

## 29 CFR 2520.102-3 (also includes other regulatory requirements) Contents of Summary Plan Description Checklist.

This material is for the sole purpose of providing general information and does not under any circumstances, constitute legal advice. You should not act on these materials without first obtaining the advice of counsel.

Section 102 of ERISA specifies information that must be included in the summary plan description. The summary plan description must accurately reflect the contents of the plans as of the date not earlier than 120 days prior to the date the summary plan description is disclosed. The following information must be included in the summary plan description of both employee welfare benefit plans and employee pension benefit plans, except as stated otherwise in paragraphs (j) through (n):

<input type="checkbox"/>	a. The name of the plan, and, if different, the name by which the plan is commonly known by its participants and beneficiaries;	Page _____
<input type="checkbox"/>	b. The name and address of-- (1) In the case of a <b>single employer plan</b> , the employer whose employees are covered by the plan, (2) In the case of a plan maintained by an <b>employee organization</b> for its members, the employee organization that maintains the plan, (3) In the case of a <b>collectively-bargained plan</b> established or maintained by one or more employers and one or more employee organizations, 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 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, as required by Secs. 2520.104b-1 and 2520.104b-30; 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 <b>plan established or maintained by two or more employers</b> , 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, as required by Secs. 2520.104b-1 and 2520.104b-30, 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	Page _____
<input type="checkbox"/>	(c) The employer identification number (EIN) assigned by the Internal Revenue Service to the plan sponsor and the plan number assigned by the plan sponsor.	Page _____
<input type="checkbox"/>	(d) The type of pension or welfare plan, i.e., for pension plans -- defined benefit, defined contribution, 401(k), cash balance, money purchase, profit sharing, ERISA section 404(c) plan, etc., and for welfare plans--group health plans, disability, pre-paid legal services, etc.	Page _____
<input type="checkbox"/>	(e) The type of administration of the plan, e.g., contract administration, insurer administration, etc.	Page _____
<input type="checkbox"/>	(f) The name, business address and business telephone number of the plan administrator as that term is defined in section 3 (16) of the Act;	Page _____

<input type="checkbox"/>	(g) 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, and in addition, a statement that service of legal process may be made upon a plan trustee or the plan administrator;	Page ____
<input type="checkbox"/>	(h) The name, title and address of the principal place of business of each trustee of the plan;	Page ____
<input type="checkbox"/>	(i) If a plan is maintained pursuant to one or more <b>collective bargaining agreements</b> , 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, as required by Secs. 2520.104b-1 and 2520.104b-30. For the purpose of this paragraph, a plan is maintained pursuant to a collective bargaining agreement if such agreement controls any duties, rights or benefits under the plan, even though such agreement has been superseded in part for other purposes;	Page ____
<input type="checkbox"/>	(j) The plan's requirements respecting eligibility for participation and for benefits. The summary plan description shall describe the plan's provisions relating to eligibility to participate in the plan and the information identified in paragraphs (j)(1), (2) and (3) of this section, as appropriate.	Page ____
<input type="checkbox"/>	(1) For <b>employee pension benefit plans</b> , it shall also include a statement describing the plan's normal retirement age, as that term is defined in section 3(24) of the Act, and a statement describing any other conditions which must be met before a participant will be eligible to receive benefits. Such plan benefits shall be described or summarized. In addition, the summary plan description shall include a description of the procedures governing qualified domestic relations order (QDRO) determinations or a statement indicating that participants and beneficiaries can obtain, without charge, a copy of such procedures from the plan administrator.	Page ____
<input type="checkbox"/>	(2) For <b>employee welfare benefit plans</b> , it shall also include a statement of the conditions pertaining to eligibility to receive benefits, and a description or summary of the benefits. 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. In addition, the summary plan description shall include 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.	Page ____
<input type="checkbox"/>	(3) For <b>employee welfare benefit plans that are group health plans</b> , as defined in section 733(a)(1) of the Act, the summary plan description shall include a description of any	Page ____
	• cost-sharing provisions, including premiums, deductibles, coinsurance, and copayment amounts for which the participant or beneficiary will be responsible;	Page ____
	• any annual or lifetime caps or other limits on benefits under the plan;	Page ____
	• the extent to which preventive services are covered under the plan;	Page ____
	• whether, and under what circumstances, existing and new drugs are covered under the plan;	Page ____
	• whether, and under what circumstances, coverage is provided for medical tests, devices and procedures; provisions governing the use of network providers, the composition of the provider network, and	Page ____
	• whether, and under what circumstances, coverage is provided for out-of-network services;	Page ____
	• any conditions or limits on the selection of primary care providers or providers of specialty medical care;	Page ____
	• any conditions or limits applicable to obtaining emergency medical care; and	Page ____
	• any provisions requiring pre-authorizations or utilization review as a	Page ____

