2011 End of Year Plan Sponsor "To Do" Lists

In this issue we provide seven "to do" lists that may require you to take action before the end of 2011 or in early 2012. For your convenience, we have broken the "to do" lists into seven categories (accessible via the menu on the left).

All Qualified Plans "To Do" List

- **Adopt Design Changes by the End of the Plan Year**: If you made any design changes to the plan during the year, you generally must amend your plan to reflect those design changes by the last day of the 2011 plan year (*i.e.*, December 31, 2011 for calendar year plans).
- **Adopt Plan Restatement if in Cycle A**: If your qualified plan is individually designed and falls in Cycle A (*i.e.*, the employer identification number associated with the plan ends in 1 or 6) you must restate the plan and submit the plan for a determination letter on or before January 31, 2012.
- **Comply with Form 8955-SSA Reporting Requirements**: Form 8955-SSA is a new form that replaces the Schedule SSA of the Form 5500. The Form 8955-SSA reports information about plan participants with deferred vested benefits. Generally, the Form 8955-SSA is due by the last day of the seventh month after the plan year ends (subject to a 2-1/2 month extension). Due to the late release of the Form 8955-SSA, the IRS delayed the due date for the 2009 and 2010 Forms 8955-SSA. The 2009 and 2010 Forms SSA are due by the later of (1) January 17, 2012 or (2) the due date that generally applies for the Filing of Form 8955-SSA for the 2010 plan year.
- **Review 2012 Plan Limits:** Familiarize yourself with the 2012 plan limits. See "*Retirement Plan Limits for 2012*" for more information.

Section 401(k) Plans "To Do" List

- **Comply with Items on All Qualified Plans List**: The items on the All Qualified Plans list also apply to Section 401(k) plans.
- **Provide Section 401(k)/401(m) Safe Harbor Notice by December 2, 2011 for Calendar Year Plans**: As a reminder, if your plan has a Section 401(k)/401(m) contribution safe harbor, you must provide the safe harbor notice at least 30 days, but not more than 90 days, before the beginning of each plan year (*i.e.*, December 2, 2011 for calendar year plans).
- **Provide Annual Automatic Enrollment Notice by December 2, 2011 for Calendar Year Plans**: As a reminder, for those of you who have adopted an automatic contribution arrangement, an eligible automatic contribution arrangement ("EACA"), or a qualified automatic contribution arrangement ("QACA"), or any combination thereof, you must give an annual automatic enrollment notice at least 30 days, but not more than 90 days, before the beginning of each plan year (*i.e.*, December 2, 2011 for calendar year plans).
- **Provide Annual Qualified Default Investment Alternative Notice by December 2, 2011 for Calendar Year Plans**: As a reminder, for those of you who are relying on the qualified default investment alternative ("QDIA") safe harbor, you must give an annual notice at least 30 days, but not more than 90 days, before the beginning of each plan year (*i.e.*, December 2, 2011 for calendar year plans).
- **Provide Participant Benefit Statements**: Defined contribution plans must provide individual benefit statements at least annually, although plans that permit participants to direct the investment of their accounts must provide the statement at least quarterly. Defined contribution plans must also provide the statement upon request.
- **If Adding Qualified Automatic Contribution Arrangement or Eligible Automatic Contribution Arrangement for 2012, Adopt Amendment Before the 2012 Plan Year**: Neither a QACA nor an EACA may be adopted mid-year. Accordingly, if you wish to add a QACA or an EACA to your plan for the 2012 plan year, you must adopt an amendment by December 31, 2011 for calendar year plans.

- **Comply with Required Minimum Distribution Waiver for 2009**: The Worker, Retiree, and Employer Recovery Act of 2008 waived required minimum distributions ("RMDs") for 2009. Plan sponsors must adopt conforming amendments by the last day of the first plan year beginning on or after January 1, 2011 (*i.e.*, December 31, 2011 for calendar year plans) to reflect the waiver of 2009 RMDs. See "*IRS Issues Additional Guidance on the Waiver of 2009 Required Minimum Distributions*" in our November 2009 Employee Benefits Update for more information.
- **Adopt In-Plan Roth Conversion Amendments**: The Small Business Jobs Act of 2010 permits participants in Section 401(k) or Section 403(b) plans to convert pre-tax amounts into after-tax amounts, commonly called "Roth amounts" inside a plan. Sponsors of 401(k) plans may offer in-plan Roth conversions beginning on or after September 27, 2010. Plan sponsors that allowed participants to convert pre-tax amounts into after-tax amounts during 2010 or 2011 must amend their plans by December 31, 2011.

