

Update

April 9, 2008



Managing details, deadlines for health plan disclosures

Summary

Employers sponsoring health and welfare benefit plans face a dizzying array of required disclosures under ERISA: summary plan descriptions (SPDs), summaries of material modifications or reductions (SMMs or SMRs), and summary annual reports (SARs). Each of these disclosures has to contain different details and meet different distribution deadlines. Failure to meet these requirements exposes employers to a variety of risks, including court-assessed fines and liability for unintended benefits. This *Update* summarizes what each disclosure must contain and when it must be distributed.

SPD contents and distribution deadlines

The SPD is the most comprehensive plan disclosure required by ERISA. Written in straightforward language for easy understanding by participants, this document sets out key benefits, conditions and operational details about an employer's health plan. New plans must distribute SPDs within 120 days of becoming subject to ERISA. Existing plans must give each new participant an SPD within 90 days and redistribute SPDs to all participants every 10 years – or every five years if the SPD has undergone updates.

While employers can add details to reflect a plan's unique features, all SPDs must cover certain information:

- Plan administration and funding
- Eligibility, benefits and claims procedures
- Participants' legal rights under ERISA and other laws

The table on page 2 summarizes required SPD contents. (Although SPDs must contain certain statements about participants' legal protections, employers also must provide separate notices of specific rights under various health laws. For more information, see [Update: Health & benefit plan notices for new hires](#), Sept. 26, 2007.)

Required SPD contents

Plan administration and funding

Details about plan administration to cover in the SPD include the following:

- Plan name and number
- Plan type, such as group health, disability or long-term care; and type of plan administration, such as contract or insurer administration
- Name, address and employer identification number (EIN) of the employer, employee organization or representative of parties establishing or maintaining plan
- Name, business address and telephone number of plan administrator
- Legal process information
- Name, title and address of principal place of business for each plan trustee
- Information on plan's collective bargaining arrangements, if applicable
- Sources of contributions and method of calculating contribution amounts
- Funding medium, if any, used to accumulate assets for providing benefits
- Insurer's role in plan financing and administration
- Plan amendment/termination provisions
- Plan year, determined using last day of plan's fiscal year
- Offer of assistance for foreign-language speakers

Eligibility, benefits, claims and conditions

SPD information on available benefits and applicable conditions must cover these areas:

- Eligibility requirements and conditions to receive benefits, including procedures for handling qualified medical support orders
- Full description of benefits or, if detailed schedules of benefits available for no cost, a summary referring to those schedules
- Emergency-care conditions and limitations
- Preauthorization and utilization-review provisions, if required for coverage
- Covered preventive services
- Drug-coverage terms and conditions
- Terms and conditions for coverage of medical tests, devices and procedures
- Network-provider provisions and out-of-network coverage conditions, including list of network providers or reference to separate list
- Conditions and limits on choice of primary and specialist providers
- Provisions or circumstances that will or could cause loss or reduction of benefits, such as coordination-of-benefits or subrogation terms
- Benefits requiring a fee or charge as a precondition
- Cost-sharing provisions
- Claims procedures
- Annual/lifetime caps or other coverage limits

Statements of participants' legal rights and protections

All SPDs must inform participants about certain rights under ERISA and related health laws. Employers can use language supplied in ERISA regulations ([29 CFR 2520.102-3\(t\)\(1\)](#)) or develop their own statements describing the following:

- ERISA rights, protections and enforcement mechanisms for benefit plan participants
- COBRA rights to continue group health plan coverage after certain events that would cause loss of coverage
- Newborns' and Mothers' Health Protection Act rights to a minimum hospital stay of 48 hours after normal childbirth or 96 hours after a cesarean section

SMR and SMM content and triggers

When a health plan undergoes modification, participants must receive notice of any “material” changes to SPD information – that is, noteworthy changes altering benefit terms or conditions. Two different notices of material changes to a health plan are required:

- **SMR.** This notice informs participants of a plan change that reduces or eliminates covered services and benefits. Examples include increases in cost-sharing obligations, reduction in the HMO service area or PPO network providers, elimination of benefits, changes in schedules or formulas, or new restrictions on benefits. This notice must be furnished within 60 days after the plan adopts the change. Alternatively, employers that routinely communicate benefit changes every 90 days or sooner can simply include SMR information in a regularly scheduled communication.
- **SMM.** This notice informs participants of any change – not just one reducing or eliminating coverage – to the required SPD information. Regulations require furnishing this notice (or an updated SPD) within 210 days after the end of the plan year in which the change was adopted. But employers should aim to provide this disclosure as soon as practical after a decision to make any noteworthy SPD change; otherwise, courts may view the change as unenforceable against plan participants. An effective way to satisfy this requirement may be to include SMM information in open enrollment communications (see [Update: Open enrollment – a focus on compliance requirements](#), July 11, 2007).

SAR contents and deadline

The SAR is a simplified, narrative description of information filed on a group health plan’s annual Form 5500. The prescribed content appears in ERISA regulations ([29 CFR 2520.104b-10\(d\)\(4\)](#)), and most Form 5500 software programs will automatically generate this summary using Form 5500 data. Participants must receive SARs within nine months after the end of the plan year covered by the report or, if later, two months after the extended due date for filing the Form 5500.

Delivering disclosures

Employers can distribute ERISA-required communications by hand-delivery, first-class mail or, if certain conditions are met, electronically (see [Update: Using e-mail and the Internet to distribute plan materials](#), July 26, 2006).

Employers also can use second- or third-class mail, but they must guarantee return and forwarding postage, request an address correction, and, if a mailing is returned with an address correction, either resend using first-class mail or hand-deliver the materials to the participant at the work site.



For more information

For additional information, please contact your Mercer consultant.

*This **Update** is for information only and does not constitute legal advice; consult with legal and tax advisers before applying this information to your situation.*

Authors

Barbara McGeoch is a lawyer and principal in the Washington Resource Group, Mercer's national legal resource on benefit laws and regulations. With more than 20 years' experience, Barbara focuses on tax and ERISA aspects of health and group benefit arrangements, including HIPAA, COBRA, FMLA and state laws. She can be reached at barbara.mcgeoch@mercer.com.

Trish Farrell is a principal and attorney in Mercer's Princeton, NJ, office who specializes in health and benefits issues. Trish has more than 20 years of experience assisting clients with compliance issues affecting their employee benefit plans. Trish can be reached at patricia.farrell@mercer.com.

Editorial Board

Amy Bergner
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amy.bergner@mercer.com
susan.lemaster@mercer.com
mark.major@mercer.com
kathleen.murray@mercer.com
chad.nicholl@mercer.com
henry.saveth@mercer.com
wade.symons@mercer.com
jennifer.wiseman@mercer.com