

Summary Plan Description Checklist Welfare Benefit Plans (Single Employer)

- Name of the Plan
- Name by which the Plan is known by participants (if different)
- Employer/plan sponsor name and address
- Plan Sponsor EIN
- Plan year
- Type of Plan (e.g., group health plan, disability plan, etc.)
- Type of Administration (e.g., contract administration, insurer administration, etc.)
- Plan administrator name
- Plan administrator address
- Plan administrator telephone number
- Agent for service of process
- Address for service of process
- Statement that service of legal process may be made upon a plan trustee or plan administrator
- Trustee name and title
- Eligibility requirements and conditions for participation
- Eligibility requirements for benefits
- Description of any circumstances that may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, offset, reduction, or recovery of any benefits

- Summary of authority of plan sponsor or others to terminate or amend the plan or eliminate benefits under the plan and the circumstances under which this can happen
- Summary of the benefits, rights and obligations of participants and beneficiaries on termination or amendment of the plan or elimination of benefits (including summary of accrual and vesting of pension benefits, and a summary of provision governing allocation and disposition of plan assets upon termination)
- Summary of any provisions that may result in the imposition of a fee or charge on a participant or beneficiary, the payment of which is a condition to the receipt of benefits
- The sources of contributions to the plan—for example, employer, employee organization, employees—and the method by which the amount of contribution is calculated.
- The identity of any funding medium used for the accumulation of assets through which benefits are provided. Identify any 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.
- Explanation of applicable subrogation and reimbursement provisions.
- Claims procedures (can be provided in a separate document along with the SPD).
- ERISA rights statement.
- If applicable, a notice, in the non-English language common to foreign-language participants, offering them assistance.
- If the plan is maintained under a CBA, include statement that: (i) the plan is maintained under a CBA; and (ii) participants and beneficiaries may obtain and examine a copy of the CBA upon written request to the plan administrator.
- Description of Qualified Medical Child Support Order (QMCSO) procedures or statement that participants and beneficiaries can obtain, without charge, a copy of QSCSO procedures from the plan administrator.
- Statement regarding the plan administrator's discretionary authority to interpret the plan. (Recommended)
- Statement that SPD is a summary of, and not replacement for, the plan document, which ultimately governs the terms of the plan. (Recommended)

- Statement describing plan administrator's right to recover overpayments from the plan (Recommended)

Additional SPD Requirements for Group Health Plans

- Description of any cost-sharing provisions (including premiums, deductibles, coinsurance, copayments, etc.)
- Description of annual or lifetime caps or other limits on benefits
- Extent to which preventive services are covered
- Whether and under what circumstances existing and new drugs are covered
- Whether and under what circumstances coverage is provided for medical tests, devices and procedures
- Description of provisions governing the use of network providers
- Description of the composition of the provider network (can be a general description of the network and a statement that provider lists are furnished automatically, without charge, as a separate document).
- Whether and under what circumstances coverage is provided for out-of-network services
- Any conditions or limits on the selection of primary care providers or providers of specialty medical care
- Conditions or limits applicable to obtaining emergency medical care
- Description of provisions requiring preauthorization or utilization review as a condition to receiving benefits or services under the plan
- A description of the rights and obligations of participants and beneficiaries with respect to continuation coverage, under COBRA or otherwise, including, among other things, information concerning qualifying events and qualified beneficiaries, premiums, notice and election requirements and procedures, and duration of coverage.
- If a health insurance issuer is responsible, in whole or in part, for the financing or administration of a group health plan, 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).

- 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 (see SPD regulations for model language).
- A disclosure regarding reconstructive surgery benefits after a mastectomy under the Women's Health and Cancer Rights Act (WHCRA). (Recommended)
- Applicable health care reform disclosures, including notice of grandfathered plan status.
- Applicable Health Insurance Portability and Accountability Act of 1996 (HIPAA) disclosures.