Defined Contribution Plans (Other Than Section 401(k) Plans) "To Do" List

- **Comply with Items on All Qualified Plans List:** The items on the All Qualified Plans list also apply to defined contribution plans.
- **Provide Annual Qualified Default Investment Alternative Notice by December 2, 2011 for Calendar Year Plans:** As a reminder, for those of you who are relying on the qualified default investment alternative ("QDIA") safe harbor, you must give an annual notice at least 30 days, but not more than 90 days, before the beginning of each plan year (*i.e.*, December 2, 2011 for calendar year plans).
- **Provide Participant Benefit Statements**: Defined contribution plans must provide individual benefit statements at least annually, although plans that permit participants to direct the investment of their accounts must provide the statement at least quarterly. Defined contribution plans must also provide the statement upon request.
- **Comply with Required Minimum Distribution Waiver for 2009**: The Worker, Retiree, and Employer Recovery Act of 2008 waived required minimum distributions ("RMDs") for 2009. Plan sponsors must adopt conforming amendments by the last day of the first plan year beginning on or after January 1, 2011 (*i.e.*, December 31, 2011 for calendar year plans) to reflect the waiver of 2009 RMDs. See"*IRS Issues Additional Guidance on the Waiver of 2009 Required Minimum Distributions*" in our November 2009 Employee Benefits Update for more information.

Defined Benefit Plans "To Do" List

- **Comply with Items on All Qualified Plans List:** The items on the All Qualified Plans list also apply to defined benefit plans.
- **Post Portions of Form 5500 on Company's Intranet:** The Pension Protection Act of 2006 requires a sponsor of a defined benefit pension plan that maintains an intranet website for the purpose of communicating with employees (and not the public) to post portions of the defined benefit plan's Form 5500 on the intranet. This new requirement first applied to the 2008 Form 5500.
- **Comply with Annual Funding Notice to Participants:** The Pension Protection Act of 2006 requires single employer defined benefit plan sponsors to provide participants with an annual notice of the plan's funding status within 120 days of the end of the plan year to which the notice relates. Plans with fewer than 100 participants do not have to provide the notice until the Form 5500 annual report is due for the plan year.
- **Comply with Participant Notice Requirement if Adjusted Funding Target Attainment Percentage is less than 80%:** In addition to the annual funding notice described above, Section 101(j) of ERISA requires a plan administrator to provide a notice to participants if the plan is subject to a restriction on payment of benefits. These restrictions become applicable if the plan's adjusted funding target attainment percentage is less than 80%. Plan administrators are not required to provide this notice to participants and beneficiaries in pay status.

