List of Information Which Must Appear in a Summary Plan Description (SPD)

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List of Information Which Must Appear in a Summary Plan Description (SPD)

ERISA and DOL regulations do not present a standard format to be used in preparing the SPD. They do, however, specify the information which must be included in an SPD. Although many of the requirements apply to all types of welfare benefit plans, some apply only to welfare benefit plans that are group health plans, and others apply only to group health plans that are not exempt from certain requirements.

Plan name – The name of the plan (and, if different, the name by which the plan is commonly known).

Plan sponsor – The name(s) and address(es) of one of the following:

- The single employer that sponsors the plan;
- The employee organization that sponsors the plan; and
- In the case of a collectively bargained plan, a list of all employers and unions involved in sponsoring the plan.

  PLUS (if applicable) one of the following:
  - A statement that a complete list of participating employers and employee organizations may be obtained by written request to the plan administrator (and is available for examination); or
  - A statement that participants and beneficiaries may receive (after written request to the plan administrator) information regarding whether a particular employer or employee organization is a sponsor of the plan (and the sponsor's address).

In the case of a plan established or maintained by two or more employers, the representative of a group of employers that sponsor a plan.

PLUS (if applicable) one of the following:
- A statement that a complete list of participating employers sponsoring the plan is available for examination by participants and beneficiaries and may be obtained by written request to the plan administrator; or
- A statement that participants and beneficiaries may receive (after written request to the plan administrator) information regarding whether a particular employer or employee organization is a sponsor of the plan (and the sponsor's address).

EIN – The plan sponsor's employer identification number (assigned by the IRS).

Plan number – The 3-digit plan number (assigned by the plan sponsor). Welfare plans begin with 501 and are numbered consecutively.

Plan year – The date of the plan's fiscal year selected for ERISA purposes.

Type of plan – The type of health or welfare benefit plan (for example, group health plan, disability, pre-paid legal services, etc.).

Administration – The type of administration (for example, contract administration, insurer administration, etc.).

Plan administrator – Name, business address, and telephone number of the plan administrator.

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Service of process – Name and address of the person designated as agent for service of legal process, and a statement that service can be made on a plan trustee or the plan administrator.

Trustee – Name, title, and address of the principal place of business of each trustee.

Collective-Bargaining Agreement – For collectively bargained plans, a statement referencing the collective-bargaining agreement, and a statement that the collective-bargaining agreement is available for examination and that a copy may be obtained by written request to the plan administrator.

Eligibility and participation – A description of the plan's requirements for eligibility to participate and to receive benefits. For example, the SPD might describe a waiting period (such as 60 days) before a participant is eligible to participate and the class or classes of eligible participants (such as all full-time, salaried employees).

Description of benefits – Welfare benefit plans must also include a general description of the benefits provided under the plan. For welfare plans providing extensive schedules of benefits, only a general description is required if reference is made to detailed schedules of benefits which are available without cost to any participant or beneficiary who so requests.

Plan benefits and exclusions – Health plan descriptions must include:

- The impact of discount arrangements with providers, insurers, or administrators on a participant's copayments, deductibles, annual and lifetime maximum benefits, and subrogation provisions;
- Any cost-sharing provisions (including limitations and out-of-pockets maximums), including premiums, deductibles, coinsurance, and co-payment amounts for which the participant or beneficiary will be responsible;
- Any annual or lifetime caps or other limits on non-essential health benefits under the plan and the elimination of annual and lifetime dollar limits on essential health benefits;
- The extent to which preventive services are covered under the plan;
- Whether, and under what circumstances, existing and new drugs are covered under the plan;
- Whether, and under what circumstances, coverage is provided for medical tests, devices, and procedures, including clinical trial coverage;
- Provisions governing the use of network providers, the composition of the provider network and whether, and under what circumstances, coverage is provided for out-of-network services (in the case of plans with provider networks, the listing of providers may be furnished as a separate document, provided that the SPD contains a general description of the provider network and indicates that provider lists are furnished automatically, without charge, as a separate document);
- Any conditions or limits on the selection of primary care providers or providers of specialty medical care;
- Any conditions or limits applicable to obtaining emergency medical care; and
- Any provisions requiring pre-authorizations or utilization review as a condition to obtaining a benefit or service under the plan.

Subrogation/right of reimbursement – The SPD must include language describing subrogation and reimbursement rights and any other plan terms and conditions that may reduce benefits.

Cessation of benefits – The SPD must include a statement identifying the circumstances which can lead to disqualification, ineligibility, or denial, loss, forfeiture or suspension of benefits.

Plan amendment and/or termination – SPDs must include the following:

- A summary of any plan provisions governing the authority of the plan sponsors or others to terminate the plan or amend or eliminate benefits under the plan and the circumstances, if any, under which the plan may be terminated or benefits may be amended or eliminated;

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- A summary of any plan provisions governing the benefits, rights, and obligations of participants and beneficiaries under the plan upon termination of the plan or amendment or elimination of benefits under the plan; and
- A summary of any plan provisions governing the allocation and disposition of assets of the plan upon termination.

