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BENEFITS REDEFINED

ERISA Welfare Plan SPD Checklist

2020

COMPLIANCE & LEGAL

Benefit Advisors NETWORK

ERISA plans must prepare summary plan descriptions ("SPDs") in accordance with specific Department of Labor regulations (DOL Reg. §2520.102-2, -3). These regulations have been amended from time to time and, therefore, SPDs should be regularly reviewed and checked for compliance against the most recent DOL regulations. This checklist is intended to provide a general guide for information that must be included in a complete ERISA Welfare Plan SPD. Please consult with your regular employee benefits attorney for an explanation of any of these requirements.

General SPD Style and Content Standard. SPDs must be written in a manner calculated to be understood by the average plan participant. At the same time, an SPD must be sufficiently comprehensive to apprise participants and beneficiaries of their rights and obligations under the plan. SPDs cannot be misleading and should not minimize the importance of exceptions, limitations, reductions or other restrictions on plan benefits. Benefits of a plan should not be exaggerated, and the disadvantages or limitations of the plan or plan participation should not be minimized.

Some SPDs are presented entirely in narrative format with examples used to illustrate certain plan features. Other SPDs are presented entirely in question-and-answer format (again, with examples used to illustrate the application basic plan provisions). No single presentation format is preferable; this is an issue that should be resolved by each plan sponsor considering the specific work force expectations.

In some cases where a significant number of participants are non-English speakers and an English language SPD would fail to inform these participants adequately of their rights and obligations under the plan, foreign language assistance must be provided. This requirement applies in two cases: (1) to a plan that covers fewer than 100 participants at the beginning of a plan year, and in which 25 percent or more of all plan participants are literate only in the same non-English language; or (2) to a plan that covers 100 or more participants at the beginning of the plan year, and in which the lesser of (i) 500 or more participants, or (ii) 10% or more of all plan participants are literate only in the same non-English language. In these cases, the English-language SPD must "prominently" display a notice, in the non-English language common to these participants, offering them assistance. The assistance provided need not involve written materials but must be given in the non-English language common to these participants and "calculated to provide them with a reasonable opportunity to become informed as to their rights and obligations under the plan."

Some plans provide different benefits for various classes of participants and beneficiaries (e.g., a single plan that covers both union and non-union employees, or employees of multiple divisions are covered at various benefit levels, or group health plans that offer different HMO and PPO options to different groups of employees). In these cases, the DOL regulations allow for separate SPDs to be provided to each of the various covered groups. DOL Reg. §2520.102-4.

This checklist is designed to help plan sponsors and administrators ensure their SPDs contain the specific information required to be included in SPDs to comply with DOL regulations.

REQUIRED ELEMENTS

- ☐ The name of the plan
- ☐ The name by which the plan is commonly known by its participants and beneficiaries
- ☐ The name and address of:
    1. In the case of a **single employer plan**, the employer whose employees are covered by the plan
    2. In the case of a **plan maintained by an employee organization** for its members, the employee organization that maintains the plan
    3. In the case of a **collectively-bargained plan established or maintained by one or more employers and one or more employee organizations**, the association, committee, joint board of trustees, parent or most significantly employer of a group of employers all of which contribute to the same plan, or other similar representative of the parties who established or maintain the plan, as well as (i) A statement that a complete list of the employers and employee organizations sponsoring the plan may be obtained by participants and beneficiaries upon written request to the plan administrator, and is available for examination by participants and beneficiaries; or (ii) A statement that participants and beneficiaries may receive from the plan administrator, upon written request, information as to whether a particular employer or employee organization is a sponsor of the plan and, if the employer or employee organization is a plan sponsor, the sponsor's address
    4. In the case of a **plan established or maintained by two or more employers**, the association, committee, joint board of trustees, parent or most significant employer of a group of employers all of which contribute to the same plan, or other similar representative of the parties who established or maintain the plan, as well as (i) A statement that a complete list of the employers sponsoring the plan may be obtained by participants and beneficiaries upon written request to the plan administrator, and is available for examination by participants and beneficiaries; or (ii)A statement that participants and beneficiaries may receive from the plan administrator, upon written request, information as to whether a particular employer is a sponsor of the plan and, if the employer is a plan sponsor, the sponsor's address
- ☐ The plan sponsor's employer identification number (EIN)
- ☐ The plan number assigned by the plan sponsor
- ☐ The type of welfare plan (e.g., group health plan, disability, pre-paid legal services, etc.)

- ☐ The type of administration of the plan (e.g., contract administration, insurer administration, etc.) [EXAMPLE OF LANGUAGE USED IN A SELF-INSURED PLAN'S SPD -- The Plan Sponsor provides certain administrative services in connection with the Plan. The Plan Sponsor may, from time to time in its sole and absolute discretion, contract with outside parties to arrange for the provision of administrative services, including access to a network of providers; claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. The external administrator is referred to as the Claim Administrator. The Plan Sponsor has selected a provider network established by _____.]