- **Comply with PBGC Notice Requirement if Funding Target Attainment Percentage is less than 80%:** Plan sponsors of defined benefit plans are required to notify the PBGC if the plan has a funding target attainment percentage of less than 80%. This filing is due within 105 days following the end of the plan sponsor's fiscal year, which is April 15, 2012 for calendar year taxpayers.
- **Provide Participant Benefit Statements:** The Pension Protection Act requires defined benefit plans to provide individual benefit statements every three years or upon request. Alternatively, defined benefit plans may satisfy the requirement by annually notifying participants that the pension benefit statement is available and how a participant may obtain such statement.
- **Amend Plans to Comply with Funding-Based Benefit Restrictions of Section 436 of the Code:** IRS Notice 2010-77 extended the deadline for plan sponsors to amend their plans to comply with Section 436 of the Code, which imposes benefit restrictions on certain underfunded defined benefit pension plans. IRS Notice 2011-96, issued on November 29, 2011, further extended the deadline to adopt interim plan amendments. Plan sponsors now must amend their plans by the latest of (1) the last day of the first plan year that begins on or after January 1, 2012, (2) the last day of the plan year for which Section 436 is first effective for the plan or (3) the due date (including extensions) of the employer's tax return for the tax year that contains the first day of the plan year for which Section 436 is first effective for the plan (*i.e.*, December 31, 2012 for calendar year, non-collectively bargained plans).
- **Amend Hybrid Plans to Comply with Three-Year Cliff Vesting**: The Pension Protection Act of 2006 requires cash balance or other hybrid plans in existence on June 29, 2005 to use a three-year cliff vesting schedule for all participants who have an hour of service in a plan year beginning after December 31, 2007. IRS Notice 2009-97 extended the deadline for adopting this change until the last day of the first plan year beginning on or after January 1, 2010. IRS Notice 2010-77 further extended this deadline until the last day of the first plan year beginning on or after January 1, 2011 (*i.e.*, December 31, 2011 for calendar year plans).

Section 403(b) Plans "To Do" List

- **Adopt Design Changes by the End of the Plan Year**: If you made any design changes to the plan during the year, you generally must amend your plan to reflect those design changes by the last day of the 2011 plan year (*i.e.*, December 31, 2011 for calendar year plans).
- **Review 2012 Plan Limits**: Familiarize yourself with the 2012 plan limits. See "*Retirement Plan Limits for 2012*" for more information.
- **Provide Safe Harbor Notice by December 2, 2011 for Calendar Year Plans**: As a reminder, if your Section 403(b) plan uses an ACP contribution safe harbor, you must provide the safe harbor notice at least 30 days, but not more than 90 days, before the beginning of each plan year (*i.e.*, December 2, 2011 for calendar year plans).
- **Provide Annual Automatic Enrollment Notice by December 2, 2011 for Calendar Year Plans**: As a reminder, if your 403(b) plan is subject to ERISA and has automatic deferrals, you must give an annual automatic enrollment notice at least 30 days, but not more than 90 days, before the beginning of each plan year (*i.e.*, December 2, 2011 for calendar year plans).
- **Provide Annual Qualified Default Investment Alternative Notice by December 2, 2011 for Calendar Year Plans**: As a reminder, if your 403(b) plan is subject to ERISA and you are relying on the qualified default investment alternative ("QDIA") safe harbor, you must give an annual notice at least 30 days, but not more than 90 days, before the beginning of each plan year (*i.e.*, December 2, 2011 for calendar year plans).
- **Provide Participant Benefit Statements**: As a reminder, plans must provide individual benefit statements at least annually, although plans that permit participants to direct the investment of their accounts must provide the statement at least quarterly. Plans must also provide the statement upon request.
- **Comply with New Form 5500 Reporting Requirements**: As a reminder, effective for plan years beginning on or after January 1, 2009, Section 403(b) plans covered by ERISA are subject to

standard Form 5500 filing requirements, including an annual plan audit for large plans (*i.e.*, plans with 100 or more participants) and detailed financial information for small Section 403(b) plans (*i.e.*, plans with fewer than 100 participants).

- **Comply with Required Minimum Distribution Waiver for 2009**: The Worker, Retiree, and Employer Recovery Act of 2008 waived required minimum distributions ("RMDs") for 2009. Plan sponsors must adopt conforming amendments by the last day of the first plan year beginning on or after January 1, 2011 (*i.e.*, December 31, 2011 for calendar year plans) to reflect the waiver of 2009 RMDs. See "*IRS Issues Additional Guidance on the Waiver of 2009 Required Minimum Distributions*" in our November 2009 Employee Benefits Update for more information.
- **Adopt In-Plan Roth Conversion Amendments**: The Small Business Jobs Act of 2010 permits participants in Section 401(k) or Section 403(b) plans to convert pre-tax amounts into after-tax amounts, commonly called "Roth amounts" inside a plan. Sponsors of 403(b) plans may offer in-plan Roth conversions beginning on or after September 27, 2010. If the Plan permitted in-plan Roth conversions, the Section 403(b) Plan must be amended by the later of (1) the end of the applicable remedial amendment period for the Section 403(b) plan or (2) the last day of the first plan year in which the amendment is effective.
- **Consider Whether to File an EPCRS Application if the Plan Sponsor Lost Tax-Exempt Status:** In June 2011, the IRS announced that approximately 275,000 organizations lost their tax-exempt status because they did not file information returns with the IRS for the last three consecutive years. The IRS has issued guidance on how such organizations can apply for reinstatement of their tax-exempt status. Only 501(c)(3) tax-exempt organizations can sponsor a 403(b) plan. Sponsors of 403(b) plans who lost their tax-exempt status should also consider whether to file an application with the IRS's Employee Plans Compliance Resolution System to correct the employer eligibility failure.

