WHY IS AN SPD NEEDED? WHAT INFORMATION MUST IT INCLUDE?

SimplifyCompliance Benefits Brief

The federal law known as ERISA requires employers to provide a summary plan description (SPD) to participants describing the terms of the group health plan in layperson's language. The SPD must be provided to newly eligible employees within 90 days of enrollment. In addition, the SPD must be restated and redistributed, generally every 5 years.

Why is an SPD needed?

There are several legal reasons employers should prepare and distribute an SPD. If an employer doesn't prepare and distribute an SPD, it is possible the U.S. Department of Labor (DOL) could order the employer to prepare and distribute an SPD and impose fines for its failure to do so. Further, the failure to do so may be grounds for the participant to ask a court to impose an up to $110 per day penalty against the employer until the SPD is provided. In addition, participants can ask a court not to apply certain plan provisions against the individual, for example, concerning eligibility or exclusions, if the participant is not furnished an SPD describing the provisions.

Form of SPD

An SPD can be prepared separately from the plan document for a group health plan or alternatively, a single document can serve as the plan document and SPD. Many times, a self-funded plan will maintain a combination document. If the group health plan is fully insured, the insurer will likely supply a certificate of coverage. Since the certificate may be missing some of the required information for an SPD, the employer may prepare a supplemental "wrap" document and consider the SPD to be comprised of the certificate and the wrap. It is permissible to satisfy the SPD obligation through multiple documents.

Content of SPD

The SPD for a group health plan must include the following information:

- The plan name.
- The name, address and taxpayer ID number of the employer/plan sponsor.
- The name, address and telephone number of the plan administrator (generally the employer/plan sponsor is the plan administrator).
- The 3 digit plan number used on the Form 5500 filing (typically begins with "5").
- The type of plan (group health plan) and type of administration (insurer or a TPA).
- The name or title of an individual to serve as the agent for service of legal process in the unlikely event the plan is sued.

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Summary Plan Description

The summary plan description is a document that employers are required to give to employees in retirement plans or health benefit plans covered by ERISA. The SPD is simply a summary of the plan document required to be written in such a way that the participants of the benefits plan can easily understand it.

- A description of the plan's QMCSO procedures or an offer to provide them separately and free of charge.
- The source of contributions to the plan (employer and/or employee) and the type of funding (insurance or self-funding).
- The plan year.
- The description of the claim and appeal procedures.
- A statement of the participant's rights under ERISA.
- A statement of the participant's rights under the Mothers' and Newborns' Health Protection Act.
- The eligibility and participation requirements for employees, spouses and dependents.
- A description of a participant's rights and obligations under COBRA.
- A summary of benefits.
- A description of any deductibles, coinsurance or copayment amounts.
- A description of any limits on benefits.
- Whether and under what circumstances preventive services are covered.
- Whether and under what circumstances prescription drugs are covered.
- Whether and under what circumstances coverage is provided for medical tests, devices and procedures.
- Provisions governing the use of network providers (if any). If there is a network, the SPD must contain a general description of the provider network and provide a current list of providers in the network or explain how to obtain the list.
- Whether and under what circumstances coverage is provided for any out-of-network services.
- Any conditions or limits on the selection of primary care physicians or providers of specific specialty medical care.
- Any conditions or limits applicable to obtaining emergency medical care.
- Any provisions requiring preauthorization or utilization as a condition to obtaining a benefit.
- A description of the 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 the employee might otherwise reasonably expect the Plan to provide.