employee benefit plans, from non-profit, multiemployer and governmental trusts to employee benefit plans sponsored by for-profit companies. We are a team of experts and thought leaders who have decades of experience in complex fiduciary liability underwriting and claims. Euclid Specialty is the prudent choice for America's best employee benefit plans. Learn more at euclidspecialty.com.

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PLEASE NOTE: This Handbook is a reference guide and is not a substitute for the advice and counsel of an experienced broker, insurance adviser or legal counsel. It does not supersede the terms and conditions of any insurance policy. Please refer to any issued policy, as coverage will be dictated by the policy's specific terms and conditions.

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