Health and Welfare Plans "To Do" List

- **Identify All Plans that Might Be Subject to the Health Care Reform Rules**: In order to comply with health care reform, you must first identify all your health plans that might be subject to any of its requirements, including, but not limited to, medical, dental, vision, wellness, employee assistance and retiree medical plans, health flexible spending accounts, health reimbursement arrangements and health savings accounts. Now would be a good time to revisit this issue to make sure you have identified all plans subject to health care reform.
- **Determine Whether Each Plan is a Grandfathered Plan and Whether You Intend to Keep Grandfathered Status**: Plans that were in existence on or before March 23, 2010 and that have not undergone significant changes since then ("grandfathered plans") have to comply with some, but not all, of the requirements under health care reform. A plan will lose grandfathered plan status if a plan sponsor: (1) eliminates all or substantially all benefits to diagnose or treat a particular condition; (2) increases coinsurance rates; (3) raises co-payments, deductibles, or out-of-pocket maximums by a significant amount; (4) lowers the rate of employer contributions by a significant amount; (5) adds or tightens annual limits; or (6) changes insurance companies if the new coverage was effective prior to November 15, 2010. If you have made any changes to your health plan in 2011, or in connection with open enrollment for an upcoming plan year, you should consider whether those changes cause you to lose grandfathered status. For example, adding a wellness feature that penalizes plan participants for failing to complete a health risk assessment or based on tobacco use may cause you to lose grandfathered status. If your plan loses grandfathered status, you will need to comply with additional requirements that apply to non-grandfathered plans as of the date you lost grandfathered status.
- **Comply With Increased Restricted Annual Limit**: As reported in our *November 2010 End of Year Plan Sponsor "To Do" Lists*, employer sponsored group health plans may continue to impose annual (as opposed to lifetime) limits on reimbursements for essential health benefits between now and January 1, 2014, but those limits must comply with regulations jointly issued by the Departments of Health and Human Services, Treasury and Labor (collectively "the Departments"). The restricted annual limit for plan years beginning on or after September 23, 2010 but before

September 23, 2011 was $750,000. For plan years beginning on or after September 23, 2011 but before September 23, 2012 the restricted annual limit has increased to $1,250,000. Annual limits are prohibited for plan years beginning on or after January 1, 2014. See *"Agencies Publish Guidance on Pre-Existing Condition Exclusions, Lifetime and Annual Limits, Rescissions and Other Patient Protections"* in our July 13, 2010 Health Care Alert for more information.

- **Provide Four-Page Summary of Benefits and Coverage**: As reported in our November 9, 2011 Health Care Alert, "*Four Page Benefits Summary Requirement For Group Health Plans Arrives in 2012*," health care reform expands ERISA's disclosure requirements by requiring that a four-page "summary of benefits and coverage" (the "SBC") be provided to applicants and enrollees before enrollment or re-enrollment in a group health plan. The SBC must accurately describe the benefits and coverage under the applicable plan. The SBC applies in addition to ERISA's SPD and SMM requirements. In August 2011, the Departments issued proposed regulations regarding the SBC. Among other things, the regulations clarify that the four-page summary may be four double-sided pages. The guidance includes a proposed SBC template and a uniform glossary. The SBC requirement takes effect March 23, 2012 and applies to initial enrollments, HIPAA special enrollments, requests for an SBC, and open enrollments occurring on or after March 23, 2012. However, the Departments issued guidance on November 17, 2011 stating that group health plans and health insurance issuers are not required to comply with the SBC requirement until the final regulations are issued. The Departments also indicated that the final regulations would likely include a compliance date that gives plans and issuers sufficient time to comply.