Contributions – The SPD must identify the source of contributions (for example, employer, and employee, union) and the method by which the amount of contribution is calculated. A plan might include the following language: "You contribute toward the cost of your insurance coverage. You will be informed on an annual basis about the level of your contributions and your actual employee contribution cost. Please refer to your latest enrollment form for your present employee contributions." Specific premium or contribution amounts need not be disclosed in the SPD.

Funding medium – The SPD must disclose the identity of the funding medium used to accumulate assets and pay benefits, along with the name of any insurance company, trust fund, or other institution which maintains the fund. If a health insurance issuer is responsible, in whole or in part, for the financing or administration of a group health plan, the SPD shall note the name and address of the insurer, whether and to what extent benefits under the plan are guaranteed under the policy or contract, and the nature of any administrative services provided (for example, contract administrator or claims payer).

Claims procedure – While most employers disclose claims rules in their SPDs, the DOL regulations allow claims procedures to be provided separately to employees, rather than in the SPD. When plan sponsors do not include the procedures in the SPD, a statement must appear in the SPD alerting participants and beneficiaries that the claims procedures will be provided separately automatically and without charge. The SPD still must generally describe the procedures by reference. The procedures governing claims for benefits include:

- Procedures for obtaining pre-authorizations, approvals, or utilization review decisions in the case of group health plan services or benefits; filing claim forms; notifications of benefit determinations; and review of denied claims in the case of any plan; and
- External review process allowing final review to be conducted by an external Independent Review Organization;
- An expanded scope of “adverse benefit determination” eligible for external review to include determinations whether a plan or issuer is complying with the surprise billing and cost-sharing protections; and
- Applicable time limits and remedies available under the plan for the redress of claims which are denied in whole or in part.

Medical claims appeal procedures – Group health plans and insurers offering individual coverage must outline a detailed claim appeal process including internal and external review. Medical claim appeal procedures also apply to benefit claims filed by participants in “top hat” plans, which are unfunded plans maintained primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees.

Disability claims appeal procedures – The DOL claims procedure regulations apply to disability and other non-group health claims. Amended regulations issued in December 2016 more closely align the claims procedure requirements for disability claims with the enhanced requirements for group health plans. The changes affect various elements of the claims process, including required content for adverse benefit determination notices, providing notices in a culturally and linguistically appropriate manner, and rules on rescissions. The changes are applicable to claims filed after April 1, 2018.

Foreign language statement – An employer subject to a foreign language disclosure requirement should include a statement, prominently displayed and in the appropriate, non-English language, telling how, when, and where participants can receive an oral, non-English explanation of the plan.

ERISA Rights – All SPDs must include the prescribed statement of ERISA rights.

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Discretionary Authority – While not required, it is advisable that the plan disclose, in the SPD, the plan administrator's discretionary authority to interpret and administer the plan.

Group health plans only

Coverage of children to age 26 – Grandfathered and non-grandfathered plans that make coverage available to children must make the coverage available until the child attains age 26.

HIPAA special enrollment rights – For group health plans, the SPD must include an explanation of events that trigger a special enrollment right and the time limits that apply to such enrollment rights. As a reminder, under HIPAA, special enrollment rights do not apply to limited-scope dental and vision benefits; however, a plan may provide a benefit which is more favorable than the law permits. Therefore, with insurer approval, special enrollment rights can be applicable to dental and vision benefits.

The federal government provided certain timeframe extensions in response to the COVID-19 pandemic, including a timeframe extension of HIPAA special enrollment periods. These extensions may have been described in a summary of material modifications (SMM) or in the SPD, if the SPD was distributed in a timely manner.

Due to the end of the COVID-19 pandemic National Emergency, based on informal comments from the DOL, the extended deadlines afforded under the Outbreak Period expire as of July 10, 2023. The end of these deadline extensions may be described in a summary of material modifications (SMM) or in an updated SPD.

HIPAA privacy – Group health plans must provide covered employees with a Notice of their Privacy Practices. It is not recommended that the Notice of Privacy Practices be included in the SPD. Instead, plans may use a shorter explanation of HIPAA privacy in the SPD.

COBRA continuation rights – In the case of a group health plan subject to the COBRA benefit continuation provisions, the regulations require a description of the rights and obligations of participants and beneficiaries with respect to continuation coverage, including, among other things, information concerning qualifying events, premiums, notice, and election requirements and procedures, and duration of coverage.

USERRA – Group health plan SPDs should also contain a reference to continuation coverage rights that may apply under the Uniform Services Employment and Reemployment Rights Act of 1994.

FMLA – Applicable group health plans should include information on the Family and Medical Leave Act since applicable employers must maintain an employee's health coverage while on FMLA leave on the same terms as if the employee continued to work.

GINA – As a plan's benefits and eligibility must be disclosed, information must be consistent with the Genetic Information Nondiscrimination Act.

