McGraw Wentworth

BENEFIT Advisor

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In This Issue

In this first issue of the McGraw Wentworth Benefit Advisor for 2002, we will examine the Department of Labor's Summary Plan Description (SPD) requirements released in November 2000 and effective on the first day of the second plan year beginning on or after January 22, 2001. We will look at the general requirements as well as the specific regulations affecting health plans. We will look at some of the details required as well as those not required to be included in the SPD.

We welcome your comments and suggestions regarding this issue of our technical bulletin. For more information on this Benefit Advisor, please contact your Account Manager or visit the McGraw Wentworth web site at www.mcgrawwentworth.com.

"SPD Requirements"

On November 21, 2000 the Department of Labor (DOL) published final regulations on the information that must be included in Summary Plan Descriptions (SPD) for both pension and welfare benefit plans. The DOL holds that while some of the regulations are new, many simply clarify existing requirements.

The final regulations were effective January 20, 2001 and must be reflected in SPDs no later than the first day of the second plan year beginning on or after January 21, 2001. For example, if a plan is a calendar year plan, the changes must be reflected in the SPD by January 1, 2003.

The overall goal of the regulations is to require plan sponsors to provide plan participants and beneficiaries with more complete information about their pension and welfare benefit plans. As a result, plan sponsors will need to invest even more administrative effort into providing SPDs that comply with requirements.

We will review the key features of the regulations affecting welfare benefit plans in this technical bulletin.

Note: Part of these regulations affecting SPDs apply to:

- *All "welfare benefit plans." Section 3 (1) of ERISA defines an "employee welfare benefit plan" as any:*

  Plan, fund or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise:

  A. *Medical, surgical or hospital care or benefits; benefits in the event of sickness, accident, disability, death or unemployment; vacation benefits, apprenticeship or other training programs; day care centers, scholarship funds or prepaid legal services; or*

  B. *any benefit described in section 302(c) of the Labor Management Relations Act, 1947 [29 USC §186(c)] (other than pensions on retirement or death and insurance to provide such pensions).*

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As a result, when "welfare benefit plan" is referenced in this Benefit Advisor, it includes medical, dental, vision, disability, life, accidental death and dismemberment, travel accident, prepaid legal service plans, Health Care Reimbursement Account plans, and other such plans sponsored by employers for the benefit of employees.

- *Only "group health plans." Section 733 (a)(1) of ERISA defines a "group health plan" as an:*

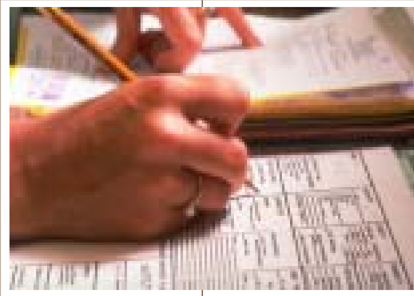
Employee welfare benefit plan to the extent that the plan provides medical care (as defined in paragraph (2) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement or otherwise.

(2) Medical care … means amounts paid for:

A. the diagnosis, cure, mitigation, treatment or prevention of disease or amounts paid for the purpose of affecting any structure or function of the body,

B. amounts paid for transportation primarily for and essential to medical care referred to in subparagraph (A), and

C. amounts paid for insurance covering medical care referred to in subparagraphs (A) and (B).



As a result, when "group health plan" is referenced in this Benefit Advisor, it applies to medical, vision and dental plans and Health Care Reimbursement Account plans. (Vision is considered a "group health plan" because eyes perform a "function" of the body and dental is considered a "group health plan" as teeth are considered part of the body's "structure.")

For Welfare Benefit Plans

Regulations require the following information to be included in the SPD:

- *Information regarding the type of benefit being provided. For example, a welfare plan that provides medical benefits, dental or vision benefits, disability coverage, life coverage, prepaid legal service benefits, etc.*
- *Termination information:*

  A. Authority of the plan sponsor to eliminate or terminate benefits under the plan and the circumstances under which the plan may be terminated and benefits may be amended or eliminated.

  B. Summary of plan provisions regarding the benefits, rights and obligations of participants and beneficiaries under the plan upon termination of the plan or upon amendment or elimination of benefits under the plan.

  C. Summary of plan provisions regarding the allocation and disposition of assets of the plan upon termination of the plan.

- *Qualified Medical Child Support Orders (QMCSO): A description of the procedures to be followed for processing a Qualified Medical Child Support Order (QMCSO) determination or a statement that a participant or beneficiary can obtain a copy of the procedures from the plan administrator free of charge.*
- *An updated model statement that addresses, among other things, a participant's right to examine all documents governing the plan, including the most recent annual report (Form 5500), collective bargaining agreements, etc.*

For Group Health Plans

Regulations require the following information to be included in the SPD:

- *The extent to which preventive services are covered.*
- *Annual or lifetime caps or any other additional limits on benefits.*
- *Limits or conditions on obtaining emergency medical care.*
- *The coverage mandated by the Newborns' and Mothers' Health Protection Act, as well as any state law requirements that apply in each area covered by the plan.*
- *The extent of cost sharing requirements (premiums, copayments, coinsurance and deductibles) for which participants or beneficiaries will be responsible for. (Specific premium and plan contribution amounts do not have to be listed.)*

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- *Whether, and under what circumstances, coverage is provided for new and existing drugs, medical tests, devices and procedures.*

  Note: The DOL states that it does not intend this to be interpreted as requiring an SPD to list all drugs, tests, devices, etc. covered by the plan. Rather, it should note the rules the plan follows to determine whether an expense is covered (i.e., this plan covers "federal legend" drugs) and then explain how a participant may obtain additional information about a specific drug, test, device, etc. free-of-charge.