- **Provide 60-Day Advance Notice of Changes Impacting Four-Page Summary**: Health care reform requires group health plans to give participants 60-days' advance notice before making any material modification in plan benefits or coverage that is not reflected in the most recently provided SBC. This applies to both benefit enhancements and reductions. The Departments have informally indicated that the 60-day advance notice requirement applies to mid-year plan changes and that changes made to the SBC in connection with new plan years would be subject to different timing requirements. As indicated above, the Departments issued guidance on November 17, 2011 stating that group health plans and health insurance issuers are not required to comply with the SBC requirement until the final regulations are issued. See "*Four Page Benefits Summary Requirement For Group Health Plans Arrives in 2012*" in our November 9, 2011 Health Care Alert for more information.

- **Review Changes to Claims and Appeals Procedures for Non-Grandfathered Plans**: PPACA requires non-grandfathered health plans to incorporate enhanced internal claims and appeals requirements and external review procedures. The changes were effective for plan years beginning on or after September 23, 2010 (*i.e.*, January 1, 2011 for calendar-year plans and policies). In July 2010, the Departments charged with regulating health care reform jointly issued interim final regulations implementing these appeal processes and external review requirements. However, since that time, the Department of Labor ("DOL") issued *DOL Technical Release 2010-02 (September 20, 2010)* and *DOL Technical Release 2011-01 (March 18, 2011),* which provides enforcement grace periods for certain requirements. In addition, the Departments issued amended interim regulations *(June 24, 2011)* and the DOL issued *DOL Technical Release 2011-02 (June 22, 2011)* further revising the claims and appeals rules and easing some of the compliance requirements. The two latest pieces of guidance made the following changes to the internal claims procedures: (1) eliminated the requirement that all notices of adverse benefit determinations (including EOBs) automatically provide diagnosis and treatment codes, so long as the notice indicates that the codes and their meanings are available upon request; (2) changed the requirements for providing notices in a culturally and linguistically appropriate manner (*e.g.*, requires non-English notices only if a claimant resides in a county where 10% or more of the population does not speak English, requires that a one-sentence statement in the applicable non-English language about the availability of language services be included in the notice, requires oral language services in the applicable non-English language and eliminated the tagging and tracking requirements for future notices); (3) changed the 24-hour rule for review of urgent care claims back to 72 hours but with deference to an attending doctor's determination whether a claim is for urgent care; and (4) provided a de minimis exception to the strict adherence standard for complying with the claims procedures, provided certain conditions are met. The guidance also made the following changes to the external claims procedures, as they apply to self-funded ERISA

plans: (a) provided that, on an interim basis, only claims involving medical judgment or rescissions of coverage will be eligible for external review; (b) revised the deadline for contracting with independent review organizations (IROs) to require that plans contract with at least two by January 1, 2012 and at least three by July 1, 2012; and (c) clarified that the requirement that an IRO's decision must be binding does not prohibit a plan from reconsidering a claim and deciding to pay the claim or provide benefits. Now is a good time for non-grandfathered plans to take a second look at their claims procedures to ensure that they are consistent with the most recent guidance. Additional information will be provided in a separate newsletter.

- **Comply with Change in Medicare Part D Enrollment Period**: Employers who sponsor health plans that provide prescription drug coverage must provide an annual notice to Medicare-eligible participants regarding whether the plan's prescription drug coverage is "creditable," or in other words, whether the plan is expected to pay on average as much as the standard Medicare prescription drug coverage. In the past, plan sponsors had to distribute the annual notice of creditable or non-creditable coverage by November 15. However, because of a change in the Medicare enrollment period, plan sponsors must distribute their annual notices by October 15, beginning in 2011. See *"Reminder – Medicare Part D Notices Must be Distributed by October 15"* in our October 3, 2011 Legal Alert for more information.

