

Plan Designs

Summary Plan Descriptions

All group health plans subject to the Employee Retirement Income Security Act (ERISA) are required to provide each participant with a Summary Plan Description (SPD). An SPD must be written in a manner calculated to be understood by the average participant and must be sufficiently comprehensive to inform the participant of his rights and obligations under the plan.

In 2000, the Department of Labor (DOL) issued final regulations that modified and expanded the information required in an SPD. Those regulations applied to plans as of the first day of the second plan year beginning on or after January 22, 2001 (e.g., calendar year plans had to comply by January 1, 2003). This article is intended to answer many of the commonly asked questions surrounding summary plan descriptions.

What is a Summary Plan Description (SPD)?

An SPD is a document that is provided to plan participants which explains the plan's benefits, claim review procedures, and the participant's ERISA rights. The distribution of and disclosures contained within the SPD are regulated by federal law. Many mistakenly believe that providing participants with the booklet issued by the insurance company fulfills their obligation to provide participants with an SPD. In the majority of cases, the group health plan sponsor will need to provide additional information which is not contained within the booklet created by the insurer.

Are all group health plans required to provide participants with an SPD?

All group health plans subject to ERISA must provide participants with an SPD, regardless of size. Both insured and self-funded group health plans must comply with the federal laws governing SPDs. While ERISA contains an exception for group health plans with less than 100 plan participants, that exception only applies to reporting requirements (e.g., 5500 filings).

Do SPDs need to be filed with the Department of Labor?

No. While ERISA originally required that plans with 100 or more participants file an SPD with the DOL, the Taxpayer Relief Act of 1997 eliminated the automatic filing requirement. Plans are required to file an SPD within 30 days of a request by the DOL. If the plan administrator fails to provide the SPD within 30 days, the DOL is authorized to impose a civil penalty of up to \$110 per day for each day such failure

continues, subject to a maximum penalty of \$1,100 per request. Multiple requests for the same or similar documents are considered separate requests.

When must an SPD be provided to a plan participant?

Participants must receive an SPD:

- Within 120 days of the plan becoming subject to ERISA,
- Within 90 days of enrollment for new participants,
- Every 5 years if material modifications are made during that period, or
- Every 10 years if no amendments occur.

When must changes to the SPD be communicated to plan participants?

A summary of material modification must be provided within 210 days after the close of the plan year in which the change was adopted. Examples of material modifications include a change in benefits or eligibility.

If benefits or services are materially reduced, participants must be provided notice within 60 days from adoption. Or, where participants receive such information from the plan administrator at regular intervals of not more than 90 days, notice of materially reduced benefits or services must be provided within 90 days.

How may SPDs be distributed to participants?

The plan administrator is required to provide the SPD to participants in a manner reasonably calculated to ensure actual receipt of the material by the participant. The following are examples of acceptable methods of delivery:

- In-hand delivery to employees at his or her worksite (Note: merely posting information in a common area is not acceptable).
- Include within a periodical distributed to employees (e.g., union newsletter or company publication).
- U.S. mail, including first, second or third class. Use of second or third class mail is acceptable only if return and forwarding postage is guaranteed and address correction is requested. Any material sent by second or third class mail which is returned with an address correction shall be sent again by first-class mail or personally delivered to the participant at his or her worksite.
- Electronic media. Regulations released by the DOL include a safe harbor provision where the plan administrator complies with the guidelines contained in the regulations.

What information must be contained within an SPD?

ERISA and its regulations require that an SPD be sufficiently comprehensive in order to inform participants of their rights and obligations under the plan. ERISA, its related regulations, as well as a general duty of disclosure under ERISA, prescribe the content of an SPD. The attached Summary Plan Description Checklist outlines basic items that must be included in an SPD.¹

Does ERISA require that SPDs be provided in a language other than English?

¹ Note that this Checklist may not be complete depending on the specific circumstances of each plan.

No. While ERISA does not require that an SPD be provided in a non-English language, in some cases the SPD must include a prominently displayed notice that assistance in a non-English language common to the plan participants is available. Sample language has been provided within the attached Summary Plan Description Checklist.

A plan is required to include this notice in the following cases:

Plan Size* (# of plan participants)	# of Participants literate only in the same non-English language
Less than 100	25% or more
Greater than 100	Lesser of: ✓ 500 or more; or ✓ 10% or more

*At the beginning of the plan year.

Example:

An employer maintains a group health plan that covers 1,000 plan participants. At the beginning of the plan year 500 participants are literate only in Spanish, 101 are literate only in Vietnamese, and the remaining are literate in English. Each of the 1,000 plan participants must receive an SPD that contains a notice in both Spanish and Vietnamese explaining the ability to obtain assistance with understanding the SPD.

If the SPD contains information on COBRA rights, is it still necessary to send an initial notice?