- ☐ The name, business address, and business telephone number of the plan administrator

- ☐ The name of the person designated as agent for service of legal process, and the address at which process may be served on such person

- ☐ A statement that service of legal process may be made upon a plan trustee or the plan administrator

- ☐ The name, title, and address of the principal place of business of each trustee of the plan

- ☐ If a plan is maintained pursuant to one or more **collective bargaining agreements**, a statement that the plan is so maintained, and that a copy of any such agreement may be obtained by participants and beneficiaries upon written request to the plan administrator, and is available for examination by participants and beneficiaries

- ☐ Description of the plan's provisions relating to **eligibility to participate** in the plan [IMPORTANT TO INCLUDE CLEAR PROVISIONS DEFINING SPOUSES AND DEPENDENT CHILDREN. ALSO, CLEAR PROVISIONS RELATING TO ELIGIBLITY FOR DOMESTIC PARTNERS, IF APPLICABLE, AND TAX TREATMENT OF SUCH BENEFITS.]

- ☐ A statement of the conditions pertaining to **eligibility to receive benefits**

- ☐ A description or summary of the benefits provided under the plan. In the case of a welfare plan providing extensive schedules of benefits (a group health plan, for example), only a general description of such benefits is required if reference is made to detailed schedules of benefits which are available without cost to any participant or beneficiary who so requests

- ☐ A statement clearly identifying circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, or recovery (e.g., by exercise of subrogation or reimbursement rights) of any benefits that a participant or beneficiary might otherwise reasonably expect the plan to provide

☐ 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.

[Example -- Although the Plan Sponsor currently intends to continue the Plan and the benefits provided under the Plan, the Plan Sponsor reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan and the benefits provided hereunder, in whole or in part, at any time and for any reason, without prior notice to or approval by Plan participants and beneficiaries, except as otherwise required by law. Any change or amendment to, or termination of, the Plan, its benefits, or its terms and conditions, in whole or in part, shall be made by a written amendment or resolution executed by the Company's Board of Directors (or its delegee). No person or entity has any authority to make any oral changes or amendments to the Plan.]

[Note, pre-PPACA, even "material" modifications had no advance notice requirement. SMRs were required 60 days from adoption, and SMMs were required 210 days after plan year. PPACA changes this, by requiring 60 days advance notice for changes that affect the content of the current summary of benefits and coverage (SBC) (other than those made at renewal).]

☐ A summary of any plan provisions governing the benefits, rights, and obligations of participants and beneficiaries under the plan on 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

☐ A summary of any provisions that may result in the imposition of a fee or charge on a participant or beneficiary, or on an individual account thereof, the payment of which is a condition to the receipt of benefits under the plan

☐ The sources of contributions to the plan (e.g., employer, employee organization, employees) and the method by which the amount of contribution is calculated [SAMPLE LANGUAGE FOR AN INSURED PLAN -- Premium costs are shared by the employer and the employees, as determined by the employer in its sole and absolute discretion and communicated in advance to employees. Employee contributions generally are made on a pre-tax basis and may change from time to time, as determined by the employer.]

[FOR A SELF-INSURED PLAN -- All benefits under the Plan are paid from the employer's general assets and employee contributions toward the cost of coverage. Employee contributions are the employees' share of the costs of Plan benefits, as determined in the sole and absolute discretion of the employer and communicated in advance to employees. Employee contributions generally are made on a pre-tax basis and may change from time to time, as determined by the employer.]

☐ The identity of any funding medium used for the accumulation of assets through which benefits are provided (insurance company, trust fund, or any other institution, organization, or entity which maintains a fund on behalf of the plan or through which the plan is funded, or benefits are provided). If a health insurance issuer is responsible for the financing or administration of a **group health plan**, the SPD must indicate the name and address of the issuer, whether and to what extent benefits under the plan are guaranteed under a contract or policy of insurance issued by the issuer, and the nature of any administrative services (e.g., payment of claims) provided by the issuer

☐ The date of the end of the year for purposes of maintaining the plan's fiscal records

☐ The procedures governing claims for benefits (including procedures for obtaining pre-authorizations, approvals, or utilization review decisions in the case of group health plan services or benefits, and procedures for filing claim forms, providing notifications of benefit determinations, and reviewing denied claims in the case of any plan), applicable time limits, and remedies available under the plan for the redress of claims which are denied in whole or in part. If the plan's claims procedures are furnished as a separate document, the SPD must contain a statement that the plan's claims procedures are furnished automatically, without charge, as a separate document.

☐ The statement of ERISA rights (applicable model language below)

As a participant in (name of 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.

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.