	condition to obtaining a benefit or service under the plan.	
	In the case of <b>plans with provider networks</b> , the listing of providers may be furnished as a separate document that accompanies the plan's SPD, provided that the summary plan description contains a general description of the provider network and provided further that the SPD contains a statement that provider lists are furnished automatically, without charge, as a separate document.	
<input type="checkbox"/>	(k) In the case of an <b>employee pension benefit plan</b> , a statement describing any joint and survivor benefits provided under the plan, including any requirement that an election be made as a condition to select or reject the joint and survivor annuity;	Page ____
<input type="checkbox"/>	(l) For both <b>pension and welfare benefit plans</b> , 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 on the basis of the description of benefits required by paragraphs (j) and (k) of this section.	Page ____
<input type="checkbox"/>	In addition to other required information, plans must include 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; 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, including, in the case of an employee pension benefit plan, a summary of any provisions relating to the accrual and the vesting of pension benefits under the plan upon termination; and a summary of any plan provisions governing the allocation and disposition of assets of the plan upon termination.	Page ____
<input type="checkbox"/>	Plans also shall include 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 foregoing summaries shall be disclosed in accordance with the requirements under 29 CFR 2520.102-2(b).	Page ____
<input type="checkbox"/>	(m) For an <b>employee pension benefit plan</b> the following information:	Page ____
<input type="checkbox"/>	(1) If the benefits of the plan are not insured under title IV of the Act, a statement of this fact, and reason for the lack of insurance; and	
<input type="checkbox"/>	(2) If the benefits of the plan are insured under title IV of the Act, a statement of this fact, a summary of the pension benefit guaranty provisions of title IV, and a statement indicating that further information on the provisions of title IV can be obtained from the plan administrator or the Pension Benefit Guaranty Corporation. The address of the PBGC shall be provided.	Page ____
<input type="checkbox"/>	(3) A summary plan description for a <b>single-employer plan</b> will be deemed to comply with paragraph (m)(2) of this section if it includes the following statement:  Your pension benefits under this plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. If the plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.  The PBGC guarantee generally covers: (1) Normal and early retirement benefits; (2) disability benefits if you become disabled before the plan terminates; and (3) certain benefits for your survivors.  The PBGC guarantee generally does not cover: (1) Benefits greater than the maximum guaranteed amount set by law for the year in which the plan terminates; (2) some or all of benefit increases and new benefits based on plan provisions that have been in place for fewer than 5 years at the time the plan terminates; (3) benefits that are not vested because you have not worked long	Page ____ Page ____

<input type="checkbox"/>	<p>enough for the company; (4) benefits for which you have not met all of the requirements at the time the plan terminates; (5) certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the plan's normal retirement age; and (6) non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.</p> <p>Even if certain of your benefits are not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money your plan has and on how much the PBGC collects from employers.</p> <p>For more information about the PBGC and the benefits it guarantees, ask your plan administrator or contact the PBGC's Technical Assistance Division, 1200 K Street N.W., Suite 930, Washington, D.C. 20005-4026 or call 202-326-4000 (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at 1-800-877-8339 and ask to be connected to 202-326-4000. Additional information about the PBGC's pension insurance program is available through the PBGC's website on the Internet at <a href="http://www.pbgc.gov">http://www.pbgc.gov</a>.</p> <p>(4) A summary plan description for a <b>multiemployer plan</b> will be deemed to comply with paragraph (m)(2) of this section if it includes the following statement:</p> <p>Your pension benefits under this multiemployer plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. A multiemployer plan is a collectively bargained pension arrangement involving two or more unrelated employers, usually in a common industry. Under the multiemployer plan program, the PBGC provides financial assistance through loans to plans that are insolvent. A multiemployer plan is considered insolvent if the plan is unable to pay benefits (at least equal to the PBGC's guaranteed benefit limit) when due.</p> <p>The maximum benefit that the PBGC guarantees is set by law. Under the multiemployer program, the PBGC guarantee equals a participant's years of service multiplied by (1) 100% of the first \$5 of the monthly benefit accrual rate and (2) 75% of the next \$15. The PBGC's maximum guarantee limit is \$16.25 per month times a participant's years of service. For example, the maximum annual guarantee for a retiree with 30 years of service would be \$5,850.</p> <p>The PBGC guarantee generally covers: (1) Normal and early retirement benefits; (2) disability benefits if you become disabled before the plan becomes insolvent; and (3) certain benefits for your survivors.</p> <p>The PBGC guarantee generally does not cover: (1) Benefits greater than the maximum guaranteed amount set by law; (2) benefit increases and new benefits based on plan provisions that have been in place for fewer than 5 years at the earlier of: (i) The date the plan terminates or (ii) the time the plan becomes insolvent; (3) benefits that are not vested because you have not worked long enough; (4) benefits for which you have not met all of the requirements at the time the plan becomes insolvent; and (5) non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.</p> <p>For more information about the PBGC and the benefits it guarantees, ask your plan administrator or contact the PBGC's Technical Assistance Division, 1200 K Street, N.W., Suite 930, Washington, D.C. 20005-4026 or call 202-326-4000 (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at 1-800-877-8339 and ask to be connected to 202-326-4000. Additional information about the PBGC's pension insurance program is available through the PBGC's website on the Internet at <a href="http://www.pbgc.gov">http://www.pbgc.gov</a>.</p>	<p>Page _____</p>
<input type="checkbox"/>	<p>(n) In the case of an <b>employee pension benefit plan</b>, a description and explanation of the plan provisions for determining years of service for eligibility to participate, vesting, and breaks in service, and years of participation for benefit accrual. The description shall state the service required to accrue full</p>	<p>Page _____</p>