- **Implement W-2 Reporting of the Cost of Employer-Sponsored Group Health Plan Coverage:** Under health care reform, employers are required to report to employees the cost of their employer-sponsored group health plan coverage. This reporting is for informational purposes only, and does not cause excludable employer-provided health care coverage to become taxable. To comply with this new requirement, employers will need to: (1) assess the applicable employer-sponsored coverage that is provided to each employee; (2) calculate the aggregate cost of such coverage for each employee; and (3) report that cost on each employee's Form W-2, in box 12, using code DD, beginning with the W-2 issued in January 2013 (*i.e.*, the Form W-2 issued for the 2012 calendar year). Employers should start gearing up to make sure systems are in place to track employee coverage and coordinate with their finance, payroll and human resources staff and vendors to ensure accurate reporting. See "*W-2 Reporting: Employers Should Start Gearing Up to Report the Cost of Employer-Sponsored Group Health Coverage*" in our October 20, 2011 Health Care Alert for more information.

- **Cover Additional Preventive Services for Women in Non-Grandfathered Health Plans**: On August 3, 2011, the Departments issued an amendment to health care reform's preventive care requirement. The new rules additionally require non-grandfathered group health plans to cover women's preventive services without charging a co-payment, co-insurance or a deductible. This rule is intended to make sure women have access to a full range of recommended preventive services without cost sharing, including: well-woman visits; screening for gestational diabetes; human papillomavirus (HPV) DNA testing for women 30 years and older; sexually-transmitted infection counseling; human immunodeficiency virus (HIV) screening and counseling; FDA-approved contraception methods and contraceptive counseling; breastfeeding support, supplies and counseling; and domestic violence screening and counseling. Non-grandfathered health plans will need to cover these services without cost sharing for plan years beginning on or after August 1, 2012 (*i.e.*, January 1, 2013 for calendar year plans). The administration also released an amendment to the prevention regulation that allows religious institutions that offer insurance to their employees the choice of whether or not to cover contraception services.

- **Consider Impact of HHS Waiver for Stand-Alone HRAs from Health Care Reform's Annual Limit Requirements:** As reported in our *November 2010 End of Year Plan Sponsor "To Do" Lists* health care reform prohibits health plans from imposing lifetime or annual limits on the dollar value of essential health benefits, but allows "restricted annual limits" with respect to essential health benefits for plan years (in the individual market, policy years) beginning before January 1, 2014. Under the interim final regulations, it was unclear how the prohibition on annual limits applied to health reimbursement arrangements ("HRAs"), which are account-based plans that typically consist of a promise by an employer to reimburse medical expenses for a year up to a certain dollar amount. Because of this uncertainty, many employers got rid of their HRAs that were not integrated with their health plan. On August 19, 2011, the Department of Health and Human Services ("HHS") released additional guidance relating to stand-alone HRAs. HHS acknowledged that applying the restriction on annual limits to HRAs would result in a significant decrease in

access to HRA benefits. The guidance exempts, as a class, all HRAs that were in effect prior to September 23, 2010 from having to apply individually for an annual limit waiver for plan years beginning on or after September 23, 2010 but before January 1, 2014. Stand-alone HRAs must still meet certain record retention and annual notice requirements to qualify for the waiver. Notwithstanding this temporary exemption, it is unclear whether HRAs will be viable after 2014.

- **Consider Whether Your HIPAA Compliance Practices Need to Be Updated:** The Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), which was a part of the economic stimulus package that was signed into law in February 2009, required that HHS periodically audit covered entities and business associates to ensure that they are complying with the privacy, security and breach notification requirements under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). In November, HHS announced that its Office of Civil Rights ("OCR") would begin its pilot audit program effective immediately and expects that these initial audits will be completed by December 2012. OCR will select up to 150 covered entities, including all types and sizes of health care providers, health plans and health care clearinghouses for audit. Business associates will not be included in this initial group of audits. Covered entities will be asked to provide documentation of their privacy and security compliance efforts and OCR will conduct a site visit. OCR will issue an audit report that identifies any compliance issues, the actions the entity has taken to resolve the issues and the entity's best practices. If an audit report reveals a serious compliance issue, OCR may initiate a compliance review. Now is a good time for plan sponsors of group health plans to review their HIPAA compliance efforts and determine whether any additional actions need to be taken.