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 welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a 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

☐ **(group health plans)** A description of the procedures governing qualified medical child support order (QMCSO) determinations, or a statement indicating that participants and beneficiaries can obtain, without charge, a copy of such procedures from the plan administrator

☐ **(group health plans)** A description of any cost-sharing provisions, including premiums, deductibles, coinsurance, and copayment amounts, for which the participant or beneficiary will be responsible

☐ **(group health plans)** A description of any annual or lifetime caps or other limits on benefits under the plan

☐ **(group health plans)** A description of the extent to which preventive services are covered under the plan (group health plans) A description of whether, and under what circumstances, existing and new drugs are covered under the plan

☐ **(group health plans)** A description of whether, and under what circumstances, coverage is provided for medical tests, devices and procedures

☐ **(group health plans)** A description of the 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. If the listing of providers is furnished as a separate document that accompanies the plan's SPD, the summary plan description must contain a general description of the provider network and a statement that provider lists are furnished automatically, without charge, as a separate document

☐ **(group health plans)** A description of any conditions or limits on the selection of primary care providers or providers of specialty medical care

☐ **(group health plans)** A description of any conditions or limits applicable to obtaining emergency medical care

☐ **(group health plans)** A description of any provisions requiring pre-authorizations or utilization review as a condition to obtaining a benefit or service under the plan

☐ **(group health plans that provide maternity or newborn infant coverage)** A statement describing any requirements under federal or state law applicable to the plan, and any health insurance coverage offered under the plan, relating to hospital length of stay in connection with childbirth for the mother or newborn child. If federal law applies in some areas in which the plan operates, and state law applies in other areas, the statement should describe the different areas and the federal or state law requirements applicable in each (federal model language below)

> 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).

☐ **(group health plans subject to COBRA)** A description of the rights and obligations of participants and beneficiaries with respect to continuation coverage, including, among other things, information concerning qualifying events and qualified beneficiaries, premiums, notice and election requirements and procedures, and duration of coverage. Include language describing the second COBRA election period available to individuals who become eligible for trade adjustment assistance pursuant to the Trade Act of 1974. Include separate provisions for FSAs, if applicable.

☐ **(grandfathered group health plans subject to Affordable Care Act)** A "grandfathered health plan" (i.e., one that was in existence on March 23, 2010 and has not been amended after that date in a way to cause it to lose grandfathered plan status), must provide a notice of grandfathered treatment. DOL has issued a model notice:

> This [group health plan or health insurance issuer] believes this [plan or coverage] is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.
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> Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information]. [For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or http://www.dol.gov/ebsa/healthreform/. This website has a table summarizing which protections do and do not apply to grandfathered health plans.] [For individual market policies and nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at http://www.healthreform.gov/.

SUGGESTED PROVISIONS

- ☐ Provisions regarding Plan procedures for enrollment, making changes, etc.

- ☐ Language clearly specifying when coverage ends (e.g., end of month in which employment ends, date of divorce, etc.)

  Bruch language (i.e., discretion to interpret etc.)

  Sample Language: The Plan Administrator (or the applicable Claims Administrator or other delegee) shall have the exclusive, right, power and authority, in its sole and absolute discretion, to administer, apply and interpret the Plan and any Plan documents and to decide all matters arising in connection with the operation or administration of the Plan. Without limiting the generality of the foregoing, the Plan Administrator (or the applicable Claims Administrator or other delegee) shall have the sole and absolute discretionary authority to: (i) take all actions and make all decisions with respect to eligibility for, and the amount of, benefits payable under the Plan; (ii) formulate, interpret and apply rules, regulations and policies necessary to administer the Plan in accordance with its terms; (iii) decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan; (iv) resolve and/or clarify any ambiguities, inconsistencies, and omissions arising under the Plan or Plan documents; and (v) process, and approve or deny, benefit claims, and rule on any benefit exclusions, and determine the standard of proof required in any case.

- ☐ Description of plan benefits during FMLA leave

- ☐ Description of plan benefits during USERRA leave

- ☐ Plan document governs language, in the event of a conflict between the SPD and the plan document

- ☐ Exhaustion language requiring claimants to follow claims procedures before filing suit

- ☐ Time limit on filing suit after claim denial language

- ☐ No guarantee of employment language

- ☐ **(group health plans)** HIPAA privacy language

- ☐ **(group health plans)** HIPAA Special Enrollment Language

- ☐ **(group health plans with prescription drug coverage)** Medicare Part D creditable/ non-creditable coverage language

☐ **(group health plans)** WHCRA language, if annual notice provided through the SPD (model language below)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Call your plan administrator [phone number here] for more information.

☐ **(group health plans)** Michelle's law disclosures, to the extent applicable.

☐ **(group health plans)** CHIPRA requires plans to provide special enrollment rights to (i) individuals who lose CHIP or Medicaid eligibility and request coverage within 60 days of coverage termination or (ii) become eligible for a CHIP or Medicaid subsidy and request coverage within 60 days after they are determined eligible.

☐ **(group health plans)** PPACA language for various requirements due to health care reform, depending on the plan and its grandfathered status; in particular, check for provisions on (among other things):

- Adult dependent children coverage
- Preexisting condition exclusions
- Rescissions of coverage
- Annual/Lifetime Limits
- Internal/External Appeal procedures (if applicable)
- Preventive care services (if applicable)
- Limits on out-of-pocket cost sharing (if applicable)
- Over-the-counter drug coverage (not allowed for health FSAs)
- Waiting periods in excess of 90 days
- Orientation periods that exceed one month (minus a day)
- Measurement and stability period language, for Applicable Large Employers that use the look-back method to determine full-time employees

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