In order for the SPD to also fulfill an employer’s obligation to provide an initial COBRA notice, the SPD must:

- Be mailed via first-class mail to the participant’s home;
- Be addressed to the participant and covered dependents; and
- Contain all of the information required to be contained within an initial COBRA notice.

You may contact your Benefit Management Solutions Inc. representative for assistance in reviewing an SPD prepared on your behalf by an insurance carrier, third party administrator, or legal counsel.

This copy of Plan Designs is not meant to be provided as legal advice. Readers seeking legal advice should contact an attorney. © 2002, 2008 Zywave, Inc.

Summary Plan Description Checklist
(For Group Health Plans)

Plan

- Name
- Type (group health plan, 401k)
- Plan Number (three digits)
- Policy Number (if insured)
- Type of Plan Administration (insured/self-funded)

Plan Sponsor

- Name
- Address
- Employer Identification #
- A statement that a complete list of employers, employee organizations, and unions sponsoring the plan is available
- Where a plan is established pursuant to a collective-bargaining agreement, a statement that a copy of that agreement is available upon request to the plan administrator.

Financing & Administration

- Fiscal Year End
- Funding medium (insurance company, trust fund)
- Source of contributions and how contributions are calculated
- Type of Administration (contract, sponsor, insurer)

Plan Administrator

- Name
- Address
- Telephone number

Agent for Service of Legal Process

- Name
- Address
- Statement that legal process can be served on the plan administrator or plan trustee

Trustees

- Names
- Titles
- Addresses

Eligibility & Benefits

- Statement of the conditions pertaining to eligibility to receive benefits
- A summary of benefits that includes a description of:
 - Cost sharing provisions (premiums, deductibles, coinsurance, copayment amounts for which the beneficiary will be responsible)
 - Annual or lifetime maximums or other limits on benefits under the plan
 - Preventive services coverage
 - Prescription drug coverage
 - Medical test, device, and procedure coverage
 - Requirements to use network providers
 - List of network providers*
 - Coverage for services provided by non-network providers
 - Limits on selection of primary care providers or providers of specialty medical care
 - Conditions or limits applicable to obtaining emergency medical care
 - Pre-authorization or utilization review requirements
 - Benefits provided pursuant to the Women's Health & Cancer Rights Act and Newborn's and Mother's Health Protection Act (Model Statement for NMHPA)
 - COBRA Rights
 - Claims and Appeal Procedures
 - Statement that a copy of QMCSO and QDRO procedures are available upon request.

**The provider listing may be furnished as a separate document, provided that the SPD contains a general description of the provider network and that provider lists are furnished automatically, without charge, as a separate document.*

Loss of Benefits Statement

- ❑ A statement clearly identifying circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, or recovery (subrogation)
- ❑ A summary of plan provisions governing the authority of the plan sponsor or others to terminate, amend, or eliminate benefits under the plan

ERISA Rights

See model statement attached.

Foreign Language Statement (if applicable)

Model Statement:

This booklet contains a summary in English of your plan rights and benefits under this Employer's group health plan. If you have difficulty understanding any part of this booklet, contact Mr. John Doe, the plan administrator, at his office in Room 123, 456 Main Street, Anywhere City, State 20001. Office hours are 8:30 a.m. to 5:00 p.m. Monday through Friday. You may also call the plan administrator's office at 202-555-2345 for assistance.

This notice must be prominently displayed within the SPD and must appear in the non-English language common to the plan participants.

This Summary Plan Description Checklist is provided to you by Benefit Management Solutions Inc.. It is not meant to be provided as legal advice. Readers seeking legal advice or assistance drafting plan language should contact an attorney.

SUMMARY PLAN DESCRIPTION

Name of Plan:

ABC Company, Inc.

Policy Number:

123456

Participants Included:

Employees actively at work and regularly scheduled to work a minimum of 30+ hours per week

Name and Address of Employer:

ABC Company, Inc.
200 East Sample Street
Any City, State, 53214

Contributions:

Employee pays \$ _____ individual coverage
\$ _____ family coverage

Plan Identification Number:

1. Employer IRS Identification #: 39-1234567
2. Plan #: 501

Plan Year Ends:

December 31

Plan Administrator, Name, Address, and Telephone #:

ABC Company, Inc.
200 East Sample Street
Any City, State, 53214
987-123-4567

Agent for Service of Legal Process on the Plan:

ABC Company, Inc.
200 East Sample Street
Any City, State, 53214

Type of Administration

Insurer Administration

Plan Modification Amendment Or Termination

The employer may modify, amend, or terminate the plan at any time at its sole discretion. Any modification, amendment, or termination will be communicated to participants under the plan.

Include if fully insured - The insurance company has the right to modify, amend, or terminate the plan as follows:

Please refer to the group master contract or application when filling out this section.

sample

WHAT ARE YOUR RIGHTS UNDER ERISA?

As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

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

Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age * * *) and if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The plan must provide the statement free of charge.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a (pension, welfare) benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal Court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.



NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).