Sample ERISA Summary Plan Document **Revised: 2013/12/31**

Instructions: This sample group health plan is intended for adoption by self-employed individuals and organizations with only one person (or family) both owning the organization and serving as the sole employee(s).

Adopting a group health plan will allow the employees to comply with the ACA individual mandate without purchasing commercial insurance and avoid associated penalties.

Fill in the information in this sample plan and revise it as necessary for adoption by your organization.

ERISA Section 102 requires an employee benefit plan furnish participants with a summary plan description which is subject to regulations in 29 CFR 2520.102-3. This plan is meant to be used with the sample plan document.

The summary plan document must state the name of the plan, the name, address, and phone number of the plan sponsor (and administrator), the sponsor's EIN, that the plan is a group health plan, that the plan is self-administered, the person designated as legal service process agent, sources of funding, and end of the plan year used for recordkeeping purposes.

The summary plan document must also describe plan eligibility, benefits, claims procedures, how benefits may be lost, and certain legal rights under ERISA.

It is recommended funding be entirely from the general funds of the business. Otherwise, fiduciaries must be bonded and the funds must be held in trust according to strict rules.

It is not necessary that a plan cover spouses or children, however the mandate penalty may apply to an individual that does not have coverage for a spouse filing a joint return or a child that can be claimed as a dependent. Spouses filing separate returns may face higher taxes.

A plan has flexibility in which benefits are covered, however it may be simpler to avoid using unwanted benefits than to try and enumerate which benefits should be excluded.

ERISA requires that plans process enrollments required by qualified child support orders and that individuals that lose coverage be issued a certificate of creditable coverage. It is simpler to allow all employees to enroll right away than to manage enrollment periods.

With respect to claims procedures, it is advisable to provide that beneficiaries are reimbursed for claims rather than pay providers, as providers can require any transaction be made electronically according to HIPAA standards. There are stiff fines for incorrectly processing a HIPAA transaction. In practice, in may be simpler not to file claims at all. Large average claims may be subject to tax.

ERISA rules require that a plan have a procedure for review of denied claims by the fiduciary, but do not detail those procedures.

This document is a sample for reference only and does not constitute legal advice. The relevant laws, regulations and guidance should be reviewed prior to adopting a plan.

[Plan Name]
Summary Plan Description
Effective *[Effective Date]*

This Summary Plan Description provides information on *[plan name]* including rights and obligations under the plan. It describes plan eligibility, benefits, enrollment, claims procedures, funding, and administration. It also explains some of the legal rights of plan participants.

Contents

Administrative Information

Plan Sponsor

This plan is sponsored by, administered by, and covers employees of:
[Sponsor Name]
[Sponsor Address]

[Sponsor Phone]

Sponsor Employer Identification Number

The Employer Identification Number (EIN) of the plan sponsor is:
[EIN Number]

Plan Type

This plan is a group health plan. It generally covers medical and surgical care including: the diagnosis, cure, mitigation, treatment, and prevention of disease and illness; maintenance of the structure and function of the body; and related expenses.

Administration & Funding

The plan is administered by the plan sponsor. This means that *[Sponsor Name]* is responsible for processing enrollment and claims requests.

The benefits are paid for using the general funds of the business. There are no assets specifically reserved for use by the plan, and there are no employee contributions required.

The plan uses the calendar year for recordkeeping purposes. Each year ends December 31st.

Plan Legal Agent

The agent for legal service process is:
[Agent Name]
[Agent Address]

Legal service process may be made upon the plan administrator.

Plan Eligibility

General Eligibility

The plan is open to all employees of *[Sponsor Name]* from the start of employment. An employee may choose to enroll in the program at any time.

An employee enrolled in coverage may elect at any time for that coverage to extend to their spouse and/or children.

If the plan administrator receives a medical child support order, the administrator shall review the order to determine if the order qualifies any children to enroll in the plan. In particular, the administrator shall determine if the order pertains to any children of an eligible employee, if the plan offers the benefits required in the order, and that the order meets legal requirements. The administrator will notify the respective eligible employee and the children (or their representatives) of the receipt of the order and the determination as to whether or not the order qualifies any children to enroll in the program. If a child is eligible to enroll in the plan, the child's custodian may enroll the child in the program during the period to which the order applies.

Loss of Benefits

Benefits will be lost if the employment relationship is terminated. Former employees do not have the right to continue to participate in the plan, but may purchase coverage from an insurer offering coverage in the individual market.

Benefits may be reduced or eliminated if the plan is modified. *[Sponsor Name]* may modify or terminate the plan at any time. If the plan provisions described in this document are modified, a summary of material modifications explaining the changes will be provided.

Enrollees may voluntarily withdraw from the program at any time. With the exception of coverage provided pursuant to a qualified medical child support order, an employee may elect to terminate the coverage provided to their spouse or children. Spousal coverage automatically terminates if the spousal relationship ends.

Plan Benefits

The plan generally pays for medical, surgical, and hospital expenses of covered individuals. Medical expenses include amounts paid for care provided in the diagnosis, cure, mitigation, treatment, and prevention of disease and illness. Medical expenses also include expenses incurred for the purpose of affecting the structure and function of the body. The plan also covers expenses for to transportation to and from medical care.

The plan covers all preventive services, drugs (including new or experimental drugs), medical tests, devices, and procedures. It specifically covers ambulatory services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management, pediatric services, oral care, and vision care. This coverage applies to covered individuals under all circumstances.

There are no premiums, deductibles, coinsurance, copayments or cost-sharing amounts which the participant will be required to pay. There is no lifetime or annual maximum benefits. There is no preauthorization or medical review required to obtain a benefit under the plan.

The plan covers all providers of primary, specialty, or emergency care irrespective of any network affiliation.

Statement on Federal Law regarding Hospital Stay in Connection with Childbirth
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).

Enrollment Procedures
Persons eligible to enroll or modify their enrollment in the plan should submit a request to the administrator including 1) their name and date of birth, 2) the name and date of birth of any other individuals to which coverage is to be or has been extended, and 3) for each respective individual the action sought (enrollment, disenrollment, extension of coverage, or termination of coverage).

Participants should notify the plan when an individual is no longer covered under the plan, such as when a death, divorce, or annulment occurs. Participants should also notify the administrator whenever a covered individual changes their name.

Claims Procedures
Beneficiaries may submit a claim to the administrator for reimbursement of expenses paid to medical providers.

The plan does not require any preauthorization, approval, or medical review of covered expenses.

The plan will not pay any claims for expenses not actually paid by a beneficiary. The plan will not pay providers directly.

The claim should include 1) the identity of the covered individuals receiving care, 2) the amount of reimbursement sought, and 3) receipts clearly showing the amounts paid for covered expenses. Claims must be submitted not later than 30 days after the day the expense is incurred.

The administrator shall examine the claim to determine if the expenses were paid for the benefit of a covered individual. If the claim is denied, the beneficiary shall be notified of the reason for the denial and shall have the opportunity to appeal the decision to the fiduciary.

Statement of Rights under the Employee Retirement Income Security Act

As a participant in *[Plan Name]* 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:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions

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, 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.

Prudent Actions by Plan Fiduciaries

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 welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a 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.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents 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.

Assistance with Your Questions

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 Employee Benefits Security 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 Employee Benefits Security Administration.

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