Executive Compensation "To Do" List

- **Opportunity to Correct Certain Section 409A Failures Expire in 2011 and 2012:** Although many of the document correction opportunities announced in Notice 2010-6 expired in 2010, a few Section 409A correction opportunities expire at the end of 2011, including:

  - Payments under two "linked" nonqualified deferred compensation plans must be corrected by December 31, 2011;
  - Employees are not required to attach a statement to their 2011 tax return identifying the correction of certain operational defects that occurred in 2011, although employers are required to attach the statement to its 2011 tax return;
  - Correction of payment schedules determined by the timing of payments received by the employer must be corrected by December 31, 2011; and
  - Payments contingent on a release of claims must be corrected by December 31, 2012.

- **Consider Shareholder Reapproval of Section 162(m) Performance Compensation Plans Approved in 2007**: The Section 162(m) regulations require that shareholders reapprove the performance goals with respect to which performance-based compensation is paid every five years (other than stock options and SARs). This means that companies that obtained shareholder approval of plans containing discretionary Section 162(m) performance goals in 2007 must resubmit the plans for shareholder approval in 2012. This is generally done by having the shareholders reapprove an updated plan.

- **Code Section 6039 Information Statements Due by January 31, 2012**: Section 6039 requires a corporation to file a return and provide a written information statement to each employee or former employee regarding: (1) the transfer of stock pursuant to the exercise of an Incentive Stock Option ("ISO"); and (2) the transfer by the employee or former employee of stock purchased under an Employee Stock Purchase Plan ("ESPP"). Section 6039 applies to stock purchased under an ESPP if the stock was purchased at a permitted discount. For ISO grants and ESPP transfers occurring in 2011, the Section 6039 information statements must be provided no later than January 31, 2012.

- **Review Grant Procedures for Upcoming Equity-Based Grants**: The stock option backdating scandals raised serious corporate, tax, accounting and legal issues that can be resolved by an employer carefully reviewing its grant practices and procedures. An employer should carefully review its stock plan to determine which entity is charged with making grants under the plan and

put in place best practice procedures to ensure the proper entity takes the appropriate action as of the date the awards are considered granted.

Retirement Plan Limits for 2012

The key 2012 dollar amounts (compared to the 2011 dollar limits) are noted below.

The Social Security Administration separately announced the taxable wage base for 2012, which is noted at the end of the chart.

Maximum Qualified Retirement Plan Dollar Limits		
	2011	**2012**
Limit on Section 401(k) deferrals (Section 402(g))	$16,500	$17,000
Dollar limitation for catch-up contributions (Section 414(v)(2)(B)(i))	$5,500	$5,500
Limit on deferrals for government and tax-exempt organization deferred compensation plans (Section 457(e)(15))	$16,500	$17,000
Annual benefit limitation for a defined benefit plan (Section 415(b)(1)(A))	$195,000	$200,000
Limitation on annual contributions to a defined contribution plan (Section 415(c)(1)(A))	$49,000	$50,000
Limitation on compensation that may be considered by qualified retirement plans (Section 401(a)(17))	$245,000	$250,000
Dollar amount for the definition of highly compensated employee (Section 414(q)(1)(B))	$110,000	$115,000
Dollar amount for the definition of key employee in a top-heavy plan (Section 416(i)(1)(A)(i))	$160,000	$165,000
Dollar amount for determining the maximum account balance in an ESOP subject to a five-year distribution period (Section 409(o)(1)(C)(ii))	$985,000	$1,015,000
SIMPLE retirement account limitation (Section 408(p)(2)(E))	$11,500	$11,500
Social Security Taxable Wage Base	$106,800	$110,100

If you have any questions about the content of this newsletter, you may contact the authors or another Snell & Wilmer attorney by email or by calling 602.382.6000.