- *If provider networks are utilized:*

  A. *Provisions governing the use of network providers, conditions or limits on the selection of primary care providers, specialty care providers, etc.*

  B. *The SPD should explain the "composition" of the network. For example, an explanation that the plan uses ABC network for medical care, XYZ network for mental health and substance abuse care and PDQ network for prescription drug coverage.*

  C. *A list of providers in the network. As an alternative, the plan sponsor may provide a list of providers in a separate document that accompanies the SPD, provided the SPD contains a statement that provider lists are furnished automatically, without charge, as a separate document.*

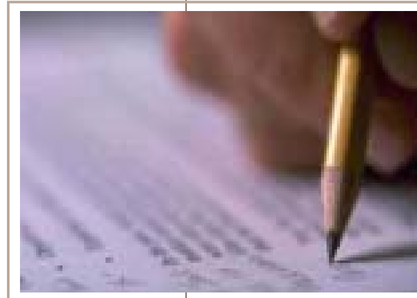
- *The procedures that govern claims for benefits, including applicable time limits and remedies available under the plan for the redress of claims denied in whole or in part. Further, procedures must also be included for:*

  A. *Obtaining preauthorizations, approvals, etc.*

  B. *Filing claim forms.*

  C. *Providing notifications of benefit determinations and reviewing denied claims.*

  As an alternative to including this information in the SPD, a plan sponsor may provide this information as a separate document that accompanies the SPD, provided the SPD contains a statement that the plan's claims procedures are furnished automatically, without charge, as a separate document.



- *COBRA:*

  A. *Fundamental information regarding COBRA, including the identification of qualifying events, defining who may be a "qualified beneficiary", how the cost of the coverage is established, a review of notice and election requirements and procedures and the duration of the coverage.*

  B. *In addition to this detailed information, the regulations provide an updated model statement of ERISA rights; it includes a summary of COBRA continuation coverage.*

  Note: The DOL has taken the position that a plan sponsor may satisfy COBRA's initial notice requirements by furnishing to a covered employee and spouse, at the time coverage commences, an SPD that includes the new and expanded COBRA information. A plan sponsor who wishes to deliver the initial notice via the SPD will be required to satisfy COBRA's mailing requirements; i.e., the SPD must be mailed to the employee's and spouse's home in an envelope addressed to both the employee and spouse.

- *Information that clearly informs participants of the role of a health insurance carrier in the group insurance plan and whether and to what extent benefits under the plan are guaranteed under a contract or a explanation that the plan is self-funded and that a third-party is serving as the claim administrator or payer, rather than as an insurer.*

Further, regarding group health plans:

- *Benefits offered through federally qualified HMOs will no longer be exempt from SPD requirements. Previously, health plan administrators were permitted to distribute the materials prepared by federally qualified HMOs instead of detailed SPDs.*

- *Notifying participants of modifications or changes to the group health plan:*

  Regulations require health plan administrators to provide notice to each participant covered under the plan of any plan modification or change in the information required to be

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included in the SPD, if the modification or change is a "material modification" in covered services or benefits. This notice is also known as a Summary of Material Modification (SMM) and must be provided no later than 210 days after the close of the Plan Year in which the modification or change was adopted.

A special rule applies if the modification is a "material reduction" in covered services or benefits.

A. *"Material": A reduction is "material" if the average plan participant would consider it an important reduction.*
B. *"Reduction" - A "reduction" in covered services or benefits is any change that eliminates or reduces a covered service or benefit; increases the cost of the covered service or benefit (for example, by increasing copayments, deductibles, annual out of pocket limits, etc.); reduces the service area in which the benefit or covered service can be obtained; or establishes new conditions to qualify for the benefit or service.*

If a modification is considered a "material reduction," notice of a material reduction (or SMM) must be provided no later than 60 days after the date of the adoption of the modification or change. The 60-day notification rule may be extended to 90 days if plan participants reasonably expect to be notified of plan modifications or changes via a system of communication already maintained by the plan administrator and the communications occur on a regular basis with a frequency that is no longer than every 90 days. For example, if a plan administrator publishes an employee newsletter that participants rely on for information about their health plans and the newsletter is published at least every 90 days, then the SMM may be published in the newsletter to satisfy the rule.

Note: The 210 days for distributing an SMM for material modifications begins on the first day of the Plan Year following the Plan Year in which the modification or change was adopted, not the Plan Year following the one in which the change became effective. Similarly, the 60-day and 90-day periods for an SMM for material reductions begin with the date the modification or change is adopted. A change is "adopted" on the date the employer approves or decides in some "official" manner to implement the change - not the date the modification or change is effective. The regulations give an example of a change to a calendar year plan that was adopted on June 1, 1978, which by its terms became effective January 1, 1979. If the change were simply a material modification, the SMM would have to be distributed by July 29, 1979. If, however, the change was a material reduction, then the SMM would have to be distributed by July 31, 1978, even if the reduction were not to be effective until January 1, 1979.

In Closing

It is important for employers to remember that compliance with ERISA is their responsibility - not the responsibility of insurers and third party administrators. Employers therefore need to be sure that the SPDs they distribute comply with ERISA regulations, and that the timelines for notifying plan participants of modifications or changes are met.

As noted in the introduction, we have reviewed the key features of the new SPD regulations in this Benefit Advisor. To review the complete DOL regulations, visit the website of the **National Archives and Records Administration, Office of the Federal Register**, at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=2000_register&docid=f:21nor7.pdf.

Your McGraw Wentworth account team is ready to assist you in developing Summary Plan Descriptions that wil comply with these new regulations.

Our technical bulletins are written and produced by the McGraw Wentworth staff and are intended to inform our clients and friends on general information relating to employee benefit plans. They are not intended to provide either legal or tax advice. Consult your legal counsel or tax advisor in matters that directly affect your benefit plans.

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