	benefits and the manner in which accrual of benefits is prorated for employees failing to complete full service for a year.	
<input type="checkbox"/>	(o) In the case of a <b>group health plan</b> , within the meaning of section 607(1) of the Act, subject to the continuation coverage provisions of Part 6 of Title I of ERISA, 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.	Page _____
<input type="checkbox"/>	(p) The sources of contributions to the plan--for example, employer, employee organization, employees--and the method by which the amount of contribution is calculated. Defined benefit pension plans may state without further explanation that the contribution is actuarially determined.	Page _____
<input type="checkbox"/>	(q) The identity of any funding medium used for the accumulation of assets through which benefits are provided. The summary plan description shall 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.	Page _____
<input type="checkbox"/>	If a health insurance issuer, within the meaning of section 733(b)(2) of the Act, is responsible, in whole or in part, for the financing or administration of a group health plan, the summary plan description shall 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.	Page _____
<input type="checkbox"/>	(r) The date of the end of the year for purposes of maintaining the plan's fiscal records;	Page _____
<input type="checkbox"/>	(s) The procedures governing claims for benefits (including procedures for obtaining preauthorizations, 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 (including procedures required under section 503 of Title I of the Act). The plan's claims procedures may be furnished as a separate document that accompanies the plan's SPD, provided that the document satisfies the style and format requirements of 29 CFR 2520.102-2 and, provided further that the SPD contains a statement that the plan's claims procedures are furnished automatically, without charge, as a separate document.	Page _____
<input type="checkbox"/>	(t) (1) The statement of ERISA rights described in section 104(c) of the Act, containing the items of information applicable to the plan included in the model statement of paragraph (t)(2) of this section. Items which are not applicable to the plan are not required to be included. The statement may contain explanatory and descriptive provisions in addition to those prescribed in paragraph (t)(2) of this section. However, the style and format of the statement shall not have the effect of misleading, misinforming or failing to inform participants and beneficiaries of a plan. All such information shall be written in a manner calculated to be understood by the average plan participant, taking into account factors such as the level of comprehension and education of typical participants in the plan and the complexity of the items required under this subparagraph to be included in the statement. Inaccurate, incomprehensible or misleading explanatory material will fail to meet the requirements of this section. The statement of ERISA rights (the model statement or a statement prepared by the plan), must appear as one consolidated statement. If a plan finds it desirable to make additional mention of certain rights elsewhere in the summary plan description, it may do so. The summary plan description may state that the statement of ERISA rights is required by Federal law and regulation.  (2) A summary plan description will be deemed to comply with the requirements of paragraph (t)(1) of this section if it includes the following statement; items of information which are not applicable to a particular plan should be deleted:	Page _____



	<p>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:</p> <p><b>Receive Information About Your Plan and Benefits</b></p> <p>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 (ESBA).</p> <p>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.</p> <p>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.</p> <p>Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age * * *) and if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The plan must provide the statement free of charge.</p> <p><b>Continue Group Health Plan Coverage</b></p> <p>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.</p> <p>Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.</p> <p><b>Prudent Actions by Plan Fiduciaries</b></p> <p>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 (pension, welfare) benefit or exercising your rights under ERISA.</p> <p><b>Enforce Your Rights</b></p> <p>If your claim for a (pension, 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.</p>	
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	<p>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.</p> <p><b>Assistance with Your Questions</b></p> <p>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 Pension and Welfare Benefits 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 EBSA.</p>	
<input type="checkbox"/>	<p>(u) (1) For a <b>group health plan</b>, as defined in section 733(a)(1) of the Act, that provides 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.</p> <p>(2) In the case of a <b>group health plan</b> subject to section 711 of the Act, the summary plan description will be deemed to have complied with paragraph (u)(1) of this section relating to the required description of federal law requirements if it includes the following statement in the summary plan description:</p> <p>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).</p>	Page _____
	<b>Additional Disclosures</b>	
	<p><b>Wellness programs</b> - Upon offer of a wellness program that requires individuals to satisfy a standard related to a health factor. Language must be included in all materials that describe the wellness program. The following is Sample alternative sample language available in <a href="#">final regulations</a>.</p> <p>"Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think</p>	

	<p>you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at [insert contact information] and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.”</p>	
	<p><b>Other Disclosures</b>            There are a myriad of required notices and disclosures for health and welfare plans. (<a href="#">See our Health &amp; Welfare Plan Reporting and Disclosure Checklist</a>). Many employers include the various notices in their open enrollment material and certain disclosures are routinely included in SPDs (e.g., the WCHRA notice)</p>	