QMCSOs – Health plan SPDs must contain either the procedures for handling a Qualified Medical Child Support Order or a statement indicating that participants and beneficiaries can obtain, free of charge, a copy of the procedures.

Rescission of coverage – Grandfathered and non-grandfathered plans must describe the limited circumstances under which a retroactive cancellation or termination of coverage is permitted.

Maternity or newborn coverage – For a group health plan that provides maternity or newborn infant coverage, under the Newborns' and Mothers' Health Protection Act (NMHPA) the SPD must contain a statement describing the federal or state law requirements applicable to the plan (or any health insurance coverage offered under the plan) relating to hospital length-of-stay in connection with childbirth for the mother

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or newborn child. If state law only applies in some areas due to certain portions of the program being insured, the SPD must describe the federal and state law requirements that apply in each area covered by the plan.

Mastectomy reconstruction – Under the Women's Health and Cancer Rights Act (WHCRA) health plan SPDs must contain a statement regarding the limits of the mastectomy reconstruction benefit.

Michelle's law – Group health plans that provide coverage for dependent children based on student status, beyond what the ACA requires, must continue to provide coverage for those dependents for up to one year when an otherwise eligible dependent takes a "medically necessary leave of absence." It is noted that the Affordable Care Act (ACA) has made Michelle's Law irrelevant for self-insured and fully-insured group health plans that only provide coverage to age 26 regardless of student status. However, Michelle's law would protect dependents who are not "child" dependents (like a grandchild) if the grandchild is covered only while a full-time student.

Mental health parity requirements – Although not specifically required by the regulations, since the Mental Health Parity and Addiction Equity Act (MHPAEA) may affect rights, obligations and benefits under the plan, information should be included. If a group health plan that provides medical/surgical benefits also provides either mental health or substance use disorder benefits, those benefits must be in parity. There must be parity between the medical/surgical benefits and mental health/substance use benefits as to annual or lifetime limits, financial requirements, quantitative treatment limitations, and nonquantitative treatment limitations.

Coverage of preventive health services – Non-grandfathered group health plans must provide in-network coverage without participant cost-sharing for certain categories of preventive health services required under the ACA. Coverage for any new preventive health services recommendation or guideline generally must be provided for plan years beginning on or after the date that is one year after the date of the recommendation or guideline is issued. However, in accordance with interim final regulations issued in October 2020 by the federal government, non-grandfathered group health plans must cover qualifying COVID-19 preventive services, including any vaccine and its administration, without cost-sharing within 15 business day of a recommendation from the United States Preventive Services Task Force or the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practice (ACIP).

Elimination of annual and lifetime dollar limits on essential health benefits - While self-funded group health plans are not required to cover EHBs, if EHBs are covered, there can be no annual or lifetime dollar limits imposed on them.

Patient protections Non-grandfathered plans must provide for certain rights relating to the coverage of emergency services, right to designate a primary care provider (PCP), and the right for women to obtain obstetrical or gynecological care without prior authorization or referral. As of January 1, 2022, this requirement is also applicable to grandfathered plans

HIPAA preexisting condition exclusion – Group health plans are prohibited from imposing any preexisting condition exclusions.

Grandfathered health plan notice – A grandfathered health plan must state, in any plan materials describing the plan benefits, its "belief" that it is a grandfathered plan.

Surprise billing and transparency – Effective for plan years beginning on or after January 1, 2022, under the No Surprises Act (NSA), group health plan participants will be protected from balance bills when they (i) seek emergency care; (ii) when they are transported by an air ambulance; or (iii) when they receive non-emergency care at an in-network hospital are unknowingly treated by an out-of-network physician or laboratory. Participants will only pay deductibles and co-payments that they would otherwise pay for in-network care under the terms of the group health plan. Amounts paid will count toward the patient's in-network deductible and out-of-pocket maximum. Information on who to contact if the participant receives a balance bill should be included in the SPD.

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Current language in the SPD may need to be reviewed for accuracy and consistency with regard to NSA requirements.

- Remove any language requiring preauthorization for emergency services
- Update the definition of “emergency services” which was expanded to include pre-and post-stabilization services, independent free-standing ER facilities, denials cannot be based solely on a diagnosis code and no time limit restrictions based on the onset of symptoms
- Include language noting that state members cannot receive balance bills for protected services
- Review definitions for out-of-network charges to evaluate if any changes are needed for protected services
- Ensure the plan provides for 90 days of continuity of care when a provider ceases to be an in-network provider during an ongoing course of treatment

Coordination of benefits – Include a description of the method by which the plan coordinates its benefits with those provided under other coverage such as group health plan coverage provided by another employer, Medicare, or Tricare.

Wellness programs – SPDs that describe the terms of a wellness program must disclose the availability of a reasonable alternative standard (or the possibility of a waiver of the applicable standard), for obtaining a reward under the program. This disclosure is not required if the SPD merely mentions the wellness program.

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